Patients' experiences of triage in an emergency department: A phenomenographic study

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Highlights

- Triage should move away from the biomedical model to being person-centred.
- Allowing patients to voice their triage experiences would raise awareness of current practice and might influence change.
- The study highlights the disconnection between patients and triage nurses and the need for attention to patient needs.

Abstract

Background: Triage, predominantly done by nurses in the emergency department, is globally accepted as essential to prioritise the acuity of patient care. Patients with low acuity illness often express frustration and disgruntlement with the triage process and long waiting times. Consequently, some patients leave the emergency department unseen, which may negatively affect their health outcomes. In order to change practice efficiently, triage nurses should provide patients an opportunity to share their experiences.

Objective: This paper deals with exploring the understanding patients' emergency department triage experiences.

Design: A phenomenographic approach was used to explore and understand patients' triage-related experiences in an emergency department.

Methods and context: Semi-structured individual interviews were conducted with 10 purposively selected participants who were triaged as yellow or green in an emergency department in a public hospital in Botswana. Collaborative creative hermeneutic data analysis by 11 nurses working in the same context identified categories of description.

Results: Three categories of description emerged from patient experiences, namely triage environment, triage nurse and waiting times. Following data analysis, the nurses reflected that they were not aware of the consequences in the way triage was currently conducted. Consensus was reached that they should move away from focusing on a biomedical model towards person-centred triage, which then underpinned the outcome space for triage in the emergency department.

Conclusion: The reality in the emergency department is that patients' needs, wishes and expectations are neglected, leaving them dissatisfied and disgruntled. Moving towards person- centred triage may improve their overall experience of triage.

What is already known about this topic?

- Globally, triage is implemented in emergency departments to ensure priority identification and management of the sickest and most injured patients first.
- Patients complain about emergency department triage, particularly prolonged waiting times.
- Focusing on the biomedical model without patient involvement will result in fragmented, uncoordinated and unsustainable triage.

What this paper adds

- Triage should move away from the biomedical model to being person-centred.
- Allowing patients to voice their triage experiences would raise awareness of current practice and might influence change.
- The study highlights the disconnection between patients and triage nurses and the need for attention to patient needs.

Keywords

Emergency department; Person-centred; Phenomenography; Qualitative research; Triage

1. Introduction

Triage has been implemented in emergency departments around the world to address overcrowding, prolonged waiting times and patient disgruntlement (Di Somma et al., 2015; Singer et al., 2018; Tabriz, Trogdon, & Fried, 2019). Patients are triaged on arrival and sorted according to the urgency of their illness or injury - giving priority to the sickest and most severely injured patients to be managed first. Healthcare professionals view triage as the core for quality care in the emergency department, but patients experience it differently. Patients classified with low acuity illness remain dissatisfied with long waiting times while critically ill/injured patients are managed first (Lusa & Bukovšek, 2019). Furthermore the lack of communication during the prolonged waiting times leads to frustration and feeling neglected (Göransson & Rosen, 2010). Some patients then leave the emergency department unseen, which could negatively affect their health outcomes and increase dissatisfaction with the quality of care provided (Piccolo, 2013).

While acknowledging the benefits of triage and recognising the process as vital in identifying and assigning critically ill or injured patients for timely life-saving management, patients are not given an opportunity to voice their experiences and have their preferences incorporated in the triage process (Gordon, Brits, & Raubenheimer, 2015). Consequently, patients triaged with low acuity illness remain dissatisfied with the triage process (Mercer, Singh, & Kanzaria, 2019), which healthcare professionals should understand in order to improve the quality of the triage process. The purpose of

our study was to understand patients' experiences of triage in an emergency department.

2. Background

Triage comes from the French *trier*, meaning ‘separate out’, and originally referred to the action of sorting items according to quality. During the French Revolution, 1789–1799 and the Napoleonic wars, 1803–1815, it referred to prioritising and managing injured soldiers on the battlefields (Robertson-Steel, 2006). In the 1930s, triage referred to the military system of assessing the wounded on the battlefield and was later used at accident scenes, disaster management, and hospitals to ensure that critically ill and/or injured patients were managed first (ElGammal, 2014). Using triage in the emergency department started in the early 1960s when there was more demand for medical care and less medical emergency resources (Farrokhnia & Göransson, 2011) and is now accepted as the golden standard to promote safe practice and reliable and effective systems (Mistry et al., 2018).

Globally, different triage processes are used in emergency departments, such as the Australian Triage Score, Canadian Triage Assessment Scale, and Manchester Triage Scale (Aacharya, Gastmans, & Denier, 2011; Farrokhnia & Göransson, 2011), all of which are sub-divided into five groups indicating the urgency of care required by the patient. The Australian Triage Score has five categories, each of which is associated with a time-and-flow schedule, whereas the Canadian Triage Assessment Scale uses levels, associated times to assessment and treatment, and frequency of assessment (Lähdet, Suserud, Jonsson, & Lundberg, 2009). The Manchester Triage Scale uses a colour and level to indicate the urgency of patient management (Andrade-Silva et al., 2019). The South African Triage Score (SATS), developed specifically for the South African context is now widely used in in the hospital and pre-hospital environment in multiple countries such as in Ghana, Rwanda, Ethiopia and Botswana (Abdelwahab, Yang, & Teka, 2017; Mullan, Torrey, Chandra, Caruso, & Kestler, 2013; Rominski et al., 2014) as well as Asia (Dalwai, 2018). The SATS uses patients' parameters, such as blood pressure, pulse rate, respiration, pain severity, level of consciousness and extent of trauma injuries, are used to calculate the patient priority score, which are then colour coded as red (emergency), orange (very urgent), yellow (urgent), green (routine) and blue (deceased) (Meyer, Meyer, & Gaunt, 2018). Triage is usually done by experienced emergency nurses who can reliably identify patients with complex conditions requiring special procedures and/or investigations and may even initiate emergency management, thereby enhancing quality care (Mistry et al., 2018; Wolf, Delao, Perhats, Moon, & Zavotsky, 2018).

Triage ensures that the quality and level of care received in the emergency department match patients' illness acuity (Hinson et al., 2018), serving as a baseline for further initiation of patient assessment and management (ElGammal, 2014). Furthermore, triage promotes fair and effective distribution of department resources based on patients' clinical needs and triage score (Mistry et al., 2018). Triage also expedites the emergency department's flow and improves family and patient satisfaction as critically ill/injured patients are seen first (Oliveira et al., 2018). Patient care improves thereby decreasing patient morbidity and mortality (Mistry et al., 2018).

Triage also has disadvantages. It redistributes the workload in the emergency department simultaneously disadvantaging patients with low acuity illness who have to wait when critically ill/injured patients are assessed and managed first, which causes dissatisfaction with service delivery (Aacharya et al., 2011). Lossius, Rehn, Tjosevik, and Eken (2012) found that triage nurses prioritised patients based on a tentative diagnosis hence there was a high possibility of over- or under-triaging patients. Moreover, triage nurses' inconsistent use of triage scores and lack of communication might cause overcrowding and patient dissatisfaction (Lossius et al., 2012). Through frustration over prolonged waiting times during triage, patients with non-urgent conditions could be denied emergency treatment by leaving without being managed, which might result in indirect harm (Aacharya et al., 2011).

Not all patients are satisfied with triage (Draper & Tetley, 2013). Patients' dissatisfaction with triage could reduce the image of both the emergency department and the hospital thereby possibly influencing families and others to avoid seeking healthcare at that specific hospital (Piccolo, 2013). Patients may leave the emergency department unseen and come back with complications needing more hospital resources and longer hospital stay (Lee Cho, Choi, Kim, & Park, 2016), which could lead to hospital loss of finance (Piccolo, 2013). Healthcare professionals in the emergency department use triage to enhance patient satisfaction, but patients are sometimes dissatisfied, frustrated and disgruntled at triage, particularly over having to wait. Frequently, patients who most complain are ones with low acuity illness. Knowing and understanding these patients' experience of and dissatisfaction over triage is necessary in order to incorporate patients' preferences to improve the process (Shankar, Bhatia, & Schuur, 2014). To change practice efficiently, healthcare professionals should involve the patients and collaboratively be partners in planning solutions to concerns (Cox & Naylor, 2013; Boomer & McCormack, 2010).

2.1. Aim

This paper deals with exploring and understanding patients' experiences of triage in an emergency department.

2.2. Ethical considerations

The researchers was granted written permission to conduct the study by the Faculty of Health Sciences, University of Pretoria (60/2016), and the Botswana Ministry of Health. Permission was obtained to recruit the participants from the ethics committee of the hospital where the research was conducted. The decision to participate depended on the patients and nurses. Patients were informed about the study, that participation was voluntary and that they could withdraw from the study at any time. The patients were also guaranteed that whether or not they wished to participate would not have any negative effect on future management in the hospital. All participants signed informed consent prior to data collection and data analysis.

3. Methodology

3.1. Context

The study was conducted in a 540-bed hospital in Botswana, where approximately 1900 patients are managed in the emergency department monthly. The majority of patients (approximately 80%) are triaged as yellow (urgent) and green (routine). Complaints regarding triage received at the emergency department are predominantly from this group of patients.

3.2. Design

People can only experience the world the way they know it (Marton, 1981). In this study we used phenomenography, which focused on discovering the qualitatively varying ways in which patients in an emergency department experience, conceive, perceive, and understand different features of being triaged (Assarroudi & Heydari, 2016; Marton, 1986). Phenomenography is a Greek word portraying two meanings, *phainomenon* (appearance) and *graphein* (description), hence phenomenography describes appearances focusing on second-order perspective (Khan, Bibi, & Hasan, 2016; Marton & Booth, 1997). An important theoretical underpinning of phenomenography is its unique second-order perspective. The second-order perspective describes the phenomenon based on the experiences and descriptions of the participants (Richardson, 1999), whereas the first order perspective focuses on explicating the general and invariant essence of a phenomenon through people (Richardson, 1999). From a first-order perspective, human experience is but the medium for collecting data and variation in human experience (Åkerlind, 2018). Second-order perspective research helps to understand the different ways people experience, interpret, understand and conceptualise a phenomenon; such as how patients experienced triage in the emergency department. Through the phenomenographic approach the researchers, in collaboration with the nurses working in the emergency department, described and interpreted the patients' experiences while bracketing our own experiences and interpretations (Marton & Booth, 1997).

3.3. Population

The target population included all the patients triaged as yellow or green and nurses working in a selected emergency department in Botswana.

3.4. Sampling

Sampling was done for two groups. Patients were purposively sampled. The first researcher approached the patients who met inclusion criteria once discharged from the ED. The researcher selected male and female participants, aged 18 years or older, from different educational backgrounds, with a Glasgow coma scale of 15/15, able to speak English, and who had been triaged as yellow or green. The rationale for selecting these participants was that the majority of complaints received in the emergency department came from patients triaged as yellow and green. A sampling principle in phenomenographic studies is to select participants from varying backgrounds and characteristics to gain different experiences (Sin, 2010: 312; Marton & Booth, 1997).

The participants were selected from the morning, evening and night shift, weekdays and weekends to have a fair representation of participants in order to obtain rich information without bias. Moreover, the data was collected at different times to capture varying experiences of participants on triage. Table 1 presents the participants' demographic information.

Table 1. Summary of participants' demographic information (data collection).

Participant	Gender	Age	Educational level	Triage colour	Approximate time triaged	Day/night of the week
Patient 1	Female	22	Diploma	Yellow	10:00	Tuesday
Patient 2	Male	53	Bachelor's degree	Green	20:00	Wednesday
Patient 3	Male	29	Tertiary	Yellow	23:50	Saturday
Patient 4	Female	24	Diploma	Green	11:00	Thursday
Patient 5	Male	23	Diploma	Green	01:00	Saturday
Patient 6	Female	28	Secondary	Green	15:00	Friday
Patient 7	Male	29	Secondary	Green	22:00	Friday
Patient 8	Male	45	Secondary education	Yellow	15:00	Monday
Patient 9	Female	48	Diploma	Yellow	08:00	Sunday
Patient 10	Male	50	Bachelor's degree	Green	13:00	Wednesday

Ten participants, five male and five female, aged between 22 and 53 years and with different educational backgrounds, volunteered to participate during data collection.

Secondly, total sampling, a type of purposive sampling (Etikan, Musa, & Alkassim, 2016) was used to select participants for data analysis. Total sampling provided all the full-time nurses involved in triage in the emergency department an opportunity to volunteer for the data analysis process. The researchers anticipated that collaborating with the nurses during data analysis would raise awareness of patients' experiences of current triage processes.

3.5. Data collection

Data was collected over a period of three months by means of face-to-face semi-structured interviews. Through giving patients the opportunity to voice their experiences during triage in the emergency department direct, rich and detailed data was obtained which gave the researchers and the nurses insight into how patients experienced triage (Gerrish & Lacey, 2010: 348). The first researcher conducted the interviews. Participants were asked one open-ended question: *Can you tell me about your experiences from when you were first checked by the nurse up to the time that you were seen by the doctor*?

Two pilot interviews were conducted to assess the clarity of the question and determine the time required for rapport and the interview. No amendments were made to the question. The pilot interviews were not used as part of the study. Interviews were then conducted and audio-recorded with 10 patients following their discharge, and transcribed verbatim (see Table 1). The interviews lasted 20 to 25 min and were conducted in a quiet room in the emergency department that ensured participants'

confidentiality, privacy and freedom to communicate their experiences (Gerrish & Lacey, 2010). The researcher made field notes following each interview.

3.6. Data analysis

The three researchers transcribed the interviews verbatim. All the nurses (29) were invited, of whom 11 participated voluntarily in data analysis (see Table 2 for demographic profile).

Table 2. Summary of participant nurses' demographic profile (data analysis).

Nurses	Gender		Age	Year of experience
	Male	Female		
1		√	52	3 years
2		√	46	5 years
3	√		34	9 years
4	√		34	9 years
5		√	44	3 years
6		√	26	3 years
7		√	28	8 months
8		√	34	10 years
9		√	33	1 year and 6 months
10		√	29	5 months
11		√	26	9 months

Data was analysed in an informal setting outside, which was not known to the participants. Boomer and McCormack's (2010) creative hermeneutic data analysis, a form of collaborative thematic data analysis was used. Collaborative data analysis was deemed appropriate because the nurses could read through the transcripts and analyse the data collected from the patients. Using collaborative data analysis could also raise awareness of patients' experiences and change nurses' current practice of triage (Flicker, 2014). The second researcher, who has experience in collaborative data analysis processes, facilitated the workshop during which the data was analysed.

The creative hermeneutic data analysis consisted of five steps: 1) The participants were paired and asked to read through the transcribed data and individually create a visual image, which captured the main ideas from the transcribed data. 2) The visual image was shared amongst the co-participants (paired partners concentrating on the captured picture representations). The paired partners captured the core ideas on a piece of paper while listening attentively. The step created an opportunity for 'buy in' to change practice and to raise awareness of patients' experiences of triage in the emergency department. 3) Using the written main ideas (categories of description) and the creative image as the centrepiece, the participants identified as many categories of description as possible, each on a separate piece of paper. 4) The pairs were placed together to form small groups of three to four people to discuss and reach consensus on shared categories. 5) Each group then shared their categories of description with the others in order to reach consensus on the set of categories of descriptions adopted by all the participants.

3.7. Trustworthiness

Trustworthiness was established using the four criteria *credibility*, *dependability*, *confirmability*, *and transferability* (Creswell, 2013). Credibility was enhanced by purposive sampling and using an open-ended question to avoid participants' misunderstanding (Marton & Booth, 1997). The first researcher conducted the interviews. The interview technique and question was discussed within the team of researchers prior to the pilot interviews and following each interview. The participants were encouraged to speak freely and give examples of their experiences during triage in the emergency department. No new understandings emerged following the last three interviews. In phemenography, researchers' prior experience is an important part of data analysis. The three researchers and all the nurses involved in the data analysis had had experience as a triage nurse. Throughout the data analysis, we and the nurses discussed and reflected to avoid interpretation of personal experiences. We continuously reminded each other to maintain an open mind while analysing the data thereby minimising any preconceptions about triage (Kettunen & Tynjälä, 2018). To support the findings, quotations are provided that support the data. The researchers described our research process in a logical and thorough way to achieve dependability.

3.8. Findings

Three categories of description emerged from the overall experiences of patients triaged with low acuity illness regarding the triage process, namely triage environment, nursing staff, and waiting times (see Table 3 for the description categories and sub-categories).

Table 3. Categories of description and sub-categories.

Category	Sub-category
Triage environment	Privacy Confidentiality Resources
Nursing staff	Sharing of information Attitude
Waiting times	Neglect Emotional distress Dissatisfaction

The categories of description and sub-categories were derived as follows.

1. Triage environment

The triage environment was situated in an open space along the emergency department's hallway and comprised two areas. One area was dedicated to triage and included two chairs, a desk and computer where the triage nurse documented the assessment findings and triage scores of each patient. Patients triaged with a low acuity illness were referred to the second area or waiting area. Patients remained seated on benches in the waiting area until called by healthcare professionals to be managed in the emergency department.

Participants expressed concerns about their privacy and confidentiality during the triage process. Patients were asked to provide information about their current health status in an open space which could be overheard by other patients in the waiting area. The participants felt that they '*had to provide private information about my current illness*' despite the discomfort it caused as they were '*worried*' about their health. Participants found it difficult to share vital information with the healthcare professionals in an area where their privacy and confidentially was affected:

- *It's an open area … everybody could hear what you were talking about. It is then difficult to state your problem because others* [*patients*] *are nearby. I sat next to the nurse facing the computer and I saw other patients' illnesses and the colours* [*triage*] *assigned to them* … (Participant 7)
- *You have to talk to the doctor with other patients around you*; *there are no curtains and we were just next to each other* … (Participant 1)
- *I think there is a need for a corner or an enclosed area where I can share my problem without others hearing* … (Participant 2)

Participants were concerned about the shortage of resources and disappointed with the emergency department triage:

- *I think there should be two doctors in a shift* … *so that there is an emergency doctor and the other one* [*doctor*] *makes the line move* [*triage*] … (Participant 8)
- *More staff* [*nurses and doctors*] *should be available to attend to patients because there are many people* [*patients*] *with many issues* [*sick*] … (Participant 7)
- *I had to ask the security guard what was going on as there were no nurses available at the waiting area to assist me* … (Participant 3)
- *There was just one doctor running around* … *this is not enough staff* [*doctors and nurses*] *to help us* [*patients*] … (Participant 5)

Some participants expressed concern over material resources in the triage area:

- *I found somebody* [*patient*] *lying on the floor*; *there was no chair available* … (Participant 2)
- *There are no curtains. I also saw patients sleeping on couches by the waiting area exposed without blankets. Aah, I was disappointed* … (Participant 5)

2. Nursing staff

The participants expressed concern about the lack of information sharing by the triage nurse during the triage process:

- *The only instructions I got from those people* [*triage nurses*] *was when they told me where to sit* … (Participant 7)
- *Nobody explained to me what was happening* … (Participant 10)
- *I did not understand what was going on* … (Participant 6)
- *I realise you* [*triage nurse*] *only have one weakness, you* [*triage nurses*] *don't communicate well with your customers* [*patients*] … (Participant 1)
- *Those ladies were* [*triage*] *nurses, they were just walking around and not explaining what was happening* … (Participant 1)

Participants raised concerns about the nurses' attitude towards patients in the triage area:

- *I greeted her* [*triage nurse*] … *I told her* [*triage nurse*] *that I was breathless, but she just kept on writing something* … (Participant 2)
- *I didn't feel good at first. I was thinking because the way the* [*triage*] *nurse responded to me, telling me I shouldn't have come here* … *I should have gone to the clinic. I was thinking the nurse was making me pay for coming here by making me wait long* … *for not going to the clinic* … (Participant 8)
- *I asked the lady* [*triage nurse*] *at the reception* [*triage area*] *why it was taking time for me to see the doctor, but she did not answer, was just keeping herself busy* … (Participant 10)
- *One* [*triage*] *nurse said there are people* [*patients*] *here in the emergency department who are hot* [*seriously ill*] *and you are cold* [*not seriously ill*]; *you will leave this place* [*emergency department*] *very late* … (Participant 8)
- *The* [*triage*] *nurse said such non-serious cases should not come this side* [*emergency department*], *that I* [*patient*] *should know better* … (Participant 6)
- *Like the* [*triage*] *nurse, after he took my vital signs he went, and the only time I could see him was when he passed by me, to go and chat with his friend, laughing* … (Participant 4)

3. Waiting times

The participants were dissatisfied with service delivery as they experienced prolonged waiting times during triage:

- *It took very, very long and then it was not even a doctor that attended to me* … (Participant 1)
- *I sat down after sitting for almost 30 min, that's why I* [*patient*] *even stood up and went to check why it was taking so long* … (Participant 10)

One participant felt '*emotionally distressed*' (and cried during the interview), stating that '*after two hours of being there with a broken arm, in pain and crying* … *no one* [*triage nurse*] *was helping me* … *I am so disappointed in them* … *oh, I was so upset* … *no one was paying attention to me because I was crying* … *I had to wait and wait and wait* …' (Participant 4).

Some participants experienced triage as poor:

- '*below standard and dissatisfying*' (Participant 4)
- *All I can say is their* [*triage nurses*] *service is very poor and very slow. I don't know how to put it, I will just say it is very, very poor*. (Participant 3)

3.9. The outcome space

The outcome space is "the complex of categories of description comprising distinct groupings of aspects of the phenomenon and the relationship between them" (Marton & Booth, 1997). The researchers created the image based on the participants' expressed experiences regarding current triage practices in the emergency department; the categories of descriptions identified by the nurses during data analysis, and the nurses'

suggestion that triage in the emergency department should move away from a biomedical model to being person-centred (see Fig. 1).

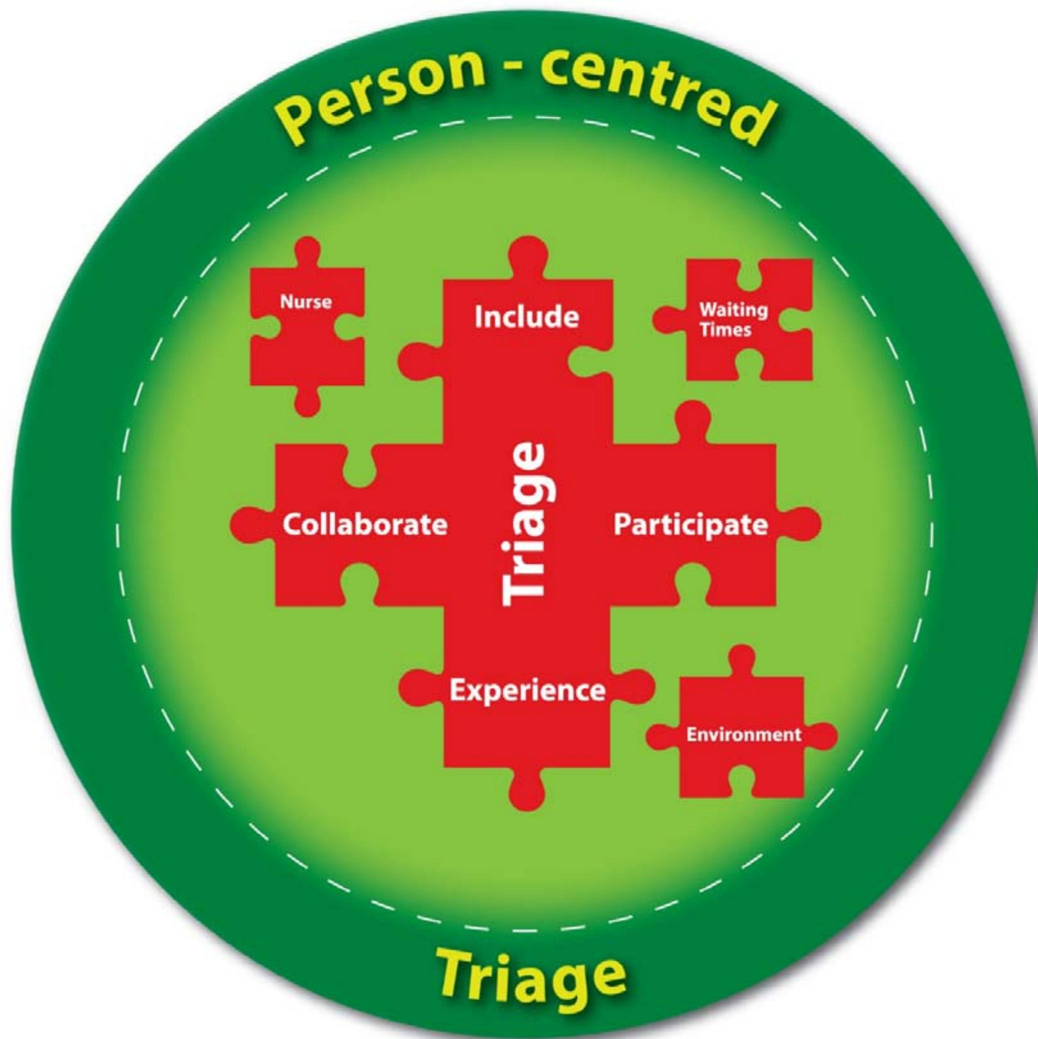

Fig. 1. Depiction of the outcome space.

In the centre of the image is a red cross. The red cross was chosen as it is associated with emergency departments and the management of ill and/or injured patients. The red cross has three loose-standing pieces, which represent the categories of description (and related sub-categories) that should be addressed and underpinned by the “collaboration, inclusion and participation (CIP)” principles (McCormack, Manley, & Titchen, 2013) in order to move towards person-centred triage: triage environment, triage nurse and waiting times.

4. Discussion

The purpose of this paper was to understand the experiences and concerns of patients triaged with low acuity illness regarding the triage process in the emergency department. Patient satisfaction is important for measuring the quality of the triage

process in emergency departments (Eshghi et al., 2016). Satisfied patients are more likely to adhere to doctors' orders, perceive the care rendered positively, complain less, be more loyal, return for further treatment and refer others for treatment consequently promoting higher institutional profits (Wu, 2011). Satisfied patients also share their healthcare experiences with positive word-of-mouth reference to the service rendered hence marketing the institution well (Kitapci, Akdogan, & Dortyol, 2014). However, the participants in this study were mainly dissatisfied with the triage process, which was consistent with findings in Sweden (Dahlen, Westin, & Adolfsson, 2012), the United States (Barish, McGauly, & Arnold, 2012) and South Africa (Piccolo, 2013).

The triage environment was of concern due to lack of privacy and confidentiality. In all triage processes privacy is viewed as an essential component that must be protected (Jenkins et al., 2011). Protection of personal privacy is vital in guarding individuals' interests, preventing harm and preserving their rights (Nass, Levit, & Gostin, 2009). Privacy is invaded if anyone gains access to another's private information. The right to privacy and protection of personal data are fundamental and essential for the protection of human dignity (European Data Protection Supervisor, 2015). Invasion of individuals' privacy could trigger adverse effects like patients withholding information. The protection of patient privacy might determine how effectively patients release their private information as patients' information should not be discussed in public where it could be overheard by irrelevant people (Avery, 2013). Withholding health information could have life-threatening consequences for patients as healthcare professionals may not have a complete picture of their health status and subsequently deprive them of optimal care in the emergency department. Patients experience discomfort when there is a breach of their confidentiality, which makes it difficult to give vital information. Accurate triage is essential for correct and timely treatment.

In the emergency department, confidentiality was affected because the patients being triaged could see other patients' information on the computer and the environment in which triage took place was not enclosed. This gave patients access to confidential information provided by others who were being triaged. Patients have a right to confidentiality (Florida Department of Health, 2014). Inadequate hospital structures in the triage environment facilitate a breach of patient confidentiality and jeopardize the patient-triage nurse relationship (Beltran-Aroca, Girela-Lopez, Collazo-Chao, Montero-Pérez-Barqueromn, & Muñoz-Villanueva, 2016). All the information patients give to healthcare professionals should be treated confidentially (Cipi, 2012).

Adequate resources are vital as the quantity of an organisation's resources equates its production (Avery, 2013: 3). Adequate material resources, such as screens at the triage area, should be available to facilitate privacy and confidentiality (Beltran-Aroca et al., 2016). However, patient satisfaction could be improved despite limited material resources if processes and systems use quality improvement approaches to improve emergency department operations such as triage (Ontario Hospital Association, 2010). If patients' surroundings are comfortable, their perception of quality of care can be doubled and reduced while they wait for their care (Nemschoff, 2015). Increasing material resources, like curtains and chairs, should therefore be considered, which might increase patient satisfaction.

A shortage of human resources, specifically the number of doctors and nurses in the emergency department, interferes with the expected standard of implementing triage assessment and treatment and negatively affects quality care and patient outcomes (National Health Services, 2016; Safari, 2012). Other factors associated with a shortage of nurses in the emergency department include patient falls; overcrowding of patients; medication errors; failure to identify a change in condition and rescue patients; staff burnout, and lower levels of patient care (Berry & Curry, 2012). Furthermore, a shortage of staff in the emergency department may cause under-triaging of patients, resulting in prolonged time of workup and length of stay in the emergency department, thereby increasing morbidity and mortality (O'Connor, Gatien, Weir, & Calder, 2014).

Nurses are the primary healthcare professionals involved in triage and therefore responsible for sharing information during the triage process. Effective information sharing on arrival at the emergency department is essential since patients who are informed may be more satisfied with care received (Silva, Paiva, Faria, Ohl, & Chavaglia, 2016). Dissatisfied patients are mostly ones who received limited information (Shah, Patel, Rumoro, Hohmann, & Fullam, 2015). If triage nurses do not explain the reason for waiting, patients become anxious, frustrated and angry and may not understand why other patients are prioritised nor why nurses at times appear to be idling but not assisting them (Burström, Starrin, Engström, & Thulesius, 2013). It is essential for nurses to not only share information, but also to display caring attitudes towards patients (Burström et al., 2013).

Waiting is a common cause of patient dissatisfaction in the emergency department. When many people seek care in the emergency department, the waiting period can be prolonged up to four to six hours, which delays diagnosis and treatment thereby compromising patient safety, risking deterioration of their medical condition, and causing anxiety and negative patient experiences in the emergency department (Burström et al., 2013). Prolonged waiting times are frustrating and can negatively affect the way patients experience care (Shah et al., 2015). If the actual waiting times and the psychological or subjective or perceived waiting time could be managed through appropriate sharing of information about the triage process, patient satisfaction might increase (Shah et al., 2015). Lack of sharing of information can leave patients emotionally stressed and feeling neglected or abandoned. Sharing information through communication improves public trust thereby improving patient satisfaction (Qureshi, 2010: 696). Even though the standard waiting time for patients triaged as low illness acuity ranges from one to four hours, patients in emergency departments experience waiting time differently from the actual time that they have to wait so healthcare professionals need to communicate effectively and show compassion to help them cope with waiting (Dahlen et al., 2012).

The main concern expressed by the nurses was the realisation that patients experience triage negatively. The patients did not comment on the competencies of the nurses, but rather expressed concerns about their 'soft skills' (e.g. attitude, communication, caring). The nurses became aware that they predominantly focused on the patient's medical status (biomedical care model) in order to identify the patient's priority and overlooked the person (McConnell, McCance, & Melby, 2016).

If nurses continue focusing on the biomedical model and not involving patients, it will result in triage being fragmented and uncoordinated (WHO, 2015). The biomedical model does not meet the needs of patients (Manley, McCormack, & Wilson, 2008) therefore there is a drive to move away from a disease-centred approach to a collaborative integrated person-centred care approach, which has been proven to have positive patient outcomes and improve patient satisfaction (World Health Organisation (WHO), 2015, World Health Organisation (WHO), 2016). The biomedical model is unsustainable, hence there is a global movement to collaborative integrated person-centred care (WHO, 2016).

Person-centredness describes a standard of care that places the person at the centre of care and emphasises the importance of valuing and respecting people. Implementing person-centred triage in the emergency department has the potential for improved access to emergency care, improved health and clinical outcomes, better health literacy and self-care, increased patient experiences and satisfaction with care, improved job satisfaction for nurses involved in triage, and improved efficiency of emergency care delivered (Santana et al., 2018; WHO, 2016). In order to move towards person-centred triage, nurses should continuously use the CIP principles and involve patients to develop a collective understanding of patients' triage experiences, regularly evaluate the triage process and plan, and implement strategies to address concerns raised.

4.1. Limitations

Although the number of participants was small, the nurses involved in the data analysis process were able to recognise the concerns raised by the patients based on their own experiences during triage. The study was conducted in an emergency department in Botswana therefore the findings may not represent the experiences of patients in other countries. Future research could include exploring the concept 'person-centred triage' as well as understanding of nurses and other healthcare professionals understanding of person-centred triage in the emergency department.

5. Conclusion

This paper presents the experiences of patients of triage in an emergency department. Evident from the findings is that nurses and patients view triage differently. Nurses focus on the patient's medical status, following a biomedical care model. Patients on the other hand focus on the triage environment which does not promote privacy and confidentiality. In addition, the patients experienced a lack of material and human resources in the environment, which affected the way triage was done. The patients stated that nurses did not share information and their attitudes negatively influenced their experiences of triage. The patients were dissatisfied with the prolonged waiting times and felt neglected and emotionally distressed due to lack of communication durieng the ptriage process.

A person-centred approach will place the patient at the centre of triage and nurses will see each patient as an individual person and not as a disease/injury, hence improving patient satisfaction with triage. Triage is and should remain a vital component in the management of patients in the emergency department. Triage ensures that patients are sorted and management prioritised by treating critically ill and injured patients with

life-threatening conditions first. However, nurses should move away from a biomedical towards a person-centred approach that puts the rights, preferences and expectations of patients being triaged in the emergency department first.

Relevance to clinical practice

Patients should be allowed to voice their experiences and concerns regarding the triage provided in the emergency department. Understanding patient experiences would raise nurses' awareness of their triage practice and its impact on patients. There is a need to move away from the biomedical model of care towards person-centred triage. Strategies to deliver person-centred triage should be planned with patients and implemented to improve the overall patient experience and satisfaction with triage.

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CRediT authorship contribution statement

Moitshepi Phiri: Methodology, Data curation, Writing - original draft, Writing - review & editing.**Tanya Heyns:**Methodology, Data curation, Writing - original draft, Writing - review & editing.**Isabel Coetzee:**Methodology, Data curation, Writing - original draft, Writing - review & editing.

Declaration of competing interest

The authors hereby declare that the content of this research is original. No conflict of interest has been declared by the contributing authors. The work has not been previously submitted for publication.

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