

Experience of being a low priority patient during waiting time at an emergency department

Ingrid Dahlen^{1,2}
Lars Westin¹
Annsophie Adolfsson¹

¹School of Life Sciences, University of Skövde, Skövde, Sweden; ²Emergency Department, Skaraborg Hospital, Skövde, Sweden

Background: Work in the emergency department is characterized by fast and efficient medical efforts to save lives, but can also involve a long waiting time for patients. Patients are given a priority rating upon their arrival in the clinic based on the seriousness of their problem, and nursing care for lower priority patients is given a lower prioritization. Regardless of their medical prioritization, all patients have a right to expect good nursing care while they are waiting. The purpose of this study was to illustrate the experience of the low prioritized patient during their waiting time in the emergency department.

Methods: A phenomenological hermeneutic research method was used to analyze an interview transcript. Data collection consisted of narrative interviews. The interviewees were 14 patients who had waited more than three hours for surgical, orthopedic, or other medical care.

Results: The findings resulted in four different themes, ie, being dependent on care, being exposed, being vulnerable, and being secure. Lower priority patients are not paid as much attention by nursing staff. Patients reported feeling powerless, insulted, and humiliated when their care was delayed without their understanding what was happening to them. Not understanding results in exposure that violates self-esteem.

Conclusion: The goal of the health care provider must be to minimize and prevent suffering, prevent feelings of vulnerability, and to create conditions for optimal patient well being.

Keywords: emergency department, patients, waiting times, nursing staff

Introduction

Many hospitals that provide different forms of care also have an emergency department (ED) which patients can attend without a prior appointment. This also means that some patients have to wait to receive care. The aim of this study was to gain further knowledge about the experience of waiting in an ED from the patient perspective. The most common reasons for patients seeking medical care at an ED are the need for acute emergency medical treatment, difficulty in making medical appointments at other places, the patient happening to live in proximity to the clinic, and having received advice to attend from relatives. Another possible reason for attendance is older age, and the elderly may also attend because of loneliness, which may leave them isolated and not knowing where else to turn to for treatment. Acutely ill patients find nursing care more satisfying than those with less urgent needs. Prioritization for treatment in the ED entails the more critically ill or injured receiving treatment first, so that patients with more acute needs are given more immediate care than those who are in less urgent need of medical attention.¹ According to Swedish medical authorities, care in emergency wards should be easily accessible, of good quality, based on respect for

Correspondence: Annsophie Adolfsson
School of Life Sciences, University
of Skövde, PO Box 408,
SE 541 28 Skövde, Sweden
Tel +465 0044 8473
Fax +465 0044 8499
Email annsophie.adolfsson@his.se

the patient's integrity, and addressing the patient's need for privacy and security.² The goal of health care is to relieve or prevent suffering and also to create conditions conducive to improving the welfare of the patient. The patient should be the focus of nursing care.²⁻⁵

Experiences of waiting time at emergency department

Waiting time in the ED is directly related to the patient's satisfaction concerning the health care that they have received.⁶ This waiting time can be divided into two distinct categories, ie, the waiting time as perceived by the patient and the actual waiting time. When patients are waiting in the ED they are experiencing this time on two different levels, ie, on a psychological level and on a physiological level.⁶ Unoccupied time is perceived as longer than occupied time, and in addition, physical discomfort, worry, and uncertainty make the waiting time feel longer than it actually is.⁷ Qualitative aspects of care in the ED, such as caring for patient's emotional needs and staff attitudes towards patients, are sometimes low priorities among ED personnel.^{1,6,8}

A patient's waiting time in the ED is determined by their triage assessment.⁹ Patients needing to wait for an assessment of their health status need to be treated with good communication skills and need to be provided with information that is timely and comprehensive.^{6,10} When a low priority is assigned to a patient's symptoms and concerns, that patient may feel ignored and that they are not being taken seriously.^{6,11} Nyström et al⁷ demonstrated that patients are offended by attitudes that communicate indifference or lack of sympathy, and this lack of caring contributes to their suffering. Negative encounters with health care professionals increases the patient's feeling of vulnerability and contributes to increased suffering.¹²

The longer patients have to wait in the waiting room, the more they feel they are not in control of their situation. Patients may feel that they are in a stressful and anxious environment surrounded by other patients in the same situation. When patients are admitted to an examination room, they may end up waiting for another extended period of time which further gives them cause to lose their sense of integrity or the feeling that they do not have control over their situation, and they may start to feel neglected.^{1,6,11,13,14} Byrne and Heyman demonstrated that patients felt dissatisfied with nursing that was poorly executed or not performed when it should have been.¹⁵ In this study, a lack of routine in nursing care reinforced the patient's negative image of their experience.

Long waiting times discourage patients and their attending relatives from leaving the immediate vicinity of the examination room because of concern that, if they were not there, it would be interpreted as a lack of interest or they might possibly miss some valuable information. Patients are very sensitive about not disturbing nurses with trivial requests, so they may decide not to request to use the bathroom or to communicate with their attending friends or relatives. They feel that they should not bother nurses with their basic needs when nurses appear to be under the pressure of a high work load and understaffed.¹³

According to Attree et al,¹⁰ patients request individualized care that is related to and based on their needs. Individualized care using a holistic approach means that each patient is treated as a whole person and respect should be shown for their individual rights, dignity, and need for privacy. Caring for patient's emotional needs in an ED situation is based on the nurse's ability to create caring relationships which target the patient's short-term needs and immediate distress about their situation.^{1,7,11}

Theoretical aspects of a nurturing care relationship

All occupations and professions within the health care system involve nurturing in human relationships.¹⁶ There are various descriptions of such relationships.^{17,18} According to Kasén,¹⁸ there is a difference between the concept of a nursing relationship and an actual nurturing care relationship, in that the former is the professional relationship that exists between the nurse and the patient, whereas the latter involves closer and more personal human dynamics between the caregiver and the patient.^{18,19}

A truly nurturing care relationship between nurse and patient is characterized by a professional commitment on the part of the nurse to rate the patient's well being as the highest priority without expecting anything in return, except perhaps the satisfaction that goes with carrying out this commitment.^{16,20} The professional relationship between caregiver and patient is characterized by reflections on what transpires in both relationships and in the act of caring. This is a unique relationship between the person who is receiving care and the person who is providing it. This is described as part of the daily duties of a health care nurse.¹⁷ When a nurturing care relationship between the nurse and patient exists, it facilitates the type of care that patients desire and need.^{17,21}

Previous research demonstrates that the emotional needs of patients and staff attitudes towards patients are

sometimes low priorities among ED personnel, despite communication between nurse and patient being important in the ED. Patients who have to wait for a long time often feel a lack of control. Commitment to the immediate needs of lower priority patients is not as great as that for higher priority patients. Higher medical priority status is associated with better immediate care. Once the most acute patients have been cared for, there is rarely enough time remaining for adequate disposition of lower priority patients. The purpose of this study was to determine the experience of lower priority patients waiting for treatment in the ED.

Materials and methods

This study used the hermeneutic phenomenological approach, which is a qualitative research method based on Paul Ricoeur's technique for analyzing text.²²⁻²⁵ The purpose of the hermeneutic phenomenological method is to be able to describe and understand the meaning of a phenomenon. Ricoeur maintains that there is a reciprocal relationship between phenomenology and hermeneutics. Phenomenology focuses on the content of a person's perceived experience, which can be accessed by an interview with the person who has had the experience. Hermeneutics entails interpreting the text of the interview in order to reveal the entire meaning of the person's experience.^{23,24}

According to Lindseth and Norberg,²³ actual phenomenological descriptions are insufficient for the purposes of research regarding a perceived experience. These descriptions must be interpreted hermeneutically to be useful and fully understood. A phenomenological hermeneutic interpretation

also means acquiring a better understanding of one's self and others in new but not unfamiliar ways.²³

Selection of interviewees

Patients are prioritized in the triage on a five-point scale. Since the aim of this study was to investigate the patient's experience of waiting in the ED for treatment, selection of interviewees for this study was made according to the two lowest priority groups in the ED who eventually wait for the longest period of time to receive treatment. Participants were selected from those who were assigned priority 4 (green) and priority 5 (blue), as seen in Figure 1, which illustrates waiting times for the assigned categories of prioritized triage status. Medical prioritization determines the time interval until the patient should meet with the doctor on duty. By determining the number of patients in each category of the triage queue, we can get a better understanding of the workload of an ED. To measure the effectiveness of the ward qualitatively, we can compare the recommended maximum waiting times for each patient with the actual waiting times.²⁶

Selection of participants for this study was done with the help of a professional information technology nurse. The inclusion criteria were age 18 years or older and a waiting time of more than three hours for medical care, orthopedic examination, or surgery. Exclusion criteria included pregnancy, age younger than 18 years, and having received previous treatment from health care personnel participating in the study. To recruit the participants, a total of 60 letters were sent out within the Skarborg area, a district in the Västra Götaland area. Of the 60 potential participants, 19 responded that they were willing to participate. Of this group, four could not be

Level	Nomenclature	Color	Waiting time in minutes
1	Immediate	Red	0 minutes, patients with life-threatening condition. In need of immediate attention.
2	Critical	Orange	10 minutes, patients that can develop into life-threatening situations if they are kept waiting or are having extreme pain. In need of attention in a relatively short period of time.
3	Urgent	Yellow	60 minutes, patients who have a medical condition but can wait some time before treatment without medical risk.
4	Standard	Green	120 minutes, patients who are able to wait while others with more critical needs go before them in priority. No medical risk in waiting.
5	Non-emergency	Blue	240 minutes, patients that have symptoms of illness but are not in immediate medical need of attention.

Figure 1 Nomenclature and waiting time for triage in the emergency department according to The Manchester Triage Group.

reached by telephone when appointments were being booked for the interview, and one person changed their mind about participating. Fourteen people signed the written consent form to participate, and this group comprised nine women and five men. The age of the participants was 36–85 (median 66.3) years. Reasons given for attending the ED included chest pain, abdominal pain, other pain complaints, and accidents. Distance travelled to the hospital was 7–80 (mean 31) km (Table 1).

Data collection

Data collection was performed during a six-week period in October to November 2007 using narrative interviews. One of the authors contacted each of the interviewees personally to arrange a time and place for their interview. The interviews took place in the interviewee's home, at their workplace, or in the actual ED that they had visited. The interviews were based on an interview guide (Figure 2).

The interview guide was not designed to be followed verbatim, but was used to provide a general structure for the interview. It was important that the interviewee felt free to explain fully their experience, in their own words, and it was important for the interviewer to feel free to ask questions for a more complete understanding of the patient's experience. A pilot interview was conducted to give the interviewer some experience in the interview technique and to help develop the interview guide.^{27,28} None of the interviews were conducted while the interviewees were still patients. All interviews started with the same open question, ie, "Can you tell me about your visit to the emergency room and please start with your arrival at the ward?" Supporting questions, such as, "Could you please elaborate?" were asked to get more complete responses from the interviewees. The interviews were tape-recorded and ranged in length of time from 15 to 45 minutes. Tapes from the interviews were transcribed as soon as possible after the interviews by

a secretary. The transcripts were then processed immediately by the interviewer to get the verbatim version of the interview. This version included how the interviewee was expressing themselves, including laughter, silence, or other gestures of emphasis. The tapes were kept in a secure place where only the authors had access to them.²⁷

Data analysis

Analysis of this study was based on a qualitative phenomenological hermeneutic research method described by Lindseth and Norberg.²³ When transcribing the interview, the text is open to interpretation whereas the dialog is not.²⁵ Interpretation of the text consists of dialectical work and the goal is to understand the text as a whole while at the same time explaining its individual parts.²⁴ Interpretation of the transcript was a three-step process, consisting of an initial, unbiased, and open-for-interpretation reading of the text, which gives the researcher a general idea of the contents of the transcript. A structured analysis is then performed on the text by assigning meaning-bearing units to key words, phrases, and sentences. Meaning-bearing units are further condensed to provide more manageable units. These units are then sorted into themes. From this analysis, the researcher receives a weighted understanding. This consists of an initial reading of the text combined with added meaning from the structural analysis, providing the opportunity for the researcher to use their previous experience and preunderstanding. This technique enables the researcher to approximate the closest understanding and meaning of the experience itself. This involves a spiraling motion between the three phases of the process, referred to as the hermeneutic spiral.²³

Credibility

To ensure credibility and reliability of interpretation, both the parts and the results as a whole were scrutinized with

Research question	Interview question
What was the experience of the low priority care patients like during their waiting period in the emergency department?	Can you describe your experience of the care during your waiting time? Begin with what happened when you arrived at the ward.
What were the patient's problems that received the low priority status in the waiting queue?	Tell me about the personnel that admitted you into the ward.
	Describe your experience of waiting for treatment.
	What was your total experience of the emergency department?
	Summarize in a few words your experience of waiting.
Open question to the patients regarding their care case.	Is there something more that you wish to add with regard to your care case?

Figure 2 Demonstrated research questions and interview questions.

Table 1 Background data of participants in the study

Interviewee	Age (years)	Gender	Reason for visit	Accompanied or alone	Emergency/referral	Distance (km)
1	73	F	Pain problems	Accompanied	Emergency	40
2	56	M	Accident	Alone	Referred	20
3	75	M	Chest pain	Alone	Emergency	17
4	43	F	Accident	Alone	Referred	80
5	69	F	Abdominal pain	Accompanied	Emergency	35
6	36	F	Abdominal pain	Alone	Referred	5
7	82	F	Neurological problem	Accompanied	Referred	42
8	70	M	Neurological problem	Accompanied	Referred	20
9	76	M	Chest pain	Alone	Referred	35
10	85	F	Heart racing	Alone	Emergency	22
11	66	F	Pain problems	Alone	Emergency	20
12	50	F	Postoperative	Alone	Emergency	42
13	75	M	Accident	Alone	Emergency	15
14	75	F	Diabetes	Alone	Emergency	40

regard to the original transcript and in accordance with the method of interpretation. To maximize the credibility of internal validity, all authors had access to the anonymous verbatim written text. Data analysis was conducted by the principal author and validated by the supervisors. The results are supported by quotes from the original transcripts. Ethical considerations applying to the humanities and social science research were taken into account in this research. Informed written and verbal consent was obtained from all participants in this study as well as from the head of department.

Results

The transcripts for this study showed how low priority patients in the ED experienced the nursing care assigned to them while they were waiting for treatment in the ward. The main impression was that patients were dependent on nursing care in order to manage their medical issues. The interviewees had been seeking adequate care from the health care system. Much of the care that was offered to low priority patients during their waiting period in the ward was being offered something to eat and drink and/or being provided with information about how long the waiting period may be. Several patients felt that their issues were never really resolved, and felt that their visit to ED had been a waste of time and money. Structural analysis of the interviews revealed four themes, ie, being dependent on care, being exposed, being vulnerable, and being secure.

Being dependent on care

The theme within the transcripts that evolves into being dependent on care is the result of a person finding themselves in a position where they cannot care for themselves. This leads

to an increased dependence upon professional nursing care in order to satisfy basic needs. As a result of being in need of emergency care, the individual finds themselves in the ED. Upon arrival, the patient makes contact with a nurse who assesses their condition. The patient immediately finds themselves dependent on the nurse's ability to assess their condition. Much of this assessment is based on the ability of the patient to express clearly what their difficulties are with their state of health. Some of the interviewees had difficulty in expressing their feelings but realized how important it was to give health care personnel an accurate account of the symptoms that prompted them to seek treatment in the ED. When the interviewees felt that they had the latitude to express their symptoms and feelings freely, they had a sense that they were being acknowledged and taken seriously. Some of the patients felt that it was important and necessary to know what the nurses were documenting in their files. Several patients expressed in their statement that they were unsure what the nurses were documenting and it made them feel unsure. "The nurse asked me when I was born ... then she wrote something on a piece of paper ... I do not know what she wrote and she never talked about it either."

On the negative side, when patients are assigned a low priority in the ED, nursing staff tend not to give them adequate attention, which discourages them from fully expressing themselves. Without proper attention, a patient in need of care may feel that they are a nuisance, which in turn leads them to feel helpless and insecure. Sometimes a patient's stay overlaps the changing of personnel from shift to shift, and this could contribute to the feeling that they are being overlooked. They may even start to reconsider if they should have sought treatment from the ward at all. "I did

not get any care during the waiting period. That felt pretty frustrating. Why is it that nobody is coming to talk to me ... to check on me? Why is there no explanation about the reason I am sitting here all alone and waiting?"

Some of the participants felt that they were not receiving the care that they had the right to expect, and this left them feeling that their rights were being violated. Others felt that a significant factor in them not receiving adequate attention was the fact that the ward was understaffed. Due to the seriousness of higher priority cases in the ward, the majority of resources had to be devoted to those cases.

Positive aspects of the participant's dependence upon nursing staff occurred when the nurses were perceived by the patients as caring. Through their dependence upon the nursing staff, the participants reported forming positive and nurturing relationships with nursing personnel. Nurses who were perceived as being available, attentive, and responding appropriately to the patient's needs were greatly appreciated by those they were tending to. "I met with the same nurse all the time ... She came back several times and told me that the doctor had been delayed ... she gave me coffee and sandwiches and she made sure that my relatives were brought to the examination room from the waiting room so we could pass the waiting time together. This support was really important to me at the time."

The presence of both negative and positive aspects of the caring situation in the ED sometimes created a feeling of conflict for patients. Sometimes they felt as if they must choose between sympathizing with staff about the stringent demands on their time and their concerns regarding their own health.

Being exposed

The transcripts illustrated that low priority patients were subjected to unnecessary suffering during prolonged waiting times in the ED. Patients who were subjected to long waiting times suffered because of basic unmet needs, such as lack of food and drink and inadequate pain relief. These types of needs were perceived as necessities by patients in order to cope with their waiting time in the ED. It is human nature to satisfy one's needs when possible, but when a patient cannot manage on their own, they must ask for help. Some of the interviewees responded that they felt that if they had more pain they would have been taken more seriously. "I probably did not have enough pain to qualify for immediate care ... If I had more pain I probably would have received better care."

The participants felt that the health care personnel had difficulty understanding how much pain and discomfort they

were experiencing during their wait for an examination. "I asked for pain relief but didn't get any ... the health care people felt that I could wait, but I didn't feel that I could ... it hurt so bad ... so I took my own medication that I had with me."

The patient exposure threshold was reached when the nursing staff did not see or understand the patient's needs. The participants felt that they were not treated with respect and that their symptoms were not taken seriously. They were powerless relative to the nursing staff, which made them feel exposed. The waiting time was difficult to comprehend for patients when they were forced to wait for medical staff from other wards. "I had to wait for a different doctor because the first one wanted to consult with another ... and when the second came ... he made an explanation to the first doctor about my case ... When it was time for me to get an explanation I met with another doctor because the original one had gone home."

Several interviewees responded that they felt useless. They wondered how they could draw attention to their needs in their vulnerable position. They felt forgotten and neglected by the nursing staff and these feelings gave way to feelings of being insulted and humiliated. "I felt useless as I lay there and waited for help ... no one seemed to care. The staff was running back and forth. I was completely helpless and felt terribly lonely and abandoned."

The nursing staff tasks consisted of some routine procedures that the patients perceived as unpleasant. When the nursing staff did not explain the procedures that they were performing and about the possible ramifications, patients were further distressed. The result of this lack of communication was that the patient was exposed to additional anxiety and concern, and this left them feeling that they were not involved in the decision-making process regarding their own health care. "The nurse took an ECG and my blood pressure, she told me that the doctors would look at the material ... then she left. After a bit, the blood pressure band was pumping up and I thought, 'My God, she's forgotten it, what if she doesn't come back? What happens then?'"

Being vulnerable

When a person becomes a patient they lose some of their personal integrity, and their illness or injury puts their vulnerability in focus. People who are otherwise considered to be strong and robust quickly find themselves vulnerable as a patient. They become even more vulnerable when their ED status is low priority. Low priority patients are more likely to feel vulnerable because they may feel that they do not

belong to the most important patient group in the ED. This vulnerability was identified when patients felt abandoned by nursing staff. "Why doesn't anyone come out to me and explain why it is taking so long? The waiting time was long but it seemed to be forever ... I felt completely alone and abandoned."

The patients explained that they felt they were being treated in a nonchalant manner by staff and that they felt invisible. "What really got to me was that they saw me all the time ... but I had the impression that they did not care."

Lack of information was perceived as contributing to their discomfort, given that the patients had to wait without knowing why. When nurses were perceived to be unsympathetic, this caused additional mental suffering for patients.

Being secure

The transcripts of the interviews showed that it is comforting for patients to be present in the ED. The sense of security stemmed from the fact that patients felt that help was close at hand and that they could count on the nursing staff being competent and to have good judgment regarding their condition. This sense of security was validated when the nursing staff showed understanding and compassion for the patient's situation. When the patients were able to delegate the responsibility for their health to competent nursing staff and doctors in the ED, they perceived that as security. Their feeling of security was enhanced when the patient established personal contact with health care personnel. "I felt calm and secure as soon as I entered the emergency room and established contact with the staff there ... I felt that I was in good hands."

Once contact with the patient has been established, it is important to maintain contact otherwise the patient can easily lose confidence in the staff if they do not follow through on their promises. "The staff just promises and promises ... but nothing happens ... they cannot be trusted."

When people are faced with injury or sickness, the natural response is to be worried and nervous about an uncertain and threatening situation. A situation that may be perceived as stressful to one person may not be seen as problematic for another. Patients responded and behaved in different ways, depending on how secure they felt in their situation. If a situation is perceived to be serious or threatening, emotional reactions ranging from anger, anxiety, to despair, may be fairly typical. When patients are initially put in the emergency room waiting queue, they begin by using their own coping strategy. Patients who have had previous experience in an ED situation may be able to draw upon their experience in order to help them feel secure and manage their reactions.

When the waiting times for low priority patients increase, fatigue and hunger also become a factor in how they cope with the situation, and their own initial coping strategy may be wearing thin at this point.

Discussion

Further interpretation of the results enabled a more comprehensive understanding, showing that when a person is exposed to illness or injury the experience focuses on their vulnerability. Low priority patients are dependent on the treatment and nursing care provided during their visit to the ED, which creates both a positive and a negative attachment to caregivers. Positive attachment occurs when nursing personnel are available and demonstrate a professional approach that responds to the patient's needs. In some cases, just being in the presence of nursing personnel creates a sense of security for the patient. When patients are adequately informed about their situation, it is easier for them to feel secure in such a situation. Negative attachment occurs when there is a lack of action on the part of nursing staff because the patient is not designated as higher priority. Lower priority treatment¹⁶ discourages patients from clearly expressing their needs, and low priority patients are more likely to be subject to unnecessary suffering during their stay in the ED. Their vulnerability increases as their basic needs go unmet. The results of the present study show that when people become dependent upon others for caring, they often get the sense that they have become a nuisance which makes them feel inferior and small.

The patient's level of satisfaction with the care that they receive on the ward is an important indicator of the quality of nursing care provided.^{6,10} According to Nyström et al,¹ to be dependent on care is to be dependent on nursing staff support and the nurse's level of attention. The participants in this study had an expectation that when they entered the ward that they would be well received, understood, and their condition accepted. When the participants were not receiving proper attention from nursing staff, it was perceived as a violation of their dignity. Health care personnel are dependent on patients to have work to perform, and patients are dependent on the health care professional's knowledge and care that they provide. Thus, health care personnel and patients have a mutual dependence, but not of a reciprocal nature because health care personnel and patients cannot change positions.¹⁸ The patients are totally dependent on nursing staff to assess their health history.^{1,11} People who are in the position of being in need of care are forced to surrender themselves to the control of nursing staff, both physically and mentally.⁸ To

understand the patient's vulnerability in the actual health care situation requires a background and a real-world perspective in the caring sciences.^{1,16} The real-world perspective is the reality we live in, and this is usually taken for granted. The results of our study show that low priority patients are not given sufficient attention by nursing staff. Patients who are not given attention feel marginalized, which is a form of care suffering. When high priority patients on the ward have been processed through the system, there is rarely enough time to allocate lower priority patients enough time to give them the level of attention that they need.^{1,11}

In this study, the patient's blood pressure, pulse, and temperature were checked in the emergency ward; this gives important information about the patient's physical condition, but that does not give the whole picture. The prioritizing system leaves are medical specialization and the nursing work is assigned a less promote role²⁹ such as little room for subjective judgments. That is why the patient's verbal description of their medical symptoms and the way in which they express their emotional state gives the health care provider important information about the patient's overall condition. Other studies have shown that when patients are not treated holistically from a nursing perspective, they can experience confusion and feel that their integrity has been violated.^{18,19,23}

The participants' stories showed that they did not always understand the system in terms of what had happened and what was going to happen. This lack of understanding can be interpreted as a violation of the patient's right to self-esteem. If patients are given better and up to date information about their likely waiting time, it gives them a better impression of the care they are receiving and enhances their sense that they are participating in a sense of togetherness with the nursing staff.¹⁴ The goal of nursing care within the ED facility should be to reduce or prevent unnecessary suffering and vulnerability. The goal of nurses should be to create conditions that enhance well being and to stabilize patients while they are waiting for treatment by integrating their medical expertise with their nursing care background.⁸ It is particularly important in the ED to preserve the patient's ethical rights, which can be lost or ignored during prioritization for treatment. When health professionals with different functions in the ward are being divided in patient care, there is a risk that the big picture will be lost. This lack of focus or continuity can potentially strengthen the patient's perception of their own vulnerability.⁹ Effective communication becomes increasingly important in nursing situations that occur under emergency circumstances.¹⁹ It is also important

in the emergency setting to provide individualized care that is related to and based on the patient's needs. This includes the patient being treated as a whole person, and their individual rights and dignity should be respected. To achieve this level of individualized attention, it is probably important to encourage a nurturing care relationship. The ability to care for a patient's emotional needs in an ED situation depends on the nurse's ability to create a caring relationship which targets the patient's short-term needs and addresses their immediate situation.^{1,15,19} Because time is of such an extraordinary and critical nature in the ED, the emphasis tends to be on how to manage and assess medical emergencies quickly and effectively and not to focus on patient needs.²⁹ Several studies have shown that heavy workloads and difficult time constraints are two major reasons causing communication between health professionals and patients to suffer.^{10,14,29} Patients have difficulty expressing their needs when caregivers are unreasonably stressed.

Conclusion

This study shows that low priority patients do not get adequate attention from nursing staff in the ED. Low priority patients are forced to endure delays because there are others in more dire need of attention. Low priority patients feel powerless when they are excluded from participation in their care without understanding why. All patients regardless of their triage prioritization should leave the hospital with a feeling that they were treated well and that their personal needs were adequately met regarding their treatment, care, and nursing. By successfully treating and meeting the needs of low priority patients, nursing staff earn significant self-esteem when they are performing their professional duties, including meeting the patient in a truly caring relationship. It is apparent from the transcripts of the interviews for this study that the care provided to lower priority patients waiting in the ED leaves something to be desired. Further discussion and evaluation of the practices and procedures for the nursing staff in the ED is needed in order for these patients to feel satisfied with their treatment.

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Disclosure

The authors report no conflicts of interest in this work.

References

- Nyström M. Meeting at an Emergency's Outpatient, about Effective Caring Culture [Möten på en Akutmottagning, om Effektiv Vårdkultur]. Lund, Sweden: Studentlitteratur; 2003. [Swedish.]
- SFS 1982:763. Law of health and nursing [Hälso-och sjukvårdslagen]. Stockholm, Sweden: Ministry of Health and Social Affairs. Available from: <http://www.socialstyrelsen.se>. Accessed April 9, 2007. [Swedish.]
- SOSFS 1993:17. The National Board of Health and Welfare Statute Book. General guidelines. Available from: <http://www.socialstyrelsen.se>. Accessed May 5, 2007. [Swedish.]
- ICN. Ethical code for nurses [Etiska Kod för Sjuksköterskor]. Stockholm, Sweden: Svensk Sjuksköterskeförening; 2002. [Swedish.]
- SOSFS 1993:9. The National Board of Health and Welfare. Quality assurance in health care including dental care. Available from: <http://www.socialstyrelsen.se>. Accessed May 5, 2007. [Swedish.]
- Thompson DA, Yarnold PR, Williams DR, Adams SL. Effects of actual waiting time, perceived waiting time, information delivery and expressive quality on patient satisfaction in the emergency department. *Ann Emerg Med*. 1996;28:657–665.
- Nyström M, Carlsson G, Dahlgren K. Non-caring encounters at an ECU – a life-world hermeneutic analysis of an efficiency driven organization. *Int J Nurs Stud*. 2003;40:761–769.
- Wiman E, Wikblad K. Caring and uncaring encounters in nursing in an emergency department. *J Clin Nurs*. 2003;13:422–429.
- Fernandes C, Tanbe P, Gilboy N, et al. Five level triage – a report from ACEP/ENA. *J Emerg Nurs*. 2005;13:39–50.
- Attree M. Patient' and relatives' experiences and perspectives of "good" and "not so good" quality care. *J Adv Nurs*. 2001;33:456–466.
- Nyström M, Nydén K, Peterson M. Being a non-urgent patient at the ECU. *Accid Emerg Nurs*. 2002;11:22–26.
- Dahlberg K. Care suffering – the unnecessary suffering [Vårdlidande – det onödiga lidandet]. *Vård i Norden*. 2002;22:4–8. [Swedish.]
- Kihlgren AL, Nilsson M, Skovdahl K, Palmblad B, Wimo A. Older patients awaiting emergency department treatment. *Scand J Caring Sci*. 2004;18:169–176.
- Stuart PJ, Parker S, Rogers M. Giving a voice to the community: A qualitative study of consumer expectations for the emergency department. *Emerg Med*. 2003;15:369–375.
- Byrne G, Heyman R. Understanding nurses' communication with patients in accident and emergency departments using a symbolic interactions perspective. *J Adv Nurs*. 1997;26:93–100.
- Dahlberg K, Segersten K, Nyström M, Suserud B-J, Fagerberg I. To understand caring sciences. [Att förstå vårdvetenskap]. Lund, Sweden: Studentlitteratur; 2003. [Swedish.]
- Berg L. Caring relation in daily meeting [Vårdande relationer i dagliga möten]. PhD Thesis. Sahlgrenska Akademin Gotenburg University; 2006. [Swedish.]
- Kasén A. The relation in caring [Den vårdande relationen]. PhD Thesis. Åbo Institutionen för Vårdvetenskap, Åbo Akademi: Åbo Akademis Förlag; 2002. [Swedish.]
- Travelbee J. *Interpersonal Aspects of Nursing*. Philadelphia, PA: FA Davis Company; 1971.
- Peplau H. *Interpersonal Relation in Nursing*. London, UK: Macmillan Education Ltd; 1991.
- Sumner J. Caring in nursing: a different interpretation. *J Adv Nurs*. 2001;35:926–932.
- Svedlund M, Danielson E, Norberg A. Women's narratives during the acute phase of their myocardial infarct. *J Adv Nurs*. 2000;35:197–205.
- Lindseth A, Norberg A. A phenomenological hermeneutical method for researching lived experience. *Scand J Caring Sci*. 2004;18:145–153.
- Ricoeur P. *Interpretation Theory: Discourse and the Surplus of Meaning*. Fort Worth, TX: Christian University Press; 1976.
- Ricoeur P. *From Text to Action. Essays in Hermeneutics*. Evanston, IL: Northwestern University Press; 1991.
- Mackway-Jones K; The Manchester Triage Group. *Emergency Triage*. London, UK; BMJ Publishing Group; 1997.
- Kvale, S. *Interviews: An introduction to qualitative research interviewing*. Lund: Sage Publication; 1996.
- Nyberg R. Writing scientific papers and theses supported by IT and the Internet. [Skriva vetenskapliga uppsatser och avhandlingar med stöd av IT och Internet] Lund, Sweden: Studentlitteratur; 2000. [Swedish.]
- Attree M. Patients' and relatives' experiences and perspectives of 'good' and 'not so good' quality care. *J Adv Nurs*. 2001;33(4):456–466.

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