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Abstract: ABSTRACT
Background: Further insight is needed to better understand how beliefs impact on contemporary Australian Emergency Department (ED) triage nursing practice. Specifically, how do cultural notions drive beliefs that give shape to nursing practice?
Methods: Ethnography was the methodological framework used to explore triage practice. A purposeful sample of 10 Triage Nurses across four EDs was selected. Two hundred hours of non-participant observation were collected.
Results: Beliefs were identified that gave meaning to triage nursing behaviour and action. Belief 1: Respecting space and privacy; Belief 2: Taking control and responsibility; Belief 3: Patients should not arrive with expectations; Belief 4: Do not ask for a bed; Belief 5: Expect a level playing field; Belief 6: No benefit from having a referral letter; Belief 7: Do not waste time. When a belief was engaged Triage Nurses implemented a range of practices, which were culturally oriented and at times at odds with patient expectations and care.
Conclusion: The ethnographic study made visible an ED culture of timeliness, appropriateness and efficiency which perpetuated beliefs that framed notions of service worthiness and appropriateness. Making explicit beliefs can assist clinicians to be more considered, sensitive and culturally competent to meet the growing demand for emergency care.

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AN ETHNOGRAPHY: UNDERSTANDING EMERGENCY NURSING PRACTICE BELIEF SYSTEMS

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Key words

Ethnography, belief systems, cultural knowledge, emergency care

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Background

Studies have reported that Australian Emergency Departments (ED) have a culture of care that is based on timeliness, appropriateness and efficiency.(Fry and Stainton, 2005, Gordon et al., 2010) Little is known about how a culture of care can sustain beliefs within nursing practice. All nurses within their specialties share knowledge systems that are influenced by the culture of care.(Long et al., 2008) Beliefs can underpin shared knowledge systems and give meaning to how practice is viewed and conducted. Within this context of care beliefs can also give meaning to how patients are viewed and 'should' behave to ensure appropriate, timely and efficient practice.

How belief systems impact on nursing roles remains unclear and so to better understand triage nursing practice within Australian Emergency Departments (ED), an ethnographic approach was undertaken. The aim of this study was to provide insight and understanding of how belief systems can impact on triage nursing behavioural patterns, actions and decision making.

METHODS

SETTING

The 12 month ethnographic study was undertaken in four metropolitan tertiary Referral Hospital EDs, which were purposely selected as they had a dedicated Triage Nurse, shared an emergency computer system, onsite diagnostics and radiology services, used the Australasian Triage Scale (ATS), and had a similar patient casemix.(NSW Health, 2009)

SAMPLING

Within ethnographic sampling, good informants are those who are experienced in the scene, confident within their field and willing to discuss the experience. (Wolcott, 2008, Morse, 2007) Therefore, in New South Wales, Clinical Nurse Specialists (CNS) are most likely to make the best informants as they have worked in a specialty area for a period of four years or have at least 12 months specialised clinical experience and hold a postgraduate qualification. (Duffield et al., 2009) One of the most senior nursing roles within an ED is the triage role.(Commonwealth Department of Health

and Aging, 2007) Ten informants were purposefully selected who were classified as CNS and working in the ED triage role.

Analysis methods

The data collection involved non-participant observation and interviews. Participant observation sessions were conducted on Fridays, weekends and public holidays and all began at 7am with the start of the nurse's morning shift. Data collection took the form of continuous memo taking and 200 hours of observations were collected. One-on-one interviews with each participant were also conducted after at least one participant observation session. While in the field informal observed interactions with Triage Nurses involved four main groups, which included clerical staff, senior emergency physicians, nurses and ambulance officers.

De-contextualising and recontextualising ethnographic data provided a systematic and coherent approach to thematic development. The De-contextualising process began with coding of key words which were placed at the side margin of transcribed notes. The systematic exploration of codes marked the process of recontextualising data and provided new ways of understanding triage practice The ethnographic framework provides a systematic and coherent approach to thematic data analysis and moves findings from simple description towards interpretation.(Wolcott, 2008)

Ethical review

Ethical approval to undertake the study was obtained from the University of Sydney, Human Ethics Research Committee. All identifiable features of the hospital, participants and patients were coded to maintain confidentiality, trust and privacy. Verbal consent was obtained from all patients interacting with Triage Nurses. Pseudonyms have been used to protect the identity of the Triage Nurses participating in the study.

Data / Results

The sample included seven female and three male nurses with an average age of 31 years. The average CNS and triage experience was 3 and 6 years respectively (Table 1). Of the ten nurses who agreed to participate, eight worked fulltime. Nurses had between four and twelve years emergency experience. Four nurses held a Masters Degree and the remaining six, postgraduate nursing certificates (Table 2).

Observations and interviews of Triage Nurse-patient interactions identified a knowledge system that was made up of a set of beliefs that helped regulate and sustain an understanding of patient conduct. Seven beliefs were identified that provided meaning for how patients should prepare their arrival, act in the emergency department, interact with and respond to the nurse's efforts and service (Table 3).

BELIEF 1: RESPECTING SPACE AND PRIVACY

The first belief of 'respecting space and privacy' surfaced when exploring expectations and attitudes towards patient conduct as they approached the triage window. Mathew, Karen, and Toni commonly spoke of the need for patients to 'respect' other patient's space. These nurses, each from different sites, expressed many instances of disappointment with patients who failed to comply with the notion of respecting space and privacy. Nurses viewed physical distance as a means to securing privacy and confidentiality for all patients. Tanya explained, *"sometimes the privacy issue is a problem. They line up and everyone hears what they have to say".*

A consistent and typical pattern of nurse behaviour was highlighted during one particular interaction between Karen and a patient arriving at the triage door. This exemplar highlights the belief of respecting space and privacy.

> *Karen calls a man into the triage room and with gloved hands stands with a sterile pad viewing the 8cm forearm laceration. At this moment, a man walked through the triage door and leaned against the doorframe. Karen looked up while still holding the 'bloody' pad. The man explains he needs a dressing to his leg ulcer, as the community nurse can't come on a public holiday. Karen turned to him and said "you'll be waiting for hours there's lots of sick people. If you want to wait that's fine I'll give you a suggestion, if you have a GP or medical centre close by then they can do it. You can wait, but it will not be done before them (the sick patients). You can wait, but I'm not going to bring nurses looking after other sick patients away to do your dressing". She then turned to the first patient and said "I don't see the other patients when I'm treating someone else" [Field note Hospital 4]*

During a similar incident Toni shared the meaning embedded in the belief, 'They [patients] don't respect space. They can see you're with someone in the room. I want them to move back and preserve the patient's privacy". Patients could experience real consequences by failing to respect space. Mathew illustrated:

I have no respect for people who just hang around while you are trying to triage. It's one of my pet hates. I've a bad habit of throwing around a little bit of [my] weight, because we're not a zoo, we're here to look after patients.

Failing to respect space and or privacy could result in negative exchanges between patient and nurse and could potentially influence triage code, clinical area allocation, and movement through the department. However, demanding that a patient provide some distance between themselves and the triage area was sufficient management of a patient's infraction. Privacy and confidentiality underpinned this belief, which brought a desire to ensure appropriate space for all patients at triage.

BELIEF 2: TAKING CONTROL AND RESPONSIBILITY

The second embedded belief was commonly observed during triage assessment. The patient was expected to act responsibly towards their condition. In this context, acting responsibly was understood by all nurses to mean taking control and responsibility by individuals to ameliorate signs and symptoms before arriving in the ED. This belief applied to patients who presented with minor conditions such as pain or fever. In these cases, nurses shared an understanding that the use of antipyretics or mild analgesics prior to presentation was appropriate and efficient patient conduct.

The usual consequences of a patient failing to adhere to the belief, 'taking control and responsibility', was to receive an explanation how 'next time' it would be worthwhile doing something to control the situation. Peter's comment to a patient illustrated this belief; *"You wouldn't feel so bad at the moment if you'd taken something for it. You should have taken some Paracetamol*". On learning that a patient has not taken steps towards controlling signs and symptoms the assessment was always momentarily stopped, while nurses tried to understand why patients had not taken steps to treat themselves. The interaction then moved towards providing education for the patient on medication benefits.

In contrast, taking control by self-medicating, suggested the appropriateness of a patient's presentation. Kylie provided a standard response when probing into the notion of self-medicating *"If they've taken something for it, I think it's better. I get annoyed if they don't. If I judge it [pain] to be legitimate then yes, this will influence decisions"*. The belief threads expectation into practice, the patient having tried to aid their condition is considered more appropriate.

Another meaning surfaced in discussions with Mathew about the characteristics of this belief in taking control and responsibility. Mathew summed up "*I like to empower patients to own their own treatment"*. A desire that patients 'take control and responsibility' was an important aspect of the culture of ED care, although patients may not be aware of this dimension.

BELIEF 3: PATIENTS SHOULD NOT ARRIVE WITH EXPECTATIONS

When patients arrived with expectations about care and service, the third belief surfaced. This group of patients were recognised the moment they entered the ED. Some people were observed to arrive with a suitcase whether by private transport or ambulance. Turning to me on many occasions, Triage Nurses would refer to this phenomenon as a '*positive bag sign'*. Tanya helped to clarify "*You have a positive bag sign, when I see the ambulance pull up and the bag's on the trolley. I just immediately think, right, you're in the waiting room"*. Nurses believed that these patients came with the expectation of being sick enough to go straight into an ED or hospital bed.

In contrast, these patients were unlikely to be considered as acutely unwell as they were well enough to pack a suitcase. While Tanya was discussing the 'positive' bag sign, an ambulance officer joined the discussion and added "*as well as the bag sign. If they've a full face of makeup on, they're not serious" [Field note Hospital 1 ambulance1]*. Shared understanding about ED acuity and appropriateness meant nurses found it incongruous when patients had time to pack a bag or put on makeup. However, clinical judgement buffeted embedded beliefs as Tanya later added "*and then I get the history and I think damn, she needs a bed*". The influence of beliefs was often balanced by clinical knowledge, guidelines and the desire to ensure the ED culture of patient safety and equity of service.

BELIEF 4: DO NOT ASK FOR A BED

The fourth belief is that patients should not arrive asking for a bed. It is the role of triage to determine whether the patient's condition warrants the allocation of a bed. The following field note provided an example of the belief operating in practice:

> *Sunday 11.30am and most beds were occupied in the department. A woman and a man walk slowly through the entrance. The woman came to the triage window, she explained she needed to see a doctor and that she has back pain. As she walked into the triage room, she asked for a bed to lie down on. She*

had been to her GP and was given an injection. Further along Karen asked about the injection. The woman was unsure; it was "something". The woman was triaged a code 5 and allocated the waiting room. She was told it would be a four- to-five hour wait. After Karen directed her to the waiting room, she turned saying "She asked for a bed before I'd even triaged her" [Field note Hospital 4].

The extract highlighted that if the patient was well enough to ask for a bed, then they were unlikely to need one urgently. The notion was that a normal pattern of triage assessment needed to occur, and that decision making about bed allocation was part of the Triage Nurse's role. This extract also demonstrated the consequence for patients ignorant of the belief system and that it is the nurse who has the authority to determine the allocation of resources, timing and appropriateness of care.

BELIEF 5: EXPECT A LEVEL PLAYING FIELD

Nurses commonly spoke of claims by privately insured patients for a 'different' service. This brought to the surface belief number 5 'expect a level playing field'. This belief emerged during interactions with people who explained that they held private health insurance. The characteristics of this belief identified a strong desire by Triage Nurses to treat every person arriving to the ED equally. Mathew illustrated, *"Everyone should be triaged in the same way*". When patients unknowingly infringed on this belief, this tested the belief of the nurse to ensure an equitable service for all. Meg described a typical response to infringements of the belief – 'expect a level playing field': "*Private patients are demanding and aggressive particularly if they've spoken to their physician. They expect immediate attention*". These conversations always followed the same pattern and ended with the same response -'*You'll be seen by our doctors first'*. Implicit within this response was that Triage Nurses would regulate the same service for all patients.

Claims by privately insured people collided with the culture of ED care and dimensions of timeliness, appropriateness and efficiency. Mathew added, "Private patients, because they've private cover, think their problems are urgent and it's difficult to explain [that] it doesn't matter in the ED". The Triage Nurse–private patient interaction was often tense because nurses wanted to do their job, which they believed was to conduct routine triage work for all patients entering the ED. In the ED, private medical cover was not legitimate currency to influence urgency code allocation, resources or movement by the majority of nurses.

BELIEF 6: NO BENEFIT FROM HAVING A REFERRAL LETTER

Nurses were observed to rely on gathering a history from the patient and using their clinical judgment to make triage decisions. However, many people arrived with a referral letter from their GP and would then explain that they needed to see a doctor urgently. During these particular interactions, patients handed over sealed referral letters to nurses which revealed the sixth belief embedded in practice. The GP envelope was usually addressed to the Admitting Medical Officer. The nurse, on being handed the letter by the patient was required to open and read the contents. Despite patients explaining that 'everything' is in the letter, the nurse on reading the letter would look up seek to ask the patient "*what's the problem*?". In these cases, while the letter was used as a reference point, it failed to override what was considered appropriate care. Hence, nurses would begin their routine triage questioning. These experienced nurses had come to rely on their own clinical experience and judgment. In some instances, letters provided little additional information, due to illegibility, as nurses were commonly heard to say, "*I can't read the letter from the doctor"* [Andrew]. Nonetheless, in preference to relying solely on the information in the referral letter, nurses maintained their beliefs in the routine patterns of practice, preferring to gather sufficient information to make safe triage decisions and patient action plans.

BELIEF 7: DO NOT WASTE TIME

In this setting, beliefs construct a tapestry giving shape to the cultural meaning of timely and appropriate ED care. Consequently, trivial conditions were believed to squander resources and place sicker patients at risk. All nurses shared a mutual understanding of, and the ability to, predict the types of conditions viewed as trivial. While observing Samantha she illustrated a typical trivial patient condition:

> *An apprentice chef arrived with his mother after cutting his left index finger on a kitchen knife. His mother is concerned - he needs his hands for his work. Samantha later reflected on this triage and commented, "it's hard sometimes for trivial things. I'd like to say, I don't care what's wrong with you; you're not getting past me for that cut finger". I was generous to do the dressing, it only needed a band-aid. Only there was nothing to do. They shouldn't be here, that was a waste of space" [Field note Hospital 3]*

Triage Nurses considered trivial conditions to be those that the patient could treat him or herself, needed no treatment, were minor or chronic and could be managed by a

Medical Centre or GP. For example, Kylie shared a standard response *"I think [if] it's a chronic problem, it should be sorted out by the GP"*.

The triaging of patients considered to have trivial conditions generated nurse resentment. "*Sometimes I'd love to be able to say -Go- but I don't and we can't refuse care"* [Karen]. The experience of resentment surfaced because nurses believed the use of time and space by patients with trivial conditions as inappropriate. Kylie provided an average response for how this group of patient was viewed, *"the Emergency Department is abused, [we] shouldn't see these sorts of patients"*.

Breaching this belief altered triage assessment and code allocation practices. Firstly, what unfolded were observable changes to the assessment process. For example, nurses tended to shorten the duration of the assessment process in that fewer questions were asked routinely of patients considered to be '*wasting ED time'*. Some nurses would not seek any further information once they had established the person had come for a dressing. The second practice consequence was usually to reduce the level of urgency. Toni provided a standard response. "*[if] I think they're wasting time; I'll give them a code 5".* Similarly, after triaging a woman with a back pain Karen turned and said "*If I could give a [triage] code 10, I would. They deserve it"*. These exemplars conveyed a view that while some patients 'deserved' service, others were less 'deserving'. All nurses viewed patients with trivial conditions as denying services to others sicker patients and squandering emergency resources, fuelling feelings of resentment.

DISCUSSION

This study, forms part of a larger study, and reports on how one shared knowledge system assisted to sustain a culture of ED care.(Fry and Stainton, 2005) Across four sites and recognisable to all participants, a culture of ED care was manifested by notions of timeliness, appropriateness and efficiency. Seven beliefs perpetuated a culture of care and enabled the operationalisation of an ED culture to be observed. The surfacing of beliefs, while they gave meaning to behaviour, could have a negative impact on patient care practices. Yet beliefs were driven by notions of timeliness, appropriateness and efficiency and concern for patient privacy, safety, respect and equity.

The study demonstrated that belief systems provide conceptual schemes in which nurses were able to convey, respond and understand the meaning of work, interactions and behaviour. However, the study identified that beliefs frame notions of service worthiness. The findings support that service worthiness is complex and evident during incidents in which triage resources were constrained. Several studies have explored the notion of service worthiness in EDs.(Nugus et al., 2010, Nugus and Braithwaite, 2010, Marvasti, 2002) This bolsters Sbaih's (2002, Sbaih, 2001) earlier findings in which emergency nurses characterised patient service worthiness in response to overcrowded situations. Educators and managers can raise the awareness of how service worthy beliefs can intrude on clinical judgment and practice. The study findings and supported by others (Nugus and Braithwaite, 2010, Sbaih, 2002, Sbaih, 2001, Taveras and Flores, 2004, Nurok and Henckes, 2009) provides evidence that belief systems do have the capacity to intensify personal emotions and thus alter care activities and decision making.(van der Geest and Finkler, 2004)

In each ED, when beliefs surfaced tension became observable in practice. When patients breached a belief, they often received advice on what to do 'next time', had alteration in their triage code or modification of resource utilisation. The collective view of beliefs offered a means to manage and understand ED service and deemed what is considered 'true', 'right' and 'good'. These beliefs, conveyed during the act of triage, provided a framework for making sense of reality, a means to understand action, and a way to view patient behaviour. Expectations frame ways of thinking and can led to quality or poor care. (Taveras and Flores, 2004, Nugus et al., 2010) These 'insider' ways of knowing give rise to expectations, provoking emotional responses, which vie for attention and influence role activities and behaviour. It is critical that nurses consider that patient responses are not intrinsically right or wrong. (Narayan, 2010)

Beliefs implicit within practice were shown to conflict with public expectations. Perceived breaches to expectations provoked moments of tension for all. While consumers remain unfamiliar and or uncertain of ED expectations, health care staff-patient negotiations could potentially fuel tension and aggression. A better understanding of embedded beliefs and attitudes towards emergency care management by staff and the public is needed.(Kington and Short, 2010)

The study demonstrated that belief systems interrelate with emotional responses. Emotions were a barometer for gauging the importance of cultural meanings. The intensity of emotions in nursing practice was labile and impacted by ED activity levels and resource availability. Cultural expectations and beliefs provided nurses with emotional response profiles for different care situations. A lack of understanding of our own cultural milieu and emotions can prejudice thinking and result in beliefs and expectations that strangle the very principles which drive nursing practice. By making apparent the interrelatedness of belief systems and emotions the potential influence of a labile response to a particular emergency situation or event can be reduced. By examining our own belief systems nurses can give rise to more discipline and thoughtful practice. In this way, clinicians can critique their own belief systems, be better informed and positioned to be more culturally competent and deliver a more equitable and just health care system.(Wolf and Calmes, 2004)

The findings of this study demonstrate how cultural dimensions frame nurse understanding, define beliefs and motivate action and emotion. Triage nurses shared a belief system that helped to maintain consistent behavioural patterns and sustain cultural meanings. Health practice behaviour, activity and decision-making needs to be viewed as a complex web derived from cultural knowledge. Beliefs embedded within practice environments can impact on nursing assessment and care practices.

LIMITATIONS

There are a number of limitations with the study. The study focused on Triage Nurses at Clinical Nurse Specialist level who may have different views and behaviours when compared to those with less experience. Given the researcher worked fulltime and was only able to collect data on the specified days the findings may be different had the study been conducted at different times. While the researcher had never worked in the participating sites she was an emergency clinician, which may have biased findings. The findings convey only the participants' story and cannot be situated more broadly within the context of emergency nursing. While the sample group was representative it was not inclusive of all Triage Nurses throughout NSW and the findings may have limited application. However, inferences can be made as the context of care is similar to most EDs nationally and internationally.

CONCLUSIONS

Cultural knowledge is tightly woven within everyday nursing practice. This study has provided a sensitive and sophisticated understanding of Triage Nurse beliefs and how they may influence nursing practice. By using ethnography to explore the context and processes embedded in this setting, an understanding of how Triage Nurses experience, make sense of, manage and define their practice and themselves has unfolded.

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Table1. Triage Nurse Age and Years of experience

Nurse	Age	RN years	ED years	Triage years	CNS* years
Andrew	30	6	4	2	1
Karen	42	20	12	10	5
Kylie	35	14	12	10	8
Mathew	27	7	5	2	2
Meg	35	5	4	2	1
Peter	41	20	10	9	1
Sally	30	10	8	6	5
Samantha	27	6	5	3	4
Tanya	30	10	8	6	3
Toni	34	12	5	4	1
Average years	33.1	11.0	7.3	5.4	3.1

*Clinical Nurse Specialist

Table 2

Table 2. Triage Nurse academic qualifications

Nurse (n=10)	Qualifications	Hospitals (n=4)
Andrew	Master Critical Care	Tertiary
Peter	Master Critical Care	Metropolitan
Samantha	Master Critical Care	Tertiary
Tanya	Master Critical Care	Tertiary
Karen	Emergency Certificate	Metropolitan
Kylie	Emergency Certificate	Tertiary
Mathew	Emergency Certificate	Tertiary
Meg	Emergency Certificate	Tertiary
Toni	Emergency Certificate	Tertiary
Sally	Postgraduate Certificate Critical Care	Tertiary

Table 3

Table 3 Seven embedded beliefs within triage care practices

Belief 1:	Respecting Space and Privacy
Belief 2:	Taking control and Responsibility
Belief 3:	Patients should not arrive with expectations
Belief 4:	Do not ask for a bed
Belief 5:	Expect a level playing field
Belief 6:	No benefit from having a referral letter
Belief 7:	Do not waste time