Trauma Mon. 2016 September; 21(4):e23260. doi: 10.5812/traumamon.23260.
Published online 2016 March 27. **Research Article**

Nonemergent Patients in the Emergency Department: An Ethnographic Study

Amir Mirhaghi,[1] Abbas Heydari,[1,*] Mohsen Ebrahimi,[2] and Mohsen Noghani Dokht Bahmani[3]

[1]Department of Medical-Surgical Nursing, School of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, IR Iran
[2]Imam Reza Hospital, Mashhad University of Medical Sciences, Mashhad, IR Iran
[3]Department of Social Sciences, Faculty of Letters and Humanities, Ferdowsi University of Mashhad, Mashhad, IR Iran

[*]*Corresponding author*: Abbas Heydari, Department of Medical-Surgical Nursing, School of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, IR Iran. Tel: +98-513859151, Fax: +98-5138539775, E-mail: Heidarya@mums.ac.ir

Received 2014 September 02; **Revised** 2014 December 01; **Accepted** 2014 December 10.

Abstract

Background: Triage in the interactive atmosphere of the emergency department (ED) has been described as complex and challenging. Nonemergent ED visits have been accompanied by ethical and legal conflicts.
Objectives: The aim of this study was to gain an understanding of ED nurses' practice regarding triage of nonemergent patients.
Patients and Methods: Focused micro-ethnography based on Spradley's developmental research sequence (DRS) was used. This study was conducted in an emergency department. Data was collected through complete participant observations along with formal and informal interviews, and then analyzed using DRS.
Results: Nine key informants were interviewed formally. Four main categories emerged from the nurses' culture: nonemergent patient as an uninvited guest, nonemergent patient as an elephant in a dark room, nonemergent patient as an aggressive client, and being nonemergency unless at risk of death.
Conclusions: Providing care in the emergency department is significantly affected by nonemergent patients, as the emergency department is a place for critically ill patients thus awareness training program is recommended.

Keywords: Nonemergent Patient, Triage, Emergency, Ethnography

1. Background

Emergency departments (EDs) around the world have faced increasing visits in the last decade. This rise has been large enough to be recognized as overcrowding (1). However, the causes of ED overcrowding are multidimensional, with increased ED patient volumes being the pivotal source (2). Nonemergent visits may account for up to 95% of all ED department visits (3), so the role of nonemergent patients in EDs has emerged as a controversial issue (4).

An upcoming issue relating to nonemergent patients as a poorly identified population concerns how they should be defined (5). Although many studies have tried to determine patient acuity more objectively (6), a critical review revealed that remarkable discrepancies exist among studies in defining nonemergent patients (4), therefore it is vital to clarify the definition of nonemergent patients. In addition, no qualitative study has yet explored clinicians' views on nonemergent patients.

Several studies have indicated that nonemergent visits as inappropriate ED use are associated with ED overcrowding, as well as with increased mortality and morbidity, service delays, patient dissatisfaction, and financial burdens (7). In contrast, some studies have argued that inappropriate effects of nonemergent patients on ED measures are insignificant (8). Also, potential savings from redirecting nonemergent patients to alternative sources of care have not been reported as being substantial compared to the high costs of EDs (9).

While emergency departments are trying to redirect nonemergent patients to alternative facilities such as clinics (10), this strategy has raised ethical and legal issues (11) as well as care safety concerns because the availability, accessibility, and affordability of alternative settings, especially for vulnerable populations, has been inconsistent (12, 13). Likewise, worldwide the governments of healthcare services mandate a medical screening examination for each individual who seeks emergency care (14). In addition, a lot of effort has been put into reducing the waiting times of ED patients (15). Violations of patient safety occur in emergency departments (16, 17), so it is critical to understand the views of clinicians on nonemergent admission to hospitals through the emergency department.

Copyright © 2016, Trauma Monthly. This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses/by-nc/4.0/) which permits copy and redistribute the material just in noncommercial usages, provided the original work is properly cited.

Hospital triage is defined as prioritizing incoming patients to the ED based on their acuteness (18). The triage nurse determines whether an incoming patient should be classified as a high or low triage priority. Nonemergent patients are primarily identified and categorized as level IV or V by the triage nurse (13). Studies have shown that agreement on prioritizing nonemergent patients among physicians, nurses, and patients is not almost perfect (4) and further studies are required to explore which criteria are essential for identifying nonemergent patients (12). Since nurses' judgment is still the main element in categorizing patients in the triage room, it is necessary to investigate nurses' belief systems regarding nonemergent patients (19).

Ethnography is the work of describing a culture. Culture as the shared acquired knowledge of people has been used to interpret experience and generate behavior (20). Ethnography brings an explicit, systematic, and rigorous approach to the collection and analysis of research data (21). Understanding beliefs in a culture of triage could provide a unique insight into how patients are viewed as nonemergent (19). Moreover, practicing triage is context-dependent and affected by various factors associated with ED processes (20).

2. Objectives

The aim of this study is to gain an understanding of ED nurses' culture of practice regarding the triage of nonemergent patients.

3. Patients and Methods

Focused micro-ethnography based on Spradley's developmental research sequence (DRS) was used (20).

The present study was approved by the ethics committee of Mashhad University of Medical Sciences and the disaster management committee of the hospital where the study was conducted. Informed consent was obtained from all staff involved in the study. The principles of professional responsibility and ethical conduct developed by the American anthropological association (AAA) were utilized in the study (22).

The hospital is a referral tertiary care center with 202 beds and an area of 24,000 square meters and is located in Mashhad in the northeast of Iran. It offers all specialty services except gynecology, obstetrics, and pediatrics. This hospital reports more than 150,000 patients being admitted to the emergency department annually, half of whom are injured patients from the northwestern part of the city. Thirty-six registered nurses (RN), 2 licensed practical nurses (LPN), 10 physicians (GP), and 6 ancillary staff work in the ED. The ED has 10 in-patient beds. The triage room is open 24 hours a day, except from 02:00 to 06:00. The triage nurse categorizes patients into five levels: level I (red), level II (violet), level III (green), level IV (blue) and level V (white). Critically ill and ill patients are referred to sections I and II in the ED respectively. Patients assigned to level V are considered nonemergent and are redirected to the outpatient clinic in the hospital, which is open in the morning (08:00 - 12:00) and the afternoon (16:00 - 20:00), except for closed days and public holidays.

The study was conducted in the ED from February to May 2014. The researcher (A.M.) was a complete participant observer and actively involved in daily practice. 120 hours of participant observation occurred in 3-hour sessions. Participant observation was gradually increased, going from passive to complete. Data was collected through ethnographic observation of cultural behavior, artifacts, and speech messages and from interactions among the researcher, staff, and patients.

Expanded and condensed field notes were recorded during observations. A fieldwork journal was kept to record experiences, ideas, fears, mistakes, confusions, breakthroughs, and problems that arose during fieldwork in order to recognize any bias could affect data interpretation (20). Formal and informal interviews were also conducted and audiotaped to collect data. Purposeful sampling was used to locate culturally sensitive informants. Nine out of 36 ED nurses who have worked for more than two years in the triage room were selected as initial candidates to be formally interviewed. Other staff members were informally interviewed.

The interview questions were semi-structured, consisting of descriptive, structural, and contrast questions in relation to each stage of the data collection process. The questions were based on Spradley's interview questions in ethnographic studies (20). Expressing interest, expressing ignorance, avoiding repetition, and taking turns were considered during the interview sessions. The interviews were tape-recorded and transcribed verbatim. All nurses were interviewed by one researcher (A.M.) in the ED.

Descriptive, focused, and selective observations were conducted. Descriptive observations included grand tour and mini-tour observations. Major features were investigated using a descriptive questions matrix, for example, What kinds of activities occur in the triage room? Participants completed free lists to answer a structural question in interviews which were held during focused observation (23). The structural question was "What kind of patient is nonemergent? Formal interviews were most frequently performed to contrast the meaning of each cultural subcategory in selective observation (24). Contrast questions

were used, for example, How do nonemergent patients differ? (Appendix 1).

Data collection and analysis is a cyclical pattern (21). Domain, taxonomic, componential, and theme analysis were conducted throughout the research period. The analysis field notes record generalizations, analyses of cultural meanings, interpretations, and insights into the culture studied (20). Nonemergent patients as a mixed domain emerged in the domain analysis. The semantic relationship was strict inclusion to describe kinds of nonemergent patients in a domain analysis worksheet including cover terms and included terms (Box 1). Similarities among the included terms based on the same semantic relationship were explored using free lists and interviews in a taxonomic analysis (Table 1). Free list data demonstrate a kind of cultural agreement. Individual salience was computed using inversely ranked items on an individual's list and likewise items increase by one moving up the list. Then the rank was divided by the total number of items that the individual listed (25). All individual salience scores for each item were added up and divided by the number of respondents (23). Attributes (unit of meaning) associated with cultural subcategories have been presented as paradigm in componential analysis (Table 2).

Box 1. Domain Analysis Worksheet for Nonemergent Patients[a,b]

Nonemergent patients Included terms:
Uncomplicated common cold
Prolonged pain which has lasted more than 72 hours
Delay in treatment does not result in life-threatening condition
Uncompromised traumatic injury
Patients request for a specific medication
Patients with long-standing symptoms presenting at midnight
Chronic neurotic patients
Uncompromised breathing and airway
Patients request for a specific laboratory test and radiography
Patients request for a specialist with a long-term condition
Common skin disorders
Hemodynamic stability
Lack of relevant technological and specialist resources
Minor pain
Uncompromised low back pain
Patients without altered level of consciousness
Patients request for a health record form
Uncompromised abdominal pain
First-degree burn
Minor wound without hemorrhage
Patients without a prior history of disease

[a]Semantic relationship: strict inclusion.
[b]Structural question: What kind of patient is nonemergent

Trustworthiness: Prolonged field experience, observing several cultural situations, varied time sampling, continuous fieldwork journaling, triangulation characterized by concordance among cultural behaviors, artifacts and speech messages, establishing a trustful relationship with triage nurses, and checking findings with triage nurses and colleagues were used in order to ensure optimum credibility. Dependability was followed by providing a thick and clear description of research methods and stepwise replication over a longer period (26).

4. Results

Thirty-six nurses working in the ED, 12 of whom contributed to triage were observed during a 120-hour period. Nine of the nurses had more than two years' experience in triage practice. Interviews and free listing survey included 9 triage nurses who were culturally sensitive informants. The nurses' ages ranged from 26 to 35 (31 ± 2.4). 55% of them were male. All nurses were registered and had a baccalaureate of science in nursing.

The researchers gained insight into nurses' beliefs on nonemergent patients. The shared knowledge of nurses revealed that nonemergent patients did not belong to the ED. Nurses identify nonemergent patients using key criteria, including non-life-threatening medical condition, low-risk history, and time to arrival or treatment. In addition, triage nurses categorize patients as nonemergent when there is both actual and implied pressure from their colleagues to prevent these patients from reaching the ED. Four main categories were identified: nonemergent patient as an uninvited guest, nonemergent patient as an elephant in a dark room, nonemergent patient as an aggressive client, and being nonemergency unless being toward death.

Nonemergent patient as an uninvited guest: There is a strong belief in the ED that nonemergent patients should not receive care under any circumstances. There are cultural artifacts in the entrance area of the ED, including several banners on the wall that state Nonemergent patients are not admitted in this emergency department. Numerous observations have verified that redirecting nonemergent patients from the ED to the outpatient clinic is a routine practice. Sara said in a mini-tour: From here nonemergent patients are rejected. [They] go to the clinic. And David said: Roxana justifies going to the clinic to anyone by any means necessary. Rejecting them to go. They cannot even go near the ED.

Nonemergent patient as an elephant in a dark room: Observation has verified that there are remarkable discrepancies among nurses or even physicians in determining whether patients are nonemergency, so daily debates

Table 1. Free Listing Response Regarding Nonemergent Patients[a,b]

What kind of patient is nonemergent?	$\sum$ Individual Salience	Composite Salience
Uncomplicated common cold	4.07	0.45
Prolonged pain which has lasted more than 72 hours	3.35	0.37
Delay in treatment does not result in life-threatening condition	3.00	0.33
Uncompromised traumatic injury	1.87	0.20
Patients request for a specific medication	1.40	0.16
Patients with long-standing symptoms presenting at midnight	1.00	0.11
Chronic neurotic patients	0.86	0.10
Uncompromised breathing and airway	0.83	0.09
Patients request for a specific laboratory test and radiography	0.80	0.09
Patients request for a specialist with a long-term condition	0.80	0.09
Common skin disorders	0.71	0.08
Hemodynamic stability	0.67	0.07
Lack of relevant technological and specialist resources	0.67	0.07
Minor pain	0.50	0.06
Uncompromised low back pain	0.53	0.06
Patients without altered level of consciousness	0.33	0.04
Patients request for a health record form	0.40	0.04
Uncompromised abdominal pain	0.33	0.04
First-degree burn	0.29	0.03
Minor wound without hemorrhage	0.25	0.03
Patients without a prior history of disease	0.17	0.02

[a] Responses are listed in order of composite salience, highest to lowest.
[b] $\sum$ Individual Salience = sum of the all individual saliences, N = total number of respondents, (composite salience = $\sum$ Individual salience/N).

about them are common in routine practice. Amir said: Each nurse triages patients individually. For example, a nurse like Miriam, do you know her? [Silence (cultural ignorance)] She tries to treat most patients. In spite of all the disagreements, three criteria were dominant in nurses' decision-making, including non-life-threatening medical condition, low-risk history, and time to arrival or treatment. Generally, nurses check a patient's medical condition to ensure that it is not life-threatening and search the patient's history to rule out any risk factors and evaluate how long he/she can wait for treatment (Table 2).

Nonemergent patient as an aggressive client: Observations have confirmed that redirecting patients from the ED to the outpatient clinic could be a threatening situation. It is not rare to see an angry nonemergent patient around the triage area. In the ED and around the triage area, there are several posters warning that if someone commits an assault on a staff person, he/she will face legal penalties. Nurses believe rejecting patients usually results in conflict and tension. Lila said: suddenly a man comes yelling at you that he will not accept going somewhere else. I have mitral valve prolapse and a heart problem too, [it] has caused the PVCs to start, [I] quickly go to take propranolol. In addition, triage nurses tolerate actual and implied pressure from their colleagues to prevent nonemergent patients from reaching the ED. Mohammed said: Triage is where you feel pressured from both inside and outside the triage room. Once when ED section II was getting crowded, an ED nurse told me At least you can reject uninsured [nonemergent patients]. Everyone wants to work less.

Being nonemergency unless being toward death: There is a belief that a patient who is near death deserves to be an emergency patient. It was observed that several critically ill patients were categorized as code red by a researcher in the triage room, but their triage codes were changed to green by a physician. David said: [Nurses] check how close [the patient] is to death. 115 had brought a patient just a while ago. The triage [nurse] had underestimated the patient. Gave him [code] green. We suddenly found the patient collapsed behind the door. He had told the triage [nurse] that he is ill. Triage is expected to save time. Imagine that the patient must have been died to receive a red [code].

5. Discussion

The findings give a deep insight into the ED nurses culture of practice regarding the triage of nonemergent patients.

Table 2. Paradigm of Nonemergent Patients Based on Dimensions of Contrast

Subcategories	Non-Life-Threatening Medical Condition	Low-Risk History	Time to Arrival or Treatment
Uncomplicated common cold	+		
Prolonged pain which has lasted more than 72 hours			+
Delay in treatment does not result in life-threatening condition			+
Uncompromised traumatic injury	+		
Patients request for a specific medication		+	
Patients with long-standing symptoms presenting at midnight	+		
Chronic neurotic patients			+
Uncompromised breathing and airway	+		
Patients request for a specific laboratory test and radiography		+	
Patients request for a specialist with a long-term condition			+
Common skin disorders	+		
Hemodynamic stability	+		
Minor pain	+		
Uncompromised low back pain	+		
Patients without altered level of consciousness	+		
Patients request for a health record form		+	
Uncompromised abdominal pain	+		
First-degree burn	+		
Minor wound without hemorrhage	+		
Patients without a prior history of disease		+	

Nurses believe that nonemergent patients do not belong to the ED, which is consistent with findings that reported nurses beliefs on inappropriate patient admissions due to misuse of the ED (27). Alienation was documented in the gatekeeping role of triage nurses (28) and in the us vs. them attitude between staff and nonemergent patients (29). Triage nurses through their gatekeeping role determine which cases are urgent or nonemergent and what is right or wrong (28) in order to embed cultural belief in place. Although some studies have showed that nonemergent patients are not significantly associated with unfavorable outcomes of ED overcrowding (8, 9), nurses strongly believe that nonemergent patients are linked to overcrowding.

Several studies have indicated that nonemergent visits as inappropriate ED use are associated with ED overcrowding, as well as with increased mortality and morbidity, service delays, patient dissatisfaction, and financial burdens (7). In contrast, some studies have argued that the effect of nonemergent patients on ED measures is insignificant (8) and that potential savings from redirecting nonemergent patients to alternative sources of care are not considerable compared to the high costs of EDs (9).

The results showed that considerable discrepancies exist among ED staff in determining whether patients are nonemergent, which is supported by other studies. Additionally, uncertainty in triage decision-making has been documented as a source of stress (30). Similar to our findings, a review showed variability in levels of agreement on defining nonemergent patients (4). Nurses believe that nonemergent patients were recognized largely unreliable and irreproducible, and relevant studies have confirmed this result (12, 13). Nonemergent patients have multiple reasons for visiting EDs and this may help explain why identifying nonemergent patients is so challenging (31). Generally, concordance of nurses on triage in the emergency department is not almost perfect regarding case mix (32). In addition, many disagreements on nonemergency situations have been reported between nurses and patients (33).

Consistent with previous results, nonemergent patients were more commonly identified using explicit criteria such as low-risk chief complaints (4). Also, componential analysis revealed that time is a critical element in identifying nonemergent patients; the concept of delay of care was previously introduced as the most frequent definition in other studies (4). In spite of the fact that staff belief in blocking access for nonemergent patients plays a pivotal role, hospital policies should examine definite sources of care and implied barriers to care for nonemergent pa-

tients.

Triage nurses believe that nonemergent patients are a significant source of stress and anxiety. Similar to our findings, it has consistently been reported that the ED is a stressful and chaotic environment (27). Although triage nurses believe that patients should not arrive with expectations, nonemergent patients strongly expected to be admitted to the ED (19), creating a persistent and frustrating conflict. Inevitable episodes of patient-related violence have occurred in the triage room, so triage nurses have expressed feelings of frustration (30, 34). A study reported that 61% of triage nurses felt more than a moderate level of anxiety (33), which is consistent with our findings. Aggression and violence in the ED violate the principle of beneficence as well as proper decisions in daily practice (11).

While both interpersonal empathetic communication and zero tolerance policies were suggested as effective methods for reducing violence in the ED (29), it is not obvious how the conflict of interest between staff and nonemergent patients in the ED could be resolved while most nonemergent patients are fully aware of the benefits of using the ED (31).

Culture as a multidimensional domain needs broad and comprehensive investigations. We mainly examined the shared knowledge of nurses in this study, which was based on Spradley's ethnosemantic method. Our limitation could be eliminated by including patients in future studies. Although this hospital was appropriately representative of all the hospitals in the city, a multicenter approach could enhance transferability of the study.

Providing care in the emergency department is significantly affected by nonemergent patients, so the mission of the ED as a place for serving critically ill patients has been challenged. An unconstructive approach to patient management could endanger safety and morale, resulting in poor outcomes. A cultural awareness training program is recommended.

Supplements

Supplementary material(s) is available at below link: http://traumamon.com/?page=download&file_id=57595

Acknowledgments

We wish to thank the ED staff of the hospital for participating in the study.

Footnote

Financial Disclosure: The research office of Mashhad University of Medical Sciences granted a doctoral dissertation (ID: 92175).

References

1. Hwang U, Concato J. Care in the emergency department: how crowded is overcrowded?. *Acad Emerg Med.* 2004;**11**(10):1097–101. doi: 10.1197/j.aem.2004.07.004. [PubMed: 15466155].
2. Javadzadeh HR, Davoudi A, Davoudi F, Mahmoodi S, Ghane MR, Goodarzi H, et al. Assigning residents of emergency medicine to screen patients before admission: a strategy to overcome overcrowding. *Trauma Mon.* 2012;**16**(4):191–3. doi: 10.5812/kowsar.22517464.2923. [PubMed: 24749100].
3. Richardson LD, Hwang U. Access to care: a review of the emergency medicine literature. *Acad Emerg Med.* 2001;**8**(11):1030–6. [PubMed: 11691664].
4. Durand AC, Gentile S, Devictor B, Palazzolo S, Vignally P, Gerbeaux P, et al. ED patients: how nonurgent are they? Systematic review of the emergency medicine literature. *Am J Emerg Med.* 2011;**29**(3):333–45. doi: 10.1016/j.ajem.2010.01.003. [PubMed: 20825838].
5. Backman AS, Blomqvist P, Lagerlund M, Carlsson-Holm E, Adami J. Characteristics of non-urgent patients. Cross-sectional study of emergency department and primary care patients. *Scand J Prim Health Care.* 2008;**26**(3):181–7. doi: 10.1080/02813430802095838. [PubMed: 18609257].
6. Norouzi V, Feizi I, Vatankhah S, Pourshaikhian M. Calculation of the probability of survival for trauma patients based on trauma score and the injury severity score model in fatemi hospital in ardabil. *Arch Trauma Res.* 2013;**2**(1):30–5. doi: 10.5812/atr.9411. [PubMed: 24396787].
7. Hoot NR, Aronsky D. Systematic review of emergency department crowding: causes, effects, and solutions. *Ann Emerg Med.* 2008;**52**(2):126–36. doi: 10.1016/j.annemergmed.2008.03.014. [PubMed: 18433933].
8. Schull MJ, Kiss A, Szalai JP. The effect of low-complexity patients on emergency department waiting times. *Ann Emerg Med.* 2007;**49**(3):257–64. doi: 10.1016/j.annemergmed.2006.06.027. [PubMed: 17049408] 264 e1.
9. Williams RM. The costs of visits to emergency departments. *N Engl J Med.* 1996;**334**(10):642–6. doi: 10.1056/NEJM199603073341007. [PubMed: 8592529].
10. Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. *Health Aff (Millwood).* 2010;**29**(9):1630–6. doi: 10.1377/hlthaff.2009.0748. [PubMed: 20820018].
11. Aacharya RP, Gastmans C, Denier Y. Emergency department triage: an ethical analysis. *BMC Emerg Med.* 2011;**11**:16. doi: 10.1186/1471-227X-11-16. [PubMed: 21982119].
12. Uscher-Pines L, Pines J, Kellermann A, Gillen E, Mehrotra A. Emergency department visits for nonurgent conditions: systematic literature review. *Am J Manag Care.* 2013;**19**(1):47–59. [PubMed: 23379744].
13. Vertesi L. Does the Canadian Emergency Department Triage and Acuity Scale identify non-urgent patients who can be triaged away from the emergency department?. *CJEM.* 2004;**6**(5):337–42. [PubMed: 17381991].
14. Berardi KL. Emergency Medical Treatment and Active Labor Act. *W New Eng L Rev.* 2007;**30**:515.
15. Mendis D, Vesely M. Improvements in the management of trauma patients with the introduction of a lower limb trauma coordinator. *Trauma Mon.* 2012;**16**(4):201–2. doi: 10.5812/kowsar.22517464.3424. [PubMed: 24749103].
16. Rosenbaum S, Cartwright-Smith L, Hirsh J, Mehler PS. Case studies at Denver Health: 'patient dumping' in the emergency department despite EMTALA, the law that banned it. *Health Aff (Millwood).* 2012;**31**(8):1749–56. doi: 10.1377/hlthaff.2012.0517. [PubMed: 22869653].

17. Khorgami Z, Gougol A, Soroush A. Causes of deceptive non-admission to the emergency department: personnel's point of view. *jmehm.* 2012;**5**(3):81–90.
18. Mirhaghi AH, Roudbari M. A survey on knowledge level of the nurses about hospital triage. 2011
19. Fry M. An ethnography: Understanding emergency nursing practice belief systems. *Int Emerg Nurs.* 2012;**20**(3):120–5. doi: 10.1016/j.ienj.2011.09.002. [PubMed: 22726943].
20. Spradley JP. Participant observation. 1980
21. Parfitt BA. Using Spradley: an ethnosemantic approach to research. *J Adv Nurs.* 1996;**24**(2):341–9. [PubMed: 8858439].
22. American Anthropological Association. . The council of the American anthropological association. 2012.
23. Quinlan M. Considerations for collecting freelists in the field: examples from ethobotany. *Field Methods.* 2005;**17**(3):219–34.
24. Spradley JP. The ethnographic interview. 1979
25. Smith JJ. Using ANTHOPAC 3.5 and a spreadsheet to compute a free-list salience index. *Field Methods.* 1993;**5**(3):1–3.
26. Krefting L. Rigor in qualitative research: the assessment of trustworthiness. *Am J Occup Ther.* 1991;**45**(3):214–22. [PubMed: 2031523].
27. Person J, Spiva L, Hart P. The culture of an emergency department: an ethnographic study. *Int Emerg Nurs.* 2013;**21**(4):222–7. doi: 10.1016/j.ienj.2012.10.001. [PubMed: 23228617].
28. Fry M, Stainton C. An educational framework for triage nursing based on gatekeeping, timekeeping and decision-making processes. *Accid Emerg Nurs.* 2005;**13**(4):214–9. doi: 10.1016/j.aaen.2005.09.004. [PubMed: 16263286].
29. Lau JB, Magarey J, Wiechula R. Violence in the emergency department: an ethnographic study (part II). *Int Emerg Nurs.* 2012;**20**(3):126–32. doi: 10.1016/j.ienj.2011.08.001. [PubMed: 22726944].
30. Chung JY. An exploration of accident and emergency nurse experiences of triage decision making in Hong Kong. *Accid Emerg Nurs.* 2005;**13**(4):206–13. doi: 10.1016/j.aaen.2005.08.003. [PubMed: 16199164].
31. Afilalo J, Marinovich A, Afilalo M, Colacone A, Leger R, Unger B, et al. Nonurgent emergency department patient characteristics and barriers to primary care. *Acad Emerg Med.* 2004;**11**(12):1302–10. doi: 10.1197/j.aem.2004.08.032. [PubMed: 15576521].
32. Farrohknia N, Castrén M, Ehrenberg A, Lind L, Oredsson S, Jonsson H, et al. Emergency department triage scales and their components: a systematic review of the scientific evidence. *Scand J Trauma Resusc Emerg Med.* 2011;**19**(42):1–13.
33. Lowe RA, Bindman AB. Judging who needs emergency department care: a prerequisite for policy-making. *Am J Emerg Med.* 1997;**15**(2):133–6. [PubMed: 9115511].
34. Pich J, Hazelton M, Sundin D, Kable A. Patient-related violence at triage: A qualitative descriptive study. *Int Emerg Nurs.* 2011;**19**(1):12–9. doi: 10.1016/j.ienj.2009.11.007. [PubMed: 21193163].