Navigating Triage: A Qualitative Study of Patient Experiences in Emergency Room Intake

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Statement of the Problem

Emergency room triage is the procedure that establishes the order in which patients receive care according to the severity of their conditions (Gilboy et al., 2011). Despite its importance in ensuring prompt and effective treatment, patients frequently report confusion, anxiety, and dissatisfaction during the triage process. An integrative review of patient experience at emergency department triage found that waiting, information, initiation of care, and interactions with staff were the factors that most shaped how patients experienced this stage of care, and concluded that current triage processes may not adequately account for individual patients' needs (Janerka et al., 2024).

The problem is that triage research has concentrated on efficiency and clinical accuracy rather than on how patients understand what is happening to them. Patients' perceptions of triage encounters, of the decisions that determine their waiting, and of their communication with healthcare workers remain comparatively under-examined. This gap limits efforts to strengthen patient-centered care in emergency settings, because interventions cannot be designed around experiences that have not been documented.

Understanding patient experience during triage also matters because it reveals how systemic pressures shape perceptions of fairness and quality. Emergency department crowding has well-documented effects on care delivery (Hoot & Aronsky, 2008), and crowding has been associated with measurably lower patient satisfaction among admitted patients (Pines et al., 2008). What those quantitative findings cannot show is how patients themselves interpret the delays and priority decisions they encounter. An in-depth examination of these lived experiences offers insight into discrepancies between clinician priorities and patient expectations, and may

inform improvements to workflow, communication, and patient-centered emergency department procedures.

Purpose of the Study

The purpose of this qualitative phenomenological study is to describe the lived experiences of adult patients during emergency room triage at a single urban emergency department. The study seeks to understand how patients perceive triage processes, how they interpret their interactions with triage nurses, and how they experience the psychological effects of waiting and prioritization.

The study additionally examines how environmental stressors such as crowding, noise, and wait times, together with perceived fairness of prioritization and clarity of information, affect patients' trust in the healthcare system. Wolf et al. (2021) argued that patient experience should be understood as a human experience encompassing emotional and relational dimensions rather than service satisfaction alone, and this study adopts that broader framing. In doing so it aims to contribute to the body of knowledge on patient experience in high-acuity care settings and to produce practical recommendations for improving patient-centered communication during triage. The intent is not only to describe experiences but to inform improvements that can be applied in clinical practice.

Research Questions

1. How do patients describe their experiences in the emergency department throughout the triage process?
2. How do patients perceive communication with triage nurses and other staff?
3. What emotions do patients report while being triaged and while waiting for medical attention?

4. Which aspects of the triage process affect patients' comprehension of, and satisfaction with, their care?

Significance of the Study

This study is significant because triage is the initial point of clinical contact in the emergency department and sets the tone for the entire patient experience (Janerka et al., 2024). By concentrating on patient perspectives, this research can help develop techniques to strengthen communication, transparency, and emotional support during triage. Improving the triage encounter may reduce anxiety, build trust, and increase satisfaction with emergency care services.

The findings should also help healthcare administrators and policymakers identify gaps between patient expectations and clinical objectives during triage. The study supports the establishment of training programs for triage nurses that prioritize empathy, communication, and cultural competence, and it adds to the expanding emphasis on patient-centered care by foregrounding patient voices.

Understanding patient perspectives can further guide measures intended to reduce perceived wait times, increase the clarity of triage decisions, and create a more supportive environment, which makes the study relevant to quality improvement work as well as to research. From an academic standpoint, the study contributes to the qualitative literature in emergency care and establishes groundwork for later research examining interventions or comparing triage experiences across other healthcare environments.

Research Design

This study will employ a descriptive phenomenological design in order to document the lived experiences of patients undergoing triage in the emergency department. Phenomenology is

appropriate because the research question concerns the meaning participants attach to an experience rather than the frequency or measurable outcome of that experience (Creswell & Poth, 2018). The study is descriptive rather than interpretive: the aim is to render participants' accounts of triage as faithfully as possible rather than to situate them within a prior theoretical frame.

Participants and Sampling

Purposive sampling with maximum variation will be used to select participants, ensuring diversity in age, gender, presenting condition, and assigned triage acuity level. Eligible participants will be adults aged 18 and over who completed triage at the study site within the previous three months, who are medically stable at the time of recruitment, and who are able to participate in an interview in English.

The study will recruit an initial sample of 12 to 15 participants, with recruitment continuing until no new themes emerge from successive interviews. Sample size is guided by information power rather than a fixed target: a narrowly defined aim, a specific sample, and a strong dialogue in the interviews all reduce the number of participants required (Malterud et al., 2016). Recruitment will halt when two consecutive interviews generate no new codes.

Data Collection

Data will be gathered through semi-structured, one-to-one interviews conducted within two weeks of the participant's emergency department visit, a window chosen to balance recall accuracy against the impracticality of interviewing patients still in acute distress. Interviews will last approximately 45 to 60 minutes and will follow an interview guide organized around the four research questions, with open-ended prompts inviting participants to describe the triage encounter in their own words and follow-up probes used to explore emerging topics.

All interviews will be audio recorded with participant consent and transcribed verbatim. The study will be submitted for institutional review board approval before recruitment begins, and participants will provide written informed consent. Transcripts will be de-identified, with pseudonyms replacing names and any identifying clinical details removed.

Data Analysis

Transcripts will be analyzed using reflexive thematic analysis following the six phases described by Braun and Clarke (2006): familiarization with the data, generation of initial codes, construction of candidate themes, review of themes against the coded extracts and the full data set, definition and naming of themes, and production of the report. Coding will be inductive, with codes derived from the transcripts rather than applied from an existing framework.

Trustworthiness will be supported through four established strategies. Member checking will invite participants to review a summary of the preliminary themes for accuracy. Peer debriefing with a colleague outside the study will test the plausibility of the developing analysis. An audit trail will document coding decisions and analytic memos so that the path from transcript to theme is traceable. Finally, a reflexivity journal will record the researcher's own assumptions as a practitioner in emergency care, since that professional background shapes what is noticed and how it is interpreted (Creswell & Poth, 2018).

Definitions

- Triage: the process of prioritizing patients according to the severity of their conditions in order to allocate care appropriately (Gilboy et al., 2011).
- Emergency room: a hospital-based facility providing immediate care for serious injuries and acute illness.

- Patient experience: the sum of interactions that shape a patient's perception of care, including communication, emotional support, and waiting, understood as a human rather than purely transactional experience (Wolf et al., 2021).
- Phenomenology: a qualitative methodology that investigates the lived experience of a phenomenon as described by those who have experienced it (Creswell & Poth, 2018).
- Thematic analysis: a method for identifying, analyzing, and reporting patterns of meaning within qualitative data (Braun & Clarke, 2006).
- Information power: the principle that the number of participants needed depends on the specificity of the aim, sample, and interview quality rather than on a fixed threshold (Malterud et al., 2016).

Limitations

This study has several limitations. The sample is small and non-random, so findings will not be statistically representative of all patient populations; the aim is transferability of insight rather than generalizability. Participants' accounts may be affected by recall bias, and because the study is conducted at a single site, results may not reflect variation in triage procedures across hospitals, geographic regions, or healthcare systems.

Reliance on self-reported data introduces further limitations, since accounts may be shaped by participants' emotions, memories, or individual expectations of care. Patients who had exceptionally positive or negative experiences may be more inclined to volunteer, producing response bias that skews the sample toward stronger reactions. Time and resource constraints may also limit the number of interviews conducted, restricting the breadth of perspectives captured.

Participant responses may additionally be influenced by the researcher's presence, since people sometimes adjust what they say to match perceived expectations. Finally, because this is a qualitative study, the conclusions are interpretive and depend in part on the researcher's analytic judgment. Subjectivity in interpretation cannot be eliminated entirely, though the reflexivity journal, audit trail, member checking, and peer debriefing described above are intended to make that judgment visible and accountable.

Delimitations

This study includes only adult patients aged 18 and over who were triaged at a single urban emergency room within the previous three months. Pediatric patients, healthcare professionals, and individuals unable to participate in interviews because of cognitive or language barriers are excluded. Because resources for translation and interpretation are not available, participation is limited to patients who speak English, and the study will only include patients who are medically stable at recruitment so that they can give considered and informed responses.

The study examines only the triage portion of the emergency department visit and does not extend to the diagnostic, treatment, or discharge processes that follow. It also does not compare triage systems or hospitals, since the aim is a detailed understanding of experience within one particular setting rather than broad generalization across settings.

Assumptions

This study rests on several assumptions. Participants are expected to give candid and thoughtful descriptions of their triage experiences, and these experiences are assumed to offer meaningful insight into broader patterns of patient perception. The study assumes that qualitative methods are suitable for examining the complexity of the triage encounter, and that participants

can reliably recall experiences occurring within the three-month window in enough detail to support thematic analysis.

It is further assumed that triage is a significant and memorable part of the emergency department visit, which makes it a suitable object of study, and that the semi-structured interview format enables rich data collection with participants interpreting questions consistently. Finally, the study assumes that the researcher will maintain reflexive awareness and limit the influence of personal bias throughout data collection and analysis, and that the themes identified will represent shared features of the triage experience despite variation among participants.

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