International Emergency Nursing 25 (2016) 65–70

Contents lists available at ScienceDirect

International Emergency Nursing

journal homepage: www.elsevier.com/locate/aaen

The meaning of being triaged to non-emergency ambulance care as experienced by patients

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ARTICLE INFO

Article history:
Received 19 May 2015
Received in revised form 30 June 2015
Accepted 3 August 2015

Keywords:
Ambulance care
Patient
Person
Phenomenological hermeneutic method
Prehospital emergency care

ABSTRACT

Background: The levels of care in the Swedish healthcare system comprise self-care, primary care as well as accident and emergency care. The Swedish system of specialist ambulance nurses enables referral by prehospital triage. However, little is known about patients' experiences of not being triaged to the emergency department.
Aim: To explore the subjective meaning of non-emergency ambulance care among patients who were triaged to levels of care below that of the Accident and Emergency Department.
Approach/Methods: An inductive design inspired by phenomenological hermeneutics. Twelve patients were interviewed using an open-ended method.
Findings: Two structural analyses resulted in three themes covering the subjective meaning of being taken seriously or not being taken seriously. When taken seriously, the patient was empowered irrespective of the outcome of the medical assessment and triage process. When not taken seriously the patient doubted her/his own judgement and felt guilty and ashamed about bothering the ambulance service.
Conclusion: N-EAC involves a strong need to be taken seriously and listened to when describing one's illness experience. When taken seriously, the patient feels as a competent person. Spending time with the patient is vital as well as listening to and inviting her/him to participate in the decision-making process. However not being taken seriously constitutes an infringement of personal autonomy.

1. Background

Little is known about patients' experiences of the Ambulance Care Service (ACS) following the introduction of primary triage, which is based entirely on the medical assessment triage system. There is also a lack of inductive studies on how patients create meaning in a situation when the ambulance does not transport them to the Accident and Emergency Department (AED), which for many patients is the expected destination. There are no statistics on the number of non-emergency ambulance care (N-EAC) assignments in Sweden as a whole. However, documentation reveals that there are about 150,000 ambulance assignments, i.e. whenever an ambulance is sent on an accident scene, to a sick person or equivalent, in the southernmost county of Sweden (Region Skåne, 2010). When assessed by the 112 operator, about 60 per cent are classified as N-EAC. When the ambulance has arrived and the specialist ambulance nurse (SAN) has assessed the patient's condition and medical care needs, about 85–90 per cent of cases are categorised as N-EAC. The emergency medical context, including the ACS, uses a different triage medical protocol than the 112 services, thus there is a lack of consistency between the two systems, which is not necessarily problematic (Ek et al., 2013).

Most first world countries have a paramedic-based ambulance care system that emphasises emergency medical treatment. However, in an otherwise extensive training course for paramedics, there is a lack of behavioural and humanistic dimensions (Melby and Ryan, 2005). A SAN, who mostly takes care of one patient at a time, should be able to initiate the assessment from a medical as well as a holistic and humanistic perspective without making the patient feel that she/he is just another routine job for the SAN (Holmberg et al., 2013; Melby and Ryan, 2005). Within the ACS, caring is described in different contexts, from acute, traumatic (Elmqvist et al., 2008) to non-traumatic situations (Ahl and Nystrom, 2012; Ahl et al., 2006; Alex et al., 2013; Holmberg et al., 2013). The key message from these studies is that patients in the care of the ACS are exposed and vulnerable, i.e., dependent on the ambulance staffs' care and decisions.

ACS care is often described as being conducted in a relaxed manner, with the exception of life-threatening situations. This enables the SAN to get to know the patient, understand the situation

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http://dx.doi.org/10.1016/j.ienj.2015.08.001
1755-599X/

Box 1. The Swedish ambulance service.
The Swedish ambulance service (in our study referred to as the Ambulance Care Service, ACS) has progressed from being purely a transport organisation to an integral and important part of the emergency care service. Patients who suffer traumatic injuries or who require medical attention can be assessed and, if necessary, interventions can take place at the accident scene or during transportation to the hospital (Borland et al., 2002; Gardelof, 1998; Jacob et al., 2008). In Sweden, it is mandatory for every ambulance crew to include at least one registered nurse. In most counties this requirement has been upgraded to a specialist nurse, preferably a SAN (Suserud, 2005). Crewing ambulances with nurses became inevitable because of the high level of technological progress that now characterises the emergency care service, including the prehospital field, resulting in an increased demand on the expertise of the ambulance crew (Ahl et al., 2005; Suserud, 2005).
In general, the levels of care in the Swedish health system comprise self-care, primary care (including home visits by the local GP) and the accident and emergency department of the hospital (AED). The Swedish ambulance service has a diversity of guidelines and policies, as healthcare is organised and controlled at regional and county level (National Board of Health and Welfare, 2012). Hence, the guidelines present different instructions to ambulance service crews, including the possibility of referring patients to a lower level of care than the AED. In the southern county of Skåne, Specialist ambulance nurses are encouraged to triage to N-EAC, where appropriate, thus avoiding overcrowding of the AED by non-acute patients. The triage consists of a two tier system and patients are sorted by means of the guidelines in the triage hand book (Region Skåne, 2010), which decides the level of care and prioritisation of patients by means of the Rapid Emergency Triage and Treatment System or RETTS (Widgren, 2012). With a few exceptions, the latter is implemented nationwide in Sweden in both ambulances and intra-hospital settings. By using the same instrument for prioritising patients in the ambulance system, the need for initial intra-hospital triage is eliminated on the arrival of the ambulance at the AED (Widgren, 2012; Widgren and Jourak, 2011; Widgren et al., 2008).

as well as the nature of the illness or medical problem and to confirm the patient's suffering (Wireklint Sundstrom and Dahlberg, 2011), after which triage of the patient is done and a decision is made of the appropiate level of care. There is potential to transform the situation into a unique and truly caring encounter. As the phenomenon of being triaged to lower levels of care than the AED is fairly new in the context of the ACS, more information is required about the basics of one-on-one ambulance emergency care and the meaning of not being triaged to the AED.

2. Aim

The aim of this study was to elucidate the subjective meaning of N-EAC among patients who were triaged to levels of care below that of the Accident and Emergency Department.

3. Methods

3.1. Methods and design

A phenomenological hermeneutic approach based on Ricoeur's philosophy (Ricoeur, 1976, 1981) was chosen, as the participants' lived experience was of interest in order to gain a deeper understanding of the subjective meaning of being triaged to N-EAC. The focus was on how patients in need of N-EAC experience deal with their health situation before contacting the universal emergency number (112) or Swedish Healthcare Direct (1177) and their subsequent encounter with ambulance clinicians until the ACS care ends and they remain at home.

3.2. Participants and setting

The inclusion criteria were Swedish speaking adults (>18 years old) with intact cognition who had received ambulance care for any reason and who were not triaged by the SAN to the AED at a hospital. The SAN recruited potential informants for the study in connection with the ambulance assignment to the patient's home. A total of 36 eligible informants agreed to be contacted by telephone and were invited to participate in the study. The final group comprised twelve patients, seven males and five females, with a mean age of 67 years (range 26 to 89 years), who had the verbal capacity to share their experiences of not being triaged to the AED by the SAN.

The Swedish ambulance service is described in Box 1.

3.3. Data collection

The first author conducted all the interviews two to four weeks after the initial encounter with the ACS to ensure that the informants had recovered sufficiently to participate. We also assumed that the informants would be able to remember their experience of contact with the ACS within that timeframe. The informants were allowed to decide the time and place for the interview and all chose to be interviewed by telephone.

Digitally recorded, open-ended interviews were conducted and transcribed verbatim shortly afterwards. The interviews started with the question "Could you please tell me about your experiences of the encounter with the ambulance care service?" After 12 interviews it was considered that the content in the interviews was rich. However, two informants were re-interviewed to expand on and verify the emerging comprehensive understanding.

3.4. Data analysis

A phenomenological-hermeneutic method developed by Lindseth and Norberg (2004) was applied. The method consists of three steps, the first being *the naïve reading*, in which the interviews were read several times in order to become familiar with the text and gain an initial understanding (Lindseth and Norberg, 2004). In the next step, *the structural analysis*, the text was divided into meaning units in accordance with the aim of the study. The meaning units were then brought together and grouped into themes and subthemes. In the final phase, *the comprehensive understanding*, the text was read again, reflecting on the themes pertaining to what it means to be triaged to N-EAC. The interpretation was guided by the authors' pre-understanding based on their extensive experience of working with and teaching pre hospital emergency care as well as knowledge from previous research, i.e. within the ambulance context in general. This pre-understanding was constantly reflected upon and reconsidered during the data analysis and interpretation process.

Trustworthiness is important in qualitative studies, which means that the research process as well as the final interpretation must be transparent. We adhered to the gold standard described by Lincoln