



## A profile of the waiting room nurse in emergency departments: An online survey of Australian nurses exploring implementation and perceptions



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### ABSTRACT

**Background:** In response to increasing waiting times, adverse patient outcomes and patient dissatisfaction, some emergency departments introduced a Waiting Room Nurse role. Despite implementation into routine practice, there remains limited formal evaluation of the role.

**Aim:** To explore the implementation of a Waiting Room Nurse role in Australian emergency departments and emergency nurses' perceptions.

**Methods:** Survey design. A 40-item survey was developed, piloted and then distributed to members of a professional College for online completion. Responses for closed-ended and open-ended items were reported using frequencies or proportions, and quantitative content analysis, respectively.

**Results:** Respondents (n = 197) reported that 51 emergency departments allocated a Waiting Room Nurse, with varying hours of operation. Five key areas of responsibility were: patient care, patient safety, escalation of care, triage and communication. Role variations were identified in experience, preparation and supporting policies. Challenges, including workload and personal safety issues, were reported.

**Conclusions:** The role was perceived as vital, especially at times of high demand, in ensuring that patients were safe to wait, detecting deterioration and escalating care as needed. Communication and therapeutic relationships were key to effective performance. Challenges identified had clear implications for the welfare of nurses performing the role.

## 1. Introduction

On presentation to an emergency department (ED), patients are rapidly assessed by a triage nurse and allocated a category based on clinical urgency. Patients are then assessed and management commenced by a Medical Officer or Nurse Practitioner based on their allocated category, ensuring the most unwell are treated first [1]. Patients are allocated to an appropriate treatment cubicle when available, where emergency care commences [2]. If a cubicle is not required or is unavailable, they are seated in the waiting room. Some departments have a waiting room nurse (WRN) dedicated to care for these patients [3].

### 1.1. Background

The WRN role was introduced to address issues relating to increased

demands and long wait times in the ED, including poor patient outcomes and experiences, and key performance indicators not being met. The presence of a WRN enables patients' episodes of care to commence in the waiting room [4]. Key responsibilities involve monitoring, communication and safety (including detecting clinical deterioration), implementing interventions early, and patient advocacy [5].

WRN practice is often underpinned by standing orders or clinical pathways [6,7]. Standing orders, referred to as nurse-initiated protocols, allow nurses to initiate interventions and/or diagnostic investigations according to pre-determined protocols [8], including administration of analgesia [9] and ordering x-rays [10]. In comparison, clinical pathways ensure a uniform approach to patient management by integrating guidelines and protocols into a coordinated and sequential plan of care [11].

Despite varying degrees of implementation into practice, there remains limited literature on the WRN role internationally. Of note, there

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is a dearth of literature describing current WRN practice in the clinical setting and perceptions of the role. The aim of the research was to explore the implementation of a WRN role in Australian EDs and emergency nurses' perceptions.

## 2. Methods

### 2.1. Design

This survey design research is the final phase of a larger multiphase exploratory sequential mixed methods study exploring the nursing role in ED waiting rooms. Mixed methods allows for multiple research methods to be used in a single study [12]. An exploratory sequential design allows for exploration of topics about which little is known. An initial qualitative (exploratory) phase is followed by a quantitative phase to explain and evaluate results [13]. A key aspect of sequential mixed methods research is that data from previous phases informs subsequent phases [14]. In this project, findings from key informant interviews [5] informed data collection and analysis in the observational phase [15] which subsequently informed data collection for this phase.

This paper reports findings from a web-based survey which allowed for systematic collection of data from a large sample enabling direct comparisons [16]. Advantages of using a web-based survey design include: ease of distribution, convenience for respondent completion, faster response times, cheap to administer [17] and elimination of data entry errors [18].

### 2.2. Sample/participants

Purposive sampling was used to identify respondents; Registered Nurses (RNs) who were members of the College of Emergency Nursing Australasia (CENA), the peak national emergency nursing professional body [CENA, 19]. CENA members were deemed broadly representative of all emergency nurses, had relevant professional knowledge and insights, and were able to reflect on and explore their experiences of the role. Recruitment was undertaken via the CENA secretariat who emailed members inviting participation.

### 2.3. Data collection

A literature search revealed no surveys that would address the research aims. A survey was designed using four stages described by de Vaus [16] – (i) identify data for collection, (ii) draft questions, (iii) establish survey validity, and (iv) pilot the survey.

First, broad concepts from the literature and findings from previous study phases were identified [16]. Next, questions were drafted and ordered so concepts could be measured. An important consideration was how data would be analysed, as this may affect how questions were constructed [16]. The research team reviewed and refined drafts of the survey for interpretation, clarity, and functionality. Multi option lists and greater use of open ended questions were added through these processes to lessen participant burden [16].

The final version of the survey included 40 items across five sections: (i) participant demographics (seven items); (ii) WRN role including title; responsibilities; experience and preparation (10 items), (iii) supporting policies (19 items); (iv) communication and documentation (two items); and (v) general comments (two items).

Items were entered into SurveyMonkey© [20], enabling skip logic to ensure respondents were not asked irrelevant questions. For example, if a respondent indicated there were no WRN in their department, then a skip logic function directed respondents to the end of the survey [16,21]. The range of items a respondent could answer was between 11 and 40.

After approval by CENA, an email containing a brief research information statement, copy of the Participant Information Form,

researcher's contact details and a link to the survey was sent by the College secretariat to members. The survey period was open for four weeks in June 2017, with a reminder email sent one week prior to the survey closing. The survey was for completion in one visit. No incentives were provided.

### 2.4. Validity and reliability

To establish face and content validity, the survey was completed by two experienced emergency nurses with familiarity of the role and research knowledge. Feedback was provided on wording and flow of questions to ensure they were appropriate and clearly written, contributed to meeting the study aim, and flowed logically. Suggestions were made for skip logic.

A pilot study was then implemented to confirm reliability. Six experienced emergency nurses, not involved in the validity check, with backgrounds in clinical management and education completed the survey. It was deemed that these nurses were able to interpret and answer the questions appropriately and were able to provide feedback. Two of the respondents were not familiar with the role, ensuring that all aspects of the survey, including skip logic, were tested. Pilot respondents completed the survey and provided feedback on the questions for clarity, flow and if questions addressed the aim of the research. Findings from the pilot study found similar responses, establishing reliability. All nurses involved in survey development were excluded from the sample.

### 2.5. Ethical considerations

Following Human Research and Ethics Committee approval from the supporting university, CENA granted permission to survey their members. Survey responses were anonymous, with consent implied by respondents' completing the survey.

### 2.6. Data analysis

Data were downloaded from SurveyMonkey© [20] in an Excel© spreadsheet, [22], cleaned and coded prior to being transferred to an IBM SPSS Statistics [23] V.24 data file for analysis. Each respondent's dataset was entered as a single observation. Continuous data were assessed using the Kolmogorov-Smirnov test, significance set at < 0.001 for violating the assumption of normality. Based on the non-normal distribution of all data variables, nonparametric tests were used for analyses [24]. Frequencies, percentages, median and interquartile range were used to describe characteristics of respondents and the WRN including presence of the role, title, experience and/or preparation of the nurse, medication administration and interventions performed. For missing values in the dataset from non-applicable items, the frequency of responses is presented.

Open-ended responses were analysed using Hsieh and Shannon's [25] quantitative content analysis framework. Keywords were initially identified from the literature and previous study phases. Responses were then reviewed with keywords identified. The research team independently reviewed the dataset and collectively agreed on keywords. Additional keywords were identified during analysis.

Words or phrases that had similar meaning to keywords were identified to ensure correct context of the data. An example of this was Item 10, 'Discuss the aim or purpose of the WRN in your ED' where the keyword 'observation' was identified and counted. Responses were then re-read to identify similar terms, such as 'reassessment' and 'monitor'. All terms were then counted together and presented as a frequency. De-identified quotes were used as exemplars and to clarify issues, using the respondent's unique identifier, a quote from respondent 1 would be reported as ID1.

**Table 1**  
Respondents demographic characteristics.

Characteristic	
<i>State/Territory (n = 197)</i>	
	n (%)
New South Wales	48 (24.4)
Victoria	48 (24.4)
Queensland	35 (17.8)
South Australia	33 (16.8)
Western Australia	17 (8.6)
Tasmania	9 (4.6)
Northern Territory	6 (3.0)
Australian Capital Territory	1 (0.5)
<i>Role/title (n = 197)</i>	
	n (%)
Registered Nurse	87 (44.2)
Clinical Nurse Specialist	47 (23.9)
Educator	15 (7.6)
Clinical Nurse Consultant	11 (5.6)
Nurse Practitioner	10 (5.1)
Nurse Unit Manager	10 (5.1)
Associate Nurse Unit Manager	8 (4.1)
Enrolled Nurse	3 (1.5)
Coordinator	6 (3)
<i>Highest educational qualification (n = 196)</i>	
	n (%)
Master	67 (34.2)
Graduate Certificate	48 (24.5)
Bachelor of Nursing	37 (18.9)
Graduate Diploma	36 (18.4)
Doctor of Philosophy	5 (2.6)
Certificate or Diploma in Nursing	3 (1.5)
<i>Years of experience</i>	
	Median (IQR)
Years of nursing experience (n = 197)	16 (2–45)
Years of emergency nursing experience (n = 196)	11 (0.3–38)
<i>Work in triage role (n = 197)</i>	
	n (%)
Yes	174 (88.3)
No	23 (11.7)

### 3. Results

Survey results are described in the following sections that broadly reflect the survey structure: respondent demographics, WRN role and characteristics, experience and preparation; supporting policies; and perceptions and challenges.

#### 3.1. Respondent demographics

Survey links were available to 1242 CENA members, and 197 surveys were completed (response rate 15.9%). Respondents were from 86 separate EDs, of which 59.3% (n = 51) allocated a WRN. Of the total respondents, 18.3% (n = 36) did not identify their hospital. Respondents had a median of 11 years' emergency nursing experience, the most common highest educational qualification was Master level, and the majority worked at triage. Almost half of the respondents were located in New South Wales and Victoria. [Table 1](#) presents respondents' demographic characteristics.

#### 3.2. WRN role and characteristics

Most respondents (n = 119, 61%) reported that their ED allocated a nurse, other than the triage nurse, to care for patients in the waiting room. The most common titles for the role were Clinical Initiative Nurse (CIN) (n = 37, 39.4%), WRN (n = 31, 32.9%) and triage assist/assessment (n = 26, 27.7%).

Five key areas of responsibility were identified from survey responses: patient care, patient safety, escalation of care, triage responsibilities, and communication.

##### 3.2.1. Patient care

A key WRN responsibility was to expedite care (n = 44); "to ensure

**Table 2**  
Patient assessment.

Characteristic	Keywords (n)
<i>Type of assessment</i>	
Primary	50
Focused	33
Secondary	13
<i>Type of focused assessment</i>	
Respiratory/chest auscultation	38
Pain	11
Neurovascular/limb/musculoskeletal	9
Neurological/Glasgow Coma Scale	8
Abdominal	5
Wound	2
<i>Frequency for reassessment</i>	
As per Australasian Triage Scale allocated category/acuity	34
Every 60 min	20
Post medication/intervention	10
Every 30 min	7
As time permits	2

that all patients in the waiting room are cared for throughout their journey" (ID162), and to assist with meeting patients' "immediate needs where possible" (ID41) including basic care needs such as assisting with toileting (ID38). The WRN was therefore responsible for commencing early management of a patient's presenting condition (n = 136); by providing "meaningful treatment within the time allocated by the [patients'] triage category" (ID30), commencing "treatment according to pathways prior to medical review" (ID180), and "ultimately [facilitated] decreasing wait times" (ID85).

Patient assessment and monitoring was a common patient care (n = 91) activity. Assessments varied, as the focus "depended on the reason for presenting" (ID42) and "what the nurse thinks is appropriate to get a better understanding of the patients' presentation" (ID38). Primary assessment was the most frequently reported assessment undertaken (n = 50) ([Table 2](#)).

Patient reassessment was a key process during the waiting period, with the WRN responsible for "early reassessment of patients waiting post-triage" (ID33). There were a variety of timeframes and indicators for reassessing patients but these commonly reflected the patients' allocated triage category; as one respondent noted, "100% of patients are reassessed according to their triage category, while waiting to see a doctor or be allocated a cubicle" (ID136) ([Table 2](#)).

A range of medications administered and interventions performed by the WRN were identified. Medications were either administered orally, topically or inhaled, with Paracetamol being the most common medication administered, and inhaled adrenaline the least common ([Table 3](#)). A wide variety of interventions performed were also reported, with basic first aid/minor injury management the most common and writing referrals and plaster checks/splitting the least. Diagnostic activities performed included blood glucose monitoring and electrocardiograms ([Table 4](#)).

The most common factor preventing medications and interventions being administered or performed in the waiting room related to patient safety (n = 65); potential for patient deterioration and adverse effects. Other factors included privacy concerns (n = 11), lack of space (n = 8), unsuitable skill mix/experience of WRN (n = 6), need for a medical order (n = 1) and infection control (n = 2).

##### 3.2.2. Patient safety

Patient safety (n = 55) was highlighted as a key responsibility, particularly ensuring that patients were safe to wait or remain waiting in the waiting room. As respondents stated, "patient safety is by far the most important reason for a WRN" (ID7). Thus, the WRN "provided a safety net to those in the waiting room" (ID34) by "ensuring patients were safe to wait [in the waiting room]" (ID112).

**Table 3**  
Medications administered (oral, topical and nebulised).

Medications (n = 119)	n (%)
Paracetamol	98 (82.4)
Nonsteroidal anti-inflammatory drugs	86 (72.3)
Endone	64 (53.8)
Ondansetron	63 (52.9)
Metoclopramide	60 (50.4)
Local anaesthetic creams	58 (48.7)
Panadeine	56 (47.1)
Panadeine Forte	53 (44.5)
Inhaled salbutamol	50 (42)
Anti-histamine	44 (37)
Aspirin	44 (37)
Prednisolone	33 (27.7)
Dexamethasone	24 (20.2)
Nitrates	18 (15.1)
Hydrocortisone	15 (12.6)
Inhaled steroids	12 (10.1)
Inhaled adrenaline	3 (2.5)

**Table 4**  
Interventions performed.

Interventions (n = 119)	n (%)
Basic first aid/minor injury management	98 (82.4)
Blood glucose monitoring	93 (78.2)
Urinalysis	89 (74.8)
Collect mid-stream urine	87 (73.1)
Commence oral hydration	84 (70.6)
Urine pregnancy test	79 (66.4)
Wound care/dressings	78 (65.5)
Electrocardiogram	77 (64.7)
Distribute food and drinks	73 (61.3)
Venepuncture (including pathology)	73 (61.3)
Cannulation (including pathology)	72 (60.5)
Take wound swabs	71 (59.7)
Venous blood gases	53 (44.5)
Bladder scan	2 (100)
Make referrals	1 (100)
Plaster check/splinting	1 (100)

Patient reassessment, as noted earlier, was a vital aspect of patient safety. The WRN “monitored waiting room patients for signs of deterioration” (ID192), and, if detected, responded to “escalate care as appropriate” (ID38). The WRN was therefore an “advocate for patients in the waiting room” (ID61) ensuring they received appropriate and timely management.

A subset to patient safety was flow of patients from the waiting room into the department treatment areas (n = 23). The WRN assisted with patient flow by allocating and “taking patients through to available cubicles” (ID103), reducing wait times and improving patient safety.

### 3.2.3. Escalation of care

If patient deterioration was detected, a number of pathways were reported for the WRN to escalate care. Commonly this was for the WRN or triage nurse to re-triage (n = 35) the patient, and in some cases notify the nurse in charge (ID22) or collaborate with senior staff to prioritise care needs and move the “patient to the most appropriate clinical space” (ID195) for further assessment and management. Other escalation pathways varied based on the structure and processes within each department, focusing on notifying a specific staff member: triage nurse (n = 49); nurse in charge/coordinator (n = 57); senior medical officer/treating doctor (n = 27); team leader (n = 9); Clinical Nurse Consultant/Clinical Nurse Specialist (n = 4); or activation of a response team e.g. Medical Emergency Team or Critical Response Team (n = 5).

### 3.2.4. Triage responsibilities

Approximately two-thirds of respondents indicated that the WRN was permitted to assist with the triage process (n = 73, 61.3%), although variability was noted. Triage assistance was permitted when the triage nurse’s workload was excessive (n = 62), to cover the triage nurse for breaks (n = 41) and triage ambulance arrivals (n = 12). As well as assisting with the triage process (ID48), the WRN collaborated (n = 43) with the triage nurse through support (ID109), and “liaised with [the] triage nurse” (ID61) to identify and prioritise patient care needs (ID41, ID196).

Conversely, in some departments, the WRN was not permitted to triage. Reasons included non-triage prepared nurses performing the role in some departments (n = 9), potential for “role confusion” (ID143) and loss of “clear role delineation” (ID70) between the triage role and WRN. Another concern was if the WRN performed triage, they could become distracted, not prioritising waiting room patient care needs (ID65), resulting in increased waiting times, delays in interventions commencing and potential for care to be missed. As noted, “the WRN is not permitted to triage patients even if they are qualified, as [if they do] patients in the waiting room are not being assessed and re-assessed, [and] meaningful treatment is not occurring” (ID30).

### 3.2.5. Communication

Communication was a key WRN responsibility (n = 46); providing “communication and support to visitors and patients in the waiting room” (ID108), and keeping “patients informed of their progress, wait times [and] cause of delays in treatment” (ID41). Effective communication skills were required to develop therapeutic relationships with patients and families which contributed to the WRN “providing comfort and reassurance” (ID197), de-escalating anxious patients and families (ID36, ID43) and “alleviating stress” (ID120). A crucial feature of patient communication was “to make sure patients felt cared for even though they are in the waiting room” (ID25). Respondents felt the development of an effective nurse-patient relationship improved the patient experience, improving consumer relations (ID71), patient satisfaction (ID165) and decreasing complaints (ID71).

Documentation was central to effective communication and was acknowledged by respondents as vital for safe, effective patient care. As noted, “contemporaneous documentation is important to ensure continuity of patient care” (ID40). One respondent acknowledged however that documentation “was not done very well” (ID23).

### 3.3. Experience and preparation

Experience and preparation required prior to commencing in the role varied (Table 5). In terms of emergency nursing experience, two years was the median. Of 64 responses for this item, approximately one-third (n = 21, 32.8%) identified no minimum duration of time required prior to commencing in the role, but rather a minimum set of skills and knowledge, which took varied time for each nurse to develop. One respondent reported, “not specified in years rather in skill, experience and communication abilities” (ID157).

Two-thirds of respondents indicated that triage-preparation was not a role requirement. The majority of respondents also indicated that postgraduate qualifications were not a prerequisite. Of the four respondents who identified postgraduate qualifications as necessary, all agreed that a Graduate Certificate was the minimum.

Approximately half of the respondents identified that additional preparation was required prior to commencing the role. Preparation was wide-ranging including in-house courses, workbooks/packages, and preceptorship, either as stand-alone activities or in combination. Two day courses (n = 6) were most common, with one day (n = 5) and three day courses (n = 1) also completed. The CIN workbook (n = 7) was most frequently utilised, followed by workbooks relating to: pathology (n = 6), triage (n = 5), x-ray (n = 4), medication/analgesia administration (n = 3), patient assessment (n = 3), cannulation (n = 3)

**Table 5**  
Experience and preparation prior to commencing as Waiting Room Nurse.

Prior to commencing in the role	n (%)
<i>Minimum years of emergency nursing experience (n = 64)</i>	
Graduate (< 1 year)	5 (7.8)
1 year	12 (18.5)
2 years	14 (21.9)
3 years	9 (14.1)
4 years	0 (0)
5 years	3 (4.7)
<i>Be triage prepared (n = 106)</i>	
No	64 (60.4)
Yes	42 (39.6)
<i>Require postgraduate qualifications (n = 106)</i>	
No	102 (96.2)
Yes	4 (3.8)
<i>Any additional preparation (n = 105)</i>	
No	56 (53.3)
Yes	49 (46.7)

and communication (n = 1). An orientation (n = 9) or preceptorship/supernumerary period (n = 14) were also included as preparation in some departments.

Some respondents felt that no additional preparation was required, instead reporting that experienced emergency nurses possessed sufficient skills and knowledge to work in the role. One respondent stated that the “level of expertise gained as an emergency nurse, and prior nursing experience should be taken into account” (ID76).

### 3.4. Supporting policies

Variation in policies underpinning practice was evident. The main policies identified were standing orders and clinical pathways. There were mixed views on whether current policies adequately supported the WRN; 13 respondents agreed while 24 disagreed, suggesting a broadening of the range of medications and skills was needed. Standing orders were identified (n = 106) as guiding practice, with nurse initiated analgesia the most common (Table 6). Clinical pathways were identified (n = 39), for clinical states ranging from pain management to sepsis and shortness of breath, with chest pain the most common (Table 6).

Other than standing orders and clinical pathways, variations in policy were also noted (Table 7), ranging from medication administration to management of particular health concerns and the use of ‘My

**Table 6**  
Policies and protocols.

Policy and Protocols	n (%)
<i>Standing orders (n = 106)</i>	
Nurse initiated analgesia	62 (58.5)
Nurse initiated x-ray	41 (38.7)
Nurse initiated pathology	41 (38.7)
Clinical pathways	39 (36.8)
<i>Clinical pathways (n = 39)</i>	
Chest pain	30 (76.9)
Nausea/vomiting/diarrhoea	28 (70)
Abdominal pain	13 (33.3)
Falls/soft tissue injury	12 (30.8)
Shortness of breath/asthma	12 (30.8)
Headache/head injury	11 (28.2)
Obstetrics	8 (20.5)
Pain management	7 (17.9)
Fever	6 (15.4)
Sepsis	6 (15.4)
Stroke	4 (10.3)
Renal colic	3 (7.7)
Fractured neck of femur	1 (2.6)

**Table 7**  
Additional policies.

Policies	Existing policy Keywords (n)	Suggested policies in other departments Keywords (n)
Detecting deterioration and clinical escalation	2	–
Administration of medications:	–	–
ADT	1	1
Antiemetics	–	1
Anti-histamine	–	1
Bronchodilator	1	1
Steroids	–	1
Administration if intravenous fluids	1	1
Cannulation	1	1
De-escalation	1	–
Hourly rounding	1	–
Care of patients with mental health presentations	1	–
Process for nurse referral to other services/specialities	1	1
Plastering	1	1
Trial of fluids	1	–
Use of ‘My Card’ information slip	1	–
Wound closure (including suturing and gluing)	2	1

Card’ (used in one department for patients to record medications administered, investigations ordered and reasons for waiting).

Suggested policies to further support the role included broadening of the range of medications that could be administered, support for specific skills such as plastering and wound closure, and to cover the paediatric population (Table 7). Respondents working in departments that did not have nurse initiated pathology (n = 3) and nurse initiated x-ray (n = 6) policies acknowledged these would also be beneficial.

### 3.5. Challenges and perceptions

Multiple challenges associated with the role were identified, including workload, resources, hours of operation, workplace reallocation, skill mix, personal safety, unclear expectations and supporting policies. The most recurrent concern was the high nurse-patient ratios/workload (n = 23) when departments became busy. As noted by one respondent, “only one nurse is available for the role with up to 30 patients in the waiting room at a time” (ID22). This had implications for patient safety as “large volumes of patients make it difficult at times to re-assess [patients]” (ID25) and made it “very difficult to keep track of who needs assessing/reassessing and when” (ID109).

Access to appropriate resources (n = 18) included difficulty accessing medical staff to write orders and prescribe medications, and lack of appropriate space to assess patients and perform interventions. Lack of available beds resulted in high acuity patients (n = 3) remaining in the waiting room (ID129), posing a risk to patient safety and increasing workload.

Limited hours of operation for the role were reported (n = 7). Respondents stated “shifts are only 10am-8 pm, so there are busy times when there is no WRN” (ID159), and this “leaves the triage nurse alone in the waiting room to attend to triage as well as reviews and CIN protocols” (ID36) potentially affecting patient care. As also noted, “restrictions on staffing in peak times is detrimental to the care that can be given to patients” (ID22). Other staffing issues included reallocation (n = 7), with the WRN “pulled to other areas when the department was busy” (ID42). When under-staffed the role was given low priority and was “often the last thought” (ID117) with allocations, potentially being “left vacant” in these circumstances (ID84).

A final staffing issue was skill mix of staff performing the role (n = 7). In some departments, where the WRN was “mostly a junior role ... and the department is busy, [the junior WRN] can be a liability

as things are missed or not assessed properly due to inexperience, or treatment is unable to be commenced early as [WRN] is incompetent at interventions” (ID197). One respondent felt that the shift ran more smoothly if the WRN was triage prepared (ID160). Enrolled nurses performing the role ( $n = 1$ ) was another limitation as initiation of standing orders or clinical pathways was not within their scope of practice.

Personal safety of the WRN was also identified as a challenge ( $n = 6$ ), as reflected by one respondent, “the waiting room can be an unsafe area” (ID193), particularly if there were aggressive or violent people present. The nurse is “very exposed” (ID85) and particularly at “risk of assault from mental health and substance abuse clients” (ID122). Long wait times ( $n = 8$ ) also influence nurse safety, as patients and families become anxious and agitated (ID36, ID110), and develop “hostility” (ID109) towards staff.

Finally, unclear expectations ( $n = 4$ ) and limited supporting policies ( $n = 3$ ) were identified as challenges. Unclear expectations were generally associated with medical staff who, for example, “order a whole lot of stuff that can’t be done in the waiting room” (ID174), while “lack of protocols and restriction on ordering pathology and imaging limits the role and benefits for patients” (ID22).

Consideration must also be given to negative aspects of the role identified by respondents. The effect of the often relentless and busy nature of the waiting room (ID85), made the role “very stressful and lonely” (ID163), and “may be confronting” (ID16), with potential exposure to continual negative experiences such as “constantly being given complaints regarding wait times” (ID85). These factors can result in the role being “generally the least satisfying role in the whole department” (ID164), with “some RNs refusing to do it” (ID80). Another contributing factor to the role being unpopular was that, as noted above, the position was not clearly defined (ID53) with a vague role description (ID187), requiring as one respondent suggested, “a nationally agreed scope of practice similar to that of triage” (ID53).

Overall, respondents’ perceptions of the role were positive; an essential role that all EDs should have ( $n = 19$ ) as “a mandated role” (ID123), and be “utilised by more EDs in order to improve patient safety and their [patient] journey” (ID51), especially during busy periods ( $n = 4$ ). The role was viewed as “vital and allows for superior care to waiting room patients as well as avoiding any deterioration that may otherwise be missed” (ID25). The WRN was identified as being particularly important when demand on emergency services increased, potentially resulting in unwell patients waiting for an extended period. As reported, the WRN is a “process to protect the patient, protect the triage nurse and ensure waiting times to definitive care are minimised” (ID80), although funding and staffing affect the ability of departments to implement the role (ID3). The WRN role could also play an important part in professional development, especially triage preparation, as it “is a great role for nurses coming to triage” (ID117).

#### 4. Discussion

This survey of emergency nurses working in 86 separate EDS across all Australian States and Territories generated some commonalities and clear variations in perceptions of WRN responsibilities. Key findings were that patient safety is potentially the most important responsibility of the role; ensuring patients are safe to wait, a safe environment is provided, and safe care is initiated. These safety aspects are explored below in the context of expediting care, assessing and reassessing for clinical deterioration, establishing therapeutic relationships and effectively communicating with those in the waiting room. Variations in practice were also evident for experience, preparation and supporting policies. Despite the role being perceived as positive, a number of challenges were identified, primarily related to workload and resources, and potential for the role to have a negative impact on nurses.

Expediting patient care was identified as a key aspect. By commencing interventions, diagnostics and management early, delays to

treatment could be minimised. This is important as increased waiting times have a detrimental impact on patient outcomes, including a 40% increase in mortality [26], as well as influencing patient satisfaction and perceptions of care [27,28].

Assessment and reassessment was viewed as a core WRN responsibility, as a patient’s clinical condition can deteriorate while waiting, resulting in adverse outcomes [29]. Through close monitoring the WRN can ensure patients are safe to wait, or detect deterioration early and escalate care needs accordingly. Reassessment facilitates early interventions, for example administration of analgesia, and monitor for adverse outcomes and effectiveness, ensuring safe, quality care [30]. Reassessment also enables inequitable access to care for self-presenting patients allocated to the waiting room compared to patients presenting via ambulance [30].

In high-risk patient areas such as the waiting room, effective communication is fundamental to the provision of safe, quality care [31], while failed communication leads to poor ED patient outcomes [32]. A crucial aspect of effective communication is therapeutic nurse-patient relationships. The waiting room is a challenging environment for the WRN to have meaningful engagement with patients and families who are often stressed and distressed due to illness and waiting [33,34]. Compounding this is the noisy, chaotic nature of this environment [35], the unpredictable workload, and multiple interruptions experienced by emergency nurses during care provision [36]. Despite these challenges, it is possible for the WRN to develop therapeutic relationships and effective communication which can develop from simple interactions, over short periods by asking straightforward questions and actively listening to responses or questions [37].

Patients and families often find emergency processes difficult to follow and the waiting room frightening and unsafe [33], with a perception that care is not provided as needed [38]. The presence and availability of the WRN contributes to the perception of a safe environment where patients are being cared for [34]. Providing updates on any delays also contributes to providing a safe environment, as patients and families often have limited insight into potential reasons for delays [27], contributing to increased stress and poor perception of care.

Disparities in experience and preparation for the role were clear, reflecting wider, limited literature [5]. Supporting policies varied broadly with both standing orders and clinical pathways underpinning practice, similar to other findings [6].

Challenges identified with the role need to be considered by clinicians, managers, policy makers and educators. Exposure to high levels of occupational stressors, including increased workloads, skill mix and exposure to violence and aggression, culminated in the role being stressful and unsatisfying according to survey respondents. Exposure to frequent and ongoing stressors can affect emergency nurses both physically and emotionally, resulting in increased risk of injury, poor job satisfaction and increased absenteeism and attrition [39]. Quality of care delivered to patients can be negatively impacted as concentration, decision-making skills, communication and ability to establish therapeutic relationships may be affected [39,40].

##### 4.1. Strengths and limitations

These findings need to be considered within the context of the strengths and limitations of the study methods. Use of an exploratory sequential mixed method design ensured that findings from previous phases of the larger study informed survey development. Use of a clear structured approach in developing the survey, including establishing content and face validity [16], and subsequent reliability testing through a pilot study [41] were also strengths.

A potential limitation was response bias, as the survey was self-reporting and responses may have been influenced by the format, construct or interpretation of questions. A risk of sampling error is noted; although the sample was a sizeable portion (15.9%) of CENA members

and was perceived to be homogeneous, findings may not be representative of all Australian emergency nurses [16]. As the sample is from a single country and public health system, findings may only be applicable to Australian EDs and not generalisable to other practice settings.

## 5. Conclusion

Clear variations in practice with the WRN in Australian EDs were identified, relating to education, preparation, responsibilities and triage. Despite these differences, respondents viewed the role as important for ensuring patient safety, including detecting deterioration and escalating care. Communication and development of therapeutic relationships were key to the role. Several challenges were identified that have implications for the welfare of nurses performing the role, including personal safety and burnout.

## Conflict of interest

Authors have no conflict of interest to declare

## Ethical statement

This study was approved by the University of Technology Sydney Human Research Ethics Committee (ETH17-1248) and supported by the College of Emergency Nursing Australasia.

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## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ienj.2018.10.003>.

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