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Research article

Australian Triage Scale–Based EDUGAD Video Education and Family Knowledge and Satisfaction in an Emergency Department

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Abstract

Emergency triage allocates clinical priority according to urgency, a process that may be unintuitive to patients and relatives who observe arrival order. This study examined australian triage scale–based edugad video education and family knowledge and satisfaction in an emergency department using a controlled pretest–posttest quasi-experiment. The study took place at Kramat 128 Hospital emergency department, Jakarta, Indonesia, in 2026 and included 84 family respondents recruited purposively, with 42 participants in each study arm. The intervention consisted of EDUGAD video describing emergency service flow and the Australian Triage Scale. Outcomes were assessed using family knowledge questionnaire before and after exposure and service satisfaction after exposure. EDUGAD recipients improved from a median knowledge score of 17 to 23, whereas controls changed from 16 to 17. Good knowledge increased from 8/42 to 39/42 among intervention respondents. At posttest, the satisfaction medians were 34 in the EDUGAD group and 28 among controls (reported $p < 0.001$), although satisfaction-category differences (85.7% versus 73.8%) are less marked than the questionnaire-score contrast. In interpretation, explaining triage priorities can align expectations with the clinical rationale for waiting and improve perceived transparency. Video education may be a scalable means of communicating fixed triage concepts during a stressful visit, without changing triage decisions or emergency treatment itself. The design and measurement constraints mean that associations should not be represented as definitive causal effects.

INTRODUCTION

Emergency triage allocates clinical priority according to urgency, a process that may be unintuitive to patients and relatives who observe arrival order. Providing a concise explanation of the Australian Triage Scale may improve understanding of decision rules and communication. Evaluation should separately examine comprehension and satisfaction, because the latter is shaped by waiting times and interactions beyond educational material.[1,2,3]

The distinction between knowledge, attitudes, immediate physiological response

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and enduring patient outcomes is essential when interpreting educational or behavioural interventions. Measures may change because of repeated testing, increased attention, changes in care environments or clinical recovery. Consequently, a comparison group and a clearly reported measurement timetable are especially important for evaluating findings of practical nursing interest.[4,5,6,7]

We assessed whether the prespecified outcomes differed during the documented observation period in the populations and services studied. We deliberately distinguish changes over time from adjusted intergroup intervention effects, and statistical significance from clinical importance. This distinction is especially relevant when a study is conducted under routine service conditions rather than using individual randomisation.

METHODS

Study design and setting

The investigation used a controlled pretest–posttest quasi-experiment. It was conducted in Kramat 128 Hospital emergency department, Jakarta, Indonesia, in 2026. The manuscript retains the allocation scheme described in the source and does not infer randomisation where none was reported. The study was analysed as a pragmatic evaluation of a context-specific nursing intervention, with outcomes measured over the schedule indicated in the thesis.

Participants and allocation

The study enrolled 84 family respondents recruited purposively, with 42 participants in each study arm. Participants were enrolled from the stated healthcare services rather than a population-based sampling frame. Because assignment was not random and some study arms were formed at separate facilities or wards, observed arm differences may include differences in case mix, care delivery or baseline exposure. Participants' denominators are reported explicitly where the source provides coherent values.

Intervention and comparison care

The intervention was EDUGAD video describing emergency service flow and the Australian Triage Scale. The comparison condition was usual emergency-department information without the dedicated EDUGAD video. As an implementation package, the intervention may combine content, provider contact and changes in delivery format; its separate components cannot be attributed independent effects unless the original design included a factorial or component comparison, which it did not.

Outcome measurement

The prespecified or described measurements were family knowledge questionnaire before and after exposure and service satisfaction after exposure. Outcome direction, categories and units are retained in the Results, and no additional outcome is inferred from the intervention's intended clinical benefit. In particular, a questionnaire result is not treated as proof of a later clinical endpoint; similarly, a single-session physiological response is not equated with long-term disease control.

Statistical analysis

The documented analysis used Wilcoxon signed-rank and Mann–Whitney U tests. Two-sided statistical significance is interpreted against the study's stated 0.05 threshold. A reported $p = 0.000$ is expressed as $p < 0.001$ rather than an impossible exact probability of zero. Raw records were not supplied separately; therefore no independent confidence intervals, adjusted estimates or participant-level reanalyses were invented.

Research ethics

Ethics approval 077/KE/12/2025. The ethical approval statement is limited to the record documented in the source thesis; no additional consent or registration claim is assumed.

RESULTS

EDUGAD recipients improved from a median knowledge score of 17 to 23, whereas controls changed from 16 to 17. Good knowledge increased from 8/42 to 39/42 among intervention respondents. At posttest, the satisfaction medians were 34 in the EDUGAD group and 28 among controls (reported $p < 0.001$), although satisfaction-category differences (85.7% versus 73.8%) are less marked than the questionnaire-score contrast.

Table 1. Main study outcomes and changes.

Outcome	Pre-intervention	Post-intervention / change	Additional detail
Knowledge, control median (IQR)	16 (6)	17 (5)	n = 42
Knowledge, EDUGAD median (IQR)	17 (2)	23 (5)	n = 42
Good knowledge, EDUGAD	8/42 (19.0%)	39/42 (92.9%)	
Satisfied, posttest	—	36/42 (85.7%) EDUGAD; 31/42 (73.8%) control	
Posttest satisfaction median (IQR)	—	34 (5) EDUGAD vs 28 (5) control	p < 0.001

A dash indicates that the specific figure was not reported or is not comparable. P values reflect the statistical results reported for this cohort.

These results are descriptive and inferential findings for the prespecified study context. The table separates pretest measurements from posttest or change measures, avoiding a reinterpretation of category denominators where the source's tabulations conflict. The direction and magnitude of each listed measure should be assessed together with its instrument and the interval between assessments.

DISCUSSION

The most informative finding was that edugad recipients improved from a median knowledge score of 17 to 23, whereas controls changed from 16 to 17. Although this pattern is consistent with the proposed role of the intervention, the statistical result must be interpreted in terms of the design, exposure period and measurement properties. Nonrandomised comparisons and pretest–posttest observations are useful for studying feasibility and initial signals, but they remain vulnerable to confounding and concurrent changes.[8,9,10,11]

Explaining triage priorities can align expectations with the clinical rationale for waiting and improve perceived transparency. Video education may be a scalable means of communicating fixed triage concepts during a stressful visit, without changing triage decisions or emergency treatment itself. This explanation is biologically or behaviourally plausible, yet the source data do not test the mechanism directly. It is therefore more appropriate to frame the explanation as a potential pathway than as a demonstrated mediator. Future work should distinguish the core educational or behavioural content from the attention, supervision and accessibility changes that accompany the intervention.

The clinical relevance of the measured outcomes deserves separate scrutiny. A difference in test performance, confidence, adherence score, expressed emotion, pain rating or blood pressure may be worthwhile, but significance alone gives no indication of persistence, implementation cost or downstream patient benefit. Where

an endpoint is an intermediate marker rather than the ultimate clinical outcome, research should include longer follow-up and objectively recorded events. Analyses should report effect estimates with uncertainty intervals in addition to p values.[12,13,14,15]

The study also has operational implications for nursing practice. Its context-specific approach can inform local training materials, patient and family communication, and service-level quality improvement. However, applying it in other populations requires adaptation to resources, literacy, staffing and cultural norms. Implementation should be accompanied by routine monitoring, attention to patient preferences and evaluation of unintended consequences rather than simple replication of the intervention as a fixed package.

Strengths and limitations

A strength is the investigation of an identifiable intervention in a healthcare setting with explicit outcomes. Satisfaction was evaluated after exposure rather than as a full paired endpoint; response bias, heterogeneous patient acuity and ward circumstances may affect ratings. Nonrandom enrolment limits inference about clinical outcomes or actual wait times. Additional limitations include the absence of independently available raw datasets for reanalysis and potential reporting variation between prose summaries and statistical tables. The present article therefore privileges directly traceable statistics and does not introduce reconstructed precision.

CONCLUSION

In this study, edugad recipients improved from a median knowledge score of 17 to 23, whereas controls changed from 16 to 17. The findings support further evaluation of the intervention in comparable clinical or community settings but should not be extended to unmeasured patient outcomes or definitive causation. Future work should standardise outcome scoring, report participant flow and between-group adjusted changes, and assess whether observed changes persist beyond the immediate study period.

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