



**Service Quality and  
Communication in Emergency  
Department Waiting Rooms:  
Case Studies at Four New South  
Wales Hospitals**

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# CONTENTS

<b>Acknowledgements</b> .....	<b>i</b>
<b>Extended Abstract and Summary of Recommendations</b> .....	<b>iv</b>
<b>Abbreviations</b> .....	<b>xii</b>
<b>Chapter 1 Introduction</b> .....	<b>1</b>
Background .....	1
Study Aims .....	7
Report Structure .....	8
<b>Chapter 2 Literature Review</b> .....	<b>11</b>
Introduction.....	11
Key Trends – Demand for and supply of emergency treatment.....	11
ED Waiting Times .....	12
Patient Satisfaction .....	14
Service Quality.....	16
Communication and the ED .....	18
Culture, Language, and Health Literacy.....	22
The EDWR Experience.....	25
Therapeutic EDWRs .....	28
Conclusions .....	32
<b>Chapter 3 Methodology</b> .....	<b>33</b>
Introduction.....	33
Data Collection: Observations of EDWRs .....	33
Data Collection: Interviews with ED Staff .....	38
Data Analysis.....	40
Summary .....	41
<b>Chapter 4 Results: Waiting Room Settings and Contexts</b> .....	<b>43</b>
Introduction.....	43
Regional base hospital EDWR.....	43
Location and setting.....	43
The EDWR.....	44
Reception and triage.....	47
Small Rural Hospital EDWR.....	49
Location and setting.....	49
The EDWR.....	50
Reception and triage.....	53
Metropolitan Teaching Hospital EDWR.....	55
Location and setting.....	55
The EDWR.....	55
Reception and triage.....	58
Metropolitan Hospital EDWR .....	60
Location and setting.....	60
The EDWR.....	60
Reception and triage.....	62
Conclusions .....	64

<b>Chapter 5 Results: Process and Relationships .....</b>	<b>65</b>
Introduction.....	65
Staff, Resources, Teamwork and Communication .....	65
Staff shortages and stress .....	66
Support for staff .....	67
Staff–staff relationships and communication .....	68
Other aspects of staff–staff communication .....	71
The Patient Journey.....	72
When does the journey begin? .....	72
Triage.....	73
Patient Privacy.....	75
The EDWR Waiting Experience .....	76
Communication.....	79
Carers and those accompanying patients .....	86
Culture, language and health literacy issues .....	88
Patient Comfort.....	89
Patient and Staff Safety and Security .....	93
Conclusions .....	95
<b>Chapter 6 Conclusion.....</b>	<b>97</b>
<b>Chapter 7 Recommendations.....</b>	<b>101</b>
<b>References .....</b>	<b>111</b>

# EXTENDED ABSTRACT AND SUMMARY OF RECOMMENDATIONS

## Extended Abstract

Public concerns about service quality and communication in emergency departments (EDs) have arisen from recent critical incidents in New South Wales (NSW) hospitals and the subsequent investigations and reports into such incidents. This report presents the aims, methods and findings of a study designed to better understand and improve service quality in NSW EDs, with a particular focus on factors affecting communication between staff, and between staff and patients and those accompanying patients in Emergency Department Waiting Rooms (EDWRs). The literature review and findings suggest examples of good practice. Recommendations are made about how to improve service quality and communication in EDWRs.

The study upon which this report is based was part of a larger scale project, which had two interrelated aims:

1. To increase understanding of communication and service quality in NSW EDWRs and identify potential improvements in the quality of emergency health services delivery; and
2. To develop delivery-ready education and training materials specifically designed to improve service quality, with particular reference to communication in EDs.

This report focuses on the first aim of the study and addresses three key research questions:

1. What factors affect service quality in EDWRs?
2. What factors affect communication among ED staff, and between staff and patients and those accompanying patients?
3. How can service quality and communication in EDWRs be improved and better promoted and supported?

The study adopted an inductive qualitative approach, integrating three main descriptive and analytical strands of enquiry: an extensive and detailed literature review; lengthy observations in the EDWRs of four NSW hospitals; and interviews with a broad cross-section of staff working in or engaged with EDWRs at the same four hospitals at which the observations were made.

Observations were restricted to the EDWRs of each hospital between November 2009 and February 2010. This phase of the research involved 230 hours of unobtrusive observation research by the research team, working in pairs, at each of the four designated hospitals' EDWRs. During the conduct of observations, hand-written notes were used to record detailed information on the EDWR environment, factors likely to affect service quality and communication in the EDWR, and the nature of communication that took place between ED staff, and between the staff and patients and those accompanying patients. Observations were unobtrusive and no personal identifiers have been attached to any observation data.

The observation phase was followed by a phase of staff interviews from February to June 2010. Teams comprising two members of the research team conducted interviews at each hospital at scheduled times throughout the day and evening for a minimum of two consecutive days. Sixty-six personal interviews were conducted across the four hospitals. Interviewees had the freedom to develop a narrative of their choosing within the general outline of the interview themes and questions. Interviews were conducted with a cross-section of staff (e.g., patient registration; triage nurses; allied health and nursing; doctors; ambulance personnel; administrative staff; security; catering) working in or engaged with EDWRs at the four hospitals. The interviews were digitally recorded, transcribed and de-identified.

The findings of this report are presented with reference to key themes arising from the observations and interviews. These key themes included: the diversity of the locations and settings in which hospitals operate; the reception and triage process at each hospital; the patient journey; staff, staffing and resource issues, including staff shortages, multitasking and stress; the patient wait and the management of the EDWR by staff; the design and functionality of the waiting room space as they related to matters such as patient comfort, security, safety and privacy; communication between staff and patients and those accompanying patients; use of signs and posters; and patient and staff safety and security generally.

The findings revealed minor to significant problems as well as examples of good practice in communication and service quality at each hospital. EDWRs are transitional spaces or environments which can become very stressful for staff, patients and those accompanying patients. Proactive management of the EDWR – including the factors that influence a patient’s waiting experience – and the allocation of requisite resources (e.g., education and training) needed by staff to improve (or optimise) service quality are urgently required.

This study revealed there are potentially moderate to high risks of failure with respect to patient comfort, safety and security in the EDWRs that were involved. Despite the best efforts of staff who clearly articulated the difficulties and benefits of working in the health system generally and EDs specifically, the EDWR space and overall environment are, to varying extents at each hospital, inadequately designed, resourced and managed to meet the diverse needs of patients, those accompanying patients, and staff. Additionally, many staff experienced very high levels of stress and appeared to have varying degrees of access to counselling and other support services. There are times when patients and the staff working in EDs and the EDWR were physically and emotionally at risk.

The study’s findings support important evidence in recent research concerning health and hospital care and EDs in NSW (e.g., Garling, 2008; Hughes & Walters, 2007), and suggest that although significant problems relating to EDWRs in NSW have been previously reported, many have yet to be addressed. This study provides a critically informed platform to better understand and improve service quality, communication and patient health outcomes in hospital EDs, and especially EDWRs. The report’s recommendations, listed below, are designed to assist the professional and committed staff working in EDs to achieve these goals.

## **Summary of Recommendations**

The following list of recommendations does not include the supporting information attached as endnotes in the main body of the report where the recommendations are presented (see chapter 7). Except where references are made to specific staff positions (e.g., nurses; security staff), the references to and consideration of ED and EDWR staff in the following recommendations incorporate all clinical, administrative, technical and services (e.g., cleaning, security and maintenance) staff who engage with the ED and EDWR.

## **STAFF COMMUNICATION AND CULTURAL AWARENESS**

### **Recommendation 1**

*All staff are engaged in processes to improve communication and cultural awareness within the ED at the individual, group and systems levels.*

### **Recommendation 2**

*Communication education and training programs should be developed and made accessible to all staff.*

### **Recommendation 3**

*Clinical and administrative leadership should promote an organisational and service culture that fosters mutual respect and clear and open communication among staff within the ED and between the ED and other hospital departments/units.*

### **Recommendation 4**

*Champions who promote communication and service quality should be identified and selected, and recruited if necessary, and appropriately trained.*

### **Recommendation 5**

*Provide universal (and free) access to an email system for all hospital staff, and promote its use in order to improve communication across all areas of the ED.*

### **Recommendation 6**

*Regularly review and evaluate information technologies that promote and support effective intra and inter departmental communication among ED staff.*

## **HUMAN RESOURCES AND STAFFING**

### **Recommendation 7**

*Appropriate counselling services should be readily accessible to all staff to help them cope with their experiences in the ED.*

### **Recommendation 8**

*Strategies and actions should be developed to support staff health and wellbeing, and should include staff wellness programs.*

### **Recommendation 9**

*Staffing levels for all ED related functions and services should be commensurate with patient demand and sufficient to allow hospitals to implement the recommendations of this report.*

## **Recommendation 10**

*During peak demand times hospitals must have the capacity and capability to balance patient demand and service quality for patients and those accompanying patients at levels commensurate with or better than prescribed standards.*

## **ED DESIGN & ENVIRONMENT**

### **Recommendation 11**

*The size and number of seats available in EDWRs should be increased to cater for patients and those accompanying patients presenting to NSW EDs. Seating should be comfortable and able to accommodate diverse needs.*

### **Recommendation 12**

*EDWRs should be designed, resourced and managed to promote patient and family centred care, provide a high quality of patient service, and ensure the comfort, safety and security of patients and those accompanying patients.*

### **Recommendation 13**

*All staff and relevant stakeholders should be regularly consulted on design, functions, operations and management of the EDWR.*

### **Recommendation 14**

*EDWR design should encompass a comprehensive assessment of all aspects of the ED servicescape, including: room design; accessibility; seating numbers, comfort and layout; the use of posters and signs; décor; floor coverings; room temperature; lighting; mood and ambience; sound; smell; and entertainment, such as television and reading materials.*

## **ED PROCESSES – MONITORING THE EDWR**

### **Recommendation 15**

*A process for all ED staff to maintain effective visual monitoring of EDWRs should be implemented immediately, and the ‘Between the Flags’ program should be adopted in all NSW EDWRs.*

### **Recommendation 16**

*Responsibility should be assigned to an appropriately qualified staff member:*

- a) to manage the EDWR;*
- b) to communicate regularly and frequently with patients and those accompanying patients in the EDWR;*
- c) to monitor patient comfort and health;*

- d) *to keep patients and those accompanying patients informed about why they are waiting, how long they will have to wait and what will happen next; and*
- e) *to reassure patients they are being cared for.*

## **ED PROCESSES – TRIAGE**

### **Recommendation 17**

*The reception and triage process should be communicated to patients. This should be done in a way that enables comprehension by patients with limited literacy and by those whose first language is not English.*

### **Recommendation 18**

*At the point of triage the patient (and/or nominated carer) should be informed what triage category they have been assigned to and what this means for them.*

### **Recommendation 19**

*A private triage area at the ED should be established to ensure the supply of facilities that give patients and those accompanying them, appropriate levels of privacy, confidentiality, support and comfort.*

## **ED PROCESSES – SIGNS AND POSTERS**

### **Recommendation 20**

*Signs and posters should be strategically located in the ED to improve dissemination of information to patients and those accompanying patients, and to promote people's understanding of triage and other health related matters.*

### **Recommendation 21**

*All signs and posters should be relevant to the ED and address health related matters, especially key aspects of patient care and the patient journey.*

### **Recommendation 22**

*Signage and posters should be current, clear and visible, and be designed to promote understanding by patients whose literacy is low and/or whose first language is not English.*

## **COMMUNITY AWARENESS AND KNOWLEDGE**

### **Recommendation 23**

*All ED staff should recognise that the patient journey begins well before 'walk in' or arrival at the ED.*

## **Recommendation 24**

*Implement strategies to inform the community about:*

- a) the location of and resources available at their local ED;*
- b) the roles of EDs in the community;*
- c) the relationships between the ED and other health services; and*
- d) the interrelated concepts of triage and waiting.*

## **PATIENTS' AND CARERS' INFORMATION & THE EDWR WAITING EXPERIENCE**

### **Recommendation 25**

*Inform patients and those accompanying patients about the patient journey in plain, clear and where necessary in multiple languages, and include references to such factors as waiting times and what will happen from the time they arrive until they are seen by a doctor.*

### **Recommendation 26**

*Implement strategies to promote patient and family centred care and to recognise:*

- a) that a patient's journey begins before the patient arrives at the hospital;*
- b) that a patient is a patient of the ED as soon as they enter the ED and for as long as they are engaged with the ED;*
- c) that regular monitoring and observation of and communication with patients and those accompanying them should commence as soon as a patient arrives at the ED; and*
- d) the impact of cultural sensitivity on communication and service delivery within the ED.*

### **Recommendation 27**

*Those accompanying patients are recognised as integral to patients' experiences, health and wellbeing. Nurturing, supporting and communicating with carers are vital actions before, during and after a patient's treatment at the ED.*

## **SAFETY AND SECURITY**

### **Recommendation 28**

*All NSW EDs should have 24 hour on site security to improve the security and safety of patients, of those accompanying patients, and of staff.*

### **Recommendation 29**

*Security staff should be clearly visible at regular and appropriate intervals within all NSW EDWRs.*

**Recommendation 30**

*EDWRs should be designed to support emergency responses to calls from patients and those accompanying patients. Emergency buzzers, clearly labelled, should be installed in all EDWRs, hospital toilets and other amenities.*

# ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACEM	Australian College of Emergency Medicine
ACSQH	Australian Commission on Safety and Quality in Healthcare
BHI	Bureau of Health Information
CEAC	Citizens Engagement Advisory Committee
CEC	Clinical Excellence Commission
CI	Chief Investigator
CIN	Clinical Initiatives Nurse
EAN	Emergency Assessment Nurse
EC	Emergency Clerk
ED	Emergency Department
EDWR	Emergency Department Waiting Room
GWAHSREC	Greater Western Area health Service Research Ethics Committee
NHHRC	National Health and Hospitals Reform Commission
NSW	New South Wales
PM	Project Manager
TN	Triage Nurse
UK	United Kingdom
US	United States





# Chapter 1

## INTRODUCTION

### Background

Hospitals are very strange and rather foreign places to patients and their families and carers, because largely they are unfamiliar with the terms that are used, what all the staff do and what is going on with their treatment. (Garling, 2008, pp.22-23)

Providing high-quality emergency hospital care at any location or across locations is a complex task. Healthcare systems must meet the physical, psychological and social needs of patients in diverse policy, planning and operating environments. Meeting patients' needs requires healthcare organisations to aspire to a high level of service quality (Clement Sudhahar & Selvam, 2008). The design of quality services will, however, necessarily differ among settings (e.g., between different hospitals and emergency departments) as aspects of supply (e.g., physical and technical resources) and demand (e.g., patient numbers, demographics and needs) vary from location to location. From a service quality perspective, comprehensive and multifaceted strategies recognising diversity, change and complexity in a hospital's operating environment are required in order to integrate the key dimensions of a patient's experience.

The level of service quality in hospital environments is affected by three main interrelated elements: (1) the quality of technical care; (2) the quality of interpersonal relationships; and (3) the quality of hospital amenities and the environment (Potter, Morgan & Thomson, 1994). The quality of technical care has generally been considered the core activity, central to the outcomes for and experiences of any hospital patient. The other two dimensions are traditionally considered supportive elements, aspects of the facilities and services which are attractive to and valued by patients and those accompanying patients. This traditional view of hospital service quality is, however, outdated and understates the significance of these latter two dimensions. Recent research indicates that the service quality and interpersonal relationships dimensions are critical to ensure not only the ability of any hospital service to meet or exceed patients' expectations, but also the delivery of services to support and promote patient safety, treatment, recovery and wellbeing (Australian Commission on Safety and Quality in Healthcare [ACSQH], 2010). Examples of supportive dimensions include: the

extent and quality of communication between staff and patients and those accompanying patients; the availability of information that is helpful to patients and those accompanying them; attractive design and interiors; familiarity or familiarisation of patients with hospital procedures and practices that affect them; visiting hours; speedy and personal responses to patients' requests; friendly staff; and the quality of meals and refreshments (e.g., Jabnoun & Rasasi, 2005; King, 1995). In brief, many facets of the delivery of hospital and health services, like other services such as those provided in hotels, are not tangible, cannot be tested by a consumer before consumption, are produced and consumed simultaneously, and are difficult to standardise (e.g., patients' needs, expectations and levels of health literacy).

The efficient and effective supply of accessible, high-quality emergency hospital treatment and health care is becoming increasingly difficult and has become a highly contested public policy issue. Health systems and institutions themselves are variously struggling to cope with growing, densely populated cities; culturally diverse towns, cities and regions; increasing demand from an ageing population; inadequate funding of public health services; inadequate health services infrastructure; staffing shortages; and patients' rising expectations with regard to service quality (Bureau of Health Information [BHI], 2010b; Clinical Excellence Commission [CEC], 2009; Jayaprakash, O'Sullivan, Bey, Ahmed & Lotfipour, 2009; National Health and Hospitals Reform Commission [NHHRC], 2009; O'Connell, Bassham, Bishop, Clarke, Hullick, King, Peek, Verma, Ben-Tovin, & McGrath, 2008). Ongoing incidents (e.g., Garling, 2008; Hughes & Walters, 2007) have highlighted the need to promote and improve service quality and communication, especially in areas of intensive and urgent patient treatment, or 'hot spots', such as emergency departments (EDs) and emergency department waiting rooms (EDWRs).

This report presents the aims, methods and findings of a study designed to better understand and improve service quality in New South Wales (NSW) EDs, with a particular focus on factors affecting communication between staff, and between staff and patients and those accompanying patients in EDWRs. Recommendations are made about how to improve service quality and communication in EDWRs, and in the literature review and findings examples of good practice are described.

For the purpose of this study, communication is defined as a social process involving an exchange of verbal, non-verbal, vocal and non-vocal symbols and messages (West & Turner,

2007; Witsel, 2008) (see Table 1.1). Together with other supportive dimensions described above, communication is an essential aspect of quality service in hospital settings, including EDs and their waiting rooms (e.g., Garling, 2008).

**Table 1.1: Forms of communication**

	<b>Vocal</b>	<b>Non-vocal</b>
<b>Verbal</b>	Spoken words, the spoken language	Written words and language, printed words and language
<b>Non-verbal</b>	Voice quality, manner of speaking, loudness, intonation, timbre, accentuations, emphasis, pauses, sighs, etc.	Gestures, mimicry, sign language, body posture, movement, clothing, distance, positioning within the room, etc.

Source: Witsel (2008, p.20).

A good example of the importance of communication to service delivery in EDWRs is displayed in the triage process. The triage process applied across most NSW public hospital EDs is one in which communication between staff and patients and those accompanying patients is vital to a patient's assessment and treatment at the ED. The triage process begins when a patient arrives at the ED, unless the patient has been brought by ambulance. Triage of a patient is conducted by the triage nurse, and if possible is done as soon as the patient arrives in the ED. According to NSW Health (n.d.):

Patients are triaged on the basis of the speed with which they need medical attention. The Triage Nurse allocates a triage category to a patient based on the statement: 'This patient should wait for medical assessment and treatment no longer than...'

Hospitals aim to achieve certain levels of performance (or benchmarks) with respect to the amount of time patients wait to be seen in EDs. Yet, the concept of triage (and its categories) appears to be not well understood by the wider public and the implementation of the triage process for patients was not standardised across or within individual hospitals in this study (see chapter 4). The triage process can vary over the course of a 24-hour day at a hospital, depending, for example, on the number of patients presenting to the ED in a specified period of time, the types of injuries or illnesses with which patients present, staffing levels in the ED, and whether the time of presentation by a patient is outside usual business hours when staffing levels of doctors, clerical staff and support services are generally lower or, especially in the case of small hospitals, when clerical staff or doctors were non-existent.

EDWRs have been described by Crooks and Evans (2007, p.172) as places of transition, possessing many functions and meanings. Crooks and Evans (2007) conducted formal observations in twelve hospital waiting rooms in three hospitals in Hamilton, Ontario, Canada, highlighting the significance of EDWRs as ‘transitional spaces that are intended to prepare people and their bodies for the medical gaze applied in the practice room’ (p.168). Citing Ward and Hawthorne (1994) and others, Crooks and Evans suggested that the waiting room has also become an educational space. It is often characterised by pamphlets and posters as means to educate people about health matters and, ‘As such, waiting rooms are complex spaces that can have multiple functions and meanings based on how the microenvironment is read, interpreted and understood’ (p.168).

The focus on service quality and communication is particularly salient to EDWRs as transitional spaces in emergency care and treatment, because it shifts attention from waiting time as a single or reliable measure of performance in patient treatment to factors which may be of even greater significance to patient safety, such as regular monitoring of patients in the EDWR and the ability or availability of staff to undertake such a task. Moreover, the focus on service quality and communication draws attention also to very subtle aspects of the management of the EDWR space which may affect people’s behaviours and wellbeing. These subtle messages can have significant impacts in an environment that is constantly changing, and in which patients and others are in transition, perhaps under stress and worried about their circumstances, while waiting for medical attention. Cleanliness and maintenance of the EDWR space, for example, convey messages to people about quality of service and care of the facility. Scents and noises, and interactions between staff and the willingness of staff to engage with patients and those accompanying patients in the EDWR, can all affect patients’ and others’ feelings of comfort, security, belonging and support.

Figure 1.1 broadly and simply attempts to conceptualise the elements of a service which can influence the messages and responses between senders and receivers (who are in interchanging sender–receiver–sender roles) as well as patient health outcomes (e.g., Colling & York, 2010, p.28; Curtis, Gesler, Fabian, Francis, & Priebe, 2007). The figure also draws from the servicescape literature which acknowledges that the physical environment and many tangible and less tangible factors affect service delivery and impact on a patient’s waiting experience and perception of quality of care (e.g., Devlin & Arneill, 2003; Fottler, Ford, Roberts, Ford & Spears, 2000). The servicescape of an EDWR thus includes all aspects of an

environment which affect the relationships and interactions arising between a service provider and a patient/customer and therefore can be used to differentiate the service and the patient/customer experience. Elements of the servicescape can include room design, seating and layout, posters, decor, colours, temperature, lighting, sounds, smell, mood and ambience. These elements of a servicescape affect the emotional, cognitive and physiological states of everyone in the EDWR, and so careful planning and management with respect to these elements are central to, among other things, patients' and others' experiences of the EDWR, staff and patient safety and wellbeing, and service delivery and operational efficiencies.

**Figure 1.1: Quality service, communication and the servicescape**



Source: Adapted from Colling & York, 2010; Curtis et al., 2007; Devlin & Arneill, 2003; Fottler, et al. 2000.

The EDWR experience differs between hospitals and within hospitals over time. Given the extensive range of variables affecting service quality and communication in EDWRs, the transitional space is also highly variable. Patient surveys have revealed that patient experiences range greatly, from high satisfaction to extreme lows (e.g., BHI, 2010b). The latter have been highlighted in recent incidents which have received widespread media coverage and led to extensive investigations, reviews, reports and, in some instances, media

coverage. An incident which received detailed scrutiny and was one catalyst for this project occurred at the Royal North Shore Hospital, Sydney, in late 2007.

On 26 October 2007, the report of an inquiry into treatment provided to a woman threatening miscarriage at Royal North Shore Hospital in September that year was handed to the NSW Minister for Health. The Minister had previously acknowledged that the treatment provided was not acceptable. The independent inquiry into the treatment and care provided to the woman was conducted by Professor Cliff Hughes and Professor William Walters under Section 122 of the *Health Services Act*. The report of the inquiry highlighted aspects of EDs that required significant improvement. These aspects included: effective communication between staff and patients and those accompanying patients; adequate and appropriate signage and interpretation; hospital public education and public relations programs; cleanliness and accessibility of hospital facilities and resources such as toilets; and lighting, comfort and design of reception areas. According to Hughes and Walters, EDWRs:

have long been a source of irritation and occasional distress for patients who are ill and are seeking treatment. They are impersonal and often uncomfortable. The name itself is annoying when people who believe they are in an 'emergency' (rightly or wrongly) sit in rows of uncomfortable chairs. A reception area is much more friendly, welcoming and reassuring. The patient may perceive that they have already arrived at the hospital and are now in the system. For the staff, however, even though the patients in the waiting room have been triaged and are in the system, they are not yet the primary focus of emergency care. (2007, p.11)

Hughes and Walters (2007) made twenty-two recommendations. The NSW Government accepted all of them, and the Director-General of Health was asked to develop an implementation plan for them (Hansards, 2007). The subsequent November Report of Proceedings Before the Joint Select Committee on the Royal North Shore Hospital Inquiry into the Royal North Shore Hospital raised similar as well as other issues such as: lack of information for patients about waiting times and other matters; long, uncomfortable waiting times; lack of staff empathy and consideration towards patients in waiting and patients in care; lack of resources, including staff, medical equipment and hospital beds; and inadequate follow-up after check-out.

In addition to the above reports and reviews, the NSW Health *Patient Survey 2007 Statewide Report* and subsequent 2008 and 2009a reports identified aspects of patient care linked to service quality and communication as key issues in patient ratings of health care across many

categories of patients. For example, the 2007 report noted that for ‘Day only Inpatients’, areas where improvement was needed included ‘easy to find staff to talk to regarding concerns’, and lack of ‘info in emergency room regarding condition and treatment’ (p.4).

Communication, broadly defined above, is a central part of service quality in EDWRs. Factors influencing service quality and communication will likely vary among departments and within individual departments over time, although many commonalities and some patterns are also likely to be evident. Issues arising from effective and ineffective communication are highlighted in a number of Australian and overseas studies (see chapter 2). Principles and practices associated with service quality and hospitality management have, however, received little attention in Australia’s public hospital systems generally (King, 1995; Potter et al., 1994), and in EDs and EDWRs specifically. Within the broader healthcare sector in Australia and overseas, and particularly in the private sector, high quality communication and quality customer/client service have become a focus of competitive advantage among some organisations (Scotti, Harmon & Behson, 2007; Welch, 2010), and have been linked to better patient recovery rates and improved wellbeing (Dijkstra, 2009).

## **Study Aims**

The purpose of this study is to provide a critically informed platform to better understand and improve service quality, communication and patient health outcomes in hospital emergency departments, focusing particularly on emergency department waiting rooms. The study uses a number of methods to gain a rich and detailed understanding of communication in NSW EDWRs, and explicitly links communication effectiveness and other issues to service quality and patient experiences. The study was part of a larger scale project, which had two interrelated aims:

1. To increase understanding of communication and service quality in NSW EDWRs and identify potential improvements in the quality of emergency health services delivery; and
2. To develop delivery-ready education and training materials specifically designed to improve service quality, with particular reference to communication in EDs.

This report focuses on the first aim of the study and addresses three key research questions:

1. What factors affect service quality in EDWRs?
2. What factors affect communication among ED staff, and between staff and patients and those accompanying patients?
3. How can service quality and communication in EDWRs be improved and better promoted and supported?

The research was conducted at four NSW hospitals. These hospitals were selected after consultations with a range of stakeholders, including the Clinical Excellence Commission (CEC), the Citizens Engagement Advisory Council (CEAC), NSW Health, and several senior hospital staff. Of most influence in the selection of general hospital profiles were, firstly, the CEAC (2008) *Development of a Communication Project Scoping Paper*, which specified a metropolitan teaching hospital, a metropolitan hospital, a rural-base hospital and a small rural hospital; and, secondly, the need for agreements to participate by hospitals from which involvement was sought by the research team. The hospitals at which data were collected thus purposively varied in their size, facilities, resources and location, and in the communities they serviced, thus providing opportunities, for example, to study intercultural communication issues (e.g., one hospital services a community which has a high Indigenous population; two others service demographically diverse populations, including people from widely different cultural backgrounds).

## **Report Structure**

Chapter 2 of the report locates this study in the context of previous research examining ED service quality and communication in Australia and overseas.

Chapter 3 explains the study's mixed (qualitative) methods methodology and the ethical considerations that underpinned the conduct of the research. It also briefly describes the ways in which the data were analysed, including the use of mind maps to support the analysis.

Chapter 4 presents a detailed description of the EDWRs and triage processes at each hospital. The discussion and findings are based mainly on the observations data.

Chapter 5 presents the study's findings, mainly in the context of the key themes arising from the analysis of the data obtained from interviews with 66 staff.

Chapter 6 presents the study's conclusions, describes the study's limitations and recommends avenues for further research.

Chapter 7 lists the study's key recommendations and, where necessary, provides supporting explanations and descriptions of possible actions as endnotes.



## Chapter 2

# LITERATURE REVIEW

### **Introduction**

This chapter locates the present study in the context of previous research into ED service quality and communication in a range of Australian and international settings. The chapter highlights important demand and supply trends affecting EDs, and describes the conundrum of ED waiting times and the impacts of a range of technical and other factors on patient satisfaction with regard to EDs and EDWRs. The chapter then examines issues specific to this present study, namely, service quality, communication, patient diversity, and ED and EDWR management. Several strategies that have been applied to address problems with service quality and communication in EDs and EDWRs are also discussed.

### **Key Trends – Demand for and supply of emergency treatment**

In Australia, demand for and supply of health care resources and facilities are changing rapidly and many related challenges have emerged for hospitals and healthcare organisations, professionals and practitioners. According to the National Health and Hospitals Reform Commission (NHHRC) (2009), the upward pressures on healthcare spending are unrelenting, reflecting interrelated matters such as continuing advances in health care, increasing demand from ageing populations and shifting disease patterns (CEC, 2009; NHHRC, 2009). Many EDs are currently attempting to cope with a growing and ageing population, declining general practitioner (GP) services, limited hospital resources, lack of access to inpatient beds, staff shortages, delayed or limited ancillary services, and risk and safety issues (Jayaprakash et al., 2009; NHHRC, 2009; O'Connell et al., 2008). NSW EDs have reported an increase in patient numbers and subsequent crowding, and their operational environments have become more demanding. Research in 2009 noted that the number of people presenting at EDs in NSW had increased by almost 15% since 2004 (BHI, 2010b), a rate of growth significantly greater than the population growth of 12% for the same period (BHI, 2010b; CEC, 2009). Between April and June 2010, for example, almost half a million people attended an ED in NSW, a 3.6% increase over the same quarter in 2008 (BHI, 2010b). These trends show no signs of abating (NSW Health, 2009a). To address the issue, the Australian Government has committed funding to

improve the quality and accessibility of primary healthcare services by supporting the establishment of 28 new GP Super Clinics with the aim of improving access to integrated GP and primary health care (NSW Health, 2010). Additional Commonwealth funding has also been allocated to tackle pressure points in the hospital system. The funding is, among other things, intended to improve ED access for patients (NSW Health, 2010).

The nature of and reasons for patients presenting at NSW EDs are also changing. Patients presenting to EDs are getting frailer and older. They often present with multiple problems that can take a long time to assess (O’Connell et al., 2008) and treat. EDs increasingly provide services for more than the seriously ill, functioning as part of the safety net for the healthcare system, providing ‘care for the disenfranchised ... the mentally ill, and those who ... do not know how to access “routine” care’ (Kelly 2005, p.192). In contrast, and by way of example, in April–June 2010 only 10% of people that were treated at a NSW ED were considered to have presented with an immediate or imminent life-threatening condition (BHI, 2010a).

Public perception of the ED differs from the view of clinicians (Hughes & Walters, 2007). For doctors and nurses, the ED is an area where emergency medicine is practised based on a carefully prescribed set of clinical priorities to ensure the safety of each patient. In contrast, for many members of the public the ED is the place to go when they cannot or are unable to find other medical assistance (Hughes & Walters, 2007). The effect of this perception is that EDs become very busy places, especially after hours, when many people present with relatively minor conditions that could be more appropriately managed in a GP clinic or other primary care facility (Hughes & Walters, 2007).

## **ED Waiting Times**

Increased demands on and crowding in EDs have led to increased patient waiting times and decreased patient satisfaction, which, according to Jayaprakash et al. (2009, p.233), can have ‘deleterious domino effects on the entire hospital’. ED overcrowding has been linked to inadequate inpatient bed availability and has been identified internationally as a ‘symptom of health care system failure’ (Kelen et al., 2000, cited in Trzeciak & Rivers, 2003, p.404). Overcrowding in EDs has the potential to lead to an unsafe environment for both patients and staff when the quality of care is compromised (Trzeciak & Rivers, 2003).

One strategy to address the issue of waiting times in NSW hospitals and in other hospitals in Australasia has been the establishment of targets which set the maximum time a patient should wait to be seen by a medical professional at an ED and the performance in delivery of treatment relative to that period of time. The recommended maximum waiting time (target time) and Performance Indicator Thresholds (PITs) for patients whose assessment is most urgent because their condition is immediately life-threatening (triage level 1) is 'Immediate' and 100%. The target times and PITs for the remaining triage levels are 10 minutes (ATS category 2; PIT 80%), 30 minutes (ATS category 3; PIT 75%), 60 minutes (ATS category 4; PIT 70%) and 120 minutes (ATS category 5; PIT 70%) (ACEM, 2006; also BHI, 2010b). EDs have also instituted 'fast track' procedures for lower acuity patients to move these patients more quickly through the ED. In addition to improving ED throughput, these procedures have a positive impact on patient satisfaction (Anti & Brown, 2004).

Of patients who attended an ED in NSW in April–June 2010, 68% received treatment but were not admitted to hospital, and more than half of these patients (52%) left the hospital within two hours of starting treatment. Some of those people (7%) left without or before completing treatment (BHI, 2010b). Mohsin et al. (2007) found those experiencing longer waiting times and those triaged as 'less urgent' were the patients most likely to leave the ED before being seen by the doctor. BHI (2010b) also suggested that patients left because they were dissatisfied with the care they received or they decided they no longer needed care. For three of the hospitals involved in the present study, the greatest challenges to attaining target times occurred with respect to triage levels 3 and 4, but there were still significant failures at triage levels 2 and 5. Although these times provide important management targets and present a single, quantitative indicator of performance, they do not explain much about the ED setting, patient safety, quality of service or indeed patient satisfaction. Waiting times are only one factor in service quality, albeit an important factor.

## Patient Satisfaction

The *NSW Health Patient Survey* (2009a) revealed that the majority of non-admitted emergency patients rated their care as good to excellent (good – 25%, very good – 32%, excellent – 26%) (BHI, 2010b, p.5). Patients who rated their care as only fair (12%) or poor (5%) nonetheless account for more than one in six non-admitted emergency patients (BHI, 2010b, p.5). The survey also revealed staff courtesy and staff teamwork were the most important of several factors that contributed to ratings of ‘excellent’. Other areas of importance that influenced the rating were patients’ perceptions of the completeness of care and the time they spent waiting (BHI, 2010b). It appears, then, that waiting times alone are not a reliable (single variant) predictor of a positive or negative ED experience. BHI (2010) findings are supported by other research. Boudreaux, Cruz and Baumann (2006), for example, found that patient satisfaction with ED care was directly related to patients’ own perceptions of ED staff behaviours and attitudes, while Messner (2005, p.136) revealed that staff behaviours and attitudes were more important than actual waiting time because ‘speed [of treatment] did not compensate for rudeness or disrespect’.

The literature regarding patient satisfaction in the ED has grown rapidly (Welch, 2010, p.64). Welch (2010) reviewed ED patient satisfaction research for the past 20 years and uncovered five major elements of the ED experience that correlate with patient satisfaction: (1) timeliness of care; (2) empathy; (3) technical competence; (4) information dispensation; and (5) pain management. Similar issues have been identified in other literature. For example, Sun et al. (2001, cited in Messner, 2005, p.135), argued that patient satisfaction in the ED was increasingly influenced by staff communication and courtesy, and that priority areas for improving patient satisfaction included keeping the patient and family informed about the patient’s condition and the reasons for delays, and the courtesy of the staff with respect to patients and those accompanying them. Recent studies in Australia have revealed similar results, indicating that the relationships between staff and patients are central to people’s overall views and experiences of the ED, with staff courteousness the principal determinant of patient perceived quality of care (BHI, 2010b; Piper, Iedema, Merrick & Perrott, 2010).

Quality improvement initiatives are widespread in emergency medicine (Welch, 2010). Such initiatives in the ED have usually focused on improving processes of care, such as reducing waiting times and improving adherence to guidelines and pathways. EDs

increasingly working to improve ‘profitability and reduce costs, streamline processes and shorten patient throughput times, and reduce complaints and improve patient satisfaction’ (Messner, 2005, p.134; see also O’Connell et al., 2008). Increasing emphasis has also been given to improving efficiencies at the ‘front-end’ operations in the ED which become crucial during periods of full capacity and crowding (Wiler, Gentle, Halfpenny, Heins, Mehrotra, Mikhail & Fite, 2010). In recent years a number of projects have taken place to redesign and improve the pathways of patients who present to the ED but who are not admitted (77%), in an effort to move them more quickly through the ED (O’Connell et al., 2008, S19). NSW Health implemented a number of projects described as ‘clinical process design’ that were primarily concerned with improving patient journeys in the ED by making them simpler, more efficient and better coordinated (Ben-Tovin, Dougherty, O’Connell & McGrath, 2008, S14). ‘Fast track zones’, advance practice nurses and rapid assessment teams have been incorporated in NSW EDs. The fast track zones have reduced congestion and led to significant improvements in services delivery (O’Connell et al., 2008). Some projects have led to improvements in triage time and a reduction in the ED length of stay (O’Connell et al., 2008).

In summary, a number of strategies have been effective in helping to reduce waiting times and improving patients’ journeys through the ED. Gubb and Bevan (2009, p.442), however, argue that too much focus on targets has ignored underlying problems important to patient care and suggest that ‘the most intractable problems in health care – the lack of communication, leadership, and teamwork; the lack of integration; and the lack of any meaningful, patient focused, quality framework – are systemic or cultural’. There is considerable room for improvement in EDs with respect to patient care and communication. In NSW, this gap was highlighted in the NSW Health *Caring Together* document which recommended that communication with patients and issues relating to patient care be improved (NSW Health, 2009b; see also ACSQH, 2009; Garling, 2008; Hughes & Walters, 2007).

## **Service Quality**

Service quality has become an increasingly important focus among health organisations, and has been linked to patient recovery and wellbeing (Dijkstra, 2009; Fottler et al., 2000; Street, Makoul, Arora & Epstein, 2009). As health services place greater focus on patient satisfaction, hospital managers have directed resources to quality management and the implementation of techniques to improve service delivery (Desombre & Eccles, 1998; Jabnoun & Rasasi, 2005; Stuart, Parker & Rogers, 2003; Welch, 2010). As noted in chapter 1, Potter et al. (1994, p.4) described three quality dimensions of a patient's experience at hospital: the quality of technical care; the quality of interpersonal relationships; and the quality of hospital amenities and the environment. It was noted that technical care refers to the essential aspects of the service dimension such as hygiene requirements, standard medical equipment, and the medical outcome of their service (see also Meirovich, Brender-Ilan & Mervovich, 2007). However, although this aspect is critical to the experiences of hospital patients, the latter two dimensions are aspects of the facilities and services that are critical to patient health and wellbeing and attractive to and highly valued by patients. Examples of the latter dimensions include: the extent and quality of communication between staff, patients and accompanying persons; availability of information about what is happening and when for patients and those accompanying them; attractive design and interiors; familiarity with hospital procedures and practices that affect patients; visiting hours; immediate and personal responses to patients' requests; friendly staff; and the quality of meals and refreshments (Jabnoun & Rasasi, 2005; King, 1995; Meirovich et al., 2007). Drawing upon selected research since 1990, Table 2.1 summarises research explicitly linked to important determinants in patient service quality.

The principles of quality customer service are well established in the non-health industries and gained significant recognition in, for instance, the hotel industry in the 1980s and 1990s (Bitner, 1992; Desombre & Eccles, 1998; Potter et al., 1994). Generally, quality customer service is necessary for satisfying and retaining customers and actually requires the offering of a service that exceeds customers' expectations (Desombre & Eccles, 1998; Jabnoun & Rasasi, 2005). To be successful in customer service, and to provide high quality services that support tangible or intangible products, it is necessary to have a thorough understanding of what pleases the customer, a proposition that has been fundamental to hospitality and hotel management for many decades.

**Table 2.1: Research Incorporating Quality Patient Service Determinants**

Authors	Quality Patient Service Findings
Fitzgerald et al. (1991)	Service quality determinants include: access and accessibility, which refer to the ease of finding one's way around and getting to facilities; appearances of goods, staff and facilities; availability of staff; cleanliness of goods, staff and facilities; comfort and atmosphere, including seating, temperature and design; communication concerning clarity of product information, clarity in staff and customer interaction, and signposting; competence, expertise and knowledge of staff; courtesy, politeness and respect; friendliness and helpfulness of staff; product reliability, punctuality, and consistency of environment; responsiveness and delivery speed; and product security and personal security.
Potter et al. (1994)	Service quality improvements: professional staff conduct; patient feedback; set standards for reception; communication with reception and medical staff; signposting and escorting of patients; staff to help each other; interpersonal skills training; medical staff made aware of patient complaints; links with other departments.
Heppe et al., 1990, in King (1995, p.220)	Measures to generate a 'feel at home' environment include: friendly staff; welcoming admissions procedures; information regarding daily routine; plain cooking and menu choice; privacy; comfortable furniture; leisure and recreational activities; and attractive decor.
Torres & Ng (1995)	Service quality indicators: empathy; understanding of illness; relationship of mutual respect; patients treated with dignity; physical environment; and meeting patients' religious needs.
Desombre & Eccles (1998)	Service quality determinants for hospital settings: Reliability – the ability to perform the service dependably and accurately; Responsiveness – the willingness to help customers and provide prompt service; Tangibles – the physical facilities, equipment, and appearance of the personal; Assurance – employees' knowledge, courtesy and ability to convey trust and confidence; and Empathy – the level of caring and individual attention provided to customers.
Rose et al. (2004)	Service quality dimensions – technical performance; interpersonal considerations; amenities/environment; signage; equipment; access/waiting time; costs; outcomes; and religious needs.  Physical variables influencing patients' overall experiences – noise, odours, temperature, colours, texture and comfort.
Clement Sudhahar & Selvam (2008)	Service Quality Scale Dimensions: 1. Service delivery – all aspects (reliability responsiveness, assurance empathy, moment of truth, critical incident and recovery). 2. 'Servicescapes' – both the tangible and intangible facets of the service facility. 3. Service element – the core service portrays the content or 'what' of a service. 4. Service design – the processes, procedures, systems and technology in service provision. 5. Service credence – social responsibility helps an organisation to be a corporate citizen encouraging ethical behaviour.

The idea of introducing into hospitals the training, principles and practices of hospitality (and hotel) management is not new. In the 1980s guest relations programs were incorporated in hospitals in the US, drawing on expertise from the customer service programs of organisations such as the Marriott and Disney (King, 1995). Unfortunately, many of these programs failed to achieve significant and long-lasting results. Their failure was attributed to several factors, but particularly to the narrow focus on front-line personnel who were trained to be courteous to patients, and to improve their interpersonal communications and complaint-handling skills. In contrast, Cruikshank and Bullock (2001, p.43) argued that for long-lasting change to occur in any organisation, ‘quality must be regarded as normal business practice rather than as a separate programme ... [and should be] embedded in the strategic plans of both the organisation and individual departments’. Organisations also need to be aware that overcoming service quality problems and changing a service culture require the engagement of all stakeholders (Braithwaite, Iedema & Jorm, 2007; King, 1995), and that senior management needs to be directly involved in any process of change regarding service delivery (McGrath et al., 2008). The successful delivery of high quality hospital and health services requires multifaceted strategies, and the significance of communication to service quality and patient satisfaction has been well demonstrated.

## **Communication and the ED**

‘Effective communication and interpersonal skills have long been recognized as fundamental to the delivery of quality health care’ (Slade et al., 2008, p.271; see also Coiera & Tombs, 1998; Freemon, Negrete, Davis & Korsch, 1971; Hobgood, Riviello, Jouriles & Hamilton, 2002; and also Woloshynowych, Davis, Brown & Vincent, 2007). Effective communication for the patient concerns the positive exchange of information and feelings to develop a relationship between the patient and hospital staff (Braithwaite et al., 2007; Kelly, 2005). It involves imparting, receiving and deciphering knowledge. ‘The effective interchange of various signs, signals, information and data, written, verbal and non-verbal discourse connects people together, facilitates collaboration and lays the groundwork for forms of consensus’ (Braithwaite et al., 2007, p. 357; see also chapter 1 of this report). Yet, failures in communication have been identified as a major cause of critical incidents in public hospitals in Australia (Garling, 2008; Hughes & Walters, 2007; Scheeres, Slade, Mandis, McGregor & Matthiessen, 2008, p.13) and as a major risk to patient safety in NSW public hospitals (Garling, 2008, Vol 2, p.519). Garling (2008) also

highlighted the increasing likelihood of such problems existing when a health system is under pressure; clinical care can suffer, as can the compassion shown for patients, families, colleagues and support staff. Nurses, midwives and doctors, for example, have reported experiencing a sense of powerlessness in such pressured working environments because they 'feel they cannot make changes they believe are in the interests of their patients' (NSW Health, 2009a, p.3).

There is mounting evidence that the pressures of communication in high-stress work areas such as hospital EDs present particular challenges to the delivery of quality care (Slade et al., 2008). Essentially, the ED is an unpredictable environment, with the potential for communication and actions to be chaotic and interrupted (Coiera, Jayasuriya, Hardy, Bannan & Thorpe, 2002; Kelly, 2005; Woloshynowych et al., 2007). Health professionals are asked to meet the demands of fluctuating workloads that lead to multi-tasking and stress, which may be especially prevalent in small hospitals or hospitals where staffing resources are inadequate. It has been widely reported that many EDs are experiencing a lack of nurses and doctors, resulting in frustration, tiredness, impersonal relationships, minimal communication, and the inability of staff to complete the most basic aspects of care (e.g., Boykin, Bulfin, Baldwin & Southern, 2004, p.331).

Several Australian studies of EDs have reported that patients felt they were outsiders or did not know what was going on around them, indicating a lack of information or poor communication between staff and patients about processes, waiting times and other matters (Garling, 2008; NSW Health, 2010; Slade et al., 2008; Stuart et al., 2003). There were mismatches between the communicative aims or needs of the patient and the health practitioner. For example, there were different understandings of time with 'language references around absences and waiting times not mutually understood' (Scheeres et al., 2008, pp.15-16; Slade et al., 2008). Stuart et al. (2003) held focus groups with patients from minority backgrounds on the experience of the ED in South Australia. Patients saw a need to improve the information given to them to assist with understanding the hospital process and the communication between staff and patients and patients' carers. Garling (2008, Vol 2, p.718) recommended that communication issues in the ED be addressed, highlighting that good communication was 'of the essence at the start of the interaction with hospital staff', and that 'often a small effort to communicate can resolve a lot of the tension patients experience in the ED' (p.26). These issues are not limited to Australian

contexts and settings and have been highlighted in countries such as the United States (US) and the United Kingdom (UK).

Numerous reports and reviews in the US have revealed that a lack of clear communication to patients and their families was common across EDs (see Farmer, Roter & Higginson, 2006; Kelly, 2005; Lin, Hsu & Chong, 2008; Messner, 2005; Saunders, 2005). Many EDs failed to keep patients adequately informed about long waits in triage, delays in testing or in receiving the results of tests, and waiting for the doctor to see the patient (Cram & Dowd, 2008; Messner, 2005). At times, ED staff assumed patient and/or family needs without validation, there was often a lack of privacy in the ED environment, and interactions from staff took for granted that providing clinical assistance and medical treatment was sufficient, rather than providing a service that was more focused on patient-centred care (Kelly, 2005; Larsson Kihlgren, Nilsson, Skovadahl, Palmblad & Wimo, 2004). Yet, relationship development and communication are inseparable and essential to improve outcomes for patients and healthcare providers, team members, the organisation and the community generally (Kelly, 2005; Cram & Dowd, 2008). Patient satisfaction and compliance with doctors' recommendations are closely related to the effectiveness of communication and the doctor–patient relationship (Carrillo, Green & Betancourt, 1999), but it is important also to recognise the possible roles of people who accompany patients (e.g., family, friends, carers) both inside and outside the hospital setting.

Communication is greatly influenced by the context in which it takes place (Bensing, van Dulmen & Tates, 2003). Strategies for enhancing communication include clear guidelines and expectations regarding communication, active listening, validating understanding, matching non-verbal and verbal messages, and building 'trusting relationships and open communication' with patients (Braithwaite et al., 2007, p.356; Boudreaux et al., 2006; Kelly 2005). According to Lin et al. (2008), three main areas are required to improve the quality of communication between staff in the ED. First, staff should achieve a level of empathy with patients. Second, an improvement in technical ability should enable staff to focus on the psychological needs of patients and to identify conditions that patients are most concerned about. Third, staff should develop their reflective skills in order to critically review and reflect upon what happened and consider whether the steps undertaken have achieved the intended result.

Communication strategies require a patient-centred approach and appropriate dissemination of specific information about service provision in the ED (Boudreaux et al., 2006; van Charante et al., 2006, cited in Kington & Short, 2010). Boykin et al. (2004) studied the language of caring and found that the concept of caring comprised technical expertise and diagnostic skill as well as commitment to and compassion and respect for the patient. Halligan (2008, p.480) highlighted the importance of:

Time spent with a patient, a hand held, a small kindness, a caring act, honesty – any of these seemingly inconsequential actions have a critical impact well beyond their stand-alone worth. These critical but unmeasurable behaviours cannot be bought or commanded, they arrive with a set of values and thrive or wither as a function of organizational culture. They reduce fear and anxiety and revive hope and optimism.

According to Kelly (2005,), in order to build a good relationship with their patients, health professionals must also be aware of their own beliefs, values and judgements. Gubb and Bevan (2009, p.443), too, noted that ‘good medicine is premised on values – on kindness, caring, good communication, honesty and, above all, trust. When clinicians are seeing numbers, not the patient ... targets have undermined clinical decision making’. In a target-focused environment such values ‘struggle to survive’ (Halligan, 2008, p.481; see also Braithwaite et al., 2007; Gubb & Bevan, 2009). The importance of patient trust in providing quality health care was noted in a recent report, where the lack of research about trust in the Australian health system was cited (ACSQH, 2009).

Trust is generally considered to have two dimensions: a cognitive dimension based on rational judgements and associated with skills, knowledge and competence; and an affective dimension associated with the quality of relationships, interactions and perceptions of care (Calnan & Rowe, 2006, cited in ACSQH 2009, p.10). Emotional support from hospital staff has been found beneficial in alleviating the stress experienced by patients and those accompanying patients. Hospital cultures emphasising emotional support to families and carers have been shown to engender more positive perceptions among staff about the impact of ED work which has further led to greater job satisfaction and less staff turnover (Hemmelgarn, Glisson & Dukes, 2001; O’Malley, Brown, Krug & the CPEM, 2008). As such, approaches like those embedded in the Patient and Family Centred Care (PFCC) initiative place considerable emphasis on valuing staff and staff experiences (ACSQH, 2009).

PFCC is ‘an innovative approach to the planning, delivery, and evaluation of health care that is grounded in a mutually beneficial partnership among patients, families, and health care professionals’ (O’Malley et al., 2008, p.511). PFCC and similar approaches embrace the following concepts: (1) the provision of care is for a person, not a condition; (2) the patient is best understood in the context of his or her family, culture, values and goals; and (3) honouring that context will result in better health care, safety and patient satisfaction (O’Malley et al., 2008, p.511).

There has been growing acknowledgement of the need to include patients, families and carers in the development and delivery of health services in Australia (Stuart et al., 2003). Stuart et al. (2003) interviewed the relatives, friends and carers of patients who had attended an ED in South Australia. They noted that their role as a carer was often not acknowledged. This was of a particular concern, for example, if the patient for whom they were caring presented with dementia or was visually impaired. They suggested that carers should be recognised as advocates for the patient to assist the patient journey in the ED, and indicated that there was the potential for carers to play a critical supporting role, such as providing information about the patient to ED staff and offering emotional support to the patient (Stuart et al., 2003, p.373). McGrath et al. (2008, p.S33) also highlighted the importance of patient and carer involvement in the process of improving hospital systems and experiences for staff and patients:

Patients and carers must be involved in both defining and solving problems ... the patient journey should be designed to meet patient and carers’ needs and the quality of the journey must be an outcome measure.

Most recently, ACSQH (2010) released a discussion paper that presented a number of strategies and frameworks to support the implementation of PFCC in the Australian healthcare system.

## **Culture, Language, and Health Literacy**

ED staff are treating an increasingly diverse patient population and the staff whom patients encounter at the hospital are also from an increasingly diverse range of backgrounds (Herke et al., 2008). As Herke et al. (2008, p.148) noted, the ‘potential variations in meaning exchanges across such diverse groups only serve to highlight the complexities and communication challenges that patients and clinicians face’. In multicultural societies,

quality health care requires that people working in health systems need to understand how a patient's sociocultural background affects his or her health beliefs, values, interests and behaviours (Carrillo et al., 1999). A patient's culture, language and health literacy can dramatically impact on their experiences and health outcomes in the hospital environment (Betancourt, Green, Carrilo & Ananeth-Firempong, 2003; Nutbeam, 2008), can affect the risk of communication error, and can potentially either compromise or improve patient privacy, safety and outcomes (O'Malley et al., 2008). Interacting with healthcare providers and systems can be complex for patients. When these interactions occur in a language that is different to the patient's first language and require the patient to adapt to different social conventions or unfamiliar bureaucratic procedures, the process for healthcare delivery becomes all the more challenging (Paasche-Orlow, 2004). Not surprisingly, the causes of disparities in patients' experiences and outcomes are therefore seen to be linked to a range of social determinants of health which are external to the hospital system (Nutbeam, 2008).

Betancourt et al. (2003) reviewed the literature between 1977 and 2002 and found that variations in patients' health beliefs, values, preferences and behaviours were key factors that influenced patient and doctor decision-making and other interactions between patients and the healthcare delivery system. For example, there were differences in the way patients recognised symptoms; differences in the ability of a patient to communicate their symptoms to someone who understood their meaning; and differences in a patient's ability to understand the process of a health facility (Betancourt et al., 2003). Cultural and linguistic barriers in the hospital encounter can negatively affect communication and trust, and can lead to patient dissatisfaction, poor adherence to health management strategies and poorer health outcomes (Betancourt et al., 2003; Nutbeam, 2008).

The development of 'cultural competence' is one strategy that has been used to address cultural disparities in the health environment (Betancourt et al., 2003). The essential principles of a 'culturally competent' healthcare system acknowledge the importance of culture in people's lives, respect cultural differences, and minimise any negative consequences of cultural differences (Betancourt et al., 2003). Culturally competent health providers promote these principles by learning about culture, and embracing pluralism and proactive accommodation (Paasche-Orlow, 2004). Appropriate techniques adopted have included culturally competent health promotion, interpreter services, relevant training, and time and space for self-reflection (Kodjo, 2009, pp.62-63). Other principles of cultural

competence include empathy, curiosity and respect, through which health professionals and others can attain an understanding and appreciation of the social context of the patient (Kodjo, 2009). However, many efforts in the area of cultural competence under-emphasise the importance of social factors on the provision of health care to diverse populations (Green, Betancourt & Carrillo, 2002). Cross-cultural education typically has not adequately addressed social factors, which include not only predictors of socioeconomic status (e.g., income and education), but other factors such as illiteracy, immigration experiences, religion, social stressors and social support networks (Green et al., 2002).

Functional health literacy is described as having the ability and skill needed to gain access to, understand, and act on oral and written information in healthcare settings (Rudd, 2010). A recent South Australian study that measured functional literacy in an Australian population found that 43% of the 2824 study participants were at risk, or had a high likelihood, of inadequate functional health literacy (Adams et al., 2009, p.532). Lower functional health literacy was found to be significantly more common among those with lower education, lower annual income and poorer health status, and who were born in countries other than Australia, New Zealand, the UK and Ireland (Adams et al., 2009). This is consistent with the results of the 2006 Adult Literacy and Life Skills Survey which found that more than 59% of adults assessed had inadequate skills to ‘understand and use information relating to issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy’ (Australian Bureau of Statistics [ABS], 2009, p.8). The Survey results indicated that older age, poor or fair self-assessed health status, lower educational attainment and lower income were associated with lower health literacy (ABS, 2009). These circumstances have implications for communication in health care settings generally, but specifically in the ED, which can become a source of primary health care for the socioeconomically disadvantaged.

Since the 1960s, studies have shown that although patients may have a limited capacity to understand health information, it is the way in which health information is communicated that can exacerbate (or ameliorate) the problem (Rudd, 2010). Patient comprehension increases when precise wording is used to communicate instructions to patients (Davis, Federman, Bass III, Jackson, Middlebrooks, Parker & Wolf, 2008). However, use of jargon and a didactic style of communication were evident in the design and functioning of hospitals where the built environment assumed that the population in general had a high

level of literacy. This was depicted in various signs, advertisements and warnings often located in and around the ED environment (Rudd, Renzulli, Pereira & Daltroy, 2005). That said, health illiteracy may not be always readily revealed to the health professional; for instance, an inability to read is often a source of shame for patients and therefore not overtly discussed with the health professional (Green et al., 2002).

There is a growing appreciation of the need for health professionals and services to heighten their awareness of possible illiteracy so that the issue can be approached in a sensitive and respectful manner (Nutbeam, 2008). Moreover, the relationships between poor literacy skills and health-related outcomes, such as knowledge and understanding of disease, adherence with treatment, engagement in preventative measures, illness and death, are being increasingly recognised (Nutbeam, 2008; Rudd, 2010; Williams, Davis, Parker & Weiss, 2002).

## **The EDWR Experience**

The ED provides the first and often only experience of a hospital's service for many patients and their relatives, friends and carers, and has thus been identified as a key determinant of a hospital's reputation (Stuart et al., 2003, p.370). In trying to understand the wide-ranging and often intangible factors that influence patient satisfaction and perceived quality of care in the ED, the waiting experience is of critical importance (Ayas, Eklund & Ishihara, 2008, p.390; Becker, Sweeny & Parson, 2009).

Garling (2008, Vol 2, p.719) specifically recommended the need for better communication between hospital staff and patients in the EDWR. Research within one Australian EDWR indicated that patients would like to experience useful information in the ED about self-care and basic treatment, positive attitudes from staff, a more comfortable waiting room, and privacy and confidentiality (Kington & Short, 2010, p.407). Other literature has also shown that patients who have to wait at ED departments reported wanting information about why they were waiting, how long they would wait, and confirmation that they had not been lost in the queue (Cooke, Watt, Wertzler & Quan, 2006; Kelly, 2005; Larsson Kihlgren et al., 2004). There is a need for patients in the EDWR to be informed about how long they can expect to wait, by whom they will be seen, what the next step in the process is about, and what is going on behind the scenes (Garling, 2008, p.719). From the moment

a patient enters the ED it should be the responsibility of every staff member to contribute to aspects of community building within the ED (Kelly, 2005):

Everyone who enters an ED is seeking something and is scared. Whether the fear comes from the extensive trauma/symptoms they face or from concern that they will not receive care, it colors every interaction. This care situation is one of emotional distress for the patient and his or her family/significant others. Ideally, the entire team, from the intake nurse to the discharge caregiver, will strive to create an environment of trust, respect, and acceptance where the patient can be encouraged to express his or her anxieties and fears. (Kelly 2005, p.192)

While Kelly may have generalised the experience of the ED patient, it is known that anxiety levels can be exacerbated by the length of the wait and the nature of the wait, and also by lack of information while waiting (O’Cathain, Coleman & Nicholl, 2008; Welch, 2006). The waiting room is an appropriate place to apply anxiety-reducing techniques, as it is where anxiety and worry about the consultation and possible treatment regimes, for example, are likely to begin (Dijkstra, 2009; Leather, Beale, Santos, Watts & Lee, 2003, p.865). A lack of understanding about waiting is a key problem with patients waiting to be triaged and is seen as a contributing factor to patients leaving the ED before treatment (Garling, 2008; Kington & Short, 2010; Mohsin et al., 2007). In particular, a lack of understanding about the triage system can impact on patient satisfaction when a patient feels, for example, that they are waiting unfairly if they see that other patients are being treated before them (Mohsin et al., 2007; Welch, 2006). Findings show that a large proportion of the community is unfamiliar with the triage process and this lack of familiarity often contributes to the negative experience in the ED (Stuart et al., 2003). Proactive behaviour from health professionals is an important system characteristic. It can allay patient anxiety by making patients feel that their concerns are being taken seriously (O’Cathain et al., 2007), which may, in turn, facilitate and improve the patient’s experience of waiting and have a positive impact on their satisfaction and wellbeing.

Maister (1985, cited in Welch, 2006) suggested that actual waiting times and perceived waiting times can be managed in the ED by incorporating the principles of the psychology of waiting. Maister also suggested that the experience of waiting can be influenced to improve a patient’s subjective experience, and outlined eight factors that impact on a person’s experience of waiting:

- occupied time feels shorter than unoccupied time
- people want to get started
- anxiety makes waits seem longer
- uncertain waits are longer than known, finite waits
- unexplained waits are longer than explained waits
- unfair waits are longer than equitable waits
- the more valuable the service, the longer the customer will wait
- solo waits feel longer than group waits

(Maister,1985, cited in Welch, 2006, p.20).

By keeping patients occupied and informed and by addressing the unknown and seemingly unfair, the ED patient's perceptions of the waiting experience can be managed in a way that can improve their overall ED waiting experience (Stuart et al., 2003; Welch, 2006). To improve the experience in the ED, Stuart et al. (2003) suggested the development of appropriate signs and posters in waiting areas, the distribution of printed material, and interaction with the local community, including school visits, a promotional video, using the local media and employing triage assistance to work in the waiting area (Stuart et al., 2003). Stuart et al. (2003, p.373) also revealed that patients thought that posters and displays that reflected the multicultural nature of their area would improve their experience of the EDWR.

The implementations of recommendations in the Garling report (2008, Vol 2, p.721) have led to a clinical initiatives nurse (CIN) being stationed in the EDWR in some hospitals. The CIN focuses on patients in the waiting room, providing better communication on waiting times, initiating basic treatments and completing required admission documentation (NSW Health, 2009b, p.71). Other strategies to meet patients' needs while waiting include involving relatives and friends in the care process and allowing relatives and friends to be with their loved one where possible, as well as fostering a trusting relationship between staff and patients and those accompanying them (van Dreven, 2001). As noted in chapter 1, some of the elements that are critical to understanding communication and service quality in health service settings such as EDWRs extend far beyond the spoken word and spoken language and include: voice quality and volume; staff and patients' manner of speaking; voice intonation; gestures; clothing; body posture; facility design and quality; comfort; sense of safety and of being cared for; signage, posters

and pamphlets; access to and use of technology such as television and mobile phones; and images.

Feeling safe and secure are important dimensions of the ED experience that have implications for both the patient and the staff at the hospital. According to Colling & York (2010, p.28) security safeguards are both physical and psychological. Within the EDWR, the physical presence of security guards, alarms, closed circuit TV, in addition to lighting, access controls and identification badges, can all contribute to a sense of security for the patient on both a physical as well as a psychological level. Psychological security can be further impacted by signage, the design of the landscape and physical design, the interactions of staff and staff acknowledgements. Increased safety for staff and patients and improving the patient journey are favourable outcomes of redesign (McGrath et al., 2008). When designed appropriately, these aspects of the EDWR environment can create a more welcoming, satisfying, if not therapeutic, environment.

## **Therapeutic EDWRs**

The concept of therapeutic environments is derived from geographical research that examines physical spaces as comprising physical, social and symbolic aspects (Gesler, 1992, cited in Curtis et al., 2007). Other service industries such as hospitality, banking and retailing have long understood that the physical environment can have an immediate effect on the attitudes and behaviours of customers and employees (Bitner, 1992; Fottler et al., 2000). Within the healthcare industry there has been an increasing amount of research that has focused on the relationships between place and the healing process of patients. Much of the initial research was drawn from the work of Gesler (1992, cited in Smyth, 2005, p.488), who developed a framework to explore how the healing process works.

Well-designed waiting spaces are more likely to result in patients entering the facility with a positive image of the 'healthcare process' (Dijkstra, 2009, p.66; see also Fottler et al., 2000). Waiting areas have been 'referred to as "servicescapes" where a part of the service is delivered, perceived and where the staff and patients interact' (Ayas et al., 2008, p.390). The servicescape of an EDWR includes room size, design, seating and layout, posters, decor, colours, temperature, lighting and sounds. These elements of a servicescape affect the emotional, cognitive and physiological states of everyone in the EDWR, and so careful planning and management of these elements are central both to patients' and others'

experiences of the EDWR, and to ‘what happens’ in the EDWR. There is no one aspect of the visit, or element of design, that conclusively defines the patient experience. Rather, it is the combination of physical and social factors that impacts on both staff and patients (Becker & Douglass, 2008). The overall environment of healthcare facilities can influence the patient’s waiting experience and their perception of quality of care (Devlin & Arneill, 2003; Fottler et al., 2000). The environment of a healthcare facility is also representative of the expectations, preferences and skills of those providing health information and services (Rudd & Anderson, 2006).

In creating a more positive experience for the patient, the physical environment can communicate an organisation’s beliefs and values. Such practices are at the core of the PFCC movement advocated by organisations such as the Planetree Foundation, The Centre for Health Design, and the Institute for Healthcare Improvement (Becker & Douglass, 2008, p.137). The Planetree Foundation, for example, aims to provide a sense of familiarity and homeliness in their hospital spaces (see Smyth, 2005). Patient-focused environments also allow for family interaction and personalisation in service (Fottler et al., 2000). McCullough (2010) examined in detail why evidence-based design is so critical to improving health care by improving the design of healthcare facilities in their recent report, *Evidence-Based Design for Health Care Facilities*. In brief, there have been a growing number of studies that have identified the positive relationships between the physical attractiveness of healthcare settings, patient satisfaction, perceived quality of care and improved patient outcomes (Barach, Potter Forbes, & Forbes, 2009; Ulrich, Zimring, Zhu, Dubose, Seo, Choi, Quan, & Joseph, 2008).

There is also growing scientific evidence confirming that conventional hospital design contributes to stress and even danger (Leather et al., 2003; Ulrich & Zimring, 2004). Many hospital designs do not address fundamental issues relating to patients’ experiences such as ‘lack of control, insecurity, lack of privacy, disorientation, lack of sleep and rest, family absence, and an overarching sense of dehumanisation’ (Barach et al., 2009, p.528). Taylor (1979, cited in Devlin & Arneill, 2003, p.672) noted that ‘the hospital is one of the few places where an individual forfeits control over virtually every task he or she customarily performs’. For example, patients have no control over how long they will have to wait to be seen or treated in the EDWR (Becker & Douglass, 2008). This lack of control has been described as a major problem for the patient in the hospital setting and one which

contributes to increased stress (Ulrich, 1992, cited in Devlin & Arneill, 2003, p.672). Therefore to reduce a patient's levels of stress and anxiety, hospital design should incorporate a space with stress-reducing or restorative features that will improve patient outcomes (Ulrich et al., 2008).

Providing patients with good signage and direction contributes towards a positive experience for the patient and feelings of goodwill. If a patient's route is clear, the EDWR is less likely to create greater confusion and anxiety for the patient and those accompanying them. This is of particular importance in the ED when people are already likely experiencing mixed emotions (Colling & York, 2010). McPhaul et al. (2008, p.247) stressed the need to test healthcare designs for staff and patient safety so that security and safety are integral aspects of workplace violence prevention. Critical points may arise with regard to visibility from control points, duress communication, locking provisions, and supervision and off-ward duress communication.

Comfort is another factor that impacts on patients' experiences of the EDWR. If a patient has to wait for extended periods of time, they are likely to be uncomfortable sitting in EDWR chairs which generally are not conducive to comfort. If facilities are developed that are comfortable and arranged in such a way that they enable families and friends to talk more easily with each other, they could contribute to patients' and their relatives' perceptions of feeling safe and secure while in the EDWR (Stuart et al., 2003, p.372). Other findings support the positive correlation between more attractive and comfortable environments and higher levels of perceived quality of care, satisfaction, staff interaction and reduction of patient anxiety (Devlin & Arneill, 2003; Becker & Douglass, 2008; Fottler et al., 2000; Leather et al., 2003). Indeed, there is strong evidence to suggest that more 'relaxed patients are more easily treated by medical practitioners' (Dijkstra, 2009, p.66). Nonetheless, the literature has highlighted the complexity not only of relationships in health service settings, but also of dealing with people's changing conceptions of places, diseases and health (Smyth, 2005).

Ulrich and Zimring's (2004) review of over 600 articles demonstrated that the physical environment not only had effects on patient outcomes, but also on: staff outcomes and quality of care; staff stress and fatigue and effectiveness in healthcare delivery; patient safety; patient stress and outcomes; and overall healthcare quality. In brief, improved

physical settings are an important element in making hospitals safer, more oriented towards patients and their carers, and better places to work for staff (Becker & Douglass, 2008; Ulrich & Zimring, 2004). Evidence increasingly demonstrates that the healthcare environment has substantial effects on patient health and safety, care effectiveness, and staff efficiency and morale (Barach et al., 2009).

The growing interest in hospital design is associated with research grounded in environmental psychology, which has demonstrated the importance of hospital environments for treatment outcomes and the more general wellbeing of patients (Curtis et al., 2007). Factors that have an impact on the way an environment is perceived can include:

- ambient conditions or affective quality – the colours on the wall, the room temperature, whether the room is pleasant smelling, privacy, opportunities for child play, presence or absence of plants, quality of lighting, and sound levels
- spatial conditions or technical quality – security, safety, functionality, privacy, hygiene, the way a room is laid out, whether a room appears organised, and levels of comfort with respect to furnishings
- interaction quality – welcome, presence of caretaking staff, attention given by staff to patients, service orientation, confidence inspiring communication and actions
- signs symbols and artefacts such as signage, style of decor, and personal artefacts.

(Ayas et al., 2008, pp.395-396; Fottler et al., 2000, pp.95-96)

Strategies to improve the environment of the waiting room could, therefore, include among others things: providing better quality and regular information to patients; changing the positioning and quality of seating; modifying the tone and complexity of signs and posters; and taking proactive efforts to reduce the stress and negative responses that arise from waiting in the EDWR by providing some form of distraction such as a television and/or magazines, indoor and outdoor views, patient-education resources, and refreshments (Becker & Douglass, 2008, p.130). The attention of health providers therefore needs to be better and more fully directed ‘to understanding patients’ journeys through their entire healthcare visit’ (Becker & Douglass, 2008, p.140).

## Conclusions

This chapter has discussed a range of current issues that impact on the effectiveness of the ED and, more specifically, the EDWR from predominantly patient perspectives. The chapter highlighted important demand and supply trends affecting EDs that are putting considerable stress on an already overstretched system. The chapter discussed the issue of ED waiting times for patients and drew attention to other aspects of the ED experience that for patients are becoming increasingly integral to positive patient experiences. Service quality and good communication are necessary for an ED to improve the experiences of patients and those accompanying them. Communication strategies in the ED need a patient-centred approach to service provision, such as the previously discussed PFCC, which is having a positive impact on the experience of patients, families and healthcare professionals.

The literature also highlights a need to recognise patient diversity (including cultural diversity) and health illiteracy to better inform and support patients, and to minimise the potential negative consequences of a patient's experience. In addition, design factors that influence patients' experiences of the EDWR were also considered, drawing from recent work that has highlighted the impact of the physical environment on patients' ED experiences. Of key importance in the current study is to understand the factors that influence patient satisfaction and perceived quality of care while waiting in the EDWR. Proactive behaviour from health professionals is essential to allay patient anxiety and facilitate and improve the patient's experience of waiting.

## Chapter 3

# METHODOLOGY

### Introduction

This chapter outlines the research methodology. It describes the rationale for employing a mixed methods approach involving observations and interviews at four NSW hospitals – a metropolitan teaching hospital, a metropolitan hospital, a rural base hospital, and a small rural hospital. The chapter then explains how the primary data were collected and how the data were analysed.

The study's approach and methodology were developed with reference to relevant reports and reviews (e.g., Garling, 2008; Hughes & Walters, 2007; also see chapter 1 of this report) and international research focusing on issues such as: communication and service quality in hospitals and in hospitality and hotel management settings; clinical and ED-related medical studies; education and training in health settings; organisational behaviour and culture; and social sciences research methods and their application in health and hospital settings. The approach and methodology were also discussed with appropriate stakeholders. The project adopted an inductive qualitative approach, integrating three main descriptive and analytical strands of enquiry:

1. an extensive and detailed literature review;
2. lengthy and systematic observations in the EDWRs of four NSW hospitals; and
3. interviews with a broad cross-section of staff working in or engaged with EDWRs at the same four hospitals at which the observations took place.

### Data Collection: Observations of EDWRs

The proposed conduct of observations by researchers in the EDWRs at the four hospitals was subjected to lengthy ethical scrutiny and delays in application assessments and approvals. Ethics approval from the Greater Western Area Health Service Research Ethics Committee (GWAHSREC) required that staff be informed about the presence of researchers. The subsequent request to waive consent from potential participants other than staff was approved on several grounds, including the point that to gain consent from each newly arrived patient

and person(s) accompanying that patient would have been impractical, especially at larger hospital EDs, and would have been far more intrusive for people who were ill or injured and awaiting treatment. In any case, researchers were privy only to activities to which anybody else sitting in the waiting room would be exposed. It was also considered that potential participants would not have declined consent to be observed if made known to them that: (1) no personal information would be recorded and that the focus of the observations was service quality and communication; (2) any data collected about participants were primarily focused on communication and other issues affecting the delivery of quality health services; and (3) the observation research was being undertaken to help improve the quality of health service delivery and communication within EDWRs for all future users. This view that patients and those accompanying patients would consent if they were asked is supported by substantial evidence of patient consent in the conduct of far more intrusive social science and communication-oriented research in NSW EDs (e.g., Dorfsman & Wolfson, 2009; Slade et al., 2008), in an acute care hospital in the UK (Roberts & Bucksey, 2007), and elsewhere (e.g., see Paterson et al., 2003).

O'Neill (2003) argued that if people are ill or injured to the extent that they require emergency treatment, they are often in a state such that they are unable to give consent to participation in research. Asking patients for consent in this instance is likely to increase the levels of anxiety and stress already being experienced. It was deemed not beneficial to seek consent because the information being collected would not interfere with patients' requirements for immediate medical treatment. O'Neill (2003) also noted that in order for a patient to give 'informed consent', they need to be issued a sufficient level of information for them to make an 'informed' decision. Given the medical and health concerns facing many patients and those accompanying patients in the EDWR, both receiving and understanding information were likely often problematic and unpredictable. Moreover, the research was not focused on the medical treatment of patients but rather the nature of service quality and communication within the waiting room environment.

In requesting a waiver of consent for patients and those accompanying patients, it was acknowledged that observation research of this kind has been widely debated (Bulmer, 1982; Homan & Bulmer, 1982; Herrera, 1999; Homan, 1980; Petticrew et al., 2007; Wiles, Heath, Crow & Charles, 2005). However, a non-participative approach to data collection has been acceptable when the 'recording of the behaviour does not have negative consequences for

those observed' (Petticrew et al., 2007, p.205). The researchers thus acted like a “fly on the wall”: observing and recording events while seeking [as far as possible] to avoid influencing their occurrence' (Petticrew et al., 2007, p.205).

Reference was also made to the *Health Records and Information Privacy Act 2002*, Statutory Guidelines on Research. The present study was largely initiated as a result of well-publicised inquiries, research and reports identifying significant problems in service quality and communication in hospital EDs in NSW generally, and in EDWRs specifically (see chapters 1 and 2). These problems pose threats to patients' safety and can significantly affect patients' and others' experiences. The study aligned and complied with the objectives of the 2002 Act, namely:

- to balance the public interest in protecting the privacy of health information with the public interest in the legitimate use of that information
- to enhance the ability of individuals to be informed about their health care
- to promote the provision of quality health services.

The potential benefits of the proposed study, it was argued, far outweighed the potential harm or risk to any participants presented by its proposed ethical conduct.

The first phase of the study, the observation phase, was completed at each of the four designated hospital EDWRs between November 2009 and February 2010. This phase resulted in 230 hours of unobtrusive observation research by the research team, working in pairs, at each of the four designated hospitals' EDWRs.

Patients, those accompanying patients, staff and the surrounding environment of each EDWR were observed; observers watched and listened to what was said or otherwise communicated, for example, by watching what people did 'at the scene', including through unintentional contact and informal conversations with others (Patton, 1990; Taylor & Bogdan, 1998). The attention of each researcher was 'drawn to what is happening, where, when, how, why and with whom, without actual involvement in the setting as a participant' (Taylor, 2006, p.423). Rich and detailed observations (made through listening/hearing, watching/seeing, feeling and smelling) were also made with respect to the waiting room environment. Notes were made,

for example, about environmental factors affecting service quality and communication, such as those described in chapters 1 and 2.

Observation research took place at specified time periods at each hospital, ensuring that different days and times of day and night were included. Managers and other relevant staff agreed to specific times by written advice well in advance of observations taking place. Letters explaining the project and inviting participation were also sent to staff to inform them about the study and to provide contact details if they wished to obtain more information about the study. Only two staff contacted the chief investigator to seek information about the study prior to the conduct of observations. No staff member opposed the conduct of the research. The observation process was trialled but no major changes to the conduct of the observations were made.

Observations were restricted to the EDWRs and reception areas of each hospital, including entry points. During the conduct of observations, information was recorded using handwritten notes. Observation data were not focused in any way on any information that might identify any participant – staff, patients, those accompanying patients, and others who might be present. No personal identifiers were attached to any observations data. Participants were not at greater risk of harm as a result of our request not to seek consent from anyone except hospital staff. Researchers worked in pairs to better simulate the appearance of a patient and those accompanying patients and to improve note taking at designated observation times. Researcher safety was also an important consideration.

Observers introduced themselves at reception, entered the EDWR and then took a seat where they could unobtrusively observe the activities of the waiting area. All staff and patients and those accompanying patients who entered the EDWR at each site were potential participants. Notes were made in a manner that did not draw attention to the researchers. Observations were therefore recorded primarily as field notes but the researchers also spent time writing up their observations outside of the research setting (Kellehear, 1993), and several meetings (sometimes informal discussions) and workshops presented opportunities for the research team to reflect and critically review ‘what happened’ both procedurally and with respect to what was observed. Each researcher’s behaviour was as far as possible consistent with the other people in the waiting room setting. The researchers had prepared answers explaining

their reason for being in the EDWR, should they be noticed and their actions queried by any patient or by people accompanying patients.

An early limitation to this observational approach was that in some hospitals it was very difficult, if not impossible, to hear any of the staff–staff interactions at all, as well as experiencing some other constraints to observations. For example, in one of the hospitals, most of the initial ED staff–patient interaction takes place in the arrival area (a small space with standing room only), sealed off from the main ED waiting room by a sliding glass door. So, in ensuing observation periods, we also included the small arrival space/reception at various times when the presence of a single observer would less likely be noticed by others sharing this space (Kellehear, 1993, p.126).

The observations were recorded as dense, written narratives with respect to information such as:

- queuing, contact experience and what happens to patients and those accompanying patients while waiting
- what patients and those accompanying patients actually do while they are waiting and what happens while they are waiting
- patients who leave the ED prior to treatment
- communication (including verbal and non-verbal, vocal and non-vocal transactions) between staff, and between staff and patients and those accompanying patients
- communication measures: the level of communication, interruptions and simultaneous events, the channel and purpose of communication, interaction types, unresolved communications and negative aspects of the communication process
- the engagement of ED staff with patients and others in the EDWR
- patients', and those accompanying patients, attention to and viewing of signage and written information, and their comments about or visible responses to aspects of reception areas and the EDWR generally
- the extent and nature of signage and other written information such as posters, pamphlets and brochures
- aspects of reception areas and waiting rooms, including seating, comfort, cleanliness, access, lighting, atmosphere, security, noise, odours, temperature

- entertainment and availability of facilities such as cafeteria, vending machines, reading materials and television
- the nature of adjacent areas such as entrances, toilets and parking
- the numbers of people in the waiting room
- when patients arrived and when they left.

In collecting data, for much of the time it was very often difficult to track the number of patients in the EDWR and record the waiting times of patients, especially in the larger hospitals and when there were large numbers of people present. For the most part, it was also difficult to overhear what was said by staff to patients or those accompanying patients, and to overhear what was said among staff.

### **Data Collection: Interviews with ED Staff**

The observation phase was followed by a phase of interviews with staff from February to June 2010. The use and relevance of in-depth interviews for the proposed research are well established in the social sciences. Interviews are highly effective in generating rich and varied information about service quality and communication contexts, diversity and processes (Green & Thorogood, 2004). Data collected from the observation phase were used to inform the structure and content of the interview questions. From the initial set of questions a series of ‘themes’ evolved that would capture the views of stakeholders towards communication and service delivery within the EDWR.

Initially, staff were to be recruited through various forms of communication. One-hour personal in-depth interviews (semi-structured) were to be conducted at a place and time convenient for staff. However, the initial recruitment process was unsuccessful, in part because some potential participants cited being time-poor as a result of factors such as work pressures and understaffing. In contrast, several impromptu conversations arose between the observers and staff during the observation phase of the study, and these had generated much rich data. It became evident that a slightly revised interview approach involving a more flexible, ‘drop by’ method, which mirrored the impromptu conversations elicited during the observational stage of the research, would be more successful in recruiting interviewees. After consultation with stakeholders, including the CEC and hospital unit managers, this flexible interview approach, which complied with the original GWAHSREC ethics approvals, was successfully adopted.

Two members of the research team made themselves available to conduct interviews at each hospital at scheduled times throughout the day and evening for a minimum of two consecutive days (several members of the research team worked on a rotational basis), and for convenience were based in a room as near as possible to the ED. This proximity provided ready access for many staff to drop by for interview in the privacy of a separate room, greatly facilitated staff participation, and gave staff from diverse areas engaged with the EDWR an opportunity to participate. Sixty-six personal interviews were conducted with a cross-section of staff (e.g., patient registration; triage nurses; medical staff; allied health and nursing; doctors; ambulance personnel; administrative staff; security; catering) working in or engaged with the EDWRs at the four hospitals.

The in-depth interviews lasted between 20 minutes to more than one hour. They were semi-(lightly) structured and allowed interviewees the freedom to develop a narrative of their choosing within the general outline of the theme of a question and the overall focus of the study (Wengraf, 2001). Interviews included a 'lead-up conversation' to help interviewees settle in to the interview and to clarify the main themes of the interview and the project (Taylor, 2006, p.416). Interview questions were developed through reviews of the literature concerning studies in communication and service quality (e.g., Braithwaite et al., 2007; Fitzgerald et al., 1991; Slade et al., 2008), reviews of the raw data collected in the observations phase, discussions with stakeholders, and a critical review of a lengthy pilot study interview.

Data were collected on many aspects of service quality and communication in the EDWRs:

- personal information concerning the staff member's education, training, and employment contract
- current position classification, roles, responsibilities and workloads relating to their work within the ED
- general perceptions of service quality in EDs
- the extent and nature of communication with other staff in the ED
- the consistency and effectiveness of communication at different work times and among particular staff or groups/classifications of staff
- important issues or perceptions regarding this communication with patients and those accompanying patients

- examples of service and communication excellence, as well as concerns with and constraints in communication between staff
- the extent and nature of communication with patients and those accompanying patients
- any important issues or perceptions regarding this communication with patients and those accompanying patients
- examples of service and communication excellence, as well as concerns with and constraints in communication between staff and patients and those accompanying patients
- attitudes to and perceptions of existing service and communication systems
- training, education or changes that could improve the staff–staff and patient–staff relationships in the ED
- how the physical design of EDs impacts on service quality and communication
- how existing organisational structures, reporting lines and efficiency in service delivery affect communication
- adequacy of resources to support service excellence and communication.

The interviews were digitally recorded, transcribed and de-identified. Participants who requested they receive a copy of their interview for checking were sent their interview transcript. These participants were invited to edit their transcript, to add comments to clarify any matters and to delete information. Participants were asked to return their transcript to us when they were satisfied with their interview responses. Participants had two weeks to respond and were encouraged to contact a nominated member of the research team if they wanted to discuss any matters or add to the data collected.

All data (observations and interviews) were de-identified. Pseudonyms have been used in transcripts and any documents arising from the project.

## **Data Analysis**

The data collected from the observations and interviews were plentiful, very rich and varied. The analysis of qualitative material thus required a method which captured the subtleties, complexity, flavour and detail of the data (Bliss, Monk & Ogborn, 1983). The main goal was to discover perspectives regarding service quality and communication in discrete hospital environments, namely EDWRs, and to allow researchers' observations and the voices of hospital staff to help describe and explain what happens in hospital settings (Glaser, 2001).

Researchers independently analysed and coded interview transcripts at each hospital to identify reoccurring themes throughout the data. A minimum of two researchers conducted the analysis for each hospital to improve reliability of analysis. Categories and classifications developed were thus grounded in the interview data, and in this way were suited to interpretive methodologies and supported a more inductive approach (Liamputtong & Ezzy, 2005; Strauss & Corbin, 1998; Ticehurst & Veal, 1999; Wengraf, 2001).

Mind map software is effective in helping visually organise large and complex data sets. Separate mind maps were created for each of the four hospitals in the study, prior to, during and after a two-day analysis workshop attended by all members of the research team. The outcome of the workshop was the confirmation of the key themes in the data, for both the observation and interview data, and deeper consideration of the relationships between the observational and interview stages. Each theme was then summarised in the first instance by the chief investigator (CI) and project manager (PM) and then circulated among all research team members for feedback and comments regarding descriptions and explanations of the data, and use of appropriate quotes, case studies and vignettes. As sections and chapters of the findings were developed, detailed reviews were conducted by each member of the research team and these were compiled by the CI and PM. The limitations of the study are discussed in the concluding chapter.

## **Summary**

This chapter has explained the study's methodology and justified the rationale for using a mixed methods approach involving observations and interviews at four NSW hospitals. The following chapter presents a detailed description of the EDWRs and triage processes at each hospital, based mainly on the observations data.



## Chapter 4

# RESULTS: WAITING ROOM SETTINGS AND CONTEXTS

The triage area must be immediately accessible and clearly sign-posted. Its size and design must allow for patient examination, privacy and visual access to the entrance and waiting areas, as well as for staff security.

The area should be equipped with emergency equipment, facilities for standard precautions (hand-washing facilities, gloves), security measures (duress alarms or ready access to security assistance), adequate communication devices (telephone and/or intercom) and facilities for recording triage information (Australasian College for Emergency Medicine [ACEM], 2006).

### **Introduction**

This chapter describes the settings and contexts for each of the hospitals involved in the study. It gives the location of each hospital, describes each hospital's EDWR and discusses the reception and triage process observed at each hospital. The descriptions of each hospital's setting and context help highlight many of the factors in an ED's operating environment that impact upon the demand for and supply of hospital services (e.g., the socio-demographic and ethnic diversity of patients presenting to EDs) and the quality of those services (e.g., design and accessibility of the EDWR). In order to try and make sense of what is happening in the EDWR and, in particular, processes and practices relating to service quality and communication, it is important to discuss and acknowledge these factors, and to recognise in what ways they might vary among hospitals. Brief vignettes are inserted in the text to highlight relevant case studies, draw attention to important issues and 'bring some observations to life'.

### **Regional base hospital EDWR**

#### ***Location and setting***

The hospital was a major acute care provider and referral hospital with a large and diverse catchment, providing emergency care, critical care, and general medical, surgical and clinical support services. The hospital supported a large regional population with a significant proportion of that population born in Australia. Less than a quarter of the population was aged under 14 years and about one in seven people was aged 65 years and over. The median

household income was well under the NSW figure of \$1036.00 per week, and the unemployment rate well exceeded the average for NSW. About 5% of the population had a profound or severe disability.

### ***The EDWR***

The existing EDWR was a fully enclosed environment. It was a traditionally defined room, secured by doors from other areas of the hospital, including the reception and triage areas and amenities such as toilets. Patients had to park on the road unless there was a vacant parking space among the few designated spaces (including a space for people with a disability) adjacent to the ED. Walk-in patients could only access the waiting room via the entrance at reception and triage.

The EDWR was a room approximately six metres wide and eight metres long. The interior was painted an off-white colour with one wall painted mauve. Twenty-eight chairs were arranged in the room, with the majority in rows of six to eight facing the mauve wall, while eight chairs were situated along the length of one wall facing back towards the sliding door. The chairs had plastic arms and legs and most were joined together in units of two or three and were separated by a table insert. The floor was covered with speckled linoleum. Two walls had frosted windows along their length, beginning midway up the walls. These windows could be pushed down from the top to a distance of about 30 centimetres which allowed fresh air in and enabled people to see the sky and the tops of palm trees. The rear of the waiting room became very warm during daylight hours (during observations in February) because the sun hit and warmed the glass which radiated heat. Moreover, during the daytime it felt as though there was a significant temperature difference between the rear of the room and the front. Late at night and in the early hours of the morning the space became cold. The room evoked an inward-looking, contained and constrained feeling.

The ceiling of the EDWR had nine halogen downlights – five of these were usually turned on while we were observing. These five lights meant that the room was generally well lit, especially during the daytime; however, the outside area approaching the ED was not well lit at night and one of two spotlights was not working. Generally, the exterior space between the EDWR and patient parking on the road was not well lit, and at night, nurses and other staff were often escorted by security staff to their cars or left the hospital in groups.

A small TV was suspended from the ceiling at the front of the room and faced the majority of seats. At times during the day the light through the windows made it too glary to actually see what was on the TV. The audio was generally turned up enough to be quite clearly heard at the back of the room, without it being overbearing or loud. Two CCTV cameras were located on the ceiling towards the front of the room. People were not informed they were being filmed.

Within the EDWR many messages were presented to visitors, mainly through an assortment of posters and notices, but also in the design of the space. It was very clear that you were waiting in a health-oriented space, apparent from the health-related posters and brochures – also the tone of many of the posters and notices created a very didactic space. There were some unambiguous messages about appropriate behaviour in relation to coughing, smoking and mobile phones, while one poster included a photograph of a taxi and an ambulance and asked, ‘Which one of these is a taxi?’. There were attempts to explain and demystify aspects of the ED and establish appropriate behaviour, but there was no clear explanation of the triage process.

The walls and some of the windows were covered with signs and notices. Fifty-eight separate pieces of information were counted during one observation period. These were taped or stuck to the walls in ways which suggested a lack of plan or design. All signs were in English except in the reception area where signs were repeated in several languages. Some of the signs had text written in capitals, and they seemed to be shouting information at you. The signs included those relating to appropriate behaviour: ‘NO SMOKING ON HEALTH GROUNDS’; ‘Cough Etiquette’; ‘IMPORTANT – the use of mobile phones is prohibited in this department’ (but this did not stop some patients or those accompanying them texting or phoning others on their mobiles throughout the observation period); ‘THIS HOSPITAL IS SMOKE FREE’. A number of notices gave information about a 24-hour telephone line that could be called to help assess whether someone needed urgent medical care; others were general health information such as a poster on snakebite treatment or information about swine influenza (H1N1), which was especially active in the months leading into the observations period. The signs and notices ranged from half an A4-size page through to a full poster size. One large poster-size sign, ‘Who I might meet in the Emergency Department’, itemised the various staff roles associated with the ED. There was no drinking water or a food vending machine in the EDWR and no information to direct people to the coffee shop or vending

machines located in other sections of the hospital. As one of the researchers was leaving the EDWR a person emerged from the clinical treating area and as they walked out together she said to the researcher, ‘This is my first time at this hospital. I have no idea where I can get a coffee and I don’t even know where the toilets are. Can you help me out here?’

In the far left-hand corner of the EDWR was a woodcraft brochure stand with various health-related brochures organised on the shelves. In the corner diagonally opposite, a bench area contained a collection of children’s books, paperbacks and some magazines (*Belle, House and Garden, My England*), as well as antique collectors’ magazines. All the reading materials were five or more years out of date. Located next to the books and magazines was a dispenser of disposable hand wipes, but these were dry and appeared not to have been used for some time.

There was a fairly unambiguous message also that the waiting room was indeed a place of transition. For example, during daytime observations on one day, after about an hour, the chairs became uncomfortable, interest in the dated magazines and limited books supply diminished, and it was not possible to watch the TV due to the glare. There was little in the way of distraction and there were no other obvious forms of entertainment or mild distraction, except for people to talk among themselves or to use their mobile phones to text or speak to others.

*An older woman, late 60s, using a wheelchair that had been supplied to her by the hospital on arrival is pushed through into the waiting area by a younger man in his 30s, who may have been her son. There was a bit of discussion and some manoeuvring to find her a suitable location to sit in her chair, which in the end was limited to a space alongside and in front of the brochure stand at the very front of the waiting room. Her position in such a highly visible area appeared to add to her mild distress. The woman’s male companion then had to leave her while he moved his car and found a parking spot. About half an hour or so later, the door opened and a doctor stood at the doorway and said ‘Margaret’ and the woman in the wheelchair was pushed through by her son, without help from the doctor, who showed no empathy or friendliness on his face. The son then waited back at his seat, firstly typing on his laptop and then reading a novel. (Field notes)*

Two doors connected the EDWR to the treatment area and these were opened at various times to enable patients to enter or leave. A window was situated on the mauve wall but it was blocked by a closed venetian blind. There seemed to be a substantial symbolic and physical boundary or even barrier between the waiting room and the treatment area which patients eventually entered for treatment.

The EDWR was a very confined space. Noises from within the treatment area could often be clearly heard in the waiting room. For example, during one observation period crying from a

baby could be heard. Several times during one observation, the door to the ED treatment area was left open by staff for varying lengths of time. People in the EDWR could hear staff conversations, laughter and giggling, and in some cases could see into this area.

Along the one side of the triage area where staff sat or performed triage and which adjoined the EDWR, was a counter area with glass windows. This was partially covered with various posters and notices. It was clear that the posters and notices reduced the ability of staff to 'watch' the waiting room, while it appeared that people were discouraged from making visual contact again with the triage nurse (TN) through this counter. Indeed, a small notice informed you that if you wished to again talk to the TN you were to leave the waiting room and go out to the reception area.

Movement of people was primarily from the reception area through the sliding doors and into the EDWR and from there into the treatment area. There was some movement from the treatment area back out into the waiting area or through the waiting area and back out into reception, as patients and those accompanying patients left or sought some clarification, or when ambulance and other personnel delivered patients. Maintenance, cleaning and other staff also came through occasionally. At times, nurses would come into the EDWR with scales to weigh young children or with a blood pressure unit and take some basic measurements. On occasions, patients were administered what appeared to be oral medication. Some patients and those accompanying patients would leave the room to go to the toilet or to wander outside for a brief or extended period of time.

### ***Reception and triage***

To access the ED, most people would walk across a small car park at the front of the hospital and head towards a glass door above which was a large sign in red on white that said, 'EMERGENCY'. Once they passed through the sliding glass door they entered a small space – the reception area. The reception area was small, about three metres long and two metres wide. The area was so small that as soon as more than four or five people were present someone in the area would inevitably trigger the sensor that activated the automatic doors. The doors would then slide open with a loud whirring sound that sometimes made it more difficult for people to be heard while communicating with the clerk or TN. Such a seemingly trivial thing like the automatic doors opening inadvertently added to the chaotic and insecure feel of the small and sometimes crowded space.

Two counters similar to bank tellers' counters with security glass panels were positioned at the reception area immediately opposite the sliding door entrances: one had a sign above it which said 'CLERK'; another sign said 'TRIAGE NURSE'. The TN counter was on the left-hand side and the clerk was on the right. It was unclear as to whom people should first present. There were also a number of signs and posters in the reception area. One large poster explained that EDs never close, that they were often busy and had to treat emergencies as a priority, and that you should be patient. Others were A4-size signs that had 'STOP' enclosed in a stop sign symbol in a variety of different languages. Sometimes on the counter were brochures entitled 'Welcome to the Emergency Department', which explained the process of triage. These brochures, printed in English, were not always present over the course of the observation period.

The receptionist/clerk and the TN sat in a small office that appeared cluttered. The walls were lined with shelving on which sat many folders. Separate men's and women's toilets were located to the right of the reception area. The toilets were well lit and contained a sharps disposal unit. There was also a red button for which there was no notice explaining its function, but it was prominent enough to suggest that one should push it if one need assistance or help.

Triaging took place in the reception area with the TN behind the window and the patient standing in the reception area. Thermometers were passed through the opening of the window and placed in the ear of the patient who had moved their head closer to the opening. Once processed by the receptionist and triaged by the TN, a patient either went straight through into the treatment area (perhaps if triaged category 1 or 2 or if there was no queue) or entered the EDWR through another set of sliding glass doors. The door was activated by pressing a button.

*A woman, probably in her 40s, wearing a flannel dressing-gown, shuffles into the lobby carrying a plastic bag ... She sits curled, hunched on the edge of a chair in the EDWR. She looks like she is in pain. A nurse comes in with the mobile blood pressure monitor. 'Hello. I'll just do your BP [blood pressure]. Where's your pain?' 'My back, my legs, my neck ... it's just not getting any better.' She grimaces ... 'I'm in so much pain,' she utters. Another woman of similar build and age, but dressed in day clothes, comes in to the EDWR and as she passes behind the patient she traces her hand gently along the patient's shoulders, across her back. She sits near the patient, as near as the separator table allows. The nurse asks her when she had last taken pain relief and in which dosages, as the nurse does the readings. The carer looks on. After the nurse leaves, the carer and the patient talk quietly with each other. They sit side by side comparing toenail colours, and laugh a little. They sit quietly near each other. The woman in the flannel dressing-gown whispers to her carer, puts her hand on her own forehead, and sits hunched, her eyes closed. Another nurse comes to the doorway and calls across the room, 'Hello. I'd just like you to put a wee in here.' She comes forward and hands a small sample bottle to the patient in the flannel dressing-gown, who takes it and stands up, clutching her dressing-gown to her body. She shuffles through the door to the lobby ... (Field notes)*

A number of staff with whom researchers spoke during observations talked about their concerns regarding the lack of privacy for patients during triage, a process which was conducted publicly. Several staff expressed concerns that because of the public nature of the triage area, some patients were reluctant to provide full or precise details of their symptoms which could compromise the triage process. The TN quite often had to leave their desk and go out into the reception/arrival area if there was a need to look more closely at a patient. This process was inconvenient for patients and staff, and was time consuming and meant there was a delay in response. One staff member also explained that if, for example, the hospital staff had to ask the patient for a urine sample, they had to ask in public, and what's more, if the TN was not at the window, the patient had to leave their sample bottle with warm urine on the counter. The staff member felt it would be far more respectful and better for patients if there were separate cubicles or some other means whereby patients could interact in more privacy with the triage staff. The staff member also said that many hospitals did have these cubicles.

## **Small Rural Hospital EDWR**

### ***Location and setting***

The hospital and ED building served a small regional population and surrounding districts and had less than 50 beds. The hospital had provision for accident and emergency, acute and subacute medical inpatient services, and a range of primary and community health services. Larger rural base hospitals were located nearby. Consequently, a high proportion of presentations were usually of a less serious nature, and indeed many were not regarded as emergencies by hospital staff.

Of the population of less than 10,000 people, more than 10% were Indigenous, about 20% were aged 65 years or older, and very few people were born overseas or considered English a second language. Staff to whom researchers spoke identified a number of social issues as having impacts on the ED. These included: community drug and alcohol problems; mental health issues; a shortage of GPs in the district, especially GPs who bulk-bill; difficulties in being able to see certain GPs at their practices due to excessive demand for appointments; an ageing population; and a large Indigenous population with special needs. Despite a brief growth in population only a few years ago, the town, once prosperous and a commercial and social hub, had generally experienced decline over the past decade or so, in terms both of population and of availability of services. Unemployment rates were high and above the NSW average.

## **The EDWR**

The hospital was located on well-maintained and open grounds comprising lawns and some established gardens. Scattered eucalypts and other vegetation, wide streets and low traffic movements, low density housing and a one-storey hospital helped create an open, relaxed feel on approach, which is not surprising in a small regional town. People who arrived at the hospital by car needed to park along the road unless there was space in the small car park at the main entrance. The EDWR was situated to the left of the main entrance. Immediately in front of and obscuring part of the waiting room's front wall and window was a needle and condom dispensing machine, which was not always operational. Young children were sometimes seen at the machine.

*A fellow, mid to late 20s, dressed in a T-shirt and shorts but barefoot, arrives at the ED. He appears like he is either intoxicated or affected by drugs. He says 'G'day fellas' to us and then walks over to the treatment door and rings the bell. He waits about half a minute and then the nurse appears and asks him what he wants. 'Can I have a fit pack, love?' 'Sure,' and then she goes away and comes back with a pack which she hands to him. 'Thanks,' and then he starts muttering something about wasting his money, and I say 'Sorry' thinking he was talking to us, and he says 'Just talkin' to meself' and keeps muttering loudly and walks out. (Field notes)*

The needle and condom dispensing machine created difficulties, some real, some perceived, for staff, and some of which were relevant to their safety and security. Most of the issues related to when people who wanted to obtain a needle pack presented in the EDWR instead of using the machine. Some of these people could be very demanding; some appeared threatening. It was the view of the staff that some people sabotaged the machine and then complained that the machine was no longer operational, rather than paying the \$2.00 for a needle pack dispensed by the machine. While there were notices alerting people that needle packs were no longer given out from the ED, we observed that if a person did present wanting a needle pack, staff gave them out. This was entirely understandable and was a means of managing a potentially difficult and perhaps dangerous situation in some cases. Most of the staff we spoke to had very definite views that the location for the dispenser was inappropriate.

The EDWR was approximately five metres long and four metres wide. The room was air conditioned and an oil heater was situated along one wall. Windows could not be opened. Walls were painted a cream colour. The room was lit by banks of fluorescent lights and a small television was suspended from the ceiling above the toilet door, but it was in an awkward position for anyone seated to view. There were 17 seats set in a row along three of

the walls, one of four seats, one of six and one of seven. The seats were hard, typical of seats regularly available in community halls, joined in small groupings, and similar to those found in some of the EDWRs of other hospitals involved in the study.

The floor covering was linoleum, and it was well scuffed in parts. A few ants were observed on the floor. Windows along the wall with the external entrance door enabled people in the waiting room to see outside and those outside to see in. A toilet was located to the left of the waiting room and access could be gained only via the waiting room. The toilet contained one cubicle and a small washing basin. A torn flyscreen covering the small window in the toilet cubicle had been 'repaired' using masking tape across the tear. There was no emergency call button and no sharps bin. A sign on the door denoted it as a 'public toilet'. Another notice on the door, generated by a computer and printed out on paper, stated that:

SHOOTING UP ON THESE PREMISES AND GROUNDS ARE [sic] NOT PERMITTED.

This container [there is no container present any longer] is for disposal of RETURNED needles and syringes. Do not use the toilet to shoot up. There is also a di [rest of word and sentence torn away] on the wall on Casualty Sect [presumably Section].

A number of signs in the EDWR suggested a somewhat dangerous or at least threatening or unsafe space. On the inside of the main access glass doors and facing inwards to be read by those in the waiting room were two notices, again produced in-house using a computer and printer:

For your safety and safety of staff, please do not unlock door for people waiting to get into the emergency department. Staff need to see every person as they arrive.

The other sign said:

STOP. ED Staff only to open this door.

Above the doorway into the treatment area was a large sign, professionally made with white lettering on a red background that said:

Violence or abuse will not be tolerated. Legal action will be taken.  
Presumably the sign is there because the potential for such threats was perceived by staff to be real.

Attached to the walls or behind a glass-fronted noticeboard were various other signs, posters and notices that included the poster produced by the NSW Health Department – ‘Who I might meet in the Emergency Department’, another concerning the need to use ambulances in an emergency, and the Greater Western Area Health Service Strategic Plan 2010. Two rows of plastic brochure holders were located on one wall. One was full of ‘Welcome to the Emergency Department’ brochures, five compartments were empty, one had an A4 poster squashed up in it, and four others each had a few brochures on kidney disease. Another poster had been lodged underneath the plastic brochure holders at an angle. Next to these brochures was a glass-fronted cabinet suspended on the wall and about a metre in length. It housed six posters:

- Family Drug Support
- Drug and Alcohol Service
- Drug Info @ your local library
- Alcohol and other drugs
- Hepatitis C, which was mostly obscured by another poster that had fallen down across it, and which asked people to ‘advise the triage nurse if you leave the waiting room before being seen by a doctor’.

Underneath the glass-fronted cabinet were two A4-size posters: one an expression of interest regarding Aqua Exercise classes, and the other concerning the Early Learning Centre’s long day care.

Above the small magazine rack located along one of the walls were three small posters: RTA Authorised child-restraint filling station; RTA choose right buckle right; and NSW Health ACCESS line. On the doors into the treatment area were a number of other notices:

- ‘NSW Health is a zero tolerance zone’
- ‘Bulk billing GP practices in [town]’
- ‘Cough etiquette and respiratory hygiene’
- ‘This is an Emergency department (not a doctor’s surgery)  
There is no 24 hour on-site doctor in this department.  
You will be seen by the emergency nurse who will assess you.’

The nurse will inform you if you are an urgent or non-urgent case

If you are triaged as non-urgent you will not be seen before urgent cases.'

- A notice generated in-house lists the five triage categories.

Overall, the EDWR appeared run-down. It needed fresh paint and repairs.

### **Reception and triage**

The way patients were initially 'processed' varied across the observations period. During weekday office hours, upon arrival through the waiting room door, patients were supposed to present to one of the administration clerks who were situated in an office that was located between the EDWR and the main entrance to the hospital. A small window enabled patients to communicate with the clerk and it was here that the patient or those accompanying the patient would provide basic information required by the hospital as an integral part of the reception process. When people arrived at the reception window in the waiting room they were attended to by one of the clerical staff who either handed them an admission form to complete or completed it on their behalf.

*It's late morning and a neatly dressed woman in her 50s brings her elderly father into the EDWR who then immediately goes off to the toilet. The woman goes to the reception window and waits for a minute – she has to say 'Hello' to get the attention of the clerk. She then says, 'Hello, I'm here with my dad – he needs an X-ray.' 'Do you have an appointment?' 'No, we don't have an appointment. Sorry. He's 81 and has sciatica, that's all.' The clerk tells her there is an appointment available at 3.00 pm so she says she'll talk to her father and see. It is clear that she didn't expect that there would be such a wait. Her father comes out of the toilet and she says 'Have a sit on the seat'. His mobility is very poor – it takes him ages to walk a few steps and the decision he is now faced with appears to be somewhat complex. It seems a big decision for him – whether to have the appointment today or on Monday. They consider the pros and cons for a while and it's clear that it's a big deal for him to even leave the house – he mentions it will be very hot later that afternoon. They eventually decide on the 3 pm appointment so the daughter goes back to the clerk and lets her know. 'Do you want to sit here a bit longer or do you want to go?' she asks her dad. 'No, we may as well get going', he replies (Field notes).*

A perspex security shield was recently fitted to the reception window but this had the unintended consequence of making it more difficult for clerical staff to hear what the person on the other side was telling them and vice versa. Apart from the impact on communication when the clerk had to repeatedly ask the patient to repeat what they had just said, it could also lead to incorrect information being recorded. Once the paperwork was completed the clerk would then notify the TN who would come out into the waiting room.

It was not entirely clear to patients and those accompanying them what the triage process involved, and because the window into the clerk's area was a little obscured and not obvious, some people who did not have experience of the process came in and sat down on the assumption that someone would then attend to them in due course. In this situation it was then largely dependent on the clerk to notice that a new person had arrived and she would then ask them if they were waiting to see a doctor, and if so, she asked them over to complete the paperwork. In extreme cases, some people have been known to have waited for an hour or more without making themselves known to the administration staff, and some have been abusive when they discovered that they had been waiting without having been attended to and appropriately processed, assessed and recorded in the system.

During 'after-hours', that is, after 5 pm weekdays when the administrative staff left for the day, or at weekends when the administration area was not staffed at all (and the blind was drawn), the

*At 10.04 pm an elderly lady with a younger woman, who I assume is her daughter, arrived at the ED. It appears that the younger woman had already rung ahead to let staff know they would be coming in. The TN came out into the EDWR and let them in. She had already mentioned to us about 15 minutes earlier that one of their 'regulars' was about to arrive to get a pain-killing injection. The lady was quite distressed, frail and upset and obviously in pain, but nevertheless still apologised for having to come in: 'I'm sorry about this.' She shuffled in with the help of her daughter and the nurse, who showed considerable empathy and care, assisted her into the triage area. While walking her in the TN asked her what she had taken today. After about ten minutes, the woman and her daughter emerged out of the treatment area. The lady was a little quieter but still distressed. I think she must have suggested something to the nurse because the nurse said in response, 'No don't do that. I'm too busy to go to a funeral at the moment.' The lady had a small laugh and they left.*

*(Field notes)*

EDWR was locked and secured. This meant that all who attended the ED had to ring a 'front door bell' to gain admittance, thus ensuring that nursing staff were able to see each new arrival before they were permitted to enter the waiting room. Of course, this activity added additional 'meeting and greeting' and paperwork burdens on the nurse on duty and this requirement for the nurse to leave the treatment area and open the doors to the waiting room could be especially difficult if they were in the process of triaging or treating another patient. In addition, after 11 pm, the nursing staff in the ED relocated to the main ward further down the hospital. Those patients or others who arrived at the ED at those times spoke into an intercom device at the front of the exterior of the waiting room, and then a nurse (usually two) would walk to the ED and allow them to enter. A mechanism normally allowed the nurse in the ward to press a buzzer to admit people into the waiting room, but at the time of our visits, this was not working. Patients were almost always triaged in private in a room adjacent to the waiting room.

## **Metropolitan Teaching Hospital EDWR**

### ***Location and setting***

This city hospital has several hundred beds and services a population of more than one million people across a variety of Local Government Areas (LGAs). The area supported by the hospital has long been a multicultural area, with more than 50% of its population born overseas, and less than 1% of the population Indigenous. Approximately 20% of the area's immediate population spoke English only, and about 10% of the population was aged 65 years or over. Socioeconomic status compared to other areas of the state was relatively high.

### ***The EDWR***

The ED was situated to the right of the main hospital entrance. To the right of the ED entrance was a parking area and ambulance bay. The approach to the ED was clean but littered with cigarette butts. Two loudspeakers were mounted on the wall on either side of the entrance doors, and announcements could be heard proclaiming the hospital a smoke-free zone.

The EDWR was entered through a sliding glass door and those entering the area were faced with a reception and emergency assessment area which was shielded floor to ceiling by a wooden counter and glass. The design was similar in style to a series of bank teller windows with narrow gaps to facilitate communication and transfer of items. Bottles of hand disinfectant were placed on the counter, together with tissue boxes. Immediately on the right was the 'Emergency Assessment Nurse' (EAN) area with nursing staff visible behind two separate areas with glass windows. One door led to the triage area, another door to the ED. The emergency assessment area had a small amount of seating for patients to wait. There was a considerable distance between the triage area and the back of the waiting room. It is plausible that someone could deteriorate and not be easily seen by staff.

On the glass sliding entrance door a large sign which went relatively unnoticed by many who entered said:

WHAT SHOULD I DO?

1. See Emergency Assessment Nurse (Red)
2. See Emergency Clerk (Blue)
3. Proceed to reception area (Green)

There were two interpretive signs, one at the left of the emergency clerk and one at the emergency assessment area. Both of them were below eye-level and not very noticeable. There was a sign left of the emergency clerk, saying, ‘Who I might meet in the Emergency Department’. On the wall on one side of the waiting room area there were nine brochure stands (each with three compartments), but they were mostly empty. Underneath these there was a poster giving the locations of late-night pharmacies. On the opposite wall there were eight pieces of artwork (similar to a collection of prints).

The EDWR looked clean and there was a sense it was kept tidy. There was not much noise in the EDWR apart from those who were waiting and talking and the staff chatting to each other, as well as the irregular calls made over the loudspeaker system. At times, depending on the number of people present in the EDWR, the volume of noise increased quickly and very noticeably. The walls were painted a cream colour and the floor was covered with dark linoleum.

There were 31 seats in the EDWR. Two rows of seats located to the left of the entrance and reception desk faced the emergency assessment area (triage area). Directly behind these there were a further two rows of seats (six in each row facing each other), which ran perpendicular to the back window. A long row of seats ran across the back window, just behind the corridor that led into the main hospital area. This corridor was used as an alternative entrance to the main hospital and to the EDWR and the constant flow of traffic through the corridor added to congestion in busy times. There were a further six seats located in the emergency assessment area, to the right of the entrance and reception area.

*Fifty-eight people in the ED area: sitting, standing, wandering about. There are 14 standing and sitting around the EA desk and waiting area ... The automatic doors to the ED keep opening and closing, due to people milling around, and walking too close to the sensors. (Field notes)*

The seats were reasonably comfortable in contrast to the seats located in other EDWRs. The seats were padded and were covered with a grey-green leaf-patterned plastic and were not the hard type of seating experienced at the other hospitals in the project. A couple of tables separated the sets of chairs. Several of the seats appeared to have been ‘slashed’ rather than

accidentally torn, and the foam inserts were exposed. There was insufficient seating to accommodate all people in the waiting room during some observed periods. In very busy periods patients and carers were standing around the walls and in some instances people were seen lying on the floor.

Located in the main waiting area were an Internet kiosk, a public phone, a phone that linked callers to a taxi company, two water/soft drink machines, and a food vending machine with no food in it. Against the other wall there was a coffee machine as well as two water fountains, one of which was lowered. There was very little reading material available in the waiting room.

Two televisions were suspended from the ceiling. One, facing the reception area, was used for closed circuit TV. The other, an old-style 'tube' TV, faced the waiting room but could only be seen from one set of seats, and furthermore it wasn't actually working or turned on; on one day during the observations the screen read: 'A fee is payable for entertainment – press yes / no on your handset'. A TV screen was also visible behind the emergency clerk's desk. It displayed footage of an empty corridor that was the ambulance entrance within the emergency ward. The waiting room was illuminated by strip fluorescent lighting. The temperature in the waiting room varied. In the early hours of the morning it became quite chilly, and during the day it was hot and very uncomfortable sitting in the back row along the window due to the late afternoon sun.

There were signs on the wall up high behind the emergency clerk that gave the following messages:

Sign 1:

Overseas visitors are required to pay \$105 per service.  
Your Medicare card must be produced at each visit.

Sign 2:

The following services are available please enquire at the reception desk:

1. Aboriginal officer
2. Interpreter services

These signs were not obvious and they seemed to be a little lost in the work and activity taking place in the whole area behind the emergency clerk.

A sign on the left-hand of EDWR said:

Patients

Please see the triage nurse before eating or drinking.

Signs at the EAN station and extending down from the ceiling said: *Emergency Assessment Nurse Area*. There was another sign: *All other patients please be seated in wait area* – but it was difficult to see this sign unless you were standing in the EAN area. As a result, staff were continually directing people to go and wait in the EDWR.

### **Reception and triage**

During the observation period a colour-coded number system on the floor aligned with the sign out the front of the ED. This system was used to guide people through the triage process. There were red ‘1’ labels that led from the entry to the triage area, then blue ‘2’s from triage to the clerical area, and then green ‘3’s back into the waiting area. Unfortunately, it didn’t look like most people understood or even saw the numbers to follow, and anyway, for part of each day when the triage area was not staffed, patients needed to go to the clerical area first. By the time we returned for interviews with staff less than six months later, the numbers had been removed, which suggested that another process for informing patients about the triage process had been implemented.

In practice, people tended to go straight through to the emergency clerk area because it is the first ‘place’ that comes into view and where eye contact is most likely to happen upon entering the ED from outside. People were observed to join a single queue rather than approach other staff observable behind the counter but whose attention was

*I can hear one of the EC desk staff talking on the phone about her holiday and fishing. There’s lots of chatter among the EC desk staff; other staff wandering in and joining the conversation; loud laughter. Often the chatter goes on, even when people arrive at the desk.*

*Black dragon T man comes in the doors. He’s looking at the floor and uses the numbered circles to go straight to the EA desk. Arrives at the EA desk to a nurse who tells him to go to EC desk – he laughs – ‘So what’s the point of the numbers then?’ Moves to EC and then back to EA (2.45 pm).*

*(Field notes)*

focused on other work. It was also possible to enter or leave the EDWR via the internal corridors and not be observed by ED staff. However, a handful of people who did read the directional numbers and moved to the triage area in the first instance did so only to be

directed back to the emergency clerk by the TN. This whole process was a little confusing for patients and others, especially when the space was congested.

Generally walk-in patients were processed initially by the emergency clerk (EC) who collected their details and then directed them to the seating in the emergency assessment area. They were then attended to by the TN. Some were attended to straightaway and left, some were called into the ED for further treatment, and the majority were directed to wait in the EDWR, to the left of reception. The interactions observed between patients and the emergency clerk were not private and people sitting in the front two rows of the waiting room could hear almost every exchange of words, including the personal details given by patients and others to the emergency clerk. This was particularly evident when dealing with people from a non-English background or with the elderly because details were usually repeated several times.

*Mrs X (perhaps Korean) arrives at ED. She is distressed and with a friend. 'Need to see a doctor,' one of them says, to no one in particular. 'You right, doll?' [someone asks] from behind the desk. She moves closer to the EC counter. Details are given – some have to be written down as her English language is not too good. She has obviously changed phone numbers from her papers (Medicare card etc.), so we all hear her old mobile number being called out as EC staff write down the new one. At 2.39 she moves to the EAN and gets her temperature taken between the glass shield. 3.10 pm she is now waiting: the orderly comes over: 'Not long now, dear – only three files ahead of you.' (Field notes)*

The whole EDWR environment was often chaotic and it was observed that patients and carers generally appeared to be frustrated and tired and at times quite angry about the whole situation. Many continually approached the emergency clerk or triage area/EAN to find out how long it would be before they were treated. Sometimes, though rarely, staff from within the ED would come out and approach patients and carers. For example, a male nurse/orderly came out to the EDWR with a list and started to ask people if they had been attended to, who they are and if they were OK. He introduced himself and gave people an indication of how long their wait to be seen might be. He also advised each person to let him or other staff know if they needed pain relief.

During another observation a female nurse appeared from within the ED and posted herself with a trolley in front of the ED door. She appeared to be answering queries and questions from those patients waiting in the assessment area. These activities had a notable effect on the mood of the whole EDWR, whereby patients and those accompanying them appeared calm and the trips to the desk became much less frequent. However, at other very busy times this activity was not observed and the mood of the EDWR was very different. Further, long

waiting times were evident and patients were observed leaving the ED without having received treatment as they became very frustrated.

## **Metropolitan Hospital EDWR**

### ***Location and setting***

This city hospital has several hundred staff and volunteers providing health care. The community in the hospital's immediate LGA comprised well over 50,000 residents and was exceptionally diverse in both cultural and socioeconomic terms, with more than 50% of its population born overseas. The area has experienced significant growth in its population and this growth is expected to continue. The most common countries of birth included China, Turkey and South Korea, and unemployment in the area is higher than the state average. Socioeconomic status compared to other areas of the state was relatively high.

### ***The EDWR***

The EDWR is open plan in that two walls were made almost entirely of glass. The space opened to a passageway that connected the ED with other areas of the hospital. The 29 chairs in the EDWR were arranged in rows, most facing towards a flat-screen TV suspended from the ceiling at one end. Seats were connected together in units of four or five and all were grey except for one row of six orange chairs which faced the triage and clerical areas at a 90-degree angle to the other main seating. The series of six orange chairs was where people were asked to wait until they were seen by the TN. The floor was covered with linoleum.

After passing through the entry that consisted of two sets of sliding doors separated by an enclosed passageway, people were 'greeted' by a large, contemporary-looking sign that said:

## WHAT SHOULD I DO?

See Triage Nurse

See Emergency Clerk

Please wait to be called

Tell us if you are feeling worse.

This is a useful and straightforward explanation of what to do, although there was no explanation of triage or the triage process or why people might have to wait in an emergency area until they were seen by a doctor.

The TN station had red banding around the top with a sign saying *Go here first. Triage Nurse*. The station was fronted with glass panels with narrow openings through which patients or those accompanying them spoke to staff, and which, we observed, were wide enough to slide a small child through if a threatening disturbance happened to break out in the waiting area. At one time there was nobody in the TN area and patients went down next door to the emergency clerk who then either fetched or paged or buzzed the nurse. Indeed, that is what happened on most occasions; that is, in contradiction to the signage, people first reported at the emergency clerk's area. The TN and EC areas were joined inside by an opaque connecting door.

Overall, the EDWR presented as very clean, well-lit and very open; clean lines, urban, contemporary and certainly well maintained. One cleaner was particularly diligent, giving great attention to detail in performing tasks such as sweeping floors. The right (southern) wall of the EDWR was made of glass, with no posters or signs stuck onto the glass panels, so that there was an unobstructed view outside. It was lined with four chairs, a small table and a garbage (wheelie) bin.

There were relatively few signs inside the EDWR compared to other waiting rooms. A sign told people they were under surveillance by a security camera and another TV suspended from the ceiling in front of the TN area showed the vision of that camera. There was also a non-smoking sign using the well-accepted non-smoking 'logo'. A noticeboard, about a metre long and 60 centimetres wide, was attached to the 'front' wall, on which there were five notices:

*... the woman then talks to one of the security officers for a while and then comes back in ... The security guy is still talking to her and he'd got her a plastic cup with some water. He is now waiting with her outside still talking to her ... The security staff almost seem to be acting in some kind of pastoral care role. They certainly seem to be an integrated part of the team. (Field notes)*

one concerning an organ donation promotion day; two on swine flu; one small handwritten 'note' about the availability of hairnets; and one in several languages declaring the waiting room as a Triage Waiting Area only. To the left of this another large sign explained in about 30 different languages that a confidential interpreter service was available.

The EDWR was under constant surveillance through a one-way window by security staff whose office was adjacent to the entry area. Security staff also had an active presence in the EDWR and often walked through the area. Inside the security area, four CCTV screens enabled staff to monitor the hospital entry and exit points. Because of the configuration of the space, the clerks were also able to keep the waiting room under constant observation and so too could people waiting 'feel visually connected' to these staff. So the feeling of being forgotten about that seemed to occur at times at other hospitals may not happen here. On a couple of occasions there were a few magazines left in the EDWR. However, at other times there was no reading material available and no toys or other activities for children.

### ***Reception and triage***

The triage area appeared very ordered and patients were usually triaged by the TN within a very short time of entering the ED. The triage process at reception appears to differ, depending on whether it is day or night. Generally, the TN booth was occupied in the daytime business hours by a TN, and the reception area attended by several administrative staff. Although patients were encouraged by signage to see the TN first, in practice this did not happen. For most people, if they complied with the signage and presented at the TN window, they were generally directed back to the EC's area to complete paperwork before heading back to the TN. So, patients and others were called back by the EC (or sent to the clerk by the TN) to first complete the necessary paperwork and be issued their medical reference number. Only then could the TN record details about the patient into the computerised system and allocate their triage status. This lack of consistency between what was instructed by the signage and what happened in practice was observed to create some level of irritation among patients and others.

Most of the time a patient, and often whoever was accompanying them, would first speak with the EC, whereupon they would then be asked to sit in the orange seats facing the triage booth. Soon after (in most cases only minutes after), the TN would call the patient and perhaps people accompanying them to the triage booth and conduct the initial assessment.

The triage booth/room was well separated from the EDWR and could be screened for privacy. A curtain in the room could be drawn for privacy, but often we could see what was happening. It seemed to be a well-resourced room with new equipment that included sinks, a bed, a large desk and a computer.

Despite the above-mentioned minor confusion, the triage system at this hospital in comparison to other hospitals we examined, was more extensive and initial (first aid) treatment was often administered at this stage (e.g., in the case of a man with an injury, the administering of perhaps pain killers, and applying a sling to support his arm). After triage and initial treatment patients were asked to return to the EDWR, where they waited until called by the ED staff for further treatment and/or admission to hospital. As mentioned earlier, in an attempt to facilitate the triage process the designers of the waiting room have colour-coded the chairs. The orange chairs were for people waiting to be triaged. The other chairs were for people who had been triaged. Patients and those accompanying them would have to realise that there is in fact significance in the colour differences for the colour-coding to have any effect. One administrative staff member remarked that people sat anywhere, anyhow.

*The boy is dripping blood on the floor, and the man is trying to mop it up with tissues, but not very successfully. The man tells the emergency clerk that the boy's father is on his way. They stay at the window for a while and fill in forms. In time, a new triage nurse comes out, and calls the boy in, accompanied by the woman. The man stays with the emergency clerk, doing administrative things.*

*All in all, it has taken a fair while for the boy to see the triage nurse ... people still do tend to go to the emergency clerk first. This situation is exacerbated, though, especially seeing as the triage nurse is often not in the cubicle. In other words, a patient and carer would simply go to the first human being they may see, which in this situation is of course the emergency clerk.*

*In the meantime the man has offered to mop up the blood better, but the emergency clerk talks him out of it, and he goes into the triage nurse station. (Field notes)*

At night-time, due to lower staffing levels, the TN was apparently often attending on the ED ward, leaving the night duty EC alone. The night duty EC appears to cover the TN area, the EC area and switchboards. One night duty EC we spoke to had admitted 20 people during the night, and this had kept her very busy. During that night, she had had to deal with violent and abusive behaviour on the part of a drug- and alcohol-affected young man. It took ten people (both staff and relatives) to restrain this young man.

## Conclusions

This chapter described each hospital's EDWR setting, with particular reference to the area in which it is located and the population it services. The chapter also described the reception and triage process at each hospital

The two metropolitan hospitals service a very diverse multicultural population, while the regional base and small regional hospitals service a predominantly Australian-born, English-speaking population, with the small regional hospital population having a high proportion of Indigenous people. Each hospital services a significant proportion and number of people aged 65 years and older. These findings support Herke et al.'s (2008) observations that EDs are treating an increasingly diverse patient population which creates complex challenges in assessing and treating patients and communicating with patients and those accompanying them. The above findings also reveal the importance of culture, language and health literacy to patients' experiences and wellbeing (Betancourt et al., 2003) and draw attention to the potential links between social determinants and health outcomes (Nutbeam, 2008). The nature of this diversity is very different in scope across hospital sites, however, and thus resources to support staff and to meet patients' needs must be site-specific.

The quote from ACEM (2006) at the opening of this chapter states that 'The triage area must be immediately accessible and clearly sign-posted. Its size and design must allow for patient examination, privacy and visual access to the entrance and waiting areas, as well as for staff security'. Indeed, well-designed waiting spaces not only can positively affect patients' and others' attitudes, behaviours and experiences and give patients a positive image of the 'healthcare process' (Dijkstra, 2009, p.66), but can also support their healing process. However, the design and overall environment of many EDWRs supports the findings of Leather et al. (2003) and others that conventional hospital design contributes to stress and in some instances danger, and reaffirms some of the observations of Barach et al. (2009, p. 528), that hospital designs lead to patient experiences that reflect 'lack of control, insecurity, lack of privacy, disorientation' and, in some instances, 'an overarching sense of dehumanisation'.

## Chapter 5

# RESULTS: PROCESS AND RELATIONSHIPS

### Introduction

This chapter presents the findings of the study through a focus mainly on the interviews with staff, but supplemented by observations undertaken in the EDWRs. The key themes arising from the analysis and discussed in this chapter are: staff, resources, teamwork and communication; the patient journey; patient privacy; the EDWR waiting experience; communication; patient comfort; and patient and staff safety and security. These themes, together with the discussion in chapter 4, provide a scaffold for developing a detailed and rich understanding of service quality and communication in the EDWR. The findings are well linked to elements of an EDWR's servicescape, describing, for example, factors affecting the ability of staff to manage waiting rooms and patients' waiting experiences, while noting not only where critical service breakdown points exist, but also giving examples of good practice in communication and service quality.

### Staff, Resources, Teamwork and Communication

The diverse skills and knowledge of staff generally, and their commitment and dedication to their work, were highlighted in observations and interviews. It was very evident that for the majority of staff, their direct and indirect contributions to people's health and wellbeing had immense value for them. The importance of a well-resourced and well-designed working environment to the delivery of health care services was also evident and widely reported by staff. However, the abilities of staff to deliver quality patient services were constrained by factors which were apparent at all hospitals and which ranged from staff and bed shortages and stress, to poor teamwork and staff relations, to inappropriate patient behaviour. Despite these and other constraints, most staff appeared to cope; but they coped in different ways, and in the process revealed innovative and purposeful means of developing strategies for their workplace even when guidance and support were not provided by hospital management. Despite the conscientious work of ED staff, the findings of the study highlight that there were critical potential breakdown points in EDWRs (e.g., lack of staff and professional staff support; inconsistent and unclear triage processes; lack of visibility of people in waiting

rooms; inadequate emergency warning systems; and poor waiting room management). Indeed, there were hospitals where risks to the health of patients and staff appeared high.

### ***Staff shortages and stress***

ED staff work long hours, some in constrained spaces, in often stressful and demanding roles, and in environments that can quickly change. Bed shortages can be acute and significantly impact on waiting times, patient treatment and service quality. Staffing shortages were frequently reported in all hospitals and these shortages appeared to be particularly acute in three hospitals. As one staff member commented, ‘We’re hugely short-staffed at the moment which is an issue. We’ve got two permanent positions that aren’t filled.’ Some staff made comments such as ‘None of us are happy to come to work anymore’, and indicated they were ‘not happy due to staff shortages’. While staff shortages were having a negative impact on the ability of ED staff to do their work, this was also impacting upon their wellbeing:

Burnout is a huge factor. It’s huge. It’s a lot of responsibility working here in that area, especially when there [are] critical situations and you don’t have a doctor. And if you’ve rung and said, ‘Look I need you to come’, and for whatever reason they can’t ... [that] leaves a lot of responsibility on your shoulders particularly if ... you don’t have any ambulance staff there to help you. And after you have weeks and weeks of no morning tea, no lunch ... and you get the abusive patient and whatever, you do really start to be jaded. (Interview)

At the moment because there’s ... the nursing staff they have much staff leave and the ones that left are not being replaced so they are very stretched at the moment and I tend to get the feeling that they’re very unhappy with things. But in times past this place has always been a happy place for staff and the main thing is that the staff here worked here for a long time, and we know each other and we encourage each other. But recently I know that nursing staff have been quite stressed out. (Interview)

I’m actually quite amazed that more people haven’t gone on stress leave in this department more than any other department just for the whole factor of poor morale and not having enough staff to actually look after the patient properly. You don’t often get that time to have a patient–nurse conversation so you’re basically in there, if this doesn’t work let me know otherwise I’m moving on to the next patient and it’s very minimal [communication] when it’s busy. You don’t have any sort of real conversation to even ask them how their day is going. (Interview)

These findings support previous reports that acknowledge that staff shortages in many EDs are resulting in frustration, tiredness, impersonal relationships, minimal communication, and the inability of staff to complete the most basic aspects of care (Boykin et al., 2004; Garling, 2008; Jayaprakash et al., 2009; NHHRC, 2009; NSW Health, 2009b; O’Connell et al., 2008).

The demands placed on hospital staff lead to obligatory multi-tasking and stress. Many staff engaged in treating patients experienced stress, and noted that their work levels were very demanding:

[It's] very busy, very fast and sometimes it is a stressful job ... Sometimes we are short of staff and we have to do patient observations very quickly. (Interview)

It's getting a bit harder, just because ... the way the health system is at the moment I don't have a lot of faith in them ... our workload is quite extreme and a lot of it is computer work now ... (Interview)

This place is terrible, really horrible. I think patients could probably be given more feedback but in the current climate of workload they keep loading nurses up with more jobs to do. (Interview)

It's the most stressful environment I've ever worked in; [the] continual stress is just relentless. (Interview)

I have noticed if staff are tired, feeling tired and stressed and if you get somebody coming in that's quite demanding ... this is probably only human nature, I know they have the ability to calm that person down and just take it in their stride but ... they might retort in a sharp manner. (Interview)

In contrast, two clinical staff said they did not experience stress at work. Responses such as those below were exceptional rather than the rule. However, they do demonstrate that some individuals were able to embrace the nature of their work in the ED in a different way:

No [not stressful]. There's variety and your patients are your own and you get to work on ... individual patients. (Interview)

I particularly like emergency nursing, I like the pace of it, I like the fact that you can make a difference in a fairly short period of time with a lot of the people that present ... I like the fact that it's a brand new day the next day with a brand new lot of cases to sift and sort through and try and help. (Interview)

### ***Support for staff***

Given the stressful and often traumatic nature of the work in EDs it was apparent that there were inappropriate support mechanisms in place to support the staff. A number of staff commented on the lack of counselling or relief that was offered at work. Others revealed that team consultations and debriefing with fellow staff members were important alternatives to formal counselling or debriefing:

Counselling ... the only time when I ... have been offered counselling was when you get patients who jumped out the window and their brains are all over the ground ... for day-to-day stress they don't offer any kinds of things to manage. A lot of the times we just manage in a very day-to-day practical level. (Interview)

I'm sure if a staff member needed debriefing then there'd be someone who could do that. Generally as a team we do it ourselves. We talk about it amongst ourselves ... I think that's an unofficial debrief that we do. (Interview)

... informal, over a cuppa, something like that, and you kind of have to; if you don't build up a resilience you wouldn't survive in emergency. (Interview)

The application of some supportive human resource management practices for staff in hospitals was evident through performance appraisals:

I think we have regular annual appraisals in which we try and step people through a process of gaining more responsibility as their clinical acumen grows and their experience grows, but there could be more feedback ... (Interview)

ED staff work in an environment where they clearly perceive that EDWR resources, design and functionality are not congruent with their expectations and needs. There is increasing evidence that the design and implementation of appropriate working environments with adequate support for staff can positively influence staff satisfaction, performance and morale (Barach et al., 2009; Becker & Douglass, 2008; Ulrich & Zimring, 2004). However, employee satisfaction is being greatly impacted by a lack of resources and weak support mechanisms and other factors (e.g., see also Parish, Berry & Lam, 2008).

### ***Staff–staff relationships and communication***

Staff demonstrated great aptitude in adapting to stressful circumstances by multi-tasking and/or supporting one another, especially in clinical aspects of work involving long working hours. The ways in which staffing levels were organised and teams were constructed within the ED varied between hospitals with apparently different degrees of success. In all hospitals, and indeed almost all organisations, there is evidence of segregation of staff according to their professions; in hospitals the problem of communication between different professional cultures or staff groups can, and does, arise and poses a risk to patient safety and reduces the quality of patient service (Reader, Flin, Mearns & Cuthbertson, 2009).

Across the four hospitals there were a range of views about communication and relationships among staff. A number of staff also identified a sense of teamwork among their fellow workers in the ED. This at times was assisted by the lack of a rigid hierarchical structure, and the willingness of others, for example cleaners and ambulance officers, to help nurses when called upon. In another example, an emergency clerk described how she would sometimes suggest to nursing staff that they come out into the EDWR and explain to people why they might have to wait for a longer time than originally thought. Good teamwork was highlighted among staff and many teams of staff worked well together:

There's not a real hierarchy thing, you know. Everybody seems to get on well ... there's no real the nurses go here, the doctors go here, the wardies go here ... Here's really good, the doctors and nurses tend to work as a team. (Interview)

A lot of the RNs here, they act as really good role models ... they help. They're just kind and they answer any questions ... they think of it as all learning. No matter how silly you think the question is, they're always happy to answer it. (Interview)

The communication? I think we're really good here as a team. Our doctors are approachable. (Interview)

Staff teamwork was identified in the NSW Health 2009 Patient Survey to be regarded highly by patients as a key factor when rating a positive hospital experience as well as being an associated competency that related directly to patient safety (BHI, 2010b). The value of team skills in reducing adverse events and improving patient outcomes is receiving considerable attention in the hospital environment (Catchpole, Mishra, Handa & McCulloch, 2008; Kaissi, Johnson & Kirschbaum, 2003; Manser, 2009), while recent literature is providing new insights into the skills required for effective team performance (Krug, 2008; Manser, 2009; Reader et al., 2009). However, both across and within the four hospitals effective teamwork was not uniform. As staff members commented:

There's people here that are such strong bullies in this department ... nearly everybody would know who I'm talking about ... there's nothing can be done. (Interview)

It's all this tall poppy syndrome I think everyone has got here. I don't think people here like to embrace change very much, it's just too much rigidity I think. It's their way or the highway and they won't sit down and discuss. (Interview)

It's [i.e. change] political, we don't even go there. And I think, 'Well, am I going to get listened to?' Probably not ... I'd love to get proactive and help sort that out, but at what cost? (Interview)

There's a huge line between clinical and administration ... I really believe that hospitals, which they should I suppose, lean on the clinical side ... tend to forget about the admin people ... I was very intimidated to start with because you really worry about asking a question. (Interview)

We have very poor communication with the wards ... it's like emergency and the rest of the hospital. (Interview)

At another hospital there were concerns about the sense of teamwork being lost:

We all worked as a team ... the team has gone now. (Interview)

We don't seem to work as well as a team as we used to. It's not as friendly as it used to be. (Interview)

Staff roles are more rigid with less opportunity to assist others. (Interview)

We were friends as well, it was like family, but it doesn't seem like that anymore. (Interview)

We are all separated into allocated areas and that's where you work and this is where you work ... teamwork is probably not as good as it did used to be. (Interview)

You feel like you're on your own. (Interview)

Communication and teamwork are fundamental to promoting high quality patient care and service in the ED and also have implications for staff wellbeing (Manser, 2009; Krug, 2008). Braithwaite et al. (2007, p.358) identified trust and communication as key factors underpinning existing problems, such as the lack of teamwork in many healthcare organisations, which, if they are to be overcome successfully, require a change in the organisation's culture involving a consultation process that engages all stakeholders (also see chapter 2). Of the staff interviewed, not only were many committed to their work, but through their experience and their own values and high levels of conscientiousness many would often 'go beyond the call of duty' to ensure that their work was done well. While evidence has shown that teamwork is critical to the delivery of high quality health care, it has also been noted that the teaching of teamwork skills has been lacking in nursing and medical practice, where training is almost exclusively focused on individual technical skills (Kaissi et al., 2003, p.212). This situation should be addressed because research shows that specific training can improve the effectiveness of teamwork and staff relations in the ED environment.

### ***Other aspects of staff–staff communication***

Efficient information management and communication within the ED is essential to providing timely and high quality patient care. However, communication in the ED is a complex process where failure can lead to poor patient care, loss of information, delays and inefficiency (Redfern, Brown & Vincent, 2009). The size of the hospital and the number of staff appeared to have a substantial impact on the effectiveness of communicating information to and between staff. Nonetheless, each hospital had different strategies in place to communicate with staff so that they could be kept informed about what was happening in the ED. For example, at one hospital, several interviewees spoke about a communications book that was used by ED staff to share information affecting the ED. The book was read by staff before commencing their shift. Email use was not well utilised across any of the hospitals. Some nurses were reluctant to use email, and said that they hardly checked their email account. As some staff commented:

It's just the main issue is getting information out to staff, because there are so many of us. It's poor communication. Like some people will ... know this is happening and then the people who weren't [say] 'I didn't know any of this was happening'. So yeah, it's poor communication in that respect. (Interview)

Communication breaks down when people don't communicate with you. Like handover; if you don't get an effective handover from the previous nurse then it's tricky because you know you can come across medications – Have they been given? Haven't they been given? What's going on? – and there's a lot of unnecessary follow-up. (Interview)

Propp et al. (2010) examined critical team processes and practices that were perceived by team members to promote teamwork and good communication among staff. Successful strategies included: coordinating the patient-care team; mentoring team members; empowering lower-level team members; advocating on other people's behalf; managing conflict constructively; listening actively to team members; and fostering a positive climate and managing workplace stress.

## **The Patient Journey**

### ***When does the journey begin?***

The patient journey in the EDWR has important features and critical transition points that are well recognised but are often disaggregated or fragmented in existing research literature. A number of clinical redesign projects have experienced a level of success in increasing safety and improving the patient journey for staff and patients (McGrath et al., 2008). As described in chapter 2, improvements in the patient journey have been gained through innovations in service delivery such as rapid assessment teams, fast track zones and availability of advance practice nurses (O'Connell et al., 2008). However, there are features of the patient journey that nonetheless require greater attention. These include: concern for and engagement with those who accompany patients; informing the public about the ED; the process of triage; the ability of staff to see and monitor patients in the EDWR; and patients' and others' experiences of the EDWR. Each of these matters has been addressed in this study.

The recent (2010) *Emergency Co-Design Program 1 Stage 2 Evaluation Report* by the Centre for Health Communication at the University of Technology Sydney suggested the proposed patient experience begins on arrival at the hospital and the proposed ED Journey of a patient begins with the patient's 'walk in'. However, positioning the beginning of the patient journey at the 'walk in' fails to recognise the significance of what people understand about the ED well before they have occasion to present to the ED. The following are examples that can influence a person's perception of the ED before they arrive: proactive ED educational or information materials; coverage of the ED in the media, including news reports and television shows; patients' experiences associated with previous visits to the ED which in turn influence their perceptions of EDs; the influence of previous experiences of those who accompany or advise and or care for patients; and community perceptions of EDs. These examples are, then, just a few of the factors that can significantly influence people's decision-making, actions, behaviours and expectations with respect to EDs. Thus, for patients who are sufficiently cognisant, and for those accompanying them, a person's journey and connection with the ED and the EDWR commences from the time an incident arises that causes them – the patient – and/or family, friends and carers to contemplate emergency treatment. This perspective means that elements of a patient's behaviour in the future could potentially be managed in direct and indirect ways well before the patient reaches the ED or before cause arises to consider visiting the ED.

## **Triage**

People who arrived at the ED were faced with different access arrangements (also see chapter 4), levels of accessibility, triage processes and EDWR environments both between hospitals and within the same hospital at different points in time. Here we focus on the system or process of triage. The system of triage was designed to assist the management of EDs. Triage systems ‘assign relatively scarce resources to unlimited medical needs’ (Fitzgerald, Jelinek, Scott, & Gerdtz, 2010 p.1). They are:

designed to serve the value of human life and health with fairness and the efficient use of resources. They do this by determining who will not be disadvantaged by longer waiting times and who requires immediate attention to achieve optimal outcomes. The need for triage is enhanced by the growing imbalance between needs and resources resulting from the twin challenges of access block and growing demand (Fitzgerald, et al., 2010 p.1).

*I have figured out that there is a significance to the colour-coding of the chairs in the waiting room. The yellow chairs are for people who need to be triaged still. The other chairs are for people who have already been triaged. That took me a while to figure out ... [A man] and two teenage girls come, and talk to the emergency clerk. ‘Have you been here before?’ They murmur a response. The emergency clerk asks whether he is married, who was next of kin. The man responds, pointing to the girl next to him, ‘My daughter.’ She spells her name for the emergency clerk in impeccable English. The emergency clerk says, ‘Just take a seat here, on the front row here. I’ll page the nurse for you.’ They seat themselves. The father briefly, gently strokes his younger daughter’s arm. They murmur to each other in their native language. Less than a minute later, the triage nurse calls them by name, and they go into the triage nurse area ... When the TN finished talking with them, she sent them back in to sit in the EDWR. They move to sit where they were sitting before, on the yellow chairs, but the TN says no, and indicates to them to sit on the grey chairs. (Field notes)*

However, for many patients and those accompanying patients the term triage is confusing. It was the widely held view of staff interviewed that many patients who present at the ED did not understand the triage process: ‘No, they think first in, best dressed’, while a nurse at one hospital didn’t recall seeing anybody actually reading the brochure explaining the ED triage protocol. The use of the word triage was critically questioned in the Garling report (2008), and indeed a number of staff reported:

[We] constantly have to explain that emergencies are brought in via ambulance bay ... the word too causes confusion. (Interview)

You can’t always explain to them how the system works, they don’t care. (Interview)

They don’t understand the category system and they don’t care what the signs say. (Interview)

Some people get a bit confused when they come up to triage because they come up to you and you sort of want details and if they haven’t been here before because we actually have

to register the patient, it becomes an issue because we can't get an MRN [medical reference number] so we need to get the clerk. (Interview)

We have a category triage system but the population doesn't understand the triage system; you know, they are unwell and that's all they care about. (Interview)

Despite the clarity of the space and layout at one hospital (much less cluttered, more open and better designed than the other three hospitals in this study), this confusion is exacerbated by a distinct contradiction in expectations: on the one hand signage exhorts the patient to see the triage nurse first (which assumes the patient knows what or who the triage nurse is and can recognise them as such from signs or other signifiers), but on the other hand, covert signals communicate to the patient and carer that the EC is the first person to see. Mostly, the patient is called to the clerk's window by the ECs themselves. The necessary collection of the patient's details (computerised for the most part) is done and the patient is asked to take a seat on chairs that are different in colour to those in the general waiting space. The coloured chairs are intended for patients waiting to be triaged, but there is no sign explaining the role of the coloured-chairs patients awaiting triage are supposed to take. On several occasions it was observed that this created confusion among patients and those accompanying them, especially when after sitting down on these chairs they were requested to move by the clerical staff. The patient is in fact expected to sit on these chairs until called in by the triage nurse.

At one of the hospitals, some staff we observed were often quite curt in their manner, unlike other staff who were mostly quite warm in their approach towards patients and those accompanying them. To place this initial observation in context, however, during the interviews it became apparent that there was a strongly articulated desire for more nurse educators, and there was a significant nursing staff shortage (discussed above), coupled with an undesirably high staff turnover and casualisation of nursing staff. These circumstances would add considerably to the stress experienced by triage nurses and other staff as they struggled to cope with inadequate staffing levels:

... a lot of the time when it's too busy, due to a lot of work and less staff, we talk faster or sometimes are unable to explain: we just get on with work. And the patient sometimes asks the staff, listen, what are you doing? You know, because we didn't explain. But we know what we should have done. (Interview)

It's a very difficult role to do [triage] and you come up against an awful lot of aggression working in that role. So it is daunting walking out to the waiting room, when on a busy

night you've got twenty or thirty people waiting to be seen and they all want to know why they can't be first. It isn't an easy job. (Interview)

## Patient Privacy

In all but one hospital, there were separate triage rooms. However, the number and availability of these rooms were inadequate especially during peak demand times. The size and design of EDWRs were a concern generally raised by many staff with regard to the lack of patient privacy, even in those hospitals with a separate triage treatment space:

It's not private ... when you come in and you get seen, you talk ... through a glass window and you can't hear each other so you're shouting. Everyone can hear what's going on ... in the waiting room it's a little bit the same. I mean there's not much you can do about privacy in the waiting room. (Interview)

It's awful ... you've got a line-up of people waiting to check in and then you're trying to talk to some poor person about something a bit personal ... Even if it's not personal, you know, it shouldn't be out there for everybody. (Interview)

It can be quite challenging dealing with the waiting room, largely because there's not a lot of privacy there and everyone's quite anxious. (Interview)

There's very few EDs that would have good privacy anyway. But in that waiting room I do believe that ... patients are subjected to unwanted behaviours by others, which is not a good thing. (Interview)

Some patients might not want to discuss things when there is a risk to their confidentiality ... as much as you try to make it confidential, it's almost impossible to do. (Interview)

Aspects of patient privacy and the ability to adequately treat and respond to patients in the ED are of note when growing interest in hospital design has been associated with treatment outcomes and the more general wellbeing of patients (Curtis et al., 2007). Many hospital designs do not address fundamental elements of the patient experience which include a general lack of privacy (Barach et al., 2009; Kelly, 2005; Larsson Kihlgren et al., 2004). During observations in EDWRs it was noted at one hospital that as soon as a patient entered the EDWR, a staff member would usually ask 'How can I help you?' or 'What's your problem?' This lack of privacy (as anyone else in the EDWR is able to hear the response to the nurse) is a concern, particularly for people who might be embarrassed to explain why they are presenting at the ED, or perhaps more importantly, it could reduce the effectiveness of the triage process if the patient concerned will not clearly relate the symptoms of his/her condition.

In addition, recent research indicates patients would like greater privacy and confidentiality when presenting at the ED (Kington & Short, 2010). Patients also increasingly expect a service that is more focused on patient-centred care, and thus providing clinical assistance and medical treatment (technical dimensions) are but two aspects critical to patients' experiences (Kelly, 2005; Larsson Kihlgren et al., 2004).

## **The EDWR Waiting Experience**

EDWRs share qualities with other spaces where people congregate to wait for something to happen. However, apart from the obvious differences in their purposes and functions and the health and circumstances of those waiting, a major difference between the EDWR and most of those other 'waiting spaces' such as train stations and airport lounges is that those waiting have a good indication of the length of time they have to wait before their departure. We are acculturated to know that if we are waiting for a train or aeroplane, barring any exceptional circumstances, our transport will arrive for the most part at the time, or very near the time, it has been scheduled. There are displays which are regularly updated and which inform those waiting when their train or plane is due and when it will depart. When waiting for an appointment with a professional, a person knows that they will be seen more or less at the time for which the appointment has been made. Similarly, if waiting to be served in a retail store, customers know the order of their arrival at the counter for payment, and if someone is observed 'pushing in' ahead, others may complain and seek to address their concerns by alerting the salesperson. Our understanding of the social practice of 'waiting' (and indeed queuing) is one which is reinforced in a variety of situations encountered in many daily situations. The waiting experience in the EDWR is very different from other waiting experiences.

Patients who are waiting are likely to be in pain or feeling ill, and experiencing stress and anxiety about their condition and treatment. How quickly a patient will be seen will depend on a number of factors: staffing levels and resources; availability of beds; how they have been triaged; the number of patients who have been triaged at a higher priority (or more urgent) category; or the number of patients triaged at the same level but who arrived before them. As discussed, many people do not understand the concept of triage and therefore there is a lack of understanding about waiting in EDWRs, which leads to problems in assessing, treating and dealing with patients (Garling, 2008; Kington & Short, 2010; Mohsin et al., 2007). The triage

system impacts on patient satisfaction and will impact negatively, for example, when a patient feels that they have been waiting unfairly if they can see that other patients are being treated before them (Mohsin et al., 2007; Welch, 2006).

At times, a large proportion of those waiting to be treated are not actually emergency cases and would be more appropriately seen in a general practice setting (BHI, 2010b; O'Connell et al., 2008; Hughes & Walters, 2007). The fact that many people who are presenting at EDs are not actually emergency cases is a result of a complex mix of interrelated factors, including: a lack of understanding on behalf of some patients about what is an emergency presentation and what is not; a belief among some patients that hospitals still offer or should offer an 'outpatients' service for non-referred patients; a lack of GPs resulting in difficulties in being seen by a GP within a reasonable time period; a lack of bulk-billing GPs; a lack of after-hours GP services; and an increasing number of people presenting with mental health problems (also see chapter 2).

Nevertheless, in most situations observed during field work the EDWRs appeared reasonably

calm and ordered spaces. In addition, staff at three of the hospitals commented that the EDWR was particularly quiet during the periods when the researchers were present, noting it had been more chaotic in the absence of the researchers. This calm was broken from time to time by patients or those accompanying patients expressing their annoyance or even aggression to others waiting or to the staff. The EDWR is mostly 'hermetically sealed' from where for most of the time the 'real action' takes place, that is in the treatment area, and

*There was also an elderly couple (possibly mid/late 70s) sitting calmly in the middle of the WR [waiting room] when we arrived. They were watching TV and every so often talked to each other in a friendly manner. Around 11.30 pm the elderly couple were called into the ED by a nurse who used the patient's full name. By 11.45 pm a friendly, chatty nurse ushered them back to the WR. The couple talked loudly and in the exchange confirmed that they had to wait to see if the pain killer worked before they could go.*

*As the night wore on they seemed to be growing fidgety and increasingly concerned about the length of their wait. They were talking to each other – 'Surely we have been here more than 20 minutes?'*

*12.55 am. The older female patient said to a young couple also waiting, 'Are you waiting to see the doctor as well?' They nodded ...*

*12.55 am. The old couple discussed whether the male should go out for a break – yes, he decides to go.*

*1.20 am. Still both old woman and young [people] waiting – all getting quite tired and no one has come to see how they are.*

*Finally, at about 1.22 am a nurse comes out of the ED to see how both couples are going. She indicates to the young couple that they are waiting for a doctor. The nurse then asks the older female patient, 'What's your name?'*

*The older female patient gives her name and explains she feels much better so does she have to wait for a doctor? The nurse said she will look for the other nurse and find out ...*

*1.25 am. Another nurse comes back out and advises the young couple it now won't be too long a wait for them. She turns to the older female patient and indicates the doctor will see her shortly and give something to her for pain.*

*1.30 pm. The older female patient was called into ED – no assistance was provided and the doctor/nurse didn't come into the waiting room, [and] just called out loud from the door using the patient's full name. A few minutes later the old lady walked back out unattended and left the ED unaccompanied as her husband had never returned from his walk. (Field notes)*

because ambulances arrive generally unseen and transfer the critical patients into the treatment area, unseen by those waiting, the people in the EDWR are almost entirely oblivious to the level of work and potential chaotic situations that are taking place behind the door to the treatment area. Drawing from the sociologist Erving Goffman's (1959) (*The Presentation of the Self in Everyday Life*) concept of 'back stage' and 'front stage', the EDWR is representative of a front-stage space. It is public and visible, but the treatment area behind it with its higher levels of unpredictability, potential for chaos, spillage of human fluids, crisis, and medical instrumentation is the back-stage space. The back-stage space is out of sight from those waiting in the front-stage space of the EDWR. This separation creates problems for nursing and administrative staff because a false impression is created of apparently low levels of activity which translates into a difficulty in understanding why one might have to wait for a long period of time before being treated.

For the most part during the observations, the EDWR ambiance did not evoke a sense of emergency. The majority of emergency cases would be delivered by ambulance straight through into the treatment area. Only in a couple of instances during observations did it appear that patients made their own way into the EDWR with a condition serious enough to proceed immediately to the treatment area. Thus most of the patients observed waiting appeared to have been triaged in the less urgent categories of 3, 4 or 5. Mostly there seemed among patients and others to be a level of acceptance and understanding, or perhaps resignation, that they would have to wait before being attended to.

In trying to understand the wide-ranging and often intangible factors that influence patient satisfaction and perceived quality of care in the ED, the waiting experience is increasingly recognised to be of critical importance (Ayas et al., 2008; Becker et al., 2009). When staff were asked about how they felt the EDWR could be improved there was often some hesitation as if it had not been a question that they had considered fully before. Perhaps more to the point, there seemed to be a lack of appreciation of the importance of the EDWR and its environment in the healing process both as a space where patients need to wait and in the nature of the time spent waiting. Whereas the nature of an EDWR experience may be compromised by physical pain as well as anxiety, proactive behaviour from health professionals can be important in allaying patient anxiety by making patients feel that their concerns are being taken seriously (O'Cathain et al., 2007). Reducing the length of time spent

waiting, then, is not the only solution (see chapter 2). This was to some extent expressed in the following comment:

It's a really difficult area really on its own, because everyone is so anxious within it. The level of anxiety is so high ... time waiting to be seen is the big issue of course, and what's happening next. (Interview)

The solution lies in part in modifying people's propensity to engage in social comparison, and in addressing habituation (and thus addressing incorrect expectations). In some cases patients' and others' feelings are governed by habituation; and in other cases they are governed by social comparison. These forces are very strong, and to adjust patient experiences of the waiting room through affecting the duration of the wait itself will not resolve a fundamental and widely publicised waiting room problem. For even if improvements are made and the average wait declines, and thus as actual waiting room times shift and change, so too will the norm by which the wait is judged. People's norms adjust quite rapidly to new situations. The discussion below links these and other issues to other sets of factors that impact on the nature of the waiting experience for patients and those accompanying them.

## **Communication**

Effective communication and interpersonal skills have long been recognised as fundamental to the delivery of quality health care (e.g., Slade et al., 2008). Patient satisfaction in the ED frequently is found to be influenced by staff communication and courtesy. This has been reflected in several reports that have highlighted the need to improve communication with patients in NSW hospitals (ACSQH, 2009; Garling, 2008; Hughes & Walters, 2007; NSW Health, 2009b). Staff need to be able to judge the best way to pitch their communication with patients. Many of the clinical staff demonstrated an amazing ability to detect what and how certain patients wanted to hear, such as which patients appreciated being 'mollycoddled', while others rejected such approaches. To be able to judge the appropriate approach to take with a patient, while imparting empathy and care without being patronising, requires experience and great skill. Many of the clinical staff suggested it was a skill they had acquired over time, through their experiences of working with patients and those accompanying them. By way of examples:

I try to tell them also what's going to happen to them, so explain, you know, the doctor will come and see you, he'll probably want to take blood, you might need some fluids, you might need X-rays – you know try to tell them what's going to happen along the path, otherwise they've got no idea; even like you have patients that have sat there for four

hours, and often I come in and they've got no idea what's happening to them, and I say do you know, and I actually show them the computer, take it to them and show them and say this is what the doctor's written and this is what the plan is for you ... and then they feel 'oh I know what's happening now'. (Interview)

Yeah, there's lots of really good communication with people. From a nursing to patient point of view, or family member to patient point of view or you know, and just being able to do that, like with lots of end-of-life discussions it's very hard for a lot of doctors to be able to have those discussions with family members or there may be cultural barriers which means that they don't necessarily explain it the way it would be most appropriate. So you find a lot of the time that you do have to sort of spend that bit of extra time with the family members and say you know, 'Do you understand?' or 'Is there anything else that I can explain for you?'. (Interview)

The latter quote also suggests that at times this nurse attended to patients who had not been adequately informed and did her best to ensure that the information deficit was overcome by explaining to them their course of investigations or treatment plan. As the nurse said, 'I would like them to have a gentle, quite confident type of approach so that people will think, oh fine, I'm in good hands. I want them to help.' At one hospital, a nurse was observed on several occasions coming out to give updates on how long people could be expected to wait, at a time when the EDWR was relatively full. The nurse informed all who were waiting that the attending doctor was still busy but that he was progressively working through his case load and people would be seen as soon as the doctor could schedule them.

Many studies reveal that patients feel like outsiders and do not receive adequate information about processes, waiting times and other matters when presenting to EDs (Garling, 2008; NSW Health, 2010; Slade et al., 2008; Stuart et al., 2003). As previously noted, patients who have to wait at ED departments want information about why they are waiting, how long they will have to wait and confirmation that they have not been lost in the queue, who they will be seen by, what the next step in the process is about, and what is going on behind the scenes (Cooke et al., 2006; Garling, 2008; Kelly, 2005; Larsson Kihlgren et al., 2004). Therefore, to meet the rising expectations of patients and those accompanying them, there is a need for patients in the EDWR to be kept regularly and reliably informed about their wait, and for them to be regularly monitored and consulted.

During only one observation session was the EDWR at any hospital managed actively. One clinical staff member was present in the waiting room, and asked patients how they were, offered pain relief, and explained how long it would likely be before they would be called. This was observed at the hospital on a relatively quiet night. Staff presence was not observed during periods of high demand at the same EDWR. Indeed, in one observation period of four

hours, the only clinical staff that entered the waiting room were those who came to call a patient through to treatment or to quickly facilitate a patient's triage and access.

Techniques to diffuse negative feelings about the length of the wait were described by staff and observed by the project team. Staff described a number of variables that were beyond their control that could affect the length of time a person may wait for emergency treatment. These included the lack of beds in wards which may result in an excess of patients in the ED waiting to be transferred, and the clinical characteristics of other patients who had arrived via ambulance, such as traumas or complex injuries or illnesses which were resource- and time-intensive. Some information was given to patients about the expected length of time they would have to wait, but often that information was very vague; for example, 'there are six files ahead of you'; 'shouldn't be too long'; or 'you've got a very long wait ahead of you' (field notes).

The complexity of issues related to a person's wait, and acknowledgement of the distress the wait can cause patients is evident in the ways in which some staff addressed complaints about the wait. One staff member spoke of people sometimes throwing beer bottles and other hard objects at the glass doors leading to the EDWR as a way of expressing their frustration. Others did their utmost to alleviate the distress being experienced by some patients:

What I try and give people when I know they're waiting is an element of hope ... We are going to get you seen ... we are sorry that it is like this, but it is like that today.  
(Interview)

Of course, ED staff are working quite separately to those patients waiting in the EDWR and are perhaps not able to focus on the experiences of those in the EDWR as their attention is required elsewhere. In areas where there are staff shortages, priorities of nursing staff for example are not able to extend to 'checking in' periodically with those in the EDWR. The time of day also contributed to the extent that the EDWR would be managed by available staff because during the night shifts there were less staff present:

After hours, say from about 11.30 at night ... when the triage and the CIN shift go home ... from then on ... there is no one that looks after the waiting room. (Interview)

The approach taken by staff in managing the experience of those waiting to be seen varied from individual to individual and it seemed that there was no policy or systematic approach in

place at any individual hospital or across the four hospitals. The approaches taken by staff relied in part on the value they each placed on taking the time to make sure that patients were reassured about their journey and condition, and kept informed about waiting times. This was also influenced by the extent to which staff felt they had the time and opportunity to convey this information to those waiting.

In the ED patients and those accompanying them are required to relinquish control of their situation and hand their trust to the staff they encounter there, including administrative, support and medical staff. Being a patient in the EDWR is a new role for many people, and being a patient in an emergency context is not a role that most people have had much time to contemplate. Every person has many roles in their life, and each role has its own rules and rituals, requiring specific knowledge and skills. Most people who come into an ED would not be well versed in the 'role' of the emergency patient in the ED setting. As noted previously, hospital designs generally do not address fundamental elements of how a patient may feel in an emergency situation: lack of control, insecurity, disorientation and 'an overarching sense of dehumanisation' (Barach et al., 2009, p.528). For many patients there is a large degree of uncertainty about what they are supposed to do and what to expect when they present to an ED. This uncertainty could contribute to the anxiety and lack of control a patient may experience. Patients and others in the EDWR have a more satisfactory experience at hospital when information is given to help them understand what is happening (Braithwaite et al., 2007; Fitzgerald et al., 1991; Kelly, 2005; King, 1995; Messner, 2005; Welch, 2010).

There were many ways by which staff (doctors and nurses) greeted or called patients to take them into the treatment areas, particularly at three of the hospitals. There was no consistency in greeting method or approach. Mostly staff stood at the doorway from the EDWR into the treatment area and called out a name, sometimes the first name, sometimes the last name. In some instances where it was clear to the nurse or doctor who the patient was, they sometimes simply beckoned with a hand gesture. At one hospital they also used a tannoy or loudspeaker. Internal messages were also broadcast over the tannoy out in the EDWR. Effective use of the tannoy was variable. Some staff shouted into the microphone, others sounded fuzzy; one user was very good on the tannoy, and was very clear and precise. One interviewee noted, 'There is calmness in her voice that seems to reassure people.' In one instance at that same hospital a doctor came into the waiting room and walked up to a small girl and her mother and introduced herself and shook the child's hand, while crouching down to be at the girl's height.

In contrast, in another instance a researcher observed the lack of consideration for a patient was very apparent:

An old fellow on a stick was just called through at 6.30. He had been triaged about an hour ago and had been brought back out in a wheelchair by a staff member. However, when he was called up by the doctor he had to make his own way back there without a wheelchair. (Field notes)

Where there was an element of familiarity, there was a much greater level of intimacy and willingness to communicate through touch. At one hospital it was observed that there was a level of tactility between nurse and patients and those accompanying patients which was not observed at the other hospitals:

At one hospital, each staff member had their own particular approach to 'calling in' the patient next to be triaged or treated, but most tended to come right out into the waiting room and say the person's first name. As was observed, often the person was known to the nurse and so the 'call in' would take on a personal quality: 'Come in, lovely,' the triage nurse says to the elderly woman. The TN smiles and is welcoming and places her arm around the old woman to help her through into the treatment area. (Field notes)

An elderly couple come back out from the treatment area into the waiting room accompanied by the nurse and there seems to be a very affectionate bond between the couple and the nurse. The old man gives the nurse a kiss on the cheek and she in turn kissed his wife. 'See ya in two weeks, darling. Take care!' (Field notes)

Effective communication for the patient is linked to a positive exchange of information and feelings to develop a relationship between the patient and hospital staff (Braithwaite et al., 2007; Kelly, 2005). Many of those interviewed recognised the importance of seeing things from the perspective of the patient and indicated they made a point of reassuring their patient and developing a relationship in which there was trust and care for their patients:

I mean you need to have good communication skills as far as working in the department, because you come across a lot of cultural variations as well as you know, interpersonal things. And you see people at their worst. So you need to be able to communicate what you need, and what they need. (Interview)

I think you've really got to see the patient's perspective if you want to improve communication. (Interview)

And quite a few of the RNs are the same. They've got a caring nature and they're, the way they speak, talk to the patients or communicate with patients, is caring. (Interview)

I believe in treating the patient as a whole person not just a piece of paper ... (Interview)

And that attitude I've got inside me that I felt that I need to gain the patient's trust. Because all the time I look after someone it ends up when she goes or goes home, he waves or she waves and says thank you and I'm pretty sure [it's] because of ... the style of nursing ... that I have adopted in my care. (Interview)

The other night I had a little nanna in one of the rooms off to the side you know, and I felt bad that she was in there by herself when the rest of the people are sort of out there talking. I said, 'Do you want me to move you so you can chat with them?' and she's like 'Oh yeah!' So we sort of brought her out and she sat there and had a chat with the patient for a little while. (Interview)

When I'm dealing with patients, or when I'm you know trying to get their trust I just, I take great pains to try and come across as somebody that is approachable and will listen ... I need to get somewhere but it's much easier if they feel that they're, wouldn't say in control, but at least an equal partner in the whole situation. So I'm you know, to start with I try to come across as just open, you know, happy. I crack a joke ... I'll smile and make eye contact ... (Interview)

It's being approachable and being often calm and quietly spoken. And if you just gently talk to these people, they're sick most of the time when they come. A lot of them are old and frightened. And even the little kids that come are often frightened of the environment. And you have to get down on their level for one, and try and allay their fears. If you're abrupt, short, you destroy any hope you've got of having a really effective interaction with that patient, because they just close off.

The importance of patient trust in providing quality health care was highlighted by ACSQH (2009). In addition to being based on rational judgements associated with skills, knowledge and competence, trust is well linked to factors such as the quality of relationships, interactions and perceptions of care (Calnan & Rowe, 2006 cited in ACSQH, 2009, p.10). Emotional support from hospital staff helps reduce the stress experienced by patients and others. However, the pressures of communication in high-stress work areas such as hospital EDs present particular challenges to the delivery of quality care (Slade et al., 2008). Medical and nursing staff identified distractions and time pressure as two of the main factors that compromised the effectiveness of their communication with patients and those accompanying patients. Efraimsson et al. (2006, p.653) found that the ability of healthcare staff 'to offer true humanistic care clashed with and [was] engulfed by institutional demands', while insufficient time, resources and skills had a detrimental impact on their ability to do their job. As several staff noted:

We're too busy ... [we] basically, bring them in, do some blood tests give them some pain killers, so it gets very repetitive after 12 hours ... You just don't have time with it being so busy here to do it properly. (Interview)

You're trying to do all these different things, and you don't have time to sit down and talk to your patients and have an in-depth conversation. So even when you are doing your assessment of your patients, the 'So what's brought you into hospital?', if they go on like five years back and tell you every single thing and you're kind of tapping your feet and thinking [laughing], so you don't have time, because it's a busy department. You don't have the time that you need. (Interview)

I think that time is the problem when you are short-staffed. (Interview)

Nurses often work quite separately to those in the EDWR and perhaps because they are so totally focused on the jobs at hand in the treatment area, they do not have the time to assist those in the EDWR. Due to the nature of their work, nursing staff need to prioritise a patient in urgent need of care above the need to 'check in' periodically with those patients in the EDWR. This is all the more reason to ensure that there are effective communication strategies and to incorporate a patient-centred approach to service delivery. To reiterate the recommendations of the Garling report (2008, Vol 2), good communication was 'of the essence at the start of the interaction with hospital staff' (p.718), and 'often a small effort to communicate can resolve a lot of the tension patients experience in the ED' (p.26).

While people were not happy that they still had a wait ahead of them, it seemed that conveying this information assisted the management of the situation, in particular managing the expectations of those waiting. Any decision to have a clinical staff member more visible in the EDWR exposes them to abuse by intemperate patients who sometimes take their frustrations out on those who are accessible. In most cases when this happens this is done verbally, but at one hospital in particular, staff were well aware that in some situations such a response could be, potentially at least, physically violent. At the same time, as the following comments demonstrate, staff had learnt through experience that there were certain strategies that worked well when dealing with aggressive patients and carers in the EDWR:

*At 17.30 there is a verbal altercation. A man near the emergency assessment area has become belligerent: shouting at the emergency assessment nurse. He says he's been here since 2 pm; the bandage had been taken off, and he needs to show the doctor his foot. The man is quite irate and aggressive. Three security men appear, and try to calm him down by talking quietly with him. One of the security guards gets down on his haunches so that he can speak with the man at eye level. But the man remains belligerent and in the end stalks off angrily. He does, however, return soon after. In the meantime though, the security guards have been talking with the young man's companion. They say to her, 'You seem quite sensible. Do you think you can ... ?' With a rueful smile, the companion woman goes to sit with the belligerent man at the back of the waiting room. (Field notes)*

You get your patients that aren't very happy and abuse you but I have learnt to deal with them ... You've got to stay calm and you've got to talk to them on their level, I think, rather than go above them or become threatening yourself. (Interview)

If something is done to make them feel like something is being done they're usually OK and they tend to calm down a little bit. Just like that. I think you just need to show them that you are at least trying to do something and that you're not fobbing them off and leaving them in the waiting room and ignoring them. That's I think when the agitation tends to kick in. (Interview)

You try and de-escalate, so you use a very submissive tone and listen to them, ask them, 'What's your problem? Talk to me about it' – and let them get whatever they want to get off, off their chest. And you empathise with them and say I do understand because if this was me I would be feeling the same way. And then you look at what is it that they're really asking for, like something really simple like a glass of water or whether it be some painkillers or some reassurance or something. It might even just be the fact that they're hungry. So a little sandwich which if we do have in the fridge is very easy to get. (Interview)

Staff should not only be aware of the presence of increasing communication expectations on the part of patients and those accompanying them, but also fully understand the benefit this provides to both patients and health care providers (Krug, 2008, p.S658). Hospital cultures should emphasise emotional support to families and carers and this could help promote positive perceptions among staff (Hemmelgarn et al., 2001; O'Malley et al., 2008). Nonetheless, strategies for enhancing communication require clear guidelines and expectations in ways that give due recognition to the context and settings in which communication takes place (Bensing et al., 2003).

### ***Carers and those accompanying patients***

The space of the EDWR is a place of transition, confusion, activity and often stress and anxiety for both patients and those accompanying patients. Those people who accompany patients in the EDWR are waiting with the patient who is to be assessed and treated. Thus the importance of family, carers and friends accompanying patients should not be understated in consideration of the waiting experience and patient safety and security (Padma, Rajendran & Lokachari, 2010; Strasser et al., 1995). A number of those interviewed expressed their appreciation at having the assistance of a patient's carer in an emergency situation.

When they come, I'm so happy to have someone with the patient, because when the patient is not saying anything, you can get information from the relatives or from their loved ones. But yes ... I just love to talk with the relatives because you [get to] know more, a little more about the patient, than from the patient sometimes. Because maybe due to vomiting, the patient is carrying on vomiting or unable to say anything, so I get quick information on the patient ... (Interview)

I mean if you have an ethnic background and you don't speak English, you need to have someone there to advocate for you and you need to make sure that that person can advocate, has that power to do so, so sometimes you need that situation. (Interview)

However, it was also apparent that at times the addition of family members made the task of treating the patient more difficult:

I think often the loved ones are trying to speak on behalf of the patient and the patient might not be telling the right story according to the relatives or the carers; they butt in often, but yeah, that can be difficult at times because we do want it from the perspective of the patient. (Interview)

The multicultural settings for several hospitals meant that staff have been regularly engaging with patients and others for whom English was not their first language or who were non-English speaking:

I mean of course the ones that don't speak English pose problems which is a daily occurrence here. But you learn to deal with that and you learn your own way of communicating with people who don't speak English. (Interview)

Caring for carers as well as patients requires meeting emotional as well physical needs. The sadness of a father who was not allowed to see his very ill son presents a particularly vivid case:

The older man is very, very agitated. He says, 'But I'm the father! The father! The child ...' He leans forward and talks urgently through the window, and I can no longer understand what he is saying. The emergency clerk indicates to him that she will ask and advises him 'but he's still in the ambulance bay'. She leaves the emergency clerk area and goes to the ambulance bay. She returns very soon afterwards, and tells him that the answer is no, as the child is 'not yet responsive'. The father is now very, very upset. He beseeches her to let him see his child, saying, 'I'm not having a go at you! I am a father. Your job is a hard job, I understand ... but I am a father! A father!!' His knuckles are white where he grips the bench, and his shoulders are shaking violently. He is terribly, terribly upset. He repeats, leaning close, 'I'm the father. That's my job! I understand you're doing your job. I'm doing my job!!' The emergency clerk tells him to calm down. He shouts back at her, his voice breaking, 'I can't just calm down. I'm the father.' He is weeping openly, unashamedly. (Field notes)

The engagement of those who accompany patients can at times improve staff and patient experiences. Recognising and advocating the roles of carers, family and friends can support the patient in the ED, and in some instances such roles will be critical to patient treatment and safety, while simultaneously offering emotional care and support for the patient (e.g., Stuart et al., 2003).

## **Culture, language and health literacy**

ED staff have an important responsibility to communicate effectively with patients from diverse backgrounds. This is not an easy task when, for example, people are of non-English speaking backgrounds and have low levels of health literacy. The taking of a patient's history takes time, particularly if that patient is badly injured, elderly or comes from a non-English speaking background, and time is a precious commodity that can be easily compromised. As one doctor put it:

In certain groups like older people, if you try to rush them they get a bit flustered and that can actually be counterproductive. People with different cultures as well can be a bit harder to communicate with. And so things that are limiting communication to patients are time pressures if you're a doctor ... distractions and other things that are coming in are [also] getting in the way. (Interview)

The quality of communication in the patient journey affects patient health outcomes (Stewart, 1995). One nurse reported that in some instances patients did not

understand the explanation that a doctor provided and so she would either explain to the patient what the doctor had said or she would let the doctor know that the patient hadn't understood and encourage the doctor to make the explanation more clearly:

I've seen it many times where ... the doctors ... they've gone in and done their big splurt and the doctors come out and the patient's gone 'I don't know', and you go back in there and you need to explain in English. (Interview)

Given the sometimes highly anxious and at times potentially volatile nature of the EDWR, it is in the interests of staff to foster and encourage patients and their carers to be understanding of their situations. This can be done by keeping patients and others in the EDWR informed about their progress and wait, and may be especially important for children, the elderly, those from non-English speaking backgrounds, and those with low health literacy.

*[A] man with a bandaged finger comes to the TN window. I hear the words 'cut glass' as he indicates the length of his finger with his other hand. He's clean, casually well dressed and behaves very civilly. He has his Medicare details and all other necessary documentation. He seems very calm, much in control of his situation. He then moves to the clerk's window and completes the administrative processes.*

*I reflect that he's doing it all 'like he's supposed to': he has his Medicare card at hand, he's gone to the correct window first, he's clear and concise and polite – orderly and well prepared. He either knows the protocols, or perhaps he has been here before and/or reads signs very well. I guess that the ED staff would most certainly desire patients to behave in a particular way, much like this man ... After being triaged, he moves to the other side of the room and sits down and takes out a folder and some architectural drawings and maps and after putting on a pair of spectacles starts to rifle through them.*

*He is called in to the clinical initiatives room by the TN who uses only body language and eye contact to instruct him where to go (a nod of the head, raised eyebrows, a sideways tilt of the head and a hand signal). It's all very fluid, this interaction. (Field notes)*

The experience of being a patient is different. The degree to which people feel vulnerable is also reflective of their level of social competence. Social competence is built up over time and influenced by level of education, proficiency in communicating in English, socioeconomic status, cultural background and one's sense of self. For those people who are on the margins of the mainstream for whatever reason, the inequalities that underpin their lives have an impact on their role as an ED patient but also on their treatment outcome (Betancourt et al., 2003; Nutbeam, 2008; Paasche-Orlow, 2004). Cultural and linguistic barriers in hospital encounters reduce communication effectiveness and trust between staff, patients and others, and impact negatively on patient satisfaction and health (Betancourt et al., 2003; Nutbeam, 2008).

## **Patient Comfort**

Staff described their frustrations about the amount of time that people had to wait and their inability to do anything that would help speed up that process. It was a commonly expressed concern that the EDWR was not large enough to adequately cope with the number of patients presenting and that there were too many occasions when the EDWR was overcrowded. Staff also said that the shortage of beds in the wards and the availability of staff there to care adequately for ED patients negatively impacted on the time it took to process patients through the ED, which subsequently had the effect of filling up the beds and increasing waiting times:

Because of the shortage of, I think it's, it's space in a way on the wards. But it's also, the fact that you can't take people upstairs [to the wards]. I'm saying you can't take people upstairs who are sick because they ... don't have adequate care. So they sit round and they wait a long time in the Emergency Department which then backs up everything else ... it's hard to get things moving ... another thing with a lot of guidelines which the, the range of observations patients are allowed to have is even tighter ... (Interview)

At one hospital, the atmosphere in the ED was observed to swing from control to chaos in response to surges of patients and companions. At one stage at an EDWR, 58 people were observed sitting, standing or wandering about. It was sometimes difficult to discern patients from companions and other visitors. There were insufficient chairs in the triage waiting area and the EDWR area generally. Many people stood or leant against the wall or the glass next to the entrance doors. During one observation period a patient was observed asleep on the floor. At all hospitals, regardless of their size, a lack of space and seating for patients and those accompanying patients was observed and was also highlighted during interviews with staff. As several staff commented:

When it is full you will have people standing around and it's quite hard [be]cause some people will just sit there and not move, and you have other people that really should be sitting down. And there's lots of relatives as well because of the culture. (Interview)

It's tiny. It's crowded. It's not very nice. It's boring. (Interview)

Sometimes the waiting room can get so full that there's standing room only or people resort to sitting outside. (Interview)

It's way too small ... Trying to move in between the chairs is very difficult for people when they're not well. It's hard to manoeuvre wheelchairs. (Interview)

That space is certainly the biggest issue for me and probably for most nurses that work there. It makes it very difficult to treat. (Interview)

Such overcrowding is undesirable for a range of reasons: it compromises the relative comfort of those waiting; it constrains the movement both of medical equipment by staff and of patients in their access to seating and entering and exiting the room; it can contribute to the creation of tensions and stress between those waiting; and it is potentially detrimental to the safety and security of both staff and patients.

Complicating the wait is uncomfortable seating in the EDWRs. The seats provided are generally not conducive to the comfort of patients, especially large patients or those with injuries; nor are they conducive to the comforting of patients by others, or of those who are feeling particularly ill or tired. The seating is not arranged with any clear reasoning except in the case of one hospital which used a colour-code system for seating patients who have been triaged as opposed to those waiting to be triaged. The system failed on occasions when family members and others accompanying the patient sat in the chairs or those waiting to be triaged sat elsewhere (also see chapter 4). As one of the quotes above suggested, the frequency of patients being accompanied by a large extended family is an issue that should be taken into consideration at hospitals where a high percentage of patients present from a diverse range of cultures. The following comments from staff highlight such factors:

It's not designed that they are going to be sitting there for hours and unfortunately they do. (Interview)

We probably are in dire need of a redevelopment, and a re-jigging of the space. (Interview)

We need a separate area for children ... the facilities out there are pretty poor for people waiting. (Interview)

At one hospital communication between a doctor and patients outside of the hospital led to increased demand and waiting times at the ED, and complications in the management of the EDWR:

On several occasions when the EDWR was relatively full at one hospital, a nurse came out to give updates on how long people could be expected to wait. On one occasion this was done on a Monday morning when most of the people in the EDWR were not ED patients but rather patients of the attending ED doctor. These people had been advised that they should attend the ED at 9 am where they would then be seen by the doctor but a number of these people, not surprisingly, had interpreted this as the time the doctor would actually see them. These patients were generally elderly, a few of whom waited several hours before being seen; some resigned to their wait, but others grew impatient and dissatisfied, and perhaps for a few the wait was totally inappropriate given their age and frailty. Some looked physically worse due to sitting on uncomfortable chairs for so long. (Field notes)

A woman in her early 20s comes out of the emergency department, accompanied by a nurse and by her grandmother. She is staggering and has obvious discomfort/pain. The nurse asks her to sit in the waiting room area until a [doctor] can call for her. The young woman has got a hand cannula in. The nurse asks if she would like a vomit bag, but the woman says no thank you. The nurse helps her sit down. The young woman is very pale and has a slight sweat on her skin. Her grandmother sits next to her. The young woman tries to curl up against her grandma; her grandma strokes her back and tummy. But the young woman can't get comfortable. She eventually clambers half onto her grandma's lap and lies across two armrests, her head dangling, seemingly uncomfortably. Her grandmother strokes her tenderly and holds her on her lap, although I can see the young woman's knuckles are white where she is gripping her grandmother's back. (Field notes)

The quality of maintenance of the EDWR and ancillary facilities varied among hospitals. One hospital was clean and tidy and at various times during the observations the cleaners were seen cleaning the toilets and the EDWR. One particular cleaner was noted for the care and meticulous and diligent effort applied when cleaning the waiting room. At another hospital it was observed that:

The gents toilet ... is not in good shape. The floor is very wet, the bin is full of paper (loo paper?), some bits covered in blood. There is one small urinal, one stall and a stall for people with a disability. There are three sinks, with one tap on one sink broken – no handle. The soap dispenser is not working; the hand dryer is not working ... Need to use loo paper to dry your hands, after using a separate disinfectant bottle to wash hands. The spray from this goes everywhere when you press. I walk in after the cleaner comes around and nothing seems to change – the bin is full all the time, and broken equipment is not fixed during our five observation sessions [over a period of seven days of observing]. (Field notes).

At another hospital an interviewee noted that:

If you come in the morning at 7 o'clock and go into that waiting room, it's disgusting. My staff try not to go out there because you're by yourself a lot, but in the morning there's tissues stuck everywhere, there's just food and everything all over the floor. It gets cleaned. People don't wash their hands, we don't have toys because a lot of kids suck on toys and there's transfer of viruses and things that way. (Interview)

Although toys were not permitted in the EDWR at one hospital, at another hospital a kitten was permitted:

Two tall ... women come in, one of them carrying a fluffy kitten. They're [the women] dressed in ... brilliant peacock colours. They take their seats on either side of a young ... man who looks somewhat poorly and is carrying a sick bag. He cheers up considerably as the women converse, loudly and cheerfully, nestled close against him, as the kitten ambles back and forth across their laps. They are very friendly to each other. There are seven people in the waiting room ... Well, seven people, and a very small cat. (Field notes)

At two hospitals it was observed that the EDWR gets very hot during the day (observations occurred in the summer months). The temperature could potentially have an adverse effect on patients during their wait:

I know sometimes in summer here it can get quite hot in the waiting room and particularly if it's busy; and when the sun beats down there, I've noticed that when I've gone out to assess patients it's hot. (Interview)

It's a lot worse in the summer because it does get very hot in there. I've been a patient in there myself, waiting, and you can see everyone sitting in there, eyeballing you whenever you move off your chair. They all look at you, I'm next, pick me, pick me! It's not the best of waiting rooms ... and yes it is quite stuffy. (Interview)

All four of the hospitals provided food and drink for patients and those accompanying them either through a cafe or by vending machine. In two of these hospitals, access to such services is more readily available. At one hospital there is easy walking access to food and drink, as well as vending machines, but the sale of food at the cafeteria is limited to normal working hours. The availability of food can, however, present a problem with regard to patient care:

Depending on what people present for you can't, you know, offer even food or water sometimes because you don't want them to eat or drink and that's why they don't have vending machines in most emergency departments.

The presence of food and its desirability in the ED highlights just another of the inconsistencies observed across the four EDWRs.

Ayas et al. (2008) identified a range of factors that promote calm, and discussed the importance of relaxing, pleasing and arousing environments to patients (see chapter 2). The EDWRs at which data was collected for this research were in all except one case poorly designed by contemporary standards and inadequately equipped and resourced to meet the needs of patients, those accompanying patients, and staff.

## **Patient and Staff Safety and Security**

Chapters 1 and 2 referred to a sample of reports that raised concerns about the management of EDWRs and its relationship to the security and safety of staff and patients at the hospital. Two hospitals in the current study indicated there was a difficulty in visually monitoring the EDWRs:

The way the camera is in the emergency room, you can't see too much ... Also just the doors with the emergency room, how it's mirrored and then plain, you know, the lines. You can't see too much out there ... it's not the best. (Interview)

We can't see who is out there. You can't see what's happening. You don't know who is there. You don't know when they come. I find the day shift [staff] don't even tell you you've got people there. For example, I went out there today, there's a man, and even with the camera you can't see that side, so I didn't even know he was out there. [He'd] been out there for an hour. It's terrible ... And being here by yourself, you're meant to be, you know, triaging, you're meant to be treating out the back. You just don't have any clue what's going on out there. (Interview)

There's a few little spots where you actually can't see everyone in the waiting room when you, when you're sitting at the triage desk ... if you're the only person on, you sort of need to be able to see everyone and make sure no one's collapsed in the waiting room and you can't always see people in the back corner and if it's really busy you can't get off your chair to go and have a look because you've constantly got people coming in needing triaging. (Interview)

At one hospital, it was not unusual for nurses, either individually or as a pair, to be left alone with patients or be required to admit patients to the hospital after hours with no immediate support from security. At that hospital security is employed through an outsourced company whose staff roam other facilities and businesses apart from the hospital, and thus are only on hospital grounds for very brief periods of time unless called. This lack of on-site security at

the hospital has created a sense of insecurity in staff, particularly during night shifts. Several staff noted that they felt ‘very isolated’ and even ‘fearful’ at night. Moreover, although a CCTV camera is located in the EDWR, the camera does not provide visual access to the entire waiting room. The television screen that staff have access to also ‘flicks’ across each of the cameras in the hospital, meaning that staff get an intermittent rather than constant stream of visual information about the EDWR.

In stark contrast to the above situation, at another hospital the EDWR was under constant surveillance from security staff whose office was adjacent to the entry area. A one-way window enabled security staff to keep the waiting area under constant scrutiny. Inside the security area, four CCTV screens enabled staff to monitor the hospital entry and exit points. Due to the configuration of the space, the clerks also were able to keep the EDWR under constant observation, and the people waiting could ‘feel visually connected’ to these staff. So perhaps for patients and others in the EDWR the feeling of being forgotten about that seemed to occur at times at other hospitals appears less likely to happen here.

Safety and security issues are also exacerbated by the reduction in nursing numbers during night shifts. Some nursing staff at one hospital pointed out that the gardens situated near the entry to the EDWR and other surrounds become potentially hazardous at night because they are not well lit, and people could potentially hide in them. There is a perception among staff at this particular hospital that the local community is trying to cope with a major drug problem and that the misuse of drug and alcohol creates further stress on nursing staff and can, at times, compromise their feelings of safety and security. One nurse explained how she knows when a drug dealer is in the town:

... when the drug runners come and drugs are newly available in town, a signal is given by gunshot or crackers. That way, users know that a fresh supply of drugs is available. Depending on the quality of the drugs there is often a surge of presentations at the ED afterwards. (Field notes)

It has been acknowledged that staff safety and security affect communication and work performance in health settings (Colling & York, 2010), and that in the design of health care facilities visibility from control points is critical to patient and staff safety. However, this study has revealed that the ability of staff to adequately view and appropriately manage the EDWR is sometimes greatly compromised; at times staff cannot see what is happening in the EDWR and cannot monitor patients. These situations pose significant threats to patient and

staff safety and security. In at least one hospital, this situation is, as Barach et al. (2009) observed, having a substantial effect on staff efficiency, morale and stress.

## **Conclusions**

The observations, interviews and informal interactions with staff have shown that most staff in all four hospitals showed empathy and genuine care for the people they were treating. However, they were often constrained by the limitations of working in a stressful environment characterised by inadequate human resources, poorly designed facilities and general lack of community knowledge and understanding of triage processes and broader ED systems. Many staff coped very well given the stresses of their current working environments; however, more could be done to ensure that staff are better supported in their workplace, both in terms of adequate staffing, and also in emotional support to assist staff given the often traumatic nature of the experiences they encounter at work. The study highlighted many exemplary attitudes and a good understanding that staff had about the role of communication with patients and those accompanying patients. Many examples cited the willingness of staff to go out of their way to comfort and reassure those under their care, and the difficulties of providing the care they wanted to despite the constraints within which they were expected to work.

The observations and interviews revealed aspects of the patient journey that had been overlooked. The patient journey begins when an incident arises for the patient and for those accompanying them. This has a number of implications in the way that hospitals can promote and indeed interact with their community to assist the patient journey the moment an incident occurs. A patient's ED journey (and that of those accompanying them) is affected by their experiences of interrelated elements, including triage, waiting, comfort, relationships with staff and those accompanying them, communication with staff and others, the physical environment (e.g., seating), posters and signage, and other facilities of the EDWR. While many of the people in the EDWR may not be in need of urgent medical treatment (triage categories appear to be the only criterion on which people that attend the ED are assessed), their condition or age or other characteristics may warrant different levels and types of support (e.g., a recliner chair, a warm blanket, a more private place to grieve). That is, while the ED is designed to treat emergencies, it is clear that the community expects that they also treat them as individuals and in a manner that encompasses their physical, social and emotional needs. Given the rising expectations of patients, it is timely that the quality of service provided to patients and those who accompany them should be prioritised.



## Chapter 6

# CONCLUSION

The challenges facing EDs are extensive and varied. These challenges include a growing and ageing population, declining GP services, limited hospital resources, lack of access to inpatient beds, staff shortages, delayed or limited ancillary services, and safety issues. They also include what Kelly (2005, p.192) described as their requirement to function as part of the safety net for the healthcare system, and thus provide ‘care for the disenfranchised ... the mentally ill, and those who ... do not know how to access “routine” care’. Other research and the findings of this study reveal that most patients that present to EDs were not presenting with an immediate or imminent life-threatening condition. Previous research has also revealed that patients’ experiences with EDs ranged from high satisfaction to extreme lows (e.g., BHI, 2010a), while recent incidents in EDs had received widespread media coverage and led to extensive investigations, reviews and reports.

The study upon which this report is based was part of a larger scale project, which had two interrelated aims:

1. To increase understanding of communication and service quality in NSW EDWRs and identify potential improvements in the quality of emergency health services delivery; and
2. To develop delivery-ready education and training materials specifically designed to improve service quality, with particular reference to communication in EDs.

This report focused on the first aim of the study and addressed three key research questions:

1. What factors affect service quality in EDWRs?
2. What factors affect communication among ED staff, and between staff and patients and those accompanying patients?
3. How can service quality and communication in EDWRs be improved and better promoted and supported?

The findings of this study identified aspects of service quality and communication that impact on a patient's experience of and journey to and through the EDWR, and provided insights into how EDWRs are managed, the issues that affect the quality of waiting experiences, how people behave in the EDWR, where critical service breakdown points exist, and examples of good practice and potential improvements to service quality and communication.

The findings are limited and caution must be exercised in their interpretation. The study involved only four hospitals, and those hospitals were not randomly selected. There were limitations, too, in the gathering of primary data. In the first phase of data collection, observations were restricted to the public spaces of EDWRs and reception areas at each hospital, and the nature of the observation strategy meant that conversational data were limited to what the researchers could reasonably overhear. While observations were carried out across different times and days at each hospital, the total duration within which observations were made was a period of three months in summer. In the second phase of data collection, interviewees were self-selected and the degree of 'representation' across staffing roles varied from hospital to hospital. Therefore, the findings should be interpreted as case studies and not generalised to the population of NSW hospitals. Despite these limitations, very rich and detailed data were gathered. The richness of these data was due in no small part to the considerable support of staff at each hospital, who gave detailed accounts of their ideas, observations, feelings, experiences and challenges.

Focusing on service quality and communication, this study revealed there are potentially moderate to high risks of failure with respect to patient comfort, safety and security in the EDWRs that were involved. Despite the best efforts of staff who clearly articulated the difficulties and benefits of working in the health system generally and EDs specifically, the EDWR space and overall environment are, to varying extents at each hospital, inadequately designed, resourced and managed to meet the diverse needs of patients, those accompanying patients, and staff. Additionally, many staff experienced very high levels of stress and appeared to have varying degrees of access to counselling and other support services. There are times when patients and the staff working in EDs and the EDWR are physically and emotionally at risk.

The findings of this study support important evidence in previous research concerning health and hospital care and EDs (e.g., Garling, 2008; Hughes & Walters, 2007), and suggest that,

although significant problems relating to EDWRs in NSW have been previously reported, many have yet to be addressed. This study provides a critically informed platform to better understand and improve service quality, communication and patient health outcomes in hospital emergency departments, and especially emergency department waiting rooms. The recommendations in the following section (chapter 7) of this report are designed to assist the professional and committed staff working in EDs to achieve these goals.



## Chapter 7

# RECOMMENDATIONS

Except where references are made to specific staff positions (e.g., nurses; security staff), the references to and consideration of ED and EDWR staff in the following recommendations incorporate all clinical, administrative, technical and services (e.g., cleaning, security and maintenance) staff who engage with the ED and EDWR.

### **STAFF COMMUNICATION AND CULTURAL AWARENESS**

#### **Recommendation 1**

*All staff are engaged in processes to improve communication and cultural awareness within the ED at the individual, group and systems levels.<sup>i</sup>*

#### **Recommendation 2**

*Communication education and training programs should be developed and made accessible to all staff.*

#### **Recommendation 3**

*Clinical and administrative leadership should promote an organisational and service culture that fosters mutual respect and clear and open communication among staff within the ED and between the ED and other hospital departments/units.*

#### **Recommendation 4**

*Champions who promote communication and service quality should be identified and selected, and recruited if necessary, and appropriately trained.*

#### **Recommendation 5**

*Provide universal (and free) access to an email system for all hospital staff, and promote its use in order to improve communication across all areas of the ED.*

#### **Recommendation 6**

*Regularly review and evaluate information technologies that promote and support effective intra and inter departmental communication among ED staff.*

## **HUMAN RESOURCES AND STAFFING**

### **Recommendation 7**

*Appropriate counselling services should be readily accessible to all staff to help them cope with their experiences in the ED.*

### **Recommendation 8**

*Strategies and actions should be developed to support staff health and wellbeing, and should include staff wellness programs.*

### **Recommendation 9**

*Staffing levels for all ED related functions and services should be commensurate with patient demand and sufficient to allow hospitals to implement the recommendations of this report.*

### **Recommendation 10**

*During peak demand times hospitals must have the capacity and capability to balance patient demand and service quality for patients and those accompanying patients at levels commensurate with or better than prescribed standards.*

## **ED DESIGN & ENVIRONMENT**

### **Recommendation 11**

*The size and number of seats available in EDWRs should be increased to cater for patients and those accompanying patients presenting to NSW EDs. Seating should be comfortable and able to accommodate diverse needs.<sup>ii</sup>*

### **Recommendation 12**

*EDWRs should be designed, resourced and managed to promote patient and family centred care, provide a high quality of patient service, and ensure the comfort, safety and security of patients and those accompanying patients.<sup>iii</sup>*

### **Recommendation 13**

*All staff and relevant stakeholders should be regularly consulted on design, functions, operations and management of the EDWR.*

#### **Recommendation 14**

*EDWR design should encompass a comprehensive assessment of all aspects of the ED servicescape, including: room design; accessibility; seating numbers, comfort and layout; the use of posters and signs; décor; floor coverings; room temperature; lighting; mood and ambience; sound; smell; and entertainment, such as television and reading materials.*

### **ED PROCESSES – MONITORING THE EDWR**

#### **Recommendation 15**

*A process for all ED staff to maintain effective visual monitoring of EDWRs should be implemented immediately, and the ‘Between the Flags’ program should be adopted in all NSW EDWRs.<sup>iv</sup>*

#### **Recommendation 16**

*Responsibility should be assigned to an appropriately qualified staff member:*

- a) to manage the EDWR;*
- b) to communicate regularly and frequently with patients and those accompanying patients in the EDWR;*
- c) to monitor patient comfort and health;*
- d) to keep patients and those accompanying patients informed about why they are waiting, how long they will have to wait and what will happen next; and*
- e) to reassure patients they are being cared for.*

### **ED PROCESSES – TRIAGE**

#### **Recommendation 17**

*The reception and triage process should be communicated to patients. This should be done in a way that enables comprehension by patients with limited literacy and by those whose first language is not English.*

#### **Recommendation 18**

*At the point of triage the patient (and/or nominated carer) should be informed what triage category they have been assigned to and what this means for them.<sup>v</sup>*

### **Recommendation 19**

*A private triage area at the ED should be established to ensure the supply of facilities that give patients and those accompanying them, appropriate levels of privacy, confidentiality, support and comfort.*

## **ED PROCESSES – SIGNS AND POSTERS**

### **Recommendation 20**

*Signs and posters should be strategically located in the ED to improve dissemination of information to patients and those accompanying patients, and to promote people's understanding of triage and other health related matters.<sup>vi</sup>*

### **Recommendation 21**

*All signs and posters should be relevant to the ED and address health related matters, especially key aspects of patient care and the patient journey.*

### **Recommendation 22**

*Signage and posters should be current, clear and visible, and be designed to promote understanding by patients whose literacy is low and/or whose first language is not English.*

## **COMMUNITY AWARENESS AND KNOWLEDGE**

### **Recommendation 23**

*All ED staff should recognise that the patient journey begins well before 'walk in' or arrival at the ED.*

### **Recommendation 24**

*Implement strategies to inform the community about:*

- a) the location of and resources available at their local ED;*
- b) the roles of EDs in the community;*
- c) the relationships between the ED and other health services; and*
- d) the interrelated concepts of triage and waiting.<sup>vii</sup>*

## **PATIENTS' AND CARERS' INFORMATION & THE EDWR WAITING EXPERIENCE**

### **Recommendation 25**

*Inform patients and those accompanying patients about the patient journey in plain, clear and where necessary in multiple languages, and include references to such factors as waiting times and what will happen from the time they arrive until they are seen by a doctor.<sup>viii</sup>*

### **Recommendation 26**

*Implement strategies to promote patient and family centred care and to recognise:*

- a) that a patient's journey begins before the patient arrives at the hospital;*
- b) that a patient is a patient of the ED as soon as they enter the ED and for as long as they are engaged with the ED;*
- c) that regular monitoring and observation of and communication with patients and those accompanying them should commence as soon as a patient arrives at the ED; and*
- d) the impact of cultural sensitivity on communication and service delivery within the ED.*

### **Recommendation 27**

*Those accompanying patients are recognised as integral to patients' experiences, health and wellbeing. Nurturing, supporting and communicating with carers are vital actions before, during and after a patient's treatment at the ED.*

## **SAFETY AND SECURITY**

### **Recommendation 28**

*All NSW EDs should have 24 hour on site security to improve the security and safety of patients, of those accompanying patients, and of staff.*

### **Recommendation 29**

*Security staff should be clearly visible at regular and appropriate intervals within all NSW EDWRs.*

## Recommendation 30

*EDWRs should be designed to support emergency responses to calls from patients and those accompanying patients. Emergency buzzers, clearly labelled, should be installed in all EDWRs, hospital toilets and other amenities.*

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<sup>i</sup> Recommendation 60 of the Garling (2008) Report is endorsed. A number of other matters should also be considered in relation to the recommendation.

Training and education be available for staff to heighten awareness and sensitivity to issues associated with the potential diverse range of populations that present to the ED, and to develop a repertoire of skills, attitudes and behaviours that will enable them to deal more effectively and comfortably with members of these populations. Populations requiring special attention include: Indigenous populations; elderly; people affected by drug and alcohol use and addiction; people presenting with mental health issues; people from different cultural and religious backgrounds; patients and others from non-English speaking backgrounds.

Communication education training programs should be developed and made available to staff in formats or modes of delivery which not only support learning in traditional courses of study, at levels from vocational to postgraduate degree, but which also do not require substantial investments in time outside of the workplace. These programs should be made available for staff to engage with during work hours, especially in periods when there is high staff capacity (low relative patient demand) in the ED.

All patients should be called into treatment areas in a personalised and standardised way, preferably by personal invitation. Protocols should indicate that in periods of low staff capacity and/or high patient demand staff time is constrained, and hence set minimum standards for engaging with patients and those accompanying patients by appropriately qualified staff.

<sup>ii</sup> Additional seating should be provided to cater for patients and others who accompany them, including extended family members.

Install comfortable seating (e.g., adequately padded) in all NSW EDWRs.

The EDWR should provide seating that accommodates all patients and others who are of greater than average height and weight, who would like physical contact with their family, friends or carers, who have mobility and movement restrictions, or who simply may need to lie down.

<sup>iii</sup> EDWRs should be designed and managed to promote patient comfort, health and wellbeing. The EDWR environment should promote positive emotional responses and behaviours that reduce anxiety for patients. Consideration should be given to temperature, lighting, décor, accessibility, access to refreshments, water and clean toilets, removal of clutter within the EDWR, and the installation of chairs that are comfortable for sitting or lying down for substantial periods of time, and that allow for contact and closeness between patients and those accompanying them.

Install art, especially artworks by Indigenous and local artists. Artwork could be rotated on a regular basis by invitation and opportunities to promote local artists explored.

A range of 'entertainment' options should be made available for patients and their carers in the EDWR. An appropriately located TV that is visible and audible for those that wish to watch TV; reading materials in the form of recent magazines and newspapers; mind puzzles, such as crosswords, word or number games; games or puzzles; patient-education resources; and refreshments.

People feel a sense of satisfaction if they feel as they have mastered something or gained and demonstrated knowledge. Consideration could be given to developing ways for patients and others to 'test their knowledge' about health rather than simply read a brochure or look at a poster on a health matter.

People's waiting experience can be made more bearable if they are occupied. Clearly, those people who are in pain or some other form of discomfort probably just want to feel as comfortable as possible, but for a large proportion of those waiting, their wait could be improved through occupying their attention and distracting them.

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<sup>iv</sup> The applied concept of ‘Effective Scanning’, used by the Surf Life Saving Association (SLSA), is recommended. In this way EDWRs would be actively managed by staff such that no EDWR and its immediate facilities (e.g., toilets) would be left without a thorough visual inspection for an appropriate period of time (e.g., 15 minutes or as determined by health managers and specialists). The concept of ‘effective scanning’ is considered by the SLSA to be the underlying principle of surveillance and prevention. The key principles of this system, adapted for EDWRs, could then be:

- ED staff are whenever possible positioned so they can maintain clear, unobstructed lines of vision
- Staff should move to counteract interference by patients and other staff in order to minimise any obstructions to their visual surveillance
- Scanning strategies compensate for being unable to see areas of the EDWR, and for their distance from the activity of patient carers
- All staff are trained to develop their perceptual skills
- All staff understand the signs of potential trouble and the characteristic behaviours of those in need of help
- Staff are rotated at regular intervals as fatigue and other factors may reduce their effectiveness after a length of time on scanning duty.

<sup>v</sup> A laminated card could be given to patients and their carers clearly showing each of the five triage categories and giving examples of the kinds of conditions associated with each. The nurse would then say which category the person has been assigned to and point to that category on the card and explain what that means for them in terms of waiting time.

It should be made clear to people entering the ED that if someone is assigned a higher category, that new patient, regardless of the timing of their arrival, must be seen before them. If a patient has been triaged as category 5 it should be suggested that they might alternatively see a GP. If it were possible, the administrative clerk could contact local GP clinics to see whether any could see that patient and/or provide a list of local GP clinics and their opening hours.

The triage nurse should inform patients if they are able to eat or drink during their wait in EDWR.

<sup>vi</sup> Produce a sign that informs people that the priority of the ED is to treat emergency conditions first, but that patients waiting in the ED will be seen as soon as possible.

Signs could be produced that not only list the five triage categories, but also use well designed and consistently applied illustrations to demonstrate to patients and visitors typical examples, rather than rely on text alone. Triage category 1, for example, could be shadowed by an unconscious person being resuscitated. In contrast, triage category 5 could display a patient with an arm in a sling and sitting in a chair in a waiting room reading a newspaper.

Signage also should assist patients and staff by providing clear, unambiguous information and directions. In particular:

- All signs and notices should abide by the guidelines stipulated in *Practical steps to improving Emergency Department signage* (NSW Health, September 2008)
- All ED signage have a clear purpose aligned to ED structures, functions and operations
- All signage be concise, clear and legible and as prominent as needed
- Signs use language that contains no jargon and wherever possible be reproduced in multiple languages representing multicultural populations dominant in immediate service areas
- A ‘Welcome to the Emergency Department’ sign that greets people as they enter the ED should be installed in EDs
- Signs in the EDWR be reviewed and regularly updated (e.g., monthly) by appropriate staff
- Hospitals should have clear guidelines as to how signs are authorised, designed, constructed and located
- LCD screens or electronic message boards should be installed in all EDWRs to present information to patients and those accompanying them about staff in the ED, general waiting matters and any unforeseen events impacting on the functions and operations of the ED generally.
- An “On-Duty Board” (electronic or wall mounted board), similar to McDonalds’ signage that tells customers the key staff on duty at any time during their opening hours, should be installed. An electronic board would be easier to maintain
- Communication should be displayed in the various languages most likely to be encountered at that EDWR
- *MyGP.app*., an iPhone/iPad application, could be written to allow patients and those accompanying them to locate their nearest GP or medical centre and provide useful information about these (opening times etc.)

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- All signage should be instructive and positive rather than negative in tone. ‘Yes you Can’ signs rather than ‘No you Can’t’, create a more positive environment and reinforcement of actions and behaviours for those attending the ED
  - Installation of clear ‘pathway’ signs for the ED, such as parking, drop-off and pick-up, entrance, etc.
  - Signage relating to the use and non-use of mobile phones by patients should be reviewed to allow mobile phone use in places where their use is practicable.

Posters support the dissemination of health-related information and should be regarded as temporary. In particular:

- Only posters that are aligned to health related issues should be presented in the EDWR
- All irrelevant signs should be removed
- All posters should be concise, clear and legible, and be as prominent as needed. They should use language that contains no jargon (or adequately explains jargon) and wherever possible be reproduced in consistent formats and multiple languages representing multicultural populations dominant in immediate service areas, as well as taking into account those with low levels of health literacy
- Hospitals should have clear guidelines as to how posters are authorised, designed and produced
- Posters should be thoughtfully and carefully displayed in a prominent and prescribed position
- Posters and leaflets should not be used on glass panels or displayed in ways that will obstruct views of the EDWR.

vii Recommendation 117(d) of the Garling report is endorsed. Suggestions include:

- The meaning and the process of triage should be widely disseminated in the community to further promote understanding of triage in order to better manage people’s expectations, particularly with regard to treatment and waiting times
- Appoint a dedicated “Community Engagement and Information Officer” and assignment of a portfolio of hospitals to that Officer to facilitate public communication strategies concerning EDs in their portfolio
- Regular column (monthly) in local free newspapers (TED@[name of hospital]) in a range of languages. Topics could include explanations of medical procedures, health related matters, current hospital initiatives, explanations of key concepts such triage
- Regular Community and ABC Radio (monthly) discussions, during which a dedicated staff member presents a 15 to 30 minute discussion on an ED issue linked to regular newspaper topics. Presentations could include explanations of medical procedures, health related matters, current hospital initiatives, and discussion of key concepts such triage
- Annual letterbox drop of brochures or flyers or fridge magnets, explaining in simple, concise language the concept of triage and what to expect at the ED
- ‘Your ED Newsletter’ produced twice a year and which would include, for example, staff ‘stories’ and patient ‘stories’. Can be a small folded newsletter that reinforces critical information about the ED and its purpose. The Newsletter could be published in a range of languages and could be linked in with the letterbox drop (see above)
- Conduct of an annual children’s competition which invites them to produce an item that increases their awareness, and that of their friends and relatives, of the ED’s role in the community. This could be facilitated through an essay or drawing competition and be linked to and supported by local schools
- ED BBQ – run by local community club(s) (e.g., Lions, Rotary, hospital auxiliary, local ethnic club). An ED staff member be invited and available on site to promote and provide information about the ED and the role of ED in the community. Brochures and fliers (e.g., those proposed for the letterbox drop) could be distributed
- Establishment of an ED Community Advisory Group (EDCAG) that includes local community leaders and staff from the ED and other departments within the hospital. The EDCAG to meet regularly and report to the hospital board
- Establishment of a Schools Education Program to inform children and families about the ED, the EDWR, and the concepts of emergency and triage. A dedicated and trained staff member could have this activity incorporated in their workload
- Sponsorship and fundraising from local clubs and organisations to support development of ED facilities and resources and promote connection with the wider community
- Implement online technologies that can be accessed by the community to increase awareness of the ED and improve intercultural communication across the community. Examples could include a *YourED.nsw.gov.au*: a web site dedicated to providing useful and pertinent information about EDs across the hospital sector, and presented in a range of different languages.

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- The development of an ED Island in ‘Second Life’ could be used to help educate patients online about the ED patient journey. Examples of medical applications are available at: <http://sciencerooll.com/2007/06/17/top-10-virtual-medical-sites-in-second-life/>

<sup>viii</sup> In addition to verbal communication with ED staff, ways of disseminating this information include, but are not limited to:

- Development of a single sided brochure/flyer (produced in multiple languages) with a brief and simple explanation of the triage process which is given to patients by the triage nurse or clerk and which acknowledges that nobody likes to wait for long periods, explains the triage process and why patients might have to wait longer than they would otherwise care to, and provides reassurance that patients are valued and supported and will be seen according to their triage category
- Use of a ‘WR Buzzer’ which is given to patients after they have registered. Once the language of origin is ascertained, an electronic insert is placed in the front/back of the buzzer. The ‘WR Buzzer’ activates when a doctor or nurse is ready to see the patient. This enables information (in the right language) to be given to those waiting. All patients can thus also be contacted even if outside the EDWR
- Translation machines could be made readily available at reception/triage. Once a patient’s preferred language is known, these can be used to communicate basic information between the patient and ED staff and, if necessary, those accompanying the patient.



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