Emergency Department Patient Experience:

Improving Patient Perception of Being Informed About Delays

Deryn Peck Milarezi

University of San Francisco
Abstract
This project took place at a level II trauma center in Northern California. The goal was to improve patients’ perception of being informed during their Emergency Department (ED) stay. This could be the most significant factor effecting overall ED satisfaction. Financial ramifications for increasing patient satisfaction in the ED include Centers for Medicaid and Medicare Services reimbursement, community reputation, and staff retention. Through unit assessment, interviews with key stakeholders and observation it was determined that there are three main root causes: Process, staff, and patient perception issues. Each issue was addressed by the implementation: Creation of a standard guideline, staff and new hire education, ICARE and Key Word reminder cards, and development of an ED Overview Patient Handout outlining the overall ED treatment process. Pre implementation data suggest that patients felt informed during the beginning of their stay but became less informed as their stay progressed which correlates with front heavy staff interaction. Both pre and post implementation data suggested that patients thought a handout would be beneficial with 75% finding the ED Overview Handout helpful. Only 17% of patients saw the Handout and although 82% of staff claimed they used the Handout in practice, 0% of patients said that staff pointed it out to them. These results suggest the Handout is beneficial however there is a need to promote staff use. The percentage of staff that used ICARE and Key Words in their practice currently or would incorporate them in the future was 64% and 82% respectively. A sustainability plan including repetition of staff education and further assessment was presented to the department director and the ED Improvement Team. It is projected that Press Ganey and HCAHPS scores will improve in the coming quarters.
Emergency Department Patient Experience:

Improving Patient Perception of Being Informed About Delays

Emergency Department (ED) patient perception of long wait and throughput times have a significant negative effect on overall patient satisfaction scores (Elmqvist, Fridlund, & Ekebergh, 2011; Perez-Carceles, Gironda, Osuna, Falcon, & Luna, 2010; Press Ganey, 2010; Press Ganey 2011; Sherrod & Brown, 2005; Taylor & Benger, 2004; Taylor, Kennedy, Virtue, & McDonald, 2006). Although waiting is negatively correlated with patient satisfaction, it has been shown that keeping patients informed throughout their stay can significantly mitigate lowered overall scores and may in fact be the most important indicator of overall patient satisfaction (Press Ganey; Appendix H). If patients feel they were kept well informed about delays, overall satisfaction scores can remain in the high ninety percent range even if patients are spending over 6 hours in the ED (Bourd-eaux & O’Hea, 2004; Press Ganey). It is important to note that patient perception and ED employee perception of delays are often not in sync. Patients often arrive at the ED with unrealistic expectations, thus perceiving delays in the general overall ED process. Since fifty percent of hospital admissions come directly from the ED (T. DeLaMontanya, personal communication, February 25th 2013) and ED patient experience sets the stage for the entire hospital stay (Press Ganey; Sherrod & Brown), it is crucial that the ED patient experience is a positive one.

Meeting the needs of our patients and keeping them satisfied is at the heart of the nursing profession and there are more tangible reasons that patient satisfaction is important as well. Increased patient satisfaction scores are correlated with improved clinical outcomes and the likeliness of patients to refer their friends or family members to the hospital (Press Ganey, 2011). Additionally it has been shown that increased patient satisfaction is associated with improved staff satisfaction, patient compliance, decreased utilization of medical resources, increased
likeliness to seek further care, less malpractice litigation, and fewer complaints (Perez-Carceles, et al., 2010; Sun et al., 2000; Taylor & Benger, 2004; Taylor et al., 2006). Furthermore, beginning in FY2013, Centers for Medicare and Medicaid Services will begin withholding 1% of their payments to hospitals as part of their Value-Based Purchasing Program, increasing to a total of 2% withholding by FY2017. Hospitals can potentially recapture all of their withheld percentage with an additional percentage added for having exemplary Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Contrarily, if hospitals score poorly as compared to their counterparts and fail to improve on their own scores, they stand to lose as much as the total withheld (Brooks, 2012; Centers for Medicare and Medicaid Services, 2012). There is more motivation than ever for emergency departments to improve their patient experience thus improving the overall hospital experience, raising HCAHPS, and increasing reimbursement.

**Hospital Demographics**

This project took place is a 572 bed, not for profit hospital serving a population of approximately 233,113 (+-3%). It is the only level II trauma center in the surrounding area (Health Care Atlas, 2010). According to an audit of Contra Costa County (CCC) done by Health Management Associates (2011), 12.1% of the population is enrolled in Medi-Cal, 2.4% in other public programs, and 13.6% are uninsured. In 2009, 17% of hospital discharges in CCC were paid by Medi-Cal, 33% by Medicare, 43% by private, 3% were Self-Pay, and 5% were other methods. Only 3% of county Medi-Cal patients were served by this hospital and there is a significant potential for increase in income in terms of payment for healthcare. Although, this hospital serves the greatest proportion of county residents, 84% of residents are taking their business elsewhere (Health Management Associates). There is great room for gains in patient
volume and financial returns if the patient experience is improved resulting in an improvement in community reputation and an increase in word of mouth referrals and return clients.

**Rationale**

**Root Cause Analysis**

After assessing the current state of the ED microsystem it was determined that there are three main categories at the root cause of patients feeling uninformed about delays: Process issues, staff issues, and patient perception issues (Appendix A). There is a need for a standard guideline (Appendix B) and staff education on patient interaction, as there is great variation in staff communication methods.

Unless a patient has previously experienced the ED they are unaware of the process and often have unrealistic expectations on the timing of stay and course of treatment. It was observed that patients’ perception of being informed changed as they moved through the overall ED care process. At the beginning of the stay there is a large amount of patient-staff interaction with a significant amount of new information being provided to the patient. This is a time when patients are under higher levels of stress and less receptive to new information (Marty, Bogenstatter, Franc, Tschan, & Zimmermann, 2013). Once the initial assessments and diagnostics are complete, patients have been reassured that their physical concerns are being addressed and their stress levels generally decrease. Once calmer, they begin to have questions. Repetition of what was initially shared coupled with new information on the patient’s current status is necessary at this time and is not consistent across the department. There is an ED information pamphlet but it is not given to patients, was not found particularly helpful by patients, and has incorrect, conflicting information on possible wait times for diagnostics.

Intrinsic to the ED, patient volumes and acuities fluctuate, often stressing staff to their maximum and making returning to inform stable patients a lower priority. Due to this
fluctuation, staff must work as a team to provide care to every patient. Furthermore, as diagnoses and treatment plans are determined, the patient’s care is also in flux making any lapses in communication detrimental to the team’s functionality and the patient’s receipt of information.

**Methodology and Pre Implementation State**

Data collection consisted of staff and patient surveys (Appendices I, J), direct observation, unit assessment, and department Press Ganey quarterly and annual reports. In observing staff interactions with patients, 41% of staff introduced themselves when entering a patient’s room, 52% explained what would be happening next, and only 0.03% of staff asked if there was anything else the patient needed before they left the room (Appendix C). Data suggested that staff and patients both agree that verbal explanation of the treatment course is the best form of communication (Appendix D). Patients found the idea of using the whiteboards or a handout with process and timing information helpful while staff believed the implementation of such tools would increase charting requirements and further inhibit their ability to be at the bedside informing patients and performing patient care (Appendix D).

It was important to retrieve data from several sources to reduce self reporting bias. Many of the staff members interviewed felt they understood what would be best for keeping patients informed and what was causing the deficit, however the evidence-base and data collected failed to back up many of the claims. Also of importance is the presence of a specific perspective of each of the interviewees as compared to the great variety of perspectives from each of the disciplines and patients. It was valuable to take into consideration staff opinions of the feasibility of proposed interventions as each intervention requires commitment from all of the disciplines and helpfulness to the patient. It became easy to rule out several of the proposed interventions based on staff and patient feedback.
Cost Analysis

Cost of implementing this project is negligible. Printing and lamination were the only costs and came in under $200. Education was performed by a student at already scheduled staff huddles, staff meetings, and in brief hallway talks adding no labor costs. Standard guidelines will be distributed by email and located on the intranet also without any cost. The savings this project stands to generate far outreach the total implementation cost of less than $200.

There are many difficult to quantify costs associated with patient satisfaction. We know that patients who are admitted to the hospital through the ED are less likely to be satisfied and less likely to refer others to the same hospital (Press Ganey, 2011). We also know that unsatisfied patients are more likely to file malpractice suits and seek care elsewhere in the future (Perez-Carceles et al., 2010; Sun et al., 2000; Taylor & Benger, 2004; Taylor et al., 2006). Loss of revenue from a reduction of patient volume due to poor patient return rates and poor community reputation is difficult to quantify and could be significant. Additionally, happier patients are associated with happier staff thus reducing turnover and the cost of training new employees (Perez-Carceles et al., 2010; Sun et al., 2000; Taylor & Benger, 2004; Taylor et al., 2006). It is hard to know the exact cost increase that low patient satisfaction scores incur, however Jones and Gates (2007) estimate the cost of RN turnover to be between $22,000 to over $64,000 per employee. Along with the advertising and training costs associated with turnover, existing staff may be short handed, errors can increase, moral could drop, and completing the circle, patient satisfaction suffers further (Jones & Gates, 2007). Therefore, it is easy to see how low patient satisfaction, causing burnout and loss of one skilled employee, could set in motion a costly series of events.

More tangibly, Centers for Medicare and Medicaid Services (CMS) has begun withholding reimbursements for FY2013. The hospital has had a total of $1.5million withheld.
At current hospital HCAHPS scores it is projected that all $1.5 million will be recovered with an early projection of an additional $100,000. This is positive, but there is a great deal of additional capital that could be claimed from CMS if HCAHPS improve further. (D. Austin, personal communication, October, 8th 2013)

**Project Overview**

After thoroughly reviewing the evidence base, assessing the current state, and performing a root cause analysis (Appendix A), it was determined that a multifactorial intervention would be most beneficial in increasing patient perception of feeling informed. The multiple causes at work make it necessary to combat the lack of patients feeling informed from several angles.

**Goals and Objectives**

**Goal:** To provide informative patient centered care to all patients in the ED by implementing a standard guideline (Appendix B) posted on the intranet and in new hire training binders, staff education sessions, ICARE and key word reminder cards posted in charting areas, and development of an ED Overview Patient Handout outlining the overall ED treatment process (Appendix E) placed in all patient rooms, the waiting room and on registration clipboards leading to increased patient understanding of the overall ED process, their personal treatment plan, and patient perception that they are informed about perceived delays.

**Objectives:**

1) To increase overall hospital HCAHPS by the end of Q2 in 2014.

2) To increase Press Ganey scores of being “Informed about Delays” for the ED by the end of Q2 in 2014.

3) To have color copies of all patient handouts distributed to rooms, waiting areas, and on registration clipboards by the end of Q4 2013.
4) To educate 100% of staff on the current state of the issue and how to improve with use of the standard guidelines and new tools by the end of Q4 2013.

5) To incorporate training into new hire materials by the end of Q4 2013.

6) To increase ED and hospital reimbursements from CMS by year-end 2014.

**Nursing Relevance**

Happier patients make for an overall happier environment. Increasing patient satisfaction has the added bonus of increasing moral (Perez-Carceles et al., 2010; Sun et al., 2000; Taylor & Benger, 2004; Taylor et al., 2006). Improved communication and team cohesiveness in an environment which relies so heavily on teamwork is necessary for a healthy ED where multiple disciplines depend on each other to deliver quality care. Keeping patients informed makes great strides in reducing patient anxiety, increasing compliance and reducing call bell use. Providing information and ensuring patient retention will decrease the nursing workload increasing job satisfaction.

**Summary Report**

This project began with the assessment of the current ED state (Appendices I, J) and formation of a root cause analysis (Appendix A). The literature review helped to identify interventions that have been effectively incorporated into similar microsystem settings. Once specific interventions were identified they were presented to the department director who assisted in narrowing options to the final selected interventions. The draft intervention tools were presented at several interdisciplinary staff meetings and suggestions for improvement were incorporated into the final versions (Appendices B, F, E). Staff education began as preliminary copies of the ED Overview Patient Handout (Appendix F) were distributed throughout the department. Departmental and national data from Press Ganey (Appendices G, H) was used to outline the current state. An email followed the staff education sessions with the staff handout
and a link to the standard guideline on the intranet. Laminated color copies of the ED Overview Patient Handout were affixed to new registration clipboards and Velcroed to the walls in all patient rooms. Laminated ICARE/Key Word cards were compiled and distributed throughout the unit.

**Post Implementation Results**

Staff and patients were interviewed (Appendix K) to determine the efficacy of the interventions. This was a highly preliminary assessment of the interventions being so soon after implementation. At this point a Plan-Do-Study-Act cycle should begin to reassess the interventions and make adjustments according to what is working and what needs improvement. Press Ganey and HCAHPS scores will be used to determine the long-term efficacy of the changes. It is projected that there will be improvements in both sets of patient satisfaction data.

Preliminary data suggests that although 75% of patients found the ED Overview Handout useful only 17% of patients surveyed saw the Handout and 0% of patients were directed to the handout by a staff member (Appendix L). This conflicts with staff reports that 82% of them pointed out the ED Overview Handout to their patients. It is possible that reporting and recall bias are affecting the results and observation will likely result in more accurate data. Based on staff comment, the majority of staff members are expected to utilize the ED Overview Patient Handout as a reference when teaching patients about the overall ED process.

It is expected that not all staff members will have integrated the standard guidelines into their practice. Staff members will likely only partially integrate the teachings and key words that suit their individual style. Preliminary data shows that 64% of staff members used at least a portion of the ICARE and Key Word tools in their daily practice while 82% said they would incorporate the tools in the future. One of the commonly cited reasons for not implementing the
Key Words is that they are easily forgotten. There will need to be ongoing reminders including the visual reminders in charting stations and repetition of huddle topics on the subject.

One hundred percent of patients, excluding those who are trauma activations, cognitively altered, unable to read, or don’t speak English are expected to receive the ED Overview Patient Handout after implementation is complete. Of those who are excluded, the family members or any accompanying persons are expected to receive the patient handout. Of those who receive the handout it is the hope that 100% of them will find it helpful, however due to different learning styles, stressful situations, and personal preferences, the real number is likely to be lower and may actually be closer to the 75% that preliminary data suggests.

**Sustainability**

Continued education, staff rallying, and huddle topic reminders will be necessary for this intervention to sustain. It was suggested by one department RN that there be a tag or sticker placed on the clipboard directing patients to look at the ED Overview Handout affixed to the clipboard itself instead of stopping at the top registration page. Possible complimentary interventions include: development of a video to play in the waiting room and on the web outlining the overall ED process, more extensive customer service training for all staff members, implementation of a patient liaison who could round to all patients and answer any outstanding questions, creation of a poster over viewing the ED process, invitation of a Press Ganey representative to assist with assessment and solutions, and/or an interactive ‘chart’ that the patient can access via tablet that shows their personalized treatment plan and current status with real time expected wait times.

Keeping patients informed while in the ED will be an ongoing and ever changing endeavor. It will require regular reassessment and continued intervention as the emergent nature of ED patient care is often in conflict with patients being fully informed at all times.
Collaboration with outside ED professionals would be incredibly useful in brainstorming creative solutions for process improvement. That being said it is necessary that great attention is given to keeping patients informed as it is an intrinsic component of quality patient-centered care.
References


Health Management Associates. (2011). *Sustainability audit of the contra costa county regional medical center and health centers: Stage 1 information memorandum* (final report). Atlanta, GA, Austin, TX, Boston, MA, Chicago, IL, Columbus, OH, Harrisburg, PN, Indianapolis, IN, Lansing, MI, New York, NY, Sacramento, CA, Tallahassee, FL, Washington, DC.


Appendix A: Root Cause Analysis

- Staff assumes patients have been told/understand process
- Staff is too busy to explain the process
- Staff is unclear on Tx course
- Key words aren’t used
- Staff is unclear on standard times and processes
- Different practice styles by staff causes the process to change and information to vary
- Patients require repetition in stressful situations
- Poor team communication
- Staff is unaware of key words
- There are no guidelines to explain how to inform patients
- Lamination and dispersing of ICARE and key words on unit
- Create standard guidelines with clear times, key words, and ICARE methodology
- Staff Education on guidelines and need for improvement
- Creation of pt tool to determine their location in process
- Every pt has different treatment course
- ED pamphlet is not given/read/accurate
- Patients don’t understand the information they receive, why?
- Patients and families are under stress and don’t retain info
- Pts have cognitive impairment or ALOC
- The ED “game board” is invisible and the “rules” are undisclosed
- Patients receive too much information at beginning of stay
- Pts require clear and repetitive explanation of process
- Why have Press Ganey scores for patients being informed of delays in the ED been a top 10 problem area for 56 quarters?
Appendix B: Standard Guideline

**Standard Guideline: Patient Interaction**

<table>
<thead>
<tr>
<th>Subject:</th>
<th>PATIENT EXPERIENCE AND GUIDELINES FOR STAFF INTERACTION WITH PATIENTS</th>
</tr>
</thead>
</table>

**I. Purpose:**

1. To provide guidelines for staff interaction with patients that keeps patients informed and up to date with their treatment throughout their Emergency Services Department (ED) visit.

**Definitions: NURSING CONSIDERATIONS**

As the ED is highly teamwork oriented it is crucial that we have a standard methods of addressing patients by using key words and formats. It is not an expectation to speak from a script or repeat things verbatim, however, incorporation of key words and repetition of the same information from all staff members is important for patients to feel informed and retain the information they receive.

**II. Policy**

A. All staff will be educated to incorporate into their practice the following items:

   - Introduce yourself
   - Take a seat when appropriate
   - ICARE
   - Key words at key times
   - Eliminate “Danger Phrases”
   - “Listen and Explain”
   - Use standard times (see posters and handouts in rooms)
     - As much as 2-3 hrs for diagnostics to be reviewed
     - Total average times: Admit=6 hours, Discharge=3 hours
     - Wait for the hospitalist to admit can be up to 4 hours
   - Check back in and have a PURPOSEFUL and INFORMATIVE conversation

B. The following key words, danger phrases, and ICARE tool are outlined to inform staff on the desired process.
Key Words

- **“Informed”**: Let me inform you about what will happen during your visit
- **“Comfortable”**: Is there anything I can do to make you more comfortable?
- **“Concerned”**: Do you have any questions or concerns?
- **“Managing your pain”**: It’s important to us to manage your pain.
- **“Privacy”**: Let me close the curtain for your privacy.
- **“Thank you”**: Foster an environment of gratitude
- Ask “Is there anything else I can do for you while I am here?”

Danger Phrases (Avoid these)

- “shortly”, “in a few”, “soon” –“Someone will be with you ____.” – These are ambiguous and reduce satisfaction.
- Guessed time - If you don’t know how long, refer to tools and/or ask someone and get back to patient in a set time period.

<table>
<thead>
<tr>
<th>I</th>
<th>Introduce self with title, Service recovery if needed (apologize even if ‘its’ not your fault), Inspire confidence (Manage Up –talk about how great you, your coworkers, and the hospital are)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Connect with the patient &amp; family, Contact – Verbal/Physical/Non-Medical</td>
</tr>
<tr>
<td>A</td>
<td>Acknowledge what the patient has said, Articulate what you have found and what you think is going on - Use Key Words</td>
</tr>
<tr>
<td>R</td>
<td>Review the plan of care, what tests and treatments are to be accomplished, and how long it is going to take, Remember Under-Promise and Over-Deliver</td>
</tr>
<tr>
<td>E</td>
<td>Educate – What to Expect next/Home Care, Ensure Understanding-Ark “What questions do you have? Is there anything else I can do for you?”, Exit - Say Good-Bye</td>
</tr>
</tbody>
</table>
Appendix C: Pre Implementation Observational Data

**Pre Intervention Observations of Staff and Patient Interactions**

- Introduced Self: 41%
- Explained What Happens Next: 52%
- Asked if Patient or Family Needed Anything Else: 0.03%
Appendix D: Pre Implementation Survey Data

**Pre Intervention Staff Survey**

- Believe Most Patients Arrive Uninformed of ED Process: 91.00%
- Believe verbal Explanation is the Best Way to Keep Patients Informed: 91.00%
- Use of the Whiteboard or Implementation of a Trip Ticket Would be Beneficial: 0.18%

**Pre Intervention Patient Survey**

- Received Existing ED Pamphlet: 0.00%
- Felt Informed: 100.00%
- Read the Timing Poster and Found it Helpful: 50.00%
- Verbal Explanation is the Best Way to be Kept Informed: 100.00%
- Utilizing the Whiteboard or Providing a Simple Patient Handout Would Help: 88.00%
Appendix E: ED Overview Patient Handout

What to expect from your Emergency Department (ED) Visit*

START: You came in your own vehicle
- You check in with registration
- A triage RN, MD, or PA evaluates you
- You have initial labs and tests if indicated
- You return to the waiting room while tests are processed and reviewed
- You are directed to a room
- You put on a gown and are assessed by an RN and MD/PA
- Additional diagnostic tests will be ordered by the MD/PA

while your tests are processing and being reviewed our team will complete any initial medications or procedures

while the team is determining your diagnosis and treatment plan a potential wait of 2-3 hours is average. Our goal is to keep you informed while you wait.

Once a diagnosis is made the ED MD or PA will discuss it with you and determine if hospital admission is required or if you can go home.

DISCHARGE
- MD/PA completes discharge packet
- RN completes any last procedures
- RN, MD, or PA goes over packet with you and answers all questions
-(Average total time in ED is 3 hours)

ADMISSION
- Hospitalist MD will come to the ED to complete your admission.
- You can expect to wait for up to 4 hours for the hospitalist to arrive.
-(Average total time in ED is 6 hours)

TRANSFER
- Occasionally you may require transport to another facility for further care.
- ED team continues your care until you are safely transferred

Assume as your hospital room is ready we will arrange transport to escort you to your room.
In the meantime our team will keep you informed of any changes and continue to care for all of your needs.

*Please note this is a general outline meant to inform you on the average ED process. Everyone’s plan of care is slightly different depending on diagnosis and our ED team will personalize your care for you.
Appendix F: Staff Education Flyer

The Patient Experience: How can you keep patients informed?

Who?
The ED Team: MDs, PAs, RNs, Techs, Phlebotomy, Pharmacy, Registration, Financial coordinators, Volunteers, EVERYONE!

Why?
- Patients feeling informed about delays has been a top 10 issue for 56 quarters, that’s 14 years. We can do better!
- CMS withholding reimbursement beginning January 2014
  - We currently expect to break even + $100,000 (Great Job!) But we can get more!
- First Impression of the hospital: what each of us does sets the stage for the whole hospital stay.
  - Better ED experience=Better hospital experience scores
- Regardless of wait time, patients rate their overall satisfaction higher if they feel they are kept informed.
- THIS HELPS YOU NOW: fewer call lights, happier patients, happier team

How?
- Introduce yourself
- Take a seat when appropriate
- ICARE
- Key words at key times
- Eliminate “Danger Phrases”
- “Listen and Explain”
- Use standard times (see posters and handouts in rooms)
  - As much as 2-3 hrs for diagnostics to be reviewed
  - Total average times: Admit=6 hours, Discharge=3 hours
  - Wait for the hospitalist to admit can be up to 4 hours
- Check back and have a PURPOSEFUL and INFORMATIVE conversation

Key Words
- “Informed”- Let me inform you about what will happen during your visit
- “Comfortable”- Is there anything I can do to make you more comfortable?
- “Concerned”- Do you have any questions or concerns?
- “Managing your pain”- It’s important to us to manage your pain.
- “Privacy”- Let me close the curtain for your privacy.
- “Thank you”- Foster an environment of gratitude
- Ask “Is there anything else I can do for you while I am here?”
**Danger Phrases (Avoid These)**

- “shortly”, “in a few”, “soon” – “Someone will be with you ____.” – These are ambiguous and reduce satisfaction!
- Guessed time - If you don’t know how long, refer to tools and/or ask someone and get back to patient in a set time period.

<table>
<thead>
<tr>
<th>I</th>
<th><strong>Introduce</strong> self with title, Service recovery if needed (apologize even if ‘its’ not your fault), Inspire confidence (Manage Up – talk about how great you, your coworkers, and the hospital are)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td><strong>Connect</strong> with the patient &amp; family, Contact – Verbal/Physical/Non-Medical</td>
</tr>
<tr>
<td>A</td>
<td><strong>Acknowledge</strong> what the patient has said, Articulate what you have found and what you think is going on - Use Key Words</td>
</tr>
<tr>
<td>R</td>
<td><strong>Review</strong> the plan of care, what tests and treatments are to be accomplished, and how long it is going to take, Remember <strong>Under-Promise and Over-Deliver</strong></td>
</tr>
<tr>
<td>E</td>
<td><strong>Educate</strong> – What to Expect next/Home Care, Ensure Understanding-Ask “What questions do you have? Is there anything else I can do for you?”, Exit - Say Good-Bye</td>
</tr>
</tbody>
</table>
**What to expect from your Emergency Department (ED) Visit**

**START:**
- You came in your own vehicle
- You check in with registration
- A triage RN, MD, or PA evaluates you
- You have initial labs and tests if indicated
- You return to the waiting room while tests are processed and reviewed
- You are directed to a room
- You put on a gown and are assessed by an RN and MD/PA
- Additional diagnostic tests will be ordered by the MD/PA

**While your tests are processing and being reviewed our team will complete any initial medications or procedures.**

**While the team is determining your diagnosis and treatment plan a potential wait of 2-3 hours is average. Our goal is to keep you informed while you wait.**

**Once a diagnosis is made the ED MD or PA will discuss it with you and determine if hospital admission is required or if you can go home.**

**DISCHARGE**
- MD/PA completes discharge packet
- RN completes any last procedures
- RN, MD, or PA goes over packet with you and answers all questions
- (Average total time in ED is 3 hours)

**ADMISSION**
- Hospitalist MD will come to the ED to complete your admission.
- You can expect to wait for up to 4 hours for the hospitalist to arrive.
- (Average total time in ED is 6 hours)

**TRANSFER**
- Occasionally you may require transport to another facility for further care.
- ED team continues your care until you are safely transferred

**As soon as your hospital room is ready we will arrange transport to escort you to your room. In the meantime our team will keep you informed of any changes and continue to care for all of your needs.**

*Please note this is a general outline meant to inform you on the average ED process. Everyone’s plan of care is slightly different depending on diagnosis and our ED team will personalize your care for you.*
### Appendix G: Quarterly Press Ganey Scores

**EMERGENCY DEPARTMENT REPORT**

#### 9.0 Priority Index (Internal)

The Internal Priority index combines information about your facility’s performance and the relative importance of each question to respondents’ overall satisfaction. Higher priority is given to those issues that are relatively important to respondents (high correlation coefficients) and that you scored low on (low mean scores). Questions are listed in decreasing priority. Pay particular attention to questions that are consistently among your top ten priorities. Questions that are among this period’s top ten priorities appear in bold italics in this and previous sections of the report.

<table>
<thead>
<tr>
<th>Current</th>
<th>Previous</th>
<th>Periods</th>
<th>Order</th>
<th>Top 10</th>
<th>Question</th>
<th>Mean Score</th>
<th>Correlation Coefficient</th>
<th>Priority Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>56</td>
<td>1</td>
<td></td>
<td>Informed about delays</td>
<td>81.8 (41)</td>
<td>.77 (33)</td>
<td>74</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>56</td>
<td>2</td>
<td></td>
<td>Staff cared about you as person</td>
<td>89.3 (31)</td>
<td>.85 (40)</td>
<td>71</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td></td>
<td>Doctor informative re treatment</td>
<td>90.0 (28)</td>
<td>.78 (36)</td>
<td>64</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td></td>
<td>Doctors concern for comfort</td>
<td>89.8 (30)</td>
<td>.77 (34)</td>
<td>64</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>23</td>
<td>5</td>
<td></td>
<td>Overall rating ER care</td>
<td>91.3 (23)</td>
<td>.86 (41)</td>
<td>64</td>
</tr>
<tr>
<td>6</td>
<td>13</td>
<td>1</td>
<td>6</td>
<td></td>
<td>Information about home care</td>
<td>88.3 (34)</td>
<td>.76 (30)</td>
<td>64</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td></td>
<td>How well pain was controlled</td>
<td>84.3 (38)</td>
<td>.74 (25)</td>
<td>63</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>2</td>
<td>8</td>
<td></td>
<td>Nurses attention to your needs</td>
<td>91.7 (19)</td>
<td>.81 (38)</td>
<td>57</td>
</tr>
<tr>
<td>9</td>
<td>12</td>
<td></td>
<td>9</td>
<td></td>
<td>Nurses informative re treatments</td>
<td>90.2 (26)</td>
<td>.76 (29)</td>
<td>55</td>
</tr>
<tr>
<td>9</td>
<td>29</td>
<td>1</td>
<td>10</td>
<td></td>
<td>Likelihood of recommending</td>
<td>92.0 (16)</td>
<td>.82 (39)</td>
<td>50</td>
</tr>
</tbody>
</table>
Appendix H: Press Ganey Patient Satisfaction by Throughput and Information Graph

Patient satisfaction by time spent in emergency department

 Represents the experiences of 1,501,672 patients treated at 1,893 hospitals nationwide between Jan. 1 and Dec. 31, 2009.
Appendix I: Staff Survey

**Staff Survey**

1. What do you do/say to keep your patients informed throughout their stay?

2. How do you inform patients about treatment delays?

3. How much about the plan of care/course of the stay do you think most patients understand before arriving in the ED? What are/should they be told in triage?

4. What do you think would help patients be more informed about the ED process?

5. How does the whiteboard help patient’s understand the ED wait times? What improvements would you make to this mode of communication to the patients?

6. How does the poster with the approximate wait times inform the patients? Does the poster inform the patients? Why or why not?

7. What have you seen other ED staff do that you think is helpful in keeping patients informed?
Appendix J: Patient Survey

**Patient Survey**

1. How well informed about the ED process do you currently feel, that is do you feel like you’ve understood what is happening while you’ve been here? Have you felt this informed the whole stay or have you felt more informed about certain things than others, which ones?

2. What has been the best thing a staff member has done to help you understand what was going on as far as treatment, waiting, tests, procedures, etc. so far?

3. What did you learn from the tri-fold Emergency Services pamphlet? Do you have any suggestions for its improvement?

4. Did you see the poster listing the wait times in your room? Did you find it helpful? If yes, what did you learn? How did it inform you of the ED process?

5. What would be helpful for staff to know about keeping you informed about the emergency department’s procedures?

Circle all that apply:

A. Whiteboard
B. Trip ticket
C. Rewrite tri-fold
D. Movie on TV
E. Verbally tell you
Appendix K: Post Implementation Surveys

**Staff**

Have you used the patient handout?

Do you think you will use it?

Have you incorporated Components of Key Words or ICARE?

Do you think you will?

Anything else you’d like to share/say about teaching?

**Patients**

Did you notice the handout?

Did Staff point it out to you?

Do you find it helpful?
Appendix L: Post Implementation Results

**Patient Reflections on ED Overview Handout**

- Saw the Handout: 17%
- Staff pointed out the Handout: 0%
- Found the Handout helpful: 75%

**Staff Reflections on ED Overview Handout and Key Words/ICARE tools**

- Used the Handout in practice: 82%
- Will use handout in future: 91%
- Already incorporated Key Words and ICARE: 64%
- Will incorporate Key Words and ICARE in future: 82%