Patient Experience in the Emergency Department: Educating and Empowering Patients to understand their journey

[redacted]

This Quality Improvement Project is all the work of [redacted]

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Abstract

Introduction: *Patient experience is being increasingly emphasised when assessing the quality of emergency care, and on my arrival at* [redacted] *a recent CQC survey had highlighted deficiencies in the information provided to patients, something I had often felt could be improved in emergency departments.*

Aims: *To improve selected patient reported outcomes of experience highlighted by* [redacted] *from the CQC National Patient A&E Survey, namely estimated waiting time, timely pain relief, decreased feeling of threat, location of refreshment provision and information regarding medication side effect. To increase positive responses to these by 100% on local surveys (except reducing sense of threat by 50%), and move* [redacted] *nationally to a "higher performing trust" in these areas of the CQC survey by January 2018.*

Analysis of problem: *Patients report through survey data, complaints and feedback that they receive insufficient information about their emergency care, and what they can reasonably expect from an emergency department visit. While the quantity of time spent in an emergency department is an important indicator of perceived experience, provision of information and quality of wait can have a positive impact on experience.*

Intervention: *Patient feedback captured via a survey and liaison with clinical, clerical and management staff produced a "Patient Passport" that was given to all patients registering at the* [redacted] *ED. It provides information about the structure, function and amenities of the department, and provides a space for clinical staff to provide written advice and instructions.*

Outcomes: *Patient feedback in repeat surveys in the waiting room area demonstrated those experiencing a sense of threat reduce from 37% to 10% (13% to 10% in 'majors' area), awareness of where to obtain refreshments increased from 25% to 90% (62% to 95% in 'majors'area), awareness of how long they might wait increased from 12% to 65% (23% to 60% in 'majors' area), and patients awareness of the next thing they were waiting for* *improved from 15% to 78% (62% to 82% in 'majors' area). There was a positive response to the intervention, with UHB Trust executive choosing to fund its longer term implementation.*

Introduction

Attending an Emergency Department occurs by definition at a time when service users are unwell or have suffered an unexpected adverse event. It is also expected they will likely have little insight into the complex workings of their local Emergency Department and the broad range of activities it undertakes. An individual's expectation of an experience is intrinsic to the perceived quality of that experience[1], and Emergency Departments commonly experience dissatisfaction and frustration amongst service users.

On arrival at the [redacted] ED, I became aware of a local departmental concern that patients receive insufficient information, and I recognised this was a potential issue in such a busy urban emergency department with a high proportion of ambulant patients.

Aims:

I undertook a Quality Improvement project beginning in 2015, to improve reported patient experience in the Emergency Department in accordance with the 2014 Care Quality Commission "A&E patient survey"[2]. An initial focus group meeting highlighted some key areas that were of concern in the CQC report that the department wish to focus on, namely reporting receiving timely analgesia, awareness of what patients were next expecting, how long they were expected to wait to see a clinician, the location of refreshments and a decreased perceived sense of threat from other patients or visitors.

The outcome aim was to improve reported patient experience so [redacted] would score as a "higher performing trust" related to the key areas listed above within the Care Quality Commission Accident & Emergency patient survey when the survey is repeated after 2018, while achieving an 100% improvement in positive responses these prioritised areas on repeat local patient surveys by January 2018.

Background – Identification of the Problem

"Quality of care includes quality of caring. This means how personal care is - the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences."

(Darzi NHS Next Stage Review 2008)[3]

Patients should be able to expect a good experience when they interact with emergency medical care in Emergency Departments, and in a public emergency health service where there is little competition for patients business or obvious alternative providers, patients should be able to understand what they can reasonably expect from their episode of care, and that providers appear to be doing all they can to improve the experience of service users. Many sources suggest that this is not achieved to a high standard in Emergency Departments, including patient complaints, direct informal feedback and national survey data.

[redacted] has worked to improve processes and resourcing to meet agreed Emergency Department key quality indicators (KQIs)[4], in particular with staffing and flow innovations to decrease the length of wait for patients to be both seen by clinicians and complete their episode of emergency care. Patient experience forms an element of the KQIs, and is perhaps the most challenging to quantify and assess. There is increasing recognition that while the duration of wait is often reported as the most important factor in a patient's experience, the quality of their experience in the department can have a significant impact on overall satisfaction.

An important element of this experience is the availability and quality of information for patients, both on arrival and at all stages of their journey, which can be variable in busy departments, and challenging during periods of peak demand when the risk of a poor patient experience is greater already. It is also at these times when this causes an increase in the number of additional enquiries to clerical and clinical staff as patients seek further information, exacerbating the demand on staff time. In the [redacted] there is currently no available information in the waiting or clinical areas to inform patients about their experience.

The Care Quality Commission recognise it is important to assess what patients think about the care they receive, and as part of a wider system of patient surveys, they perform a national survey of A&E patients using a standardised questionnaire[2]. The survey is conducted using postal questionnaires, and then a complex scoring mechanism recognising responses that "deserve credit" and those that are a "problem response" to give trusts a numerical score with some correction for the demographic variation of their respondents. This allows departments to compare the experience of their patients with others nationally but also highlight areas where focus is specifically required. It was important for a Quality Improvement Project dealing with a broad range of patient experience information to highlight "priority areas" and so as a team, we reviewed our local CQC survey results and highlighted some key data sets (Appendix A), noting areas where we were unhappy with our ranking amongst trusts nationally, and those that we felt were emphasised further in local pre-existing waiting room electronic patient feedback (Appendix B). This allowed the team to generate a "priority list" of areas of concern.

Fig 1: [redacted] priority list of areas within CQC survey

- Awareness of how long you would wait to be examined
- Awareness of availability of analgesia and its prompt use
- Feeling of atmosphere of threat/violence from other patients or visitors
- Ability to get suitable food & drinks when in the A&E department
- Staff informing patients about side effects of medications to watch out for

Background – Analysis of the problem

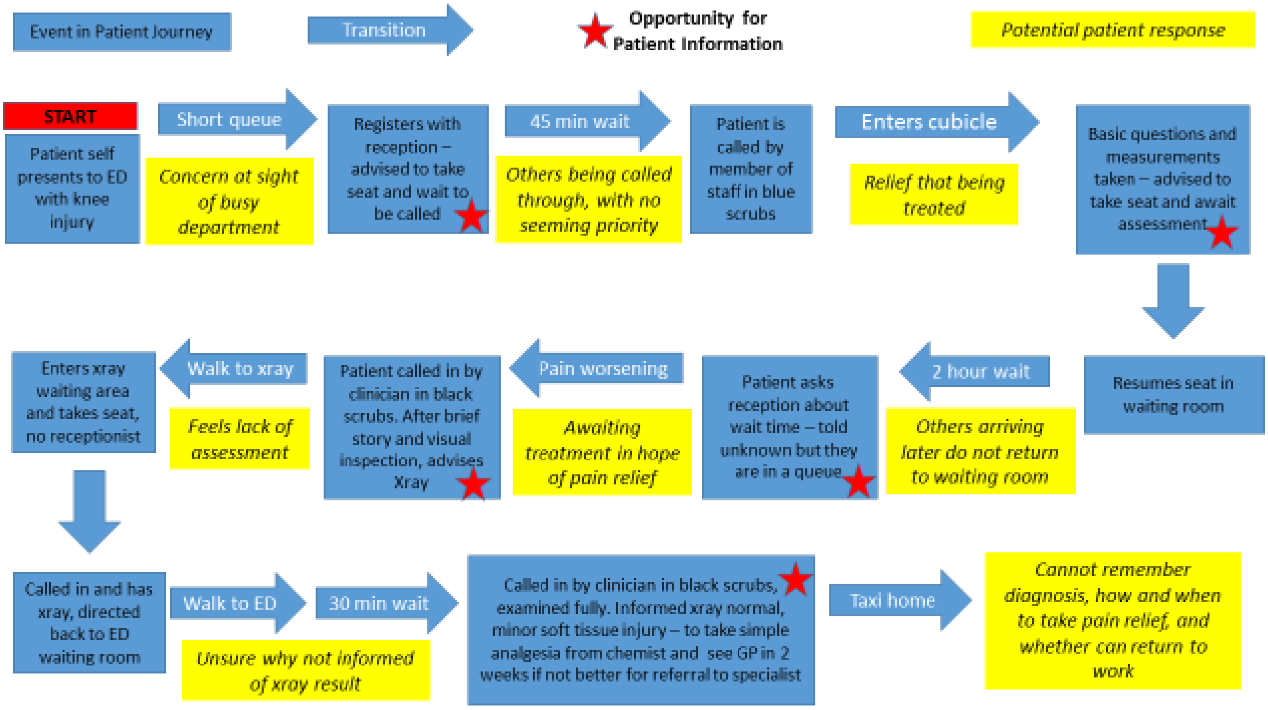
We considered a Driver Diagram as a useful tool to better translate a more general goal into more specific principles and development activities. I met with Emily Spencer and Richard Jeavons to develop this, seeking input from the senior nursing team, along with clinical and clerical staff in the ED. It was possible to inform this analysis in the context of anecdotal evidence, patient feedback and the CQC survey data. Many of the change ideas were raised by frontline staff, who are often most aware of problems and potential solutions within organisations.

It is recognised that all systems have structures, process and patterns, from the physical environment, the steps involved in a patient pathway, to the recognised repetitive cultural and behavioural features of patients' experiences. I personally developed a process map of a potential individual patient journey through their care in the Emergency Department. In taking a simple injury, it was possible to map out the known process events that commonly occur, but also highlight the transitions experienced by the patient, and finally use the information gathered from complaints and feedback to consider how a patient may likely respond to the experience. This process map isn't based on a particular real patient, yet provided an opportunity to consider the potential points in this journey for increasing information provision, and it was decided within a team meeting that giving comprehensive information at reception likely provides the most consistent provision and means the patient can understand the earlier phases of their care better, including the possibility of requesting pain relief.

Fig 2: Driver Diagram formulated with small focus group (AL/ES/RJ)

Aim	Primary Drivers	Secondary Drivers	Change Ideas
Improve patient experience in the Emergency Department and meet quality indicators	Improve understanding of the purpose, structure and flow of emergency departments	Patient awareness of breadth of cases seen in ED	Provide information about activity
		Patients in waiting room aware that high acuity patients seen elsewhere	Explain ED clinical areas to patients
			Explain triage system
		Patients aware that multiple entrance and exit points to department	Explain ambulance/walk in entry
			Engage with design council project
			Waiting room graphics
	Improve quality of information received by patient while waiting for clinical assessment	Patients aware of expected waiting times	Provide current/estimated wait time
		Patient awareness of what activity they are waiting for	Explain process of investigation/review
			Provide area for clinician to note plan
	Give patients greater control and autonomy over what they can expect from their care in an ED.	Encouraging patients to take initiative in progress of their care	Provide patient with activity checklist
			Inform patient when to seek help
		Patient awareness of key information they need on discharge	Provide discharge checklist to patient
		Patient awareness of personal rights and expectations	Define realistic expectations for patients
	Improve staff awareness of ability of patient experience as important element of care	Staff knowledge of previous CQC performance	Present CQC and audit data to staff
		Staff awareness of evidence base for recognition of patient experience	Present project at governance meeting
		Engagement of staff in processed to improve patient experience	Staff training when providing leaflet
			Training in interaction with document

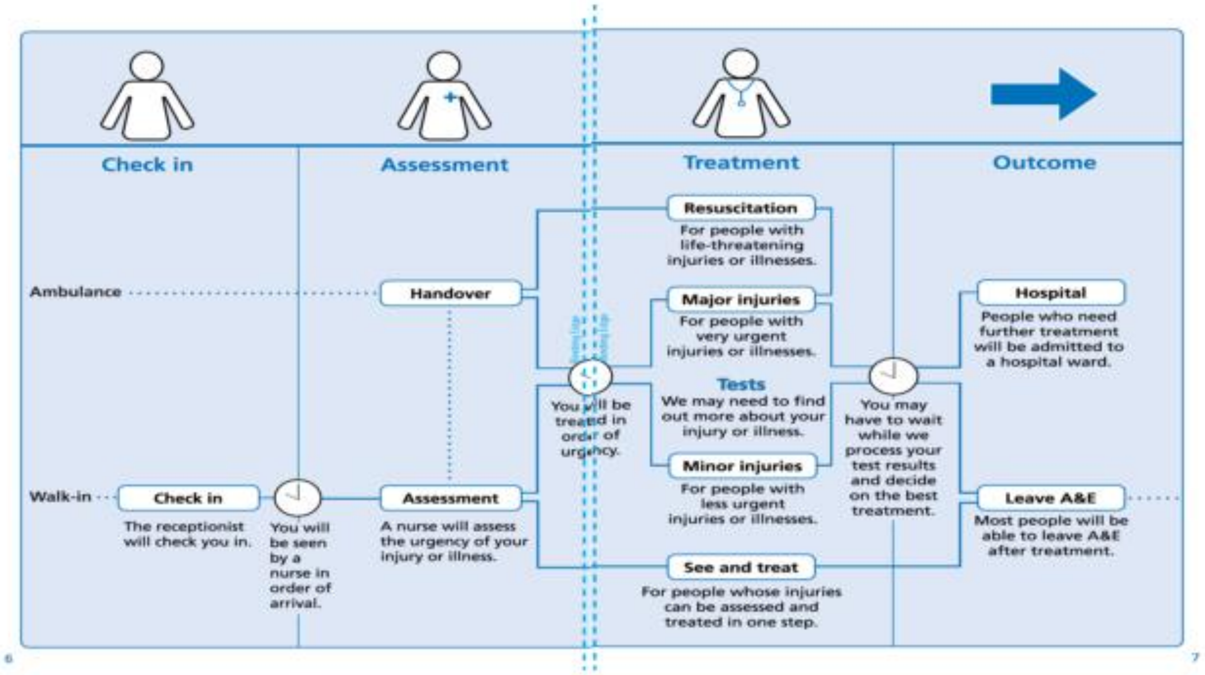
Fig 3: Process map of Theoretical Patient to [redacted]



In establishing the process mapping of the patient journey I began to work on the principles in a focussed map based on the [redacted] with the local patient design and information team. This recognised the key events in every patient's journey through the department, but with the awareness that there is currently no reliable information provided to the patient at each of the junctions in this journey.

These process maps are excellent for demonstrating several concurrent processes and we hypothesised it may be useful to share a form of the process mapping with patients to improve their understanding.

Fig 4: Local generic process map for department generated with patient information team



Literature Review

It was important when considering interventions to achieve our aims to understand if there was good evidence for which interventions are most effective in improving patient experience, and to evidence many of the anecdotal assumptions that information provision improves patient satisfaction. Also, given the emphasis given to the CQC survey data here, it is useful to understand the evidence and background behind its validity. Therefore a review of the literature around the survey, patient experience and satisfaction in Emergency Departments via the trust library services was useful to the team.

There is an increasing momentum to put patient experience at the heart of quality assessment in the NHS, with significant political and corporate will to improve patient experience when utilising NHS services. This began in simple terms with the Patients Charter in 1991[5], through the NHS Plan in 2000[6] and up until the NHS constitution for

England in 2013[7], setting out what rights and expectations patients may have when using the NHS.

Initial work by The Kings Fund investigated approaches to measuring patient experience using interview, survey and online feedback data[8]. This summarised that in line with the outcomes framework against which NHS performance is assessed (Accountability, Quality Improvement and Transparency), Patient reported experience measures (PREMS) should be utilised alongside Patient reported outcome measures (PROMS) and Quality of Life assessments as a marker of quality. This work informed the Department of Health's "Patient Experience Framework"[9], allowing the DOH to define a list of what matters to patient's and helping therefore define what questions to ask patients to assess their experience when using NHS services, but it should be noted this is not specific to Emergency Departments.

The Kings Fund research was commissioned by the "NHS institute for innovation and improvement", and sponsored by the "Patient and public experience and engagement team" within the Department of Health. This study involved 50 interviews with patient/carers, a survey of 36 patient/voluntary organisations, analysis of 11000 postings from patient feedback websites, and analysis of 2600 patient experience responses used by hospitals. One of the challenges of this data is it is extensive and heterogenous, with many biases inherent in the sources of information, and the methodology is less clear in terms of how patient responses are directly transferred into validated measures. The Department of Health guidance has been based on this single funded project over all areas of NHS care, rather than perhaps a broader analysis of literature.

This work does at least provide a validated method of assessing patient experience, and so the NHS/CQC National Patient Survey[2] was then able to gather information regarding patient experience in Emergency Departments retrospectively via questionnaires, and inform assessment and comparison of individual departments. There are great challenges to assessing patient experience in emergency departments, owing to factors such as the validity of responses either during an acute illness, when patients are intoxicated, or recall for surveys a significant time after a stressful event[10,11], but there are now validated tools to attempt to address this[12, 13,] and the CQC methodology aims to correct numerical outcome scores for distortions in demographic responses.

While patient experience has been demonstrated to deteriorate with factors such as increased wait times[14,15,16], consistent information provision would be less affected by the unpredictable demand on emergency services. Waiting times including “wait to be seen”, or “time in department” are commonly reported as the most important determinant of patient experience by patients themselves, but a literature review[11] in 2004, which utilised 32 papers and divided them into attempts to assess and rank determinants of patient satisfaction alongside suggested interventions to improve satisfaction, suggested that increased information on arrival in ED and improved interpersonal skills of staff could both improve experience and perhaps decrease patients’ perceived waiting times. One study demonstrated that 66% of patients reported receiving no information at all on arrival to the ED[14], and those who had received information demonstrated a statistically significant improvement in not only general experience, but interestingly in their experience of the respect and attitude subsequently shown by staff, and satisfaction with subsequent information received. This study did however, only analyse 187 patients over a 4 week period in a Swedish University Hospital Emergency Department, so is difficult to extrapolate conclusions and suggests a selective group responding to the study.

I attempted to find if any other trusts in the wider region had developed any successful interventions to improve patient experience, and the only project of note was Southampton ED introducing a patient information leaflet, where they reported an improvement in patient satisfaction outcomes.

As there is some evidence that information on arrival may improve patient experience, then it must be considered what type of information is most effective. It has been shown that predicted waiting times on arrival are inherently inaccurate, and this was demonstrated well when testing a retrospective linear regression model on 50000 ED patients in a UK Emergency Department to generate predicted times[17], and this inaccuracy may impair general overall experience, so it is possible that generic accurate information will be of most use. It has also been demonstrated that environmental factors such as noise, security and comfort can affect experience[15,18], and even if these cannot be readily modified, a better understanding of these situations and challenges for patients may improve patients' perception of such factors.

In summary, there is some evidence that the quality of experience can have a significant impact on patient satisfaction, and there is some recognised validity to the CQC survey, although some weaknesses in its evidence base. An intervention to improve patient information could likely improve patient experience.

Team Formation

Once the problem had been identified, I worked with my educational supervisor to identify key stakeholders, and was able to use those actively engaged to expand a potential list of team members who could contribute to making a positive change to patient care with this project.

I undertook analysis using a team assessment tool[19], to better visualise the balance of skills available and ensure I would find effective roles within the team for this project. This would allow me to identify gaps within the team, and by establishing the team early, I would engage team members and stakeholders to give the project momentum to perpetuate change. The evidence from my literature review suggested that there would be a requirement for a design element to the production of new information for patients, requiring the trust patient information and design team's early involvement.

Fig 5: Team Assessment Tool

Name	Role	Team Sponsor	Technical Expert	Day-to-Day Leader	Other strengths
[redacted]	EM SpR			X	
[redacted]	EM Consultant	X			Awareness of local structures
[redacted]	Senior Nurse	X		X	Champion for nursing engagement
[redacted]	Nurse Consultant		X		On Design Council project team
[redacted]	Medical Student				Time available for surveys
[redacted]	Speciality Manager	X			Links to trust executive
[redacted]	Patient Information Officer		X		Knowledge of trust documentation requirements
[redacted]	Patient Information Officer		X		Artwork skills
[redacted]	Patient Experience Lead		X		Support within Trust

This allowed the following roles to develop, and is was most effective to not allocate specific tasks within the team at the outset, but to ensure all members were engaged, up to date with progress and then liaised with and allocated tasks as appropriate. Some sample communications are presented in Appendix G.

Fig 6: Team formation and roles

Team Member	Key Roles
[redacted]	Team Leader, Co-ordination, Overall responsibility
[redacted]	Support, Liaison to ED Consultant body, Submission guidance
[redacted]	Champion of nursing engagement, data collection, new ideas
[redacted]	Ensuring co-ordination with Design Council artwork project
[redacted]	Conducting Patient Surveys
[redacted]	Liaison to Trust Executive to support funding
[redacted]	Patient Passport production, finance and payment co-ordination
[redacted]	Patient Passport Design, Patient feedback co-ordination
[redacted]	Liaison to Trust Patient Experience team, Support to Trust executive

This team and their roles grew as the project developed and I learned where barriers to change and interventions would be. Most day to day communication was easily managed by e-mail, with face-to-face meetings for key moments in the project to ensure progress. It was important to initially gain face-to-face contact with those within the Trust management to improve professional relationships and gain support for my goals. Appendix G contains some sample evidence of team communications.

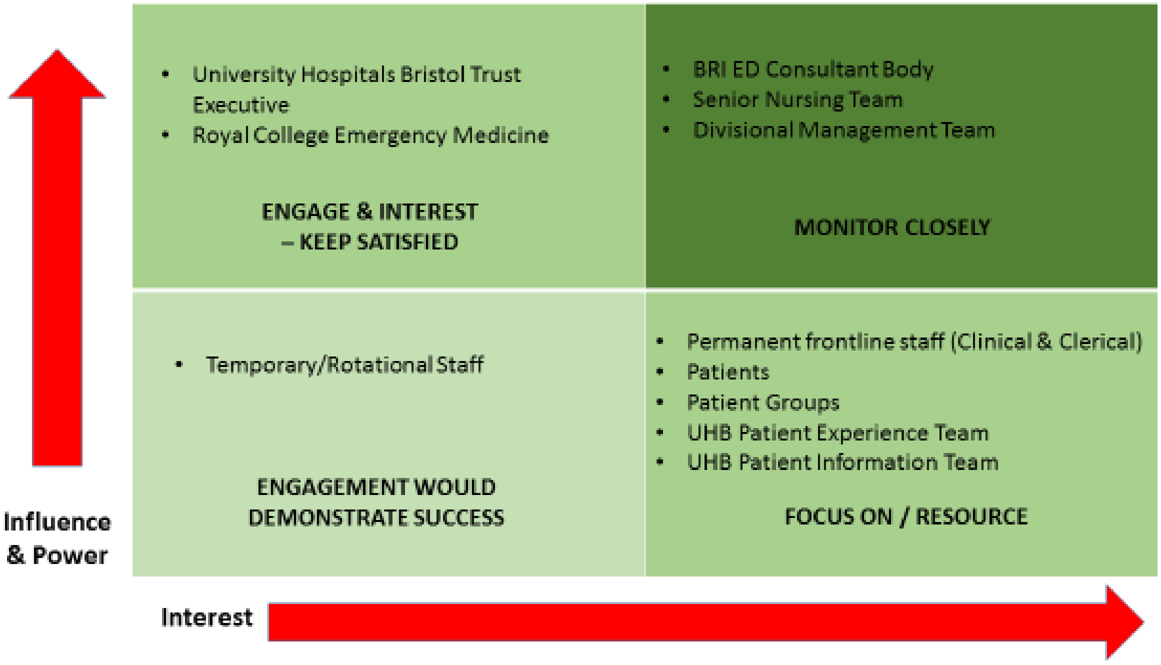
The Design Council project[20] was a separate piece of work funded by the Department of Health, with a view to introducing artwork into clinical areas in the Emergency Department to improve information provision and reduce violence and aggression. This was co-incidental but provided the opportunity to increase the effectiveness of both pieces of work, but also the challenge that there should be no discrepancy or confusion associated with the simultaneous interventions.

Stakeholder Identification & Engagement

A simple stakeholder "grid" can be used to identify parties who have some involvement in the project intervention[21], although for some they may not play as active part in the project activities. This grid broadly defines the level of interest stakeholders may have in the quality improvement and the power they may hold to influence its success.

This initial assessment might overlook stakeholders that are not yet apparent, but while it allows a "brainstorm" of groups that mean to be considered, one of its main benefits is to highlight strategies when dealing with the various groups. An example of this would be recognising that the UHB Trust Executive have great local power to ensure sustainability and success of the project so the focus of interaction with them must be to improve their interest in the project and demonstrate its positive effect. Similarly, recognising there are stakeholders who have no clear interest in the project or ability to influence it, but should not be missed as key to its ongoing success.

Fig 7: Stakeholder Assessment "Grid"



• University Hospitals Bristol Trust Executive • Royal College Emergency Medicine **ENGAGE & INTEREST – KEEP SATISFIED**	• BRI ED Consultant Body • Senior Nursing Team • Divisional Management Team **MONITOR CLOSELY**
• Temporary/Rotational Staff **ENGAGEMENT WOULD DEMONSTRATE SUCCESS**	• Permanent frontline staff (Clinical & Clerical) • Patients • Patient Groups • UHB Patient Experience Team • UHB Patient Information Team **FOCUS ON / RESOURCE**

Description of change and Quality management process involved

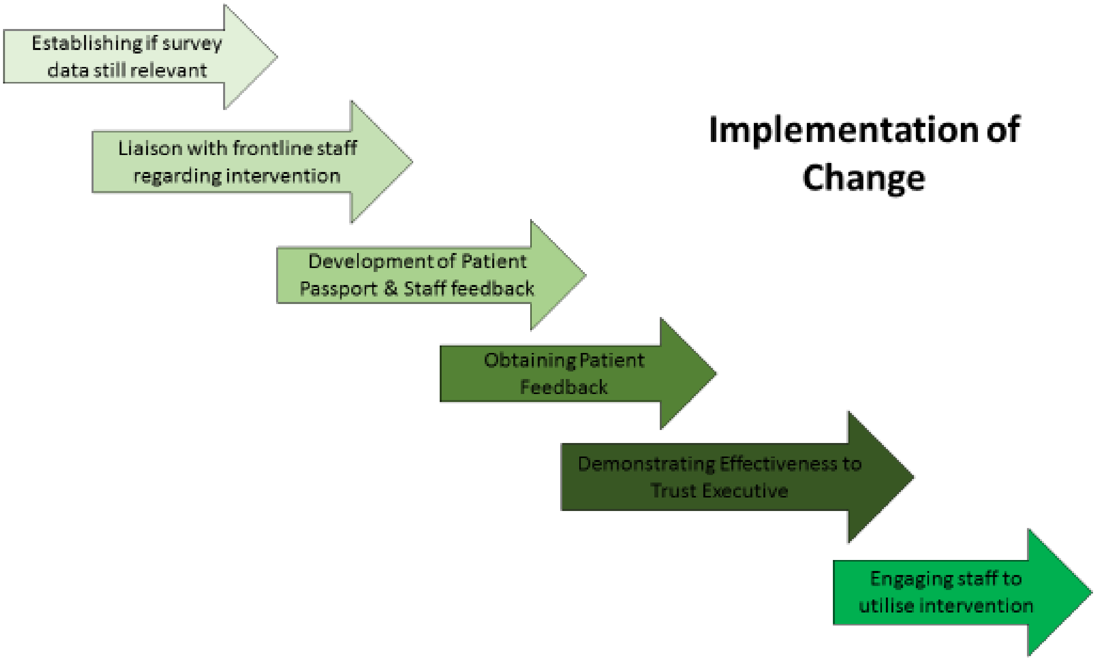
It was clear from the analysis of the problem, literature review and process mapping that providing a reliable source of generic patient information would be the most resilient and reliably accurate way to inform patients. We had highlighted in our meeting, reviewing the process map, that registration would be the best opportunity to provide this. We also discussed that staff and patients being able to interact with the information could allow it to be specific and take it beyond a mere "patient advice leaflet/resource". We were aware that the nature of information provided and how staff and patients interacted with the information would be crucial to effecting an actual change in patient experience.

The concept of a "Patient Passport" was developed early in the project, inspired as a development beyond the work discovered to be done in Southampton, with the hope it would provide information to suit a variety of patient journeys and interactions with the Emergency department, but was a document to be potentially interacted with and encourage patients to take responsibility for their own experience and what their expectations might be.

I was aware that the success of this intervention would be decided by how well it met the needs of patients and the organisation itself. I also reflected that much of the activity around its introduction and acceptance into use would determine any ongoing positive effects.

A general project plan was developed below on the basis of the Driver diagram, which would remain flexible but give some steps to ensuring the development and introduction of the [redacted] Patient Passport and thus achieve the project aims. This would then form the basis of a series of PDSA cycles, which are a quality improvement tool designed to allow the testing and modification of small interventions, to assess change and future activities. In this project I felt the PDSA cycles broadly would focus on developing the right information for patients and staff, while allowing us to recognise the key effective actions around implementation.

Fig 8: Planned implementation of change diagram for project



It is also useful to understand a more chronological timeline of the project, to understand sequential nature of key activities involved in this project. Much of the communication and planning was regular and ongoing but certain events represent the structure of the work. The timeline was certainly more prolonged than anticipated, and this was often attributed to awaiting the return of communications while working clinical shift work myself, while I was also learning more about the requirements of the project as it progressed. Significant delays would've been likely to occur due to the nature of other demands of Emergency medicine training, and in particular that I undertook subspecialty training in Prehospital EM, meaning I was only present in the [redacted] for 50% of my clinical time, limiting access to communications. Below is the early timeline to this point in the project, with a complete final timeline included within the outcomes review.

Fig 9: Project timeline 1 (Planning phase only)

Project Timeline

September 2015: Following arrival at [redacted] for ST5 training year, potential project identified through educational supervisor meeting

13th October 2015: Plan for QIP submitted to educational supervisor and requests commenced to potential team members. Initial contact made with stakeholders to register commencement of project

January-April 2016: Liaison with Trust Patient Experience team, gaining permission for patient contacts, initial development of Patient Passport concepts, informal contacts with frontline staff

Proposed Measurement of Change

We considered at this stage how we would attempt to measure improvement in this project. I recognised this was challenging in the absence of a regular clinical data measurement to utilise, so we would need to innovate to find measurements within current practice or perform our own data collection to measure improvement. We decided after meeting on the following measures.

Outcome measures: We would perform our own patient surveys reflecting the prioritised areas of the CQC survey, and would then review the results of the next CQC survey conducted after our interventions. I presented our local survey templates to the trust patient information team who approved their use. We felt surveying 80 patients in total was a reasonable sample and achievable given our resources (approx 1 week of data collection). It is later reflected that we could have considered more alternative outcome measures for overall change.

Process measures: We would like to consider availability of patient information as a process measure, and at this stage this was simplified to information provided reliably to patients. This is again reflected on later as something challenging to assess and more could have been done to assess this process and whether it was achieved in reality.

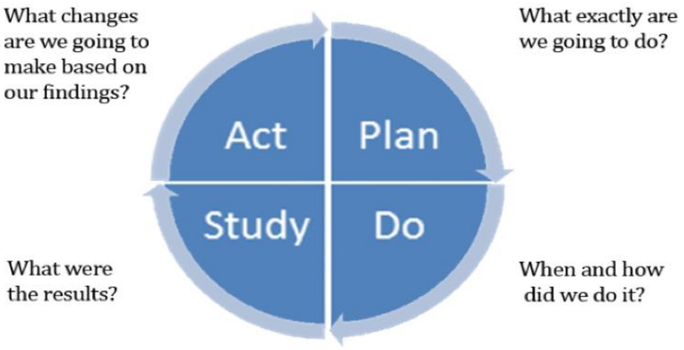
Balancing measures: We would liaise with clerical and clinical staff for any negative impact of an intervention, in terms of time required or patient dissatisfaction specific to any information provided. Once more, this was simplified and is reflected on as requiring more specific analysis.

In summary, the cornerstone of measuring our change was the CQC survey data and our local replication of it regarding elements of patient experience. We would later reflect on and recognise not only the challenges inherent in measuring patient experience, but that we had applied a potential lack of emphasis and detail to our process and balancing measures.

PDSA Cycles

PDSA cycles form a model for Quality improvement, by structuring interventions and their effect on progression of the project.

Fig 10: PDSA cycle structure



The key PDSA cycles throughout this project can be identified and summarised:

PDSA 1 (June 2016): ***Clarification of problem and priorities***

PLAN	Clarify specific data prioritised from CQC survey, expecting it to be replicated in current local survey data within the [redacted] Emergency Department, and confirm failure to meet validated expectations for patients
DO	Gain permission from Trust and conduct 80 face-to-face surveys within the Emergency Department within the "Majors" and "Waiting Room" areas (40 in majors and 40 in waiting room)
STUDY	Survey data confirms areas where department could improve in meeting validated areas of expected patient information (See Figs 11 & 12)
ACT	Further prioritise focus of intervention in terms of information provision to patients

Fig 11: [redacted] Patient survey data (June 2016) for 'Majors' area (40 patients)

MAJORS Question	Yes	No	%
Have you been told how long you would wait to be seen by a clinician	9	31	**23%**
Were you offered pain relief when you were seen	35	5	**87%**
Did you know where you/relatives could obtain refreshments	25	15	**62%**
Did you at any stage feel threatened by other patients or visitors	5	35	**13%**
Do you know what the next thing you're waiting for is	27	13	**68%**

Fig 12: [redacted] Patient survey data (June 2016) for 'Waiting room' area (40 patients)

WAITING ROOM Question	Yes	No	%
Have you been told how long you would wait to be seen by a clinician	5	35	**12%**
Were you offered pain relief when you were seen	35	5	**87%**
Did you know where you/relatives could obtain refreshments	10	30	**25%**
Did you at any stage feel threatened by other patients or visitors	15	25	**37%**
Do you know what the next thing you're waiting for is	9	51	**15%**

PDSA 2 (July 2016): ***Staff input to Patient Information requirements***

PLAN	Understand experience of frontline staff and information that could improve patients experience and understanding. Expect to find some informal trends in what staff are asked by patients and reasons they receive informal complaints and requests for information
DO	Informal discussions with clinical and clerical staff, noting anecdotal areas of information highlighted as often requested by patients, or concerns regarding their experience in Emergency Department
STUDY	Areas noted frequently were patients wishing to know expected waiting times, reason for overall delays and where they could obtain refreshments.
ACT	Summarise response to key areas for development of patient passport, so that information can be made relevant to concerns raised (See Appendix C)

PDSA 3 (July 2016): Development of 1st draft of Patient Passport

PLAN	Develop "Patient Passport" including key information highlighted from surveys and informal feedback. Also liaise with "Design Council Project", aiming for some information to work symbiotically with waiting room information educating patients around structure and flow of department. Expect Patient information team to produce document to standard acceptable to trust and then to gain positive feedback from local team
DO	Met with designers from Trust and patient information team, and over series of technical corrections, produce draft of "Patient Passport". Present this to meeting of Consultants, management and senior nursing team and request feedback.
STUDY	Received positive feedback from consultants, senior nursing team and management within the weekly senior management meeting, for project and appearance of "Patient Passport". In this meeting, request made for information around options for patient transport home to be included in document.
ACT	Patient transport information added to design, and further minor technical adjustments made

PDSA 4 (January 2017): ***Patient feedback on intervention***

PLAN	Plan to gain patient feedback on structure and design of "Patient Passport" to ensure it is appropriate for potential audience. Expect to receive some guidance on minor amendments but that document is acceptable to sample of potential users.
DO	10 patients to complete structured feedback form provided in standardised format by Trust information team and use to inform amendments (standardised feedback process for any trust documentation)
STUDY	Feedback was unanimously positive with only suggestion was to consider an electronic form of information in the future. (Specific comments reported in Appendix D)
ACT	Report to Patient information team with results and confirm current version as final draft of Patient Passport. (Final Draft – Appendix E)

PDSA 5 (June 2017): ***Introduction of Patient Passport to Department***

PLAN	To introduce Patient Passport during "pilot period" and gain limited funding for production of 2000 colour/gloss leaflets of good quality. Aim to repeat patient surveys during the "pilot period" and establish if any immediate improvement in patient reported experience. Expect to see improvement in survey data. Required to engage with clinical staff through e-mail, face-to-face and poster communication that project commencing and all patients should receive "Patient Passport". Expect incomplete provision initially as staff adjust to new routine.
DO	Obtained grant for £250 from "Above and Beyond" charitable fund and arranged printing through external contractor but with liaison from trust print room. Repeated 80 patient surveys as in previous cycle (40 in "majors" and 40 in "waiting room").
STUDY	Patient survey data improved (See Figs 13&14). Note anecdotally from clinical staff that not all patients receiving Patient Passport, and so need to improve engagement with clerical staff.
ACT	Publish new survey data to trust executive in an attempt to secure funding for the ingoing intervention, and promote benefits of intervention to clerical staff with further poster highlighting success of intervention and benefits to individual staff of decreasing interruptions. Understand balancing measure that increased information is a burden on clerical staff and may stimulate new queries. Will need to assess concordance with provision of passport to patients, so suggest spot audit of patients seeing clinician and asking if they have received a patient passport. Then would be possible to briefly survey clerical staff for reasons behind not providing patient passports (e.g time, communication issues, lack of awareness)

Fig 13: [redacted] Patient survey data (June 2017) for ‘Majors’ area (40 patients)

MAJORS Question	Yes	No	%
Have you been told how long you would wait to be seen by a clinician	24	16	60%
Were you offered pain relief when you were seen	38	2	95%
Did you know where you/relatives could obtain refreshments	38	2	95%
Did you at any stage feel threatened by other patients or visitors	4	36	10%
Do you know what the next thing you’re waiting for is	33	7	82%

Fig 14: [redacted] Patient survey data (June 2017) for ‘Waiting room’’ area (40 patients)

WAITING ROOM Question	Yes	No	%
Have you been told how long you would wait to be seen by a clinician	26	14	65%
Were you offered pain relief when you were seen	37	3	93%
Did you know where you/relatives could obtain refreshments	36	4	90%
Did you at any stage feel threatened by other patients or visitors	4	36	10%
Do you know what the next thing you’re waiting for is	31	9	78%

PDSA 6 (October 2017): ***Gaining Trust funding for ongoing production***

PLAN	To present data to the trust executive following the trial introduction of the Patient Passport, recognising alignment with trust goals and mission, improvement in objective measurements and additional benefits expected. Expect positive response to changes but realistic about limited funding for new projects within trust.
DO	Summary presentation given to trust executive highlighting very brief summary of the problem and this project’s response, but highlighted the positive repeat survey results. (See presentation in Appendix F) The possibility of presenting at this high level meeting was possible due to the championing of the project by Michelle Jarvis and the credibility leant by the senior members of the team.
STUDY	The Trust Executive agreed to fund the project and printing of Patient Passports for the next 3 years, and a budget identified to secure this.
ACT	Utilise this support to not only arrange a full print run of 25,000 Patient Passports through the trust print room, but to promote the recognition and importance of this project with local staff to increase momentum with providing the guides to patient and increased interaction with them.

PDSA 7 (October 2017): ***Improving Staff Engagement***

PLAN	To further promote the patient passport with clerical and clinical staff to ensure improved provision to patients and increased interaction respectively. I would predict there would be resistance to both of these elements if people were unaware of the benefits. I was concerned that one staff members had placed the passports in a general leaflet rack, showing a lack of understanding that each patient would have their individual guide as a matter of routine.
DO	Produced poster highlighting the key improvements and benefits for staff and patients, and presented this in clinical and reception areas. Used senior clerical co-ordinator to champion project and present the new protocol for providing the patient passport.
STUDY	Anecdotal increased use of Patient Passport and interaction
ACT	Consider intermittent surveys to assess how many patient have a Patient Passport when they are clinically assessed to gain an idea of more accurate usage. Aim to further present project at clinical governance to improve awareness of project.

Development and Implementation of mechanisms to assess effect of Quality Improvement Project

There were a number of factors that made this a challenging, and I think on reflection I feel demonstrating continuous objective improvement in the broader aims is one of the weaknesses of this project, although this was in part due to the less clearly defined methods and purpose of quality improvement within the local area when the project was commenced.

Firstly, while the CQC surveys are validated, the repetition of the surveys is the only clear available data point for improvement, as patient experience generates no easily accessible simple continuous data point to assess when improvements occur as other clinical projects may (e.g patient falls reporting). This makes it more challenging to assess objective effects of PDSA cycles and the overall trajectory of the project to see whether it is the Patient Passport itself causing an overall change in outcomes. In retrospect and with an improved understanding of quality improvement, our reliance on extrinsic data was recognised as a weakness, and we could have considered collecting other data sources such as frequency of interruptions to reception and clinical staff or assessing how many patient passports where being written in or used for advice to assess engagement.

Secondly, I feel that when this project was conceived, it was with an understanding of a more one-dimensional model of highlighting a problem, creating an intervention and assessing a single change, and this is a failure therefore of the project design to allow broader assessment of change.

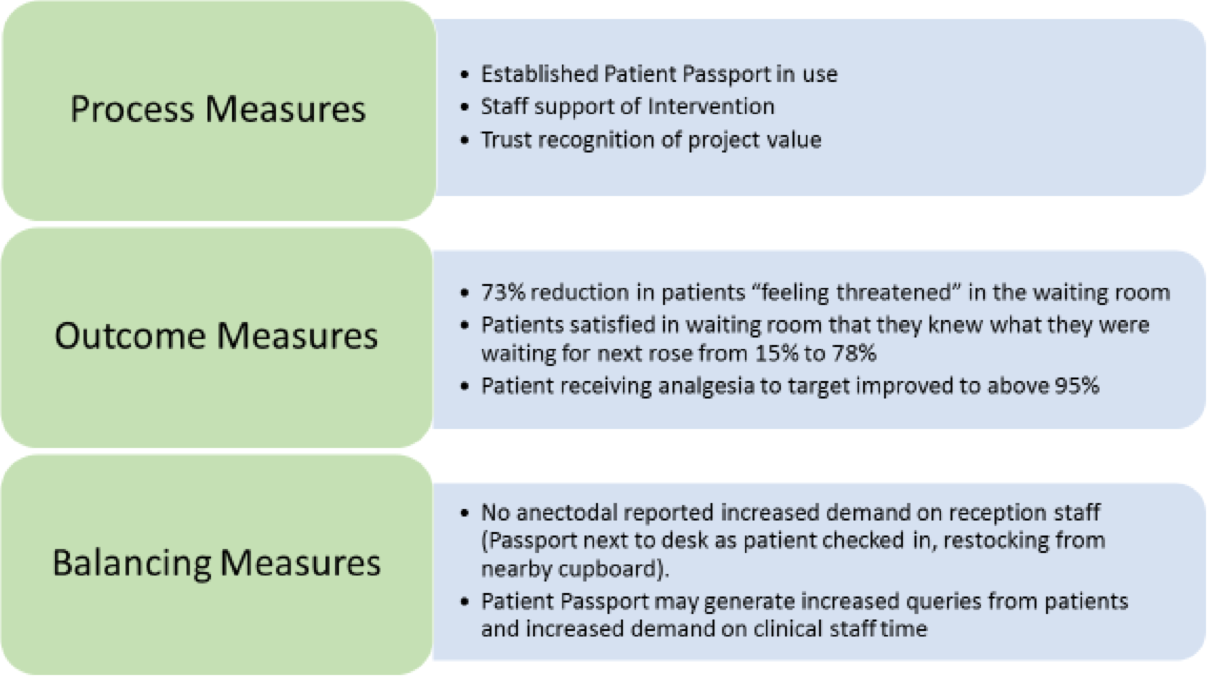
However, the repeat survey data within the department allows a clear way to demonstrate whether aims have been satisfied. The timing of the more recent 2016 CQC survey would have been too soon to have been affected by this project, but certainly the next cycle of this survey will allow some demonstration of any impact of this work.

One further area of work, will be to collate complaints data to assess any decrease in adverse reports regarding information provision.

Assessment of the effect of change

When considering the effect of an intervention and the overall Quality Improvement project, there needs to be consideration of Process measures, Outcome measures and Balancing measures.

Fig 15: Summary of key distinct measure types for project



Process Measures

- Established Patient Passport in use
- Staff support of Intervention
- Trust recognition of project value

Outcome Measures

- 73% reduction in patients "feeling threatened" in the waiting room
- Patients satisfied in waiting room that they knew what they were waiting for next rose from 15% to 78%
- Patient receiving analgesia to target improved to above 95%

Balancing Measures

- No anectodal reported increased demand on reception staff (Passport next to desk as patient checked in, restocking from nearby cupboard).
- Patient Passport may generate increased queries from patients and increased demand on clinical staff time

Outcomes

I am very pleased with the overall project and feel it has had a positive effect with a professional looking intervention. There are objective benefits to be seen, although there are some key areas of progress and analysis still required.

Fig 16: Project timeline 2 (current)

September 2015: Following arrival at [redacted] for ST5 training year, potential project identified through educational supervisor meeting

13th October 2015: Plan for QIP submitted to educational supervisor and requests commenced to potential team members. Initial contact made with stakeholders to register commencement of project

January-April 2016: Liaison with Trust Patient Experience team, gaining permission for patient contacts

5th-15th June 2016: Initial surveys of patients conducted following permission from UHB Trust regarding interviewing patients

July 2016: Initial development of Patient Passport concepts, informal contacts with frontline staff

21st July 2016: Presentation of initial Patient Passport concepts and information to [redacted] ED consultant meeting and followed with email request for structured feedback

7th November 2016: Formal meeting with UHB Patient information and Design team to work on Patient Passport design

19th December 2016: Patient information team produce first full draft of Patient Passport

4th January 2017: Presentation of first draft Patient Passport to [redacted] ED Audit meeting

25th January 2017: Complete structured patient feedback on Patient Passport wth 10 patients

2nd February 2017: First complete draft of Patient Passport ready for production

29th March 2017: Request for quotes for printing externally via trust print room

3rd May 2017: Confirmation of “Above & Beyond” charitable funding for initial trial print run

5th June 2017: Commence introduction of Patient Passport for trial period

10th-17th June 2017: 2nd period of patient surveys completed

3rd October 2017: UHB Trust Approval to fund production of Patient Passport for at least 3 years

Here are the comparative results of the repeat survey data in the [redacted] following introduction of a patient passport, demonstrating positive changes in all measures.

Fig 17: Comparison Survey Data before and after introduction of Patient Passport for 'Majors' area

MAJORS Question	BEFORE	AFTER	CHANGE
Have you been told how long you would wait to be seen by a clinician	23%	60%	**+160%**
Were you offered pain relief when you were seen	87%	95%	**+9%**
Did you know where you/relatives could obtain refreshments	62%	95%	**+53%**
Did you at any stage feel threatened by other patients or visitors	13%	10%	**-23%**
Do you know what the next thing you're waiting for is	68%	82%	**+21%**

Fig 18: Comparison Survey Data before and after introduction of Patient Passport for 'Majors' area

WAITING ROOM Question	BEFORE	AFTER	CHANGE
Have you been told how long you would wait to be seen by a clinician	12%	65%	**+442%**
Were you offered pain relief when you were seen	87%	93%	**+7%**
Did you know where you/relatives could obtain refreshments	25%	90%	**+260%**
Did you at any stage feel threatened by other patients or visitors	37%	10%	**-73%**
Do you know what the next thing you're waiting for is	15%	78%	**+420%**

This clearly demonstrates a varied improvement to the elements of the local survey, but in some areas a marked improvement well beyond that of our aims, and we will await the next cycle of the CQC survey to see if these improvements are reflected there.

Process and Balancing outcomes were only really measured anecdotally and informally from the wider clinical and clerical team, so while we are demonstrating the successful provision of patient information, and no detrimental effects of clinical and clerical time, we need to examine the impact of and interaction with the information more objectively.

In terms of better understanding the measures detailed above there are some further pieces of ongoing analysis to be completed:

- Review of the next cycle of CQC Patient Survey in Accident & Emergency Departments, now that the Patient Passport is fully active
- Formal assessment of compliance with distribution to patients, and assessment of how much the Patient Passport is interacted with by clinical staff
- Better investigation of Balancing measures, with audit of additional time requirement for activity related to distributing and stocking leaflets, and queries as a result of content
- Review of complaints over subsequent time period, including issues around Patient information, and specifically any feedback regarding Patient Passport

Reflections

It is useful to reflect at this stage over two main areas of this project. Firstly more broadly about Quality Improvement and my experience and learning around its purpose and methods as a result of this work, and secondly some more specific reflections around some of the underpinning aspects of this specific project relating to NHS structure and activity.

Planning Quality Improvement and Chronology of events:

The clearest reflection I have taken from the experience of this project as a whole, is the complex way in which QIPs require thorough planning and co-ordinated activity, but unless it is a topic you are already familiar with, it will intrinsically end up being an extensive learning process and the project will evolve and change. In this case, my understanding was simpler at the beginning of the project and I focussed my efforts on a simple intervention to improve some objective data, and my team were largely found roles as required. I now feel I relied on a sense that providing patients with information must be a positive thing, and was therefore not clear about how this would be best achieved or measured.

I still feel that it is difficult to engage a broader team in a project like this until you been able to demonstrate its potential for success and worth. This leads to having to make some individual progress in a less team-focussed model and then forming your team around a mobile project. On reflection, much more emphasis could be placed on the planning phase of the project as perhaps a higher quality of planning and structure would be enough to engage others without having demonstrated the beginnings of a high quality intervention.

I have subsequently recognised the benefits of more continuously recording measures of progress to highlight which interventions have an effect rather than a simple “before and after” approach to data collection.

Challenges around continuous measures:

I have looked at other projects around clinical problems, and found that many QIP methods are more easily applicable to measurable clinical events. For example some QIPs that measure numbers of admissions, or frequency of events that are routinely recorded by a trust, can then be used as measures for a QIP intervention. In this instance, the data points were much more rare and complex, such as the CQC survey or patient interviews.

I think a QIP considering Patient Experience needs more thought around how to measure progress, and perhaps less emphasis on outcome measures that are complex. In hindsight, I would have looked more at process measures such as patients requesting information, or whether clinicians found the Passport useful, to ensure the project was achieving its process goals, rather than relying heavily on more rarely documented extrinsic measures.

Similarly, balancing measures are hard to quantify. While it is simpler to state if a QIP aimed at reducing length of stay for patients causes higher readmissions from looking at simple data, it is difficult to define the burden on clerical staff against an increase in patient information and the effect on patient satisfaction in the short term.

NHS Trust Structure and team formation:

I found this complex, and even using the vast amount of information on trust intranet sites, found it challenging to put together the chain of interests and stakeholders in a project, and how they might interact. You often only learn the necessary steps required for an intervention as you attempt to make progress. This is also reflected in that there will rarely be a senior clinician who can accurately guide you through the expected process as this will unlikely be exactly replicated in other projects, and a broader understanding of levels of governance and trust management is a more useful framework. I think that as long as you have quality planning and an aim that is reflected by your trust and department goals, a more “top down” approach to initial planning may be more effective, for example, knowing what the trust executive would like to see in order to support a project from the beginning.

A commonly understood element of teamwork is that all team members will bring different skills and experience to a team, but will also be driven by different motivators. A good example in this project was that a medical student who assisted with data collection provided the most rapid, comprehensive and reliable response to task allocation, due to a motivation to impress the local clinical team, broaden their CV and aim to enhance their own training experience, but would be expected to show little insight into the overall project direction and implications. Senior management however, while harder to engage, are a huge source of direction and influence once they feel a project is in line with their own goals. I would reflect that estimating the potential motivators of team members when the team is formed would help to maximise the effectiveness of their roles.

NHS Policy and Values:

Looking deeper into Department of Health aims, and the work of “think tanks” gave me greater insight into the workings of NHS policy at a higher level. This taught me to look for the source of widely publicised initiatives and targets as the underlying data and evidence require scrutiny to ensure the goals you are aiming for are ones you consider locally valid.

Patient Experience:

This project caused me to have greater time to reflect on both the nature of patient experience and satisfaction, and spend time to reflect on the words of patients and empathise with their experience in our Emergency Department. I felt as if the true benefit of the project became clearer in time but as an individual, my understanding of patients’ frustrations and experience grew.

Patient satisfaction is an interaction of their experience against their expectations, and altering patient experience in a major way is more costly and requires much greater resources, but presenting more realistic expectations is a simple way of improving satisfaction. I felt this could be the beginning of a wide range of ways in which we make patients feel more engaged with the department and the complexity of activity. This may give patients more realistic expectations, but also may allow them to make their own health care choices in future in a better manner. (E.g. comparing attending an emergency department for a more chronic musculoskeletal complaint may involve an assessment and x-ray of a patient, but in the context of other clinical activity in an ED, the patient can understand the options and convenience of accessing this process through primary care or acute emergency care). I considered if another step to the project could be mapping care pathways of common complaints within the local NHS so patients experiencing long waits could consider other providers.

Project funding: I had some insight into the complexities and restrictions on even modest funding with an NHS Trust to make a project succeed, as well as the role of charitable funds. The clearest conclusion was around the concept that generally a project must not only be demonstrated to be effective, but to align with key trust goals and targets, as well as be seen positively within local departments, to have a greater chance of achieving ongoing funding for an intervention.

Summary

This was an interesting and engaging Quality Improvement Project where the great satisfaction was the production of a profession “end product” but with great challenges in measuring progress.

The introduction of a Patient Passport has been demonstrated to improve patient satisfaction, and provide potential for meeting key emergency department targets. There is great scope for this to form part of ongoing work to improve patient experience locally.

I personally feel that the provision of information to ED patients is something that has been done poorly in the past, and that this is a huge step to better informing and empowering patients to understand their journey. I think the areas we’ve have not fully explored in our measurements now provide great opportunities moving forwards to make greater improvements.

I was personally inexperienced in Quality Improvement in its modern form and had been used to working through an audit cycle approach to making interventions, so this project has allowed me to reflect and learn extensively, and would significantly change my approach in future, with the benefit of this learning, alongside a rapidly moving knowledge of this process amongst the healthcare community.

I have recently been offered a substantive consultant post at the [redacted] which gives me the opportunity to continue this project myself, as well as aim to take a lead role in patient experience in the department.

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Appendices

Appendix A: Selection of [redacted] Trust data (4 areas) from CQC Accident and Emergency Patient Survey (2014)

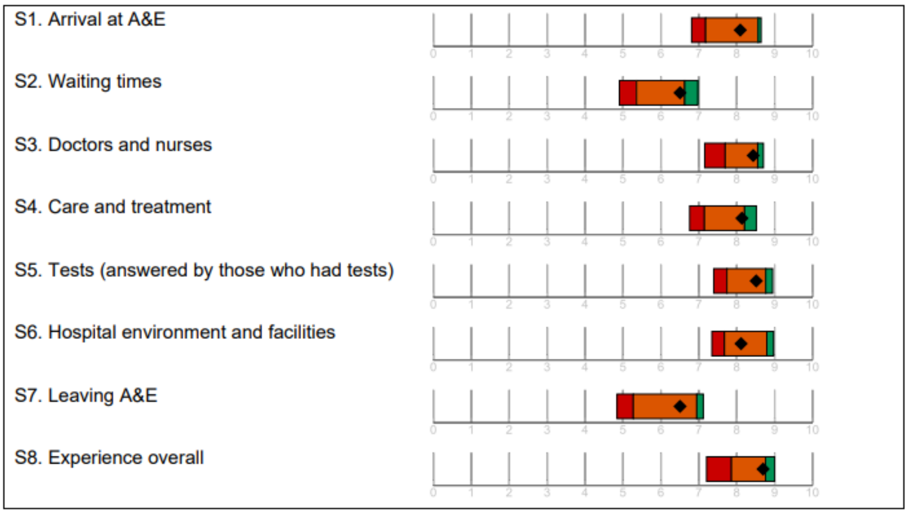
🟩 Best performing trusts
🟧 About the same
🟥 Worst performing trusts

'Better/Worse' Only displayed when this trust is better/worse than most other trusts
◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

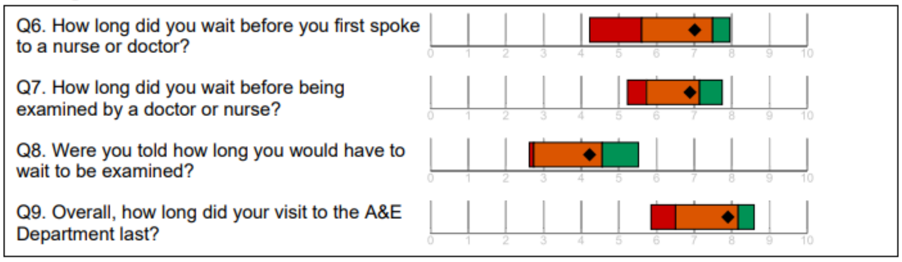
Accident and Emergency Survey 2014

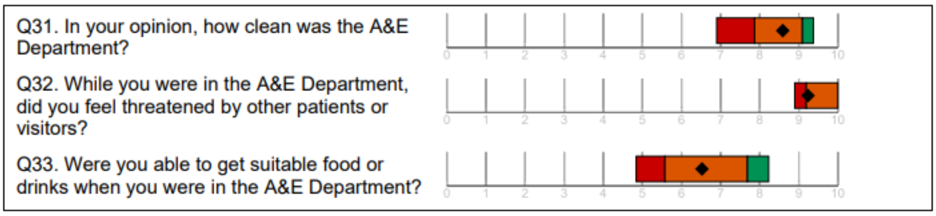
[redacted]

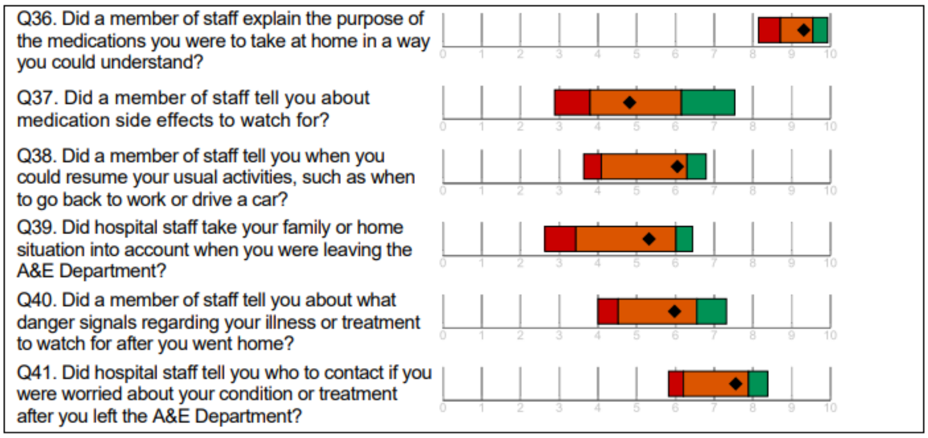
Section scores



Waiting times







Q36. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?

Q37. Did a member of staff tell you about medication side effects to watch for?

Q38. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?

Q39. Did hospital staff take your family or home situation into account when you were leaving the A&E Department?

Q40. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?

Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&E Department?

Appendix B: Summary of recent electronic feedback comments from terminal in [redacted] waiting room

- POOR TRIAGE, TERRIBLE COMMUNICATION WITH PATIENTS
- 5 HOUR WAIT AND COUNTING
- POOR CUSTOMER SERVICE
- I HAVE BEEN HERE FOR 8 HOURS AND PEOPLE ARE ONLY BEING SEEN AT A RATE OF ONE PER HOUR.
- WE HAVE BEEN HERE FOR 8 HOURS AND STILL WAITING TO BE TOLD WHAT THE XRAY SAYS
- YOU ARE ONLY CALLING 2 PEOPLE THEN NOTHING FOR A HOUR THIS IS TOTALY NOT ON
- ON ARRIVAL TOLD IT WOULD BE A 4-5 HOUR WAIT. 6HOURS 20MINS LATER WE WERE INFORMED IT WOULD BE 7 HOURS. 8 HOURS 30 MINS LATER WE ARE STILL WAITING MATTERS
- THE TIME IT TAKES THE DOCTORS TO CALL THE NEXT PERSON IN IS TAKEING THE MICK
- I AM DYING IN PAIN FOR 5 HOURS
- SIX HOURS WAITING FOR SURGERY WITHOUT ANY TREATMENT OR CONDITIONS FOR WAITING.
- TOO MANY PAINFULL AND HAVE TO WAIT WITHOUT SEATING, WITH NO ANSWERS BY THE STAFF.
- LONG WAIT FOR RESULTS OF XRAY...............UNACCEPTABLE
- 2 HOURS FOR X RAY RESULTS
- IVE BEAN WAITING THE LAST 3 HOURS FOR NOTHING
- 1 HOUR MINIMUM TO BE SERVED
- STILL WAITING FOR PAINKILLERS
- NOT CLEAR WHAT A&E IS MEANT FOR? WHAT KIND OF ACCIDENTS, ETC.
- WAITING FOR THE DOCTOR FOR AN HOUR
- I WAIT TWO HOURS AND NOTHING HAPPEN

Appendix C: List formulated of key areas of concern from PDSA cycle 2

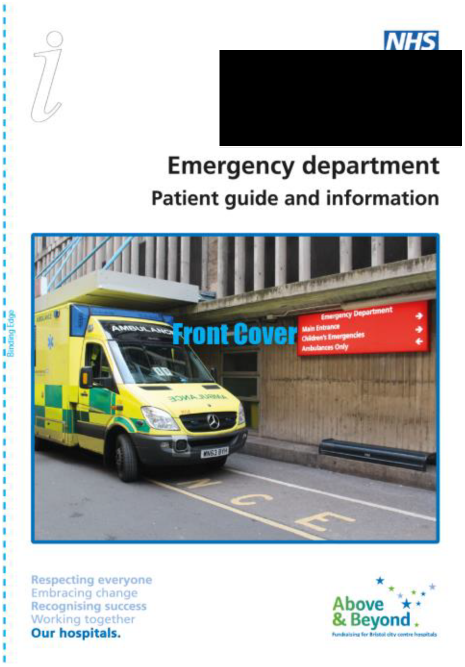
Key Areas highlighted for inclusion in Patient Passport

- Summary of role or Emergency Department
- Recognition of fluctuating and unpredictable demand
- Diagrams explaining uniforms and staff roles
- Chart showing patient journey and ED activity
- Checklist of patient expectations including initial analgesia
- Area for clinician to document advice and instructions
- Practical information regarding toilets and refreshments
- Information regarding complaints or feedback

Appendix D: Comments specifically left during structured feedback from 10 patients on draft patient passport in PDSA 4

- “This helps the experience a lot”
- “It is not knowing what you’re waiting for that is hard”
- “The information is really clearest”
- “I didn’t realise what was going on away from the waiting room”

Appendix E: Pages of Patient Passport Final Draft



NHS

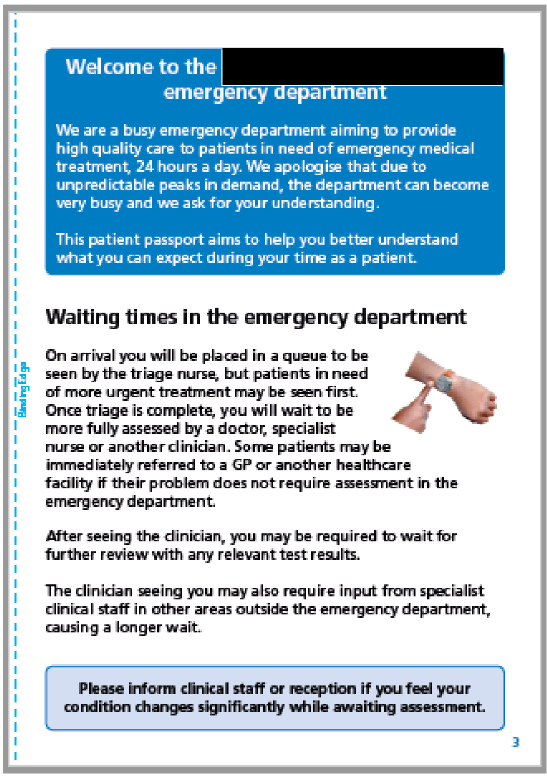
[redacted]

Emergency department

Patient guide and information

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Above & Beyond
Fundraising for Bristol city centre hospitals



Welcome to the [redacted] emergency department

We are a busy emergency department aiming to provide high quality care to patients in need of emergency medical treatment, 24 hours a day. We apologise that due to unpredictable peaks in demand, the department can become very busy and we ask for your understanding.

This patient passport aims to help you better understand what you can expect during your time as a patient.

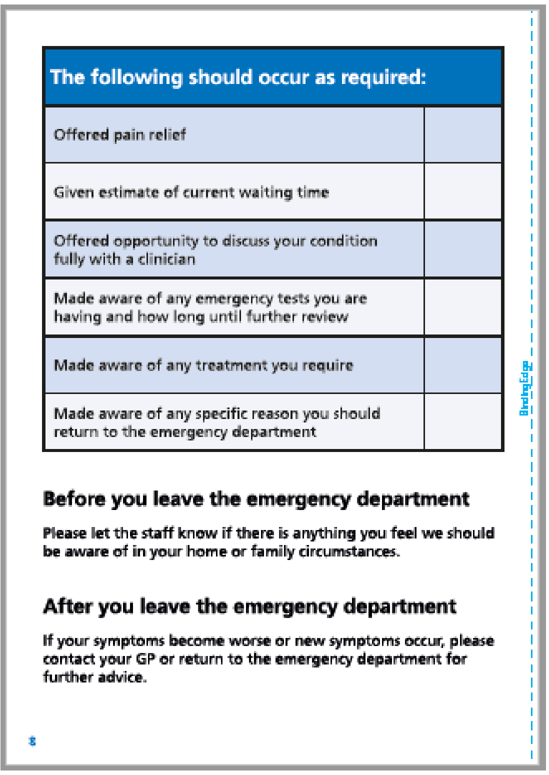
Waiting times in the emergency department

On arrival you will be placed in a queue to be seen by the triage nurse, but patients in need of more urgent treatment may be seen first. Once triage is complete, you will wait to be more fully assessed by a doctor, specialist nurse or another clinician. Some patients may be immediately referred to a GP or another healthcare facility if their problem does not require assessment in the emergency department.

After seeing the clinician, you may be required to wait for further review with any relevant test results.

The clinician seeing you may also require input from specialist clinical staff in other areas outside the emergency department, causing a longer wait.

Please inform clinical staff or reception if you feel your condition changes significantly while awaiting assessment.



The following should occur as required:

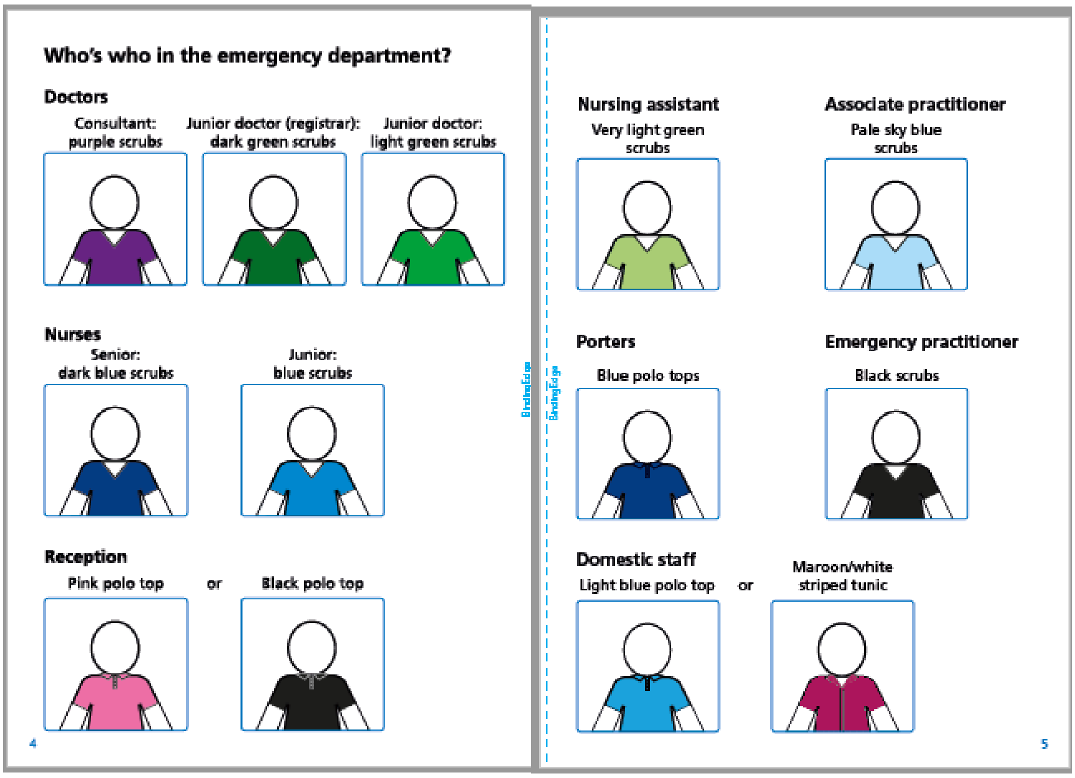
Offered pain relief	
Given estimate of current waiting time	
Offered opportunity to discuss your condition fully with a clinician	
Made aware of any emergency tests you are having and how long until further review	
Made aware of any treatment you require	
Made aware of any specific reason you should return to the emergency department	

Before you leave the emergency department

Please let the staff know if there is anything you feel we should be aware of in your home or family circumstances.

After you leave the emergency department

If your symptoms become worse or new symptoms occur, please contact your GP or return to the emergency department for further advice.



Who's who in the emergency department?

Doctors

Consultant: purple scrubs

Junior doctor (registrar): dark green scrubs

Junior doctor: light green scrubs

Nurses

Senior: dark blue scrubs

Junior: blue scrubs

Reception

Pink polo top or Black polo top

Nursing assistant

Very light green scrubs

Associate practitioner

Pale sky blue scrubs

Porters

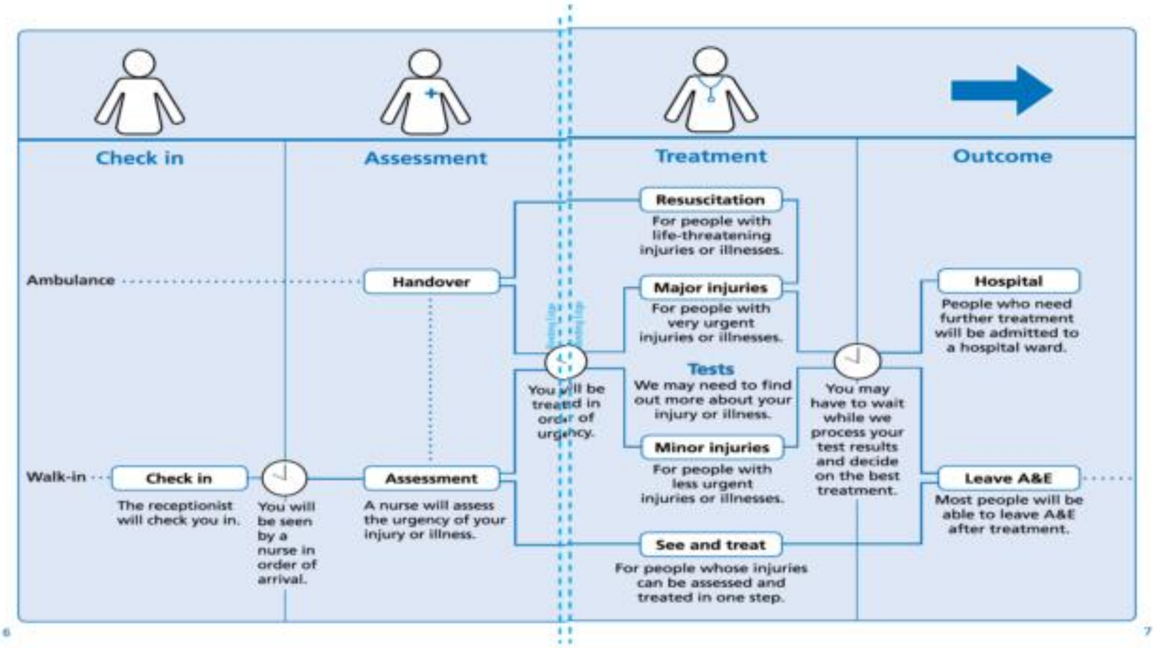
Blue polo tops

Emergency practitioner

Black scrubs

Domestic staff

Light blue polo top or Maroon/white striped tunic



Check in | **Assessment** | **Treatment** | **Outcome**

Ambulance → **Handover**

Walk-in → **Check in**

The receptionist will check you in.

You will be seen by a nurse in order of arrival.

Assessment

A nurse will assess the urgency of your injury or illness.

You will be treated in order of urgency.

Resuscitation

For people with life-threatening injuries or illnesses.

Major injuries

For people with very urgent injuries or illnesses.

Tests

We may need to find out more about your injury or illness.

Minor injuries

For people with less urgent injuries or illnesses.

See and treat

For people whose injuries can be assessed and treated in one step.

You may have to wait while we process your test results and decide on the best treatment.

Hospital

People who need further treatment will be admitted to a hospital ward.

Leave A&E

Most people will be able to leave A&E after treatment.

Refreshments

Vending machines

There are basic refreshment vending machines available in the corridor outside the main waiting room.

Patient meals

There is a service providing sandwiches and drinks to the 'major injuries' area at 10am, 12.30pm and 3pm daily.

For relatives

Level 2 Welcome Centre

Costa Coffee	Monday to Friday: 7am to 8pm Saturday: 7am to 9pm Sunday: 7am to 8pm
M&S	7am to 9pm every day
WH Smith	Monday to Friday: 6.30am to 9pm Saturday: 7am to 9pm Sunday: 7am to 8pm

Level 9 DeliMarché

Every day 7.30am to 2.30pm

We would suggest that patients confirm with the clinician assessing them if they can safely eat and drink while awaiting investigations or treatment.

Transport home

It is not possible for the emergency department to routinely provide transport home for patients when they are discharged from the department, but the following information may assist you in your onward journey if you are unable to be collected from the hospital by a friend or family member. We appreciate that this can be challenging, particularly when patients have been brought to hospital by ambulance, but we ask for your understanding that transport cannot be provided. If you have any specific concerns, please speak with a member of staff.

Taxis

There is a free-to-use telephone in reception to call for a taxi, which can collect you from outside the main waiting room.

Buses and trains

A free shuttle bus service is provided for patients, visitors and staff. The circular route includes Bristol Temple Meads railway station and our hospital sites. Please ask staff for a copy of the leaflet 'How to get to our hospitals' to see the latest timetable.

First Bus provides a number of bus routes and park and ride facilities which stop at or near all of our hospital sites. Bristol bus station, in Marlborough Street, is a few minutes' walk away.

Bristol Temple Meads railway station is approximately 30 minutes' walk from the BRI. The other main railway station is Bristol Parkway, which is outside the city. Bus services run between Bristol Parkway and the city centre and the journey time is approximately 40 minutes.

Alternative care

If you need assistance in future but do not feel a problem is appropriate for a visit to the emergency department, dialling **111** allows you to access medical support more rapidly. Please remember that you can also contact your own duty emergency GP via your normal surgery in office hours.

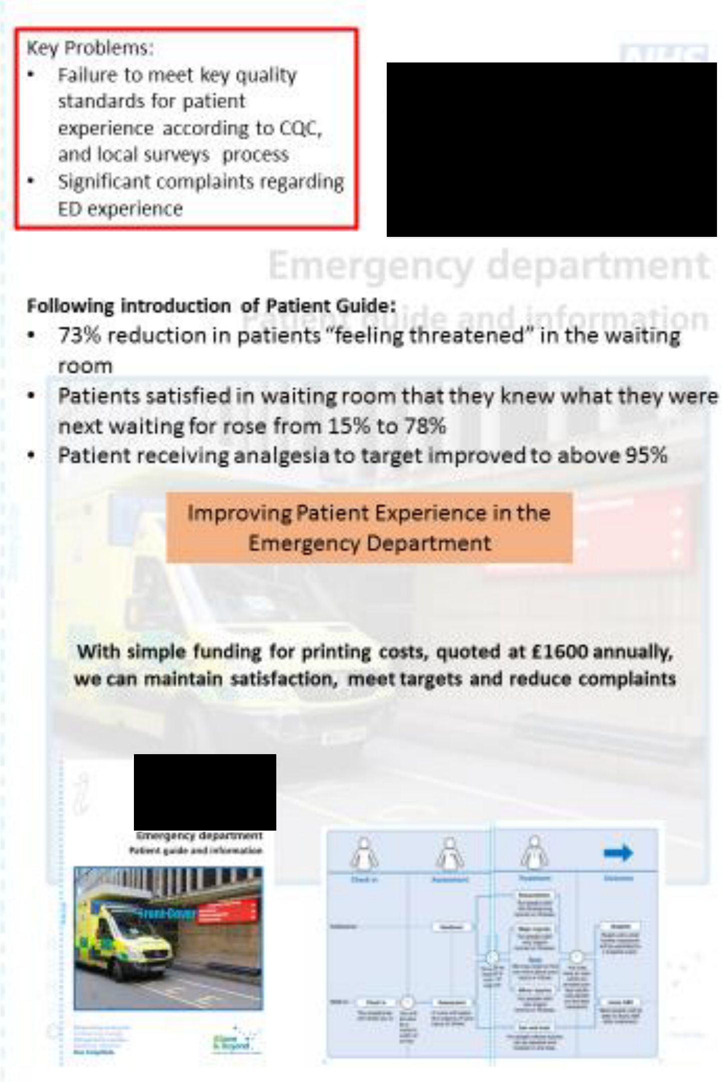
NHS 111 service provides:

- acute medical advice/assessment
- information regarding local dental care
- GP appointments (both visits and surgeries).

Notes and queries

[redacted]

Appendix F: Poster presentation to Trust executive alongside patient passport



Key Problems:

- Failure to meet key quality standards for patient experience according to CQC, and local surveys process
- Significant complaints regarding ED experience

[redacted]

Following introduction of Patient Guide:

- 73% reduction in patients "feeling threatened" in the waiting room
- Patients satisfied in waiting room that they knew what they were next waiting for rose from 15% to 78%
- Patient receiving analgesia to target improved to above 95%

Improving Patient Experience in the Emergency Department

With simple funding for printing costs, quoted at £1600 annually, we can maintain satisfaction, meet targets and reduce complaints

[redacted]

Emergency department
Patient guide and information

Appendix G: Sample communication within the broader project team

Making contact with the Patient information team, to assess support available for design resources

From: [redacted]
Sent: 03 July 2016 11:34
To: [redacted]
Cc: [redacted]
Subject: RE: Patient leaflet

Hi [redacted]

The patient information team here in Communications can help you with that. [redacted] oversees the service and [redacted] (both cc'd) is the patient information assistant.

There's a fairly strict process for creating patient information leaflets with regards to approvals/version control/ownership and there is a leaflet design template, but if you feel this design is too restrictive we can be flexible and open to ideas.

Maybe send your content plan over to [redacted] and [redacted] so they can advise on timescales and next steps etc?

Many thanks

[redacted]

[redacted]
Print manager

Engaging with the Patient Experience Lead, providing support on planning patient surveys

From: [redacted]
Sent: 03 March 2016 11:37
To: [redacted]
Subject: RE: Patient experience project

Thanks [redacted] – there is a registration process for patient survey type stuff (QIS). It's a kind of light touch research ethics process: the intention is to be supportive and though I don't think it is an onerous process, there is no denying it is also a bit more paperwork for you sorry!

If you could send over the interview schedules when you have a mo I can give you a view on whether we need to go down this route and any initial thoughts.
Regards, [redacted]

[redacted]
Patient Experience Lead (Surveys and Evaluation)
[redacted] NHS Foundation Trust

From: [redacted]
Sent: 16 March 2016 10:17
To: [redacted]
Subject: RE: Patient experience project

[redacted], very sorry about the delay – I was caught up in a wave of reporting deadlines just after we last emails.

It looks like you would be talking to patients face to face to ask these questions – is that correct? I've got a few minor suggestions for some of the questions but it depends on whether it is an interview schedule or self-completed questionnaire.

We do need to get the interview schedules signed off by the QIS group. To do this I will need you to complete the attached for (aim for a 20 minute-ish job – it doesn't need to be hugely detailed). A couple of things to include – 1) when the interviews will be carried (with ED one tends to think in terms of it being quite a stressful situation, so timing is important and I'm sure you would have thought about already), 2) who will be doing the interviews

Any queries just let me know.

Regards, [redacted]

[redacted]
Patient Experience Lead (Surveys and Evaluation)

Meeting summary by e-mail regarding the Design Council Project, where I sat on the committee

From: [redacted]
Sent: 12 April 2016 16:13
To: [redacted]
Subject: RE: Design Council Project

Dear all
Many thanks to all of you for attending todays first meeting
Kelly gave us an overview of the aim of the project and the learning from where the design strips had been implemented in other hospitals. There was a useful opportunity for Q&As from the group.

<u>Key points from the meeting were:</u>

- A large process map in reception/waiting room is really helpful for patients
- We discussed the design strips extending into x-ray and into the ambulance corridor
- Resus room, suggestion of a bay number in each bay and minimum information seems to work best
- Relatives room would be useful to include
- Mental health interview rooms , consider a signs on the door
- Important to include the observation unit
- A locator map of the department for visiting staff (specialty staff, ambulance crews etc) has been found to be useful in other EDs
- Background can be green, blue or navy blue (Decided because of newly covered waiting room chairs in pink and purple, green background is ruled out)

Actions from meeting,

1) include [redacted] from reception, [redacted] Radiology in the group
2) Email new floor plan of ED to [redacted]
3) [redacted] will liaise with purchasing and [redacted]

Going forward:
Contract to be signed,
Group members to identify where signs should be situated in each area (please feedback to [redacted])
Once contracts have been signed then text on the strips will be devised and sent to the group for editing

Liaison with the team co-ordinating "Friends & Family" feedback and adding it to our patient information

From: [redacted]
Sent: 28 November 2016 09:54
To: [redacted]
Subject: RE: Friends and Family

[redacted]
Just checking this is referring to Adults.

Great idea. In terms of FFT you can mention that patients/families can complete Friends and Family Test by card and on screen and they may receive a SMS text too.