Quality Improvement Project

████████████

Aim

To improve reported patient experience to meet all local and national target measures as per national patient satisfaction survey and CQC guidance by August 2017.

Problem

CQC feedback at ██████████████████ reported a failure to meet expected standards regarding Patient Experience and Satisfaction. While there have been many systemic changes made to improve patient waiting times, I had both personal and reported anecdotal experience of patients reporting they received insufficient information regarding their expectations of the Emergency Department, and this was reinforced further by a review of local complaints and the waiting room electronic feedback system.

Introduction

Emergency Departments (EDs) have worked to improve processes and resourcing to meet agreed ED key quality indicators (KQIs)[1], with the greatest attention seemingly given to decrease the length of wait in departments for patients to be both seen by clinicians and complete their episode of emergency care, along with prevention of patients leaving prior to treatment or re-attending in an unplanned manner. Patient experience forms a small 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. The CQC National Patient Satisfaction Survey[2] and Department of Health work around managing violence and aggression in Emergency Departments[3] both recognise that improving the quality of a patient's time in the Emergency Department, improves the overall experience of both patients and staff.

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. This is a phenomenon seen in our local department.

This project aims to look at system changes that could educate and empower patients to take control of their own journey through the emergency department, and allow clearer expectations of what may be involved in their clinical journey. This aims to improve patient experience for a minimal additional resource requirement, and improve patient satisfaction overall, with the quantitative aim of satisfying the acceptable requirements of the CQC and local patient experience surveys.

Identification, Analysis of Problem & Current practice

Currently, patients arrive to the ED by various means, most commonly self-presenting to reception, or via an Emergency Ambulance. Patients will be registered with the ED via either route, before a triage assessment by a member of the nursing staff. The gold standard for triage assessment is that it should happen within 15 minutes, and a patient can be offered any urgent medication for symptom relief, or initial clinical investigations can be commenced. At present an ambulant patient would commonly be asked by reception staff to take a seat in the waiting room and await triage assessment as a basic level of information, while a non-ambulant patient would be transferred to a cubicle and assigned a nurse.

After triage, an ambulant patient would now wait, most commonly in the main waiting area, after triage, for assessment by a decision-making clinician and the gold standard for this assessment is that it should commence within an hour of initial arrival. Once the ambulant patient is assessed they will either be discharged or admitted to the hospital, or the clinician will provide further treatments and potentially undertake further investigations, most commonly bloods test or radiological investigations. Once more the ambulant patient will commonly await the results of these investigations and subsequent clinical decisions in the main waiting area, before they are reviewed with a decision regarding hospital admission or discharge, and any treatment and follow-up required. Currently there is no standardised information to patients regarding this process, and the patient relies on each clinical interaction to understand each step in the journey. When the patient is not with a clinician, their current single point of contact with the department is the main reception desk.

The non-ambulant patient follows a similar pathway, but commonly remains in a set cubicle under the care of a named nurse caring for 4 patients simultaneously, and will have regular access to that nurse via an alert bell, along with room for their family/friends in their cubicle and visible access to other clinical staff when required.

When a patient is admitted from either area, they will likely be informed verbally and should relatives enquire, a named ward can be provided if it has been confirmed. Patients who are discharged will ideally be provided with written and verbal information regarding advice and clinical follow-up but this is at the discretion of the assessing clinician. Some clinical follow up information has standardised documentation while others do not.

The CQC data clearly identify a problem in the sense that patients reporting on their own experience are expressing a dissatisfaction with the current system. To further investigate individual patients' experience to understand this better would be intensive to gain any reliable sense of what interventions would best address the problem. Given the aims of this project, a "Driver diagram" was a useful exercise to highlight interventions that could best ultimately satisfy the patient experience quality indicators, taking into account that the Kings Fund work was based on extensive patient feedback. While the structure of this project is to introduce a main single intervention, the driver diagram allows not only to consider the content of a patient leaflet, but also the delivery of it within the department.

The ED waiting area has an electronic system in place for patients to indicate their level of satisfaction with their experience, and provide more detailed feedback. Such opportunistic feedback is at risk of bias, as those with negative experiences are more likely to provide comments, and these may be given at the peak of a stressful experience, but regardless the details in the statements given can be of great use in

identifying areas of concern. Informal discussions with clinical staff were also useful to establish key trends where clinicians have patients who have expressed a direct dissatisfaction with their experience in the ED. While this is not as reliable as survey data, it perhaps accessed a different patient group to those who would be engaged in the survey process.

Some quotes taken from the electronic waiting room feedback demonstrate the focus on a lack of information regarding what patients are waiting for, and that lack of understanding regarding the purpose and workings or an emergency department are crucial to the context of a patient's experience.

Fig 1 : Quotes from electronic ED waiting room feedback

- POOR TRIAGE, TERRIBLE COMMUNICATION WITH PATIENTS

- 5 HOUR WAIT AND COUNTING

- POOR CUSTOMER SERVICE

- TOO LONG WAIT FOR HEAD/FACE INJURYS.

- 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.

- WAIT TOO LONG FOR A BLEEDING ON HEAD - UNACCEPTABLE

- WAITING FOR THE DOCTOR FOR AN HOUR

- I WAIT TWO HOURS AND NOTHING HAPPEN

- WAIT TOO LONG FOR TRAUMA

Fig 2: QIP Driver Diagram

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

Literature Review

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[4], through the NHS Plan in 2000[5] and up until the NHS constitution for England in 2013[6], 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[7]. This summarised that in line with the outcomes framework against which NHS performance is assessed, comprising Accountability, Quality Improvement and Transparency, that 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"[8], 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.

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. This provides a good broad source of reliable data but the Department of Health guidance has been based on this single funded project rather than broad analysis of other data.

As this work allowed a validated method of assessing Patient Experience, the NHS National Patient Survey[2] was able to gather information regarding patient experience in Emergency Departments retrospectively via questionnaires, and inform CQC 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 [9,10], but there are now validated tools to attempt to address this.[11, 12]

Alongside this national framework for assessment and improvement of patient experience, there has been an increasing interest amongst clinicians to look more closely at what affects the quality of experience of patients who attend Emergency Departments and systems that could be introduced to improve experience. Key Quality Indicators[1] have more easily focussed on quantitative outcomes in Emergency Departments, such as wait times, duration of episode, numbers of patients not waiting to be assessed and unplanned return visits, and resources subsequently allocated to optimise departmental performance as such. Many for these factors are intrinsically affected by fluctuations in demand and inpatient hospital resource demands. While patient experience has been demonstrated to deteriorate with factors such as increased wait times[13,14,15], 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[10] in 2004 suggested at the time, 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 patient reported receiving no information at all on arrival to the ED[13], while 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.

As there is reasonable 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 when using a retrospective linear regression model to generate predicted times[16], and this inaccuracy may impair general overall experience, so it is likely 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[14,17], 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.

Team assembly

The following project team was assembled:

Project Lead: ███████████████ ST5/6 EM
Project Supervisor: ███████████████ EM Consultant and Department Lead
Nursing Lead: ████████████ (Band 7 Nurse)
Medical Student: █████████
Design council liaison:███████████

This project began with a small team of local clinicians, and while many stakeholders began to put momentum behind the project and take on key roles in facilitating the progress of this work, I consider the small project team to have remained the same.

Once our initial planning meeting had established our expectation and timeline for this project, we recognised that while clarifying the extent and detail of the problems with patient experience locally and preparing an intervention locally would be a reasonably straightforward challenge, the great complexity of this project would be taking on an intervention on a scale that would without doubt include a complex array of stakeholders, who would likely have strong feelings and potential restrictions on this project.

It was therefore decided that within the team, I would take a strong lead on navigating the journey of the project, and enable the team members to utilise their strengths in engaging local staff and providing guidance and education regarding local processes and expectations.

████████ regularly oversaw progress to ensure the project remained an appropriate RCEM QIP, while also meeting our local departmental leads, and gave advice on local trust structure and contacts. ██████████ also provided access to the senior clinical and management teams throughout the project, while ████████████ was instrumental in engagement with nursing and clerical staff, as well as co-ordinating the audit patient surveys.

████████████ provided a direct link to the Design council project which through one-on-one and committee meetings, allowed the projects to work in unison to a positive conclusion.

Engagement with stakeholders

The stakeholders in this project are complex, but can be subdivided into the local department, the NHS trust, patients themselves and the Design Council Project. The diagram below gives an indication of the groups immediately involved.
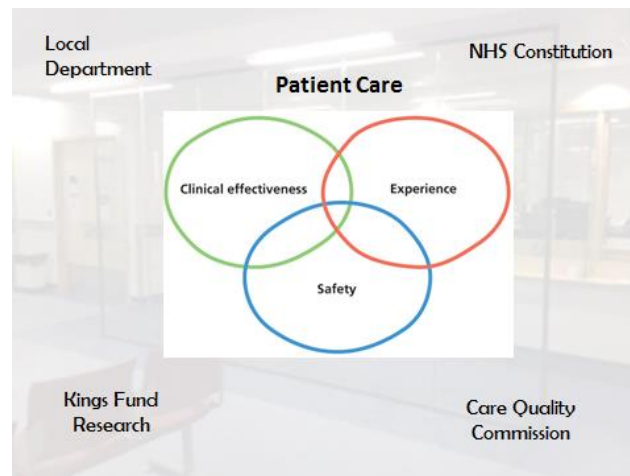

The challenges with a project such as this are also complex. Firstly there is the engagement of front-line staff whose clinical work and experience we are trying to assess and influence. It was important to be honest and open with staff during the survey and assessment process and ensure clinical staff have an opportunity to provide comment on the project and planned interventions, and this was achieved with opportunistic verbal explanations, clinical governance presentations, and e-mailing stake holders updated drafts of project materials inviting comment, including all Emergency Department consultants and senior nursing staff.

Secondly, this project overlaps with the work of others within the trust. The support of the ▮▮▮ Trust Patient Experience team was essential, and so there was regular communication with their lead during project planning. Their support made it simpler to gain trust approval for conducting questionnaires with patients in clinical areas, and helpful changes were suggested via this process. Similarly the Trust team regarding Patient information, along with patient material design and production were closely engaged with to ensure all work met the requirement for any official trust documentation and patient information.

Thirdly, there was a simultaneous grant via a Design Council Project focussed on reducing patient violence and aggression in the ED which integrated well with this project, allowing new instalments of information for patients to complement this projects intervention, and benefit both projects. ▮▮▮▮▮▮▮ (Nurse Consultant) was the lead for the Design Council project and we worked alongside one another closely and positively, while I joined the Design Council project committee to improve communication links.

Finally, and most importantly, patients are the key stakeholder in this project, and so during the survey process patients were informed that questionnaires were related to attempts to improve patient experience, and the subsequent repeat survey process allowed to us to engage and reflect on whether patients felt they had benefitted
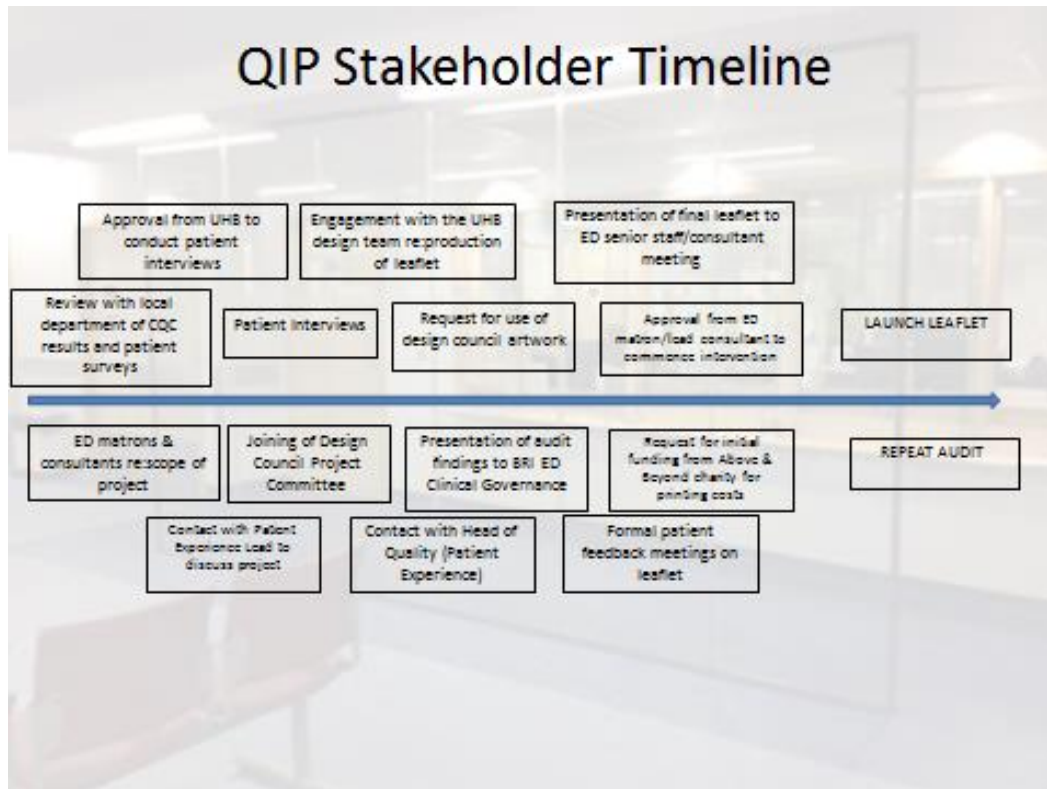
Development & Implementation of assessment mechanisms

The process measures set out in the patient survey would form the basis of measurement of the success of the project. We would expect the intervention to provide an initial positive effect on markers of positive patient experience, but the necessary engagement of other stakeholders, would hopefully provide other benefits with increased staff awareness of patient experience, and this may be seen in other trust markers such as "friends & family" approval surveys.

Quality management process and project plan

A timeline of the key events in this project allow for a sense of the development of the "patient passport" and its introduction. This project works along the framework in the figure below, and while there is a single main "intervention" when the passport is introduced, the project can be seen as a series of more minor PDSA cycles in its development. It should be noted, however, that other than the work alongside the Design Council project for ED graphics, there would be no expected improvement in outcomes until the main intervention, so I cannot demonstrate any gradual improvement in outcomes in response to the initial PDSA cycles.

The PDSA Cycle for Learning and Improving
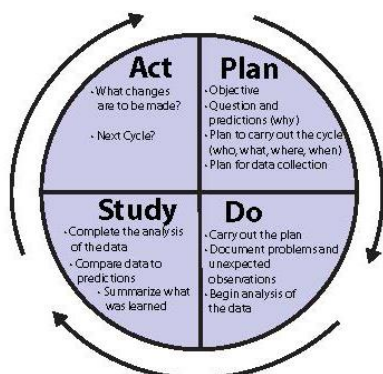
Cycle 1: First iteration of Patient Passport produced

PLAN
The questions raised are based on the CQC Patient Satisfaction questionnaire, and in response to areas where our local trust could focus improvements in response to the most recent results. The prediction is that an apparent lack of quality patient information and a reliance on busy clinicians and clerical staff to keep patients informed at all steps of their journey would lead to deficiencies in patient experience and satisfaction. A focussed questionnaire based on the key CQC areas in need of improvement allowed us to objectively measure patient experience. These are process measures to ensure we are compliant with recognised quality care.

We decided that partly due to the fluid nature by which patients can move between areas of the department, and to give the best overall impact, that we would both study and make an intervention in all areas of the department. We therefore aimed to conduct 40 questionnaires in the main ambulant waiting room area, and 60 questionnaires in the non-ambulant nurse-supervised cubicles area. The survey was proposed to the UHB Trust team responsible for patient experience and they approved the structure with minor amendments.

DO
We obtained the following data using the planned questionnaire/survey format.

MAJORS Question	Yes	No	%
Have you been told how long you would wait to be seen by a clinician	14	46	23%
Were you offered pain relief when you were seen	52	8	87%
Did you know where you/relatives could obtain refreshments	37	23	62%
Did you at any stage feel threatened by other patients or visitors	8	52	13%
Do you know what the next thing you're waiting for is	41	19	68%

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%

The data was analysed, and the planned intervention was to produce a generic patient information passport that they could receive at registration and would educate and guide them through their journey in the Emergency Department. The information would empower the patient to understand the potential steps in their journey, why there may be multiple periods of waiting, and what they could expect to happen next. The passport would encourage patients to ask relevant questions regarding their management, but aim to satisfy more common queries and not require additional interactions with staff.

STUDY
Review data with regard to expected findings from CQC results

ACT
Confirm need for ongoing project and develop intervention to improve patient experience

Cycle 2: Patient passport shown to senior staff and management

PLAN
There was now a clear need established to make efforts to improve patient information as a key step in improving patient experience. A positive response to this plan within the trust was expected, and due to the problems being common and affecting staff negatively, I expected a positive and informed response to the project from within the department.

DO
I confirmed with my senior project supervisor that an intervention such as a patient passport would seem to meet the deficiencies noted in our survey data, while I engaged with the Patient Experience team within the trust, and received encouragement to progress with the project. Responses as expected were positive and others were enthusiastic about the project.

STUDY
The engagement locally encouraged me that the prediction was correct, and there was adequate momentum and enthusiasm with this project to move onto development of a patient passport.

ACT
Begin development of the advanced patient information leaflet

Cycle 3: Development of patient guide to the ██ ED

PLAN
The aim was to develop simple, informative leaflet that encompassed the direct deficiencies of patient information highlighted in the survey, while engaging with the design council artwork that would be visible throughout the ED, and also acknowledging an opportunity for experienced staff to include information they felt would be relevant and helpful to our ED patients.

DO
I provided basic wording on clear areas such as waiting times, the reasonable expectations of an ED patient, a "who's who" of staff and simple information regarding refreshments and other conveniences. The Design Council "flow diagram" of the clinical journey through the department was incorporated into the plans, and this was all passed to the UHB trust design and patient information team. A draft leaflet was produced.

STUDY
This initial leaflet was presented at a meeting of senior clinicians and management staff in the ██ ED, and both immediate and delayed feedback was obtained regarding any changes to the leaflet and any additional pieces of information. Key additions were the provision of onward travel information, and clarification of alternatives ways to seek urgent care beyond the ED.

ACT
Feedback was passed onto the trust design team, along with new wording and information requirements, to allow a final draft production.

Cycle 4: Draft Patient Passport shown to 10 patients

PLAN
Once the final leaflet draft was completed, the aim was to see how a selection of patients would assess the leaflet and check whether it used appropriate language, and whether patients found the format and content acceptable.

DO
10 randomly selected patients were given the final draft of the leaflet while in the Emergency Department and asked to fill out an anonymous feedback/assessment found, which is standardised for all trials of patient information within the trust.

STUDY
Feedback from patients was positive and no major amendments were suggested.

ACT
Progress to launch of trial introduction of leaflet and assessment of any effect on patient experience.

Cycle 5: 2000 leaflets printed and patient surveys repeated while in use

PLAN
I needed to gain initial funding to cover the printing costs of a trial introduction of the information leaflet, and then once produced, confirm the commencement of the intervention with departmental leads. While the trial introduction was in process, I would expect to see a repeat of the patient surveys demonstrate an improvement in patient experience in the ED.

DO
I applied via the UHB Trust Charity "Above & Beyond" for a £200 grant to produce 2000 patient leaflets initially and commenced production. Once the leaflet was available, it was offered to all patients registering in the ED from the 10th June 2017. The initial patient survey was repeated during the period when leaflets were available to patients.
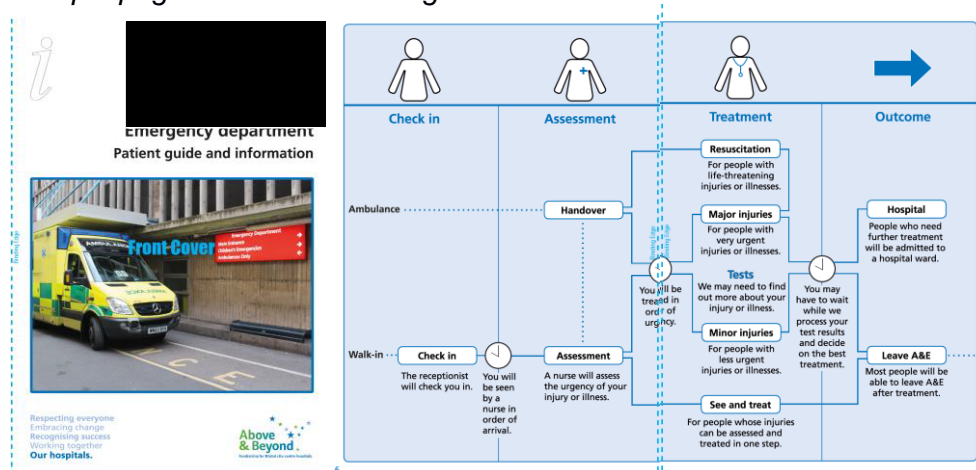
STUDY
Review process measures in patient survey data in ED following intervention.

ACT
If positive effect demonstrated, move to funding application for long term use in the ED and ongoing reassessment.

Sample pages from ED Patient guide:

Outcomes & Effects
The initial patient feedback on the guide was positive, including the following comments when replying to a standardised feedback proforma for new trust documentation.

- "The information included is clear and concise"
- "Really excellent leaflet"

100% of respondents agreed/strongly agreed that guide was:

- Useful
- Easy to understand
- Explained clearly
- There was enough information in the leaflet

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%

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

Comments relating to Patient information leaflet

- 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

Reflection

My reflections on this project can be divided into some distinct areas:

NHS Trust Structure: 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. It is also not clear for any given project what requirements there are within the trust for each stage of a project, and I have realised that early simultaneous contact at the time of project proposal allow an individual a chance to map those interactions and requirements accurately as they can be unique for each project. 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.

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.

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.

In summary, it appears the success of a Quality Improvement Project largely requires a clear simple goal mapped to the goals of key stakeholders, in order to generate the momentum for the project. When moving your own experience beyond isolated audit cycles and interventions, I realised that you have to clarify from the outset whether any change you make can be ongoing, and whether you have the dedication and enthusiasm to engage on a sufficient level to make a longer term difference to patient care. I feel as if I came to the challenges in engagement and particularly funding, and importantly that this project is impossible without a funding commitment, much later in the project, having focussed first on what seemed instinctively a good idea answering a specified problem. I would advise anyone now to spend much longer on their project planning, to allow many of these element of project design, stakeholder engagement and reflection to all run concurrently during the project period.

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