Patient Experience

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Introduction

Every person who receives emergency medical services, including those that involve the ED, has a 'patient experience' (PX). This can be described in terms of patients' reactions, amongst other things, to staff, facilities and systems. All the preceding sections of this document help define what the patient should expect of the ED in all these areas. Standards should be set and recommendations made with the patient clearly as the focal point.

While PX is an inherently subjective issue, it is emphatically not a secondary concern in health care, to be considered after other technical, clinical, or medical matters have been dealt with. It is a primary concern that forms an integral part of the overall 'service' provided. There is a considerable body of evidence which confirms that positive patient experiences correlate with better patient outcomes – e.g., reduced morbidity, mortality - as well as improved staff satisfaction, decreased health costs and improved organisational reputation. [1]

What follows deals with PX as an outcome. It covers the collection of data, qualitative and quantitative, around PX, and also the way that such feedback is turned into action.

Standards

1. The NHS Friends and Family Test (FFT) must be administered to give a baseline indication of overall patient experience. Given its limited scope, however, it must not be relied upon to give service managers direction and focus for making improvements.

2. Where feedback on emergency health care (e.g., letters of complaint or appreciation) is given to a hospital, or an emergency department directly, staff in the ED must always either respond directly to that feedback or make the substantive contribution to that response. Unless there are legal considerations which make it inappropriate, staff in the ED must always be included in communications with patients/ carers.

3. Responsibility for ED responses must be assigned to a designated consultant to ensure consistency of administration. Such responsibility must be for a pre-determined period, and shared over time within the consultant group, making appropriate allowance for the administrative load that this may create for any individual consultant.

Recommendations

1. Methods designed to collect PX data, referred to as Patient Reported Experience Measures, should be created to enable proactive management. The elements of PX that should be investigated are well defined within the Care Quality Commission's (CQC) Urgent and Emergency Care Surveys. [2] e.g., waiting times, staff empathy, shared decision-making, communications, discharge and physical environment. Such tools, typically developed and owned locally, should be simple and provoke discussion and action. RCEM should act as a repository for best practice in this arena.

2. Where formal and more complex quantitative feedback is sought, from an information management perspective, it is strongly recommended that standardised tools are created that enable cross-system comparison/learning. In such cases, central coordination should play an important part.

3. Formal feedback gathered at the time of attendance from those attending the ED, whether as patients or carers, should be interpreted with great care. However, patients/carers should be provided with information about how to give feedback in the days following attendance, emphasising why it is important to give information and how it will be used.

Recommendations

1. Members of staff at all levels should be given the opportunity and encouraged to observe and report on their own EDs to identify where PX can be improved. This could mean that:

    a. Medical students and post-graduate doctors in training - observe the workings of the department and report/audit as part of their portfolio development, bringing to bear their own experiences of other departments in which they have worked.

    b. Nursing staff - similarly to medical students as part of their training and continual development.

    c. SAS doctors, LE doctors, Consultants – network with colleagues in other Trusts to share/compare/observe initiatives.

    d. Agency Staff – undertake a formal review at the end of their assignment, using a CQC framework to highlight the best opportunities for PX/quality improvement.

2. Whatever process is developed to collect data, there should be a formal mechanism for reviewing/discussing what is learned and for setting actions for team leaders and members to take – the feedback loop. The purpose of such a process is both practical e.g., to correct system faults but also cultural - to ensure that PX is a matter for regular discussion and kept in the forefront of minds. The regularity of meetings to discuss feedback will depend on the purpose.

    a. Daily/Weekly – operational focus on immediate issues

    b. Monthly/Biannually – most importantly for the leadership group, to discuss feedback from all sources e.g., letters, social media, Patient Liaison, staff meetings, and identify patterns/issues/ actions. These discussions should include the impact that recent changes in the ED have had on PX. Further, it should consider planned changes over the coming period to identify potential harm to PX and mitigating actions.

Background

The real focus on PX should be in the design of new services, and ensuring that the patient is taken fully into account when changes are made that might affect them.

Hospitals/EDs collect a mass of data on how well these processes and systems work in practice, and report it regularly to a variety of audiences. In fact, measurement of processes and outcomes takes place at an 'industrial' level. But while there is an abundance of data, it is not always in a format that helps inform the ED leadership.

The problem with PX that needs to be dealt with, as a cultural imperative, is ensuring that decisions and actions are taken on the basis of the information already available. There should be a bias towards action and away from data collection for its own sake. This should be evident to staff within and outside the ED and to patients who typically share their experiences in the hope that others benefit from good practice repeated and bad practice eliminated.

From an ED leadership perspective, feedback on performance has to be treated as a vital asset, rather than something of which to be fearful.

All of the above commentary and recommendations accept that EDs are, and perhaps always will be, under great, pressure and that time and energy is in short supply. Despite this, PX should remain a top priority, just as are those areas that have 'harder', and perhaps more objective, measures.[3]

References

1. *Should Health Care Providers be Accountable for Patients' Care Experience? Anhang Price R, Elliott MN, Cleary PD, et al, J Gen Intern Med 30(2): 253-6. doi: 10.1007/s11606-014-3111-7. 2014.*
2. *Urgent and Emergency Care Survey 2022. CQC. 2023:* https://www.cqc.org.uk/publications/surveys/urgent-emergency-care-survey-2020).
3. *Measuring the Quality of Patient Care in the Emergency Department. RCEM. Sep 2022.*