ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

Satisfaction Of Patients In Emergency Medicine

Dr. Manish Sabharwal, Dr. Sonali Saklani, Dr. Shaik Salman Khan
Department of Emergency Medicine, Santosh Medical College, Santosh deemed to be university, Ghaziabad UP

Dr. Manish Sabarwal
Senior Consultant
Department of Emergency Medicine,
Santosh Medical College, Santosh deemed to be university, Ghaziabad UP

Dr. Mohd Yaseen
Assistant Professor
Department of Emergency Medicine,
Santosh Medical College, Santosh deemed to be university, Ghaziabad UP

Dr. Sonali Saklani
Junior Resident
Department of Emergency Medicine,
Santosh Medical College, Santosh deemed to be university, Ghaziabad UP

Dr Shaik Salman khan
Junior Resident
Department of Emergency Medicine,
Santosh Medical College, Santosh deemed to be university, Ghaziabad UP

Corresponding author

Dr. Manish Sabharwal,
Senior Consultant
Department of Emergency Medicine,
Santosh Medical College, Santosh deemed to be university, Ghaziabad UP

ABSTRACT

To find published data on patient satisfaction in emergency medicine, a systematic review was conducted. Both articles that identified the variables impacting emergency department patients' overall satisfaction and those that assessed a particular intervention were included in the review process. In some trials, but not all, the patient's race and age had an impact on their satisfaction. Satisfaction and triage category were highly connected, but waiting time

ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

was also a factor. The three service factors that were most commonly mentioned were perceived waiting times, interpersonal skills and staff attitudes, and informational and explanatory efforts. There were found to be seven controlled intervention studies. These claimed that better ED arrival information and training programmes intended to enhance staff attitudes and communication could increase patient satisfaction. The impact of cutting down on perceived waiting times was not particularly examined in any of the intervention studies. The development of staff interpersonal and attitudinal skills, an increase in the amount of information offered, and a decrease in perceived waiting times will all be crucial treatments to boost patient satisfaction. Future studies should examine particular interventions using a combination of quantitative and qualitative methodologies.

Keywords: Casualty, paradox, census, proxy respondent, Likert scale, analogue scales.

INTRODUCTION

Since the Patients' Charter of 1991 and the NHS Plan, there has been an increase in interest in "customer satisfaction" in the NHS over the past ten years. [1] The core idea behind the NHS Plan is to make patient opinions and interests the catalyst for change. The idea that "quality will not merely be constrained to clinical aspects of care, but include... the complete patient experience" is one of the plan's main tenets. Every NHS organisation is now required to produce an annual account of the feedback received from patients and the action done as a result in order to demonstrate that the service is responsive to patient priorities. [2]

Few doctors would deny that raising patient satisfaction is a desirable goal in and of itself. Related advantages could include a rise in staff morale and work satisfaction in emergency departments (EDs), a decline in patients' propensity to seek second views, and a drop in complaints and legal action. Additionally, there is proof of increased patient compliance. [3, 4] The public's perception of hospitals and emergency treatment in general is likely to be significantly impacted by increased satisfaction in EDs. In order to inform physicians and direct future plans for assessment and improvement in this area, the purpose of this systematic review was to identify the published data relevant to patient satisfaction in emergency care.

METHODS

ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

Using the WebSPIRS from SilverPlatter interface, which can be accessed through the SWICE gateway, a literature search was conducted. From January 1990 to January 2002, the phrases [PATIENT-SATISFACTION and ("Emergency Department" or "Accident and Emergency" or "Casualty" (TW))] were used to search the Medline, CINAHL, EMBASE, ASSIA, and HMIC databases.

The retrieval of papers with potential relevance was followed by a search of the references for further papers with potential relevance. Up until there was no longer any new information, this process was repeated.

Review articles were divided into two categories:

1. Research to determine and rank variables affecting overall patient satisfaction in EDs.
2. Interventional research meant to increase ED patient satisfaction.

RESULTS

Initially, 583 papers with probable relevance were found in the computerised database search. There were numerous studies that "tagged on" measures of patient satisfaction, but these studies tended to demonstrate the acceptability of the intervention rather than its impact on satisfaction. Therefore, these research were disregarded.

The examined studies were too diverse for a systematic meta-analysis. However, the following crucial ideas emerged:

Choosing factors to assess

The majority of publications evaluated a range of service characteristics, process of care measurements, or patient-related criteria that were either arbitrarily selected by the authors, based on staff input, or both.

The perceived and real waiting times, explanations and information on various parts of the process and treatment, staff attitudes, the environment in the emergency department, and perceived technical care standards were the emergency medicine service factors that were most commonly evaluated.

Patient factors that influence satisfaction

ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

The majority of research gathered information on a few "background variables," including age, sex, and social status, ethnicity, and sickness severity. In some studies [5–6], but not all, satisfaction was influenced by race and age. [7] Although this could be seen as another indication of the waiting time, triage category had a substantial correlation with satisfaction [5, 6, 8].

Between research, inclusion and exclusion criteria varied greatly and in other cases were not specified at all. Due to the "point of view paradox," which states that patient expectations for non-clinical service components must decrease as the severity of the illness rises, it is critical to understand the demographic being tested for satisfaction.

The majority of papers reported single centre research, with the exception of Yarnold's comparison of an academic and community ED [11] and Morgan et alsurvey .'s of Sheffield residents. The various survey demographics, methodology, and response rates. A few studies sought to enrol each patient in the research population during the course of the study period, sampling the population in the manner of a "census." Others employed quota-based, systematic, or random population sampling.

Service factors that influence satisfaction

The most frequently recognised areas of relevance are divided into three main sections. These include "waiting times in connection to patient expectations," specifically "interpersonal skills/perceived staff attitudes,"[7 10-13],"provision of information/explanation,"[5 -7, 13-18],” and "aspects connected to waiting times.” [7, 8, 10, 12–14, 17–19] Unresolved is the relative importance of many service-related factors in relation to overall satisfaction.

Intervention studies

Two of the seven controlled studies that looked at satisfaction as the main outcome measure were conducted in the UK. Three looked explored whether giving patients broad information when they arrived had an impact on their general satisfaction. [20–22] One of these was a reference to an educational film, while the other two were written references. All three showed that the informed groups had higher levels of satisfaction as well as a higher perception of other service factors. Improved patient satisfaction has been linked to staff training, according to two studies. In one study, all ED employees had "customer service

ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

training,"[23] while in the other, doctors participated in a course on communication techniques. [24]

The two UK articles emphasise nurse triage [25] and a service provided by emergency nurse practitioners (ENPs). [26] Patient satisfaction was not significantly impacted by nurse triage, however a comparison of typical ED and ENP care revealed that ENP care increased patient satisfaction with some communication-related service aspects.

DISCUSSION

The analysis of patient satisfaction in EDs has many inherent issues. First of all, it is difficult to define "satisfaction," second, emergency physicians treat the most extensive and heterogeneous patient population, and third, methods for measuring and classifying satisfaction are still developing.

Quantifying ‘‘satisfaction’’

Studies that seek to link particular aspects to "overall satisfaction" have used a variety of instruments to gauge both overall and factor satisfaction. Techniques include employing straightforward questions with binary responses and non-directive interviewing methods where "main themes" are identified. The word "satisfaction" has been used in direct inquiries, or overall contentment has been inferred from indirect questions like "willingness to recommend" or "willingness to return." [5] Although this method has been questioned, combined factor satisfaction scores have also been used to predict total satisfaction. [8]

Due to the lack of a "gold standard" for patient satisfaction, it is challenging to determine the validity of questionnaires. However, in certain research, patient opinions have been "validated" in comparison to objective assessments of the communicative, interpersonal, and technical aptitude of doctors. [27]

Response rates

It can be difficult to acquire adequate survey response rates, yet they are essential for meaningful results. Although studies utilising convenience sampling sometimes exclude late-night attendance, "on the spot" questionnaires in the ED will enhance response rates. When surveys are completed after a patient has left the emergency department, the delay may

ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

introduce bias, and if the acute issue has been resolved, responses tend to be more favourable.[28]

Although a small number of studies make more than one approach to the respondent, few studies conducted to date have been longitudinal, measuring changes in attitude over time. [5] A large number of ED patients are unable to respond. As a result, some surveys ask participants to bring a "accompagnating person" or, in cases when the study population includes children, a parent or guardian. [11, 13, 16–19] The factors that are most likely to have an impact on the proxy respondent, such as waiting times, facilities, communication, and patient access, are likely to have an impact on reported satisfaction levels in these circumstances.

Future directions

Local intervention studies are unlikely to demonstrate considerable increases in overall satisfaction due to the complexity of the relationship between many care parameters and satisfaction overall. However, the body of existing literature does provide guidance for future research studies regarding the topics to focus on and the methodologies to adopt.

An initial baseline must be established in order to evaluate the effects of particular interventions and changes over time. Methodologies for measuring patient satisfaction with specific service elements as well as their overall experience in the emergency department are now being more fully developed and improved. A Likert scale, which includes options from strongly positive to strongly negative, is the most frequently used tool. Many researchers have utilised "asymmetrical" or "weighted" scales to get around the fact that patient answers are skewed toward positive selections. [27] It has been demonstrated that scales with more than five replies do not offer a significant advantage, albeit the amount of points on the scales varies within and between articles. [27] Visual analogue scales are also common and produce outcomes similar to those of Likert scales. [27] Recently, some authors have suggested different techniques for measuring satisfaction. [5, 28]

Focus groups may be used to pinpoint the main concerns of patients. Data from these groups have been used to validate questionnaire design and to compare with government preconceptions about what patients want. [29] Reviewing complaints (and complements) will also yield qualitative data that could prove very helpful locally.

ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

According to prior research, the following three strategies merit more research:

1. Developing the communication, interpersonal, and attitude skills of ED employees. There is proof that a quick training session could be quite helpful in this area. [23 24]
2. Giving further details and justification.
3. A shorter perceived waiting period.

In the UK, the last one is currently the focus of a lot of government attention, [30] with the hope that waiting times would decrease and, presumably, patient satisfaction will rise. Future studies could clarify the relative importance of the key service characteristics highlighted as well as examine the impact of this and similar treatments in the ED.

Future intervention studies' preferred methodological approach will rely on the factor(s) being studied as well as the local environment. The design and interpretation of satisfaction studies have advanced significantly during the last ten years. Since qualitative research methods are becoming more popular than quantitative ones, some recent studies have merged the two strategies in an effort to create tools for measuring satisfaction that are more accurate and valid. [10, 29] Although fewer multi-centre studies have been reported to date, they are generally preferred due to their enhanced external validity. A randomised design is viable for some elements, such patient information, but different or unique approaches may be needed for other initiatives, including decreasing perceived waiting times.

CONCLUSIONS

Patients must have a great deal of faith in their clinicians to regularly evaluate and advance their clinical and technical abilities. This duty is now acknowledged by the focus on evidence-based practise. However, the art of medicine may be suffering as a result of efforts to advance medical science. If we are successful in recognising and addressing broader patient needs, the balance will be partially restored. A step in the right path is the study of patient satisfaction.

The broad features of the service that our patients care about the most have been identified through research so far. The articles that have already been published can be helpfully used to drive future strategies for monitoring and increasing patient satisfaction in emergency care. There are numerous potential interventions that might be adjusted to local needs. We may

ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

never be able to please "all of the people all of the time," but within our own departments, we can now look into strategies that will more frequently make patients happy.

REFERENCES

1. Department of Health. The NHS plan: a plan for investment, a plan for reform. London: HMSO, 2000.
2. 2 Anonymous. Involving patients and the public in healthcare: a discussion document. London: Department of Health, 2001.
3. 3 Thomas EJ, Burstin HR, O'Neil AC, et al. Patient non-compliance with medical advice after the emergency department visit. Ann Emerg Med 1996;27:49–55.
4. Murray MJ, Le Blanc CH. Clinic follow-up from the emergency department: Do patients show up? Ann Emerg Med 1996;27:56–8.
5. Sun BC, Adams J, Orav EJ, et al. Determinants of patient satisfaction and willingness to return with emergency care. Ann Emerg Med 2000;35:426–34.
6. Hansagi H, Carlsson B, Brismar B. The urgency of care need and patient satisfaction at a hospital emergency department. Health Care Manage Rev 1992;17:71–5.
7. Hall MF, Press I. Keys to patient satisfaction in the emergency department: results of a multiple facility study. Hosp Health Serv Admin 1996;41:515–32.
8. Lewis KE, Woodside RE. Patient satisfaction with care in the emergency department. J Adv Nurs 1992;17:959–64.
9. Schwab RA. Emergency department customer satisfaction: the point of view paradox. Ann Emerg Med 2000;35:499–501.
10. Morgan A, Shackley P, Pickin M, et al. Quantifying patient preferences for out of hours primary care. J Health Serv Res Policy 2000;5:214–18.
11. Yarnold PR, Michelson EA, Thompson DA, et al. Predicting patient satisfaction: a study of two emergency departments. J Behav Med 1998;21:545–63.
12. Boudreaux ED, Ary RD, Mandry CV, et al. Determinants of patient satisfaction in a large municipal ED: the role of demographic variables, visit characteristics, and patient perceptions. Am J Emerg Med 2000;18:394–400.
13. Bursch B, Beezy J, Shaw R. Emergency department satisfaction: what matters most? Ann Emerg Med 1993;22:586–91.

ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

14. Britten N, Shaw A. Patients' experiences of emergency admission: how relevant is the British government's Patients Charter? J Adv Nurs 1994;19:1212–20.
15. Bjorvell H, Steig J. Patients' perceptions of the healthcare received in an emergency department. Ann Emerg Med 1991;20:734–8.
16. Maitra A, Chikhani C. Patient satisfaction in an urban accident and emergency department. Br J Clin Pract 1992;46:182–4.
17. Thompson DA, Yarnold PR. Relating patient satisfaction to waiting time perceptions and expectations: the disconfirmation paradigm. Acad Emerg Med 1995;2:1057–62.
18. Thompson DA, Yarnold PR, Williams DR, et al. Effects of actual waiting time, perceived waiting time, information delivery and expressive quality on patient satisfaction in the emergency department. Ann Emerg Med 1996;28:657–65.
19. Rhee, Bird J. Perceptions and satisfaction with emergency department care. J Emerg Med 1996;14:679–83.
20. Kologlu M, Agalar F, Cakmakci M. Emergency department information: does it affect patients' perception and satisfaction about the care given in an emergency department? Eur J Emerg Med 1999;6:245–8.
21. Krishell S, Baraff LJ. Effect of emergency department information on patient satisfaction. Ann Emerg Med 1993;22:568–72.
22. Corbett SW, White PD, Wittlake WA. Benefits of informational videotape for emergency department patients. Am J Emerg Med 2000;18:67–71.
23. Mayer TA, Cates RI, Mastorovich MJ, et al. Emergency department patient satisfaction: Customer service training improves patient satisfaction and ratings of physician and nurse skill. Journal of Healthcare Management 1998;43:427–42.
24. Lau FL. Can communication skills workshops for emergency department doctors improve patient satisfaction? Emerg Med J 2000;17:251–3.
25. George S, Read S, Westlake L, et al. Evaluation of nurse triage in a British accident and emergency department. BMJ 1992;304:876–8.
26. Byrne G, Richardson M, Brunsdon J, et al. Patient satisfaction with emergency nurse practitioners in A&E. J Clin Nurs 2000;9:83–93.
27. Fitzpatrick R. Surveys of patient satisfaction: I—Important general considerations. BMJ 1991;302:887–9.

ISSN PRINT 2319 1775 Online 2320 7876

Research paper UGC CARE Listed (Group -I) Journal Volume 11, Iss 7, Oct 2022

28. Trout A, Magnusson AR, Hedges JR. Patient satisfaction. Investigations in the emergency department: What does the literature say. Acad Emerg Med 2000;7:695–709.
29. McKinley RK, Manku-Scott T, Hastings AM, et al. Reliability and validity of a new measure of patient satisfaction with out of hours primary care in the UK: development of a patient questionnaire. BMJ 1997;314:193–8.
30. Department of Health. Reforming emergency care. London: HMSO, 2001.
31. Booth AJ, Harrison CJ, Gardener GJ, et al. Waiting times and patient satisfaction in the accident and emergency department. Archives of Emergency Medicine 1992;9:162–8.
32. Bruce TA, Bowman JM, Brown ST. Factors that influence patient satisfaction in the emergency department. J Nurs Care Qual 1998;13:31–7.