

## Patient expectations of emergency department care: phase I – a focus group study

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### ABSTRACT

**Objectives:** To explore the public's expectations of emergency department care and to compare these with emergency department staff perceptions of patient expectations.

**Methods:** Focus groups were conducted with the residents of Calgary, Alta., and with emergency department staff in the Calgary Health Region. Both recent users of the emergency department and people who had not used the emergency department in the past 3 years were included in this study. An experienced moderator conducted the focus groups, which were taped and then transcribed. A well established method of qualitative analysis identified common themes.

**Results:** The focus groups identified common expectations of emergency department care. Public expectations were categorized into 6 thematic areas: staff communication with patients, appropriate waiting times, the triage process, information management, quality of care, and improvements to existing services. Those who had recently used the emergency department had similar expectations to those who had not. Emergency department care providers understand some, but not all, of the public's expectations.

**Conclusions:** Public expectations of emergency department care were identified by this study. The findings are important for quality improvement initiatives and were used to develop a quantitative questionnaire.

**Key words:** patient expectations; communication; emergency care

### RÉSUMÉ

**Objectifs :** Explorer les attentes du public face aux soins au département d'urgence et les comparer avec les perceptions du personnel de l'urgence face aux attentes des patients.

**Méthodes :** Des groupes de discussion furent menés avec les résidents de Calgary, Alberta et avec le personnel du département d'urgence de la Région sanitaire de Calgary. Les utilisateurs récents du département d'urgence et ceux qui n'avaient pas visité l'urgence depuis au moins trois ans furent inclus dans cette étude. Un modérateur expérimenté dirigea les groupes de discussion, dont les rencontres furent enregistrées et transcrites. Une méthode bien établie d'analyse qualitative identifia les thèmes communs.

**Résultats :** Les groupes de discussion identifièrent les attentes courantes face aux soins administrés au département d'urgence. Les attentes du public furent classées sous six domaines thématiques : communication du personnel avec les patients, temps d'attente adéquats, processus de triage, gestion de l'information, qualité des soins et amélioration des services existants. Les attentes des personnes ayant visité le département d'urgence récemment ou non étaient sem-

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blables. Le personnel du département d'urgence comprenait certaines des attentes du public, mais pas toutes.

**Conclusions :** Les attentes du public face aux soins administrés au département d'urgence furent identifiées dans le cadre de cette étude. Les constatations sont importantes pour les initiatives d'amélioration de la qualité et ont servi à élaborer un questionnaire quantitatif.

## Background

Non-clinical aspects of health care quality have become a major focus in emergency medicine.<sup>1</sup> In 2001, the US Institute of Medicine of the National Academies identified patient-centered care as a key goal for improving health care quality.<sup>2</sup> But, to provide patient-centered care we must first understand what patients need and expect from an emergency department (ED) visit.

Although patient expectations of ED care may seem intuitive, there has been little research in this area. There is, however, extensive literature on patient satisfaction as a quality outcome measure, particularly in the consumer-driven US health care system.<sup>3,4</sup> It is important to clarify that patient expectations and patient satisfaction are not the same thing. Expectations are formed prior to the ED visit, whereas satisfaction is determined by perceptions formed during and after the ED encounter. Satisfaction is a function of met and unmet expectations but is influenced by many other factors;<sup>4,6</sup> consequently, patients may report a high level of satisfaction despite having many unmet expectations.<sup>7</sup> In Canada, where health care is publicly-funded, an understanding of the public's needs and expectations may be more useful than focusing on patient satisfaction.

The literature has identified several predictors of patient satisfaction, including a higher patient acuity level, effective staff communication and a caring bedside manner.<sup>4,8-13</sup> Waiting times have not been clearly shown to predict satisfaction; however, patients' perceived wait times do correlate with satisfaction.<sup>5,6</sup> The available literature on patient expectations suggests health care providers may not be accurate in predicting patients' needs and expectations. In a study of ED nurse and patient perceptions, patients rated "kindness and compassion," "explanations of results and illness" and "speed of care" as having greater importance than did the nurses.<sup>14</sup>

The primary goal of this qualitative study was to compare public expectations of ED care with the perceptions of ED care providers. A focus group design was chosen to gather a range of beliefs from diverse people without attempting to generalize findings to the public at large. Qualitative methodology "enables the researcher to understand

and capture the points of view of other people without pre-determining those points of view through prior selection of questionnaire categories."<sup>15</sup> Secondary goals were to compare expectations of patients who had recently used the ED with members of the general public who had not, and to determine the relationship between patient expectations and acuity level. Lastly, we wished to solicit suggestions for improving emergency care services in the Calgary Health Region. The results of this study were used to design a quantitative telephone survey; these results will be reported later.

## Methods

This study used focus groups, a standard qualitative research method.<sup>15,16</sup> A focus group is an interview with a small group of people on a specific topic. The purpose is to gather participants' views within a social context and in the context of the views of each other. Several groups are conducted until recurring themes emerge (i.e., "saturation of themes" occurs).<sup>15</sup> Regional ethical requirements for quality improvement projects were followed.

### Setting

This study was conducted in the Calgary Health Region, a large urban integrated health region with 4 EDs; 1 a regional trauma centre and 1 a pediatric hospital. Combined, the 4 EDs have approximately 250 000 patient-visits per year.

### Focus group composition

Twelve focus groups were conducted between October and November 2001. Participants were 14 years of age or older. Five groups consisted of people who had used the ED within the past 12 months ("users"). Three groups were composed of people who had neither used nor accompanied someone who had used the ED within the past 3 years ("non-users"). Three years was felt to be sufficient time to eliminate any detailed recall of the ED experience. Participants in the user and non-user groups were divided into age groups for the interviews: 14-18, 19-29, 30-50, >50, and parents of patients 0-13 years. Four focus groups were composed of ED staff from the 4 sites, consisting of

physicians, nurses, therapists and unit clerks (“providers”).

### **Participant recruitment**

Participants for the user groups were selected from recent ED discharge data. The non-user groups were selected from residential phone listings. A purposeful sample of users and non-users was selected from all 4 geographic quadrants of the City of Calgary, based on address of residence, to avoid socioeconomic and ethnic misrepresentation. Gender was balanced in each group. In the user groups, patient acuity levels using the *Canadian Emergency Department Triage and Acuity Scale* (CTAS) were equally balanced in order to elicit views from patients representing all triage groups, not from a statistically representative sample of the ED population.<sup>17</sup>

Participants were recruited by a telephone call explaining the purpose and nature of the study. Participation was voluntary and confidential. Those who agreed to participate received a follow-up letter describing the focus group process, and were notified that an honorarium would be provided upon completion of the focus group. Providers were recruited by the investigators from each site.

### **Data collection**

A specialist in qualitative health care research (G.B.), who has no ED affiliation, moderated each of the focus group interviews. The moderator prepared a set of open-ended questions and probes to encourage free-flowing discussion while ensuring all essential topics were covered. Below are 2 examples of the discussion questions used:

- “What would you say are your expectations of an emergency department? What things happened that met your expectations? Exceeded your expectations?”
- “Now, I’d like to hear about the other side of things. What things happened that didn’t meet your expectations?”

A co-moderator attended to take field notes. Each focus group was audiotaped and transcribed.

### **Analysis**

The focus group transcripts and field notes were analyzed using combined question and thematic analysis methods.<sup>16</sup> This method combines analysis of each question individually and analysis by overall themes. Each transcript was individually coded, then sorted by emerging themes. Themes were grouped into headings (e.g., triage process). A summary of themes from each set of focus groups was reported. The investigation team validated the summaries, and identified common themes.

## **Results**

Of 344 recent ED users who were contacted, 34 (9.9%) agreed to participate in 1 of the 5 user focus groups. Of 590 eligible non-users who were contacted, 22 (3.7%) participated in 1 of the 3 non-user groups. A total of 31 ED staff participated in 4 provider groups, 1 from each hospital site. Common themes emerged from all focus groups, including staff behaviour and communication, wait times, triage, health record management, quality of care and improvements to services.

### **Staff communication**

Participants in the user and non-user groups felt strongly about the importance of staff behaviour and communication. Several participants commented that ED patients are often frightened, anxious and in pain. They expect staff to treat them as individuals, listen to their concerns and provide reassurance. Participants said they expect frequent updates on what is happening at all stages of their ED visit, including explanations of delays, investigations, results and treatments. Several groups commented on the inadequacy of staff communication and explanations during their ED visit. Some participants felt staff behaviour was inappropriate: they perceived staff to be “standing around,” ignoring them, and engaging in personal conversations within earshot of patients. As one participant said:

[ED staff] see this all the time. But try to understand that we don’t see it all the time, so yes, we are nervous and we do need some of the explanations and ... I guess a little bit of empathy.

Providers believed they understand patients’ expectations regarding communication, and that they do a good job in communicating with patients and families. They acknowledged the difficulties in meeting these expectations during busy times in the ED.

### **Wait times**

Participants’ expectations of appropriate wait times in the ED varied considerably. While some expected to be seen by a physician within 1 hour, others expected a 3- to 6-hour wait. Non-users seemed to expect faster service than users. All groups were asked about their experience as well as their expectations. Long waiting times (3–6 h) was a frequent complaint. Once brought from the waiting room to the treatment area, many participants did not expect to wait to be seen by a physician, have tests done and receive results. Both users and non-users expected to be seen faster when arriving by ambulance. Participants in the user groups expressed frustration and anxiety with being left alone in

the waiting room or treatment area for what seemed like long periods of time without an update or reassessment. These sentiments were characterized by one participant:

Give me an explanation why I keep getting bumped down the line or what is happening ... don't just stick me in a corner and leave me. That bugs me. Let me know what's going on. If I've got to wait 8 hours because you only have 1 doctor on staff, then tell me that.

### ***Triage***

Both users and non-users expect the sickest patients to be seen first. Some non-users expected a "take-a-number" system for patients with minor complaints, so patients could leave and come back at their discretion. Participants expected triage nurses to be highly skilled and efficient, and to streamline patients to a minor emergency area when appropriate. Participants also expected to be given an accurate estimate of the waiting time at triage. Several of the provider participants felt the public does not understand the triage process, but once explained to them, understands and accepts it.

### ***Patient health record***

Users and non-users expected communication between ED staff and their primary care physician to occur in a timely manner, if not instantly. Many believed this communication link is missing or inadequate. Several participants suggested developing a patient health record database to provide ED and community clinicians with up-to-date information to improve patient care and continuity.

### ***Quality of care***

Participants in both the user and non-user groups expected a definitive diagnosis and immediate treatment during an ED visit. Many participants expected the use of diagnostic tests. Participants made several comments regarding the high quality of care in the ED. Although the purpose of the study was not to determine patient satisfaction, several user groups felt the quality of care either met or exceeded their expectations. Providers also felt the quality of care is high.

### ***Improvements to ED services***

Participants from all groups were asked to suggest improvements to the existing emergency services. Four areas of improvement emerged from all the groups. The first was the implementation of a 24-hour telephone advice line to provide health advice to patients and to direct patients to the appropriate resource. Secondly, participants felt a public education campaign is needed to educate about existing emergency and non-emergency services available in the Calgary Health Region, and the appropriate use of each.

Participants suggested developing a centralized patient health record database to improve patient care. Lastly, participants recommended opening more urgent care clinics, where non-emergent care and basic diagnostic tests are available. In 2 user groups and 1 non-user group, participants felt the scope of care of nurses and therapists should be expanded to allow them to treat minor problems and write prescriptions without involving a physician. Providers suggested increasing resources and improving discharge planning. They expected more inpatient beds and improved access to primary care and out-patient diagnostics.

## **Discussion**

Quality care involves meeting community needs and expectations.<sup>18</sup> Currently, these expectations are not well understood and are primarily based on provider assumptions. This study showed that ED care providers had an accurate understanding of public expectations, that staff and patient perceptions differed with respect to the effectiveness of communications, and that the public had limited knowledge of the triage process. These areas of misunderstanding should be examined further. The study did not demonstrate any important differences in expectations between people who have used the ED recently and those who have not, suggesting recent ED experience does not alter expectations.

Our findings highlight the importance of staff communication in meeting patient expectations and improving quality of care. This is consistent with previous studies on patient satisfaction.<sup>3,4,12</sup> ED care providers may have different priorities than patients. Providers may feel that quality is most closely linked to clinical factors, and patients place a high value on communication. The gap may be a primary cause of patient dissatisfaction; therefore it is important for public and providers to understand each other's perspectives.

Consistent with prior literature on patient satisfaction, waiting times emerged as an important theme, but the striking variation in wait time expectations (1 v. 6 h) was unexpected. Recent media attention on hospital overcrowding may have led the public to expect long waits. Determining wait times that are acceptable to the public will enable institutions to set reasonable goals and educate the public on what to expect.

Patient participants in this study felt the overall quality of care they received in the ED was good. However, they may have unrealistic expectations that are not being met, thus affecting their perceived quality of care. These expectations include the use of diagnostic tests, which are not always indicated, and the establishment of a definitive diagnosis, which is sometimes not possible. As one participant stated:

We live in an environment where there's a McDonald's mentality. We want a drive-through, be diagnosed, and feel better.

Further studies are needed to determine how prevalent these expectations are.

Focus group participants had several innovative suggestions to improve emergency services. These included a 24-hour telephone advice line and a patient health record database. The former has already been implemented in Alberta, and the latter is now being developed. Participants challenged the traditional scope of care of health care providers, and this issue merits further study.

### Limitations

Due to the qualitative nature of this study, it was limited to a small number of participants. Combined question and thematic qualitative analysis techniques were used to ensure saturation of themes; however, as noted above, the generalizability of these themes to the larger ED population is being explored. While the possibility of selection bias exists, it is not a major limitation in qualitative research as it is in quantitative research. Saturation of themes is a better indicator of the inclusion of all significant viewpoints. Participants were fluent in English, thus the views of non-English speaking residents were not included. The findings of this study reflect the perceptions of a small group of people and may not represent the views of the population at large. The results of this study could be important in improving the patient-centred quality of care in the ED, assisting policy-making decisions, and developing staff and public education programs.

### Conclusions

This qualitative study suggests the key issues important to the public are staff communication with patients, appropriate waiting times, the triage process and information management. Clinical quality of care was not identified as an important issue in this sample as the public represented here believes the clinical quality of care to be high. The results were used to develop a quantitative telephone survey to further explore these findings in the broader ED population.

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### References

1. Sanders A. Quality in emergency medicine: an introduction. *Acad Emerg Med* 2002;9(11):1064-70.
2. Committee on Quality Health Care in America, Institute of Medicine. *Crossing the quality chasm*. Washington (DC): National Academy Press; 2001. Available: [www.nap.edu/books/0309072808/html/](http://www.nap.edu/books/0309072808/html/) (accessed 2004 Nov 16).
3. Sun BC, Adams J, Orav EJ, Rucker DW, Brennan TA, Burstin HR. Determinants of patient satisfaction and willingness to return with emergency care. *Ann Emerg Med* 2000;35:426-34.
4. Trout A, Magnusson AR, Hedges JR. Patient satisfaction investigations and the emergency department: What does the literature say? *Acad Emerg Med* 2000;7:695-709.
5. Thompson DA, Yarnold PR, Williams DR, Adams SL. 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.
6. Thompson DA, Yarnold PR. Relating patient satisfaction to waiting time perceptions and expectations: the disconfirmation paradigm. *Acad Emerg Med* 1995;2:1057-62.
7. Peck BM, Asch DA, Goold SD, Roter DL, Ubel PA, McIntyre LM, et al. Measuring patient expectations: Does the instrument affect satisfaction or expectations? *Med Care* 2001;39:100-8.
8. 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.
9. Brown K, Sheehan E, Sawyer M, Raftos J, Smyth V. Parent satisfaction with services in an emergency department located at a paediatric teaching hospital. *J Paediatr Child Health* 1995;31:435-9.
10. Boudreaux ED, Ary RD, Mandry CV, McCabe B. 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.
11. Bursch B, Beezy J, Shaw R. Emergency department satisfaction: What matters most? *Ann Emerg Med* 1993;22:586-91.
12. Krishel S, Baraff LJ. Effect of emergency department information on patient satisfaction. *Ann Emerg Med* 1993;22:568-72.
13. Yarnold PR, Michelson EA, Thompson DA, Adams SL. Predicting patient satisfaction: a study of two emergency departments. *J Behav Med* 1998;21:545-63.
14. Hostutler JJ, Taft SH, Snyder C. Patient needs in the emergency department: nurses' and patients' perceptions. *J Nurs Admin* 1999;29:43-50.
15. Patton MQ. *Qualitative evaluation and research methods*. Newbury Park (CA): Sage; 1990. p. 9-25.
16. Krueger R. *Analyzing and reporting focus group results: focus group kit 6*. Thousand Oaks (CA): Sage; 1998. p. 41-52.
17. Beveridge R, Clarke, Janes L, Savage N, Thompson J, Dodd G, et al. Canadian emergency department triage and acuity scale: implementation guidelines. *Can J Emerg Med* 1999;1(3 suppl).
18. Cone D, Nedza S, Augustine J, Davidson S. Quality in clinical practice. *Acad Emerg Med* 2002;9(11):1085-90.

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