'They do not care how much you know until they know how much you care': a qualitative meta-synthesis of patient experience in the emergency department

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ABSTRACT

Background Patient experience is positively associated with both clinical effectiveness and patient safety and should be a priority for emergency care providers. While both quantitative and qualitative approaches can be used to evaluate patient experience in the emergency department (ED), the latter is well aligned to develop a detailed understanding of features influencing the lived experience of ED patients. This study aimed to systematically review the literature of qualitative studies to identify determinants of adult patient experience in the ED.

Methods A Preferred Reporting Items for Systematic review and Meta-Analysis compliant systematic review was conducted using PubMed, CINAHL, EMBASE, BNI and bibliography searches to identify qualitative studies exploring patient experiences in ED published in English between 1997 and 2018. Quality assessment was conducted using the Critical Appraisal Skills Programme checklist. Descriptive text and quotations relating to patient experience were extracted from included studies and a meta-synthesis conducted using thematic analysis.

Results A total of 625 records were screened from which 40 studies underwent full review and 22 were included. Results were coded by two researchers (BG and JML). Meta-synthesis identified 198 discrete units of analysis which were clustered around five analytical themes. These were based on the perceived 'needs' of patients visiting the ED and were defined as communication, emotional, competent care, physical/environmental and waiting needs. Findings were translated into a conceptual model for optimising patient experience in the ED.

Conclusion This meta-synthesis provides a framework for understanding the determinants of patient experience in the ED. The resulting conceptual model and recommendations may have the potential to directly inform practice and improve the patient experience.

INTRODUCTION

The emergency department (ED) environment presents many conceivable barriers to providing an optimal patient experience. Patients often arrive following acute illness or injury, in pain and distress.[1] Time for the establishment of rapport with providers is limited, and patients find themselves the subject of many new interactions that occur over a short time period.[2] Previously unanticipated investigations, procedures and treatments may be required, some of which may be invasive, painful or infringe personal dignity. Additionally, the physical environment may be noisy, crowded and unfamiliar.[3 4] Despite these challenges, providing patients with a positive experience should take high priority.[5] A positive experience is not only associated with improved satisfaction but superior outcomes across a range of domains including mortality, morbidity, length of stay and medication adherence.[6]

Qualitative research offers a means to rigorously address gaps in comprehension of the patient experience and facilitate the formation of a more detailed understanding than may be obtained by quantitative or cross-sectional approaches alone. This may facilitate the identification of specific determinants of experience, as viewed by patients themselves.[7 8] Reliably transferring findings from individual qualitative studies into external settings is often cited as a limitation of the qualitative approach in general.[9] Meta-synthesis provides a potential solution to this problem by systematically identifying available qualitative literature surrounding a topic and subsequently undertaking detailed analysis and structured synthesis of the findings. This provides a means of harnessing disparate qualitative studies to inform clinical practice, policy formation and research priorities.[9 10] A key feature of meta-synthesis is that it aims to provide a deeper level of understanding, affording researchers new confidence to suggest wider reaching conclusions and even generate recommendations. Approaches to meta-synthesis include meta-ethnography and thematic synthesis.[11 12] Meta-synthesis has been employed to enhance understanding of a range of issues in emergency care such as staff experiences of aggression and violence,[13] perceptions of people who self-harm[14] and delay in seeking treatment for myocardial infarction among female patients.[15]

Aims
This study aims to (i) identify qualitative research exploring patient experiences of ED care and (ii) conduct a meta-synthesis to identify recurring themes that could be applied to a framework aimed at improving the patient experience.

METHODS
Design
A systematic review and meta-synthesis adhering to Preferred Reporting Items for Systematic review and Meta-Analysis guideline was conducted.

Eligibility criteria

Publications written between January 1997 and June 2018 were identified. Studies exploring the experience of adult patients using qualitative data collection methods such as interviews, focus groups, observation and open-ended questionnaires were included. Papers focussing on a certain ED presentation or demographic group were included if the authors agreed that findings had relevance to the general ED population.

Quantitative studies, including closed-ending questionnaires and cross-sectional methods, those conducted in non-ED settings and those not written in English or accessible in full, were excluded from the review.

Information sources

Database searches of PubMed, CINAHL and EMBASE and BNI were undertaken. Manual bibliography searches were also conducted.

Search and screening

The search was undertaken using Medical Subject Heading (MeSH) terms where appropriate. An example strategy using the Pubmed database is provided in the online electronic supplementary material 1.

To determine suitability for inclusion a single researcher (BG) extracted study characteristics including year of publication, country, research question, methods, key findings, major limitations and main conclusions. Papers with relevance to study aims were selected for quality appraisal.

Quality appraisal & rigour

Quality appraisal of included studies was then undertaken by two researchers (BG and JML). This included scoring against the 10-item Critical Appraisal Skills Programme (CASP) Qualitative checklist to assess for study validity, reporting of results and relevance (online electronic supplementary material 2).

Open dialogue between the researchers was encouraged throughout the review to identify and challenge assumptions. Reflexive notes and an audit trail were maintained.

Synthesis

Thematic synthesis was used to analyse the qualitative data from the included articles. The synthesis consisted of three discrete stages.[12] First, text fragments representing narratives of study participants were coded to identify similarities. In the second stage, individual codes were grouped and data were summarised through the creation of descriptive themes. These were organised into a hierarchical structure, representing the content of included studies. In the final stage of the thematic synthesis, distinct analytical themes were defined. The result of the synthesis was, therefore, both to consolidate existing knowledge and also generate new insights surrounding the topic. Uniquely, this review accomplished the latter by deriving pragmatic recommendations for clinical practice directly from the findings of the synthesis.

For this study, any text within the included studies that described the patient experience—either by patients themselves in the form of direct quotations or authors in the form of discussion—was extracted into the computer-aided qualitative analysis software QSR NVivo 11™. Analysis was undertaken collaboratively by two researchers (BG and JML). The opinion of a third researcher (RE) was consulted where agreement could not be reached. The face validity of pragmatic recommendations for
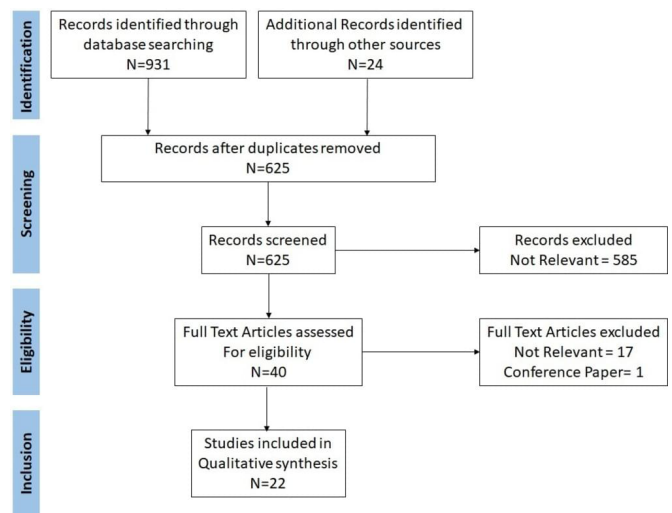
practice was agreed by two researchers who are also practising emergency physicians (BG and JS).

Figure 1 PRISMA diagram. PRISMA, Preferred Reporting Items for Systematic review and Meta-Analysis Protocols.

FINDINGS

A total of twenty-two studies were selected for inclusion. A PRISMA diagram summarising the search strategy can be found in figure 1.

Study selection

Results of quality appraisal

All studies identified for this review met all 10 items featured on the CASP checklist, indicating adequate quality.

Study characteristics

Included studies were published between 1999 and 2017 and were drawn from nursing (10), medical (7), social sciences (4) and health services journals (1). Studies most frequently originated from Sweden (6), Canada (6) and the USA (4).

Studies were conducted within >33 EDs, ranging from rural to large tertiary centres and geographic regions. At least 677 non-professional participants were recruited overall (range 7–60 per study). Two studies sampled patients based on the demographic characteristic of older age. Four studies selected patients based on presentation, including major trauma (2), mental health and suspected miscarriage. Epistemological approaches included ethnography, phenomenology, grounded theory and descriptive analysis. Methods included interviews, focus groups and direct observation. A summary of individual study characteristics can be found in table 1.

Results of individual studies

Two hundred and twenty-nine units of analysis were extracted from the literature and were assigned codes. Data were then organised within four major descriptive categories ('Personal', 'Technical', 'Cultural' and 'Physical and Environmental' determinants of experience). Expansion revealed eleven descriptive subthemes. Consideration was then given to how subthemes represented patient 'needs' during their ED stay, resulting in the derivation of the analytical themes.

Figure 2 outlines the relationship between themes. The contribution made by individual studies towards each analytical theme can be found in table 1.

Table 1 Characteristics of the 22 included studies and contributions to meta-synthesis

(a) Characteristics of individual studies						(b) Principal contribution(s) of individual studies to each analytical theme ('need') C=Communication; E=Emotional; CA=Care W=Waiting P=Physical/Environ.				
First author (year) country	Setting	Summary of aims	Approach Methods Sampling	Patient population	Key findings	C	E	CA	W	P
Burström (2013)[30] Sweden	3 EDs	To explore waiting in the ED	Grounded Theory Staff interviews and patient observation Theoretical sampling	Observation of patients in the waiting room	Indicators of 'non-acceptable' waiting included physical densification, contact seeking and emergence of critical situations. Staff were ashamed and frustrated with non-acceptable waiting. Waiting management may be achieved by changing the patient experience	●	●		●	●
Caldicott (2005)[21] USA	1 ED	To compare the experiences of ED patients in the context of those 'turfed' to other specialities vs deemed appropriate	Descriptive approach Semi-structured interviews Convenience sampling	26 adult patients	10 themes divided between two main categories, which were (i) interpersonal issues' and (ii) technical/systems issues. Themes classified as either 'favourable' or 'unfavourable'. Global experience was negative for 'turfed' patients	●	●		●	●
Clarke (2007)[32] Canada	1 ED	To determine satisfaction with mental healthcare in ED	Descriptive approach Focus groups Convenience sampling	27 adult mental health service users	Themes included: 'waiting in the ED', 'attitudes of treatment staff', 'diagnostic overshadowing', 'nowhere else to go', and 'family needs' Devised a list for ideal services	●	●			
Cypress (2014)[24] USA	1 ED	Experiences of patients triaged as 'critically ill'	Phenomenology Interviews Purposive sampling	23 participants including 10 patients	Patients and relatives valued 'critical thinking', 'communication' and 'sensitivity and caring' behaviours in nurses. Desirable aspects of communication included listening, identifying, greeting and interacting with patients. 'Sensitivity and caring' included advocating for critically unwell patients and empathy	●		●		●
Hillman (2014)[44] UK	1 ED	To examine the concept of legitimacy and processes of negotiation between patients and staff in the ED	Ethnography Observation with follow-up interviews Thematic analysis Convenience sampling	50y older adult patients	Patients were compelled to legitimise their reasons for attendance and justify these in order to be perceived positively by staff, which shaped their access to resources and determined their ED experience	●	●		●	
Kihlgren (2004)[25] Sweden	1 ED	To explore the experience of waiting in the ED	Grounded theory Observation Convenience sampling	20 patients aged >25 years	6 core variables emerged, which were (i) unpleasant waiting, (ii) unnecessary waiting, (iii) lack of good routines during the waiting stage, (iv) suffering during the waiting stage, (v) bad feelings during the waiting stage and (vi) nursing care during the waiting stage	●	●	●	●	●
Lin (2008)[26] Taiwan	1 ED	To investigate the patient experience of empathy	Descriptive In-depth interviews Convenience sampling	28 participants including 7 patients	4 themes emerged. These were (i) when patients expressed their feelings, physicians did not resonate with concerns, (ii) patient required psychological comfort, (iii) patients needed feedback from physicians but did not always get this and (iv) physicians found the physical environment difficult to overcome	●	●			
MacWilliams (2016)[20] Canada	3 EDs 1 Tertiary 2 Local	To explore the experiences of women attending the ED to get care for a miscarriage	Interpretive Phenomenology Semi-structured interviews Convenience sampling	8 female patients (suspected miscarriage)	5 themes resulted, which were: (i) pregnant=life vs miscarriage=death, (ii) deciding to go to the ED, (iii) not an illness—a different type of trauma, (iv) need for acknowledgement and (v) leaving the ED: What now?. Patients felt that staff were dismissive of their loss	●	●			
Nyden (2003)[31] Sweden	1 ED	To examine older peoples' basic needs in ED	Interpretive approach Interviews Convenience sampling	7 participants between 65 and 88 years	Needs of older adults attending the ED were interpreted according to Maslow's Hierarchy of Needs. Basic needs at the lower tiers of the hierarchy were well represented. Higher needs tended to be neglected, including the need to know and understand. Patients needed to feel safe	●	●		●	
Nystrom (2003)[27] Sweden	1 ED	To analyse and describe experiences of being a 'non-urgent' patient in ED	Descriptive approach Interviews Convenience sampling	11 patients	The non-urgent patient experience was interpreted as fragmented. Patients had difficulty being 'seen or heard', and were cognizant of the effect of non-urgent problems on nurses' workloads and perceptions. Patients strived to maintain their own integrity	●	●		●	
O'Brien (2004)[17] Canada	1 ED Level 1 trauma centre	To examine patient perceptions of trauma resuscitation in ED	Interpretive Phenomenology Semi-structured interviews Purposive sampling	7 adult patients with major trauma as the presenting complaint.	4 themes results, which were (i) 'I was scared', (ii) 'I felt safe', (iii) 'I will be okay' and (iv) 'I remember'. System factors were contributed to a positive overall experience	●	●			
Olsson (2001)[33] Sweden	1 ED	To explore patients experience of repeat ED attendance	Inductive Interviews Purposive sampling	10 adult participants Frequent users of ED	Experience of repeat attenders was adversely affected when the patient perceives that use of the ED is inappropriate or when symptoms are belittled		●		●	
Olthuis (2014)[28] Netherlands	1 ED	To determine the actual experiences of patients who received ED care	Ethnography Direct observation Convenience sampling	55 patients in ED	Patients' 'concerns' related to anxiety, expectations, care provision, endurance of symptoms and need to receive or express recognition	●	●		●	●

Table 1 Continued

(a) Characteristics of individual studies

| First author (year) country	Setting	Summary of aims	Approach Methods Sampling	Patient population	Key findings	(b) Principal contribution(s) of individual studies to each analytical theme ('need') C=Communication; E=Emotional; CA=Care W=Waiting P=Physical/Environ.				
						C	E	CA	W	P
Revell (2017)[16] New Zealand	1 ED tertiary centre	To determine the information needs of patients receiving procedural sedation in the ED	Descriptive Interviews Convenience sampling	8 adult patients who had received procedural sedation	Major themes included (i) safety and trust, (ii) competence and efficiency of staff, (iii) explanations of procedures and progress, (iv) supporting person presence, (v) medico-legal implications and (v) written information	•	•	•	•	
Rising (2015)[22] USA	2 related EDs	To examine the experience of ED discharge processes through return attenders	Descriptive Semi-structured interviews Convenience sampling	60 patients who returned within 9 days	Themes included (i) discharge process (wanted more tests/wanted admission/ complaint unaddressed), (ii) discharge process (no problem/problem understanding/rushed out/limited explanation) and (ii) prescriptions (did not receive what was wanted)	•		•	•	
Shearer (2015)[36] Australia	1 ED	To explore why patient choose to attend a private ED in Australia	Content analysis Semi-structured interviews Purposive sampling	Thirty adult patients	Themes included (i) prior experience of the hospital, (ii) convenient location, (iii) anticipated high-quality care and (iv) anticipated short wait times			•		
Stuart (2003)[23] Australia	1 ED	To identify 'consumer expectations' with respect to the ED	Ethnography Focus groups Purposive sampling	98 adults including minority ethnic and disabled groups	Major themes were communication triage, waiting area, cultural issues and carers	•		•	•	
Vaillancourt (2017)[29] Canada	2 EDs	To define outcomes of ED care that are valued by patients discharged from the ED	Descriptive Semi-structured interviews Convenience sample	46 adults	Patients valued outcomes that related to 4 themes. These were: (i) understanding the cause and expected trajectory of symptoms, (ii) reassurance, (iii) symptom relief and (iv) having a plan to manage symptoms, resolve the problem or pursue further medical care	•	•	•		
Watson (1999)[18] USA	3 EDs	To describe elderly patients' perceptions of care in the ED	Descriptive In-depth interviews Convenience sampling	12 elderly patients	5 themes emerged, which were 'needs for information', 'observations of waiting time', 'perceptions of professional competency', 'concerns about process and facility design' and 'personal tolerance'	•	•	•	•	•
Watt (2005)[34] Canada	Calgary region	To compare public expectations of ED care with healthcare professionals	Descriptive Focus groups and interviews Purposive sampling	87 adults including 34 recent ED users	6 themes emerged which included: (i) staff communication with patients, (ii) appropriate waiting times, (iii) the triage process, (iv) information management, (v) quality of care and (vi) improvements to existing services	•		•		
Wellstood (2005)[35] Canada	4 EDs across one health system	To gain an understanding of patient perceptions of ED care	Descriptive In-depth interviews Pseudorandomised sampling	41 adults	Aspects of care most commonly negatively associated with experience were waiting times, patient perceptions of quality of care and staff–patient interactions		•	•	•	
Wiman (2007)[19] Sweden	Two EDs (1 trauma centre; 1 rural)	To explore trauma patients conceptions of their encounter with the ED team	Inductive Semi-structured interviews Purposive sampling	23 adult patients with a presenting complaint of trauma	Three phases of trauma patient reception, which were: (i) the instrumental mode, (ii) the attentive mode and (iii) the uncommitted mode. The uncommitted mode could generate emotions of abandonment and dissatisfaction	•				

ED, emergency department.
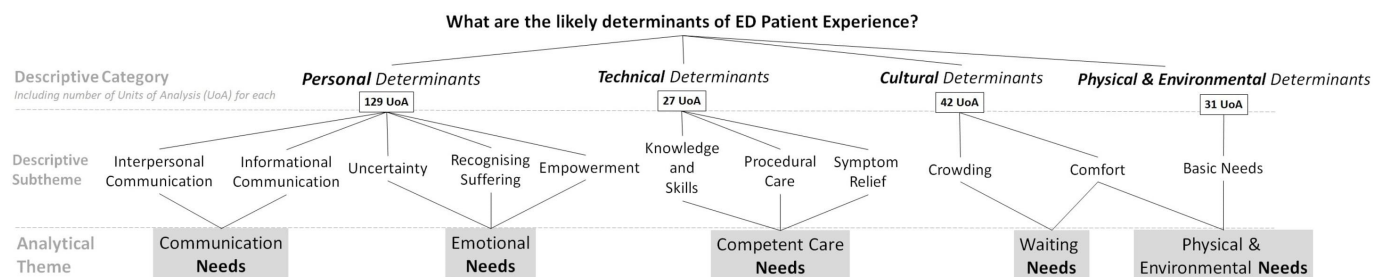
Figure 2 Tree diagram illustrating the relationship between descriptive categories, descriptive subthemes and analytical themes derived as a result of thematic synthesis.

Synthesis of results

Findings of the meta-synthesis are reported by analytical theme, with discussion based around respective descriptive subthemes. Examples of how data, including 'verbatim' patient quotations and relevant analysis, have been extracted to inform each analytical theme is outlined within the text.

Communication needs

The analytical theme of communication consisted of two descriptive subthemes: interpersonal and informational communication.

Interpersonal communication featured prominently and focused on provider–patient interaction. Desired qualities included actively listening to patient concerns, maintaining eye contact and a calm tone of voice.[16] [17] Specifically, some patients reported that communication helped resolve anxiety and helped them stay calm during stressful procedures:

'I mean they were just telling me what they were doing really. Just probably that constant reassurance of knowing what is going to happen and how I am going to feel… and yes, just knowing the situation I suppose'.[16] p22

When perceived as appropriate, humour could help reframe otherwise negative experiences[16] [18] or defuse a difficult or tense situation.[19] Empathic interpersonal communication was frequently helpful in assisting patients to cope with their experience of illness and being in the ED[20] and included purposeful touch.[17]

Repetition of questions by healthcare staff frequently caused frustration among patients:

'It drives me crazy to have to say the same things over and over and over. I am tempted to get a tape recorder'.[21] p107

Patients also expressed the need for clear answers to their questions, becoming frustrated when this was not the case or where communication was inconsistent. Specific difficulties were encountered by patients who were non-English speaking or who had pre-existing sensory deficits.[21–23]

Informational communication formed the second descriptive category of communication needs and was recognised as a discrete component of the patient experience in the ED. Patients had a clear expectation for clear and accurate information[24] and for this to be free of jargon.[18] Where information was not forthcoming, patients became very frustrated and were more likely to complain.[25–27]

Ensuring patients receive a flow of information throughout their ED journey was important. For example, Wiman *et al* define an 'uninvolved' phase of the trauma patients' resuscitation that occurred following initial examination and treatment, often while the patient was waiting for tests or results:

'…here, 'lack of information about the injury and its consequences, or about further care …or information about the psychological consequences of the injury' were prevalent'.[19] p719

Contemporaneous delivery of information was appreciated, even where this was 'bad news' delivered within an imperfect environment.[21] In addition to psychological anxiety, Kihlgren *et al* reported that failure to give clear and timely explanations to confused patients could exacerbate delirium:

'Patients that arrived in a confused state became noticeably more confused if the information was given in an unclear manner'.[25] p173

Although written information is commonly delivered in settings such as the ED, the use of leaflets was directly challenged.[16] [17] Patients reported problems reading and retaining information when in acute distress and discomfort, and reported that written information lacked 'human warmth', compassion and undermined confidence in providers' knowledge.

Discharge instructions are an aspect of informative communication in the ED. Within the identified studies, a lack of provision of discharge information was negatively associated with the experience of several patients, who desired basic information about follow-up care. Crucially, where adequate discharge advice was not provided, patients did not always feel compelled to speak up:

'And then it was just like, 'Okay, we're done. See yah.' You know? And it's like you just walk out of there and you're going 'Did that really happen? And was that…is that it?'[15] p507

Emotional needs

The analytical theme of emotional needs encapsulates three subthemes: 'coping with uncertainty', 'recognition of suffering' and 'empowerment'.

Coping with uncertainty principally arose from a lack of information during care processes and generated anxiety for patients in several studies.[22] [25] More specifically, patients with extensive lived experience of long-term health conditions expressed frustration when ED clinicians failed to take into account their perspective or where clinicians expressed diagnostic uncertainty for a condition perceived as a relapse by the patient.[28] Patients were also critical of being allocated diagnostic labels which they perceived as trivial (eg, 'viral illness') and could become concerned about 'missed' pathology.[29]

Patients became more anxious as their length of stay in the ED increased, out of fear that this could be due to the identification of a serious condition requiring further investigation, treatment or admission.[30]

Suffering expressed by patients included harmful events that might occur, such as falling from the bed, not receiving pain

killers and being 'forgotten' by ED staff.[25] Longer term fears among older adults were related to the loss of independence resulting from an acute condition.[28]

Feeling lonely, abandoned and depersonalised while in the ED contributed to a negative experience in several studies, including among older patients.[19 20 25 27]

'…to sit here and wait, and the only contact I have with the staff is when they carry out tests on me, you feel that you are not being seen as a person…'.[25] p172

The provision of simple measures such as a call bell was reassuring.[31] Boredom was an emotion expressed by one patient, although no solutions were proposed.[27]

Empowerment was identified as a further subtheme for codes describing or discussing measures taken by health professionals in the ED to encourage patient participation in their care. In particular, patients reported feeling empowered when encouraged to express themselves and their narrative during their ED stay:

'An important contribution to the experience of being cared for was that patients were given the opportunity to explain why they had come to the ED preferably at an early stage'.[25] p173

Patients longed to be viewed as 'sensible', which in turn left them feeling empowered in their decision to attend the ED.[28 32 33] Where patients perceived that they were not being taken seriously, their experience was negatively affected:

'Patients felt listened to, reassured and felt as if they were being given professional support and advice…stated that they wanted to be perceived as worthy people who were suffering and legitimately seeking assistance'.[32] p128

Patients greatly valued staff who took the time to empower them to feel safe and cared for in the ED, for example, by frequently checking observations, showing diligence, communicating certainty and reinforcing feelings of safety.[16 17 19 27] Patients also expressed a clear desire to be involved in shared decision-making processes.[25]

Care needs

The analytical theme of care needs comprised three subthemes: 'knowledge and skills', 'procedural care' and 'symptom relief'. Fewer units of information were identified for technically oriented themes in comparison with relational aspects of care. Indeed, patients were observers of a conflict between technical and relational aspects of care and could be critical where they perceived the former to take precedence.[27]

Knowledge and skills featured relatively infrequently compared with other themes; however, patients demonstrated that they could be pertinent observers of clinical processes and that these observations could influence their experiences. One such example occurred with trauma patients, the study by Wiman et al who reported that witnessing the team operating in an organised and predetermined manner was 'central to feeling safe'.[19] Patients expected triage nurses to show skill and efficiency in streamlining them to appropriate areas,[34] mentioning the need for improved training where this was not perceived to be the case.[32] Few patients in the studies were identified as the recipients of life-saving interventions, with the exception of a mother who remarked specifically on the technical skill employed by an emergency team when her child stopped breathing.

'The skill of the staff was absolutely incredible; not enough words of thanks could describe their efforts'.[23] p371

In the subtheme procedural care, patients expected to receive diagnostic tests, observation and a 'definitive' diagnosis and immediate treatment, whereas in the ED,[34] all products of technical competence and skill. Revell et al identified that interprofessional communication using technical terms during procedures reassured patients of providers' competence.[16]

Patients frequently commented on pain as a symptom requiring treatment, but also displayed a tendency towards tolerating pain as opposed to actively asking for analgesic medication.[17] Where there was failure to provide pain relief, it was of major concern to patients and negatively impacted their experience.[22] Inadequate pain management was also observed to contribute towards patient anxiety.[29]

Waiting needs

Waiting needs were characterised by two subthemes: crowding and comfort. Wait time was the most commonly reported determinant of experience in one study[35] and was described as the 'critical factor' in determining experience by another author.[18] Waiting was also commented on in many other studies.[18 26 27 31 33 34 36] In particular, long waits were a frequent source of dissatisfaction and complaints.[34 35] Patients reported a desire from staff for information during their wait including the reasons for their waiting.[18 25] Revell et al observed that the provision of timely and accurate information could mitigate against the deleterious effects of waiting on a patient's satisfaction and experience, and that staff were generally aware of this need.[16]

Patients valued comfort, including the provision of regular and spare seats near the entrance area of the ED,[30] but the 'milieu' of the waiting room environment created feelings of anxiety and uncertainty for some:

'The actual waiting situation was characterised by a lack of privacy, with the patients sitting on a chair or lying on a bed, in a waiting room or a corridor. A lot of activities took place at the same time, with uniformed staff coming or going and often running.'[25] p171

Patients were generally accepting of a long wait and could conceptualise that this was the result of higher priority patients requiring attention prior to them:

'If other patients need more help, of course, I stand aside. If someone has heart trouble, he must be taken care of before me'.[27] p25

The relationship between age and satisfaction with waiting is less clear. Whereas one study reported that long waits were a particular hardship for the elderly,[18] another observed that older adults were most likely to tolerate waiting without displaying dissatisfaction.[18 31]

Physical and environmental needs

The ED environment was perceived as unfamiliar and uncomfortable to patients, and this was often remarked on as being a negative determinant of experience. Examples of this include environmental determinants related to noise, lack of privacy while waiting, not being able to reach the call buzzer, physical disorientation[28] and unfamiliarity with the environment.[30] Patients resented the use of physical barriers and glass windows in reception areas.[23]

The requirement for EDs to meet basic physical needs was remarked on by several patients. This included the provision of comfortable beds[13] and items such as clothing,[19] blankets, toilets, food and drink.[25] In particular, nurses who were attentive to a patient's basic physical needs were seen as providing a positive experience.[25]

It was observed in at least two papers that older patients seemed less likely to express dissatisfaction overall, and they were especially perceptive observers of the physical environment.[18 33]

'Well, I expect that (the beds) have to be made a certain way. But they just are not very comfortable when you have to lay there for an hour or more'.[18] p90

DISCUSSION

The identified literature suggests a particular focus on relational aspects of care offered by ED staff. This is in keeping with existing findings which suggest that the majority of complaints are related to communication skills rather than competence[37] and that enhanced technical training may not translate to improved patient satisfaction.[38] Determinants of experience relating to interpersonal communication are prevalent in this review and highlight patients' desire for a kind, empathetic approach from within the ED. Informative communication relates to the need for timely and clear information delivery, as well as a preference for clear verbal communication, especially at times of pain or distress.

The need for patients to have emotional needs addressed is emphasised, as is ensuring an adequate environment. The concept of 'patient suffering' within the ED has previously been defined to include a range of elements such as nausea, vomiting, dizziness and anxiety.[39] This review has identified additional emotional components of suffering such as fear, uncertainty, isolation and loneliness. Although measures for pain scoring are now well developed,[40] there are no similar measures to monitor the emotional consequences of being an ED patient. Further studies could explore whether a more holistic assessment of 'suffering' may improve the patient experience.

Empowerment is defined by the WHO as 'a process through which patients gain greater control over decisions and actions affecting their health'[41] and is important to patients in the ED. Within the identified studies, ED care providers frequently displayed skill to overcome challenges and deliver a sense of reassurance and empowerment to patients.

Waiting was most frequently reported as a determinant of experience and was considered an intrinsic component of ED culture in several studies. Waiting itself—particularly the uncomfortable waiting room environment—featured as a negative determinant of experience, with patients having to 'endure' this component of their stay. However, the provision of information regarding wait times and the reasons for waiting may ameliorate this experience. Likewise, simple adaptations to the waiting room—such as the provision of ample and comfortable seating—is important to reduce the negative experiences of waiting.

The impact of the physical ED environment and the ability of the ED to meet patients' basic physical needs were considered important. Patients cited the importance of the provision of food, water, blankets, and comfortable bedding and toilet facilities as important to their experience. The emphasis placed on waiting by many of the studies identified in this review suggests that there is great scope to improve this aspect of the ED patient journey.

A proposed conceptual model for understanding patient experience in the ED

A conceptual model is defined as a diagram of proposed linkages among a set of concepts related to a particular problem.[42] Descriptive conceptual models are designed to provide paradigmatic ways of thinking through phenomena.[43] In the context of increasing understanding of a clinical problem, this may increase the relevance of an otherwise academic synthesis to practising clinicians and policy-makers. An appealing and user-friendly descriptive conceptual model of ED patient experience is therefore proposed as a result of this synthesis (figure 3). The model is based around five core patient needs based on the analytical themes of the synthesis. These are presented in the inner circle. In the middle circle, associated descriptive subthemes are presented as determinants of experience. For example, the
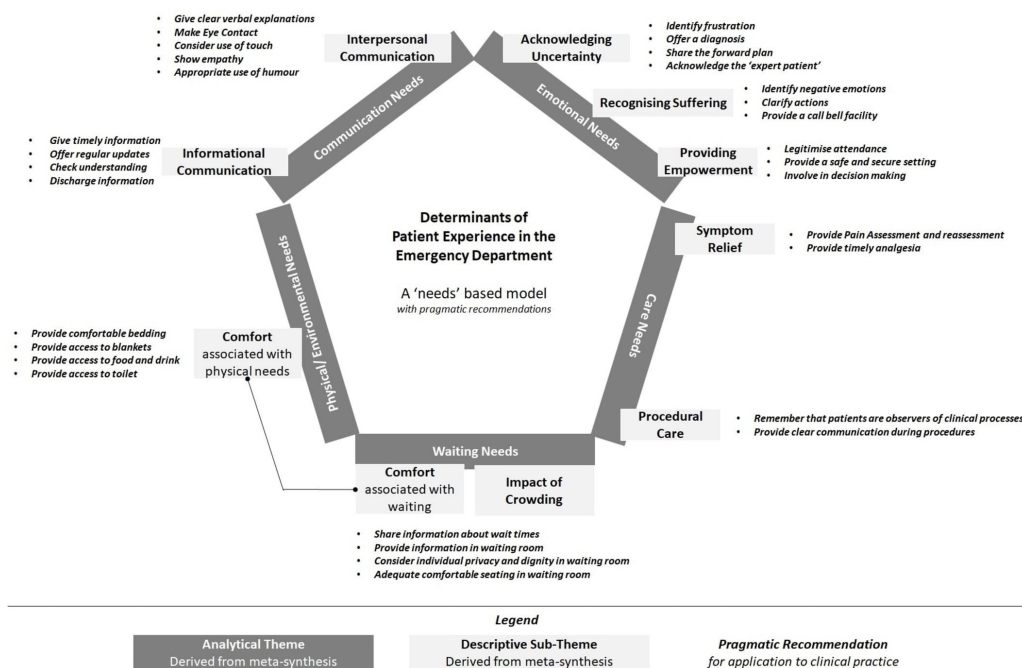

Figure 3 Conceptual model of patient experience in the ED. The inner circle (dark grey boxes) consists of five analytical themes. Linked to each are the descriptive sub-themes (light grey boxes) with associated pragmatic recommendations for clinical practice (italics). ED, emergency department.

analytic theme 'communication needs' has been constructed from the subthemes 'interpersonal communication' and 'informational communication'. In the outer circle of the model, a range of practical recommendations are presented. These recommendations demonstrate how qualitative themes, derived as a result of the synthesis, can be translated into suggestions for clinical practice. Each recommendation represents a desirable care process reported by at least one patient in the literature. The majority of recommendations—such as offering a warm blanket or information during waiting—are simple and deliverable with minimal resource implications.

Further validation of this model is needed. Potential applications may include training and assessment of healthcare professionals and informing the design of patient-centred care processes. The model also provides a basis for future research aiming to understand and optimise patient experience in the ED.

LIMITATIONS

The lack of a standard taxonomy of keywords for the literature exploring patient experience means it is possible that some studies have been missed. Additionally, while effort has been made to describe some major contributions from identified studies towards the synthesis and resulting conceptual model, integrating an expansive body of qualitative literature into a single review is inherently challenging. Nonetheless, conceptual saturation had been reached during the review, however, indicating that the unidentified literature is unlikely to substantially influence findings.

The apparent priority assigned by patients to relational aspects of experience over technical skills may be as a consequence of selection bias to the included studies. Intuitively, interview participants are likely to have lower acuity problems. It is possible that those with higher acuity or life-threatening conditions would place more value on the technical skills and competence of providers. Indeed, this seems to be partly reflected in the paper by Cypress.[24] Future work should seek out this population to confirm or refute this possibility. It is also possible that interviews simply focused on exploring relational aspects of care. Retrospective interviews are also likely to be subject to recall bias—patients with little knowledge of medical care may be more inclined to recall the interpersonal aspects of care afforded to them.

CONCLUSION

This meta-synthesis identifies a range of factors responsible for determining patient experience in the ED and confirms that patient experience is associated with perceptions of care. As such, we would suggest that the aphorism 'they (patients and relatives) do not care how much you know until they know *how much* you care' should be embraced at every stage of the patient journey by care providers in the ED. With this in mind, the review offers a framework with pragmatic recommendations that may be translated to directly enhance ED patient experience. With further validation, this framework and its suggestions may be harnessed as a tool for engaging practitioners and organisations in providing better patient experience, potentially improving clinical outcomes and patient safety.

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