

Patient Satisfaction Regarding Emergency Department: Literature Review

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Introduction

Hospital is an industry has a direct impact on people's lives at their most vulnerable times. It is critical to note that the perception of care is nearly as important as the quality of care (Deji-Dada et al., 2021). Hospital emergency departments (EDs) should provide a prompt care for the acutely ill or injured persons that require the attention of specialized nurses and physicians (Alharbi et al., 2018).

Patient satisfaction is an important quality indicator that allow identification of areas for improvement in EDs in order to provide better care & services to patients. Patient satisfaction refers to a patient's perception of whether or not their expectations and needs have been met. It is a measure of justice and fairness of care perceived and the expected care by patients (Khursheed, 2014).

Delivering health care in modern-day medicine involves not only getting the patient well but also paying attention of the patient's overall experience while receiving health care services. Despite the fact that many public health systems are not extremely expensive and readily available, patients were dissatisfied with healthcare services (Fufa & Negao, 2019).

So that, patient satisfaction depends not only on cost of care provided but also there are many factors affecting patient satisfaction like behavior of healthcare providers, hospital factors, wait time, level of experience of physician, perception of care and cost of treatment (Biglu et al., 2014).

Hospital EDs provide critical services, and the quality of those services impacts the

patients' living standard and, in some cases, the difference between death and life (Maa, 2011). Patient satisfaction with healthcare services is sometimes linked to their expectations prior to or during their encounter with care providers (Ogunfowokan & Mora, 2021).

Literature Review

While there is an increasing need for healthcare improvement across a variety of functional areas within the broader healthcare service, the ED has been identified as a critical functional area due to its impact on the overall value of the care delivered to patients (Dickson et al., 2009) and a variety of issues related to ED operations, such as overcrowding and lengthy waiting times in the admission process, which have an impact on patient flow, cost of care, speed of healthcare service, satisfaction, and patient safety (Holden, 2011).

I. Emergency Department

In the present time, there is a growing risk of sudden epidemics and high accident rate that increase burden on ED. Natural or man-made disasters, accidents, sudden surge of infectious virus borne diseases, etc. are the major reasons for crowding the ED (Ministry of Health of Saudi Arabia, 2014). Efficient care in hospital EDs is critical for achieving positive patient outcomes (Wu et al., 2015).

Hussein et al. (2017) identified ED as an acute care unit that is affiliated to a healthcare facility and provides unplanned healthcare services. Simultaneously, emergency rooms should remain open at all times as an extension

of a hospital's continuity of care (Ganem et al., 2016).

Due to the unscheduled nature of the patient admission, the ED is required to provide not only high-quality medical service but also rapid access to resources. In the process of providing care, EDs handle emergency situations resulting from incidents such as crimes, road accidents, and infectious diseases, and, among others, natural disasters (Spikes, 2019).

Everyone has a distinct interpretation of the term "emergency". An emergency could refer to an allergic reaction, difficulty breathing, chest pain, a fractured bone, or abdominal pain. Additionally, EDs are unique in that treatment cannot be refused regardless of a person's financial situation (McGuire, 2020). Taher (2012) claimed that patients in EDs are experiencing a lot of inconveniences in a strange and complex environment. All of these feelings are beyond their control, which makes it a very stressful setting.

I.1. Emergency Department Design

The design of the EDs must promote productive interactions between staff and patients, family, and caregivers, as well as the flow of clinical treatment. The design of ED has an effect on patient safety, satisfaction, and level of care provided to patients (Joseph et al., 2018).

According to Cutter (2014), ED should be located on the ground floor. Parking should be adjacent to the entrance and mostly designated for patients, their families, and staff. The ED should be located near critical regions and diagnostic facilities that are needed to support emergency activities, such as inpatient clinics and wards, intensive care unit (ICU), operating room (OR), and diagnosing imaging department (Marsh et al., 2020).

Protected adjacent parking spaces should be available to emergency call personnel. Patients and guests must be aware of their intended destination. Customers should be directed to critical sites, such as lobby, reception,

and waiting rooms, by floor patterns, signs, and color-coding. This gives control over how the design is distributed (Taher, 2012).

Light should be dimmed and arranged to minimize glare, it should not be placed directly over the patient's eyes. Dimmable lighting is ideal in the patient care areas (Cutter, 2014). According to Loupa et al. (2019), high noise levels in the EDs are linked with poor patient care, increasing stress for both staff and patients, and leading to poor communication between staff and patients. Thus, noise control strategies, such as sound-absorbing ceiling tiles using solid doors and walls instead of curtains, should be applied in the unit.

After patients' arrival to the ED, they are directed to a triage area for the initial clinical examination and assignment of an urgency level (Gilboy, 2020).

It has a single entrance of access for acute patients and regulated access to treatment areas and the whole hospital facility. To achieve the triage first principle, the triage and reception areas should be arranged so that the triage nurse is the patient's first point of contact. After triage, patient registration at the reception area enables the recording of the personal information of patients (Marsh et al., 2020).

The waiting room is designed for patients to stay in before and after triage, for entry into treatment areas for post-discharge transportation, and for families. The interaction between the waiting areas and the reception / triage facilities should be properly planned to ensure that patients and visitors receive enough communication. Both comfort and the quantity of furniture should be considered (Marsh, 2016).

I.2. Patient Rights and Responsibilities

Ghazawy (2017) added that patient rights are crucial pillars for providing adequate healthcare and promoting ethical medical practices. As a result, patient rights are regarded as a vital component of quality improvement attempts in healthcare, as well as one of the key

component for establishing a high quality of service. The major objective of patient rights is to improve patient care, patient respect, and the performance of healthcare personnel. By encouraging people to evaluate the healthcare system, patients' rights also have a significant impact on the overall quality of care (Awad, 2015).

According to Zeina et al. (2013), patients have the right to access medical treatment at any time and to receive emergency care if necessary. Additionally, they have the right to be aware of the cost of services, the names of healthcare providers, the type of treatment offered, and to participate in their plan of care. Also, they should be informed about all the necessary information regarding their rights or treatment in a comprehensible manner, as well as to have any important questions answered, in addition to advising them about the available alternatives.

Moreover, Younis et al. (2017) added that patients have the right to receive the required treatment and human care that is consistent with their beliefs and values. Furthermore, patient's security and confidentiality of his / her related information should be maintained during the physical examination. that means the information should be disclosed by himself / herself to the healthcare practitioners in private and sensitive manner, with constraints on how and when it can be shared with a third party. In addition, the patients should have the opportunity to write a complaint or make a recommendation anonymously (Algamal et al., 2019).

On the other side, Algamal et al. (2019) defined patients' and family members' responsibilities as complying with the organization's policies and procedures. Also, they are accountable for meeting financial commitments under relevant laws, regulations, and organizational policy, exhibiting decency toward other patients and healthcare personnel, and following the recommended treatment plan.

I.3. Emergency Department Process

EDs are designed primarily to handle critically ill and injured patients who required immediate treatment 24 hours a day, seven days a week. In practice, EDs attempt to offer quick care to all patients, regardless of the reason for their visit (Abdulaal, 2012). Every ED has a different patient flow. The patient flow process in EDs refers to the processes that patients undergo on admission to the hospital ED to get safe and effective treatment and disposition (Wiler et al., 2015).

Patient flow starts with patient arrival, triage, registration, physical examination, and tests conduction if needed and ends with the decision for admission to inpatient units, referral, discharge, or death (Brady, 2016).

Patient arrival is sudden and unplanned. Depending on the seriousness of the illness, a patient may be examined immediately or may wait for further examination by a healthcare provider after entering the ED (Arha, 2017).

Patient flow starts with their arrival to ED either on foot, by car, or by ambulance. When patients enter ED, they are assessed by a triage nurse or physician to determine their acuity level (Al Owad, 2015; Willoughby et al., 2010).

Triage is a French word, meaning 'sort' or 'select'. Triage nurses collect key information like 'vitals' (arrival mode, height, weight, temperature, blood pressure, etc.) and identify the patient problems as well as assess patient condition frequently. The aim of patient triaging is to identify cases as priorities/ needs immediate interventions and less critical ones. The triage nurse will sort and direct patients to either the outpatient department (OPD) to book an appointment or to the ED to be examined by a doctor (Qiu, 2014).

Incorrect triage acuity-level assessments (eg. over-triage or under-triage) have negative patient consequences. Over-triage is a term that refers to patients who receive a higher degree of triage acuity than their medical condition needs. So that, the limited resources and materials used for them as ED beds limit the bed's availability for another patient who might require immediate care. On the other hand, under-triage refers to

patients who get lower triage acuity than their medical condition needs leading to catastrophic consequences (Qiu, 2014; Whitfield, 2009).

Registration is the second process of patient journey in ED and sometimes occurs before patient triaging. After triaging, the patient is taken to reception for registration and waiting to be seen by the doctor, except for triage levels 1 and 2; the patients must be seen immediately by the doctor (Demo, 2021).

Registration is the process of gathering and documenting all information needed to create a patient-specific record. Financial guarantor information, insurance data, and socio-demographic indicators might be recorded. The primary function of registration is to produce an ED record for future inclusion with the patient's permanent record. Registration also allows the ED to acquire the information needed to bill for the encounter (Wiler et al., 2015). Some patients may choose to depart without being seen by a physician while waiting in a bed (Abdulaal, 2012).

Then the **medical examination** comes as the third process when a physician evaluates the patient, conducts further medical examinations as lab investigations and radiological services, and therefore the patient is treated based on the results of this examinations. If the doctor determines that the patient needs admission or other medical services from various departments, he / she will contact a consultant. Patients have held in the ED until the results of any necessary tests are available. After having the results, the doctor talks with the patients about their condition and the decision regarding admission, referral or discharge is made (Arha, 2017).

In the same line the nurse has a role in this phase which include recording patient histories (medical and surgical), obtaining vital signs, maintain patient preparation for required tests, administer medication, participate in patient management plan and educate patient about disease management (Smith & Pharam, 2021).

Patients discharge is the final process of the patients in the ED where discharge takes one

of three forms. Some patients are discharged to be admitted to an inpatient unit within the same hospital (Treat and Admit T&A), other patients leave the ED to go home (Treat and Released T&R), finally, those Left Without Being Seen (LWBS) (Brady, 2016; Abdulaal, 2012). The diversion occurs if there is a partial or complete limitation in an institution's ability to provide acute care services, such as a limitation of inpatient beds or specialized services (e.g., burn). Diversion is the process by which the ED's patients are temporarily transferred to another facility and is calculated as the time taken to divert ambulances away (Wiler et al., 2015).

II. Patient Satisfaction

Customer satisfaction has been growing as a management concern for both profit institutions and non-profits, a phenomenon also experienced by health care sector. This corresponds to the acknowledgement of the importance of including patients' opinions in assessing health care services (Soares & Farhangmehr, 2015).

Patient satisfaction has been highly used as an outcome measure for overall healthcare performance and the quality of nursing and medical care (Coetzee et al., 2013). Leva and Sulis (2017) defined the metrics that are used to evaluate ED performance as the key performance indicators (KPI's). That means the processes which are carried out in the EDs must be measurable to be analyzed, that is accomplished by defining the KPI's (Oskarsson et al., 2013). Patient satisfaction was reported by Madsen et al. (2015) as a KPI.

Patient satisfaction is defined as a subjective perception of service quality derived from matching the expectations regarding the service quality derived from matching the expectations regarding the service with the actual experience and outcomes (Jain et al., 2017).

Patient satisfaction is a critical factor in determining the effectiveness of healthcare delivery; it is also critical in the quality

assessment since its complete analysis can reveal both well-functioning and problematic parts of a hospital (Aljudaie et al., 2020). Due to ease of access to emergency services, which is determined by the number of patients who are not seen by a nurse and / or a doctor, as well as the efficiency (Carter et al., 2014). In the same context, Bhakta & Marco (2014) found that communication, the whole experience, quick treatment, and quality of care are the most critical criteria related to patients' satisfaction.

Patient satisfaction is greatly influenced by verbal communication, and non-verbal behaviors. In particular, patients appreciate the physical closeness of the nurses and doctors and their role as leaders in the communication network during their stay in the ED. In addition, patients would like to be actively involved into the healthcare providers' communication and they welcome the staff's effort to continuously monitor their health condition (Stefanini et al., 2021).

Individuals anticipate a certain level of service, but when they obtain a higher level of service, the client is satisfied. In contrast, if a client interprets that the level of service received less than expectations, he or she may become dissatisfied. From marketing perspective, there are different factors that contribute to patient's level of satisfaction. Among these factors are waiting in line for long time which may cause patient dissatisfaction. Also, time taken as occupied time makes patient feels shorter than unoccupied time, anxiety makes waits seem longer, uncertain waits are longer than known or finite waits, unexplained waits are longer than explained waits, and unfair waits are longer than equitable waits. The more valuable the service the longer the customer will wait, and solo waits feel longer than group waits (Davenport et al, 2017).

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