THE DEVELOPMENT OF A VOLUNTEER RESOURCE MANUAL IN THE EMERGENCY DEPARTMENT

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Abstract

Background & Purpose

Satisfaction plays a pivotal role in patients' overall perception about their health care experience (Ontario Hospital Association, 2010/2011). Patient satisfaction within the Emergency Department (ED) is largely dependent on wait times, awareness regarding wait times, and communication from ED staff (Ontario Hospital Association, 2010/2011). Unfortunately, ED wait times are lengthy and staff are challenged with meeting the communication needs of the patients (Ontario Hospital Association, 2010/2011). The current literature has revealed that volunteer programs in waiting rooms have demonstrated insurmountable improvements in patient satisfaction (Lorhan, van der Westhuizen, & Gossman, 2015; Stone & Lammers, 2012). However, a volunteer program in the HSC ED waiting room is yet to exist due to limited training for the volunteers. Therefore the development of a volunteer resource manual that can be utilized in the training of volunteers in the ED waiting room is a strategy to address this issue.

Methods

1.Literature review 2. Consultations with key informants 3. Environmental scan

Results & Next Steps

The results of the literature review and consultations reiterated the importance of establishing a volunteer program within the HSC ED waiting room to improve patient satisfaction. A needs-based resource manual was developed for the volunteers to utilize during their volunteer experience in the ED waiting room. Future goals include the implementation of a volunteer program within the HSC ED waiting room.

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INTRODUCTION

It is known that Canadian EDs have very lengthy wait times due to overcrowding of patients, increased patient acuity, and limited hospital beds (Canadian Association of Emergency Physicians, 2016). These factors are largely responsible for patient dissatisfaction. It was once believed that actual wait times were the greatest contributors to patient dissatisfaction, however, recent studies have proven otherwise. It is now known that decreased communication from ED staff, and lack of awareness regarding wait times has a significant role in patient dissatisfaction (Bleustein et al., 2014; Boudreaux, Friedman, Chansky, & Baumann, 2004; Cooke, Watt, Wertzler, & Quan, 2006; Grafstein et al., 2013; Taylor, Kennedy, Virtue, & McDonald, 2006). However, it is challenging for staff to meet the communication needs of patients due to heavy workloads (Ontario Hospital Association, 2010/2011). Patients may feel misinformed, misguided, and are left with many questions and concerns in the waiting room which negatively impacts their overall experience (Boudreaux & O'Dea, 2004). Patients have reported feeling 'ignored' when their expectations are not met, which negatively contributes to patient satisfaction (Ontario Hospital Association, 2010/2011). Although patient safety is the number one priority in healthcare, patient satisfaction is also important to patients' overall healthcare experience. Improved patient satisfaction also contributes to increased staff satisfaction and retention of staff at facilities (Ontario Hospital Association, 2010/2011).

Great efforts have been deployed nationwide to reduce patient wait times in EDs. However, lengthy wait times remain to be one of the biggest issues facing the Canadian EDs (Canadian Association of Emergency Physicians, 2016). As this issue remains unresolved despite great efforts, additional strategies must be implemented to improve patient satisfaction while waiting in the EDs. The development of a resource manual and probable establishment of a volunteer program within the ED waiting room is therefore justified. Without the proper training and preparation, volunteers may not possess the required skills or knowledge to provide services to a very diverse and unique population. This proposed program is important for not only the patients, but for the staff as well. The volunteers will be able to inform, assist, and interact with patients with the goals of alleviating any fears, concerns or questions they may have to improve their overall experience in the ED. The manual would also prepare the volunteers to assist the staff and alleviate some of the pressure and demands placed on the triage nurses by performing simple, non-nursing duties such as directing patients to radiology and informing patients of estimated wait times. Currently, there are no volunteer positions in the HSC ED; however, volunteers are utilized throughout other departments in the hospital and throughout other healthcare organizations. Previous reluctance from staff in the ED has prevented the establishment of a volunteer liaison program in the ED waiting room for concern of the well-being of the volunteers, as well as lack of training for the volunteers. Along with the triage RNs, the volunteers will be at the forefront of the ED. This can be a challenging position to be in as the volunteers may receive many patient complaints and frustrations as they are often the first point of contact for the patients. Through proper

preparation, education, and training, it is hoped that the volunteers will be well-equipped to provide first hand assistance to those in need.

OBJECTIVES:

1. Conduct a literature review to determine the effects of volunteer programs on patients' satisfaction in ED waiting rooms
2. Determine the needs of volunteers, patients, and staff members through consultations
3. To develop a resource manual to prepare volunteers to provide their services in the ED waiting room in hopes to improve patients' satisfaction while waiting. These will be accomplished while adhering to the Advanced Nursing Practice (ANP) core competencies; clinical, leadership, research, and consultation and collaboration.

OVERVIEW OF METHODS

An extensive literature review was conducted to gain a greater understanding about the effects of volunteer programs on patient satisfaction in ED waiting rooms. As the literature on this topic was limited, additional searches using different search engines were performed which will be further discussed in greater detail. The results of the literature review assisted in the development of the interview guide used in the consultations with key stakeholders. A resource manual was then developed based on the needs of the key stakeholders. The questions, concerns, and learning needs of the volunteers were identified in the consultations and were addressed in the resource manual.

LITERATURE REVIEW

Literature Review Methods

A literature review was conducted on the effect of volunteer programs on patient satisfaction with wait times in the ED. Pub Med was the main search engine used in this literature review. However, as a result of the specificity of the topic, limited literature was retrieved using the research question. Therefore, multiple search terms and phrases were used to broaden the search. "Patient satisfaction", "volunteers", and "wait times" were the MESH search terms that were used in this literature search which retrieved only one relevant article. "Volunteers in the ED", "Patient satisfaction with wait times", and "strategies to improve patient satisfaction in the ED" were common search phrases that were used in the PubMed search engine. However, undesirable results were obtained. Google scholar was the next search engine that was used in the search. However, only two articles retrieved were pertinent to this topic. The author then searched the references of articles to determine whether any articles were of relevance to this topic. This search strategy was most successful, retrieving the remaining 14 articles included in this literature review. Due to the specifics of the topic and the limited literature available, the studies included those conducted in developed countries outside of Canada, such as the United States of America and dated back to 1993.

Summary of the Literature Review

After critically analyzing the literature, three themes became apparent: the importance of perceived versus actual wait time on patient satisfaction in the ED, the importance of good communication between staff and patients on improving patient satisfaction, and the benefits of volunteer programs on overall patient satisfaction and perception of quality of care received.

The first theme revealed from the literature review stressed the importance of 'patients perceptions about their wait time compared to actual wait time' in relation to patient satisfaction (Boudreaux et al., 2004; Grafstein et al., 2013; Thompson, Yarnold, Williams & Adams, 1996). Although actual wait times were once believed to be the causative factor of patient dissatisfaction, only few studies are available to justify that view. Rather, greater emphasis is now focused on 'perceived' wait time compared to the actual length of time patients wait (Bleustein et al., 2014; Boudreaux et al., 2004; Grafstein et al., 2013). It is suggested that patients have greater satisfaction with their overall ED visit when their actual wait times are less than their perceptions about their wait times (Bleustein et al., 2014; Boudreaux et al., 2004; Grafstein et al., 2013). If the proposed program is implemented, the volunteers could inform patients of approximate wait times making their expectations about their wait times more accurate and possibly decrease their dissatisfaction when wait times are long. Implementing strategies to improve perceived wait time is also much more feasible and realistic than attempting to improve actual patient wait times (Boudreaux et al., 2004). Although strategies have

been implemented to improve actual patient wait times within Newfoundland and Labrador (Government of Newfoundland and Labrador, 2015/2016), the development of a volunteer program in the waiting room is an attainable, complementary strategy to improve patient satisfaction while waiting. The results of the literature review support the development of the volunteer resource manual and potential volunteer program. It is hoped that after adequate preparation and guidance from the resource manual, the volunteers will feel prepared to assist in the HSC ED. When the volunteers are available to inform patients of their approximate wait times or any expected delays in patient assessments, with support from the literature, it is hoped the patients will experience greater satisfaction during their wait and have a greater perception about their overall healthcare experience.

The second theme revealed in the literature review highlighted the importance of good communication between the ED staff and the patients to improve patient satisfaction (Cooke et al., 2006; Nielsen et al., 2004; Papa et al., 2008). The literature suggested that ED staff were not meeting the patients' expectations in regards to communication (Ontario Hospital Association, 2010/2011). The patients expected to be communicated to frequently in which the ED staff were unable to accommodate their demands (Ontario Hospital Association, 2010/2011). The volunteers could make up for the missed communication from the staff and tend to the communication needs of the patients. Taylor et al. (2006) also provide support for the prospective volunteer program. In their study, Taylor et al. (2006) reported the benefits of good communication in a liaison program which was implemented as a strategy to improve patient satisfaction. A

patient liaison program, staff communication workshops, and patient education videos were implemented as strategies to improve patient satisfaction which resulted in a 22.5% decrease in patient complaints post intervention (Taylor et al., 2006). Therefore, by utilizing the resource manual, the volunteers will receive the basic tools that are required to effectively communicate to a variety of patients in the waiting room. If the volunteers are unable to answer the patients' questions they will then notify the ED staff who will be responsible for communicating with the patient.

The third theme that became apparent in the literature review was the benefits of volunteer programs in all healthcare settings (Lohan et al., 2015; Stone & Lammers, 2012). As the literature available on volunteer programs in EDs, in particular, was limited, the benefits of volunteer programs in other healthcare areas, such as palliative care and operating room (OR) waiting rooms were reviewed (Lohan et al., 2015; Stone & Lammers, 2012). The results of these studies reiterated the importance of volunteer programs, despite the healthcare setting. From personal experience working in the ED, the volunteer program in the OR waiting room relates to this prospective program as the author believes these families share similar characteristics to those in ED waiting rooms. In the OR waiting rooms, the volunteers and staff members were able to alleviate family members' uncertainty which greatly contributed to their satisfaction (Stone & Lammers, 2012). Although an RN was present in the OR waiting room with the volunteer, the volunteers' presence and assistance cannot be undermined or discredited (Stone & Lammers, 2012). Stone and Lammers (2012) contend the most important contribution from the volunteers was their ability to provide 'distraction' to the family members

through communication. The volunteers were available to communicate to the family members which would distract them from the situation (Stone & Lammers, 2012). The volunteers in the palliative setting provided physical, emotional, spiritual, and informational support which allowed patients to achieve higher levels of satisfaction with their care (Lorhan et al., 2015). Through proper training, preparation, and support it is hoped that the volunteers will be able to provide similar assistance to those mentioned in the literature. Despite the different healthcare setting, it is apparent that volunteers contribute overwhelming support which is paramount in improving patients' overall satisfaction.

Theoretical Framework

The social exchange theory served as the foundation to this practicum project. Although not a nursing theory, it is applicable to the nursing profession and this practicum project. The theory contends that individuals enter into reciprocal relationships with one another, in a 'give and take' relationship (Cropanzano & Mitchell, 2005). It is expected that relationships are mutual and that in order to receive; one must give (Cropanzano & Mitchell, 2005). However, 'negotiated agreements' may arise which can lead to distrusting relationships when the agreements are broken (Cropanzano & Mitchell, 2005). The principles of the social exchange theory are highly prevalent within the ED between the staff and the patients. In the ED, the staff and patients form rapports and reciprocal relationships. The staff have a personal and professional obligation to provide their patients with optimal care. In return, the patients have an obligation to be

respectful and courteous to the staff and comply with their treatment regimes. However, one example where the social exchange theory may not apply to the nursing practice is when patients form negative rapports with the staff. A negative rapport can form when patients are disrespectful or aggressive towards the nurse. In this case, the nurse is obligated to provide optimal care to patients, even when the relationship is not reciprocal and when the patient is disrespectful towards the staff. However, it is hoped that the patients will recognize the great time and effort that the volunteers put into making their experience more enjoyable, thereby treating them with respect. Although the social exchange theory is not formally a nursing theory, the principles of the theory are applicable to the nursing practice and the prospective volunteer program.

SUMMARY OF CONSULTATIONS

The results of the consultations revealed useful information which was used in the development of the resource manual.

Participants

Data was obtained from key stakeholders through convenience sampling. Four ED RNs were consulted to determine their opinions on patient satisfaction in the ED waiting room and the prospective project. RNs of varying ages, gender, and years of work experience were interviewed. Three patients and their family members with varying ED wait times were consulted. The purpose for consulting the patients and their family members was to determine their level of satisfaction in the ED and possible methods to improve their satisfaction while waiting. Three hospital volunteers were

interviewed to identify their learning needs which would determine the components of the resource manual. It was also important to determine whether the volunteers would be interested in volunteering in the ED waiting room. Two security guards were consulted to determine their opinions on the prospective program and to determine what learning and safety materials should be included in the manual. The manager and clinical educator of the ED, and the HSC volunteer coordinator were consulted to receive approval and to determine their opinions on the proposed project.

Methods Used

Data was obtained by three methods. The patients, RNs, and security guards participated in the face-to-face semi-structured interviews which were led by an interview guide. However, as significant information was revealed from participants, new questions arose that were not part of the interview guide. The data was transcribed verbatim and analyzed using thematic analysis. Data collection from the volunteers differed from the proposal plan. The original plan was to conduct semi-structured interviews with all participants. However, due to conflicting schedules and personal preference, emails were used as an additional method of data collection from the volunteers. The interview guide was emailed to the volunteers. Once complete, it was emailed back to the interviewer. Informal interactions also occurred with a number of ED RNs throughout the development of the resource manual.

Ethics was addressed prior to the consultations. The practicum proposal was reviewed by Memorial University's ethics officer and was granted approval without

review. To protect the privacy of participants, the interviews were conducted in private areas within the HSC. To protect confidentiality, no identifying factors were used; rather, participant results were organized numerically.

Key Results of Consultations

The results of the consultations suggest that a volunteer program would be highly supported within the ED and would have many advantages which would outweigh the said disadvantages.

The benefits to the resource manual as mentioned in the consultations include: the resource manual would prepare the volunteers for any challenges they may face, it would provide information on hospital routines and policies, it would set clear boundaries to avoid legalities, and it would introduce them to medical conditions or illnesses that they may witness or be exposed to during their volunteer experience. As revealed in the consultations, the advantages to the prospective volunteer program include: increases in communication to patients leading to increased patient awareness, minimizing the number of patients feeling "forgotten about" when waiting in the waiting room, and reduced workload on the ED staff as the volunteers would perform non-nursing duties. The security guards were also highly receptive to a volunteer program in the ED waiting room. Along with the triage RN, the security guards are stationed in the forefront of the department and they often witness and receive many patient complaints and frustrations. They reported that with the proper training, the volunteer program would be very beneficial within the waiting room. The security guards highlighted important points to

consider regarding the recruitment of the volunteers. They reported that volunteers must possess certain qualities and traits in order to withstand the challenging environment of the waiting room. Assertiveness and confidence are two traits deemed important for the volunteers to possess. Only one participant was resistant to the idea of implementing a volunteer program in the HSC ED waiting room. This participant was concerned for the well-being of the volunteers in the waiting room as they would be at the forefront of the ED which can be a challenging due to its unpredictable nature. It was also mentioned that without proper training and education, the volunteers would succumb to the busy and often overwhelming department. There was concern that the volunteers would not be able to withstand the high demands and stress of the ED which would result in termination of the program. Therefore, it is hoped that the volunteers will receive enough training and preparation from the resource manual to assist them through the challenges that they may face when volunteering in the ED waiting room.

SUMMARY OF RESOURCE MANUAL

With the information obtained from the literature review and consultations, a resource manual was developed to meet the needs of the key stakeholders. As lack of specialized training was a major barrier to program establishment in the past, the learning needs of the volunteers became known to ensure appropriate components were included in the manual. The manual was created to be esthetically pleasing and easy to follow and comprehend. The level of reading material included in the manual was considered to meet the varying reading levels of the volunteers. When developing health-related

material, it is important that the reading material is at the grade 7-8 level (MedLine Plus, 2016). The automated readability index (ARI) was used to determine the reading level of the manual. The ARI is a formula which takes into account the number and difficulty of words, characters and sentences in material to determine its readability and grade level (Smith & Kincaid, 1970). After imputing the number of sentences, characters, and words into the formula, the result was 6.6. This suggests that the resource manual is at a grade 7 reading level.

The first section of the resource manual contains introductory material to the HSC ED. The process and function of the ED are explained in detail. This material is important to include in the manual as the volunteers must be cognizant of the function and process of the ED in order to provide services to the patients in the waiting room. It was also important to incorporate a brief introduction to the Canadian Triage Acuity Scale (CTAS) as it is evident that there is a learning gap regarding patients' knowledge of the triage process. Patients become frustrated when other patients are brought in to be assessed ahead of themselves, not knowing that acuity determines wait times. Therefore, volunteers who are educated on the triage process will be able to explain the process of the ED in hopes to alleviate common frustrations.

The second section of the manual is titled "expectations". To ensure the volunteers are adequately trained, it is imperative to educate the volunteers on their roles and boundaries within the ED waiting room. One of the interviewees mentioned that legalities may be an issue faced when implementing a volunteer program in the waiting

room. Therefore, to prevent any legalities, strict boundaries and rules are enforced in the manual to ensure the volunteers are aware of their expected roles and do not cross their boundaries.

'Your Protection' is the third section in the resource manual. It is a required the volunteers are aware of the emergency hospital codes (Eastern Health, 2015). Also, as a volunteer in the ED waiting room the volunteers are at the forefront of the ED where they may be exposed to unpredictable patients, or unexpectedly and unknowingly placed in violent situations. Therefore, educating the volunteers on actions to take to protect themselves is imperative. It is important the volunteers are educated on the codes and how to respond in order to protect themselves, the staff, and the patients. Education on hand hygiene and personal protective equipment (PPE) is another important component of this section. It is crucial that the volunteers practice strict hand hygiene to avoid contracting the many illnesses that they may be exposed to. Patients often present to the ED with contagious, life- threatening illnesses in which the whole waiting room are exposed to. Therefore, in order to protect oneself, hand hygiene must be practiced and continuously reinforced.

'Communication in the ED' is the next section of the manual and contains a brief overview of communication techniques that can be used by the volunteers. It was a recurrent topic mentioned in the consultations with the key stakeholders about the importance of the volunteers' abilities to communicate with the patients in the waiting room. It was also mentioned that effective communication techniques and possibly

communication workshops may be important in volunteer preparation. Therefore, a very brief overview of communication strategies has been incorporated into the manual. The possibility of incorporating communication workshops into volunteer orientation will be discussed with the volunteer coordinator and ED manager.

'For Your Information- What You May See…' is the final section of the manual. In the consultations, it was suggested by the staff that volunteers should be briefed on common illnesses and occurrences seen throughout the ED to lessen any anxiety, fear, or concerns that they may have. The volunteers also reported interest in learning about common cases they may witness during their volunteer experience. To address the interests and learning needs of the volunteers the final section contains information on the common illnesses and the more life-threatening or traumatic cases that present to the ED. This section was important to include in the manual as the unpredictable and often overwhelming environment of the ED can be intimidating to some and possibly lessen the likelihood that they would be willing to volunteer within the department.

ANP COMPETENCIES

The CNA (2008) have developed four competencies which are expected of nurses in the ANP roles to demonstrate: Clinical, research, leadership, and consultation and collaboration. It is expected that each nurse in the ANP role demonstrates these core competencies to ensure they are providing safe, ethical, and quality care to their patients (CNA, 2008). The four competencies served as a foundation for the development and completion of this practicum project.

Clinical

The CNA (2008) reports the clinical competency as being the "cornerstone" of advanced nursing practice. As suggested by the CNA (2008) the clinical competency served as the foundation to this practicum project. "Through a holistic and integrated approach, the nurse works in partnership with the client and other members of the health-care team in the provision of comprehensive care (CNA, 2008, pp.22). Throughout this practicum project, I worked in partnership with many members of the interdisciplinary team as well as key stakeholders. Working together with the ED staff, patients, family members, and volunteers was imperative for the successful completion of this project. I incorporated my ED clinical experience, with my knowledge, judgment, and research skills. From my clinical experience, I was able to recognize where inadequacies exist and advocate for the patients. Recognizing patient dissatisfaction and working with key stakeholders in attempts to resolve this issue demonstrates the clinical competency. I was able to act upon the inadequacies through the completion of the volunteer resource manual and possible development of a volunteer program in the ED waiting room.

Research

"Generating, synthesizing, and using research evidence is central to advanced nursing practice (CNA, 2008, pp. 23). An extensive literature review and environmental scan were conducted which required great amounts of research. The research competency was demonstrated when conducting the literature review which allowed me to recognize the gaps in the literature and the healthcare setting. All relevant literature on

the topic was critically analyzed to determine the needs of the target population. The literature was then categorized into themes and utilized to develop the foundation to this practicum project. In completing the environmental scan, I researched various volunteer programs throughout Canada and the United States to determine their efficacy which could also be used as the foundation to the possible volunteer program. Without the research component, this project would not have met the needs of the patients, ED staff or volunteers. The research allowed me to recognize the extent of patient dissatisfaction as well as possible methods to improve their satisfaction. From the research results I was able to develop a resource manual which is tailored to the needs of the patients, family, staff members, and volunteers.

Leadership

Advocating for patient populations, mentoring or being a leader to colleagues, identifying gaps in the healthcare system, and informing populations about nursing or health-related issues are actions that demonstrate the leadership competency (CNA, 2008). Leadership was demonstrated through all stages of the practicum project as strategic assessment, planning, and development was necessary to successfully complete the resource manual.

"Identifying the learning needs of nurses and other members of the health-care team and finding or developing programs and resources to meet those needs" (CNA, 2008, p. 24). In this practicum project I identified the learning needs of the volunteers in

order to develop a resource manual that would adequately prepare them to volunteer within the ED waiting room.

Advocating for patients where inadequacies exist demonstrates leadership (CNA, 2008). Throughout the practicum project I advocated for patients and their family members as their dissatisfaction with ED wait times became apparent. By developing the resource manual, it is hoped that volunteers will be adequately prepared to implement a volunteer program within the ED waiting room.

Recognizing the needs of patients and initiating action to produce positive change also demonstrates leadership (CNA, 2008). I recognized the need to improve patient satisfaction, advocated for the patients, and developed a resource manual which will hopefully lead to the development of a volunteer program in the ED to improve patients' overall ED experience.

Consultation and Collaboration

Collaborating with members of the interdisciplinary team to identify needs and improve healthcare challenges is a requirement of nurses in the ANP role (CNA, 2008). Consultations were imperative towards the development of the resource manual. Consultations occurred with patients, family members, ED staff members and volunteers. The purpose of the consultations was also to identify areas of weakness and attempt to improve the inadequacies recognized within the ED. The consults were also useful to determine opinions on patient satisfaction while waiting in the ED waiting room and the perspectives about a possible volunteer program within the ED waiting room. During the

consultations it was important that I remained professional and unbiased when interviewing the participants. The results of the consults were imperative in the development of the resource manual and possible implementation of a volunteer program.

NEXT STEPS

The development of the volunteer resource manual is the first step towards the development of a volunteer program within the HSC ED waiting room. As revealed in the consultations and literature review, the benefits of volunteer programs in EDs cannot be overlooked as they contribute greatly to patient satisfaction.

In order to establish a volunteer program within the HSC ED waiting room, key stakeholders will need to be involved in the development. The manager and the volunteer coordinator will have to work together to implement a program that meets the needs of both the volunteers, as well as the staff in the HSC ED. Interested volunteers will need to be recognized and screened to ensure they meet the expected requirements. As well, volunteer orientation will need to incorporate the new resource. Additional training such as communication workshops may need to be incorporated into the orientation based on the results of the consultations. When sufficiently prepared, the volunteers would then be introduced to and integrated amongst the staff of the HSC ED environment to ensure they are comfortable within their environment and within their role. It is hoped the program will be created to assist the needs of the patients and ultimately improve their satisfaction as they wait in the waiting room.

CONCLUSION

After reviewing the literature, it is evident that wait times within the Canadian healthcare system remain to be ongoing issue (Canadian Association of Emergency Physicians, 2016). However, despite great efforts, it is evident that wait times in Canadian EDs remain lengthy which is discouraging and dissatisfying to patients (Ontario Hospital Association, 2010/2011). As patient satisfaction is an important indicator of patients' overall healthcare experience, it is paramount that this issue is addressed (Ontario Hospital Association, 2010/2011). Rather than attempting to solve the issue of actual wait times, employing strategies to improve patient satisfaction while waiting in the ED is more attainable within the scope of this practicum project. It is hoped that the resource manual will provide the volunteers with a solid foundation which allows them to feel adequately prepared to provide their services within the ED waiting room. Following the introduction of the resource manual to the volunteer department, it is hoped that the volunteer program in the ED waiting room will be established. Until actions are taken to improve patient satisfaction while waiting in the waiting room, it is anticipated that unsatisfied patients will continue to fill EDs. However, if the goal is to improve patient satisfaction with their overall healthcare experience, the development of the resource manual and prospective volunteer program are the first steps to achieving positive change and a healthier, happier ED.

References

Bleustein, C., Rothschild, D, B., Valen, A., Valaitis, E., Schweitzer, L., & Jones, R. (2014). Wait times, patient satisfaction scores, and the perception of care. American Journal of Managed Care, 20 (5), p. 393-400.

Boudreaux, E, D., O'Dea, E, L. (2004). Patient satisfaction in the emergency department: A review of the literature and implications for practice. The Journal of Medicine, 26 (1), p 13-26

Boudreaux, E, D., Friedman, J., Chansky, M, E., Baumann, B, M. (2004). Emergency department patient satisfaction: Examining the role of acuity. Academic Emergency Medicine, 11 (2), p. 162-168. doi: 10.1197/j.aem.2003.08.018

Canadian Association of Emergency Physicians. (2016). Overcrowding. Retrieved: from: http://caep.ca/advocacy/overcrowding

Canadian Nurses Association. (2008). Advanced Nursing Practice: A National Framework. Retrieved from: https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/anp_national_framework_e.pdf

Cooke, T., Watt, D., Wertzler, W., Quan, H. (2006). Patient expectations of emergency department care: phase II- a cross sectional survey. Canadian Journal of Medicine, 8 (3), p. 148-157

Cropanzano, R., & Mitchell, M, S. (2005). Social exchange theory: An interdisciplinary review. Journal of Management, 31 (6), p. 874-900. doi: 10.1177/0149206305279602

Eastern Health. (2015). Volunteer Handbook-Eastern Health: Eastern Health

Government of Newfoundland and Labrador. (2015/2016). Department of Health and Community Services: Annual Performance Report. Retrieved from http://www.health.gov.nl.ca/health/publications/pdf/hcs_annual_report_2015.pdf

Grafstein, E., Wilson, D., Stenstrom, R., Jones, C., Tolson, M., Poureslami, I., Scheuermeyer, F, X. (2013). A regional survey to determine factors influencing patient choices in selecting a particular emergency department for care. Society for Academic Emergency Medicine, 20 (1), p. 63-70. doi: 10.1111/acem.12063

Lorhan, S., van der Westhuizen, M., & Gossmann, S. (2015). The role of volunteers at an outpatient cancer centre: How do volunteers enhance the patient experience? Support Care Centre, 23, p. 1597-1605. doi: 10.1007/s00520-014-2505-8

MedLine Plus. (2016). How to write easy-to-read health material. Retrieved from: https://medlineplus.gov/etr.html

Nielsen, D. (2004). Improving ED patient satisfaction when triage nurses routinely communicate with patients as to reasons for waits: One rural hospital's experience. Journal of Emergency Nursing, 30 (4), p. 336-338. doi: 10.1016/j.jen.2004.06.015

Ontario Hospital Association. (2010/2011). Leading practices in emergency department patient experience: Prepared for the Ontario Hospital Association by Infofinders. Retrievedfrom:https://www.oha.com/KnowledgeCentre/Library/Documents/Leading%20Practices%20in%20Emergency%20Department%20Patient%20Experience.pdf

Papa, L., Seaberg, D, C., Rees, E., Ferguson, K., Stair, R., Goldfeder, B., Meurer, D. (2008). Canadian Journal of Emergency Medicine, 10 (4), p. 347-354.

Smith, E., A., & Kincaid, P. (1970). Derivation and validation of the readability index for use with technical materials. The Journal of the Human Factors and Ergonomics Society, 12 (5), p. 457-564

Stone, A, M., & Lammers, J, C. (2012). The uncertainty room: Strategies for managing uncertainty in a surgical waiting room. The Permanente Journal, 16 (4), p. 27-30

Taylor, D., Kennedy, M, P., Virtue, E., & McDonald, G. (2006). A multifaceted intervention improves patient satisfaction and perceptions of emergency department care. International Journal for Quality in Health Care, 18 (3), p. 238-245. doi: 10.1093/intqhc/mzl002

Thompson, D, A., Yarnold, P, R., Williams, D, R., & Adams, S, L. (1996). Effects of actual waiting time, perceived waiting time, information delivery, and expressive quality on patient satisfaction in the emergency department. Annals of Emergency Medicine, 28 (6), p. 657-665.

Appendix A
Literature Review

The Effects of Emergency Department Wait Times on Patient Satisfaction: Can Satisfaction be Improved?

A Review of the Literature

Rachel Price

Memorial University

201485562

Feb 3rd, 2015

INTRODUCTION

Canada is renowned for its well-established, quality care healthcare system. The Canada Health Act is a legislation passed by the Canadian government, which allows Canadians the right to receive publicly funded healthcare (Health Canada, 2012). Universality, portability, accessibility, comprehensiveness, and public administration are the founding principles of this act which make Canada's healthcare system one of the highest ranked healthcare systems worldwide (Health Canada, 2012). It is important however to determine Canadians' satisfaction with their healthcare to ensure the principles of the Canada Health Act are being met. Accessibility to healthcare services is one principle of the Canada Health Act, which has received great attention as patient dissatisfaction with wait times has become apparent (Health Canada, 2012). A report generated in 2007 by Employment and Social Development Canada (2016) reported that 85.7% of Canadians were very or somewhat satisfied with the overall healthcare services that they were receiving. Evidently, however, these statistics vary in regards to specific healthcare services. In particular, inaccessibility to Emergency Departments (EDs) within Canada has led to increased patient dissatisfaction as lengthy wait times, inadequate communication between staff and patients, and limited access to healthcare services contributes to patient dissatisfaction (Government of Newfoundland and Labrador, 2012)

PATIENT SATISFACTION

Patient satisfaction has become a large priority in today's healthcare system as patients often associate their satisfaction to the quality of care that they receive (Ontario

Hospital Association, 2010/2011). The literature suggests that improving patient satisfaction is associated with additional benefits to both the patients as well as the healthcare staff (Ontario Hospital Association, 2010/2011). In addition to improving patients' healthcare experience, patient satisfaction also contributes to compliance of prescribed treatment and medication regimes, and reduced complaints and lawsuits from patients (Ontario Hospital Association, 2010/2011). As well, the literature suggests that patient satisfaction contributes to improvements in staff satisfaction and retention (Ontario Hospital Association, 2010/2011). The literature also suggests that communication and interpersonal skills play an important role in in patients' overall satisfaction (Ontario Hospital Association, 2010/2011). It has been suggested that patients are often dissatisfied with their healthcare experience as they often feel that healthcare professionals are too busy and that they are 'ignored' when they are in their most vulnerable state (Ontario Hospital Association, 2010/2011). Fortunately, strategies have been employed to improve patient satisfaction that will be discussed in further detail.

WAIT TIMES IN CANADIAN EMERGENCY DEPARTMENTS

Canada's healthcare system has been receiving negative attention regarding the inaccessibility of Canadian EDs in regards to overcrowding and wait times (Wellstood, Wilson and Eyles, 2005). Canadians make approximately 16 million ED visits annually (CIHI, 2012). In 2010-2011, with a population of 512 000, Newfoundland and Labrador EDs received 520 000 patient visits (Government of Newfoundland and Labrador, 2012). Both the Health Science Centre (HSC) and St. Clare's Mercy Hospital in St. John's, NL

account for approximately 85 000 of those ED visits annually (Government of Newfoundland and Labrador, 2012). In 2012-2013, 90% of Canadians waited on average 7.4 hours in EDs (Canadian Institute for Health Information (CIHI), 2014). Canada is now known to have some of the longest wait times in comparison to EDs throughout the rest of the world (CIHI, 2012). The increased wait times in Canada's EDs are primarily a result of overcrowding. Lack of inpatient beds, shortage of ED staff, lack of access to family physicians, and increasing acuity of patients in the ED contribute to the issue of overcrowding (Canadian Association of Emergency Physicians, 2016). The improper use of EDs and emergency medical transport systems is also another factor that negatively contributes to the inaccessibility of Canada's EDs (Government of Newfoundland and Labrador, 2012).

Many efforts have been taken to improve wait times in Canada by increasing resources and improving patient flow throughout departments (CIHI, 2012). In the past decade, the government of Newfoundland and Labrador has instilled $140 million dollars in its healthcare system in an effort to improve wait times (Government of Newfoundland and Labrador, 2012). However, the issue of lengthy wait times has yet to be resolved (Government of Newfoundland and Labrador, 2012). The HSC implemented the Rapid Assessment Zone (RAZ) as a strategy to improve patient flow throughout the department and increase accessibility (Newfoundland and Labrador, 2014/2015). Similar strategies have also been employed throughout Canada with the implementation of "see & treat" areas in the ED which attempts to have patients triaged as level 3,4, and 5 to be seen and discharged home promptly by physicians (CIHI, 2012). The LEAN initiative was a

program founded from the Toyota company framework which aimed to improve quality care (Moraros, Lemstra & Nwankwo, 2016). The program was implemented in the HSC in an attempt to improve patient flow throughout the ED and the hospital (Eastern Health, 2014-2015). Organizing the supplies in the ED to make them more easily accessible, "pulling" patients to fill stretchers, and predetermining which patients would be admitted versus discharged were a few of the LEAN strategies employed by Ng, Vail, Thomas and Schmidt (2010). However, a recent review released by Moraros et al. (2016) concluded that the program as a whole did the exact opposite of what it intended (Moraros et al., 2016). Instead, staff morale decreased, patient satisfaction decreased, increased funding was utilized as a result of the program (Moraros et al., 2016). Additional efforts have been implemented to correct the causative factors outside of the ED including increasing the number of admissions to medical school and family physician residencies, as well as increasing the number of nursing school admissions (Government of Newfoundland and Labrador, 2012).

Evidently, solving this issue is a complex, multifactorial process that will require additional funding, time, and effort in order to produce positive change. Although improving actual wait times is a lengthy goal, other strategies can be implemented to ensure patients are achieving satisfaction and quality care healthcare. Improving patient satisfaction is an area that should be acknowledged by the government and focused upon to improve patients' overall healthcare experience and perception of care that they receive. Therefore, the goal of this literature review is to gain a further understanding on wait times, patient satisfaction in the ED, and the use of volunteer programs to improve

patient satisfaction. It is hoped that the current literature will offer support for the implementation of a volunteer program in the Health Science Centre (HSC) in St. John's, NL.

THEORETICAL FRAMEWORK

The social exchange theory is the framework used to develop the proposed ED waiting room volunteer program. The social exchange theory is founded on a 'give-receive' basis (Cropanzano & Mitchell, 2005). The social exchange theory seeks to explain the nature of relationships when rewards are exchanged (Cropanzano & Mitchell, 2005). One only enters a "social exchange" if benefits will be reaped (Cropanzano & Mitchell, 2005). Six resources can be exchanged in the relationship: love, information, status, money, goods, and services (Cropanzano & Mitchell, 2005). The two main components or "rules" of the social exchange theory are reciprocity and negotiated agreements (Cropanzano & Mitchell, 2005). Reciprocity is defined as "a mutual exchange of privileges" (Merriam-Webster, 2015). Relationships are formed when both sides of the relationship are mutually benefited as a result (Cropanzano & Mitchell, 2005). A negotiated agreement is the other main principle of the social exchange theory (Cropanzano & Mitchell, 2005). This principle postulates that those in relationships have to negotiate in order to achieve desired benefits and results (Cropanzano & Mitchell, 2005). Cropanzano and Mitchell (2005) report that reciprocal relationships are more favourable than negotiated agreements as the latter often leads to distrusting relationships of unequal power (Cropanzano & Mitchell, 2005). The social exchange theory is rooted in anthropology, psychology, and social psychology. However, this theory has been used

as a foundation to nursing practices as well (Byrd, 2006). The author will reveal the theory's applicability to nursing and the proposed volunteer program.

Social Exchange Theory and Nursing

Although not of nursing origin, the social exchange theory is highly applicable to the nursing practice. Nursing practice is founded on the nurse-patient relationship (College of Nurses of Ontario, 2006). Nurses have a professional obligation to maintain therapeutic relationships with their patients to promote optimal well-being (College of Nurses of Ontario, 2006). Byrd (2006) conducted a study on utilizing the social exchange framework as a theory during a maternal home visit. The nurse provided the patient with his or her knowledge and skills, whereas the mother in turn provided the nurse with information, her home to work, and demonstrated competence in caring for her child (Byrd, 2006). Byrd (2006) was able to reveal associations between the nursing practice and the exchange theory and concluded that this theory may be useful in this specific nursing field. No literature was available which links the social exchange theory to ED nursing practice. However, the author is able to make associations that support the use of this theory as the foundation to ED nursing and the volunteer program. Triage nurses enter reciprocal, therapeutic relationships with their patients as the patients provide the nurse with the information about their health and presenting complaint. The nurse is then able to triage and care for the patient appropriately. The nurse expects that the patient accurately provides them with the information that they need to perform their job and carry out their professional responsibilities. In return, the patient expects that the nurse will provide them with optimal care. The social exchange theory is also highly

applicable to the volunteer program as the goal of the program is to improve communication and rapport with the patients to improve their satisfaction. The volunteers enter a relationship with the patient in which effective communication is paramount. Through the social exchange theory, the volunteer is able to provide the patient with information, and the patients in return are to be respectful of the volunteers. However, as Cropanzano and Mitchell (2005) stated, negotiated agreements may also arise. Negotiated agreements are less favourable as distrust results leading to a weaker rapport (Cropanzano & Mitchell, 2005). For example, negotiated agreements may arise in the ED between the nurse and patient due to extensive wait times when patients often threaten to leave the ED without being seen by a physician. Although busy, nurses may then inform patients of their approximate wait time or how many patients remain ahead of them to be seen by a physician. However, distrusting relationships may develop when patients of higher acuity are prioritized and moved ahead of other less urgent patients in the waiting room. It is hoped that the development of the volunteer program will allow therapeutic relationships to form between the patients and the ED staff as the volunteers will be in constant communication with the ED waiting room patients, informing them of any delays.

One limitation noted when linking the social exchange theory to the nursing practice is when nurses care for uncooperative, aggressive, or combative patients which is common in ED nursing. Although these patients may not be 'exchanging' resources with the nurse, the nurse still 'exchanges resources' as he or she has a personal and

professional obligation to care for these patients and form a relationship, despite their unruly behaviour.

It is apparent that the social exchange theory is applicable to the nursing practice (Byrd, 2006). However, additional studies must be conducted on nursing and the social exchange theory in order for it to become a recognized nursing theory. The author has revealed how the nurse-patient and volunteer-patient relationship can be viewed through the lens of the social exchange theory. Therefore, this framework is appropriate to support the development of the ED waiting room volunteer program.

METHODS

A literature review was conducted on the topic of interest which is the effect of volunteer programs in Canadian EDs on patient satisfaction with wait times. Seventeen articles were retrieved. However, as a result of the specificity of the topic, limited literature was available. Therefore, a broader search was conducted on ED wait times, patient satisfaction in the ED, and volunteer programs in healthcare. PubMed was the main search engine utilized in this literature review. "Patient satisfaction", "volunteers", "waiting times" were the MESH search terms that were used in this literature search which retrieved only one relevant article. "Volunteers in the ED", "Patient satisfaction with wait times", "strategies to improve patient satisfaction in the ED" were common search phrases that were used in the PubMed search engine. However, undesirable results were obtained from the PubMed search. Google scholar was another search engine that was used in the search. However, only two articles retrieved were pertinent to this topic. The author then searched the references of articles to determine whether

any articles were of relevance to this topic. This search strategy was most successful, retrieving the remaining 14 articles included in this literature review. The author aimed to primarily include studies that were conducted within Canada. However, due to the limited literature on this topic, the author had to expand the literature to include studies conducted in other developed countries, such as the United States.

LITERATURE REVIEW

The purpose of this literature review is to further understand the effects of volunteer programs on patient satisfaction while waiting in the ED. However, after reviewing the literature, it is evident that gaps in the literature exist. Minimal literature is available on the implementation of volunteers in the ED to improve patient satisfaction. Therefore, studies purporting to patient satisfaction, ED wait times, and the effects of volunteer programs on patient satisfaction and care are included in this review. The author will use this literature to support the practicum proposal which includes the implementation of volunteers in the HSC ED to improve patient satisfaction with wait times. After conducting the literature review, three themes became apparent: the importance of perceived versus actual wait time on patient satisfaction in the ED, the importance of good communication between staff and patients in improving patient satisfaction, and the benefits of volunteer programs on overall patient satisfaction and perception of quality of care received.

Actual Wait Time versus Perceived Wait Times

After reviewing the literature, it is evident that wait times play a significant role in patient satisfaction and their perception of quality of care received (Cooke, Watt,

Wertzler & Quan, 2006; Wellstood, Wilson & Eyles, 2005). It has been suggested that actual wait times strongly influence patients' satisfaction scores with their ED visits (Cooke et al., 2006; Wellstood et al., 2005). However, the current literature now suggests that patients' expectations about their own wait times may be more influential on their satisfaction scores compared to the actual amount of time they spent waiting in the ED.

Only two articles were obtained which suggest that actual wait times have an effect on patient satisfaction (Cooke et al., 2006; Wellstood et al., 2005). Wellstood et al., (2005) is a qualitative study that was conducted in Hamilton, ON using face-to-face interviews. The purpose of the study was to explore the experiences of patients who attended a Hamilton ED department (Wellstood et al., 2005). The most important theme revealed from the study was that actual wait time greatly influenced their satisfaction with their overall ED experience, with 33 of 37 patients revealing this data (Wellstood et al., 2005). Cooke et al. (2006) revealed a similar, yet important surprising finding. The participants of the study revealed that patients valued wait times, communication, and process improvements above their own safety and expectations about their treatment (Cooke et al., 2006). The results of this study are perplexing as one would expect patient health and safety to be the biggest predictor of satisfaction with one's healthcare experience. This study has many strengths making its results more convincing to the reader. A large number of study participants were included in the study and were selected through random sampling which increases the likelihood that the sample population is a good representation of the target population. Additionally, the data produced significant results with a 95% confidence interval (CI) (Cooke et al., 2006).

However, there are few studies that disprove that actual wait time's effect patient satisfaction. Sun, Adams, Orav, Rucker, Brennan & Burstin (2000) conducted a prospective survey study on EDs of 5 teaching hospitals in the United States. The purpose of the study was to determine what factors influenced patients decisions to attend that specific hospital's ED (Sun et al., 2000). Sun et al. (2000) concluded that actual wait times have no effect on patients overall satisfaction with their ED experience. They also concluded that patients were less likely to return to that same ED if they were not given any information about wait times which is consistent with current literature on the topic (Sun et al., 2000). One of the major limitations of this study is that it was conducted in the United States where there are significant differences to the healthcare system from that of Canada's. Krishell and Baraff (1993) also revealed similar results as wait times did not significantly affect participants' satisfaction between the control and experimental groups. However, Krishell and Baraff (1993) had many limitations to their study, such as not being able to control for extraneous factors, convenience sampling as method of participant selection, as well as being outdated. These factors may have influenced the results of the study and are taken into consideration when drawing conclusions from this literature review.

As the literature suggests, 'perceived wait times' appear to have a greater impact on patients' satisfaction then actual wait times (Bleustein, Rothschild, Valen, Valaitis, Schweitzer and Jones, 2014; Boudreaux, Friedman, Chansky and Baumann, 2004; Grafstein, Wilson, Stenstrom, Jones, Tolson, Poureslami, Scheuermeyer, 2013; Nerney et al., 2001; Sun et al., 2000; Thompson, Yarnold, Williams & Adams, 1996; Watt,

Wertzler & Brannan, 2005). Boudreaux, Friedman, Chansky & Baumann (2004) sought to examine whether patients' perceived wait times, or how long they believed they would wait for, would influence their ED satisfaction experience. The researchers also wanted to explore whether patients who presented to the ED with higher acuity reported increased satisfaction with their overall ED experience and care that they received (Boudreaux et al., 2004). Boudreaux et al. (2004) conducted a prospective survey in an inner-city hospital on patients who had visited the desired ED. Boudreaux et al. (2004) concluded that patient acuity and perceived wait times both significantly influenced patients' satisfaction scores. Patients triaged as "emergent" were much more satisfied with their care than those triaged "urgent" or "routine" (Boudreaux et al., 2004). This finding is to be expected, however, as priority to see a physician is based on the acuity of their presenting complaint. The study also suggests that patients' perceptions and expectations of their wait times significantly influence their satisfaction (Boudreaux et al., 2004). Patients who waited longer than they had expected reported decreased satisfaction with their experience versus those patients who were seen by a physician quicker than they had expected (Boudreaux et al., 2004). Nerney et al. (2001) also suggests that perceived wait time is a greater predictor of patient satisfaction than is the actual time the patient spent in the ED. Nerney et al. (2001) conducted a study on elderly patients over the age of 65 to determine the biggest factors that influenced their satisfaction with their ED experience. The results revealed that 70% of patients reported their overall experience as "excellent" or "very good" (Nerney et al., 2001). Fifty-eight percent of patients reported their wait time as "just right" (Nerney et al., 2001). The

biggest predictors of patient satisfaction were their perception of wait times in the ED, physician and nurse communication, as well as pain management (Nerney et al., 2001). The results of this study may be significantly influenced by the age of the patient as elderly patients tend to be more satisfied with their healthcare than are younger patients (Nerney et al., 2001). This finding is consistent with Jaipaul and Rosenthal (2003) who conclude that age significantly effects patient satisfaction as satisfaction scores increase between the ages of 65-80, and then begin to decrease again. It is suggested that patient satisfaction increases as patients' age as elderly patients are more accustomed to the healthcare system, therefore have lower expectations of their healthcare experience (Jaipaul & Rosenthal, 2003). Thompson et al. (1996) also concluded that 'perceived waiting time' significantly influences patients' satisfaction scores and this study consisted of participants of all ages. However, the study by Thompson et al. (1996) has few limitations which decrease its credibility. The participants in the study waited approximately 28 minutes, which is minimal in comparison to other EDs throughout Canada. As well the study was conducted in 1996 that serves as a major limitation when concluding the findings from this literature review. 'Perceived wait times' also dictates which hospitals patients attend (Grafstein et al., 2013). A study was conducted in a Vancouver Health Region to determine why patients chose to attend certain hospitals over others. Grafstein et al. (2013) revealed that perceived wait times do not influence patient satisfaction. However, perceived wait times do play an important role in choosing which hospital ED to attend, where 65.3 % of patients reported that wait times were 'very' or 'extremely' important in their decision (Grafstein et al., 2013).

The study by Bleustein et al. (2004) is the only study in which researchers studied the effect of wait times in relation to different waiting rooms within ambulatory clinics. The purpose of the study was to determine whether wait times affected patients' satisfaction, but also to determine if satisfaction was affected by waiting room location (Bleustein et al., 2004). The results of the study revealed that patients reported increased dissatisfaction when waiting in the exam room opposed to the main waiting room (Bleustein et al., 2004). Researchers suggest this finding may be due to solidarity in the exam rooms with lack of reading materials (Bleustein et al., 2004). Although the results of one study cannot prove a casual association, the results of this study are significant in the development of the practicum program. The study suggests that simple strategies, such as having reading materials available for patients may improve their overall ED experience satisfaction. This study also has few limitations worth noting. The study was conducted on ambulatory care clinics where the average wait time is 15-23 minutes (Bleustein et al., 2004). The researchers also did not determine whether time spent with the physician influenced participants'' satisfaction scores which may have influenced the results.

Through conducting the literature search, it has become evident that wait times, whether perceived or actual, play some role in predicting patients' overall satisfaction with their ED experience. However, the majority of literature favours implementing strategies to improve perceived wait time versus actual time spent waiting in the ED. This finding is important to the proposed practicum project as it reveals how wait time contributes to patients overall healthcare experience and their perception of care that they

receive. Boudreaux et al. (2004) suggests that strategies to improve perceived waiting time opposed to actual wait time is a much more realistic and achievable goal. Although improving wait times has proven to be a challenge, stakeholders should explore other methods to improve patient satisfaction with their ED visit. The implementation of a volunteer program into the HSC ED is one possible strategy that may be effective in improving patients' overall satisfaction.

Communication Improves Patient Satisfaction

The importance of good interpersonal skills, in particular, communication between the staff and patients, is another theme that has developed through conducting this literature review (Cooke et al., 2006; Krishel & Baraff, 1993; Nerney et al., 2001; Nielsen et al., 2004; Papa et al., 2008; Sun et al., 2000; Thompson et al., 1995; Taylor, Kennedy, Virtue & McDonald, 2006; Toma, Triner & McNutt, 2009). In fact, the Ontario Hospital Association (2010/2011) reports that lack of communication between staff and patients is a greater predictor of patient dissatisfaction then are actual wait times.

Taylor et al. (2006) conducted a prospective pre-posttest study to determine whether implemented interventions would have an effect on patients' satisfaction scores. The interventions included implementation of a nurse liaison in the waiting room to communicate, inform, and direct patients to their desired locations (Taylor et al., 2006). The intervention also included a communication workshop for staff and education videos in the waiting room for patients to inform them of the ED process (Taylor et al., 2006). Only one month after the interventions were implemented, researchers reported a 22.5%

decrease in patient complaints (Taylor et al., 2006). Nielsen et al. (2004) also developed an intervention to employ nursing rounds in the waiting room to determine whether it had any significant effect on patient complaints. The results of the study revealed a decrease in complaints from 18 complaints in one month prior to the intervention, down to 1 complaint post intervention (Nielsen et al., 2004). The "excellent" and "good" scores increased from 44%-88% post intervention (Nielsen et al., 2004). Although supportive, this study has many limitations. The study was not generalizable, did not account for other factors contributing to patient complaints, and the sample size of complaints was very small. Krishel and Baraff (1993) also conducted a study and implemented an intervention to determine whether it had any effect on patient satisfaction. The study is an experimental study using convenience sampling of 200 patients who visited EDs within California (Krishel & Baraff, 1993). Participants in the control group received information through a pamphlet while waiting which included information on physicians, prioritizing of patients, billing, and the ED process whereas those in the control group did not receive any information (Krishell & Baraff, 1993). The results of the study reveal that written communication is valued by patients attending the ED (Krishell & Baraff, 1993). Participants in the control group reported receiving greater quality of care, which contributed to greater overall satisfaction with their ED experience (Krishell & Baraff, 1993). The experimental group also reported greater satisfaction scores in the areas of whether the patient would return to the same ED, the ability of the staff to reduce patients' anxiety, physician skill, and greater satisfaction with time spent in the ED. Papa et al. (2008) took a similar approach to studying the effectiveness of communication but

utilized a television in the waiting room to relay the information. The study is an experimental study, where the experimental group was subject to an informational video in the waiting room informing patients of the ED process (Papa et al., 2008). Researchers concluded that informing patients about the ED process significantly improves their overall satisfaction with their ED experience, where 65% of patients reported their overall experience as 'excellent' or 'very good' versus 58.1% in the control group (Papa et al., 2008). However, unlike the majority of other studies reviewed in this literature review, there was no significant effect on patients' satisfaction with wait times (Papa et al., 2008). Although this method of communication is not direct, face-to-face communication, its implications are important and significant for the purpose of this paper and in developing the volunteer program.

Patients' expectation of their interactions with staff in the ED was also reviewed, as patients' expectations often exceed staffs' ability as a result of the busy environment (Cooke et al. 2006). In their cross-sectional survey study on patients attending EDs in the Calgary Health Region, seventy-six percent of patients believed that staff should communicate with patients about their wait time every 30 minutes or less (Cooke et al., 2006). This finding is significant to the implementation of a volunteer program in the waiting room as the chaotic, high acuity environment of the ED often makes it difficult for effective communication between the triage nurse and patients in the waiting room to occur (Mickelson & Takeno, 1996). Therefore, non-nursing staff should be available to communicate with the patients to alleviate their fears and anxiety, as well to alleviate pressure on the ED staff (Mickelson & Takeno, 1996).

The importance of communication in improving patient satisfaction cannot be undermined. As the literature suggests, interpersonal communication is important not only for improving patient satisfaction with wait times, but also for improving their perception of the care they receive. This literature strongly supports the implementation of a volunteer program in the waiting room of the HSC ED. The literature by Cooke et al. (2006) strongly supports a volunteer liaison program. Although a staff nurse was employed in the patient liaison role in their study, they believe that other ED staff could equally fill the role and receive the same results (Cooke et al., 2006).

Volunteers Improve Patient Satisfaction

Unfortunately, studies on volunteer programs in EDs have not been conducted despite their use and reported benefits by healthcare institutions. As well, the literature available on volunteer programs in other areas of healthcare is very limited. For the purpose of this review, the limited literature available on the effects of volunteer programs within healthcare will be reviewed. The most obvious theme that became apparent in the limited literature that is available is the benefits of volunteer programs in improving patient satisfaction and overall quality of care (Block, Casarett, Spence, Gozalo, Connor & Teno, 2010).

Volunteer programs have been established in hospice care, which the literature suggests is highly beneficial to the family members (Block et al., 2010). Block et al. (2010) conducted a cross-sectional study to determine whether volunteers improved the satisfaction of family members of patients in hospice services. The researchers concluded that those programs with a higher usage of volunteer services reported greater

satisfaction, where 75.8% of family members reported excellent care in comparison to 67.8% in the group with the lowest usage of volunteers (Block et al., 2010). Lorhan, van der Westhuizen, and Gossman (2014) also reported similar findings and concluded that volunteers in their British Columbia action research study with cancer patients enhance the patient experience by providing non-nursing duties that are often overlooked due to the busy environment in the nursing field. Through emotional, physical, practical, informational support, the volunteers were able to allow patients to experience higher satisfaction and quality of care (Lorhan et al., 2014). Although this study pertains to hospice care, it demonstrates the importance of volunteers in improving patient care and satisfaction.

Stone and Lammers (2012) conducted a qualitative study using semi-structured interviews to determine the experience of family members' uncertainty while waiting in an OR waiting room where both staff and volunteers would be stationed. The results of the study revealed the importance of communication of both the staff and volunteers in the waiting room on relieving family members' uncertainty (Stone & Lammers, 2012). The waiting room staff and volunteers achieved this by 'proving information ', 'providing distraction ',' reassuring and 'tangible assistance' (Stone & Lammers, 2012). Although this study was conducted on the waiting room in the OR, the ED waiting room consists of many family members and patients who experience fear, anxiety, and uncertainty. Although one study cannot prove a causal association, this literature does support the practicum proposal. The gap in the literature is apparent as many more studies need to be conducted on this topic.

Many healthcare institutions have reported positive contributions that volunteers in ED waiting rooms have on the patients, staff, and department as a whole. The Alta View Hospital in Sandy, Utah is one hospital that implemented a volunteer patient advocate liaison specialist (PALS) program to acknowledge and correct their staff-patient communication issues (Mickelson & Takeno, 1996). The main barrier with communication between staff and patients related to the busy and often chaotic dynamic of the ED in which high acuity patients prevented constant communication from staff (Mickelson & Takeno, 1996). Patient liaisons were expected to round on patients every 30 minutes and constantly communicate with the triage nurse (Mickelson & Takeno, 1996). Although statistics on the program are not available, Mickelson and Takeno (1996) comment on how the program has allowed for increased communication between patients and staff and patient reports have also revealed the benefits of this program (Mickelson & Takeno, 1996). A hospital in Rutland, VT also implemented a volunteer program in which volunteers in triage acted as liaisons between patients and the staff (Fortin & Everson, 2006). The volunteers were responsible for communicating with patients, informing them of approximate wait times or delays, and directing them to their assigned locations (Fortin & Everson, 2006). As a result of the program, the hospitals ED satisfaction scores increased from 76.1% to 84.3% post implementation of the 'triage volunteer program' (Fortin & Everson, 2006). Ninety-one percent of participants reported volunteers to be helpful in their experience (Fortin & Everson, 2006). It is important to note that these two hospitals reside in the United States where the healthcare system differs substantially from Canada's healthcare system. Volunteer programs have

also been implemented in Canadian EDs, yet literature has not been conducted on their successors. However, institutions have reported on the benefits of volunteer programs in Canadian ED waiting rooms (Cambridge Memorial Hospital, 2014).

A hospital in Belleville, ON recently implemented a volunteer program in the ED to act as a liaison between staff and patients which staff and patients have reported great feedback on. The Jewish General Hospital in Quebec was also awarded an award from the Canadian Association of Volunteers due to its ED volunteer program (Jewish General Hospital, 2014). The institution reports great benefits to the patients, staff, and the overall functioning of the department (Jewish General Hospital, 2014). Cambridge Memorial Hospital in Cambridge, ON and St. Joseph's Hospital in Hamilton, ON are two other institutions which support volunteers in the waiting room of their EDs (Cambridge Memorial Hospital, 2014; St. Joseph's HealthCare, n.d).

CONCLUSION

Important themes have been revealed in the literature that highlights the importance of improving patient satisfaction. A major gap in the literature was also revealed which necessitates the need for further research to be conducted on the implementation of volunteers throughout the healthcare system, specifically in EDs. Although the literature is limited on volunteer programs in EDs, literature is available that supports implementing change in order to produce patient satisfaction and quality care. Increasing staff-patient communication and acknowledging the importance of perceived waiting times to patients ED experience are strategies that may improve patients' satisfaction with their ED experience (Boudreaux et al., 2004; Cooke et al.,

2006). As the literature reveals, promptly resolving the issue of actual wait times far exceeds the ability of the healthcare system (Government of Newfoundland and Labrador, 2012). However, strategies to improve patient satisfaction while waiting in the ED are much more attainable (Cooke et al., 2006). The implementation of a volunteer program in the ED waiting room is one strategy that has been commended by many healthcare institutions throughout Canada and the United States to improve staff-patient communication and alleviate common fears and anxiety of the patients (Fortin & Everson, 2006; Cooke et al., 2006). Significant efforts and time will be needed to resolve the actual waiting time issue. In the meantime, a much simpler and possibly more beneficial strategy is to focus on improving patient satisfaction (Ontario Hospital Association, 2010/2011). It is now apparent that patient satisfaction contributes greatly to patients' perception about the quality of care that they receive (Ontario Hospital Association, 2010/2011). Therefore, the implementation of a volunteer program into the HSC ED waiting rooms is a more easily attainable strategy to improve not only patient satisfaction, but also the overall quality of patient care, which serves as one of the most important goals of the Canadian healthcare system.

References

Bleustein, C., Rothschild, D, B., Valen, A., Valaitis, E., Schweitzer, L., & Jones, R. (2014). Wait times, patient satisfaction scores, and the perception of care. The American Journal of Managed Care, 20 (5), p. 393-400.

Block, E, M., Casarett, D, J., Spence, C., Gozalo, P., Connor, S, R., Teno, J, M. (2010). Got volunteers? Association of hospice use of volunteers with bereaved family overall rating of the quality of end-of-life care. Journal of Pain and Symptom Management, 39 (3), p. 502-506. doi: 10.1016/j.jpainsymman

Boudreaux, E, D., Friedman, J., Chansky, M, E., Baumann, B, M. (2004). Emergency department patient satisfaction: Examining the role of acuity. Academic Emergency Medicine, 11 (2), p. 162-168. doi: 10.1197/j.aem.2003.08.018

Byrd, M, E. (2006). Social exchange as a framework for client-nurse interaction during public health nursing maternal-child visits. *Public Health Nursing, 23* (3), p. 271-276.

Cambridge Memorial Hospital. (2014). Volunteer Opportunities. Retrieved from: https://www.cmh.org/about/volunteers/volunteer-opportunities

Canadian Association of Emergency Physicians. (2016). Emergency department overcrowding. Retrieved from: http://caep.ca/advocacy/romanow-commission/emergency-department-overcrowding

Canadian Institute for Health Information. (2012). Health care in Canada, 2012: A focus on wait times. Retrieved from: https://secure.cihi.ca/free_products/HCIC2012-FullReport-ENweb.pdf

Canadian Institute for Health Information. (2014). Emergency department trends: 2013-2013. Retrieved from: https://www.cihi.ca/en/nacrs_infosheet_feb2014_en.pdf

College of Nurses of Ontario. (2006). Therapeutic Nurse-Client Relationship: Revised. Retrieved from: http://www.cno.org/globalassets/docs/prac/41033_therapeutic.pdf

Cooke, T., Watt, D., Wertzler, W., Quan, H. (2006). Patient expectations of emergency department care: phase II- a cross sectional survey. Canadian Journal of Medicine, 8 (3), p. 148-157

Cropanzano, R., & Mitchell, M, S. (2005). Social exchange theory: An interdisciplinary review. *Journal of Management, 31* (6), p. 874-900. doi: 10.1177/0149206305279602

Eastern Health. (2014/2015). Annual Performance Report: 2014-2015. Retrieved from: file:///C:/Users/Rachel/Downloads/RPT_APR_2015_09_21_final%20(2).pdf

Employment and Social Development Canada. (2016). Indicators of well-being in Canada: Health-patient satisfaction. Retrieved from: http://well-being.esdc.gc.ca/misme-iowb/.3ndic.1t.4r@-eng.jsp?iid=7

Fortin, I., Everson, F, P. (2006). Using volunteers at triage in the emergency department: One successful program. Journal of Emergency Nursing, 32 (4), p. 340-342. doi: 10.1016/j.jen.2006.04.017

Government of Newfoundland and Labrador. (2012). A strategy to reduce to emergency department wait times in Newfoundland and Labrador: 2012. Retrieved from: http://www.health.gov.nl.ca/health/wait_times/pdf/emergency_department_strategy.pdf

Grafstein, E., Wilson, D., Stenstrom, R., Jones, C., Tolson, M., Poureslami, I., Scheuermeyer, F, X. (2013). A regional survey to determine factors influencing patient choices in selecting a particular emergency department for care. Society for Academic Emergency Medicine, 20 (1), p. 63-70. doi: 10.1111/acem.12063

Health Canada. (2002). Canada's healthcare system. Retrieved from: http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php

Jaipaul, C, K., & Rosenthal, G, E. (2003). Are older patients more satisfied with hospital care than younger patients? *Journal of General Internal Medicine, 18,* p. 23-30. doi: 10.1046/j.1525-1497.2003.20114.x

Jewish General Hospital. (2014). Volunteers. Retrieved from: http://www.jgh.ca/en/ER_Volunteers?mid=ctl00_LeftMenu_ctl00_TheMenumenuItem001-subMenu-menuItem003

Krishel, S., & Baraff, L, J. (1993). Effect of emergency department information on patient satisfaction. Annals of Emergency Medicine, 22 (3), p. 568-572.

Lorhan, S., van der Westhuizen, M., & Gossmann, S. (2015). The role of volunteers at an outpatient cancer centre: How do volunteers enhance the patient experience? Support Care Centre, 23, p. 1597-1605. doi: 10.1007/s00520-014-2505-8

Mickelson, A., & Takeno, J. (1996). Clinical Notebook: Volunteer patient advocates in the emergency department. Journal of Emergency Nursing, 22, p. 427-428

Moraros, J., Lemstra, M., Nwankwo, C. (2016). Lean interventions in healthcare- do they actually work? A systematic literature review. International Journal for Quality in Healthcare, p 1-16. doi: 10.1093/intqhc/mzv123

Nerney, M, P., Chin, M, H., Jin, L., Karrison, T, G., Walter, J., Mulliken, R., Miller, A., Hayley, D, C., & Friedmann, P, D. (2001). Factors associated with older patients' satisfaction with an inner-city emergency department. Annals of Emergency Medicine, 38 (2), p 140-145. doi: 10.1067/mem.2001.114304

Newfoundland and Labrador. (2014/2015). Department of health and community services: Annual performance report 2014-2015. Retrieved from: file:///C:/Users/Rachel/Desktop/PRACTICUMLit%20Review/EH%20report%202

Ng, D., Vail, G., Thomas, S., & Schmidt, N. (2010). Applying the lean principles of the Toyota production system to reduce wait times in the emergency department. *Canadian Journal of Emergency Medicine, 12* (1), p. 50-57.

Nielsen, D. (2004). Improving ED patient satisfaction when triage nurses routinely communicate with patients as to reasons for waits: One rural hospital's experience. Journal of Emergency Nursing, 30 (4), p. 336-338. doi: 10.1016/j.jen.2004.06.015

Ontario Hospital Association. (2010/2011). Leading practices in emergency department patient experience: Prepared for the Ontario Hospital Association by Infofinders. Retrieved from:https://www.oha.com/KnowledgeCentre/Library/Documents/Leading%20Practices%20in%20Emergency%20Department%20Patient%20Experience.pdf

Papa, L., Seaberg, D, C., Rees, E., Ferguson, K., Stair, R., Goldfeder, B., Meurer, D. (2008). Canadian Journal of Emergency Medicine, 10 (4), p. 347-354.

Reciprocity. (2015). In Merriam-Webster online. Retrieved from: http://www.merriam-webster.com/dictionary/reciprocity

St. Joseph's Healthcare. (n.d). Volunteers. Retrieved from: http://www.stjoe.on.ca/about/volunteers.php?opportunities

Stone, A, M., & Lammers, J, C. (2012). The uncertainty room: Strategies for managing uncertainty in a surgical waiting room. The Permanente Journal, 16 (4), p. 27-30

Sun, B, C., Adams, J., Orav, E, J., Rucker, D, W., Brennan, T, A., Burstin, H, R. (2000). Determinants of patient satisfaction and willingness to return with emergency care. Annals of Emergency Medicine, 35 (5), p 426-434

Taylor, D., Kennedy, M, P., Virtue, E., & McDonald, G. (2006). A multifaceted intervention improves patient satisfaction and perceptions of emergency department care. International Journal for Quality in Health Care, 18 (3), p 238-245. doi: 10.1093/intqhc/mzl002

Thompson, D, A., Yarnold, P, R., Williams, D, R., Adams, S, L. (1996). Effects of actual waiting time, perceived waiting time, information delivery, and expressive quality on patient satisfaction in the emergency department. Annals of Emergency Medicine, 28 (6), p. 657-665.

Toma, G., Triner, W., & McNutt, L-A. (2009). Patient satisfaction as a function of emergency department previsit expectations. Annals of Emergency Medicine, 54, p.360-367. doi: 10.1016/j.annemergmed.2009.01.024

Watt, D., Wertzler, W., & Brannan, G. (2005). Patient expectations of emergency department care: Phase I- a focus group study. Canadian Journal of Emergency Medicine, 7 (1), p. 12-16.

Wellstood, K., Wilson, K., & Eyles, J. (2005). "Unless you went in with your head under your arm": Patient perceptions of emergency room visits. Social Science and Medicine, 61, p. 2363-2373. doi: 10.1016/j.socscimed.2005.04.033

Literature Summary Tables

Name, Author, Date, Study Objective	Sample/ Group	Design and Methodology	Key Results/ Findings	Strengths/ Limitations	Conclusion and Rating
Emergency Department patient satisfaction Examining the role of acuity. Boudreaux et al., (2004). The purpose of this study is to determine whether acuity, and perceived vs. actual throughput times are associated with increased patient satisfaction in the Emergency Department (ED).	1865 patients of the ED were included in the study (Both adult and pediatric patients were included) Study took place at Cooper Hospital, level 1 trauma centre in New Jersey.	Patients were approached to participate in the study prior to ED discharge or transfer to another unit. Questionnaires were completed by each patient. If patients were unable to read/write, interviews were conducted by staff members.	ANOVA and Pearson's Correlation were methods used to analyze data. Chronbach's alpha used to determine internal consistency. Patients triaged as emergent had increased overall ED satisfaction and increased perception about their wait times, in comparison to those patients triaged as urgent or routine. The study also revealed that patients' perceptions of their wait time in	**Ethics:** Study approved by the appropriate hospital review board- written consent was not required **Inclusion Criteria:** -Any patient that is able to competently complete questionnaire -If under the age of 16, parent must be present **Exclusion Criteria:** -Patients too ill to complete questionnaire **Limitations:** -Patients with severe illness were unable to participate in the questionnaire -Questionnaires were used to collect data which is not the most accurate/reliable method of data collection -Researchers report 'emergent' patients receive more attention and diagnostic studies which may have contributed to their	The study suggests that patients with higher triage scores are more satisfied with their overall ED experience. It is also suggested that patients' perceived wait times vs. actual wait times are big predictors of satisfaction in their ED experience. **Strength of study:** Strong

			relation to their actual wait time greatly contributed to their overall ED experience.	increased satisfaction with their ED experience	

Name, Author, Date, Study Objective	**Sample/ Group**	**Design and Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Effects of actual waiting time, perceived waiting time, information delivery, and expressive quality on patient satisfaction in the Emergency Department. Thompson et al., (1995). The purpose of this study was to determine whether or not wait times influenced patients satisfaction in their ED experience. The purpose of the study	The study was conduct-ed in Chicago, Illinois in MacNeal hospital. 3641 was the initial projected number of participa-nts however only 1631 patients respond-ed to the survey. The patients were chosen through random selection, and were selected over a two week	Patients were randomly selected and a survey was administered by a trained healthcare interviewer.	**Statistically significant:** Patients who received information (information on delays, procedures, discharge instructions) from staff were more likely to rate their experience as positive ($P<0.001$). Admitted patients were more likely to be satisfied with their ED experience than discharged patients. Men were more satisfied with their ED experience	**Ethics:** Researchers did not mention whether the study was approved by the appropriate ethics review board. Researchers ensured anonymity by not including identifying information **Inclusion Criteria:** -Any patients seen in the ED over the two week period -Pediatric and adult patients **Exclusion Criteria:** -If data on wait time was not generated in the computer by registration Strengths: **Limitations provided by the researcher:** -Wait times of patients were not overly long (approximately 28 minutes)	The results of the study that staff communication to patients about wait times and information delivery are big predictors of patients' satisfaction. As well, patients who had good interactions with the ED staff were more likely to have a positive experience in the ED. The study also revealed that actual wait times do not predict patients' satisfaction in their ED experiences. Strength: Moderate

is also to determine whether perceived wait times and the amount of information delivered to patients influence patients' satisfaction.	period. The research-ers attempt-ed to include equal particip-ants in regards to the number of admitted vs. discharge-ed patients.		than women Patients whose waiting time was shorter than their perceived waiting time revealed increased satisfaction with their ED experience. Patients who believed they had positive interactions with ED staff were more likely to rate their ED experience as positive.	-Not all factors were accounted for.	

Name, Author, Date, Study Objective	**Sample/ Group**	**Design and Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Determinan-ts of patient satisfaction and willingness to return with emergency care. Sun et al., (2000) The purpose of the study	A total of 2899 patients participat ed in the study-2333 of those patients complete d the follow-up telephone	Questionnaires were administered to patients at the five separate hospitals and were given a follow-up telephone call within 7-12 days. Participants were selected through	Communic-ation is a big predictor of patient satisfaction. Actual wait time is not a predictor of patient satisfaction. Older patients were more satisfied	**Ethics:** Researchers obtained informed consent **Inclusion Criteria:** Patients with complaints of abdominal pain, asthma, chest pain, hand laceration, head trauma, vaginal bleeding **Exclusion Criteria:**	The study suggests that communication with patients is an important predictor of patient satisfaction and their willingness to return back to that ED. The study also revealed that actual wait time in the ED department to see a physician is not a reliable indicator of patient satisfaction.

was to determine what factors are associated with patient satisfaction in the ED.	call	convenience sampling- researchers approached those eligible to participate	with their care (P< .01). African American patients were more likely to be less satisfied (P<0.1).	Intoxicated, confused, non-pregnant minors, leaving the ED before being assessed by a physician, or if patients have participated in a previous study on the ED **Strengths:** -Large sample size **Limitations revealed by the researchers:** -The study took place in the same city -Severely ill patients were unable to participate -Unable to generalize results -Convenience sampling	**Strength of study:** Moderate due to limitations

Name, Author, Date, Study Objective	**Sample/ Group**	**Design and Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
A multifaceted intervention improves patient satisfaction and perceptions of emergency department care. Taylor et al., (2006).	Royal Melbourne Hospital in Victoria, Australia Both males and females included in the study,	Prospective, Pre-post test design Study included the implementation of a patient liaison (nurse in this study who provided patients with information, directed them	**Statistically Significant with 95%CI:** Patient satisfaction was improved when: patients were informed about delays, after	**Ethics:** The appropriate review board was approach, and they denied the use of an ethics review board as this study was a 'quality improvement' study **Inclusion Criteria:** -Patients visiting the ED **Exclusion**	Communication is important in ensuring patient satisfaction is achieved (as demonstrated through the implementation of patient liaisons who kept the patients informed and performed simple tasks in accordance with the nurses) **Strength of study:** Strong

The purpose of the study is to implement interventions and determine which interventions will improve patient satisfaction with their ED experience.	ages 0-80+ **Pre-intervention:** 321 participants **Post-intervention:** 545 participants	through the department, communicated with them about any delays), communication sessions for staff and education videos in the waiting room to inform patients about the general process of the ED. Evaluation of intervention done through surveys, the rates of complaints after the intervention, and report from the patient liaisons. Surveys were mailed randomly to 100 patients every week for 6 weeks who had been discharged from the ED.	the intervention patients reported greater perceptions that the staff believed they truly cared about them and their well-being. Overall rating of the ED and 'overall assessment of the facility' were areas which improved significantly post interventions. Post intervention, researchers reported a 22.5% decrease in patient complaints after the implementation of the interventions (0.7 per 1000 decrease in patient complaints post intervention.	**Criteria:** -Patients admitted to hospital **Strengths:** -Pre and posttest study design -Good sample size **Limitations acknowledged by researchers:** -Decreased external validity due to study conducted on one ED -Study was conducted in winter months when ED has high visit numbers	

Name, Author, Date, Study Objective	Sample/ Group	Design/ Methodology	Key Results/ Findings	Strengths/ Limitations	Conclusion and Rating
Wait times, patient satisfaction scores, and the perception of care. Bleustein et al., (2014) The purpose of this study was to determine how waiting times (in both the waiting room and exam rooms) affect patient satisfaction scores	Study took place over 1 year in 44 ambulatory clinics in -49000 surveys were administered; 11 352 patients responded to the survey	-Researchers utilized the Press Ganey HCAHPS survey tool (46 questions) over the 2008 year -Surveys were mailed to the patients after a visit at the outpatient clinics	-77% chance of receiving the highest score if waiting ten minutes or less; as waiting time increases, chances of receiving the highest score decreases -Chi squared test and univariate logistic regression were used to analyze the data -Participants waited approximat-ely 23 minutes in the waiting room and 15 minutes in the exam rooms -Statistically significant: -Elderly patients perceived care more positively-increased between 0.5 and 2.9% for every 10	**Ethics:** Ethics was not addressed by the researchers **Strengths:** -Large sample size -Surveys not most accurate data collection method **Limitations as mentioned by researchers:** -did not determine whether time with physician impacts patients' satisfaction	-Wait times are important in patients' perceptions about quality of care -Patients are less satisfied when waiting in the exam rooms opposed to the large waiting room (researchers suggest may be that exam rooms are less comfortable and do not have any reading materials to engage the patients) **Strength of the study:** Moderate due to limitations -Survey as method of data collection -Unable to control for extraneous factors

			years of age -Patients visiting physicians for the first time were less likely to rate their experience score high		

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Does a waiting room video about what to expect during an emergency department visit improve patient satisfaction ? Papa et al., (2008) The purpose of this study was to determine whether playing an informative video in the waiting room for patients about what to expect during their	Convenience sample of patients-given surveys in triage and collected by research assistant -Total of 1132 participants in the study (61% female); 551 pre intervent-ion and 581 post intervent-ion	-Cross-sectional study with control group -Took place over two month period-video played two months prior to instructional video and two months after to determine its effects -12 question survey using 5-point lickert scale to determine patient satisfaction pre and post intervention -Researchers hired professional video company -Instructional video included	**Statistically significant:** -Participants were much more satisfied post video (65% of participants ranked their experience as 'excellent' or 'very good' vs. 58.1% pre intervention) (p=0.019) -No statistical significance results regarding participants' perceptions about wait times -Calls to outpatient communicati on line increased post	**Ethics:** Study reviewed by appropriate review board **Inclusion Criteria:** -At least 18 years of age -Discharged home from the ED -Triaged Monday-Friday between 10-6, and every other weekend **Exclusion Criteria:** -Admitted patients -Younger than 18 years of age without an adult -Severely ill patients **Strengths:** -Experimental study -Large sample size **Limitations mentioned by researchers:** -Not controlled randomized study	-Informing patients about the ED process through an instructional video significantly increases patients' satisfaction **Strength of study:** Strong

ED visit would improve patient satisfaction, increase calls to referral line, and impact perception on wait times		basic ED process, triage process, educational material	intervention	-Only at one hospital	

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Factors associated with older patients' satisfaction with care in an inner-city emergency department Nerney et al., (2001) The purpose of this study was to determine what factors are associated with elderly patients' satisfaction with their ED visits	Questionnaires completed by 983 participants 778 patients completed the follow-up satisfaction survey -Patients aged 65 and older between 1995-1996 who presented to ED of university hospital -63% of participants were	-Prospective cohort study -Assistants provided patients with questionnaires to complete during their ED visit. -A follow-up telephone survey was also completed by researchers	-70% of patients rated care "excellent" or "very good" -Patients perception of time spent in ED, pain management, and communication from staff significantly affected patients' satisfaction with their ED experience	**Ethics:** The study was approved by the appropriate review board **Inclusion Criteria:** -65 years of age and older -Presented to ED **Exclusion Criteria:** -Younger than 65 years of age Strengths: **Limitations provided by the researchers:** -Only conducted in one hospital -Unable to include entire patient population, i.e. patients too ill -Majority African American patients which isn't representative of the rest of the	Elderly patients' satisfaction with EDs is similar to that of the younger population -Good communication is imperative to achieving satisfaction -Perception of time spent in the ED, and being informed of delays or the process is greatly affects elderly patients' satisfaction -Pain in the elderly significantly affects their satisfaction with their ED experience **Strength of study:** Moderate

	female -Average age 76 years -79% of participants were African American			population -Researchers unable to control for all factors associated with satisfaction	

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Patient expectat-ions of emergency department care: Phase II- a cross sectional survey Cook et al., (2006) The purpose of this study was to understand ED patients' experiences in regards to staff communication, the ED process, and wait times	-In 2002 in 3 tertiary care hospitals in Calgary -Random sample of 35 patients weekly between September and Decem-ber -2219 patients were originally included in the study; 726 patients were excluded from the study based on	-Cross-sectional study -Computer-based telephone survey conducted by researchers up to 9 times post discharge from the ED	-Chi square and logistic regression used to analyze the data With a 95% CI: -76% of patients expected to be communicated to by hospital staff every 30 minutes -66% of patients believed that it was 'very' or 'extremely important' that they be told how long they would wait -40% of participants believed that they should	**Ethics:** -Not addressed in the study **Inclusion Criteria:** -18 years of age and older -English speaking **Exclusion Criteria:** -Patients under 18 years of age -Patients who were not residents of Calgary -pregnancy loss as presenting issue -non-English speaking -Patients who left without being seen **Strengths:** -Canadian study -Strong analysis of data **Limitations:** -Not all patients included in study -Small number of participants -Surveys not most	-Short wait times and good communication are associated with increased patient satisfaction; regardless of the triage score -Patient safety and treatment efficacy held lower importance to patients satisfaction and overall experience **Strength of study:** Moderate

	missing informati on; 382 patients refused to take part in the study; language barrier excluded 169 patients -837 patient surveys were utilized in the study		be able to dictate what tests and procedures the physician orders for them	accurate method of data collection -Unable to generalize results of study	

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
A regional survey to determine factors influencing patient choices in selecting a particular emergency department for care Grafstein et al., (2013). The purpose of this study is to	Convenience sampling -38 participants in the focus group -February to April 2010 in six EDs in Vancouver Coastal Health Region -634 patient surveys were	Qualitative, cross-sectional study -Face-to-face survey interviews conducted -Focus groups were conducted by trained interviewers to reveal data -38 participants were involved in the focus group; based	-Chi square and multivariate logistic regression used to analyze the data -With 95% CI: -65.3% of patients reported that wait times were 'very' or 'extremely' important in their decision -60.6%	**Ethics:** Implied consent when patients agreed to participate in the study **Inclusion Criteria:** -19 years of age and older -Patients triaged level 3-5 **Exclusion Criteria:** -Intoxicated patients -Communication difficulties -Transported by EMS -Unable to give	-Distance from the ED serves as the most important factor in determining which ED to attend to -Perceived wait times also dictates which ED patients attend to **Strength of study:** Weak due to limitations

determine what factors make EDs more appealing to visit than others	included and analyzed in the study	on their responses, 5-point Likert scale surveys were created	reported that their distance to the ED was 'very' or 'extremely' important in their choice -44% determined distance to be the most important factor when choosing which ED to attend to -9.3% reported that anticipated wait times was the most important factor -8.2% chose the ED in which their specialist worked	informed consent -Those not living within the health region **Strengths:** -Canadian study -Interviews/focus groups conducted **Limitations by researchers:** -Convenience sampling -Exclusion criteria list large -Only conducted on one region -Very small sample size -Results not generalizable to other populations	

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Improving ED patient satisfaction when triage nurses routinely communicate with patients as to reasons for waits:	-Patients who attended the ED of the Hillsdale Community Health Centre	-Pilot study over 6 weeks -Triage nurses rounded on waiting room patients every half an hour	-One month before the pilot project began, the ED had received 18 patient complaints regarding wait times -One month after the pilot	**Ethics:** Not required- quality improvement project **Inclusion Criteria:** -None specified **Exclusion Criteria:** -None specified **Strengths:** **Limitations:**	Patients demonstrate improved satisfaction with their ED experience when they are informed about their wait times and the reasons for any unanticipated delays **Strength of study:** Weak; not much information included

One rural hospital's experience Nielsen et al., (2004) The purpose of this study was to determine whether patient satisfac-tion improved when ED staff communi-cated with patients regarding their reasons for waiting			project, only one patient complaint had been received -"Excellent" and "good ratings" increased from 44% to 88% from patients	-Small sample -Did not account for other factors -Study not generalizable	about the study in the literature

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Patient expectatio ns of emergen-cy depart-ent care: Phase I- a focus group study Watt et al., (2005). The	-Calgary Health Region (combinati on of 4 EDs in Calgary). Purposeful sampling of participant s who had been discharged from ED	-Qualitative study -Focus groups were conducted -Focus groups conducted until data saturating achieved -Focus groups lead by non-biased, professional interviewer	**Common themes:** Communicati on: patients reported feeling anxious and fearful when at the ED, and they expected staff to be courteous, understandin g, and be in	**Ethics:** Ethics was considered **Inclusion Criteria:** -Live in Calgary (on phone directory or have attended 1 of 4 EDs) **Exclusion Criteria:** -None specified **Strengths:** -Canadian study -Use of open-	-Public have limited knowledge on ED process -Staff and public have different expectations on staffs ability to communicate in the ED -Wait times influence patients' perceptions about quality of care **Strength of study:** Moderate

purpose of this study is to explore the experi-ences and expectat-ions of ED patients. The study also aims to explore the perception of ED staff in regards to patient expectat-ions	between all 4 sites -344 participant s who had used the ED had been contacted; only 35 agreed to participate -Of the 590 particip-ants who had never used the ED, only 22 agreed to participate in the study -12 focus groups (5 groups consisted of patients who had themsel-ves visited the ED within the past year; 3 groups consisted of particip-ants who had never used the ED or never been with a patient to the ED within the	using open ended-questions	constant communicati on with them **Wait times:** expectation of wait times varied from 1-6 hours; decreased satisfaction was apparent as wait time increased **Triage:** participants expected to be given wait time by staff **Health record:** participants expected their ED visit to be communicate d to their GP **Quality of care:** Improvement to services: (4 themes emerged): 24 hour phone line available, education campaign to public, generalized, central patient database, establishment of urgent care clinics -The staff reported difficulty in	ended questions **Limitations:** -Only one region -Not generalizable -Purposeful sampling	

	past 3 years; 4 groups consisted of staff from the EDs) -Particip-ants were divided according the age group; participant s 0-13 had parents accomp-any them; particip-ants who hadn't used the ED were randomly selected in the phone listings		meeting participants'' expectations due to busy environment		

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
"Unless you went in with your head under your arm: Patient percept-ions of emergenc y room visits" Wellstood	Hamilton, ON -Two neighborh oods were surveyed (Chosen based on different socioecon omic statuses) -Total of	-Qualitative study -Face-to face interviews were conducted and tape recorded until data saturation was achieved	-Increased wait times was largely associated with patient dissatisfact-ion (33 of 37 patients) -Quality care greatly influenced the participants	**Ethics:** Implied consent was obtained when participants agreed to participate in the study **Inclusion Criteria:** -Residents of two specific neighbourhoods (1 industrial, 1 in	Increased wait times was the greatest predictor of patient dissatisfaction with their ED visit **Strength of Study:** Moderate

et al., (2005) The purpose of this paper was to explore the experi-ences of patients who attended an ED in Hamilton, ON	37 participant s Participant s chosen through random selection-letters were then delivered to house-holds informing particip-ants of the study -10 women and 10 men from each neighborh ood intervi-ewed (11 women from one particular neighbour hood)		satisfaction with their ED visit -Patient interaction also influenced patient satisfaction with their ED visit -Elderly above 65 years of age were more satisfied with their ED visit	mountains) **Inclusion Criteria:** -Living in desired neighbourhoods **Exclusion Criteria:** -Not a resident of specified neighbourhoods **Strengths:** -Face-to-face interviews good method of obtaining data -Canadian study **Limitations:** -Study only conducted on one region in Hamilton (2 neighbourhoods) -Small sample size	

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Effect of Emerg-ency Departme nt Informat-ion on Patient Satisfact-ion	Convenien ce sample of 200 patients who had visited EDs in California -Every other	-Experimental study using experimental and control group -Experimental group received information while in ED regarding wait	-Chi square and Mann Whitney U test used to analyze data -Statistically significant ($P<0.0001$); those in the experimental	**Ethics:** Not addressed **Inclusion Criteria:** -English-speaking -Patients attending the EDs **Strengths:** -Experimental study	-Receiving information on functioning of ED is associated with increased reports of patient satisfaction and perception on quality of care given. Wait time did not affect the satisfaction of patients in this study

Krishel & Baraff (1993) The purpose of the study is to determine whether receiving information on ED process increases patients' satisfact-ion with their ED visit	hospital chosen to participate (total of 186 EDs) (list alphabetic al) -Control and experimen tal group. Particip-ants not receiving informat-ion on function-ing of ED. Experime ntal group(Rec eived informat-ion) and control group	times, billing, physicians, priority of patients -Upon discharge, patients asked to complete a survey about their satisfaction with their visit	group who received information on functioning of the ED reported their experience greater than those in the control group who did not receive information on ED -Patients who received information on functioning of ED rated overall satisfaction with ED experience higher than those in the control group who did not receive any information -No difference on wait time between the experimental and control group -Physician skill and caring was rated higher in the experimental group in comparison to the control group.	-Only in one region **Limitations:** -Not up to date -Small sample size -Unable to generalize results of study -Study did not control for extraneous factors -Convenience sampling	**Strength of study:** Moderate

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Patient satisfact-ion as a function of emerg-ency departm-ent previsit expectat-ions Toma et al., (2009) The purpose of this study is to determine whether patients' prior expectat-ions of their ED visit influences their overall satisfact-ion with their current visit	-June-September 2006 - 504 Participant s included patients who attended the ED between the time June to September 2006 -Took place in trauma and pediatric hospital	-Cross-sectional observational study -Data collected via survey in three phases: 1. Patient expectations prior to arriving in ED 2. Patient perceptions after self-care 3. Chart review	-50% of patients were 'very satisfied' with their ED visit -46% of patients who did not expect any intervention reported being 'very satisfied' -51% of patients who expected at least 1 intervention reported being 'very satisfied' -No correlation between having an expectation met and patient satisfaction -Receiving analgesia was the most common	**Ethics:** The study was approved by the appropriate review board **Inclusion Criteria:** -Age 18 years or older -Patient or someone accompanying patient on ED visit **Exclusion Criteria:** -Severely ill/injured -Prisoners -Patients who did not agree to participate -Patients unable to communicate effectively **Strengths:** **Limitations:** -Sample size not adequate as determined by researchers -Not generalizable	-Physicians' interpersonal skills appear to be the most important factor in patient satisfaction -Explanation of the medical condition as well as the time the patient spent with the physician also contributed to patient satisfaction -Patient satisfaction was not associated with whether or not the physician treated the patient appropriately as the patient had expected **Strength of Study:** Moderate

			theme that emerged from the data in regards to treatment and previsit expectations		

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
The Uncertainty Room: Strategies for managing uncertain-ty in a surgical waiting room Stone & Lammers (2012) The purpose of the study is to determine the experien-ces of family members in the OR waiting room, and ways that they are able to cope with the uncertain-	-Total of 7 participants in the study (three volunteers who were primarily responsible for communicating with patients, 3 'technical staff' who performed clerical roles, one 'circulating nurse' who communicated between the OR and the waiting room) Convenie-nce sampling used to choosepartic-ip-	-Qualitative study -Semi-structured interviews using open-ended questions, each with individual participant -Observation of waiting room for 40 hours also occurred	-Data analyzed using constant comparative analysis **-Themes:** -Staff provide information -Staff provide distraction -Staff reassure patients -Staff provide 'tangible assistance' (anything physical that the staff could assist the family members with)	**Ethics:** Study was approved by the appropriate review board **Inclusion Criteria:** -Family members in OR waiting room waiting for family member **Exclusion Criteria:** -None specified **Strengths:** -Open ended questions **Limitations:** -Small sample size -Results not generalizable -Convenience sampling -Researchers report interviews should have been conducted prior to the patient going in to the OR.	The results of the study reveal that staff in the waiting room appear to improve the uncertainty that family members experience when waiting in the OR waiting room. Communication is important in supporting family members Further studies need to be conducted on this topic **Strength of study:** Weak due to limitations

ty that they experience	ants Participants sent an email about the study				

Name, Author, Date, Study Objective	**Sample/ Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
Got Volunteers? Association of hospice use of volunteers with bereaved family members' overall rating of the quality of end-of-life care Block et al., (2010). The purpose of the study is to determine whether bereaved family members who have patients in hospice	Conducted in 2006 in -305 hospice surveys completed and submitted 57 353 survey results regarding their use of volunteers and the patient surveys (At least 20 surveys had to be completed for the hospice institution to be included in the study) -Survey results divided in quartiles	-Cross-sectional study -Hospice centres completed and submitted surveys to determine the number of volunteer hours volunteers worked and how family members rated their experience at their centre	-The average use of volunteers peer week was 0.71 hours; not for profit utilized volunteers more often at 0.83 hours per week -The hospice programs in the lowest quartile of all the surveys received had family members who reported lowed satisfaction with their experience than those in the group with the highest usage of volunteers (67.7% vs. 75.8%)	**Ethics:** Was not addressed in the study **Inclusion Criteria:** -Hospice centres that wanted to participate -Had to submit at least 20 surveys in order to participate in study **Exclusion Criteria:** -Under 20 surveys submitted **Strengths:** -Good sample size **Limitations revealed by researchers:** -Not generalizable -Only those hospice centres that wanted to respond to the survey did -Unable to account for other factors that may have influenced results	The results of the study reveal that bereaved individuals whose family members are in hospice care report increased satisfaction with the care they receive when volunteers were present to provide assistance **Strength of the study:** Moderate- due to limitations (strong sample size, however, convenience sample used and researchers did not control for extraneous variables)

care have increased satisfact-ion with the care they receive when volunteers are present to be of assistance					

Name, Author, Date, Study Objective	**Sample/Group**	**Design/ Methodology**	**Key Results/ Findings**	**Strengths/ Limitations**	**Conclusion and Rating**
The role of volunteers at an outpatient cancer center: How do volunteers enhance the patient experience ? Lorhan et al., (2015) The purpose of the paper is to determine how volunteers are of assistance to patients at an outpatient	-7 patients who were currently receiving cancer treatment from the British Columbia Cancer Agency , Vancouver Island Centre were involved in the study -Five participants were involved in individual interviews ; 2 participants were	-Action Research -Individual interviews and focus groups were conducted	-Volunteers were of assistance with 'emotional', 'information-al', 'physical', and 'practical' needs of the patients. -Emotional and social support was the greatest assistance provided to the participants	**Ethics:** The study was approved by the appropriate review board **Inclusion Criteria:** -Patients attending British Columbia Cancer Agency -Currently being treated **Exclusion Criteria:** -Not a patient of British Columbia Cancer Agency -Not receiving cancer treatment **Strengths:** -Interviews and focus groups **Limitations revealed by researchers:** -Participants in the study were coping well with their illness	-Volunteers improve overall quality of care provided to the patients in this study -Healthcare institutions need to recognize the importance of volunteers on improving quality of care and patient satisfaction. Volunteers should become important members of the healthcare team Additional studies need to be conducted **Strength of study:** Weak due to limitations

cancer centre	involved in focus groups Convenie-nce sampling			-Study not generalizable -Small sample size	

Rating of studies done with assistance of the Public Health Agency of Canada (PHAC) Critical Appraisal Tool Kit

Public Health Agency of Canada. (2014). Infection prevention and control guidelines: Critical appraisal tool kit. Retrieved from:

http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

APPENDIX B

Consultation Report

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NURS-6081

April 1st, 2016

BACKGROUND

The overall goal of this practicum project is to develop a resource manual which will prepare volunteers in the Health Science Centre (HSC) ED waiting room. Although beyond the goals of this practicum project, the developer hopes to assist with the implementation of volunteer services within the HSC ED waiting room. The rationale for developing this program originates from common themes revealed in the literature. As the literature suggests, patient satisfaction is an important indicator of patients' overall healthcare experience (Ontario Hospital Association, 2010/2011). It is known that wait times have a significant impact on patients' overall satisfaction with their healthcare experience, particularly in relation to the lack of communication between staff and patients (Ontario Hospital Association, 2010/2011). After reviewing the literature, it has become apparent that continuous communication between ED staff and patients in the waiting room has a positive effect on patients' overall healthcare experience (Taylor et al., 2006). With the development of a resource manual and implementation of volunteer services within the ED waiting room, it is hoped that volunteers will act as liaisons between the staff and patients to improve overall patient satisfaction.

During consultation with the manager and educator of the HSC ED and the HSC volunteer coordinator, it was identified that the major barrier to establishing a volunteer program is fear for the well-being of the volunteers due to the vulnerability of patients in the ED. Therefore through the development of the resource manual, the goal is for volunteers to become prepared to safely interact with the patients in the ED waiting

room. The results of the consultations with key stakeholders will determine their needs and what components will be necessary to incorporate in the resource manual to increase success.

CONSULTANTS

A variety of key informants were consulted to guide the development of the proposed volunteer resource manual. Four Eastern Health Registered Nurses (RNs) were consulted. The RNs varied in age, gender, and years of nursing experience. These participants were selected through convenience sampling due to their accessibility to the interviewer. The purpose of consulting the HSC ED nurses was to determine their opinions on patient satisfaction within the department, and whether or not they believed a volunteer program would improve patient and staff satisfaction. It was important to consult the triage nurses, in particular, as these nurses will have direct interaction and communication with the volunteers in the waiting room. As the triage nurses are the forefront of the ED, their input is extremely valuable in determining what skills and knowledge the volunteers must acquire before volunteering in the unpredictable environment of the ED waiting room.

Two security guards employed by Paladin security were also consulted as part of this practicum project. The participants were selected by Paladin management. The purpose of consulting the security guards was to gain their outlook on patient satisfaction within the HSC ED waiting room. As the security guards are largely responsible for the

safety of all individuals within the HSC ED, it was important to gain insight on their expertise on the prospective volunteer program.

Three patients and two family members from the HSC ED were consulted. The patients varied in age, gender, wait time, and Canadian Triage Acuity Scale (CTAS) which is a tool utilized by the triage RN to determine patients' acuity levels and prioritize their care appropriately, and presenting complaint. Patient selection was challenging due to the poor physical and mental health statuses of the patients. The patients were selected by convenience sampling with assistance of the charge RN. The purpose of consulting the patients was to gain their perspectives on wait times in the HSC ED and possible strategies to improve their satisfaction while waiting.

Understanding the needs of the volunteers was imperative to determine the components of the resource manual. Four Eastern health volunteers were consulted. The volunteer coordinator of the HSC emailed volunteers to determine if they were interested in being interviewed. Four volunteers agreed and were consulted. The demographics of the volunteers were not known to the interviewer to protect their confidentiality.

One ED nurse in Ontario was also consulted through informal consultation via telephone. The purpose for consulting this RN was to understand her experience with working in an ED in which volunteer services are implemented. This participation was completely voluntary, and informed verbal consent was obtained.

METHODS

Semi-structured interviews were conducted with the patients and their family members in private rooms within the HSC ED. The interviews were led by interview guides created by the interviewer (see Appendix A). Additional questions were asked when significant information was revealed by participants.

Semi-structured interviews were also conducted with the two Paladin security guards. The interviews took place in a quiet Paladin office and were led by a guide developed by the interviewer.

Four RNs at the HSC ED were consulted through both informal interactions, as well as through semi-structured interviews. Informal consultations occurred frequently as patient dissatisfaction is evident within the department and is a common topic voiced by the RNs.

Due to personal preference and conflicting schedules of the volunteers, data was collected by email. The results were received by email via the volunteer coordinator and forwarded to myself.

DATA COLLECTION AND ANALYSIS

Data obtained from the semi-structured interviews were transcribed verbatim. The data was then transferred into Microsoft Word onto a password coded- computer to ensure security of the data. Data obtained from the volunteer interviews were received through email and reviewed through Microsoft Office on a password coded computer.

Thematic analysis was used to analyze the data. Important themes were extracted from the data, which will further be discussed.

ETHICAL CONSIDERATIONS

Prior to commencement of the consultations, approval was received by the program supervisor, as well as the manager of the HSC ED. The project was also screened by Memorial University's Research Ethics Board, where approval was granted without full review.

To protect the rights of the patients, a patient information sheet was developed to ensure informed consent was obtained. The purpose of this information sheet was to inform patients of the rationale for the interviews, as well as to inform them of their rights as participants (see Appendix E). The patient interview guide was also reviewed by the ethics officer to ensure the questions were appropriate and would not infringe upon the rights or safety of any of the participants. To ensure confidentiality, interviews were conducted in private rooms and assigned numbers, to avoid using identifying factors. The patients were approached by the interviewer and verbal consent was obtained.

Prior to consulting with the volunteers, the volunteer coordinator at Eastern Health was consulted where approval was received to conduct the interviews. Along with the interview questions, the volunteers also received the information script informing them of the goals of the project, as well as their rights as participants.

The program developer consulted with the Paladin security company to receive approval to consult their employees. As well, the Eastern Health security manager was

contacted to gain approval to conduct the interviews. The interview script and questions were reviewed and approved by Eastern Health's security services, who then forwarded the questions and interview script to security officers at Eastern Health.

RESULTS

A variety of key stakeholders were consulted to guide the development of the volunteer resource manual. The consultations are important to determine the needs of the volunteers, patients, and HSC staff which will guide the development of the program. From the results, a resource manual will be developed that will be tailored to the needs of the patients, volunteers, and staff. Main themes were identified across interviews with all participants which will further be discussed.

Registered Nurse Consults

Four themes became apparent in the consultations with the RNs: patients generally are not satisfied with their ED visits, communication from staff in the ED contributes to patient satisfaction, concern of the well-being of volunteers in the waiting room, and the support received from the RNs for the prospective program. The first theme that became apparent from the interviews was that patients are generally dissatisfied with their ED visits. The RNs in the interviews reported that patients' need for instant gratification contributes to their dissatisfaction. Patients have high expectations about wait times which are not met when they wait lengthy hours in the waiting room.

Another significant theme that became apparent through the consultations with the RNs was the need for increased communication from the triage nurse to the patients to improve their overall satisfaction. All four RNs believed that lack of communication was the greatest predictor of patient dissatisfaction while waiting in the waiting room as they believed patients often feel ignored due to infrequent communication. However, the triage RNs reported that their inability to communicate frequently with patients in the waiting room is due to the high volumes of patients.

Another major theme revealed from the interviews was the receptiveness of the prospective program from the HSC ED RNs. The proposed volunteer program was well received by all but one RN who was unsure whether the program would be beneficial for the patients. She was fearful for the mental and physical well-being of the volunteers as they would be immersed in the waiting room with unhappy and often aggressive patients. The three other RNs that were interviewed also commented on the well-being of volunteers while volunteering in the HSC ED, but did not believe this should prevent implementation of the program. Rather, they believed incorporating Therapeutic Crisis Intervention (TCI) training, Cardiopulmonary Resuscitation (CPR) training and communication workshops are necessary to ensure the volunteers are well prepared to interact with the patients. This constructive criticism based on the RNs' experiences and legitimate concerns will be addressed and considered upon development of the resource manual. The RN from Ontario who was interviewed refuted the idea that patients would be too aggressive towards the volunteers. She reported that the triage nurses may be hesitant to implement the program as some nurses may believe that the volunteers will

interfere with their ability to work. Therefore, it is imperative to develop a program that takes into account the needs of the staff to ensure they can continue to provide quality care for patients and work alongside the volunteers.

Patient Consults

After analyzing the data from the patient interviews, two significant themes became apparent: communication is important in improving patients' satisfaction, and that patients are highly supportive of the prospective volunteer program.

The first theme revealed that communication from staff in the waiting room is the greatest contributor to overall patient satisfaction. The patients and their family members in the interviews believed that being informed about wait times was the biggest contributor to achieving satisfaction while waiting in the ED. This response is consistent with the current literature which suggests that perceived wait time is an important contributor to patient satisfaction (Boudreaux, Friedman, Chansky and Baumann, 2004). One patient reported that hospitals in the United States have designated employees in the waiting room who interact with and are attentive to the patients which she believed contributed greatly to patients' satisfaction. Another patient who had waited approximately 4 hours reported that the triage nurse informed all patients in the waiting room of the expected lengthy wait. The patient found this gesture to be extremely helpful and contributed to her overall satisfaction. However, she believed that increased communication from the staff is needed when the wait times are lengthy. These results are consistent with the literature which reveals that perceived wait time vs. actual wait

time is a great predictor to achieving satisfaction while waiting in the waiting room (Boudreaux et al., 2004).

The second theme revealed that volunteer programs would improve patients' overall satisfaction. The patients believed that volunteers would be able to assist the nurses with simple non-nursing duties that would make a significant difference in patients' overall satisfaction while waiting. Although these participants were in support of the volunteer program, one family member reported that issues with liability of the volunteers may arise. The liability of the volunteers is one foreseeable barrier that will need to be addressed within the resource manual to ensure the volunteers act within their scope. Patients may expect the volunteers to answer questions or perform tasks outside of their role, which is why clear boundaries must be established. As well, the volunteers must be aware of their resources to rely on when faced with challenging situations.

Security Guard Consults

Communication, distraction, and support of the volunteer program were three themes that became apparent after consultation with the Paladin security guards. As revealed in the patient and RN interviews, communication was believed to be the biggest predictor of patient satisfaction while waiting in the waiting room. When asked about patient satisfaction in the waiting room, both of the security guards responded synonymously. The security guards believed that communication to patients regarding wait times was the biggest predictor of patient satisfaction. As well, frequent communication to patients during lengthy waits is important to prevent patients from

feeling alone or ignored. Distraction, such as having music playing in the background, was another method revealed by the security guard to improve patient satisfaction.

Both security guards were highly supportive of a potential volunteer program in the HSC ED. It was important to consult with the security guards about foreseeable barriers to the program and what skills and knowledge volunteers should possess, as the safety of volunteers was the primary concern which prevented the implementation of the program in previous years. The security guards stressed the importance of having mature, responsible, and friendly individuals to volunteer. Consistent throughout the interviews, assertiveness is another trait that is deemed important for volunteers to possess by all participants. One idea mentioned was to utilize Royal Newfoundland Constabulary (RNC) trainees or nursing students as volunteers in the program. The rationale was that these individuals would possess the skills and personality traits deemed necessary to successfully volunteer in the challenging environment of the ED waiting room.

Volunteer Consults

As revealed in the interviews with the RNs, patients, and security guards, lack of communication about wait times was believed to be the biggest factor contributing to patient dissatisfaction. The three volunteers that were interviewed believed that implementing a volunteer program in the HSC ED would improve patient satisfaction as patients' non-nursing needs, questions and concerns would be addressed when the staff is

too busy. The volunteers would be attentive to the needs and concerns of the patients, and would address those needs with the ED staff.

It is also important to determine the needs of the volunteers in order to increase the likelihood of success of the program. One of the volunteers reported that a foreseeable challenge to the program would be the volunteers having to interact with unhappy or aggressive patients. This response is important to the development of the resource manual as it is evident that communication and conflict management training must be included. Preparing the volunteers to witness traumatic situations was also deemed important to the volunteers prior to program implementation.

CONCLUSION

The results of the consultations are important in the successful development and implementation of the volunteer program in the HSC ED waiting room. The results of the consultations revealed the needs of the volunteers, staff, and patients which are imperative in order to successfully develop the resource manual. Communication was the common theme revealed across all of the interviews. This result is highly supportive of the volunteer program as the volunteers will be present to communicate with the patients about their wait times, and address any questions or concerns that they may have. As the literature suggests, perspective wait time vs. actual wait times are extremely important in patients' overall satisfaction (Boudreaux et al., 2004). Therefore, through communication with the triage nurse, the volunteer will inform the patients of their perspective wait times, in hopes to improve their overall satisfaction.

Without determining the needs of the key stakeholders the resource manual would be inadequate in preparing volunteers to volunteer within the ED waiting room. All of the foreseeable barriers reported by the participants will be addressed in program development to increase the likelihood of program success. Although actual wait times will not improve as a result of the proposed program, patient satisfaction may improve which is the ultimate goal of the volunteer program.

References

Boudreaux, E, D., Friedman, J., Chansky, M, E., Baumann, B, M. (2004). Emergency department patient satisfaction: Examining the role of acuity. Academic Emergency Medicine, 11 (2), p. 162-168. doi: 10.1197/j.aem.2003.08.018

Government of Newfoundland and Labrador. (2012). A strategy to reduce to emergency department wait times in Newfoundland and Labrador: 2012. Retrieved from: http://www.health.gov.nl.ca/health/wait_times/pdf/emergency_department_strategy.pdf

Ontario Hospital Association. (2010/2011). Leading practices in emergency department patient experience: Prepared for the Ontario Hospital Association by Infofinders. Retrievedfrom:https://www.oha.com/KnowledgeCentre/Library/Documents/Leading%20Practices%20in%20Emergency%20Department%20Patient%20Experience.pdf

Taylor, D., Kennedy, M, P., Virtue, E., & McDonald, G. (2006). A multifaceted intervention improves patient satisfaction and perceptions of emergency department care. International Journal for Quality in Health Care, 18 (3), p 238-245. doi: 10.1093/intqhc/mzl002

APPENDIX C

Volunteer Resource Manual

Health Science Centre

Emergency Department

By: Rachel Price

This document is not an Eastern Health Report.

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The Manual's Mission

WHO: All volunteers interested in volunteering in the ED.

WHAT: Hospital volunteers will work together with the ED staff and act as patient 'greeters' or 'links' betweeen the staff and the patients. With guidance from the ED staff, the volunteers will be available to communicate with patients about their wait times or any questions or concerns they may have. Directing patients through the department from the waiting room is also another responsibility of the volunteers. With permission from the ED staff, the volunteers will also provide the patients with water, blankets, etc. in the waiting room to make their wait more enjoyable.

WHERE: Health Science Centre (HSC) Emergency Department (ED) waiting room.

WHEN: After reviewing the resource manual it is hoped that the volunteer will be prepared to assist patients in the waiting room and make their experience more enjoyable.

WHY: Current studies suggest that good communication between staff and patients in ED waiting rooms improves patients' satisfaction with their ED experience [8,16,19]. Despite the lengthy wait times, patients have reported improvements in their experience when they are informed about their wait times, and when the wait times meet their expectations [8, 16, 19]. However, it is often difficult for the staff to meet the needs of the patients due to high patient volumes [16]. As the ED can be a challenging, yet exciting enviornment to be in, this resource manual is created to guide the volunteers throughout their ED experience. With proper prepartaion and guidance, it is hoped the volunteers will be well equipped to assist patients during their lengthy wait times in the waiting room and increase their overall satisfaction.

WELCOME TO THE HSC ED

The HSC serves as Newfoundland and Labrador's trauma center. The staff members care for patients throughout the province with a variety of illnesses and injuries with the exception of pediatric patients who are assessed at the Janeway Hospital. However, pediatric patients with life threatening conditions who present to the HSC ED will be assessed and treated by a HSC ED physician. The HSC ED has 23 beds including an acute and subacute unit, a rapid assessment zone (RAZ) and a fast track unit, which will further be discussed. Hallway spaces are also available for patient care. When including the hallway spaces, 33 beds are open for patient care.

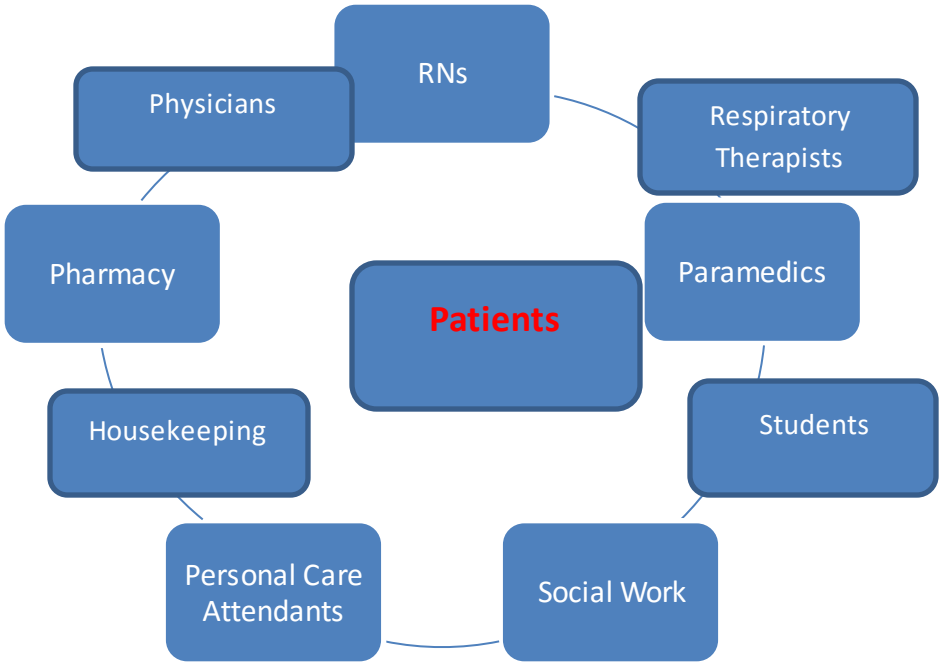
STAFF IN THE ED

The ED team consists of individuals from both healthcare and non-healthcare professions. The department could not function without the expertise of each team member. Each member contributes unique knowledge and skills which allows for great patient care to be provided.

All team members are of equal importance!

As part of the ED team you will interact with each of these team members on a daily basis to assist patients in receiving the appropriate care and treatment they require. Members of the healthcare team which you may interact with include: ED physicians and specialists, nurse practitioners, registered nurses (RNs), respiratory therapists, social workers, paramedics, personal care attendants, pharmacists and pharmacy technicians, housekeeping staff, laboratory technicians, registration clerks, security guards, and nursing, medical, and paramedic students.

As a volunteer patient liaison, you will be stationed in the main waiting room. Therefore, most of your communication will occur with the patients, triage nurses and the registration clerks. However, all of these staff will be available to assist you should any questions or concerns arise!



Layout of the ED

The patients triage score along with the judgment of the RN, determines which unit patients will be assessed in. Patients are triaged according to the CTAS system which is a five point scale used by the triage RN to determine severity of illness and how long patients can safely wait before being assessed by RNs and physicians [4]. The CTAS will be discussed in further detail. There are 4 different patient assessment areas within the HSC ED:

1. Unit 1- Patients with severe illnesses are assessed by ED staff in unit 1. Patients with presenting complaints such as chest pain, stroke-like symptoms, shortness of breath, traumas, or patients who are unresponsive are assessed in unit 1.

2. **Unit 2-** Patients with urgent, but not severe illnesses are assessed in unit 2. Patients who present with abdominal pain, back pain, and elderly patients who are immobile are often assessed by an ED physician in unit 2.

3. Fast Track- Patients with non-life threatening health issues are assessed in the fast track area. This unit is located off of the main waiting room. Patients assessed within this unit are expected to be assessed and discharged home efficiently by the ED physician.

4. Rapid Assessment Zone (RAZ)- The RAZ unit was a 2015/2016 Government of Newfoundland and Labrador initiative to improve 'urgent', CTAS level 3, patient assessment times [12]. This unit is combined with the fast track unit and is located off of the main waiting room.

5. Triage- Patients present to the ED and are assessed by a designated triage RN who will triage the patient according to the CTAS system.

Other important areas of the ED to make note of:

Security office: located in the main waiting room across from the registration desk.

As a volunteer, you may need to locate the security guards in their office if violent situations arise.

Satellite X-ray: located beside the main waiting room.

Patients may need to be directed to satellite X-ray.

Mental Health RN office: located beside the main waiting room.

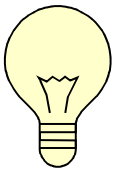
Patients may need to be directed to the mental health RN's office.

Social work office: located behind the triage desk.

Patients may need to be directed to the social worker's office.

Ambulance Bay: located behind the triage desk.

Patients may need to be directed to the ambulance bay.



As a volunteer 'patient liaison' you will be stationed in the main waiting room. However, when directing patients to x-ray, ultrasound, or CT scan, you may be required to walk through these units. You may also be required to provide instructions on how to get to these units. Therefore, it is important that you understand the layout of the ED which will better allow you to assist patients.

ED PROCESS

Understanding the process of the ED can be challenging for patients and visitors for many reasons. The long wait times, large layout of the ED, and being unfamiliar with the CTAS system can lead to patient and visitor frustration.

Understanding the process of the ED will better allow you to assist the patients with their questions or concerns regarding the process.

1. Patients present themselves to the triage RN, who triages the patients according to the CTAS system.
2. The patient will then have a seat in designated chairs and wait until their name is called to be registered. However, if patients are too ill and must be assessed by an ED physician immediately, the triage RN will take the patient to unit 1 or unit 2. The registration clerks will then be responsible for registering the patient.
3. After registration, patients who are triaged to the fast track area will be handed their charts to drop in the drop box located on the door to the fast track unit. The designated nurse will then retrieve the chart and assess and treat the patients accordingly.
4. Patients who are triaged to the RAZ unit will be assessed in the fast track/RAZ unit but will not be given their charts. As these patients can be quite ill, their charts remain behind the triage desk so that the triage nurse can continuously reassess the patients in the waiting room as required.

Canadian Triage Acuity Scale

The CTAS is a five level score system used in emergency departments and by paramedics to determine the severity of patients' health statuses, and to determine the length of time patients can safely wait before being assessed by a physician [4]. The CTAS also requires continuous reassessment of patients by the triage RN as they wait in the waiting room to make sure their health remains stable while waiting [4]. Other goals of triage include: decreasing overcrowding in the ED, and providing patients with approximate expected wait times [4]. The CTAS score is performed by a skilled triage nurse who has been properly trained in the CTAS course [4]. These nurses apply their knowledge, skills, and judgment to determine who can safely wait in the waiting room and who cannot. Due to the high patient volume in the HSC ED, the CTAS system is very important!

IMPORTANT

Performing patient assessments and using the CTAS system is NOT within your scope. This is FYI! However, understanding the triage process is helpful to be able to assist the patients in understanding the reasoning behind their wait time. For example, many patients are unfamiliar with the triage process and become frustrated when other patients are seen ahead of themselves who have waited less time. As a volunteer in the main waiting room, it is highly likely that patients will approach you with these frustrations. Therefore, in order to best assist these patients, understanding the basics of the triage process is important.

CTAS 1-IMMEDIATE ASSESSMENT BY A PHYSICIAN [4].

CTAS 2- ASSESSMENT BY A PHYSICIAN WITHIN 15 MINUTES FROM ARRIVAL [4].

CTAS-URGENT- ASSESSMENT BY A PHYSICIAN WITHIN 30 MINUTES FROM ARRIVAL [4].

CTAS 4-LESS URIGENT- ASSESSMENT BY A PHYSICIAN WTIHIN 60 MINUTES FROM ARRIVAL [4].

CTAS 5-NON-URGENT-ASSESSMENT BYA PHYSICIAN WITHIN 120 MINUTES FROM ARRIVAL [4].

Although the triage RNs must follow to the CTAS guidelines, patients are not always assessed by physicians within the appropriate time period due to high patient volumes. Therefore, it is the responsibility of the triage RN to reassess patients according to the CTAS guidelines to ensure patients remain stable while waiting in the waiting room.

***REMINDER*- Learning about the CTAS guidelines is FYI! As a volunteer you are not expected to be knowledgeable on these guidelines!**

EXPECTATIONS

Roles & Responsibilities

WHERE: As a volunteer patient liaison, you will be stationed in the main waiting room so you are available to communicate with the patients and direct them throughout the ED. You will be in constant communication with the triage RN as he or she will report to you about patient wait times, unexpected delays in assessments, or how you can assist patients to make their wait more enjoyable.

WHAT: As a volunteer patient liaison, it is important strict boundaries and expectations are set to ensure you provide services within your designated role.

As a volunteer patient liaison in the ED you will be responsible for:

• Greeting patients at the front entrance of the ED.

• Communicating with patients in the main waiting room (about wait times, any questions or concerns with advice from the triage RN).

*Any medical questions must be addressed by the triage RN- If patients do have medical questions your role is to inform the triage RN who can speak with the patient directly).

• Communicating with the triage RN about specific patient wait times, delays in treatment, or any other issues that may arise and report back to the waiting room.

• Directing patients or instructing them how to get to certain areas of the ED.

• With permission from the triage RN, providing patients with water, blankets, etc.

• Being an approachable and friendly face for the patients to communicate with.

• HAVE FUN!

IMPORTANT!

You may be approached by staff members to perform tasks outside of your roles and responsibilities as a volunteer. In this case, it is important to politely refuse and inform the staff members of your role. It is also important to inform the charge RN, ED manager or volunteer coordinator to prevent this situation from re-occurring. Therefore, it is important to know your roles within the ED team and stay within your set boundaries as a volunteer.

DO'S	DON'TS
Communicate with patients.	Give medical advice.
Ask for help when needed.	Try to answer questions that you do not know the answers to.
Stay within your set responsibilities.	Perform tasks outside of your role if asked by a member of the healthcare team.
Work alongside the healthcare team.	Work alone without any direction from the healthcare team.
Be confident.	Allow patients or healthcare team members to disrespect you or be violent toward you (in this case- inform charge RN).
Believe your actions make a difference!	Believe that just because you aren't providing medical care that your assistance does not go unnoticed or unappreciated.
Assist the healthcare providers in the ED.	Perform medical tasks.
Direct patients to the radiology department and throughout the ED.	
Inform triage RN if patients have questions about their illness/ experience.	Look through patient charts.
Communicate to patients about the lengthy wait times and triage process.	Give false hope by telling patients they are "next to be seen".
Provide patients with water/blankets/etc.	Provide water/blankets/etc. without the triage RNs permission (certain patients must not eat or drink until assessed by an ERP). Do NOT hand out medication if asked by a staff member.
HAVE FUN!	

Patient Confidentiality

Protecting the privacy and confidentiality of patients is very important in healthcare settings. By volunteering you will be indirectly exposed to patient information [10]. It is mandatory that you review, accept and abide by the Personal Health Information Act (PHIA) [13]. This education can be accessed online with assistance from the volunteer coordinator [10].

Issues with Confidentiality in the ED:

Due to the physical layout of the ED, ensuring privacy and confidentiality can be challenging. Within the units, curtains are all that separate the patient rooms which makes it difficult for the staff to protect patients' privacy. The triage desk also lacks patient privacy.

Helpful Hints to Protect Patient Privacy and Confidentiality:

- Lower your voice when communicating with patients.
- Lower your voice when communicating with staff members about patients.
- Photography, filming, and the use of cell phones in the ED is prohibited .
- Ensure patients remain a distance back from the triage desk as patients are giving their personal information to the triage nurse.
- NEVER look through patient charts.
- NEVER give out any patient information- inform the RN if patients are looking for medical information.
- NEVER communicate about patients outside of the department.
- NEVER communicate about patients or your experience in the ED to family, friends, etc.

Shhhh

Importance of Communication in the ED

Communication in the ED plays an important role in protecting the health and safety of the patients and staff members. As the current literature suggests, communication between staff and patients plays a vital role in patients' overall satisfaction with their ED experience [8, 16, 19]. As a volunteer liaison in the main waiting room, effective communication is your greatest tool!

Two important communication techniques are assertiveness and active listening skills[3]. Both of these techniques are important to use when volunteering in the ED. Focusing, humour, silence, and questioning are also important communication techniques [3].

Examples of active listening:

•Good eye contact & nonverbal communication[3]

•Engaged and show care and concern[3]

•Do not interrupt[3]

Examples of poor listening skills:

•No eye contact or glaring at the speaker[3]

•Interrupting the speaker[3]

•Not showing care or concern for the other[3]

YOUR PROTECTION

Hospital Emergency Codes

CODE RED	Fire
CODE BLUE	Cardio-pulmonary arrest
CODE WHITE	Violent Situation
CODE ORANGE	External Disaster
CODE YELLOW	Missing Adult- Patient/Resident
CODE GREEN	Evacuation
CODE GREY	Loss of Utility
CODE SILVER	Active Shooter
CODE PURPLE	Hostage Taking/Abduction
CODE AMBER	Missing Child
CODE BROWN	Internal Hazardous Material Spill/Leak
CODE BLACK	Bomb Threat/Suspicious Package [9]

Your Responsibility as a Volunteer

As a volunteer within the HSC ED waiting room, it is important that you are familiar with the emergency codes in the chance that a code occurs. If an emergency code is called, it will be broadcasted on the speaker system throughout the hospital. The type of code and location will be announced and repeated three times. For example, if a code red is called in the ED, you will hear "code red, Health Science Centre, Emergency Department". This will be repeated overhead three times. If an emergency code is called overhead, seek advice from the charge RN to determine your plan of action.

Code reds and code whites are the most common emergency codes within the HSC ED.

Code Reds in the ED

Code reds are called frequently throughout the HSC. When a code red is declared, it is important for all ED staff to follow hospital policies. As a volunteer, it is your responsibility to seek advice from the charge RN for your plan of action. During code reds, patients are not to be triaged unless they present with life threatening "life or limb" conditions. All other patients are to wait until the fire code is cleared before they can be registered or triaged. Ambulances are unable to offload their patients in an ED bed unless their condition is severe.

Code Whites and Security in the ED

Violent situations, or code whites, occur quite frequently in the ED. The HSC ED has its own security team located within the department. Therefore, when violent situations arise, "code white" is not called on the speakers throughout the hospital. Instead, the security guards are notified and are paged within the department. "Security stat to HSC Emergency" is often called on the speakers within the department to notify the security guards when situations become violent quickly. As a volunteer, your safety is most important! If a violent situation arises, protect yourself and when safe notify a staff member [10]. If you are unaffected by the code but it occurs in another area in the ED, remain in the waiting room unless instructed otherwise by the charge RN.

Violence in the ED

It is important that you can recognize the verbal and nonverbal signs of patients or visitors to protect your safety!

Violent patients or visitors may:

• Be loud, have inappropriate language, yelling [1]

• Have a tense or clenched posture [1]

• May pace around the environment [1]

• Threaten the staff or other patients [1]

VIOLENCE WILL NOT BE TOLERATED IN THE ED!

If you do encounter a frustrated patient, always ensure your safety is protected first! Contact the charge RN and security guards who can determine the appropriate action.

Hand Hygiene

Basic hand hygiene is an expectation of the staff, patients, visitors, and volunteers within the HSC ED. Hand hygiene is the number one defense against spreading and getting an illness [7]. Basic handwashing with soap and water and the use of hand sanitizer are expected[7]. However, when to use hand sanitizer vs. soap and water changes depending on the situation [7]. When hands are visibly dirty, washing with soap and water is required [7]. If not visibly dirty, hand sanitizer is preferred as it requires less time to do, is more effective in killing bacteria, and reduces skin breakdown compared to soap and water [7]. Hand sanitizer units can be found mounted on the walls throughout the ED. Sinks can be found throughout each unit in the ED. A sink is located in the triage area which is easily accessible to you.

How to wash hands with hand sanitizer:

-Apply hand sanitizer to hands (the label will instruct you on how much sanitizer to use) [7]

-Rub on all areas of hands for approximately 20 seconds or until hands are dry [7]

Example of hand sanitizer stations throughout the HSC ED

How to wash hands with soap and water:

-Wet hands with warm water [7]

-Apply a nickel size amount of hand soap to hands [7]

-Rub hands together with soap and water until soap foams. Be sure to cover all areas of your hands! [7]

-Wash hands for approximately 15 seconds and dry hands with a paper towel [7]

-Drying hands is important as there is a greater spread of bacteria from wet skin than dry skin [15]

-Drying hands with a clean, disposable paper towel is the preferred method to hand drying compared to hot air dryers [15]

-Turn faucet off with a different paper towel to avoid getting germs from the faucet back on your hands! [7]

FYI & TIPS ABOUT HAND HYGIENE

- Over a 12 hour shift, healthcare providers may clean their hands up to 100 times [7]
- Wash your hands for at least 15 seconds with soap and water [7]
- Make sure you clean all areas of your hands! This is more important than the time spent washing your hands with soap and water [7]
- Both good germs and bad germs are killed using alcohol based hand sanitizer- the good germs grow back quickly [7]
- Hand washing reduces breathing illnesses by 16-21% and intestinal illnesses (diarrhea) by 31% [6]

Personal Protective Equipment (PPE)

As a volunteer liaison in the main waiting room, the need to wear PPE would be rare as you are not involved in direct patient health care. However, there may be instances where there are no available beds within the department and patients in the waiting room are instructed by the ED staff to wear PPE. It is possible that you will be communicating with these patients. Therefore, to protect your own health and safety, understanding the basic principles of PPE are important. PPE is clothing/equipment used by healthcare professionals to protect against infectious diseases [5]. PPE is used by trained healthcare staff when providing direct care to patients who have a confirmed or suspected contagious infection [5].

Basic face masks are located behind the triage desk as well on walls throughout the department for anyone to use. These masks are to be worn by patients who are actively coughing to prevent possible disease transmission. Triage nurses will use their judgment to provide patients with these masks. Patients undergoing chemotherapy or treatments that weaken their immune system may also be seen wearing masks to protect their own health.

Throughout the HSC ED, signs will be posted on rooms of patients with confirmed or suspected contagious illness. There are three different types of precautions that healthcare staff will take to prevent catching an illness. The three precautions are: contact, droplet, and airborne [5].

Contact Precautions

Patients are on contact precautions if they have an infectious disease which can be transmitted by touching a patient with the illness [5]. Staff caring for patients on contact precautions are required to wear gloves when in the patient's environment, and a gown if they will be close to the patient when providing care [5]. For example, patients with vomiting and diarrhea will be placed on contact precautions [5].

Example of gloves worn by staff at the HSC ED

Droplet Precautions

Patients are put on droplet precautions if they are known to or are suspected to have an infection which can be spread by droplets from saliva or secretions [5]. Examples of patients on droplet precautions include those with respiratory viruses such as influenza [5]. For protection, healthcare professionals are expected to wear a simple face mask, as displayed in the image below. If in close contact with the patient, gowns and gloves are also recommended [5].

Example of face mask worn by staff at the HSC ED

Airborne Precautions

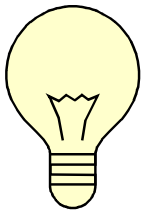
Patients are put on airborne precautions if they are known or suspected to have an infection that can be transmitted through the air [5]. Examples include tuberculosis and chicken pox [5]. It is expected that healthcare professionals wear N95 masks to protect themselves [5]. As a volunteer you will not be caring for these patients. Therefore you will not be required to be fitted or wear an N95 mask. Below is an image of an N95 mask. Special testing is required for proper fit of the N95 mask. Gloves and gowns are also recommended if the spraying of saliva is anticipated, as in coughing or sneezing [5]. These patients also must stay within a negative pressure room to ensure the airborne bacteria do not escape the room when the door is opened [5].

One example of an N95 mask worn by staff at the HSC ED

Who to ask

IT IS IMPORTANT TO KNOW WHO TO ASK! All staff members in the ED will be available to assist you should any questions or concerns arise. It is important to ask if any questions arise to best protect the health and safety of the staff, patients, and most importantly yourself.

- If any questions or concern arise about your volunteer experience, please approach the charge RN and volunteer coordinator.
- The triage RN and registration staff should be available to address any of your questions or concerns. However, if the triage RN and registration staff are unavailable, please approach the charge RN or any other member of the healthcare team.
- The Paladin security guards should be available with assistance if required. However, if they are unavailable, please approach the charge RN or any other member of the healthcare team.



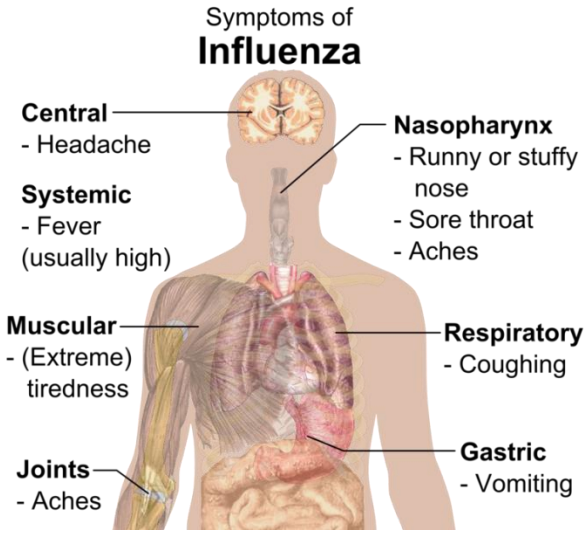
****If at any time during your volunteer experience you don't feel supported by the staff, please inform the ED manager or volunteer coordinator.****

FOR YOUR INFORMATION-
WHAT YOU MAY SEE…

As a volunteer patient liaison, you are not responsible for direct patient care. However, it is possible that you may witness patients presenting with serious or life threatening health issues which may be shocking to some individuals. Therefore, it is important that you are briefed on common non-life threatening and life threatening occurrences in the ED to make your volunteer experience more enjoyable.

Influenza

Influenza is caused by the Influenza virus [11]. Influenza affects the respiratory system, therefore can be spread through coughing, sneezing, talking, or any action which spreads infected droplets [11]. In patients with poor immune systems, children and the elderly, influenza can be life threatening [11]. Symptoms of influenza include: fever, cough, muscle aches, headaches, nausea and vomiting [11]. In the 2014/2015 flu season, 6720 adult hospitalizations and 584 adult deaths were reported in Canada from Influenza [18]. As a volunteer in the ED, there is a chance you will be exposed to Influenza. Therefore, prevention is extremely important!



Medical Gallery of Mikael Haggstrom, 2014

Prevention:

Getting the flu shot is one of the best defenses against getting Influenza [11].The flu shot is highly recommended when being around ill individuals. All staff in the department are offered the flu shot free of charge during the "flu season". However, it is ultimately your choice whether or not you get the flu shot.

Other ways to protect yourself against getting Influenza are:

- Hand washing! [11]
- Avoid coughing or sneezing into your hands [11]. Cough or sneeze into a tissue or the bend of your elbow [9]. Wash your hands if visibly soiled, or used hand sanitizer if hands are not soiled.
- Eating healthy and exercising [11]
- Getting proper amount of rest [11]

Myocardial Infarction (M.I) or 'Heart Attack'

A M.I. also known as a "heart attack" occurs when a blockage in the vessels of the heart slows down or stops blood flow to areas of the heart [2]. When blood flow to the heart is slowed down or stopped, the cardiac muscle dies due to lack of oxygen [2]. The amount of damage depends on the amount of time the heart has had decreased blood flow and oxygen [2]. The signs and symptoms of an M.I vary amongst male and female patients [2]. Although not all patients with chest pain are having heart attacks, it is important for all lay persons to know the signs and symptoms of a heart attack and when to seek medical attention. The treatment for heart attacks depends on their severity [2]. Receiving a medication to thin the blood is a common treatment for heart attacks [2]. If a patient is having a serious heart attack, the patient will be given a drug to break down the clot, and/or will be taken to the cardiac lab to have a device which resembles a tube placed in the vessel to open up the blocked vessel [2].

Signs of Symptoms of an M.I include, but are not limited to:

- **Chest pain** [2]
- **Nausea** [2]
- **Sweating** [2]
- **Shortness of Breath** [2]

Heart attacks can be diagnosed by a physician in triage when the nurse performs an electrocardiogram (ECG), which is a tracing of the heartbeat, or by elevated cardiac levels in bloodwork [2]. As a volunteer in the waiting room, it will be common to see patients in the ED with chest pain.

Strokes

Along with heart attacks, it is important for everyone to know the signs and symptoms of a stroke [21]. There are two different types of strokes [21]. An ischemic stroke occurs when there is a blockage of blood flow in the vessels of the brain [21]. Oxygen and nutrients cannot travel to the brain tissue due to the blockage and the brain tissue dies [21]. A hemorrhagic stroke occurs when a vessel in the brain bursts which causes the blood to leak out of the vessel and put pressure on the brain tissue which damages brain function [21].

Signs & Symptoms:

The signs and symptoms of a stroke will differ depending on the type and size of stroke, area of stroke in the brain, and the time it took to get treatment [21].

Common signs and symptoms include:

- Weakness or sudden weakness on one side of the body [21]
- Facial numbness [21]
- Slurred speech [21]
- Headache [21]
- Vision changes [21]

TIME IS IMPORTANT! [21] If someone demonstrates the signs and symptoms of a stroke, it is very important for them to seek medical attention immediately[21]. The treatment for an 'ischemic' stroke or blockage in the brain is time specific and must be given within 4.5 hours from the time the symptoms started[21].

During your volunteer experience, you may see patients present to the triage desk with signs and symptoms of a stroke. These patients will be triaged immediately and taken to unit 1 for immediate assessment by an ED physician.

Trauma

The HSC ED is the trauma centre for the island of Newfoundland and Labrador. As a volunteer in the main waiting room, you may not see trauma patients often as these patients most often arrive to the department by ambulance. However, some trauma patients do travel by car and will arrive to the triage desk for assessment.

The HSC has its own trauma team which consists of surgeons, orthopedic physicians who are responsible for repairing broken bones, anesthesiologists who are the doctors responsible for putting patients to sleep during surgery, medical students, as well as the ED team. When the paramedics notify the ED team that they are on route with a large trauma with severely injured patients, the ED team will dial **'2000'** on the phone. The operator will then announce 'TRAUMA CODE' over the P.A system to notify the trauma team.

REMINDER!

THIS IS FYI! VOLUNTEERS ARE NOT RESPONSIBLE FOR BEING KNOWLEDGEABLE ABOUT ANY MEDICAL CONDITIONS OR HEALTH-RELATED INFORMATION!

When physicians assess 'trauma patients' the acronym 'ABCDE' is used to make sure no injuries are missed [20]:

Airway- First, the trauma team will examine the patient's mouth, teeth, etc. to make sure the patient has an open airway that allows them to breathe effectively [20].

Breathing- The trauma team will make sure the patient is breathing effectively. Monitoring the patient's oxygen saturation or rate and depth of breathing are two ways to assess a patient's breathing status [20].

Circulation- The trauma team will make sure the patient's blood is properly circulating throughout his or her body. Checking the patient's blood pressure, skin colour and warmth are methods to assess the patient's circulation [20].

Disability- The trauma team will assess whether the patient has any noticeable signs of neurological issues or 'brain injuries' [20]. The physicians will assess how awake the patient is and whether or not they are moving their limbs on their own [20].

Exposure- The trauma team will remove all of the patients clothing to make sure no injuries were missed [20].

References

1.American College of Emergency Physicians. (n.d). Emergency department violence fact sheet. Retrieved from: http://newsroom.acep.org/fact_sheets?item=30010

2.American Heart Associaton. (2016).About heart attacks. Retievd from: http://www.heart.org/

3.Atai-Otong, D. (2007). *Therapeutic Communication Techniques.* In Nurse-Client Communication: Life Span Approach (chapter 2). Jones & Bartlett Publishers: Sudbury MA. Retrieved from: http://www.jblearning.com/samples/0763735884/Antai-Otong%20Chapter%20Two.pdf

4.Canadian Association of Emergency Physicians. (1998). Implementation guidelines for the Canadian Emergency Department Triage & Acuity Scale (CTAS). Retrieved from: http://caep.ca/sites/caep.ca/files/caep/files/ctased16.pdf

5.Centers for Disease Control and Prevention. (2011). Basic infection control and prevention plan for outpatient oncology settings. Retrieved from: http://www.cdc.gov/hai/settings/outpatient/basic-infection-control-prevention-plan-2011/transmission-based-precautions.html

6.Centres for Disease Control and Prevention. (2015). Show me the science- why wash your hands? Retrieved from: http://www.cdc.gov/handwashing/why-handwashing.html

7.Centers for Disease Control and Prevention. (2016). Hand Hygiene in Healthcare Settings: Show me the science. Retrieved from: https://www.cdc.gov/handhygiene/science/index.html

8.Cooke, T., Watt, D., Wertzler, W., Quan, H. (2006). Patient expectations of emergency department care: phase II- a cross sectional survey. *Canadian Journal of Medicine, 8* (3), p. 148-157

9. Davis, J, L. (n.d). Prevent flu: Cover up when you say achoo! Retrieved from: http://www.webmd.com/cold-and-flu/features/prevent-flu-cover-up-when-you-say-achoo

10.Eastern Health. (2015). Volunteer Handbook-Eastern Health: Eastern Health

11.Government of Canada. (2015). Flu (Influenza). Retrieved from: http://healthycanadians.gc.ca/diseases-conditions-maladies-affections/diseasemaladie/flu-grippe/index-eng.php

12.Government of Newfoundland and Labrador. (2015/2016). Department of Health and Community Services: Annual Performance Report. Retrieved from http://www.health.gov.nl.ca/health/publications/pdf/hcs_annual_report_2015.pdf

13.Government of Newfoundland and Labrador. (2016). The personal health information act. Retrieved from: http://www.health.gov.nl.ca/health/phia/

14.Haggstrom,Mikael. (2014). Medical gallery of Mikael Haggstrom. *Wikiversity Journal of Medicine 1* (2). doi: 10.15347/wjm/2014.008 ISSN 20018762

15. Huang, C., Ma, W., & Stack, S. (2012). The hygienic efficiency of different hand drying methods: A review of the evidence. Mayo Clinic, 87 (8), p. 791-798. doi: 10.1016/j.mayocp.2012.02.019

16.Nielsen, D. (2004). Improving ED patient satisfaction when triage nurses routinely Communicate with patients as to reasons for waits: One rural hospital's experience. *Journal of Emergency Nursing*, 30 (4), p. 336-338. doi: 10.1016/j.jen.2004.06.015

17.Ontario Hospital Association. (2010/2011). Leading practices in emergency department patient experience: Prepared for the Ontario Hospital Association by Infofinders. Retrieved from:

from:https://www.oha.com/KnowledgeCentre/Library/Documents/Leading%20Practices
%20in%20Emergency%20Department%20Patient%20Experience.pdf

18.Public Health Agency of Canada. (2016). Reported influenza hospitalizations and deaths in Canada: 2011-12 to 2015-16 (data to May 21,2016). Retrieved from: http://www.phac-aspc.gc.ca/influenza/flu-stat-eng.php

19. Taylor, D., Kennedy, M, P., Virtue, E., & McDonald, G. (2006). A multifaceted intervention improves patient satisfaction and perceptions of emergency department care, *International Journal for Quality in Health Care, 18* (3), p 238-245. doi: 10.1093/intqhc/mzl002

20. Thim, T., Krarup, N., H., V., Grove, E., L., Rohde, C., V & Lofgren, B. (2012). Initial assessment and treatment with the airway, breathing, circulation, disability, exposure (ABCDE) approach. *International Journal of General Medicine, 5*, p. 117-121. doi: 10.2147/IJGM.S28478

21. WebMD. (2016). Slideshow: A visual guide to understanding stroke. Retrieved from: http://www.webmd.com/stroke/ss/slideshow-stroke-overview