CO-DESIGNING PATIENT-CENTRED COMMUNICATION IN AN EMERGENCY DEPARTMENT

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Declaration

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I declare that **CO-DESIGNING PATIENT-CENTRED COMMUNICATION IN AN EMERGENCY DEPARTMENT** is my own work and that all sources that have been used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at any other institution.

Leanne van Rooy

Date

Dedication

I dedicate this work to **all healthcare professionals working in the Emergency Department** that welcomed the concept of patient-centred communication and wanted to be part of improving communication in the Emergency Department, thank you.

We took the first step to create moments of patient-centred communication in the Emergency Department. I trust this work will serve as a basis to continuously improve communication between the patient and healthcare professional in the Emergency Department and create a culture where the voice of the patient is heard.

Acknowledgements

This study would not have realised without the generous contribution of numerous people. I have a tremendous appreciation for the healthcare professionals in the Emergency Department where the study was conducted. They gave freely of their time, input and expertise throughout the study. A special thank you to all the willing patients that told their stories and share their experiences, you are the centre of this study.

ABSTRACT

Introduction: Patient-centred communication is vital to ensure a good patient experience in the emergency department. Visits to the emergency department leave patients disillusioned regarding the communication experienced and this increases patient dissatisfaction. There is a need to put the "patient" back in communication in order to make it more patient-centred and provide the patient the opportunity to voice their individual needs pertaining to patient-centred communication.

The aim of the study was to co-design patient-centred communication in an emergency department. In order to reach the aim of the study the following objectives were set:

• To explore current communication in an emergency department as experienced by patients and healthcare professionals.

• To collaboratively co-design strategies to enhance patient-centred communication in an emergency department.

Research design and methods*: An Experience-based Co-design has been used. Unstructured observation was done to observe existing communication in the emergency department. Patients have told their stories through narrative-based film interviews and healthcare professionals have been interviewed to share their experiences regarding communication in the emergency department. The observation notes and interviews have been shared during a Co-design event. Patients and healthcare professionals have collaboratively analysed the data to identify key touch points and co-design strategies to enhance patient-centred communication in the emergency department.

Results*: Three (3) key touch points were identified namely; professionalism, communication and daily focus. The patients and healthcare professionals were equal partners to change the communication culture in the emergency department to be more patient-centred. This may lead to positive patients' experiences with an increase in patient satisfaction.

Conclusion: The ultimate goal of this study was to raise awareness relating existing communication in the emergency department and collaboratively plan strategies to work towards patient-centred communication.

Key words

Communication, patient-centredness, patient-centred communication, emergency department, experience-based co-design.

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List of abbreviations

ED   Emergency department

EBCD   Experience-based Co-design

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*For the purpose of **anonymity**, the hospital in which the study will be conducted is referred to as **the hospital**, in both text and referencing.*

Illustration by participant at Co-design event, July 2016.

CHAPTER 1

ORIENTATION TO THE STUDY

"Experiences are one of the most valuable memories we have… Successful experiences are valuable both financially and emotionally and the more we learn about how to create them (whether through approach, process, understanding, or specific criteria), the better the experiences we can create and the more enriching our lives can become." - Nathan Shedroff

1.1   INTRODUCTION

The emergency department (ED) of a hospital is a very busy, tense and stressful environment for patients and healthcare professionals, and presents unique and significant communication challenges (McCarthy, Buckley, Engel, Forth, Adams & Cameron, 2013:441-448). Patients' first encounter with emergency care and the ED can be highly traumatic (Elmqvist, Fridlund & Ekebergh, 2012:2614). Managing tensions in the ED and gaining the trust of the patients while at the same time communicating effectively with them and rendering critical care is vital (Fiscella, Meldrum, Franks, Shields, Duberstein, McDaniel & Epstein, 2004:1049-1055; Dean & Oetzel, 2014:257-266). Patient-centred communication emphasises building a relationship with the patient and encourages patient interaction. Furthermore, practising patient-centred communication leads to better health outcomes, greater patient satisfaction and enablement, and improves the quality of patient care (Mead, Bower & Hann, 2002:283-299; Pretorius, van Rooyen & Reinbrech-Schutte, 2010:9; Lusk & Fater, 2013:90). Furthermore Ferguson, Ward, Card, Sheppard and McMurtry (2013:283) emphasise the need to put the "patient" back into communication in order to make it more patient-centred, give patients the opportunity to voice their individual needs, lessen their feelings of powerlessness, and consequently increase patient satisfaction.

1.2   BACKGROUND TO AND RATIONALE FOR THE STUDY

In the ED exchanging and seeking information is the most common daily activity performed simultaneously with other tasks (Forsberg, Athlin & Von Thiele Schwarz, 2014:59). In the stressful ED environment with high patient loads and time constraints, healthcare professionals do not have in-depth conversations with patients (Forsberg et al, 2014:59). The authors Patterson, Pfeiffer, Weaver, Krackhardt, Arnold, Yealy and Lave (2013:1) state that one third of all communication amongst healthcare professionals is interrupted and 10% of communication regarding care decisions is made simultaneously, which could result in unsafe outcomes for patients. Cameron, Engel, McCarthy, Buckley, Kollar, Donlan, Pang, Makoul, Tanabe and Gisondi (2010:617) found that the ED is filled with many barriers affecting patient-centred communication, such as time constraints, multiple interruptions and overcrowding.

Healthcare professionals often do not give patients information on potential procedures that could be done or on the expected waiting times in the ED. Elmqvist et al (2012:2612) found that this gap in communication is often caused because healthcare professionals mistakenly assume that the patients know the procedure and flow of care in the ED. The patient-healthcare professional relationship is complex therefore the healthcare professionals in the ED should place more emphasis on building a relationship with patients and encourage patient interaction (Elmqvist et al, 2012:2610). Patients do not know what is wrong with them when they arrive at the ED or how it will impact their lives, making their visit a frightening experience (Pretorius et al, 2010:45). Healthcare professionals sometimes see the patient as a disease or illness and not as a whole person. Healthcare professionals need to communicate with patients to understand the patients' perception of their illness, which will ultimately enhance patient-centred communication in the ED (Pretorius et al, 2010:46).

Healthcare of today embraces patient-centred communication in an effort to improve quality of care and emphasise patient experience. When the focus is on the patient as the centre of all care initiatives, communication should be the aim of all healthcare facilities (Ferguson et al, 2013:283). Good quality patient care involves good communication, a trustworthy patient-healthcare professional relationship and active participation in decision-making leading to improved patient satisfaction (McMillan, Kendall, Sav, King, Whitty, Kelly & Wheeler, 2013:567). Patient-centred communication by healthcare professionals encourages patient autonomy, leads to individualised patient care and demonstrates a caring attitude (Lusk & Fater, 2013:90). The healthcare professional's ability to listen, take the patient seriously, demonstrate respect and clearly explain the patient's condition and treatment to the patient, contributes to patient-centred communication thereby indicating high quality health care (Mohammed, Nolan, Rajjo, Shah, Prokop, Varkey & Murad, 2014:4). Patient-centred communication will improve the quality of patient care and have a positive impact on patient outcomes (Lusk & Fater, 2013:90).

The aim of patient-centred communication in the ED should be to involve the patients in discussion and decision-making while attending to their specific needs (Ferguson et al, 2013:283). Practising patient-centred communication in the ED involves giving patients a voice and an opportunity to be active participants in managing their illness or disease (Pretorius et al, 2010:71). Patient-centred communication should be initiated with the patients from the time of arrival at the ED to ensure that they know what to expect. This will enhance good patient-healthcare professional interaction in the ED and make patients feel free to express their individual needs and preferences (Pretorius et al, 2010:1). To make the patients the centre of communication in the ED the healthcare professionals' daily programme should complement the patients' agenda and make them aware of their options (Pretorius et al, 2010:2).

1.3   PROBLEM STATEMENT

Patient-centred communication is challenging but vital in the ED (McMillan et al, 2013:568). The ED healthcare professional is task-orientated and focuses on stabilising and transferring the patient to the appropriate care areas as quickly as possible, thus excluding the patient from decision making (Webster, Rice, Dainty, Zwarenstein, Durant & Kuper, 2015:56). Emergency Department healthcare professionals need to see the patients as active members in their healthcare plan and should practise patient-centred communication on a daily basis (Jalharbi, Olsson, Ekman & Carlstrom, 2014:105). Practising patient-centred communication leads to an exchange of information between healthcare professionals and patients, which if not realised affects patient outcomes and patient satisfaction (Abourbih, Armstrong, Nixon & Ackery, 2015:80; Chan, Chan, Lee & Henderson, 2014:85). The 'patient' needs to be put back in the middle of all communication if patient-centred communication in the ED is to realise (Ferguson et al, 2013:283).

Patients visiting the ED have their own perceptions of how communication should be and should therefore be given a 'voice' to allow them to express their individual needs, ask questions and be involved in decision-making relating to their own healthcare (McCarthy et al, 2013:262). The researcher worked in the ED of a selected hospital and found that the majority of patients' complaints were about communication with healthcare professionals in the ED. The patients' main complaints were that the healthcare professionals did not communicate sufficient information to them about their expected journey in the ED. This included not informing them about what to expect (procedures and diagnostics), information about medication being administered or how long they would wait to see a doctor. The researcher examined the patient complaints regarding communication from the weekly hospital surveys and statistics for 2016. This led the researcher to believe that collaboration and communication between healthcare professionals and patients would raise awareness of current communication practices in the ED between the healthcare professionals and the patients. The researcher envisioned that healthcare professionals and patients could co-design strategies to make the communication in the ED more person-centred thereby positively affecting the quality of patient care in the ED.

1.4   SIGNIFICANCE OF THE STUDY

There are different ways to give patients' a voice and get feedback about the service they receive. Some of these ways are retrospective and focus on post-treatment feedback in different formats, such as e-mail surveys from the hospital to the patient after discharge. The surveys focus on what is good and bad rather than on the patient's experience and consequently often fail to tell the whole story of the patient experience (Larkin, Boden & Newton, 2015:1464). The patients and healthcare professionals will be equal partners to change the ED towards a more patient-centred communication ED where patients' experiences will be positive with positive patient outcomes and patient satisfaction (Tsianakas, Maben, Wiseman, Robert, Richardson, Madden, Griffin & Davies, 2012:271). The patient should be given a 'voice' and be part of the design process to develop an ED where patient could have good experiences.

Experience-based co-design (EBCD) is an innovative process that combines the patient's everyday experience and specialist's (healthcare professionals) knowledge making it different to other designs. The unique element in this design is the partnership between the expert (healthcare professional) and the user (patient) (Paul Bate, 2007:31). A good and efficient ED does not necessarily ensure a good patient experience; the key is to create a whole experience and not just a service (Paul Bate, 2007:31). Experience-based co-design focuses on how a process "feels" rather than how it "is" (Paul Bate, 2007:53). Using the EBCD, healthcare professionals give patients a voice and listen to their story, which is of great importance since it represents the actual experience of communication in the ED. Through these patient stories healthcare professionals gain insight into the patients' world and their views of communication in the ED (Dewar, Mackay, Smith, Pullin & Tocher, 2010:30). The healthcare professionals and patients become equal partners to change the communication practices in the ED to more patient-centred communication practices where patients' experiences are positive with positive patient outcomes and increased patient satisfaction. An ED that practices patient-centred communication may decrease the number of patient complaints on communication in the ED in future.

1.5   AIM AND OBJECTIVES

The aim of the study was to co-design patient-centred communication in an ED. In order to achieve the aim, the objectives of the study were to:

- Explore current communication in an ED as experienced by patients and healthcare professionals.
- Collaboratively co-design strategies to enhance patient-centred communication in an ED.

1.6   CONCEPT CLARIFICATION

For the purposes of this study and clarity, the following terms are used as defined below.

Experience describes "how well people understand the healthcare service, how they feel about the healthcare while they are using the healthcare services, how well the healthcare service serves its purpose, and how well the healthcare fits into the context in which they are using healthcare" (Bate & Robert, 2006:308). Experience cannot be observed or accessed directly, but only indirectly through words people use to describe an event when thinking back about it. It is what the person makes of what was lived through (Bate & Robert, 2006:308). Furthermore Bate (2007:39) state that happenings become experiences "when they are digested, reflected on, related to general patterns and synthesised". For the purpose of this study, experience refers to the patients' and healthcare professionals' understanding and feelings about current communication in the ED.

Key touch points are the patients' and healthcare professionals' subjective, personal feelings. Key touch points refer to the key moments that shape the whole experience of receiving and delivering healthcare (Tsianakas et

al, 2012:2640). Key touch points are the core experience that shapes the patient's and healthcare professional's overall experience of the healthcare service (Ziebland, Coulter, Calabrese & Locock, 2013:144).

Patient-centred communication is communication aimed at building a relationship with patients by involving them in their healthcare and decision-making in order to meet their needs and place the patient at the centre of the healthcare services (Sandhu, Dale, Stallard, Crouch & Glucksman, 2009:400; Tsianakas et al, 2012:2640).

Triage: is used as a medical process of sorting a wide range of patients according to their critique level using a pre-set tool, the South African Triage Score, and assigning a colour to each patient in order to identify and prioritise the critically ill patients who need to be seen first (Twomey, 2012:3).

Priority 2 and 3 patients. Once a patient is triaged, a colour is assigned based on the patient's level of illness according to the South African Triage Score (Ehlers, Hattingh & Augustyn, 2007:28). Priority 2 patients are assigned yellow and their target time to treatment should be within 60 minutes (Twomey, 2012:6). Priority 3 patients are triaged as green, who are admitted to the ED with minor illness or injuries, and have a target time to treatment of 240 minutes (Twomey, 2012:6, Ehlers et al, 2007:28).

Healthcare professionals. All medical doctors and nurses managing patients in the ED where the study was conducted.

1.7 PARADIGM

Research is underpinned by a paradigm or the researcher's philosophical worldview. Polit and Beck (2012:496) describe a paradigm as "a way of looking at natural phenomena that encompasses a set of philosophical assumptions and that guides one's approach to inquiry". The researcher used an interpretive paradigm to guide the study. Brink, van der Walt and van Rensburg (2006:25) define an interpretive paradigm as an approach to social science that values and stresses the importance of insiders' views (patients and healthcare professionals), in an effort to understand social reality (communication in the ED). An interpretive paradigm is concerned about people's experience and the researcher entered the patients' world of knowledge, wisdom and understanding through observation and interviews. The data from the interviews was interpreted collaboratively and the researcher tried to understand the participants' experiences (Polit & Beck, 2012:129).

1.8 PHILOSOPHICAL ASSUMPTIONS

Assumptions are basic principles that are assumed to be true based on logic and reason, without proof or verification (Polit & Beck 2012:129; Brink, van der Walt & van Rensburg, 2006:33). Assumptions are referred to as statements taken for granted or considered true even though they have not been scientifically tested (Brink et

al 2006:533), and the reader is expected to believe them without offering evidence. In this study, the researcher was guided by ontological, epistemological and methodological assumptions.

1.8.1 Ontological assumptions

Ontology refers to a theory of existence and is concerned with the nature of reality and of human beings. Ontological assumptions focus on what the nature of reality is (Polit & Beck, 2012:130). In this study, the reality was the narratives (stories) the patients and healthcare professionals shared about their experiences of patient-centred communication in the ED. The stories are perceptually constructed by the patients and healthcare professionals, spontaneous, subjective and exist within the ED context (Pollit & Beck, 2012:12) with the focus on communication between the patient and healthcare professional.

1.8.2 Epistemological assumptions

Epistemology is a theory of knowledge that investigates how researchers establish rapport with participants to gain insight into their world and obtain knowledge. The question is how researchers relate to those being researched (Polit & Beck, 2012:130). The researcher interacted with the patients and healthcare professionals to inquire about their experiences (Polit & Beck, 2012:130). The researcher interviewed the patients and healthcare professionals separately. Then the researcher had a facilitator facilitate the co-design event where patients and healthcare professionals collaboratively strategized to improve patient-centred communication in the ED (see figure 1.1).

1.8.3 Methodological assumptions

Methodology refers to the process and procedures of the study. Evidence is best obtained through stories patients and healthcare professionals tell about their experience of patient-centred communication in the ED (Polit & Beck, 2012:130). Rich, in-depth information was obtained through narrative film-based interviews (with patients) and interviews (with healthcare professional) that captured the real-life experiences of the patients and the healthcare professionals (Polit & Beck, 2012:130).

1.9 CONCEPTUAL FRAMEWORK

A conceptual framework refers to the theoretical underpinnings of a study, often implicit with the main purpose to provide information about the study (Polit & Beck, 2012:129-130). Every study has a framework because without one it is difficult for the reader to understand and follow what the researcher plans to do (Polit & Beck, 2012:129). The conceptual framework gives information about the study and the rationale for conducting it (Polit & Beck, 2012:128).

The researcher developed a conceptual framework based on Bate and Robert's (2007:10) "continuum of patient influence" and Donetto, Tsianakis and Robert's (2014:12) "experience-based co-design cycle". Figure 1.1 presents the conceptual framework as it was used to 'co-designing patient-centred communication in the ED'.
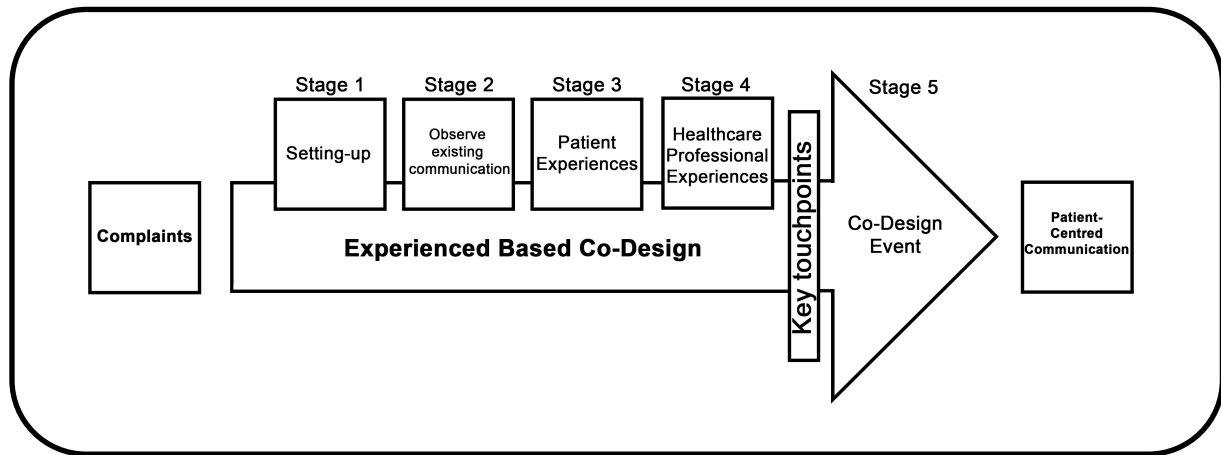
Figure 1.1 Depiction of co-designing patient-centred communication in the emergency department.
Source: Bate and Robert (2007:10) and Donetto, Tsianakis & Robert (2014:12)

The components of the conceptual framework and how they apply in the study are discussed next.

Complaints represent patients' dissatisfaction and negative experiences of healthcare service in the ED (see Section 1.3). The researcher collected patient surveys conducted by the hospital before commencing the study and developing the framework. Patient experiences are essential in assessing the performance of healthcare services, by judging the clinical quality of care as well as listening to patients' stories of their experiences (Tsianakas, Maben, Wiseman, Robert, Richardson, Madden, Griffin & Davies, 2012:271). Complaints were the starting point of this study as the researcher wished to make patients' experience of communication in the ED more patient-centred. Since the complaints used as the basis for the study where done retrospective in e-mail format with set questions, the researcher wanted to include the patients voice by giving them a chance to tell their stories.

The study was conducted in five stages and each stage will be discussed.

Stage 1: Setting up.
After obtaining ethical approval from all the relevant organisations, the researcher obtained consent to do research in the ED from the hospital and introduced the research project and the improvements it may bring in the ED to the unit manager and doctor in charge of the ED.

Stage 2: Observe existing communication.

The researcher conducted unstructured observation with voluntary co-observers in the ED. Observation was valuable to understand how the service operated, and what was the existing communication practices in the ED (The King's Fund, 2012). The aim of this stage was to acquire insight into and understand how communication happened between patients and healthcare professionals in the ED on a daily basis.

Stage 3: Engaging patients and gathering experiences.

The researcher engaged with patients by asking them to share their experiences of communication in the ED during narrative-based film interviews. Patients told their stories and were part of the process. By giving them "a voice" regarding their experience in the ED the patients felt empowered as they were included in the co-design process (Donetto et al, 2014:30). According to Bate and Robert (2007:65), stories are the "structure, sense and significance given to the experience by those whose experience it. It is free of any external structure or meaning imposed by others." The story each patient told was a memory the patient created and by listening to the story, other patients and healthcare professionals were given the opportunity to be part of sharing the action replay. Stories awaken emotions and thus were an effective way to start the design process in the EBCD. Stories were used to identify what changes were needed to move towards more patient-centred communication in the ED.

Stage 4: Engaging healthcare professionals and gathering experiences.

The researcher engaged with the healthcare professionals to gain volunteers to participate in the study. The volunteers were interviewed and given an opportunity to tell their stories and share their experiences about patient-centred communication. The healthcare professionals formed part of the co-design process with the patients to improve patient-centred communication in the ED.

Stage 5: Co-design event with patients and healthcare professionals.

The co-design event is "central to the philosophy and practice of EBCD" (Donetto et al, 2014:24). The researcher edited the narrative-based film interviews into a 12-minute film; listened to the interviews of the healthcare professionals, and transcribed all 15 interviews to be used at the co-design event. The aim was to collaboratively identify the key touch points to redesign a better healthcare service in terms of patient-centred communication in the ED (Paul Bate, 2007:137).

Outcome: Patient-centred communication in the ED:

The key was to create a whole experience of receiving and delivering healthcare that is a positive experience for the patient and healthcare professional (Paul Bate, 2007:31). Healthcare professionals and patients shared their experiences and were part of the data analysis and co-constructed strategies to enhance patient-centred communication in the ED (see chapter 3 for full discussion). The researcher envisioned that through raising

awareness of current communication with patients, the strategies would be implemented and communication would move towards patient-centred communication in the ED.

1.10   DELINEATION

The focus of the study was patient-centred communication in one selected ED in a private hospital in Gauteng, South Africa. The study was about patients' and healthcare professionals' experience of communication in the ED. The focus was on communication between patients and healthcare professionals during triage, management, diagnostic investigations and discharge out of the ED.

1.11   CONTEXT

The context or setting of the study was the ED in a 469-bed private hospital in Gauteng. The healthcare professionals triage, admit and manage patients of all ages with a variety of medical and trauma conditions before they are discharged home or admitted in the hospital for further management. There are 12 permanently employed medical doctors that work shifts in the ED. The nursing staff consists of 1 unit manager (UM), 12 trauma trained registered nurses, 17 registered nurses (RN), 7 enrolled nurses (EN), and 4 enrolled nurse assistants (ENA) working shifts in the ED. Approximately 12 doctors and 40 nurses manage 3 500 patients in the ED each month. On a 12-hour shift during the day, from 07h00 till 18h00, there are 3 doctors and 13 nursing staff on duty. During the night shift there are 2 doctors on duty from 18h00 till 24h00, and only 1 doctor from 24h00 till 07h00 with 12 nursing staff. Table 1 summarises the number and type of patients seen in the ED where the study was done.

Table 1.1 Summary of the number and priority of patients admitted to the ED from 1 to 30 April 2016

Adult P1	Adult P2	Adult P3	Paeds P1	Paeds P2	Paeds P3	Patients admitted	Transfers	
							In	Out
270	2052	125	30	551	46	449	5	32

Deaths	EMS calls	Follow-up	Code Blue	Direct admission	Assess not seen	Sexual assault	Refusal of Hosp Treatment	Total patients seen
2	300	363	30	52	38	3	13	2854

Adult P1: Include both trauma and medical cases
Trauma: Patients admitted following trauma with mechanism of injuries including blunt trauma, and accidental, caused by motor vehicle accidents and motorbike accidents.
Medical: Include mainly patients with cardiac conditions (e.g. chest pain, acute myocardial infarction)
Adult P2: Include both trauma and medical cases
Trauma: Patients admitted following injuries that are mostly caused by falls, sport, motor vehicle accidents who sustained lacerations, soft tissue injuries and/or orthopaedic injuries.

Medical: Patients admitted with conditions such as abdominal pain, infectious diseases, neurological disorders, renal and respiratory infections

Paediatric patients: Included mainly trauma P2 patients

Trauma: Patients admitted due to falls from heights and sport injuries.

Medical: Paediatric patients where mostly diagnosed with infectious diseases and respiratory infections.

Source: Hospital survey records (2016)

Patient complaints are received on a monthly basis regarding communication. Feedback is given to the healthcare professionals during patient handover in the morning. The most complaints from patients included that they did not know what the expected pathway through the ED was. Statements like: "; healthcare professionals do not listen when we are talking" and "do not explain the procedures" they do not know where to go, and finally the waiting times. Patients wait long to see a doctor and this is not explained to them.

1.12   RESEARCH DESIGN AND METHODS

A research design is "the overall plan for obtaining answers to questions being studied and for handling some of the difficulties encountered during the research process" (Polit & Beck 2008:66). Research methodology refers to the techniques used to structure a study, and gather and analyse the data in the course of the study (Polit & Beck, 2008:328). Methodology includes the population, sample, data collection and data analysis.

An Experienced-based Co-design (EBCD) was used as the research design. The EBCD was first developed in the Head & Neck Cancer service in England in 2005-2006 (Donetto et al, 2014:11). The EBCD is aimed at improving the quality in healthcare services through user experience design tools, processes and participatory design. The challenge with EBCD is to move from sharing an experience to getting concrete *knowledge* about that experience that might improve the patient's next visit to the ED (Paul Bate, 2007:43). Patients' positive and negative feelings regarding the service are strongly formed from their stories and are called key touch points (Paul Bate, 2007:120). These key touch points are then examined by both the patients and healthcare professionals to identify priorities of change. Once the priorities of change are identified, they can be used for the improvement of patient-centred communication in the ED (Paul Bate, 2007:120).

The EBCD is a patient-centred not a patient-led design due to the partnership between patients and healthcare professionals. EBCD is a process that gets patients and healthcare professionals together in order to improve the quality of care (Donetto et al, 2015:237). It involves utilising the patients' and healthcare professionals' experience regarding patient-centred communication in the ED to collaboratively plan and implement strategies to enhance patient-centred communication in the ED (Paul Bate, 2007:119-120). It is grounded in the stories of patients' experiences of the healthcare service (Donetto et al, 2015:237). The golden thread of EBCD is the participatory collaborative approach in the co-design phase that improves the quality of patient-centred

communication in the ED (Donetto et al, 2015:239). The patient is an equal partner in the design process and generates collective ownership by being part of the design process as a stakeholder to enhance patient-centred communication in the ED (Donetto et al, 2015:240).

The study was done in five stages, which were guided by the conceptual framework (see figure 1.1). Table 1.2 now summarises the research methodology used in this study.

Table 1.2 Summary of Research methods

Stage 1: Setting up			
Activities	Introduce study to • Hospital manager • Unit manager • Healthcare professionals in the ED		
Stage 2: Observe existing communication			
Population	**Sampling**	**Sample size**	**Data collection**
All the permanently employed healthcare professionals working in the ED Inclusion criteria: • Medical doctors • Nurses	• Purposive and convenient sampling	• 18 observation sessions	• Unstructured observation
Stage 3: Engaging patients and gathering experiences			
Population	**Sampling**	**Sample size**	**Data collection**
Priority 2 and 3 patients who sought emergency care at the hospital and were not admitted in the hospital after following their management in the ED, but discharged home. The inclusion criteria: • patients who volunteered to participate, • were 18 years and older, • spoke English, • had a Glasgow Coma Scale of 15/15 at the time of discharge and • were discharged from the ED following treatment.	• Purposive sampling	• 13 Patients	• Narrative-based film interviews
Stage 4: Engaging healthcare professionals and gathering experience			
Population	**Sampling**	**Sample size**	**Data collection**
All permanently employed healthcare professionals working in the ED. Inclusion criteria: • Medical doctors • Nurses	• Purposive sampling	• 15 Healthcare professionals	• Semi-structured interviews

Stage 5: Co-design event			
Population	**Sampling**	**Sample size**	**Data analysis**
All healthcare professionals working permanently in the ED. Inclusion criteria: • Medical doctors • Nurses Priority 2 and 3 patients who sought emergency care at the hospital and were not admitted in the hospital after following their management in the ED, but discharged home. Inclusion criteria: • patients who volunteered to participate, • were 18 years and older, • spoke English, • had a Glasgow Coma Scale of 15/15 at the time of discharge and were discharged from the ED following treatment.	• Purposive sampling	• 2 Patients • 18 Healthcare professionals	Creative hermeneutic data analysis (Boomer & McCormack 2010:644) All data collected during Stages 2 to 4 analysed

Chapter 3 discusses the research design and methodology in detail.

1.13   ETHICAL CONSIDERATIONS

Ethics deals with matters of right and wrong. When humans are used as participants in a study, special attention must be given to ethical considerations (Polit & Beck 2012:150). In this study, the researcher upheld the ethical principles of the *Belmont Report* (1979). The Belmont Report endorses the principles of beneficence, respect for human dignity, and justice, and allows for the protection of participants in research studies (see chapter 3 for full discussion).

Trustworthiness confirms that the data collected accurately reflect the patient and healthcare professional experiences to provide quality results (Polit & Beck, 2012:62). Trustworthiness was assured through credibility, confirmability, dependability, transferability and authenticity (see chapter 3 for discussion).

1.13.1 Permission

Permission to conduct the study and ethical approval was obtained from the University of Pretoria, the healthcare organisation and the hospital (see Annexure A.1, A.2 and A.3). The approval of the healthcare institution and the letter from the ethical committee of University of Pretoria were given to the patients and healthcare professionals.

1.13.2 Beneficence

Beneficence means to limit harm and to create benefits for participants or the situation and secure the well-being of participants (Polit & Beck, 2012:152; Brink et al, 2006:32). The *right to freedom from harm and discomfort (non-maleficence)* means that the researcher will protect the participants from possible harm or discomfort (Polit & Beck, 2012:152). To protect participants against physical harm is easier than protecting them against psychological harm, because participants are sharing personal information (Polit & Beck, 2012:153). The researcher needs to be attentive to participants' emotions and sharing of unresolved issues that may upset them (Brink et al, 2006:33). During data collection no harm was done to the patients and there was no interference in the care delivered to patients (Pera & van Tonder, 2007:161). Interviews with healthcare professionals took place when they were not on duty.

The *right to protection from exploitation (do good)* means that participants should not be exposed to harm or discomfort and the information provided by them cannot be used against them (Polit & Beck, 2012:153). The participants formed a special relationship with the researcher and the relationship was not exploited (Polit & Beck, 2012:153).

1.13.3 Respect for human dignity

Respect for human dignity is the second ethical principle of the Belmont Report and consists of the right to self-determination and to full disclosure (Polit & Beck, 2012:154). Informed consent is also based on the right to self-determination and full disclosure (Polit & Beck, 2012:154). The researcher obtained informed consent from the participants (see Annexure C.1, D.1, E.1 and F.1).

The *right to self-determination* means that participants should be treated as autonomous agents who can voluntarily decide to participate, have the right to ask questions and refuse to give information, and may withdraw at any stage of the study without judgement or penalty (Polit & Beck, 2012:154). Patients and healthcare professionals could terminate the interviews and withdraw from the study at any stage even after giving informed consent, without penalty (Pera & van Tonder, 2007:152). All patients and healthcare professionals were informed about their involvement in the study and invited to be part of stage 5, the co-design event (Pera & van Tonder, 2007:153).

The *right to full disclosure* means the researcher must explain the nature of the study, the right of the participants to refuse participation, the researcher's responsibilities, and any risks and benefits involved (Polit & Beck, 2012:154). Patients and healthcare professionals were informed about the implications of the study and volunteered to participate in the study (Pera & van Tonder, 2007:152). The autonomy of the healthcare facility was respected and all information given to patients and healthcare professionals was also given to the healthcare facility (Pera & van Tonder, 2007:154-155).

1.13.4 Justice

Justice is the third principle of the Belmont Report and consists of the right to fair treatment and to privacy (Polit & Beck, 2012:155). The *right to fair treatment* means the researcher should select the participants based on the requirements of the study and not exploit individuals who cannot protect their own interest (Polit & Beck, 2012:155). The participants were selected fairly on the basis that they were directly related to the research problem and not because they were easily available (Brink et al, 2006:33). The researcher kept to the specific times scheduled with the patients and healthcare professionals and terminated the interviews at the agreed time to treat all participants fairly (Brink et al, 2006:33). Fair treatment includes that the researcher treat people who refuse participation in a non-prejudicial manner, keep agreements made with participants, and show respect for people's values, beliefs and backgrounds (Polit & Beck, 2012:156).

Right to privacy is an important principle because research can be an intrusion into the participant's lives (Polit & Beck, 2012:156). The researcher needs to ensure privacy is maintained continuously and that the stories and experiences shared by the participants are not more intrusive than they need to be (Polit & Beck, 2012:156). The participant that agreed on participation in research has the right to expect the data collected will be kept in confidentiality (Polit & Beck, 2012:156).

1.14 DISSEMINATION OF RESULTS

The results will be disseminated by giving feedback to all the healthcare professionals who participated in the data analysis and planning of strategies (stage 5). The dissertation, including the research findings will be available on-line as well as in the library at the University of Pretoria. The researcher plans to present the research findings at the Emergency Medical Society of Southern Africa Conference in 2017 as well as publish the findings in an accredited journal.

1.15   LAYOUT OF THE CHAPTERS

The study consists of five chapters.

Table 1.3 presents an outline of the chapters

Chapter	Title	Description
Chapter 1	Orientation to the study	Introduces the study, briefly describing the problem, aim and objectives of the study, research design and methodology, and defining key terms.
Chapter 2	Literature review	Presents the literature review conducted for the study on which the researcher developed the theoretical underpinning.
Chapter 3	Research design and methodology	Discusses the research design and methodology used, including the population, data collection and analysis, trustworthiness and ethical considerations.
Chapter 4	Data analysis and interpretation and findings	Discusses the data analysis and interpretation and findings, with reference to the literature reviewed.
Chapter 5	Conclusion, limitations and recommendations	Concludes the study, briefly presents its limitations, and makes recommendations to enhance patient-centred communication in the ED, and for further research.

1.16   SUMMARY

Patient-centred communication is vital in an ED to ensure a good patient experience. Practising patient-centred communication leads to better health outcomes and greater patient satisfaction. In the researcher's experience patients complain that healthcare professionals communicate insufficient information to them about their expected journey in the ED. A 'voice' needs to be given to the patient in the ED. Experience-based co-design (EBCD) provides healthcare professionals and patients with an opportunity to become equal partners in patient-centred communication in the ED. The ultimate goal of this study was to raise awareness and plan collaborative strategies to work towards patient-centred communication in the ED.

In Chapter 1 an orientation to the study was presented and attention was paid to aspects that included the research design and methods used and the ethical considerations that were taken into account. Chapter 2 provides an in-depth literature discussion that supports the introduction and background given in Chapter 1.
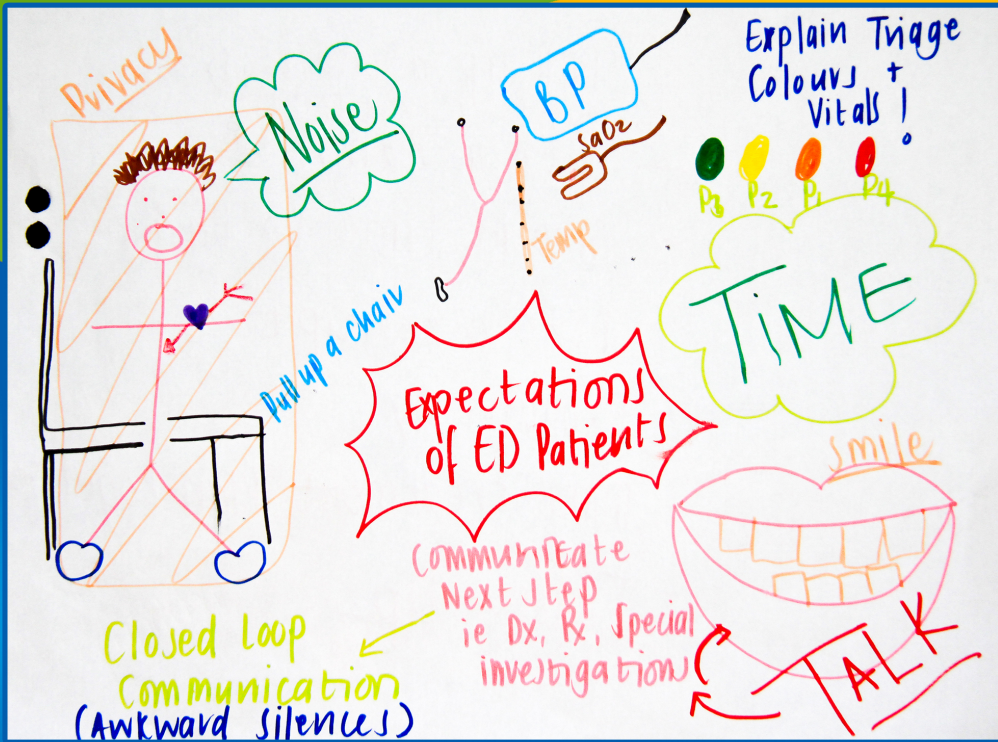
Illustration by participant at Co-design event, July 2016.

CHAPTER 2

THEORETICAL UNDERPINNING

"*There is no lived experience without language and no language without lived experience*" – Robert Burch (Bate & Robert, 2007:59)

2.1 INTRODUCTION

Chapter 1 introduced the study and briefly described the problem, aim and objectives, and research design and methodology of the study, and defined key terms. This chapter discusses the literature review conducted on patient-centred communication in an ED to provide a theoretical underpinning for the study. The literature review covered communication, patient-centredness and patient-centred communication.

2.2 COMMUNICATION

Dyche (2007:1035) defines communication as the exchange of information, thoughts and feelings. Dyche (2007:1035) adds that interpersonal skill in medicine is the essential partner of verbal communication. Kourkouta and Papathanasiou (2014:65) describe communication as a transaction and message creation that is an intrinsic characteristic of human nature, consisting of content and value where the content is what was said and how it was said. Communication is an interaction between people in which the sender becomes the receiver and vice-versa. The communication process consists of a sender, a receiver, the message and the environment in which the process happens (Pretorius et al, 2010:59). The authors Kourkouta and Papathanasiou (2014:66) point out that there is a difference in the message sent and the message received, thus the decoding of messages is based on subjectivity and individual factors. The sender starts the communication process when he/she encodes the message (Pretorius et al, 2010:59). Every individual interprets the message according to his/her own code, and not according to what the sender actually said. The sender uses communication skills to enhance the message and to achieve the objective in the particular situation (Pretorius et al, 2010:59). The receiver of the message decodes the message (Pretorius et al, 2010:59) and gives feedback, which makes it communication (Kourkouta & Papathanasiou, 2014:66). Communication is not just what is said, but involves the way (how) it is said and expressed and the interplay between the verbal and nonverbal factors of communication (Pinto, Ferreira, Oliveira, Franco, Adams, Maher & Ferreira, 2012:78).

Communication can be verbal and non-verbal, and is a two-way process. In the ED, the patients express their concerns, fears and complaints and the healthcare professionals receive the message (Deese, 2015:29). If the message involves the reason the patients visited the ED, the healthcare professionals can take and use the information to make a diagnosis and plan treatment for them (Kourkouta & Papathanasiou, 2014:65). For

effective communication to take place, it is vital that the healthcare professionals communicate the message clearly to the patients so that they understand and accept it (Kourkouta & Papathanasiou, 2014:65). Patients also need to communicate the message clearly to the healthcare professionals, because communication is a two-way process. Communication is the most important skill in healthcare, more especially in the ED as patient care consists of the coordinated efforts of the multi-disciplinary team that shares information and plans care accordingly (Parush, Kramer, Foster-Hunt, McMullan & Momtahan, 2014:48). Sharing and conveying clinical information among healthcare professionals is one of the main and most risky activities in the ED (Parush et al, 2014:49).

For communication to be effective, it needs to be understood and involves three interdependent skills, namely content, process and perceptual skills. Content skills are about the message and information shared by the messenger (Rider, Kurtz, Slade, Longmaid, Ho, Pun, Eggins & Branch, 2014:277). For example, patients share information about their illness with healthcare professionals and the healthcare professionals share medical information with the patients. Process skills are about the method of communication, like the use of verbal and nonverbal communication (see chapter 4, section 4.4). This includes the healthcare professionals' interaction with and response to the patient's message as well as how the patient is involved in decision-making (Rider et al, 2014:277). Perceptual skills are about what a person thinks and feels about the information that is shared. Perceptual skills include the healthcare professionals' clinical reasoning and thinking as well as attitudes, biases, intentions and values like integrity and respect (Rider et al, 2014:277). Perceptual skills are about the healthcare professionals' values (see chapter 4, section 4.3) and what the patients think and feel as individuals. These skills are used in all the different types of communication.

2.2.1   Types of communication

There are three main types of communication, namely written, electronic and face-to-face communication. These will be discussed next.

2.2.1.1 *Written communication*

Olson and Oatley (2014:4) describe written communication as a technology of communication and an instrument of thought. Writing allows communication across time and space and takes up implicit and explicit resources of speech (Olson & Oatley, 2014:8). In contrast to face-to-face communication, written communication produces an artefact that is an object fixed in space that lasts through time and allows for rereading and revising (Olson & Oatley, 2014:8-9). In writing the units of meaning are the words and sentences. Written communication has several functions. In the healthcare environment written communication is used to inform the public about health matters and to tell stories of science in medicine. Writing skills are an important part of communicating a message with clarity (Olson & Oatley, 2014:4). Healthcare professionals use written communication for patients' notes.

2.2.1.2 *Electronic communication*

Fitze (2006:67) describes electronic communication as typing and viewing messages while seated in front of a computer, or using a Smartphone during a lunch break or before falling asleep at night. Electronic communication happens only through typed messages, and lacks the aural and visual paralinguistic cues present in face-to-face communication (Fitze, 2006:68). The skills involved to interpret electronic messages are different from those required in face-to-face communication (Fitze, 2006:68).

Electronic mail (email) started in 1971 but was very limited and only became part of society in the 1990s. By 1997 email had overtaken postal mail and today email is the most important form of electronical communication in the world of business (Jones, 2016:vi). Furthermore Jones (2016:vi) states that 2.6 billion people use email and over 200 billion emails are sent and received daily as emails the most convenient form of electronic communication. One of the biggest electronic communication options today is Facebook.

Facebook was launched in 2006 and is still one of the largest social networks in the world with 1.59 billion active users (Jones, 2016:vi). Twitter is the second largest social network with 320 million users worldwide (Jones, 2016:vii). The introduction of Smartphones changed the world of communication and caused a massive shift from voice communication to text communication (Jones, 2016:vii). Short message service (sms) was taken over by instant messaging because it is more user-friendly and almost cost free (Jones, 2016:vii). In 2009, WhatsApp was created to build a better sms alternative and was then bought by Facebook in 2014 (Kumar, Singh, Gupta, Gupta, Gupta, Singh & Prakash, 2016:855). Facebook also has its own instant messaging system with 900 million users, more commonly used by younger people (Jones, 2016:vii). Other electronic ways of communicating include LinkedIn, more a professional network, and Skype, which was launched in 2003 and is used for video and voice chatting all over the world (Jones, 2016:vii). Skype, although an electronic communication methods, can therefore also be linked to face-to-face communication.

2.2.1.3 *Face-to-face communication*

Face-to-face is the most universal way of communicating in the ED. Face-to-face communication consists of verbal and non-verbal communication. Face-to-face interactions are a central part of patient-centred communication, which influence clinical outcomes like patient satisfaction and compliance (Henry, Fuhrel-Forbis, Rogers & Eggly, 2012:298). Non-verbal communication plays a big role in face-to-face interactions especially when conveying emotional information (Henry et al, 2012:298). Patients' emotional experience of the patient-healthcare professional relationship is mainly determined by the healthcare professionals' ability to use verbal and non-verbal communication cues and to interpret it correctly (Riess & Kraft-Todd, 2014:1110). For the purpose of this study face-to-face communication will be discussed in detail. Verbal and non-verbal communication forms part of empathy. Empathy is the core of communication in this study as guided by the

conceptual framework (Figure 2.1). Empathy is a cognitive skill and the healthcare professional should demonstrate empathy to enhance patient-centred face-to-face communication. Empathy the concept will be discussed shortly and then verbal and non-verbal communication.

▪ **Empathy**

Empathy is essential for effective communication and can be used by healthcare professionals to understand patients' perceptions of their illness (Pretorius et al, 2010:47). Empathy is a cognitive skill expressed by caring, emotional responsiveness and understanding of the patient's feelings (Dyche, 2007:1036). Empathy forms part of verbal and non-verbal communication. Empathy as a cognitive skill can be used by healthcare professionals to enhance patient-centred face-to-face communication. In this study, empathy is the core of communication as guided by the conceptual framework (see Figure 2.1).

Healthcare professionals who are caring and empathic when communicating, influence patients' healthcare experience positively (Riess & Kraft-Todd, 2014:1110). The word empathy as an acronym are used to help healthcare professionals remember all the important components of face-to-face (verbal and non-verbal) communication skills as follows (Riess & Kraft-Todd, 2014:1110):

- *E: Eye contact* is the first sign that a person has noticed another person and is the most important element of communication in patient engagement (Riess & Kraft-Todd, 2014:1110). Other authors like Pretorius et al (2010:64) emphasise that eye contact plays an important role when assessing body language (non-verbal) and emotional expression as a person's eyes are the windows to the soul. Moreover, eye contact plays a positive role in the healing relationship between patient and healthcare professional. Gorawara-Bhat and Cook (2011:446) stress that eye contact is part of non-verbal communication and critical to enhance patient-centred communication.

- *M: Muscles of facial expression* are a key component of non-verbal communication to achieve patient satisfaction (Riess & Kraft-Todd, 2014:1110). Decoding of facial expressions, especially detecting fear, is a strong predictor of prosocial behaviour in patients (Riess & Kraft-Todd, 2014:1110).

- *P: Posture* is independent of facial expressions and a strong sign of positive and negative emotions (Riess & Kraft-Todd, 2014:1110). Patients experience healthcare professionals as more empathetic when conveying a posture of mutual respect and openness towards them. Dominant postures of the healthcare professional influence the neuro-endocrine levels and are associated with anxiety and stress by the patient (Riess & Kraft-Todd, 2014:1110).

- *A: Affect* is achieved through asking patients about their emotional state, thus "perspective getting". Riess and Kraft-Todd (2014:1110) point out that the brain's inherent capacity for emotional understanding is improved if the focus is on patients' affective states. This increases patient satisfaction, patient compliance with treatment and decreases patient anxiety (Riess & Kraft-Todd, 2014:1110).

- *T: Tone of voice* during communication has a major influence on patient-centred communication. A tone of voice that conveys warmth about the patient's condition shows empathy and leads to increased patient satisfaction (Riess & Kraft-Todd, 2014:1110).

- *H: Hearing* "the whole" patient means the healthcare professional takes the non-verbal communication signals together with the patient's story and his/her social world and listens to the patient as a whole (Riess & Kraft-Todd, 2014:1110).

- *Y: Your response* refers to the healthcare professional's response. It is important when dealing with a difficult patient to disengage from negativity, frustration and anger and respond with emphaty (Riess & Kraft-Todd, 2014:1110).

It is clear from the literature that patients are more satisfied with healthcare professionals who show empathy towards them which, in turn, leads to patient satisfaction and better patient outcomes (Riess & Kraft-Todd, 2014:1110). Empathy is therefore an important part of verbal communication to enhance patient-centred communication.

- **Verbal communication**

Verbal communication is accomplished by using words when asking questions, providing answers and making announcements (Parush et al, 2014:50). Verbal communication consists of qualities of empathy and listening (Riess & Kraft-Todd, 2014:1109).

Listening is an important skill in communication as well as in healthcare (Kourkouta & Papathanasiou, 2014:66). In a study on improving communication in healthcare, Gordon, Deland and Kelly (2015:24) found that healthcare professionals interrupted patients 77% of the time, on average every 18 seconds. Pretorius et al (2010:68) maintain that healthcare professionals should make an effort to not only hear the words patients speak, but to understand the whole message. Practising empathetic listening as a skill will effectively allow healthcare professionals to diagnose with fewer misunderstandings and negotiate better treatment options with their patients (Pretorius et al, 2010:68). According to Ford, Rolfe and Kirkpatrick (2011:198-199), patients tell stories of their illness and their most important need is to be heard. Therefore healthcare professionals need to listen to their patients' stories as they might share important information. Stories are part of the human condition and provide healthcare professionals with the logic and meaning of events (Ford et al, 2011:199). Most importantly, stories help healthcare professionals to link evidence-based practice to specific patients (Ford et al, 2011:200). Healthcare professionals who listen to their patients' stories will deliver better quality care that will ultimately lead to better patient satisfaction and outcomes. Non-verbal communication and verbal communication together with empathy plays a significant part to move towards patient-centred communication.

▪ **Nonverbal communication**

Non-verbal communication happens without words and is expressed by facial expressions, posture and gestures (Kourkouta & Papathanasiou, 2014:66). According to Mast (2007:315) non-verbal communication are behaviours without linguistic content. Non-verbal signals are processed faster by the brain than verbal content and therefore play a vital role in communication (Riess & Kraft-Todd, 2014:1109). Since non-verbal messages are processed faster, they have a bigger impact on the perceiver than the corresponding verbal communication and consequently play a significant role in the communication between patients and healthcare professionals in the ED (Riess & Kraft-Todd, 2014:1109). Non-verbal communication consists of expressing and perceiving messages. Healthcare professionals should be aware of their non-verbal communication as non-verbal signals are very subtle and are perceived by patients without conscious awareness (Riess & Kraft-Todd, 2014:1109). Overlooking non-verbal emotional behaviours can lead to misunderstanding of the patient, which can result in patient anxiety, non-adherence to treatment and also poor patient outcomes (Riess & Kraft-Todd, 2014:1109). Healthcare professionals who are good at reading patients' non-verbal communication signs have more satisfied patients (Mast, 2007:316).

Patient satisfaction is increased with healthcare professionals using non-verbal communication like listening and increased attentiveness (Henry et al, 2012:308). Change in tone of voice and body language is non-verbal communication and often happens without the patient or healthcare professional's awareness (Henry et al, 2012:298). Patient satisfaction increases when healthcare professionals smile, make eye contact and lean forward with an expressive tone of voice (Mast, 2007:317). These positive non-verbal communication signals are the result and not the cause of positive and satisfying interaction between healthcare professionals and patients, and may increase the trust in their relationship (Henry et al, 2012:308). Trust plays a vital role in the patient-healthcare professional relationship and non-verbal communication is a significant predictor of how much the patient trusts the healthcare professional (Riess & Kraft-Todd, 2014:1109). Effective communication between patient and healthcare professional is dependent on non-verbal communication where the healthcare professional can better understand and attend to patients by decoding non-verbal communication that is a critical diagnostic clinical skill (Riess & Kraft-Todd, 2014:1109). Non-verbal communication is vital to achieve patient satisfaction, patient compliance, and shared decision-making between patients and healthcare professionals and lead to a healing relationship (Riess & Kraft-Todd, 2014:1109).

2.2.2 Communication between the patient and healthcare professional

The healing relationship between the healthcare professional and patient is an important aspect of effective communication. It is visible when healthcare professionals express sincere concern for patients and include them in decision-making relating to their treatment (Kourkouta & Papathanasiou, 2014:66). Healthcare professionals need to master effective communication skills in practice to improve their patients' healthcare (Pinto et al, 2012:77). Enhancing effective communication requires collaboration, cooperation and coordination between

healthcare professionals and patients (Pinto et al, 2012:77). The quality of communication between healthcare professionals and patients has a big impact on patient outcomes (O'Hagan, Manias, Elder, Pill, Woodward-Kron, McNamara, Webb & McColl 2014:1344). Patients consider interpersonal skills like listening, friendliness, empathy and caring demonstrated by healthcare professionals as more important than the spoken message itself. The ED environment is chaotic and effective communication between patients and healthcare professionals is a challenge.

The ED environment is turbulent with a never-ending intake of patients. The modern ED has moved from exclusively managing critically ill or injured patients to serving more clinic-like populations like children, pregnant women, disabled, chronically ill, mentally ill, and HIV/AIDS patients (Dean & Oetzel, 2014:258). An ED has unique challenges that influence communication, such as time constraints, patients in need of immediate treatment (critically ill or injured), a variety of distractions and lack of previous clinical data on the patient (Dean & Oetzel, 2014:257). In addition, 95% of observed communication in the ED is considered to be information; for example, giving and receiving information, asking and being asked questions (Dean & Oetzel, 2014:259). In the ED information exchange happens at a high pace and is therefore very challenging.

Information exchange between the healthcare professional and the patient in the ED happens in a highly stressed and time-sensitive environment (Dean & Oetzel, 2014:259). According to a study done by Gordon et al (2015:23) patients could only recall 40% of the information given to them by healthcare professionals, of which only half of that recalled was correct. In the ED this often means that healthcare professionals have little face-to-face time with patients and that time is shortened and challenged by interruptions (Dean & Oetzel, 2014:259). This shortened face-to-face time with all the interruptions slows down the care and could lead to mistakes being made with negative patient outcomes (Dean & Oetzel, 2014:259). It can be time-consuming for patients to explain the reason for visiting the ED and for healthcare professionals to diagnose and treat patients correctly according to their signs and symptoms (Dean & Oetzel, 2014:259). Effective communication with the patient implies that the healthcare professional needs to communicate the diagnosis and treatment plan to the patient clearly to ensure that the patient adheres to the treatment (Dean & Oetzel, 2014:259).

2.2.3   Outcomes of effective communication

Effective communication refers to creating meaning in communication where healthcare professionals and patients exchange information and patients are able to take part in the decision-making of their healthcare (Deese, 2015:40). Effective communication is a critical clinical skill in healthcare and not just a social skill (Rider et al, 2014:278). Effective clinical communication contributes to better patient outcomes and improves patients' trust in healthcare professionals (Rider et al, 2014:278). Patient outcomes are also improved by effective communication as it assists healthcare professionals in making a more accurate diagnosis of the patient's illness (Rider et al, 2014:278). Effective communication enhances the collaboration between patients and healthcare

professionals and may also improve patient satisfaction (Rider et al, 2014:278; Gordon et al, 2015:24). As effective communication improves coordination of patient care, it is vital that it is practised in the ED on a daily basis to ensure safe quality care to the patients visiting the ED (Rider et al, 2014:278). Effective communication between patients and healthcare professionals decreases the chance of medico-legal mistakes. Rider et al (2014:278) emphasise that with effective communication and patient involvement in their care adherence to treatment will improve, costs will be reduced, hospital stays will be shortened and patient complaints decreased. Quality communication between patients and healthcare professionals leads to positive patient outcomes and is therefore a vital skill for healthcare professionals working in the ED (Gordon et al, 2015:24).

In a fast-paced ED with time constraints, efficient transparent communication is a priority (Dean & Oetzel, 2014:264). Communication in the ED needs to be clear, accurate and relevant with information like what is wrong with the patient and what the next steps in the treatment plan are in order to have a positive impact on patients' experience and satisfaction in the ED (Dean & Oetzel, 2014:261). According to Mohammed et al (2014:4), patients identified effective communication as an important indicator of good quality healthcare. Healthcare professionals, who see patients as partners have the ability to listen, show respect and courtesy, explain procedures, involve the patients in the discussions and build a relationship with them, which leads to effective patient-centred communication.

In Hong Kong, Slade, Chandler, Pun, Lam, Matthiessen, Williams, Espindola, Veloso, Tsui and Tang (2015:69) found that effective communication between healthcare professionals and patients led to safe and effective healthcare. According to Gordon et al (2015:23), healthcare professionals do not take time to communicate with each other about the patient's needs and also do not take enough time to communicate with the patient. Effective patient-healthcare professional interaction or communication results in positive health outcomes, which include more accurate patient diagnosis; better patient compliance with treatment, and increased patient trust in healthcare professionals (Slade et al, 2015:70). Clearly then, effective communication has to be a part of the daily routine in the ED to ensure good, safe quality patient care. Ineffective communication could have a detrimental effect on both patient and healthcare professional.

2.2.4   Ineffective communication

Ineffective and insufficient communication remains one of the main reasons for complaints about healthcare professionals when delivering healthcare to patients (Jack, O'Brien, Kirton, Marley, Whelan, Baldry & Groves, 2013:1554). Healthcare professionals either fail to understand patients or fail to express their own meaning, which leads to patient dissatisfaction (Hantho, Jensen & Malterud, 2002:244). Patients complain when healthcare professionals do not listen to their problems and concerns, or when they do not receive enough information from healthcare professionals (Levinson et al, 2010:1311). According to Jack et al (2013:1550) increased complaints by patients leads to reduced patient compliance with treatment. Dean and Oetzel

(2014:257) point out that ineffective communication between patients and healthcare professionals can result in medical errors and malpractice suits. Poor communication skills could leave patients dehumanised, especially when healthcare professionals do not see patients as individuals but rather as a disease or body part (Riess & Kraft-Todd, 2014:1110).

One of the challenges in the busy ED is that healthcare professionals spend insufficient time with patients to establish rapport and empathy due to the stressed environment (Slade et al, 2015:69). Communication between patients and healthcare professionals is not like everyday conversation. It is more interview structured conversations with no time for healthcare professionals to listening attentively and understand patients' perspectives (Dean & Oetzel, 2014:259). Providing information and creating time for patients' stories is lacking which causes ineffective communication and dissatisfaction of patients regarding the treatment received in the ED. A patient-centred approach is needed to improve patient satisfaction and outcomes. The core of patient-centredness is healing relationships grounded in trust and effective communication (Epstein et al, 2010:1489) (see conceptual framework figure 2.1).

2.3 PATIENT-CENTREDNESS

Patient centredness is all about involving the patient in the healthcare system, and forming a healing relationship between the patient and healthcare professional based on mutual understanding, trust and shared knowledge (Murante et al, 2014:273; McCormack, 2003a:203). According to Anhang Price, Elliott, Zaslavsky, Hays, Lehrman, Rybowski, Edgman-Levitan and Cleary (2014:526) patient-centredness involves being responsive and respectful to patients' needs, values and individual preferences as well as respecting their human dignity. Respecting and knowing patients' values reflects a deep understanding of them as human beings with feelings and thoughts and forms part of patient-centredness (McCormack, 2003b:181).

Patient-centredness is when patients' experience, perceptions, feelings, expectations and preconceptions are combined with taking their history and doing a clinical examination to make a diagnosis (Hantho et al, 2002:20). Patient experience is a key measure of patient-centredness since it is the patient's perspective that counts (Anhang Price et al, 2014:527). Practising patient-centredness leads to positive patient experiences associated with good patient compliance with recommended treatment and prevention strategies that result in positive patient outcomes (Anhang Price et al, 2014:522). Patient-centredness during an episode of illness or injury is when the patient's experience of the illness is acknowledged and understood by the healthcare professional (Williams & Grant, 1998:87). Once healthcare professionals understand patients' experience and perception of the illness or injury, they can plan treatment that fits into the patients' beliefs, values and social context (Williams & Grant, 1998:88). Patient-centredness is about the patient who experiences healthcare as an individual rather than the object of the disease and the patient as an individual (Gorawara-Bhat & Cook, 2011:442).

Ford, Rolfe and Kirkpatrick (2011:200) maintain that in order to treat a patient as an individual, proximity is the "being" of patient-centredness and is essential to develop a sense of the patient as a whole. There are three proximities, namely physical, narrative and moral proximity. Physical proximity is the closeness when the healthcare professional *connects* with the patient and forms a healing relationship. Narrative proximity is when the healthcare professional takes time and *listens* to the patient's story about the illness, trying to understand the patient's experience, and trust is built between them (Ford et al, 2011:200). Moral proximity develops out of the patient's experience, when the healthcare professional is able to *appreciate* the moral significance and act as the patient advocates, put the patient at the centre, and involve the patient in the healthcare (Ford et al, 2011:200).

Healthcare professionals need to get more involved with patients as individuals. Getting more involved with patients as human beings means getting closer to them. To get closer to patients, healthcare professionals need to understand them as whole human beings and the experience of illness from their perspective (Constand et al, 2014:1). According to Nolan et al (2004:46) patient-centredness is "to know what it is like to live a certain kind of life" through gaining knowledge of the patient as an individual. The key to patient-centredness is responding to the patients' needs, preferences and values and sharing all information and decisions with them thereby making them equal partners in their healthcare (Phelan, Stradins & Morrison, 1998:975).

In order to deliver quality health care and achieve positive patient outcomes today, it is necessary to understand and practise patient-centredness and build healing patient-healthcare professional relationships. The components of patient-centredness; healing patient-healthcare professional relationships; healthcare today, and positive patient outcomes are discussed next.

2.3.1 Interconnected components of patient-centredness

Mead and Bower (2000:1087-1105) developed a conceptual framework (model) to illustrate the five interconnected components of patient-centredness. The five components are:

1. Explore both disease and illness experiences of the patient.
2. Understand the whole person.
3. Find common ground concerning treatment.
4. Integrate prevention and health education.
5. Improve patient-healthcare professional relationship.

Each of these components will be discussed in 2.3.1.1 to 2.3.1.5.

2.3.1.1 *Explore both disease and illness experiences of the patient*

Individuals interpret illness differently depending on their social, cultural, economic and religious background and what significance the illness has for them (Mead & Bower, 2000:1089). It is vital to listen to the patient's story of

illness, explore the presenting symptoms and also the broader life in which it occurs, including the patient's expectations, fears and feelings (Mead & Bower, 2000:1089). The goal for the healthcare professional is to understand the patient's complaints (illness), the signs and symptoms (disease), problems and conflicts (personality) as expressed by the patient that will lead to understanding the patient as a whole person (Mead & Bower, 2000:1089).

2.3.1.2 *Understand the whole person*

By understanding the patient as a whole person, the healthcare professional lets the patient feel emotionally understood and treats the patient as a whole person and not just a disease (Little et al, 2001:2; Oates et al, 2000:2). This enables the patient and healthcare professional to find common ground.

2.3.1.3 *Find common ground concerning treatment*

During this process a relationship is formed between the patient and healthcare professional and each plays a specific role to work together towards the same treatment goals and share the same priorities (Little et al, 2001:2). Finding common ground creates a healing relationship between the patient and healthcare professional which is a requirement in patient-centredness and not just an addition or "extra" (Mead & Bower, 2000:1090). The healthcare professional can then give better health education to the patient.

2.3.1.4 *Integrate prevention and health education*

Prevention and good health education are crucial to prevent and detect diseases early, reduce the risks of certain illnesses and improve patients' healthcare outcomes (Little et al, 2001:2). A relationship is built between the patient and healthcare professional that will lead to collaboration.

2.3.1.5 *Improve patient-healthcare professional relationship*

Listening to the patient and encouraging collaboration helps to identify patient's needs and preferences, which will improve the patient-healthcare professional relationship (Mead & Bower, 2000:1090). The aim is to encourage significantly greater patient involvement in decision-making, thereby creating a caring and healing relationship where there is shared power between the patient and healthcare professional (Mead & Bower, 2000:1090; Little et al, 2001:2). Patient-centredness in practice is demonstrated when the healthcare professional respects, identifies and cares about the patient's differences, values, preferences and expressed needs (Deese, 2015:44). Clearly, then, patient-centredness should be practised in all healthcare settings, including the ED. Patient-centredness is part of effective communication to improve patient-centred communication in the ED. Practising patient-centredness results in healing relationships between patient and healthcare professional.

2.3.2   Healing patient-healthcare professional relationship

One of the principles of patient-centredness is building a healing relationship between the patient and healthcare professional based on mutual respect and trust, and understanding the patient as an individual with rights (McCormack et al, 2010:621). Healing relationships consist of two-way sharing of information, exploring and including the patient's preferences and values, involving the patient in decision-making and assisting in lifestyle changes that are essential to maintain and improve the patient's health (Epstein et al, 2010:1490). The biggest determinant of patient satisfaction is interpersonal relationships and healthcare professionals who demonstrate empathy and listen to their patients (Williams & Grant, 1998:88). Healthcare professionals' interpersonal skills are indispensable to improving patient experience and satisfaction and developing good patient-healthcare professional relationships (McCormack et al, 2010:628).

The patient-healthcare professional relationship can only improve when both patient and healthcare professional are honest, open and practise disclosure in this relationship (McCormack et al, 2011). Patients need to be honest and share information about their health behaviours, and healthcare professionals should not withhold any information from them. The healing relationship goes further than caring for patients and involves knowing them as individuals as well as including them as active participants in their healthcare (Epstein et al, 2010:1490). The aim of a healing patient-healthcare professional relationship is to be patient-centred and enable patients to follow the path they have chosen with the healthcare professionals' support and clinical expertise (McCormack, 2003a:205). Patient-centred interactions are about sharing the mind, information and discussion (Epstein et al, 2010:1490). Sharing the mind is a big challenge in the ED, as the healthcare professional needs to gain the patient's trust in a single visit (Epstein et al, 2010:1491). Trust and effective communication is the key to patient-centredness as illustrated in the conceptual framework for the study (see figure 2.1). A healing patient-healthcare relationship should include four vital elements, namely mutual respect, trust, shared decision-making and understanding (see figure 2.1).

Respecting patients' values is central to patient-centredness (McCormack, 2003a:205). Healthcare professionals who are patient-centred understand and respect their patients' values and way of making sense of everyday life, as well as what is important to them (McCormack, 2003a:206). All patients are individuals that see and experience health differently and have different perceptions of their own well-being (McCormack, 2003a:206). When making decisions, there should not just be one correct intervention or treatment for patients, but their individual circumstances and values should determine the most appropriate decision (McCormack, 2003a:206). Healthcare professionals should not be the only ones who have the final say in decision-making, but should include, guide and negotiate with the patients, based on their individual values (McCormack, 2003a:206). Healthcare professionals who practise patient-centredness and respect their patients provide information on a level that is understandable and includes their concerns, understanding and expectations (Epstein et al,

2010:1491). Respecting the patient improves patient-centred communication and trust between patient and healthcare professional.

Fiscella et al (2004:1049) emphasise that patients' trust is based on healthcare professionals' competency, having the patients' best interest at heart, being honest, and maintaining patient confidentiality. Trust plays a big role in patient satisfaction, compliance with treatment and patient outcomes (Fiscella et al, 2004:1049). Patients trust healthcare professionals who make them feel that their experiences of illness are important enough to be explored and understood. The healthcare professionals communicate clearly and build a healing relationship with them (Fiscella et al, 2004:1049). McCormack et al (2011:1090) maintain that trust relates to healthcare professionals' communication style and interpersonal skills. Healthcare professionals promote the healing relationship through communication to build rapport and a connection with patients, acknowledging each one as a "whole person" (McCormack et al, 2011:1090). Both patient and healthcare professional bring knowledge and experience to the healthcare setting and these ingredients are needed to make shared decisions fundamental to patient-centredness (McCormack, 2003a:205).

The third essential element in patient-centredness is shared decision-making and helps healthcare professionals become more responsive to patients' individual needs and preferences (Barry & Edgman-Levitan, 2012:781). During the patient's visit to the ED, it is important that patient and healthcare professional share information with each other. Healthcare professionals give the patients different treatment options, explain the risks and benefits and patients share their preferences and beliefs in order to reach a common understanding where both parties share the responsibility (Barry & Edgman-Levitan, 2012:781). The advantage of shared decision making is that patients are aware of the options and understand the treatment much better, which enhances their adherence and healthcare outcomes (Barry & Edgman-Levitan, 2012:781). The key is to keep person-centredness central to decision-making to improve patient outcomes and deliver high quality care (McCormack, 2003b:179). Healing relationships enhance patients' autonomy through various treatment options and patients are equal partners in decision-making, and mutual understanding is reached (Epstein et al, 2010:1491).

Healthcare professionals reach a shared understanding with patients about the treatment plan by acknowledging the patients' values (Epstein et al, 2005a:1517). Experiences are shared through implementing the plan and outcomes are discussed by the patients and healthcare professionals to build on previous choices (McCormack et al, 2011:1091). Through shared discussion, patient and healthcare professional question assumptions and facts that the patient believes are true and the family's opinion is also taken into consideration (Epstein et al, 2010:1491). Healthcare based on patient-centredness demonstrates empathy with patients' experience, involves them as individuals, and recognizes and respects their values and beliefs (Williams & Grant, 1998:88). Respect, trust, shared decision-making, and mutual understanding are the four key elements of a healing relationship between patient and healthcare professional that leads to positive outcomes of patient-centred communication.

2.3.3   Healthcare today

Patient-centredness plays a vital role in today's healthcare when the aim is to improved patient satisfaction and delivery of high quality care (Mead & Bower, 2000:1087). However, making patient-centredness happen remains a challenge in practice, although it is increasingly being acknowledged and advocated (McCormack et al, 2010:620). The principles of patient-centredness come from the ancient Greek school of Cos, who was interested in each patient as an individual and believed patient-centredness should be the core of healthcare (Oates et al, 2000:2).

From the above discussion, patient-centredness can be described as understanding the patient as a unique human being, using the patient's knowledge and experience to guide the interaction, trying to enter the patient's world to see the illness through the patient's eyes, and being responsive to the patient's needs and preferences. In a study of patients' perceptions of quality of care at an ED and identification of areas for quality improvement, Muntlin, Gunningberg and Carlsson (2006:1046) found that a patient-centred approach not only improved but was essential to healthcare today.

In today's ED environment the focus should not only be on the outcomes of care but rather the personal experience of the care (Mohammed et al, 2014:1). The ED is unique in comparison with other units in a hospital as there is a big variation of illness, diseases and injuries treated in the department (Muntlin et al, 2006:1046). Furthermore Muntlin et al (2006:1047) state that the majority of patients in the ED are non-critically ill or injured and are not satisfied with the care they receive because they feel their specific needs and expectations are not met. There is increased demand for more effective healthcare with improved patient outcomes. Dean and Oetzel (2014:264) stress the need for patient-centredness in the ED that will result in increased patient satisfaction and involvement, and effective communication.

2.3.4   Positive outcomes

Patient-centredness leads to effective communication and has positive patient outcomes where patients are involved in decision-making and a partnership is formed between patients and healthcare professionals (Little et al, 2001:1). Patients perceive healthcare professionals as approachable and friendly and feel that the healthcare professionals understand them when effective communication is part of the patient-healthcare professional relationship (Little et al, 2001:6). Patients want a partnership with the healthcare professional to discuss their problems and treatment plan (Little et al, 2001:6). The stronger the patient-healthcare professional relationship, the better the patient adherence to treatment (Constand et al, 2014:9). Patients who are equal partners in their healthcare and participate in healthcare decisions have better compliance with treatment and chronic disease control (Epstein et al, 2010:1491). According to Little et al (2001:327) patients feel positive when elements of person-centredness like effective communication a good patient-healthcare professional relationship and good

health promotion are included in their management. Health promotion is part of treating the patient as a whole by considering the patient's past health history and current health status, and developing the healthcare plan based on the patient's previous healthcare experiences (Constand et al, 2014:1-2).

Healthcare professionals should therefore explore the patient's healthcare experiences to develop an understanding of the patient's illness (Constand et al, 2014:2). Patient involvement in decision-making adds significant value in the primary prevention of possible complications and is therefore a vital element of patient-centred relationships in health care. Patient-centredness is based on patients' stories of their previous healthcare experiences with the aim to better health outcomes, reduce health risks and detect illness earlier (Constand et al, 2014:8). The core of patient-centredness is healing relationships that are grounded in trust and effective communication (Epstein et al, 2010:1489). Patient-centredness is aimed at delivering the right care for the right patient at the right time (Epstein et al, 2010:1490). Effective communication is vital in patient-centredness and increases patient satisfaction (Constand et al, 2014:2).

2.4   PATIENT-CENTRED COMMUNICATION

Patient-centred communication is an important element of patient-centredness to improve communication and healthcare (McCormack et al, 2011:1085). Patient-centred communication is vital because communication is regarded as the art of medicine (Epstein, 2000:2). To deliver healthcare that responds to patients' needs, values and preferences, communication is the most important key element in patient-centredness (Saha & Beach, 2011:386). Patient-centred communication refers to a set of skills and behaviours to enhance the patient-healthcare professional relationship, in which patients are equal partners and actively involved in their own healthcare (Saha & Beach, 2011:386). Patients' perception that the interaction was patient-centred and common ground was established with healthcare professionals positively impacts on patient-centred communication (Oates et al, 2000:2). Central to patient-centred communication is how patients experience and understand healthcare professionals' communication regarding medical knowledge and expertise (Gorawara-Bhat & Cook, 2011:442). Effective communication between patient and healthcare professional is patient-centred communication and consists of unique qualities that are illustrated in the conceptual framework (see figure 2.1).

2.4.1   Qualities of patient-centred communication

In patient-centred communication, the patient is an individual and an equal partner, who participates in shared decision-making and effective communication with the healthcare professional. The two parties together make patient-centredness complete (McCormack et al, 2011:1086). The qualities of patient-centred communication are two-way communication; patient participation; equal partnership; individual person; patient's experience of illness; mutual understanding; shared decision-making; empathy, and correct diagnosis and treatment plan.

- *Two-way communication*: Patient-centred communication is implemented in order to focus on patient needs through effective two-way communication between the healthcare professional and patient (McCormack et al, 2011:1085). Effective two-way communication leads to positive patient outcomes and patient satisfaction.

- *Patient participation*: Patient-centred communication encourages patient participation when patients seek healthcare in the ED. The key is to ensure that healthcare is delivered that responds to the patient's needs, values and preferences (Saha & Beach, 2011:386). This leads to patient satisfaction and positive patient outcomes with adherence to treatment plans and positive engagement with healthcare professionals (Swenson, Buell, Zettler, White, Ruston & Lo, 2004:1069).

- *Equal partner*: Healthcare professionals using patient-centred communication skills respond to patients' needs and preferences, give all the information to patients to be equal partners in decision-making, and build a healing trusting relationship with their patients (Levinson, Lesser & Epstein, 2010:1311). Patient-centred communication skills, such as reflective listening with directive discussion, improve patient compliance and involve patients as equal partners in the healing relationship (Zandbelt, Smets, Oort, Godfried & De Haes, 2007:337). Patients are encouraged to take "ownership" of and responsibility for their own health and be equal partners in decision-making (Mead, Bower & Hann, 2002:287).

- *Individual as person*: Seeing the patient as a "whole person" is the key element when healthcare professionals include the psychosocial factors in healthcare (Saha & Beach, 2011:386). The psychosocial component of patient-centred communication is important for a trusting and healing relationship between patient and healthcare professional. The psychosocial aspect of patient-centred communication is all about giving patients the confidence that their experience of the illness is explored and understood (Mead et al, 2002:287). It is not just the experience of patients' illness but life issues that need to be explored to understand and respond to their psychosocial status (Mead et al, 2002:289). According to Swenson et al (2004:1073) patients felt healthcare professionals' interest in them as persons and were open-minded when healthcare professionals used patient-centred communication skills. Patients' perceived healthcare professionals who communicated in a patient-centred way not just as good communicators but as more competent (Saha & Beach, 2011:390).

- *Patients' experience of illness*: The way in which healthcare professionals communicate with patients is a key determinant in the individuals' experience of the "illness", preferences in treatment and health in general (Gorawara-Bhat & Cook, 2011:443). Using patient-centred communication acknowledges patients as individuals with unique life histories and needs (Zandbelt et al, 2007:330).

- *Mutual understanding*: Patient-centred communication in the ED means that there is a mutual understanding between patient and healthcare professional that they have common healthcare goals (Hantho et al, 2002:20). Patients will demand fewer diagnostic tests if they trust healthcare professionals' judgment and if the healing relationship is built on trust and mutual understanding (Epstein et al, 2005b:416). Patients will feel less anxious and have more confidence in healthcare professionals' competence when the healthcare professionals show understanding of their experience of illness (Epstein et al, 2005b:416).

- *Shared decision-making*: Decision-making starts with communication between patient and healthcare professional, by sharing information to support the decision and thus create an opportunity for patient involvement and participation (McCormack et al, 2011:1091). The level of patient involvement in decision-making depends on patients' preferences and how critically ill they are (McCormack et al, 2011:1091). Patient-centred communication is used to change the dynamics of decision-making to shared decision-making where patients are equal partners and actively involved in the decisions (Saha & Beach, 2011:387). Shared decision-making does not give patients more responsibility, but their concerns and preferences are used to direct the care decisions. Patients' perception of shared decision-making is that healthcare professionals understand their emotional and cognitive needs, preferences and concerns which the healthcare professionals use to then suggest a path (Saha & Beach, 2011:387). Patients are more likely to follow healthcare professionals' suggested path when having a choice and a voice (Saha & Beach, 2011:389). As patient-centred communication has evolved in healthcare, it has become a core element in quality care programmes and patients prefer shared decision-making.

- *Empathy*: The emotional component of patient-centred communication is important for a trusting and healing relationship between patient and healthcare professional. Active listening and empathy are two important communication skills healthcare professionals use when interacting with patients (McCormack et al, 2011:1092). The authors Gorawara-Bhat and Cook (2011:445) refer to listening when healthcare professionals listen to patients and try to understand and pay attention to their stories. Active listening of both patient and healthcare professional, and building a healing relationship is enhanced through shared decision-making (McCormack et al, 2011:1091). Eye contact (non-verbal communication) is a central component of listening to get in alignment with the patient as a key component in patient-centred communication (Gorawara-Bhat & Cook, 2011:445).

- *Correct diagnosis and treatment plan*: Two imperatives are balanced with patient-centred communication in the clinical setting, namely the healthcare professional making a correct and accurate diagnosis with a treatment plan and the patient's experience of illness being understood, and involving the patient in the healthcare (Epstein et al, 2005b:420). The qualities of patient-centred communication are the core of effective communication and building a healing patient-healthcare professional relationship.

2.4.2   Patient-healthcare professional relationship is a healing relationship

A good healing relationship between patient and healthcare professional leads to a therapeutic alliance, positive health outcomes and patient satisfaction (Pinto et al, 2012:77). Trust and empathy are part of a good healing relationship which is stronger when healthcare professionals use patient-centred communication; listening to the patient; focusing on the emotional factors, and encouraging shared discussion and participation from the patient (Pinto et al, 2012:86). A collaborative and interactive patient-healthcare professional relationship is essential to enhance patient-centred communication and establish the roles and responsibilities of the patient and healthcare professional (McCormack et al, 2011:1092). The healing relationship between the patient and healthcare

professional is largely related to non-verbal communication and should be focused on patient-centred communication involving the patient as a human being (Epstein, 2000:2). Patient-centred communication is vital to ensure effective communication in the ED.

2.4.3   Patient-centred communication is effective communication

Patient-centred communication is effective communication and essential to improve the patient's experience in the ED. The three main advantages of patient-centred communication are improved patient satisfaction; patient involvement, and positive patient outcomes (Saha & Beach, 2011:386). Patient-centred communication improves patient satisfaction and patients have more trust in the healthcare professional (Phelan et al, 1998:444; Saha & Beach, 2011:386). Patients who experience patient-centred interaction with healthcare professionals have fewer diagnostic tests, better recovery and emotional health and, in effect, decrease health costs (Epstein, 2000:1). Patient-centred communication is one of the six elements of high quality care (Levinson et al, 2010:1310). Patient-centred communication can positively influence healthcare professionals to use evidence-based practice more effectively, especially when patients rely more on the healthcare professional to guide the decision-making and improve the quality of healthcare (Saha & Beach, 2011:391). There is growing patient expectation for healthcare professionals to adopt patient-centred communication (Saha & Beach, 2011:390). Patient-centred communication is vital to ensure effective communication to improve patients' experience in the ED.

2.5   CRITICAL REFLECTION

Based on critical reflection of the literature reviewed, the researcher constructed a conceptual framework to enhance her understanding and indicate the link between the three main concepts, namely communication, patient-centredness, and patient-centred communication, and how the components relate to one another and influence outcomes. The conceptual framework was based on Mead and Bower's (2000:1090) model of patient-centredness (see figure 2.1). Figure 2.1 indicates the role of communication in the ED in order to achieve patient-centred communication.
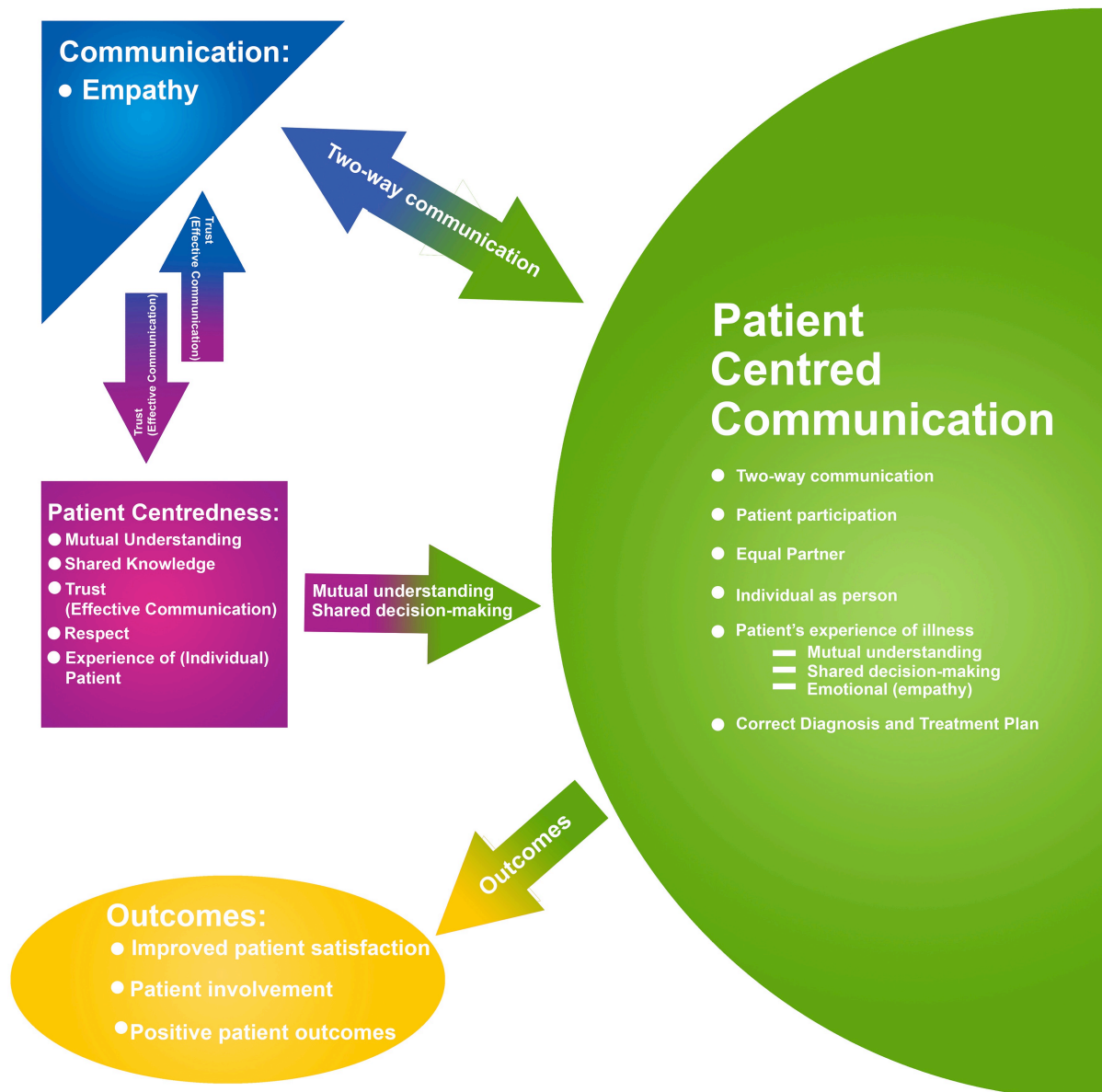
Figure 2.1 Conceptual framework of patient-centred communication adapted from: Mead and Bower (2000:283-299).

Communication is vital in the ED and is a two-way process between patient and healthcare professional. Empathy is essential for effective communication and forms part of the core of patient-centred communication (Pretorius et al, 2010:47). Patients are more satisfied with healthcare professionals who show empathy to them which, in turn, leads to an increase in patient satisfaction and better patient outcomes (Riess & Kraft-Todd, 2014:1110). The core of patient-centredness is healing relationships that are grounded in trust and effective communication (Epstein et al, 2010:1489).

Patient-centredness is about forming a healing relationship between the patient and healthcare professional based on trust and effective communication. Respect, trust, shared decision-making, and mutual understandings

are the four key elements of a healing patient-healthcare professional relationship that leads to positive outcomes of patient-centred communication (Epstein et al, 2010:1491). Patient-centredness is about patients who experience healthcare as individuals rather than the objects of the disease (Gorawara-Bhat & Cook, 2011:442). Effective communication is vital to patient-centredness and increased patient satisfaction, and the ultimate goal of patient-centred communication.

Patient-centred communication is effective communication between patient and healthcare professional. Two-way communication that is effective leads to positive patient outcomes and patient satisfaction. Patient participation is a quality of patient-centred communication to ensure that the healthcare delivered to patients responds to their needs, values and preferences (Saha & Beach, 2011:386). Patients are encouraged to take "ownership" of and responsibility for their own health and be equal partners in the decision-making (Mead et al, 2002:287). The psychosocial aspect of patient-centred communication involves giving patients the confidence that their experience of the illness is explored and understood (Mead et al, 2002:287). Not only their experience of the illness, but life issues need to be explored to understand and respond to patients as individual persons (Mead et al, 2002:289). According to Epstein et al (2005b:420), healthcare professionals making correct and accurate diagnoses with a treatment plan that involves the patient and is based on the understanding of the patients' experience of their illness is patient-centred communication. The qualities of patient-centred communication are the core of effective communication and building healing patient-healthcare professional relationships. The desired outcomes of patient-centred communication are improved patient satisfaction, patient involvement and positive patient outcomes.

2.6   SUMMARY

This chapter discussed the literature review conducted for the study and on which the researcher based her conceptual framework used in the study. Chapter 3 discusses the research design and methods of the study.
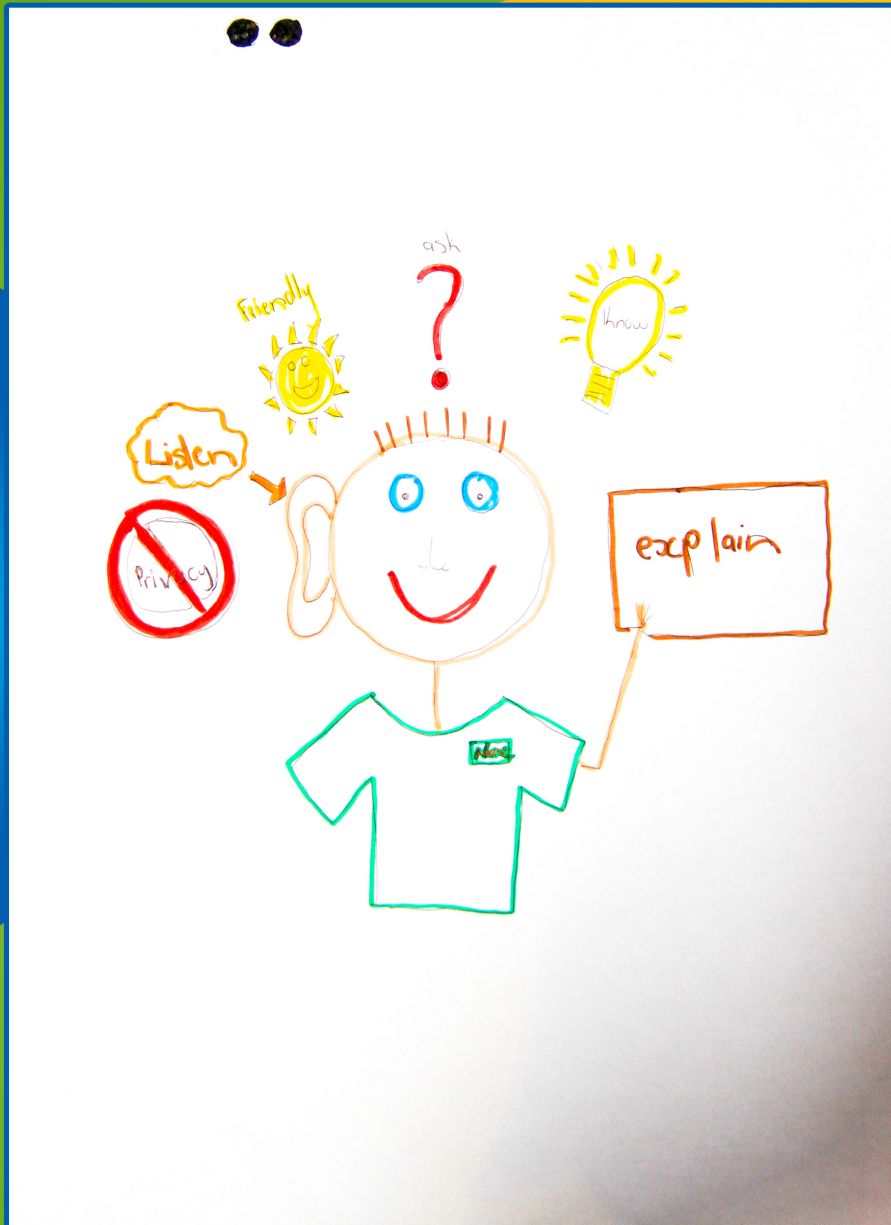
Illustration by participant at Co-design event, July 2016.

CHAPTER 3
RESEARCH DESIGN AND METHODS

"No man's knowledge can go beyond his experience." – John Locke (Bate & Robert, 2007:14)

3.1   INTRODUCTION

Chapter 2 discussed the literature review on communication, patient-centredness, patient-centred communication, its importance in the ED, and the link between the concepts. This chapter describes the research design and methods used in the study.

3.2   RESEARCH DESIGN

A research design is the plan for addressing the research question and specifications to enhance the study (Polit & Beck, 2012:741). In this study, the researcher used a qualitative approach and selected an Experience-based Co-design as the research design. The EBCD is a patient-centred not patient-led design through a partnership between patients and healthcare professionals. EBCD is a process that brings patients and healthcare professionals together in order to improve the quality of care (Donetto et al, 2015:237). It involves utilising the patients' and healthcare professionals' experience of patient-centred communication to collaboratively plan and implement strategies to enhance patient-centred communication in the ED (Bate & Robert, 2007:119-120). Once the priorities of change are identified, they can be used to improve patient-centred communication in the ED (Bate & Robert, 2007:120). The researcher selected the EBCD as a research design because she considered it appropriate for the study as she value the collaboration between the patients and the healthcare professional.

3.2.1   Historical overview

Robert and Donetto (2015:1) cite Don Berwick who said that by listening very carefully to the people they serve, namely patients and families, healthcare professionals and leaders can often best find the gaps that matter. The EBCD is a participatory approach to bring patients and healthcare professionals together to improve the quality of care by co-designing services with the patients (Bate & Robert, 2007:307). EBCD uses patients' stories to create change (Springham & Robert, 2015:2). It was first introduced at Luton Hospital in the United Kingdom in a head and neck cancer service (Donetto et al, 2014:11). The project explored touch points and experiences of two breast and two lung cancer patients to identify improvements that could be implemented. The emphasis is on "co-design" where patients and healthcare professionals reflect on their experiences of the healthcare and then work together to identify key touch points, improve the priorities and implement the changes (Donetto et al, 2015:229).

EBCD was successfully implemented in the United Kingdom National Health Service (NHS) head and neck cancer service (Tsianakas, Robert, Maben, Richardson, Dale & Wiseman, 2012:2640). EBCD was subsequently implemented in head and neck cancer, renal, dementia, orthopaedic, mental health and emergency departments (Boyd, McKernon, Mullin & Old, 2012:76-77). In Australia, healthcare professionals learned new skills and engaged service users in a "deliberative" process, qualitatively different to traditional forms of engagement (Donetto et al, 2015:239). Consequently, the solutions implemented met patients' wishes, advice and insights. Furthermore, there was an improvement in both operational efficiency and inter-personal dynamics of care.

Today, business and service organisations want to make the customers' experience good since a good customer experience equals good customer service because the experience is the service (Bate & Robert, 2007:1). Healthcare organisations are service organisations and are under pressure to become more user- or patient-centred (Bate & Robert, 2007:1). The core of patient satisfaction is the patient's experience (Bate & Robert, 2007:1). Assessing healthcare has changed and the patient's experience has become the central criterion or judgement of quality of care (Tsianakas, Maben, Wiseman, Robert, Richardson, Madden, Griffin & Davies, 2012:271). In the United States and the United Kingdom, rather than surveys, healthcare organisations now use data from patient interviews and focus groups with patients and healthcare professionals to explore how the care was experienced (Tsianakas et al, 2012:272). The main advantage of patient interviews is that the meanings patients attach to particular elements of care they received can be grasped. Patients communicate the multi-layered texture and human experience in their stories, which can be used to guide the enhancement of patient satisfaction and quality of care (Tsianakas et al, 2012:272).

EBCD captures the patient's emotional experience and serves as the foundation of patient-centredness (Russ, Phillips, Brzozowicz, Chafetz, Plsek, Blackmore & Kaplan, 2013:91). According to Russ et al (2013:92) patient-centredness is one of the six dimensions of quality in healthcare, and the focus should be on patients' experience if healthcare needs are to be redesigned. EBCD aims to redesign healthcare service delivery to be more patient-centred through exploring patient experiences (Russ et al, 2013:91).

3.2.2   Experience

Bate and Robert (2006:308) describe experience as "how well people understand it; how they feel about it while they are using it; how well it serves its purpose, and how well it fits into the context in which they are using it". The whole idea is to begin to design experiences rather than processes by identifying key touch points (Bate & Robert, 2006:308). It is during those key moments when the patients come in contact with the ED and the healthcare professionals delivering healthcare when the subjective experiences are formed, and an emotional and sensory connection is established. Those moments become their key touch points (Bate & Robert, 2006:308). Further Bate and Robert (2006:308) add that happenings become experiences "when they are

digested, when they are reflected on, related to general patterns and synthesised". Words translate those happenings into experience and that is the reason why narrative (storytelling) is one of the core components used to improve the whole experience of the patient (Bate & Robert, 2006:308).

Experience is unique and special knowledge acquired through observation and storytelling. Knowledge is expressed through feelings, thoughts and what the patients say about the healthcare service (Bate & Robert, 2006:309). EBCD is about collecting that knowledge and using it to redesign the healthcare service for a better patient experience on a cognitive and emotional level (Bate & Robert, 2006:309).

3.2.3 Design process

EBCD is a patient-focused design process with the goal of making users' (patients') experiences of the service available to the designers so that the designers can design experiences rather than designing services (Bate & Robert, 2006:308). EBCD is an approach that improves the quality of healthcare through a combination of participatory and user (patient) experiences, design tools and processes (Springham & Robert, 2015:1). The key to change is moving away from the traditional mind set where patients were placed in the passive role of listening and responding to ideas generated by others (Lindqvist & Tishelman, 2016:22). The emphasis is the experience of the user (patient) and the patient needs to be at the centre of the design (Lindqvist & Tishelman, 2016:22). EBCD uses different methods to co-produce knowledge that is based on the experiences of the user (patient) and then used to co-design the healthcare process (Lindqvist & Tishelman, 2016:22). EBCD is becoming a popular research design to understand and facilitate change in healthcare services based on patient experiences (Palmer, Gunn, Herrman, Callander, Weavell & Furler, 2015:43). It is emphasised by Bate and Robert (2007:119) who pointed out that EBCD is a patient-centred not patient-led design due to the partnership between patients and healthcare professionals.

EBCD is a process that brings patients and healthcare professionals together in order to improve the quality of care (Donetto et al, 2015:237). It involves using the patients' and healthcare professionals' experiences to collaboratively plan and implement strategies to enhance patient-centred communication in the ED (Bate & Robert, 2007:119-120). It is grounded in the stories of patients' experiences of the healthcare service (Donetto et al, 2015:237). The golden thread of EBCD is the participatory approach in the co-design phase that improves the quality of patient-centred communication in the ED (Donetto et al, 2015:239). The patient becomes an equal partner in the design process and generates collective ownership by being part of the design process as a stakeholder to enhance patient-centred communication in the ED (Donetto et al, 2015:240).

The EBCD cycle consists of six stages: (1) setting up the project; (2) gather patient experiences through observation and narrative-based film interviews; (3) gather healthcare professionals' experiences through in-

depth interviews; (4) bring patients and healthcare professionals together in the co-design event and show a 12-minute edited film of patients' narratives – patients' experiences and identify priorities for change; (5) maintain co-design work in small groups formed around priorities for change, and (6) celebration and review event (Donetto et al, 2014:11). In this study, the researcher used the first five stages. Although the sixth stage will be done in the ED following the implementation of the suggested strategies for change, it did not form part of the study.

3.2.4   Rationale

The quality of patient experience is of central concern for delivering healthcare and improving the overall experience of healthcare (Ponsignon, Smart, Williams & Hall, 2015:460). According to Robert, Cornwell, Locock, Purushotam, Sturmey and Gager (2015:g7714) patients provide insights, ideas and wisdom urgently needed to improve the quality of care and make the patient an equal partner in change. In EBCD patients and healthcare professionals come together in a partnership and reflect on their shared experiences of the healthcare service in significant ways that improve the whole healthcare service experience for patient and healthcare professional (Robert et al, 2015:2). The quality of the patient experience influences patient outcomes and is the core building block of healthcare delivery (Ponsignon et al, 2015:461).

Using patients' subjective experiences is important to determine what works and what needs to be changed and how to implement the changes to enhance the quality of healthcare (Coulter, Locock, Ziebland & Calabrese, 2014:3). The way patients respond to illness, emotionally and the responsiveness of healthcare professionals to the patients has a direct impact on all the dimensions of healthcare and quality (Coulter et al, 2014:g2225).

Using EBCD has shown that the communication, inter-personal dynamics of care, and operational efficiency improve after changes have been implemented (Larkin, Boden & Newton 2015:1463). The aim is to provide not only quality healthcare but a good experience for patients as well (Rogers, Pickles, Hide & Maher, 2008:52). Patients have lives outside their illness and their knowledge, wisdom and expertise inside and outside of healthcare are available to the healthcare professionals to use to redesign the service (Rogers et al, 2008:57). EBCD is really about understanding the patient's experience, and involving the patient in the redesign of the healthcare service (Rogers et al, 2008:57). The ultimate goal is to create not just a service but a whole experience that attracts the patient on a cognitive and emotional level. The focus is to understand and appreciate how patients experience the healthcare they receive (Bate & Robert, 2007:31-32).

3.2.5   Advantages and challenges

The challenge with EBCD is to move from sharing an experience to getting concrete knowledge about that experience that might improve the patient's next visit to the ED (Bate & Robert, 2007:43). The core of EBCD is

that patients become partners with healthcare professionals and sit around the table and have a greater impact on feedback (Vennik, Van de Bovenkamp, Putters & Grit, 2015:7). EBCD results in innovative improvements because the active role the patients play and the way they express their experiences create a sense of urgency to act on the identified priorities (Vennik et al, 2015:13-14). Stories make visible the impact of already known problems on the patient (service user) (Vennik et al, 2015:13). Patient empowerment, opportunities for healthcare professionals' development, setting new standards in the quality of care delivered, and positive outcomes for both patients and healthcare professionals are among the benefits of EBCD (Boudioni, Hallett, Lora & Couchman, 2015:540).

In a survey done by Donetto et al. (2014:30) on the positive effects of EBCD on patients, the following was evident:

o   A voice is given to the patient and the patient feels listened to.
o   The way healthcare services are delivered to future patients is enhanced because now patients are part of the project to redesign the healthcare service.
o   Good patient-healthcare professional relationships are formed.
o   Patients understand the healthcare professionals' experience through storytelling which is a therapeutic experience for patients.
o   Patients feel empowered to be part of the co-design process.
o   Patients have the opportunity to get involved in other projects and training.

Donetto et al (2014:29) further found that the following are positive effects EBCD has on healthcare professionals:

o   Healthcare professionals developed a different perspective of the way they work and that leads to increased knowledge of the patient's journey.
o   Reminding healthcare professionals why they did what they did led to behavioural changes in the way healthcare is delivered to the patient.
o   Hearing the patients' voices had an emotional impact on the healthcare professionals.
o   Healthcare professionals' attitudes and how they listened to their patients changed.
o   Healthcare professionals were motivated and encouraged by receiving positive feedback from patients, on what they did well.
o   Healthcare professionals felt they were listened to and motivated to work more with patients in the future.

In the United Kingdom, Tsianakas et al (2012:2645) found that healthcare professionals' participation in EBCD gave them a sense of empowerment to make changes in the ED where they worked and delivered care to their patients. In their study, Larkin, Boden and Newton (2015:1463) found that healthcare professionals appreciated

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the opportunity to understand patient perspectives and work together to make changes to provide collaborative care in mental health. According to Donetto et al (2015:28), healthcare professionals developed accountability and responsibility after the EBCD project.

Patients participated in redesigning their own healthcare based on their actual experience of healthcare received (Rogers et al, 2008:51). The changes made with EBCD motivated patients and healthcare professionals to continue to make the experience of health care feel better (Rogers et al 2008:58). In EDs in New South Wales (NSW), Australia, EBCD resulted in significant improvements in patient satisfaction, learning opportunities for healthcare professionals, and effective patient involvement in the process (Robert et al, 2013:145). Furthermore, teamwork improved with better communication between patient and healthcare professional and between the healthcare professionals a culture of patient involvement was established (Robert et al, 2013:145).

Robert et al (2015:1) point out, however, that together with the advantages, EBCD also has challenges. For example, patient-healthcare professional conflict and tension may develop over the issue of power, or patients might be afraid to express their views and tell their stories because of previous experience of poor healthcare service (Robert et al, 2015:g7714). Furthermore, despite the concept of patient-centredness and patient involvement, many healthcare settings still do not give the patient a voice (Bate & Robert, 2006:307). For this reason, EBCD is an important design to change healthcare services. EBCD focuses on the positive and negative aspects of the healthcare service; the parts that work well need to be kept and replicated in redesigning the healthcare service (Rogers et al, 2008:57).

3.3   RESEARCH METHODS

Research methods are the techniques used to structure a study and to gather and analyse information relevant to the research questions (Polit & Beck 2012:741). The researcher used EBCD to structure the study in 5 stages, namely (1) Setting up; (2) Observe existing communication in the ED; (3) Engage patients and gather experiences; (4) Engage healthcare professionals and gather experiences, and (5) Co-design event (See Chapter 1, Figure 1.1). The research methods used for each of the five stages in the study are discussed in Sections 3.3.1 to 3.3.5, which were guided by the conceptual framework (See Chapter 1, Figure 1.1).

3.3.1   Stage 1: Setting up

Prior to commencing the study and stage 1 of EBCD, the researcher obtained permission and ethical approval from the University of Pretoria, the institution and the hospital (see Annexure A1, A2 and A3). The researcher made an appointment with the unit manager and the doctor in charge of the ED to introduce the study. A power point presentation was shown to the nursing staff working in the ED at the monthly unit meeting on 29 April 2016, and 37 nurses were present (see Annexure B). Consent was obtained from all the nursing staff for Stage 2 (see

Annexure C.1). The researcher invited the nursing staff to participate in Stage 2, 4 and 5 of the study. Specific dates and times to conduct the observation in stage 2 in the ED were negotiated and a poster put up in the ED with the planned observation times for transparency (see Annexure C.2).

The researcher showed a power point presentation to the four directors of the doctors' practice on 5 May 2016 to introduce the study (see Annexure B). The directors invited the researcher to show the presentation to the other 8 doctors working permanently in the ED at their next meeting on 20 May 2016 (see Annexure B). Consent was obtained during this meeting and all the doctors (12) signed the participant information leaflet (see Annexure C.1). The researcher invited the doctors to participate in Stage 2, 4 and 5 of the study.

3.3.2 Stage 2: Observe existing communication

Observation is the one activity of EBCD that is most frequently neglected (Donetto et al, 2014:23). One advantage of observation is that healthcare professionals actually see what really happens during the patient's journey through the ED. Healthcare professionals are not always aware of the patient's experiences during this ED journey (Donetto et al, 2014:23).

Observation was a valuable technique used to make the healthcare professionals aware of and helps understand the way communication in the ED was currently done. Observation is about using the senses to see and hear what happens at key points of the patient's journey through the ED and then record what was observed as well as what the observer thought and felt during the observation (The King's Fund, 2012:3). The researcher and a co-observer (healthcare professional that volunteer) observed existing communication in the ED for about four (4) to forty five (45) minutes, at various different times. The observations made the healthcare professionals aware of the existing communication in the ED and clarified whether the expected path was explained to the patient when entering the ED. Valuable data was collected during the unstructured observations.

3.3.2.1 Population

The population for this stage included all the healthcare professionals working in the ED.
The inclusion criteria were all the medical doctors and nurses permanently employed at the ED and working a minimum of 3 shifts per week in the ED.

3.3.2.2 Sampling

Purposive sampling as well as convenient sampling (Pollit & Beck, 2012:517) has been used (Pollit & Beck, 2012:517) to include healthcare professionals with different viewpoints and experiences. Unstructured observation has taken place during weekdays and weekends, when the ED is busy and then again when it is quiet (View Annexure C.2). Some of the unstructured observation has been in the day and others were done

during the night. The researcher did 10 sessions of unstructured observation before data saturation and redundancy was achieved, where no more new information was collected (Pollit & Beck, 2012:521). The researcher continued to do eight more unstructured observation sessions to ensure that no new data emerged. A total of 343 minutes of observation was done in the ED.

Table 3.1 Outlay of unstructured observation done in the ED

Observation	Date	Time	Timeframe	Co-Observer present
1	17 May 2016	07h14-07h42	28 min	Yes
2	17 May 2016	08h42-08h55	13min	Yes
3	17 May 2016	09h22-09h30	8min	Yes
4	17 May 2016	10h00-10h15	15min	Yes
5	19 May 2016	16h00-16h10	10min	Yes
6	19 May 2016	17h47-17h52	5min	Yes
7	18 May 2016	19h07-19h11	4min	Yes
8	18 May 2016	19h14-19h20	6min	Yes
9	20 May 2016	06h35-07h20	45mim	Yes
10	22 May 2016	11h12-11h25	13min	Yes
11	22 May 2016	11h45-12h10	25min	Yes
12	28 May 2016	14h30-15h00	30min	Yes
13	21 May 2106	21h00-21h10	10min	Yes
14	21 May 2016	21h24-21h50	26min	Yes
15	29 May 2016	06h30-07h00	30min	Yes
16	24 May 2016	21h00-21h20	20min	Yes
17	25 May 2016	03h20-03h30	10min	Yes
18	1 June 2016	18h30-19h15	45min	Yes
Total = 18 observations	11 different days	Several different times	Total minutes = 343	Total times co-observer present = 18

3.3.2.3 Data Collection

Data was collected to develop an understanding of how communication between patients and healthcare professionals happens everyday in the ED. Observation notes (See Annexure C.3) record what the observer's thoughts and feelings were about the communication between the patient and healthcare professional through recording senses; feeling, hearing, smell and what was seen. Observation focuses on the interactions of the patient and healthcare professionals and the process of communication (The King's Fund, 2012:3).

Unstructured observation was used to observe communication in the ED and was guided by the 7 steps as described by the King's Fund (2012:5-7):

• **Step 1:** The co-observers have taken part voluntarily with the researcher. Each co-observer has signed the participation leaflet and informed consent (see Annexure C.1) before unstructured observation has taken place in the ED. The researcher has explained all procedures and the co-observer could have withdrawn at any time from the observation.

- **Step 2**: The researcher has met with the co-observers (healthcare professionals that voluntarily took part in Stage 2) 15 minutes before scheduled unstructured observation in the ED to discuss the observation tool. The researcher and co-observer have brainstormed about what to observe relating to communication in the ED.

- **Step 3:** The researcher has negotiated the unstructured observation dates and times with the unit manager and healthcare professionals (co-observers). A notice has been placed in the ED, which was visible for all healthcare professionals to see which dates and times unstructured observation would take place for transparency (See Annexure C.2).

- **Step 4:** The researcher negotiated to ensure that the co-observers who volunteer for the unstructured observation sessions would do so in their off duty time, or come in a while before their shift start to not interrupt the healthcare services of the ED. The researcher conducted all the unstructured observation in the ED with several different co-observers.

- **Step 5:** Observation sheet for recording observations on has been used by the researcher and co-observers who volunteer to write notes (see Annexure C.3).

- **Step 6**: Ten (10) unstructured observation sessions were done in the ED for 4to 45 minute per sessions. See Annexure C.4 for example of observation notes done by researcher and co-observer.

- **Step 7:** The researcher has thanked the co-observers for their participation and invited them to the co-design event that has take place in Stage 5 (See section 3.3.5).

3.3.2.4   Data analysis

Analyse and interpretation of the data collected in this stage will be discussed in Stage 5, as part of the activities done during the Co-design event section 12.6, Chapter 1 and under 3.3.5, Chapter 3.

3.3.2.5   Hawthorne effect

The Hawthorne effect can be defined as the effect on dependent variable results from the subjects' awareness that the subject is a participant under study (Pollit & Beck, 2012:729). Hawthorne effect is the placebo-type effect caused by a person's expectations (Pollit & Beck, 2012:216). To overcome this source of bias the researcher could use methods of data collection where participants are unaware they are being observed, but that is not always possible especially when informed consent needs to be obtained (Brink et al., 2006:101). That is why unstructured observation, stage 2 has been done in the ED on different times by volunteers in the ED that does not require specific skills and equipment in the healthcare professional's daily working environment (Brink et al., 2006:102). The researcher and co-observers were wearing uniform to blend in and was standing out of the way and did not interfere with the patient care.

3.3.3 Stage 3: Engage patients and gather experiences

The researcher engaged with patients to collect and understand their experiences by means of narrative-based film interviews.

3.3.3.1 Narrative film-based interviews

"We grasp our lives in a narrative… Making sense of one's life as a story is not an optional extra. Our lives exist also in this space of questions, which only a coherent narrative can answer" (Charles Taylor, cited in Bate & Robert 2006:309). EBCD is based on the stories and storytelling of patients (Bate & Robert, 2006:309). Patients' stories form the structure, significance and sense of their experience (Bate & Robert, 2007:65). Patients share their experience and the key is to develop an appreciative understanding of the strengths and weaknesses of the healthcare facility and what is needed to redesign the service (Bate & Robert, 2006:309). Filming patients is time consuming but an important catalyst for improving healthcare (Robert et al, 2015:2). The narrative film is a persuasive starting point for change. Seeing and listening to patients' experience helps healthcare professionals to connect with them and identify and explore emotional touch points together to improve their experience (Robert et al, 2015:1). The purpose of patients' stories is to get at the *experienced reality* rather than the *real reality* (Dewar, Mackay, Smith, Pullin & Tocher, 2010:31). According to Dewar et al (2010:31) using emotional touch points as a method of tapping into the experience of receiving compassionate care in a hospital setting is vital.

Patients' stories tell the multi-layered texture, intensity and complexity of the experience they had in the ED and the meanings they attach to specific elements of care (Tsianakas et al, 2012:2). Storytelling is about recalling the healthcare received to reflect on these experiences and their impact on the individual (Rogers et al, 2008:53). Seeing the healthcare service through patients' eyes motivates and activates EBCD (Rogers et al, 2008:56). Hearing the patient's voice has an impact on the healthcare professionals, while seeing the patient's face (blurred for confidentiality) and hearing the voice makes a difference to the healthcare professionals (Donetto et al, 2014:22). The difference is in seeing the patient because it is not written down so it is not just words that the healthcare professional is reading but peoples stories they are seeing that means so much more (Donetto et al, 2014:22).

3.3.3.2 The patient's story

"Fill your life with experiences, not things. Have stories to tell, not stuff to show." – Unknown

Knowledge and experience kept by the patient is unique and priceless (Bate & Robert, 2006:307). The aim of improving patients' experience is partly to reduce suffering associated with care delivered because of healthcare service dysfunction; to train healthcare professionals to see patients as equal partners, and to support patients to

maintain autonomy and give them a voice (Cornwell, 2015:11). Understanding the patients' perceptions (stories) and informing them leads to patients becoming equal partners with their healthcare professionals that contributes to higher quality care and lowered costs (Bergman et al, 2015:29). The researcher gave the patient participants a voice and the opportunity to tell their story about their experience in the ED relating to communication, through filmed narrative interviews.

3.3.3.3   Population

The population for this stage includes priority 2 and 3 patients that seek emergency care at the hospital but was not admitted in the hospital after following their management in the ED but rather discharged home. .
The inclusion criteria was:

• patients who volunteer to participate,

• are 18 years and older,

• speak and understand English,

• has a Glasgow Coma Scale of 15/15 at the time of discharge and

• discharged from the ED following treatment.

3.3.3.4   Sampling

The sampling method in stage 3 was purposive sampling (Pollit & Beck, 2012:517). The aim was to provide a maximum variation sampling to ensure inclusion of a wide range of patients with different viewpoints. Patients that was willing to participate in the project, and to take the lead together with the healthcare professionals to work together on the priorities for change in Stage 4 (See Chapter 1, Figure 1.1). The researcher has interviewed approximately 12 patients after which data saturation and redundancy was achieved (Pollit & Beck, 2012:517). The patients shared and reflected on their experiences while they told their stories.

3.3.3.5   Data collection

The researcher gathered patient experience through narrative-based film interviews, to capture patient experiences (Donetto et al., 2014:22). The purpose of the narratives was to compile a film that illustrates the 'touch points' experienced by patients during their journey in the ED (Tsianakas et al., 2012b:2-3). The filmed narrative interviews happened after the patient was discharged and lasted less than 20 minutes with consented patients. Semi-structured interviews were used and patients were encouraged to tell their stories (Pollit & Beck, 2012:537) and share the experiences they had in the ED associated with communication. The filmed stories was edited by the researcher with the inputs of her supervisors (experienced researchers) to form a 12 minute film that reflects all the key touch points of the ED about patient-centred communication. The film (with facial blurring) was shown to all the patients and healthcare professionals at the Co-design event during stage 5 (See 3.3.5).

Patients who meet the inclusion criteria was identified while still in the ED by the researcher and the patient was approached and the value of the research, to improve patient-centred communication in the ED, was explained to the patients. Almost all the patients that were approached were willing to participate and like the idea of being given a voice. A patient information leaflet was given to the patients that were approached to read while they still received treatment, explaining the purpose of the research study. When the patient was discharged out of the ED and once the patient agreed to participate, the patient was take to a private room with comfortable chairs where some refreshments was served before the interviewed was filmed. The researcher was conducting the narrative-based film interviews alone with the patients, to ensure confidentiality of the patient. Before the interview, informed consent was signed and participant questions were answered. The patient was also informed of their right to terminate the interview at any stage.

Patients were informed of the Co-design event planned with the healthcare professionals, which is stage 5 (Fig 1). The date, time, venue and length of the joint event (about 3 hours) was given to the patients together with a formal invitation to invite them to come and participate in the co-design event (See Annexure D.3). The aim of the event, to collaboratively identify priorities of change to move towards a patient-centred communication in the ED, was explained to the patients.

Interview guide: Patient

After the researcher did two pilot interviews, the questions was changed to make it more understandable for the patients as the use of less medical terms was suggested to make the questions more user friendly and understandable to the patients as laymen. The researcher used one main question and several probing questions to ensure that the data collected was a true reflection of the patients' experience. The main question was (see Annexure D.2):

- Tell me about your experience as a patient in the ED, relating to communication.

Examples of the probing questions used were:

- Did you understand what is your Triage colour? And was the triage process explained to you?
- Did the nursing staff and doctors explained and told you about you treatment and the reasons for it, for example why did you get a drip?
- Did you go for x-rays and why?
- Did they draw blood and did the doctor explain why it is necessary?
- Do you know what is wrong with you and what are the orders when you go home now?
- Is there anything that needs to be improved in the ED relating to communication?
- Any suggestions to improve the experience in the ED?

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3.3.3.6   Data analysis

Analyse and interpretation of the data collected in this stage will be discussed in Stage 5, as part of the activities done during the Co-design event section 12.6, Chapter 1 and under 3.3.5, Chapter 3.

3.3.3.7   Patients response and interaction before the Co-design event

Short explanations are given about the patient's response and the interaction before the Co-design event. In another study done patients have different thoughts about the importance to participate in healthcare activities with the aim to improve the patient's experience and there are a lack in understanding patient participation and the factors that facilitate the process (Drach-Zahavy & Shilman, 2015:137) . Patients that take part and participate in such a co-design event must take responsibility and play an active role. Do personality traits of patients link to patient participation? The presence of healthcare professionals for example the unit manager and a doctor directors influence patient participation at a Co-design event (Drach-Zahavy & Shilman, 2015:137) ?

- When the researcher started with Stage 3, three patients was identified in the register and the researcher phone them. All 3 patients were interested and give permission that researcher could sent an email with information about the study. Of the 3 only 1 lady replied in an email and said she was unfortunately too busy to take part in the study.

- Another 2 patients were identified on a Sunday, the one patients was interested in the interview but no the event because she was working. The researcher emailed both patients and got no reply from them. The researcher phoned the other lady 2 days before the event and she said she was definitely coming to the event, but she did not come.

- The researcher emailed another 5 patients after been approached in the ED and not one replied via email. The researcher phoned all 5 patients 2 days before the event, 2 did not answer and the other 3 said either they stay too far from the hospital and other patient said her employer can't give her off work and the other patient was still sick in bed.

- Three of the patients that participated in the video was phoned 2 days before event and they both said they were working and can't get off at the work, but would like to come to the event and the 3rd patient got his final injury on duty report.

- There were 2 patients that had a bad experience in the ED, I contact them twice and sent an email but got no response back from them after the email. When I contact them again, 2 days before the event, 1 said she was interested in the event but unfortunately were working.

- Three patients were identified by the researcher 3 days before the event in the ED and was invited to the event, the researcher email and sent an sms the day before the event, the researcher got no reply and the patients did not come to the event.

- Of the 8 patients that did the interview, all was emailed a week before the event and the researcher phone all 8 patients 3 days before the event and all confirm they will come to the event. The researcher sent a sms

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the day before the event as a reminder of the event. Just one patient phoned the morning of the event and apologise and said there is a crisis at work. But the other patients did not come to the event.

• The researcher contacted another 2 patients that was in the ED 2 weeks ago, 3 days before the event, the purpose of the event was shortly explained and emails was sent and the 2 patients replied by Thursday to confirm they will attend the event on Friday.

3.3.4   Stage 4: Engage healthcare professionals and gather experiences

In this stage the researcher interviewed the healthcare professionals. The aim of interviewing the healthcare professional participants was to understand their experiences of delivering healthcare to patients in order to co-design more patient-centred communication in the ED.

3.3.4.1   Population

The population for this stage includes all the healthcare professionals working in the ED. The inclusion criteria were the medical doctors and nurses permanently employed and working a minimum of 3 shifts per week in the ED.

3.3.4.2   Sampling

The sampling method used in stage 4 was purposive sampling to purposeful attempt (Pollit & Beck, 2012:517) to include healthcare professionals with different viewpoints and experiences in the study. Healthcare professionals' core experiences in the ED about patient-centred communication has been captured and used as data to provide valuable input to form priorities for change. The researcher did 15 interviews with the healthcare professionals. Data saturation and redundancy was achieved (Pollit & Beck, 2012:521) after 10 interviews, but the healthcare professionals approached the researcher and wanted to share their experience in the ED relating to communication, which led to the researcher doing 5 (five) more interviews.

Table 3.2 Summary of the semi-structured interviews with healthcare professionals

Interview	Healthcare professional	Date	Time	Timeframe
1	Trauma Trained RN	8 June	14h00	22min35sec
2	Trauma Trained RN	8 June	16h30	11min51sec
3	Doctors	9 June	16h34	28min31sec
4	Doctor	23 June	14h00	9min25sec
5	RN	23 June	14h20	9min26sec
6	Doctor	23 June	8h10	6min01sec
7	RN	13 June	10h06	6min11sec
8	Unit Manager	13 June	15h10	17min09sec
9	RN	14 June	11h07	10min52sec
10	Doctor	24 June	11h15	19min18sec
11	Doctor	22 June	11h30	20min01sec
12	Trauma Trained RN	22 June	8h00	13min51sec
13	Doctor	18 June	10h05	14min10sec
14	Enrolled Nurse	19 June	11h00	07min57sec
15	Trauma Trained RN	23 June	06h10	24min17sec

Total:
Interviewed 15 Healthcare professionals
         9 nursing staff
         6 doctors
Total time of interviews:
         221 minutes 58 seconds (3 hours, 41 minutes and 58 seconds)

3.3.4.3 Data collection

Semi-structured interviews were used to collect the data (Pollit & Beck, 2012:731). A list with probing questions has been used, the healthcare professionals had the freedom to tell their stories and experiences as they want to (Pollit & Beck, 2012:537). The questions asked provided a rich description of the healthcare professionals' experiences of patient-centred communication in the ED and how to improve patient-centred communication.

The researcher have asked the volunteers who took part in the semi-structured interviews to also be part of Stage 5 (See Chapter 1, Figure 1.1) during the Co-design event with the patients (Donetto et al., 2014:12). A healthcare professional information leaflet (Annexure E.1) has been handed out with the questions that will be covered in the interview, the length of the interview and the aim of the interview. The healthcare professionals have been reminded about their interviews a day before the agreed time. The interviews were between 6minutes to 28 minutes long. Interviews have been held at times and dates that suits the healthcare professional. The venue was the hospital and most interviews happened before or after the healthcare professional's shift, or when not on duty and therefore did not interfere with the healthcare professionals' daily activities or duties. Before the healthcare professional's interview, informed consent has been signed and questions was allowed. Healthcare professionals could terminate the interview at any stage, but all 15 participants finished their interviews. Interviews have been in a private room with comfortable chairs and some refreshments have been served. Interviews have been audio-recorded on an audio recorder that has been placed out of sight as to not intimidate the participants (Pollit & Beck, 2012:542). The questions asked by the researcher were guided by The King's Fund (2012) and was included in the interview guide (view Annexure E.2). All the healthcare professionals working in the ED was invited to the Co-design event and an invitation was handed out by the researcher (See Annexure E.3) to all the healthcare professionals working in the ED.

Interview guide: Healthcare professionals

The researcher used one main question and several probing questions to ensure that the data collected was a true reflection of the healthcare professional's experience. The main question was (see Annexure E.2):

- In your experience, how do healthcare professionals communicate with patients?

Examples of the probing questions used were:

- In your experience, do healthcare professionals involve the patient during:
  Triage, management, diagnostic tests, discharge?
- Share positive experiences relating to communication with patients in the emergency department.
- Share experiences that could be improved on relating to communication with patients in the emergency department.

After the 3ʳᵈ doctor's interview, the participant made a comment about Injury on duty patients being treated differently in the ED. Then the researcher added a question.

- In your experience how do healthcare professionals treat Injury on duty patients, any different from medical aid or private paying patients?

An example of one healthcare professional interview that has been transcribed, see Annexure E.4

3.3.4.4   Data analysis

Analyse and interpretation of the data collected in this stage will be discussed in Stage 5, as part of the activities done during the Co-design event section 12.6, Chapter 1 and under 3.3.5, Chapter 3.

3.3.5   Stage 5: Co-design event

The 'co' can be defined as an action that happens together or mutually between patients and healthcare professionals. Co-design is also sometimes referred to as patient participation and patient involvement (Vennik et al, 2015:2). "Co" suggests a shared leadership between the patient and healthcare professional (Bate & Robert, 2006:308). According to Vennik et al (2015:2) co-design in healthcare is patients contributing to the delivery of healthcare services as equal partners with the healthcare professionals (Vennik et al, 2015:2). Co-design refers to patients and healthcare professionals working together in a partnership to improve the healthcare services while still retaining the breadth of perspectives that each party brings to the table (Springham & Robert, 2015:2). The patients and healthcare professionals reflect on their experiences of the service and then work together to identify touch points (improvement priorities), implement the changes and have a celebration event and reflect on their achievements (Springham & Robert, 2015:1).

This concept is receiving increasing attention to improve the quality of care through the involvement of both patient and healthcare professional in the design of healthcare delivery (Vennik et al, 2015:2). Until the 1980s the traditional model of healthcare service was characterised by healthcare professionals who were exclusively responsible to design and provide high quality healthcare to patients (Vennik et al, 2015:3). Passive patients trusted that healthcare professionals would practise according professional ethics (Vennik et al, 2015:3). Today

patients are asked to participate actively in their healthcare by interacting with the healthcare professionals and be policy makers (Vennik et al, 2015:4). In healthcare today patients share their experiences in order to improve the quality of care and active patient involvement is a priority (Vennik et al, 2015:3). The co-design is not only to improve safety, functionality and quality of healthcare but rather to improve the whole interaction with it and how the patient feels or experiences it (Vennik et al, 2015:4). The aim is to make the whole experience of the healthcare delivered to the patient better (Vennik et al, 2015:4). Co-design projects bring a series of improvements and changes that lead to deeper, longer-term changes in attitudes and behaviours (Robert et al, 2015:1). The aim is not to make patients "design experts" but rather to use the special kind of first-hand knowledge that is experience (Bate & Robert, 2006:309).

The co-design process leads to an increased understanding of the 'other' (patient's and healthcare professional's) perspective that creates a broader cultural change in mindset and behaviours (Tsianakas et al, 2012:2645). The heart of EBCD is the sharing of experiences of both patient and healthcare professional that receive and deliver the care (Rogers et al, 2008:52). Co-design awakens patient participation in decision-making and leads to more information and participation leads to more effective and meaningful relationships.

The Co-design event was a joint event with participants who took part in Stage 2 and 3 and any other healthcare professional working in the ED or patients seen in the ED that volunteered (Donetto et al, 2014:11). See Annexure F.2 for the co-design event programme. All healthcare professionals working in the ED were invited to the Co-design event and received a formal invitation (see Annexure E.3). The event was held in the lecture room at the hospital and refreshments were served. The researcher set the date and time to suit most of the participants (patients and healthcare professionals).

3.3.5.1   *Key Touch points*

Key touch points are defined as that place and ways that patients and healthcare professionals come in touch with the healthcare received or delivered and how these interactions and engagements can be experience as positive or negative (Palmer et al., 2015:42). Key touch points can also be described as the interactions between the patient and healthcare professional, positive or negative, that both parties perceive as crucial to the whole experience of receiving or delivering care (Robert et al., 2015:1). Areas for improvement are identified through key touch points (Palmer et al., 2015:42).

The aim of the key touch points is to gather knowledge and design actions for change through a facilitated co-design process as part of EBCD (Palmer et al., 2015:42). Patient's positive and negative feelings regarding the service they received are strongly formed from their stories and are called key touch points (Paul Bate, 2007:120). These key touch points are then examined by both the patients and healthcare professionals to

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identify priorities of change. Once the priorities of change are identified it can be used for the improvement of patient-centred communication in the ED (Paul Bate, 2007:120).

The aim of the EBCD event was to understand the patient and healthcare professionals' experience of patient-centred communication in the ED in order to move towards patient-centred communication in the ED. The core of the EBCD was the co-design where the patient and healthcare professionals worked together as equal partners to identify priorities of change to enhance patient-centred communication in the ED (The King's Fund, 2012). The event highlight and opening move was the 12-minute film of the patient's stories. Healthcare professionals and patients collaboratively analysed the data and identified priorities for change in the ED together that needed to be addressed to co-design more patient-centred communication in the ED. There were 18 healthcare professionals and 2 patients present at the Co-design event on the 15 July 2016. Before the commencement of the Co-design event all the participants, signed the informed consent and questions was allowed. The participants could leave at any stage, the 2 patients left before Step 9 of the data analysis, while all 18 healthcare professionals stayed until the end.

3.3.5.2   Data analysis

In this research the creative hermeneutic data analysis method and steps as suggested by Boomer and McCormack (2010:644) was used to analyse the data:

Step 1: Data collected by means of the interviews with the patients as well as the healthcare professionals were transcribed verbatim and was clarified in this step by the researcher and the participants to ensure that there were no misinterpretations. The transcriptions were then used in step 2.

Step 2: The participants present at the Co-design event watched the edited 12-minute film (Annexure D.3) as part of the data collected and was asked to make notes on paper about their general impressions, thoughts and feelings pertaining to the video The 15 transcribed interviews and observation notes were handed out and participants read through all the data. Each participant was then asked to form general impressions, thoughts and feelings pertaining to the transcribed interviews and observational notes.

Step 3: Participants where then paired and two healthcare professionals paired with the patients, while the other healthcare professionals paired with each other. Each participant was asked to create a visual image – capturing the core idea of what they have read (transcribed data, observation notes) and seen (video).

Step 4: Each participant then shared their story with the co-participants (paired partner - Step 3), focusing on what their picture represents. The co-participants (paired partners) were asked to listen attentively and write down the main ideas. The role where then reversed and the process was repeated to allow all participants to tell the story their picture presented. This step created an opportunity to raise awareness amongst the participants regarding about the current communication in the ED.

Step 5: Using the creative images as a centre piece as well as the captured stories, the paired participants was asked to design as many touch points as possible.

Step 6: Participants were grouped into small groups consisting of four to five participants. An opportunity was given to each small group to discuss their touch points and create shared touch points that everybody agreed on. The touch points were then written on loose strips of paper and distributed amongst the members of the small group.

Step 7: The small groups then got together in a central point of the venue and every participant within a small group presented the shared touch points to the whole group by putting the strips of papers on the floor until all touch points were lay out.

Step 8: Through discussion touch points where group together and consensus was reached on the final touch points (and categories). The final touch points were representative of all the identified touch points by the smaller groups.

Step 9: Each participant was asked to note down only three strategies on separate sticky notes that could be implemented to enhance patient-centred communication in the ED. The participants were given a chance to display their strategies under the applicable touch points their strategy aimed to address. (Boomer & McCormack, 2010:644) . The participants identified Three (3) key touch points (see Chapter 4, section 4.2).

3.4   Ethical considerations

The researcher upheld the ethical principles of the *Belmont Report* (1979). The Belmont Report endorses the principles of beneficence, respect for human dignity, and justice, and allows for the protection of participants in research studies. The 3 ethical principles will be discussed in the following section 3.4.1, 3.4.2 and 3.4.3.

3.4.1   Beneficence

This is the right to freedom from harm and discomfort (non-maleficence); the researcher used good clinical judgement (Brink et al., 2006:33) throughout all the stages. In Stage 2 when the researcher was doing unstructured observation in the ED (Brink et al., 2006:33) in such a way that it did not interfere with patient care and healthcare professionals could resume their normal duties. In Stage 3 and Stage 4 the narrative-based film interviews with the patient and interviews with the healthcare professionals was not harmful. In Stage 5 the researcher made sure there was no harm was done to the participants at the Co-design event (Brink et al., 2006:33). There was no psychological harm done to the participants at the Co-design event.

The right to protection from exploitation (do good), in Stage 2 and Stage 3 the researcher did not expose the patients to harm and the observation notes made was not used against the patient and/or healthcare professionals (Pollit & Beck, 2012:153). The researcher has structured the questions (Brink et al., 2006:33) in such a way that the patients could tell their stories and the researcher made the patients feel comfortable. The

researcher used good clinical judgement (Brink et al., 2006:33) when conducting the narrative-based film interviews with the patients to avoid psychological harm. The researcher did not expose the patients to harm and the stories the patients told were not used against them (Pollit & Beck, 2012:153) and participation was voluntary. The relationships that formed between the patient and researcher was not exploited and the researcher did not experience any conflicts that could have interfered with the healthcare of the patient.

In Stage 4 the researcher has structured the questions (Brink et al., 2006:33) in such a way that the healthcare professionals could tell their stories and feel comfortable. The researcher did not expose the healthcare professional to harm and the information the healthcare professional shared was not used against them (Pollit & Beck, 2012:153). The relationships that formed between the healthcare professional and researcher was not exploited and the researcher did not experience any conflicts that could have interfered with the healthcare professional delivering healthcare. In Stage 5 the researcher did not expose the participants to harm and the information the participants shared was not used against them (Pollit & Beck, 2012:153) .

3.4.2   Respect for human dignity

This included the principle of the right to self-determination that was applied in all the stages by the researcher.

In Stage 2 the healthcare professionals have signed the Participation information and informed consent document (See Annexure C.1) before the unstructured observation was conducted in the ED. The healthcare professionals had the right to ask questions and the right to withdraw from the study at any stage (Brink et al., 2006:32). There was no healthcare professional that withdrew or discontinued as participant during the study.

In Stage 3 the patients have signed the Participation information and informed consent document (See Annexure D.1) before the interviews. The patients voluntarily participate to take part in the narrative-based film interviews and were informed of their right to ask questions and the right to withdraw from the study at any stage (Brink et al., 2006:32). There were no patients that withdrew or discontinue the narrative-based film interview.

In Stage 4 the healthcare professionals have signed the Participation information and informed consent document (See Annexure E.1) before the interviews. The healthcare professionals voluntarily participate in the semi-structured interviews and had the right to ask questions, as well as the right to withdraw from the study at any stage (Brink et al., 2006:32). There was no healthcare professional that withdrew or discontinued the interview. In Stage 5 the participants have signed the Participation information and informed consent document (See Annexure F.1) before the Co-design event. The participants voluntarily participate in the data analysis and identifying of strategies. The participants had the right to ask questions and the right to withdraw from the event at any stage (Brink et al., 2006:32). The two patients left the Co-design event before the strategies were identified.

The right to full disclosure was done by the researcher throughout all the stages. In Stage 1 the researcher introduced the research to all the healthcare professionals (see 3.3.1). The researcher explained in detail the benefits and possible implications of the study to all the healthcare professionals before signing the Participation information and informed consent document (See Annexure C.1). *The right to full disclosure* was done by the researcher in Stage 3 when the researcher introduces the research to the patients. The researcher explained more in detail the risks and benefits of the study as well as the procedure that would be followed during the interview to the patient before signing the PIL (See Annexure D.1) and the patient had the right to withdraw from the study at any time. In Stage 5 the researcher explained the Co-design event's agenda (See Annexure F.2) to all the participants on the day of the event and also when the researcher invited the patients and healthcare professionals to the Co-design event.

3.4.3   Justice

The right to fair treatment was adhered to by the researcher throughout all 5 (five) stages.

In stage 2 (see 3.3.2) the researcher kept to the agreements made with the healthcare professional regarding the observation sessions like the time negotiated to do observation and not interfering with patient care. In Stage 3 (see 3.3.3)*, the right to fair treatment* was adhered to by the researcher by selecting the patients fairly. The researcher has treated all the patients equal (Pollit & Beck, 2012:156). The researcher did not exploit patients who were unable to protect their own interest (Pollit & Beck, 2012:155). The researcher kept to the agreements made by the patient and end the narrative-based film interview in the agreed time. In stage 4 (see 3.3.4) the researcher selected the healthcare professionals with fairness. The researcher has treated all the healthcare professionals equal even those healthcare professionals that refuse participation (Pollit & Beck, 2012:156) . The researcher kept to the agreements made by the healthcare professionals and end the interviews in the agreed time. In Stage 5 (see 3.3.5) the researcher has treated all the participants equal at the Co-design event (Pollit & Beck, 2012:156) . The researcher kept to the agenda of the Co-design event and the event finished on time. The researcher provided refreshments as indicated on the invite that was handed out to the patients and healthcare professionals (See Annexure D.3 and E.3). The researcher has shown respect towards all the participants with different backgrounds, values and beliefs and different opinions throughout the research project (Pollit & Beck, 2012:156).

The right to privacy was applied by the researcher. The researcher has ensured patients and healthcare professionals' privacy by keeping information collected confidential (Brink et al., 2006:34). In Stage 2 (see 3.3.2), after the unstructured observation the observation notes have been kept confidential by the researcher and have been used at the Co-design event. All the names and ranks of the healthcare professionals have been covered by blank stickers to maintain confidentiality and privacy of the healthcare professionals (see Annexure C.4). In Stage 3 (see 3.3.3), after the narrative-based film interviews were done, the video material has been kept

confidential by the researcher and has used the data in the 12 minute film. Facial blurring of the film has been done to protect the patient and keep the confidentiality of the patient (See Annexure D.4). In Stage 4 (see 3.3.4), after the healthcare professionals' interviews, the data has been kept confidential by the researcher and has been used to transcribe the interviews with no names or ranks that appeared on the hard copies of the transcriptions.

3.5   TRUSTWORTHINESS

Trustworthiness is "the degree of confidence qualitative researchers have in their data, and is assessed using the criteria of credibility, dependability, Confirmability, transferability, and authenticity" (Polit & Beck 2012:584).

3.5.1   Credibility

Credibility refers to confidence in the truth of the data and interpretations of them (Polit & Beck, 2012:584-585). Qualitative researchers must strive to establish the truth of the findings for the particular participants and context of the research. Credibility is one of the most important factors to ensure trustworthiness by making sure that the study measures what was actually intended and that the findings are congruent with the reality (Shenton, 2004:63). In this study, the researcher used three strategies to ensure credibility, namely 1) showing the 12-minute film (that enhanced the believability of the patient's experiences and highlighted their touch points); 2) transcribing the health care professionals' interviews, and 3) analysing the data collaboratively in the co-design event and identifying priorities by the patients and healthcare professionals.

It is important to develop familiarity with the culture of the ED early before data collection. Brink et al (2006:118) recommend prolonged engagement with participants to establish rapport and a trusting relationship and develop an understanding to ensure that the data are not misconstrued. The researcher established rapport with the participants and they felt free to tell their stories and share their experiences because there was no right or wrong answer (Shenton, 2004:67). Participants had the right to withdraw from the study at any point without explanation (Shenton, 2004:67). The researcher did 'reflective commentary' to establish credibility by recording her impressions after each data-collection session and theories formed, especially after each observation session (Shenton, 2004:68).

Data accuracy was checked 'on the spot' and at the end of data collection by asking the participants to view the film in which they had participated to verify that their words reflected what they actually meant (Shenton, 2004:68). A thick description of the phenomenon under study was an important part to promote credibility because without this information it would be difficult to determine the extent to which the overall findings "ring true" (Shenton, 2004:69). The researcher conducted a vigorous literature review to determine whether the study's results concurred with other EBCD studies (Shenton, 2004:69).

Triangulation helps to capture a more complete and contextualised representation of the central phenomenon (Polit & Beck, 2012:590). In this study, the researcher used triangulation for data collection by selecting multiple methods, namely unstructured observation, narrative-based film interviews, and semi-structured interviews, to converge on an accurate representation of the reality (Polit & Beck, 2012:745). The aim of triangulation is to "overcome the intrinsic bias that comes from single-method, single-observer, and single-theory studies" (Polit & Beck, 2012:590). Triangulation helps to capture a more complete and contextualised representation of the central phenomena (Polit & Beck, 2012:590). The researcher made use of time, person, data and method triangulation.

o *Time triangulation* involves collecting data on the same phenomenon at different times (Polit & Beck, 2012:590). Time triangulation involved unstructured observation at different times, over the weekend, in the week, when the ED was busy and when it was quiet (see Annexure C.2). Person triangulation was used to validate data through participants' (healthcare professionals and patients) different perceptions of and perspectives on communication in the ED (Polit & Beck, 2012:590). Data was collected from different types and levels of people to validate data through multiple experiences of people under study (Polit & Beck, 2012:590). In this study various healthcare professionals were interviewed, namely doctors, trauma trained RNs, RN's, EN's and the unit manager, to obtain different experiences. In addition, the patients were different ages, cultures and races (see Annexure D.3).

o *Data triangulation* is the use of various data sources to confirm conclusions. The data sources in this study included the literature reviewed, and the participants (healthcare professionals and patients) who were interviewed. The use of supporting documents to provide a background to the study was also part of triangulation. The patient surveys of the hospital helped the researcher to identify a problem in the ED.

o *Method triangulation* involves various methods of data collection about the same phenomenon under study (Polit & Beck, 2012:590). In this study data was collected through unstructured observation in the ED and interviews with patients and healthcare professionals to obtain their stories about their experiences in the ED, and develop an understanding of the communication in the ED. The advantage of using different methods for data collection is that it compensates for each method's limitations and exploits the respective benefits (Shenton, 2004:65). The patients and healthcare professionals' stories were individual experiences and perspectives, which created a rich, clear picture of the needs and touch points in the ED (Shenton, 2004:66).

3.5.2 Dependability

Dependability is the reliability of data over time, meaning that a repetition of the study with similar participants, in a similar context and in a similar setting would produce the same findings (Polit & Beck, 2012:585). Dependability refers to the stability of data over time and conditions. In this study, dependability was obtained by overlapping of methods, namely observation, narrative-based film interviews and semi-structured interviews. Moreover, the researcher ensured dependability by reporting the study in detail so that another researcher can repeat the work and have the same results (Shenton, 2004:71). Finally, the researcher reflectively appraised the study to evaluate its effectiveness (Shenton, 2004:72).

3.5.3 Confirmability

Confirmability refers to the objectivity of the data, meaning there was congruency between the patients' and healthcare professionals' information provided through in-depth interviews (Polit & Beck, 2012:585). Triangulation was used to reduce researcher bias and to promote Confirmability by unstructured observation; narrative-based film interviews, and semi-structured interviews. The findings reflected the participants' experiences.

3.5.4 Transferability

Transferability refers the descriptive information that the researcher provides to make it possible to extrapolate the findings to another setting or group. Transferability shows how the concepts can be applied in another healthcare organisation (Polit & Beck, 2012:525). The results of the study need to be understood in the context and culture of the selected organisation with its particular characteristics. To determine how the findings are true of other participants and settings, similar studies should be done in different environments to add value (Shenton, 200470). At the same time, should other studies deliver different findings, it does not mean that this one is untrustworthy. It simply reflects multiple realities and appreciation and understanding for the reasons behind the results and may be useful to the reader (Shenton, 2004:71).

3.5.5 Authenticity

Authenticity has been achieved if patients and healthcare professionals' stories with emotion, feeling, language and experiences are the reality and delivered with truth and faithfulness (Polit & Beck, 2012:585). The patients' narrative stories reflected their experiences in the ED and provided a better understanding of communication in the ED regarding how patients experienced the communication. The interviews with the healthcare professionals portrayed the reality of their experiences in the ED. The co-design event described the participants' experiences and the collaborative insight gained improved the authenticity.

3.6   SUMMARY

This chapter discussed the research design and methods used in detail, including the population and sample, data collection, trustworthiness and ethical considerations. Chapter 4 discusses the co-design event (Stage 5) collaborative data
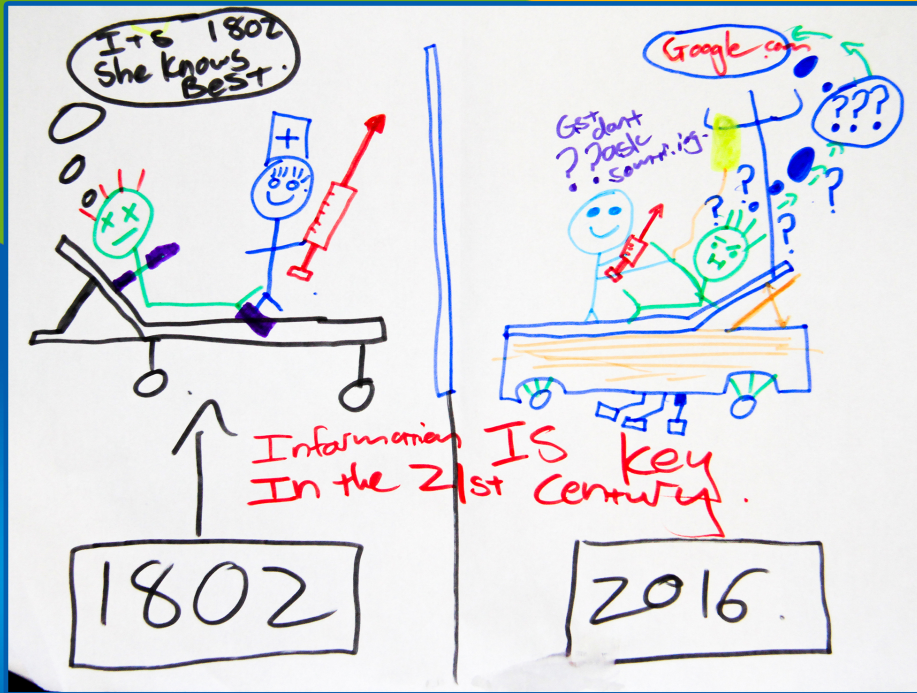
Illustration by participant at Co-design event, July 2016.

CHAPTER 4

DATA ANALYSIS AND FINDINGS

"We grasp our lives in a narrative… Making sense of one's life as a story is not an optional extra. Our lives exist also in this space of questions, which only a coherent narrative can answer." – Charles Taylor

4.1   INTRODUCTION

Chapter 3 described the ECDB research design and methods of the study. This chapter discusses the data analysis and findings as well as the strategies proposed to implement patient-centred communication in the ED. During the Co-design event the participants analysed the data and identified three key touch points, namely professionalism, communication and daily focus. The key touch points are discussed with reference to the literature review. The strategies suggested by the participants to enhance patient-centred communication in the ED are also presented.

4.2   OVERVIEW OF KEY TOUCH POINTS

The researcher collected data through unstructured observation, narrative-based film interviews, and semi-structured interviews. All the participants were invited to attend the Co-design event. The Co-design event took place on 15 July 2016 from 07:00 to 11:00 and 20 participants (2 patients and 18 healthcare professionals) attended.

Table 4.1 Participants at Co-design event

Participants		Number
Patients		2
Doctors		6
Nurses	Professional nurses, with experience in emergency nursing	4
	Professional nurses with an additional qualification in emergency nursing	6
	Enrolled nurses	2
	Total	**20**

Although 12 patients had expressed interest and willingness to participate, on the day of the co-design event only 2 attended. Phillips, Short, Kenning, Dugdale, Nugus, McGowan and Greenfield (2015:2618) state that achieving patient-centred care involves the potential and challenges that comes with the patient participating in a professional role. Patients' willingness to participate is a key aspect of EBCD, but their involvement in their healthcare is still a new concept. Phillips et al (2015:2616) found that many patients were of the opinion that healthcare professionals should realise that not all patients wish to be involved in their care, they might not have the required knowledge to be involved and being involved is time consuming. King and Hoppe (2013:389) point out that not all patients want to play a role in decision-making and not every clinical situation allows for a shared

decision-making approach. In retrospect this may be relevant in the ED environment. In this study, the Co-design event was held on a Friday morning (convenient for the health care professionals as part of their monthly in-service training session), which may have been inconvenient for the patients as most of them worked office hours from Monday to Friday. A Saturday morning might have been more convenient for the patient as they would then be having a rest day and would not have to complete leave from work to attend.

Key touch points refer to the key moments that shape the whole experience of receiving and delivering healthcare (Tsianakis et al, 2012:2640). According to Ziebland et al (2013:144) key touch points are the core experience that shapes the patient's and healthcare professional's overall experience of the healthcare service. Using the hermeneutic data analysis method, the participants' analysed the data during the Co-design event (see Annexure D.3 and E.3). The participants identified three key touch points to explore patient-centred communication in the ED, namely professionalism, communication, and daily focus (see table 4.2).

Table 4.2 Key touch points with categories and sub-categories

Key touch points	Categories	Sub-categories	Outcome
1. Professionalism	*Values*	Empathy	Patient-centred communication
		Respect	
		Patience	
	Quality care	Competence	
		Knowing yourself	
		Treatment	
	Time management		
	Team approach	Trust	
2. Communication	*Verbal language*	Introduction	
		Humanise	
		Reassurance	
		Explain processes	
		Layman's terms	
		Listen	
		Educate	
		Regular updates	
	Body language	Attitude	
		Eye contact	
		Facial expression	
		Pull up a chair	
		Touch	
3. Daily Focus	*Holistic approach*	Balance	
		Patient expectations and misunderstandings	
		Hidden truth	
		Participate	
		Consent	
	Consideration	Patient and family	
		Healthcare professionals	
	Privacy	Disturbances	
	Equality		

The three key touch points and related categories and sub-categories derived from the data will be discussed in Sections 4.3 to 4.5. Colour codes were used to indicate the source of the data that supported the key touch points. Purple represented unstructured observation; blue represented the patients' narrative-based film interviews, and green represented the healthcare professional interviews (see table 4.3).

Table 4.3 Depiction of colours used that represents the data

Colour	Data-collection technique
Purple	Unstructured observation
Blue	Narrative film-based interviews
Green	Healthcare professional interviews

4.3   KEY TOUCH POINT 1: PROFESSIONALISM

Professionalism is a key touch point in healthcare and a pre-requisite for patient-centred communication in the ED (Shahini, Sanagoo & Jouybari, 2012:4; Yu & Wright, 2015:790). Professionalism is emphasised by Shapiro, Nixon, Wear and Doukas (2015:2) as one of the six essential competencies in healthcare. Professionalism is the collection of behaviours that are responsible for trust amongst healthcare professionals, as well as between patients and healthcare professionals (Shahini et al, 2012:4). The authors continue to describe professionalism as qualities of competence, respect, and communication skills that healthcare professionals need to demonstrate to deliver quality care to patients (Sari, Prabandari & Claramita 2016:56). Communication skills of healthcare professionals' are a core quality of professionalism regardless of level of training (Sari et al, 2016:58; Turner, Mink, Lee, Winkler, Ross, Hornik, Schuette, Mason, Storgion & Goodman, 2013:455).

Effective communication is one of the main requirements of patients and promotes trust between patient and healthcare professional (Shahini et al, 2012:6). According to King and Hoppe (2013:386) to move towards patient-centred communication in the ED, healthcare professionals need to communicate effectively and be responsive to the patient's needs, values and preferences and should allow decision-making to be guided by the patient.

The participants identified four categories in professionalism, namely values, quality care, time management, and team approach. The categories and their related sub-categories will be discussed next.

4.3.1   Category 1: Values

The participants reached consensus that values are the core of professionalism. Value clarification is important to guide healthcare professionals to be professional and enhance patient-centred communication in the ED.

Quote to support the importance of Values:

- *"I (HCP) think the patient always come first. What is good for the patient must be given to the patient."* (Interview 9)

Rider, Kurtz, Slade, Longmaid, He, Ho, Pun, Eggins and Branch (2014:273-274) stress that values of effective communication are essential in healthcare delivery. Moreover, well-developed and clarified core values together with effective communication are essential in patient-healthcare professional interactions (Rider et al, 2014:273-274). Effective communication that is embedded in core values improves patient satisfaction and patient outcomes (Rider et al, 2014:273; Pretorius et al, 2010:47).

Effective communication together with core values, such as empathy and respect, improves health outcomes, quality of care and patient satisfaction (Rider et al, 2014:274; Pretorius et al, 2010:47; Riess & Kraft-Todd, 2014:1110). Empathy and respect convert communication from perceptions and feelings into actions by bringing those values to life and making them visible to patients through communication (Rider et al, 2014:276). Communication is an important clinical skill that needs to be adjusted in the way healthcare professionals' lives out values based on the individual needs, values and preference of the patient to become more patient-centred (Rider et al, 2014:278).

The participants in this study identified three (3) sub-categories relating to values, namely empathy, respect and patience.

4.3.1.1   *Sub-category 1: Empathy*

The data revealed that all the participants regarded empathy as an important value to effectively communicate with patients and enhance patient-centred communication in the ED.

Quote to support the importance of Empathy:

- *"A lot of quiet moments after patient answered… unsure what to ask or say… no empathy shown towards the patient by the sister (healthcare professional) and continue with questions…"* (Observation 3.2)
- *"Communication is professional, but not patient-centred. Patient remarked that she (patient) was in shock at one point, but no reassurance was given and no time allowed for her to tell her story…"* (Observation 3)

Wilson, Prescott and Beckett (2012:24) refer to empathy as "to see the world as others see it, be non-judgmental, understand another's feelings, and communicate the understanding". Wilson et al (2012:24) add that empathy is a characteristic of professionalism and has an element of respect for self and respect for others.

Communication skills including empathy are factors that are strongly linked with professionalism (Dyer, Owens & Robinson, 2016:6). The authors Derksen, Bensing and Lagro-Janssen (2013:e77) regard empathy as an important component of professionalism and the basis for patient-centred communication. Empathy plays a big role in building relationships and improves patient satisfaction (Duke, Frankel & Reis, 2013:362). Empathy in the patient-healthcare professional relationship improves mutual understanding and trust between the patient and healthcare professional and leads to treatment plans that involve that patient's needs and improve patient outcomes (Derksen et al, 2013:e80). By showing empathy healthcare professionals convey that they understand the patients' experiences, values and concerns, and communicate such understanding to them (Batley, Nasreddine, Chami, Zebian, Bachir & Abbas, 2016:1).

Taking time to listen to the patient, which is not currently practiced in the ED, is a key element of empathy and a value of professionalism (Wilson et al, 2012:2). Empathy as part of verbal and non-verbal communication is critical to achieve patient satisfaction and improve shared decision-making between the patient and healthcare professional (Riess & Kraft-Todd, 2014:1109). Empathy is the key to effective communication and creating a positive patient experience (Riess & Kraft-Todd, 2014:1110).

4.3.1.2 *Sub-category 2: Respect*

The participants identified respect as another core value of professionalism.

Quote to support the importance of Respect:

- *Irrespective how little problem the patient has, we (HCP) still have to respect them (patient), value them…"* (Interview 1)
- *'There is a lot of respect amongst the healthcare professionals. And friendliness is one of the good things…"* (Interview 2)
- *"For one respect, there is a lack. Between healthcare professionals, between the different ranks…"* (Interview 5)
- *"…and respect. Mutual respect and patient respect. I (HCP) mean we try to respect our patients."* (Interview 3)
- *"…I (HCP) would rank 98% in the way we communicate with them, because we show them respect."* (Interview 9)

King and Hoppe (2013:391) maintain that respect and trust need to be given back to the patient, to meet the patient's needs and to ensure better communication with the patients. One of the values of professionalism is respect, respect for others, using evidence-based care and focusing on the promotion of patients' best interests and trust.

Respecting patients' needs and values is central to the healthcare system and involving patients in decision-making is seen as respecting them (Abadel & Hattab, 2014:1). Improving the patient's experience is not just about caring; it is also about being cared for with respect (McConnell, McCance & Melby, 2016:38). According to Cuesta-Briand, Auret, Johnson and Playford (2014:6) respecting patients and colleagues are an important component of professionalism. This was also emphasised by the participants when one participant remarked that;

> • *"The other thing respect. That goes hand in hand with good communication. We have to respect each other, juniors, subordinates, colleagues, even the cleaner…"* (Interview 1)

Empathy and respect promote patients' satisfaction; improve adherence to treatment; are the cornerstone of a patient-healthcare professional relationship, and ultimately improve patient-centred communication in the ED (Wilson et al, 2012:1).

4.3.1.3   *Sub-category 3: Patience*

Patience as a value was identified by the participants to guide healthcare professionals regarding patient-centred communication in the ED. In this study, one participant indicated that the healthcare professionals were patient with her and she had a positive experience.

Quote to support the importance of Patience:
> • *"I am very happy with the staff and I even thanked them a lot because at that time you in pain, you need patience…"* (Patient 10)

Waiting is described as 'being patient' and 'showing patience' and, depending on the situation, can be experienced as either negative or positive (Burström, Starrin, Engström & Thulesius, 2013:9). Patience is a value that contributes to healthcare professionals' professionalism. Patients are unfamiliar and anxious when coming to the ED as well as concerned about their illness (Burström et al, 2013:9). Healthcare professionals need to be patient when communicating with their patients and give them information as well as the expected waiting time in the ED because well-informed patients are satisfied patients and will be less anxious (Burström et al, 2013:9).

4.3.2   Category 2: Quality care

The participants agreed that the second category of professionalism is delivering quality care to patients because quality care is associated with quality service delivery.

Quotes to support the importance of Quality care:

- *"…you (patient) are greeted with a smile, the doctors are friendly… I would say it is a quality healthcare facility."* (Patient 3)
- *"All I can say is I am happy with the service."* (Patient 9)

The focus of quality care is the relationship between the healthcare professional and patient that reflects professionalism (Sari et al, 2016:56). Patient-centredness and patient experience are central to quality assessment (Dyer et al, 2016:1). One visit to an ED may not meet the patient's expectations but positive experiences over a long period might lead that patient to recommend the ED (Dyer et al, 2016:7). Patients' experience plays a big role in quality care delivery.

Patients' perception of quality care at the ED is an important component in quality improvement strategies (Storm-Versloot, Vermeulen, Van Lammeren, Luitse & Goslings, 2014:13). The more satisfied patients are with their treatment and quality of care, the more likely they are to adhere to their treatment which, in turn, will lead to improved patient outcomes (Storm-Versloot et al, 2014:135). In the ED the waiting times influence quality care because patients' condition can deteriorate or they can become more anxious and worried, and experience discomfort and lack of care. Patients need to be cared for immediately to determine a diagnosis and commence treatment otherwise patient safety is at risk and may have an impact on the quality of care. Furthermore, overcrowding of the ED environment is a challenge that influences the quality of care delivered to patients (Burström et al, 2013:1).

Anhang Price, Elliott, Zaslavsky, Hays, Lehrman, Rybowski, Edgman-Levitan and Cleary (2014:524) examined the role of patients' experiences in measuring the quality of care provided. Quality improvements to enhance patients' experience might improve clinical quality and are part of patient-centredness (Anhang Price et al, 2014:534). The better the patient's experience of the ED, the better the patient's adherence to treatment and the better the patient' outcomes (Anhang Price et al, 2014:535). Patient-centred communication in patient-physician consultations is widely regarded as a key component of high quality health care (Epstein, Franks, Fiscella, Shields, Meldrum, Kravitz & Duberstein, 2005:1516).

The participants in this study identified three (3) sub-categories relating to quality care, namely competence, knowing yourself, and treatment.

4.3.2.1   *Sub-category 1: Competence*

Healthcare professionals need to be competent to be able to deliver quality care.

Quotes to support the importance of Competence:

- *Although light was switched off patient was left in dark and ask about the cause numerous times with no direct answer. Doctor spoke to staff in short sentences… staff unsure and question doctor…"* (Observation tool 7)

- *"The nursing staff is excellent…"* (Patient 8)

Quality service delivery is identified when healthcare professionals are competent. Competency is also related to communication (Spitzberg, 2013:e23). According to Spitzberg (2013:e23) communication competence is an impression of behaviour that is effective and appropriate related to individual motivation, knowledge, skills and constraints. Spitzberg (2013:e23) emphasises that good and effective communication leads to positive health outcomes and patient-healthcare professional relationships. In this study, according to participants,

- *"Patients relate communication skills with competency. And unfortunately how they (patients) see it and you (healthcare professional) market yourself by how you communicate with your patient, so if you not going to communicate, the patient has no way of knowing if you (healthcare professional) are competent or not."* (Interview 11)

- *"Doctors don't communicate properly with patients. They (Doctor, healthcare professional) will discharge patient on documentation, if you (Nursing staff, healthcare professional) tell patient that they are discharged, they (patients) have a lot of questions example prescription, what did blood test say and when do they need to come back…"* (Observation tool 17)

Good patient-healthcare relationships improve the patients' perception of the healthcare professional's competence (Sari et al, 2016:56). Effective, relevant and adequate communication leads to high quality care and healthcare professionals who are competent in their work (King & Hoppe, 2013:388).

4.3.2.2   *Sub-category 2: Knowing yourself*

Quality service can also be affected by how well you as a healthcare professional know yourself. Knowing yourself means not only having the knowledge about the treatment but also knowing your personal strengths and weaknesses.

Quote to support the importance of Knowing yourself:

- *"… you (healthcare professional) want to be part of the solution. You (healthcare professional) want to improve yourself, and first realise there is a problem and then want to be part of the solution."* (Interview 11)

The advantage of quality improvement is that healthcare professionals improve themselves as professionals and simultaneously improve patient outcomes (Walsh, 2015:e0034). Furthermore Walsh (2015:e0034) points out that another important component of quality care is a team approach. Quality improvement is part of teamwork; the healthcare professionals are members of the team to improve the quality of communication in the ED and also to improve themselves as healthcare professionals (Walsh, 2015:e0035). According to Dyer et al (2016:7) the patient's trust in the healthcare professional may influence the effectiveness of care and is perhaps a better indicator of quality than satisfaction. The participants agreed that it is important that healthcare professionals know what they are capable of in order to be trusted by patients and other healthcare professionals.

4.3.2.3   *Sub-category 3: Treatment*

Quality treatment means to deliver quality service to patients to improve patient satisfaction and better patient outcomes. Professionalism is about delivering quality care to patients and using evidence-based practice to improve the service delivery (Walsh, 2015:e0034).

Quotes to support the importance of Treatment:

- *"Patient re-assured. The sister (healthcare professional) inserts an iv (intravenous) infusion, introduce herself to the patient, explain the procedure, patient give consent and understand. Good communication among them, patient is laughing. That shows good care."* (Observation tool 14)

- *She (HCP) gave me the injection before I could fill in the form, because she said: it will ease the pain…"* (Patient 1*)*

- *"My experience was very good." (Patient 12)"… a lot of times, we (healthcare professional) will give them (patients) something for pain and don't specify… we are actually suppose to tell them a little bit more and elaborate on the side-effects…".* (Interview 6)
- *So we (healthcare professional) have to liase with each other and interact with each other, we are here for… core reason is patient care…Because if you don't communicate properly, there will be some loopholes, … medication is been prescribed but not executed. Then what happens, you delay the patient treatment times and make the patient stays longer unnecessarily…"* (Interview 1)

Patient-centred communication leads to patients' having more confidence and the likelihood of accepting evidence-based recommendations (Saha & Beach, 2011:390). The communication between the patient and healthcare professional influences quality care and is the most significant component of the healthcare visit (Duke et al, 2013:358). According to a participant,

> • *"The doctor that day took long and I was in pain… he was like he doesn't care… The nursing staff, they are nice, and the doctors, maybe they should improve somewhere..."* (Patient 13)

Addressing the patient's needs, values and preferences through understanding of the experience of illness will lead to the best treatment options for the patient (Barry & Edgman-Levitan, 2012:781). Shared decision-making, mutual understanding and the opportunity for the patient to participate in his/her treatment results leads to better adherence and patient outcomes (Epstein et al, 2010:1491). To deliver quality service with optimal treatment a patient-centred approach is essential to improve the healing patient-healthcare professional relationship (Epstein et al, 2010:1494). A good patient-healthcare professional relationship has intrinsic effects on healing (treatment) and thus improves patient outcomes (Duke et al, 2013:358).

4.3.3   Category 3: Time management

The participants all agreed that time management is a major part of professionalism and managing time in the ED is important to achieve patient satisfaction. Time spent with patients is a critical component of effective communication (Cuesta-Briand et al, 2014:4). In the ED however time is limited because of the busy and chaotic environment and it reduces the healthcare professionals' ability to communicate with their patients for long periods (Cuesta-Briand et al, 2014:4). Patient-healthcare professional relationships vary according to the volume of patients and the pressure to see as many patients as possible within a specific timeframe, which consequently leads to ineffective communication between patients and healthcare professionals (McConnell et al, 2016:41). Time therefore influences the healing relationship between the patient and healthcare professional.

Quotes to support the importance of Time Management:
> • *"25:40 seconds announced by registered nurse (healthcare professional) in charge of resus and staff (healthcare professional) congratulated on a job done well and fast*..." (Observation tool 1)
> • *"The patient is not given enough time to fully explain their symptoms… because the doctor will continue and assess the patient without them finishing their sentences…"* (Observation tool 16*)*

> • *They (healthcare professional) attend to me (patient) within 45 minutes."* (Patient 5)
> • *"I (patient) remember I sat here on one specific day and it was total chaos, and it was especially on a weekend, so it is total chaos… although that forms tell you, you can end up being seen after an hour…"* (Patient 4)

- *"Time equals poor communication…"* (Interview 3)
- *"I think we (healthcare professional) will communicate best when we have more time, where there is no rush. Time is our big fallout in communication…"* (Interview 3)
- *"Communication is equal to care. Care is equal to communication … but we (healthcare professional) can't chase time and say we communicated well with the patient or the family… care, communication and time are important..."* (Interview 15)
- *"When the unit is busy and you (healthcare professional) do the sort of pushing the meat type of thing, you say very little to the patient in terms of communication… where the unit is busy we get to fail this much in communication…"* (Interview 13)
- *"I (healthcare professional) think we try to communicate very efficiently with patients but I don't think we (healthcare professional) manage to do it properly. I think time is a big issue."* (Interview 10)

Time management is a core component of professionalism and is important for building relationships among healthcare professionals and patients (Nancarrow, Booth, Ariss, Smith, Enderbury & Roots, 2013:2). Healthcare professionals are pressured for time, and time is limited, which impacts on the effectiveness of communication (Derksen et al, 2013:e81). The ED is a stressful work environment and healthcare professionals are emotionally exhausted by their work environment (Person, Spiva & Hart, 2013:226). The stressful environment is aggravated by rapidly changing patient numbers, illness and injury severity, and patient activities and leads to a high amount of pressure and volume of work (Person et al, 2013:226; Johnston, Abraham, Greenslade, Thom, Carlstrom, Wallis & Crilly, 2016:7). Consequently, effective communication does not happen because of limited time spent with patients and this affects patient satisfaction and outcomes.

A busy or "overcrowded" ED has a big impact on the quality of care mainly because of inadequate communication, prolonged waiting times, prolonged delay in treatment of pain and suffering, and consequent patient and healthcare professional dissatisfaction (McConnell et al, 2016:38; Amina, Barrati, Sadeghifar, Sharifi, Toulideh, Gorji & Feazbakhsh, 2015:144). Healthcare professionals are task-orientated and focus on symptoms instead of the person as an individual and getting the patient out of the ED as quickly as possible (McConnell et al, 2016:38). The ED is fast-paced, high volume and not predictable and time is a factor for life-threatening and critical ill patients (McConnell et al, 2016:42).

Less critically ill/injured patients do not understand the delay in treatment when a critically ill/injured patient is attended to before them. Forsgärde, Attebring and Elmqvist (2016:32) found that patients come to the ED with the expectation of waiting but also expect to be told how long the waiting time will be. When they are not informed, they feel powerless. According to a participant,

- *"I (patient) was there for quite a while, I must say, for 3 hours... hhmmm… Maybe the time issue, I know that is a big issue, I understand they (HCP) are busy, but even when they were not busy with me… the bloods delay, x-rays all that obviously does delay the situation "* (Patient 12)

Patients want to be informed about the waiting times and the healthcare professional wants to get the patient out of the ED as soon as possible, therefore time management is an important component of professionalism to achieve patient-centred communication in the ED.

4.3.4   Category 4: Team approach

The participants agreed that a team approach is needed, to work as a team and also to communicate as a team to improve patient-centred communication.

Quotes to support the importance of Team Approach:
- "*Good communication, who is next with chest compressions. Once ETCO2 up, doctor stand by patient and gives feedback about quality of chest compressions…"* (Observation tool 12)
- *"Communication amongst nursing staff and doctor and each other clear and good…"* (Observation tool 1)

- *"There is a big misperception form the patient side they (patients) should actively participate in their own treatment…"* (Interview 10)
- *"…they (patients) must take responsibility... patient responsibility… then the patient will be part of the treatment, and the patient will be involved."* (Interview 3)
- *"… I just love the teamwork… we (healthcare professional) can handle patients in a short amount of time and pick up all the ends… teamwork is the best." (*Interview 14)

Working collaboratively within inter-professional teams is not just essential but critical to deliver quality care and patient-centred communication. A team approach is part of professionalism to improve patient-centred communication in the ED. The World Health Organisation (WHO) states that effective communication and teamwork can be achieved through a collaborate process described as "multiple health workers from different professional backgrounds working together with patients, families, carers and communities to deliver the highest quality of care" (Thomson, Outram, Gilligan & Levett-Jones, 2015:635). The participants agreed that collaboration is part of a team approach and requires values of professionalism, like competence, trust, respect for one self and respect for other healthcare professionals and patients (Nancarrow et al, 2013:2).

Healing patient-healthcare-professional relationships are the ideal team approach between the patient and healthcare professional (King & Hoppe, 2013:387). The patient is an equal partner and the healthcare professional is approachable and friendly and shows a caring attitude (King & Hoppe, 2013:387).

The participants in this study identified one (1) sub-category relating to team approach, namely trust.

4.3.4.1 *Sub-category: Trust*

Trust is part of a team approach, because it is important to trust each other. There must be trust between doctors, doctors and nursing staff, and the patients and the healthcare professionals.

Quotes to support the importance of Trust:

- *"Doctor X and doctor F were both giving orders and wanted everything done. We (nursing staff-healthcare professional) gave things and gave feedback to RN (Healthcare professional) in charge of resus but then still the doctor wanted to know if it was done."* (Observation tool 12)

Patients' trust in healthcare professionals is important because choices are made about the patients' treatment, with their partial knowledge (Dyer et al, 2016:4). Building long-lasting and trusting patient-healthcare professional relationships is important for listening to the patients' stories of illness (Derksen et al, 2013:e77). According to a participant,

- *"The days are long gone whereby the healthcare professionals knows what is best for the patient and forces upon them. I think we should spent more time in communicating with the patient…* (Interview 4)

The patient-healthcare professional relationship needs to be focus on being holistic, collaborative and the patient needs to be put at the centre of care delivery, which is ultimately patient-centredness (McConnell et al, 2016:38). Healthcare professionals need to have a patient-centred approach, and work towards mutual understanding with patients to improve patient-centred communication in the ED (Dyer et al, 2016:6). To deliver safe, quality health care necessitates highly effective communication between healthcare professionals (Thomson et al, 2015:1). Building trust with patients by using effective communication skills is part of patient-centred communication in the ED (Sari et al, 2016:59). Trust between the patient and healthcare professional leads to patient engagement. According to a participant,

- "Communication between healthcare professionals and between the patients has increased and is better…" (Interview 5)

Patient engagement means patients should participate in their healthcare and decision-making. Involving patients in that experience improves patient satisfaction and patient outcomes (Phillips, Short, Kenning, Dugdale, Nugus, McGowan & Greenfield, 2015:2617). To achieve patient involvement patients need to actively participate by bringing their knowledge, skills and motivation to the table (Phillips et al, 2015:2617). Both patient and healthcare professional bring expertise to the table. Patients' expertise is their experience of illness, values and preferences. Healthcare professionals' expertise is their knowledge relevant to the diagnosis, disease, treatment options and outcomes. The end result is the management of the patient that takes into account the patient's values, needs and preferences and a successful outcome and establishes a trusting healing patient-healthcare professional relationship (Phillips et al, 2015:2617).

4.3.5 Strategies for key touch point 1: Professionalism

The participants suggested the following strategies for professionalism that could be implemented to enhance patient-centred communication in the ED every day:

- Be well groomed. Wear the following:
    - o Uniform
    - o Name tag
    - o Epaulettes (nurses only)
- Have the same look (uniform) for all staff (healthcare professionals – doctors and nurses).
- Maintain professionalism, no matter what; especially when the healthcare professional is feeling negative or down.
- Always be professional – what and how you communicate is who you are.
- Reinforce the nurse's pledge.
- Set daily and monthly goals for all these strategies and evaluate them.

The participants suggested the following strategies for the sub-categories of professionalism, namely values, quality care, time management and team approach that could be implemented to ensure that patient-centred communication happens in the ED every day.

For **values:**

- Treat all patients equally.
- Make a good first impression.
- Maintain a calm tone of voice.

For **quality**:

- Quality care should be our daily mind-set.
- To ensure the delivery of quality services and care– continuously educate and update yourself as a healthcare professional.
- Keep abreast of the latest information and do regular in-service training.
- Role play professional body language and professional communication
- Regular feedback needs to be given to the healthcare professionals regarding communication skills, improvement and experiences.
-

For **time management:**

- Regular unit rounds by a designated person to inform the patient about their expected journey in the ED and specify how long blood results will take before it will be available to the doctor etc.

For **team approach:**

- Socialise more regularly and get to know your colleagues better.
- Enhance and promote teamwork at all times.

4.4   COMMUNICATION

Patient-centred communication is essential to be more patient-centred in the ED (McCarthy, Buckley, Engel, Forth, Adams & Cameron, 2013:442). The demand for high efficiency and quality patient care is accompanied by a big demand for proper documentation that could lead to less time to communicate with patients (Füchtbauer, Nørgaard & Morgensen, 2013:1). The healthcare professional needs to understand, listen to, respect and care for the patient as an individual to improve patient-centred communication, because communication is vital in the ED (Sari et al, 2016:58).

Patient satisfaction is greatly influenced by communication, behaviours and interaction between the healthcare professional and the patient (King & Hoppe, 2013:386). Task-orientated behaviours, like active listening and providing detailed information, and affective behaviours, such as responding with empathy and addressing the patient's fears and concerns, contribute to patient satisfaction. At the same time, to achieve patient-centredness the following questions should be asked and answered:

- Did the patient understand?
- Was the information in line with the patient's values and beliefs?

King and Hoppe (2013:386) found that patients' generally want a patient-centred approach that will improve communication between them and the healthcare professional and also want the healthcare professional to:

- Explore the patient's ideas about the problem and take the patient's input seriously.

- Try to understand the patient as an individual and part of a family and how the illness will affect the patient's life.

- Tell the patient what is wrong in layman's terms.

- Involve the patient in decision-making, and seek common ground, to agree on the nature of the problem, priorities and goals of the treatment.

Communication is a skill that healthcare professionals use to diagnose and treat patients (Shahini et al, 2012:1). In a trilingual ED in Hong Kong, Pun, Matthiessen, Murray and Slade (2015:6) found that the core is to communicate effectively to deliver effective care to patients. A patient-centred approach includes effective communication and leads to a positive therapeutic alliance. Communication is not only what is said but also the manner or style in which the message is expressed thus a connection between verbal and non-verbal factors (Pinto, Ferreira, Oliveira, Franco, Adams, Maher & Ferreira, 2012:78).

The participants in this study identified two categories relating to communication, namely verbal language and body language.

4.4.1   Category 1: Verbal Language

Verlinde, de Laender, de Maesschalck, Deveugele and Willems (2012:1) define verbal language as the "spoken language". Emergency care relies a lot on the effective spoken communication between the patient and healthcare professional and often the importance of communication is downplayed (Chandler, Slade, Pun, Lock, Matthiessen, Espindola & Ng, 2015:2).

Quotes to support the importance of Verbal language:

- *"Doctor (healthcare professional) did introduce himself to patient and made eye contact and gave the patient a chance to explain his signs and symptoms…"* (Observation 15)

- *"… when you (healthcare professional) are in the front (at reception) and you show that smiling face, and you ask the patient what is wrong and you asked the relevant questions and I think that is how I convey my message…"* (Interview 2)

Verbal language refers mainly to open-ended questions and body language refers to facial expressions, gestures, eye contact, and attentive listening which are all important aspects in patient-centred communication (Pinto et al, 2012:78; King & Hoppe, 2013:386). Communication that is patient-centred involves seeing the

patient as an individual with an individual personal history and needs and consists of the following dimensions (Pinto et al, 2012:86; Verlinde et al, 2012:8):

- Biopsychosocial perspective that understands patients as individuals, their experience of illness, patients as whole persons.

- Power and responsibility sharing.

- Relationship based on care and empathy and a healing relationship between the patient and healthcare professional.

- Provide emotional support and respond to emotional cues.

In the ED a lot of human interaction takes place and an ED culture of effective communication plays a role in positive patient outcomes (Person, Spiva & Hart, 2013:222). Communication is critical in the ED (Person et al, 2013:225).

Under verbal language the participants identified eight (8) sub-categories namely introduction, humanise, reassurance, explain processes, layman's terms, listen, educate, and regular updates.

4.4.1.1 *Sub-category 1: Introduction*

Introducing yourself as the healthcare professional is part of verbal language. Identifying patients from the moment they come into the ED reassures them that this is what is going to happen throughout their ED journey and directing patients is important.

Quotes to support the importance of Introduction:

- *"Doctor went to see patient and he did introduce himself to the patient…"* (Observation 17)

- *"Patient wheeled into ED on a wheelchair… Nurse (healthcare professional) at triage made no eye contact and no introduction… insert information on the computer… "* (Observation 9)

- *"…patient lead to triage area then patient was unsure where to go… stood in the passage for about 1 minute…"* (Observation 6)

- *"Patient was not explained to of why is she being triaged… patient was not explained what will happen after triage and what will happen in the ED…"* (Observation 5)

- *"… they (healthcare professional) didn't explain the colour… the most important thing is the aim of the patients is to see the doctor…"* (Patient 4)

- *"… they did explain but I think I was in too much pain to understand but they did check my blood pressure and everything…"* (Patient 10)

- *"… I was scared like I didn't understand…"* (Patient 6)

- *"… they (healthcare professionals) triaged me and explained to me I was yellow and what does yellow mean…"* (Patient 7)
- *"… we (patient) didn't know where to go, they direct us to reception…"* (Patient 6)

- *"… from the door if the patients are greeted properly… telling the patients, reassure them and start reassuring them from triage to the bed… If you (healthcare professional) start reassuring them from triage the patient will understand why the doctor takes half an hour to come and see them (patient)… "* (Interview 10)
- *"We (healthcare professionals) identify them (patient) and ourselves when we go to them. We introduce ourselves. We don't just nurse them, without knowing our names and our ranks… "* (Interview 9)
- "… by welcoming them with a smile and greeting them, introducing yourself to them and then you can start by asking them how can we help them?" (Interview 1)

Patients come to the ED as strangers without readily accessible medical records or an established relationship with the healthcare professionals therefore introduction is important (Chandler et al, 2015:2). When healthcare professionals introduce themselves to the patients and orientate the patients to the ED, they are put at ease and that is a patient-centred approach (Chandler et al, 2015:7).

4.4.1.2   *Sub-category 2: Humanise*

In the chaotic environment of the ED it is vital to treat the patient not as a number but respect the patient as a person and apply the principle of humanisation. Effective communication and the manner in which one communicate are equally important.

Quotes to support the importance of Humanise:
- "*Nursing staff (healthcare professional) that are handing over the patients to nighstaff are diagnose specific, like patient in Bed 4 with abdominal pain… not using the patient's name*" (Observation 18)
- *"… no questions asked about the patient's preference on medication, the patient was so not involved in her treatment. The doctor was the decision maker and her decision was final…"* (Observation 10)
- *"Staff and doctors (healthcare professionals) refer to patient as Mr X in Bed 8, they do not know what is the patient's surname…"* (Observation 11)
- *"Everyone (healthcare professionals) speaking to each other, not to the patient… staff (healthcare professionals) asking one another for surname of the patient and not the patient … "* (Observation 1)

- *"… the doctor's reception staff must learn how to speak to people…"* (Patient 8)

- *"Because I think our unit logistically is not layed out for patient-centred communication, it makes it difficult. Because the staff is splitted in different areas and when a patient come into the unit we don't know what is wrong with the patient in Resus Bed 3 and we don't know what is in casualties Bed 3. So the book person tells you where it is, but we don't know has the person been to x-rays, and the family comes in, how can you not know. But they do not know the outlay of the unit. So definitely the layout of the unit makes it difficult…"* (Interview 8)

- *"… the basic of treating the patient, as a human and not as the next patient. I think is something we can all work on. And I think just that human factor; will already improve a lot of communication…"* (Interview 11)

- *"They (patients) arrive here they (patients) get allocated as a number; they (patients) get dehumanise by the triage process to a number. Now they (patients) get allocated a code, so we now digitising their (patients) problem … I have a firm believe that every person's emergency is their emergency. So they (patients) wouldn't come to the ED if they thought it was rubbish"* (Interview 11)

- *"… they should communicate with the patients nicely. It shouldn't just be like, they shouldn't just working like they are working on an object. Taking in consideration that the patient is also an human being, they got emotions and they got feelings…"* (Interview 1)

- *"They (patients) are not like an object they (patients) are a human being. You need to tell them (patients), 'listen mam the reason for turning you for me to see bruises at your back'… don't just go there and turn the patient. Because she is not an object it is a human being. We need to explain to them (patients), always everything that you do…"* (Interview 9)

Humanisation is a complex concept that consists of patient-healthcare professional relationships, effective communication, patient-centred physical environment and healthcare professionals' attitudes (Bosia, Marino & Peretti, 2016:33). The risk of losing the patient as a "human being" is high in the ED due to the chaotic environment (Lovato, Minniti, Giacometti, Sacco, Pialatto, Barberis, Papalia, Bert & Siliquini 2013:487). To not treat the patient as a number in the ED, but respect the patient as a person and apply the principle of humanisation is vital. In the triage area of the ED the patient's urgency is determined as quickly as possible according to the patient's condition and the patient is categorised accordingly (Chandler et al, 2015:6). Triage is basically the first encounter the patient has with the ED and sets the first impression of the type of quality care the patient will receive (Chandler et al, 2015:6). Communication tends to appear as if the healthcare professionals are working through a checklist, and are task-orientated and working at a fast pace (Chandler et al, 2015:6-7), and not in a humanised manner.

Healthcare professionals are task-orientated and do not always apply the principle of humanisation. Healthcare professionals need to refer to the patient as a person and not refer or see the person as a patient as the patient is a person with personhood that means human agency and authenticity (Miles & Mezzich, 2011:425). In patient-centred communication, the humanisation principle should be applied and healthcare professionals should see the patient as a person. Informing and directing the patient to the specific areas of treatment in the ED is essential for patient-centred communication in the ED. Healthcare professionals need to allow the patients to tell their story without interruptions, make sure the patients understand and that they are part of the treatment plan, and treat patients as human beings in the ED (King & Hoppe, 2013:387).

4.4.1.3   *Sub-category 3: Reassurance*

The participants identified reassurance as a sub-category of communication to enhance patient-centred communication but reassurance did not happen daily in the ED. Thus effective communication was lacking and patients were not reassured. Reassuring patients from the moment the healthcare professionals introduce themselves to the patients is vital for effective communication (King & Hoppe, 2013:387). Reassure patients about what to expect during their journey through the ED and what is going to happen.

Quotes to support the importance of Reassurance:

> • *"…sister (healthcare professional) explained to the patient there is no bed but she's going to make a plan and that she wants her to be comfortable when doing CTG… then if patient is on the bed the doctor will come see patient…"* (Observation 7)

> • *"… the nursing staff (healthcare professional) should in particular patients that have been long in the unit, always try to reassure them that the unit is busy, doctor will come and see you…"* (Interview 13)
> • *"… we can do it but it is a bit difficult, because what we do is we look at the time and we are more rushed in the moment, we don't spent much time with patients to get information or to reassure anything. We do the history, write and get done with it, so it will be in between to say we can try to be more in patients cubicles, hear what they want and what is it that we can do for them, are they satisfied, any information that they want to ask or any leaflets that we can provide to them. We can try to do that, but it's a bit difficult, it is not realistic, realistically it is not happening…"* (Interview 7)

Chandler et al (2015:9) found that patients want more information about their ED journey to relieve anxiety and reassurance about their expected path and the outcomes so that they are treated as partners in their healthcare.

4.4.1.4 *Sub-category 4: Explain processes*

Participants stated that healthcare professionals need to start explaining the process to patients in triage already. Although some moments of excellence where healthcare professionals explained procedures to patients, this was identified as still being a challenge at times in the ED.

Quotes to support the importance of Explain processes:

- *"The doctor (healthcare professional) explained the whole procedure to the patient and reassure the patient it would not be painful. The sister doing the dressing didn't explain what type of dressing she is doing but explained to the patient she needs to keep the toe closed till patient come back for follow-up…" (Observation 16)*

- *"… explained procedures to be done but not detailed… "* (Observation 13)

- *"In triage… no explanation given when vital data been done in triage… then the healthcare professional took patient out of triage on a wheelchair but did not explain what now and what is the expected path in the ED… the grandson of the patient that was triaged just now come to search for his grandmother and looked confused… he didn't know what is going on…"* (Observation 11)

- *"… wheel patient to room for triage… no explanation… do observations (vital signs)… no communication or explanation of what is happening… once vital signs done… explain that patient will now be seen in ED and that it will take about 45 minutes*... Doctor did not explain the treatment to the patient, he (healthcare professional) just written up the medication and chest x-ray without informing the patient…"* (Observation 9.)

- *"… the doctors (healthcare professional) explained what was going to happen, the tests they doing…"* (Patient 12)

- *"… she (healthcare professional) didn't go into detail to explain what specific bloods she just indicate she is going to draw my bloods…"* (Patient 4)

- *"… yes they (healthcare professional) did explain what are they going to give me and ask me many times if I am allergic to anything…"* (Patient 10)

- *"I don't think the results are properly explained to the patients, you just tell them 'your bloods like fine' but some of us don't tell the patient what bloods we doing, you tell them we doing infection markers but then you do kidney functions and liver functions, and we didn't really tell them, we just said; 'the bloods are fine'…"* (Interview 10)

- *"… explaining to them (patient) as soon as we (healthcare professional) got an empty bed available will take you in…. you already take history while the patient was waiting, the minute they come in, they are comfortable and just waiting to be seen by the doctor. So it should be driven in triage. More than any other place because it is where they start. So if it is not well driven there then automatically the patient is very much in tears, they rude to us and everybody and they start scolding and getting angry and just leaving without being seen…"* (Interview 1)

- *"… we (healthcare professional) give the patient a differential diagnosis and the reasoning behind it would then be explained to them (patient), what tests should be done and for what reasons. I (healthcare professional) don't think, sometimes the time constraints in the ED is in such nature that it is not enough. So I really think that patients should be involved more. And more should be explained especially diagnostic tests and then cost comes into it as well…"* (Interview 4)

- *"… you (healthcare professional) try not to become to technical in explaining, because it either confuses the patient or they misinterpret it and it raises more questions and concerns… in terms of explaining I try to keep it simple and brief."* (Interview 13)

Explaining should start when the patient walks into the ED. Explain the whole process to patients at the start of their journey through the ED, including the expected outcomes and discharge process to enhance patient-centred communication in the ED (Chandler et al, 2015:9). To explain the processes to patients is important. Explaining medications, procedures and expected outcomes to patients will lead to effective communication and patients being more involved in their journey through the ED. The more informed patients are, the more they can be involved and the more in control they feel. Therefore providing adequate explanations is important to establish rapport and empathy with the patient (Chandler et al, 2015:7). In a study by McConnell et al (2016:32) the authors found that most patients are dissatisfied with the lack of communication and information given to them. Healthcare professionals do not go into detail when explaining to patients. Patients that are well informed will engage more and have the courage to participate in their own healthcare which will improve patient outcomes and patient adherence to treatment when discharged (Chandler et al, 2015:7-8). Healthcare professionals are aware that explaining and informing is important to patients but it was found to be lacking in the ED, but identified as needed to enhance patient-centred communication in the ED.

4.4.1.5   *Sub-category 5: Layman's terms*

Healthcare professionals stated that they need to communicate with patients using layman's terms in order to ensure that the patients understand. To communicate on a level the patient will understand was emphased to be very important if patient-centred communication was to be practiced.

Quotes to support the importance of Layman language:

- *"Doctor (healthcare professional) explains what 'tests' will be done to make a diagnosis. Use language that patient may understand e.g. look at heart and language that patient may not understand e.g. 'electrolyte'. No opportunity for patient to ask questions, one way communication and focus on signs and symptoms…"* (Observation 9)

- *"… they (healthcare professionals) explained everything to me (patient) in a manner that I could understand, which is saying a lot because a lot of times people speak around you and you have no idea what they are saying… so I really appreciate the fact that they spoke on my level …"* (Patient 3)

- *"… people don't understand and just using the word triage, half the community don't know what the term means… use the colours to explain the triage system they just see colours they don't comprehend fully what all that means…"* (Interview 13)

Healthcare professionals need to communicate to patients using layman's terms and words they can understand. Cuesta-Briand et al (2014:4) emphasise that healthcare professionals should communicate at the appropriate level and adjust the communication style to suit patients' individual needs and thereby enhance patient-centred communication. King and Hoppe (2013:387) state that it is important to give information clearly to the patient without jargon.

4.4.1.6   *Sub-category 6: Listen*

Participants emphasized that how they as healthcare professionals communicate is important. Listening to the patient, and asking the patient questions and not just assuming is an important verbal communication skill. The participants all agreed that patients want healthcare professionals to listen to their stories.

Quotes to support the importance of Listen:

- *"Healthcare professional ask about progress and patient still complain of chest pain… Healthcare professional was listening to her concerns of chest pain…"* (Observation 9)

- *"… give patients time as well, to understand their questions that they want to ask. Because what they want to ask is more relevant to what we (healthcare professionals) want tell them. I think by listening to our patients….*
- *Listening is a skill; let's just listen to them (patient). And we will be able to help them and go forward. "* (Interview 7)

> • *"… we sat down and try to pull up a chair and actually I think the biggest difference is when we have positive outcomes with communication is asking the patient what they want… you actually listen to them and they were able to tell you what they want…" (Interview 10).*

Listening improves effective communication between patients and healthcare professionals. The listener (healthcare professional) has to uncover what is wrong with the patient. This can be seen as a journey to discover who the patient is as an individual and ask, look, test, clarify and invite the patient to collaborate in the healthcare (Mohl & Carr, 2015:4). The authors Mohl and Carr (2015:4) continued to list five (5) key listening skills healthcare professionals should use when communicating with their patients:

- Hear the meaning of words, associations, idiosyncratic use of language, and hear the deeper story and voice notes.

- See the posture, gestures and facial expressions as patients tell their story.

- Compare by taking note of what is omitted while the patient is talking.

- Intuit to pay attention to your internal reactions.

- Reflect and think what was said while the patients told their story.

While listening, the healthcare professional experiences the patient's world and hears the patient's story, because listening can be healing and diagnostic (Mohl & Carr, 2015:4). Listening to the stories of patients and asking questions that focus on emotional issues can improve the communication between the patient and healthcare professional (Pinto et al, 2012:86). When healthcare professionals listen to the patients or family members, it is more than just medical information that is conveyed. The fact that the healthcare professional listens can be spirit healing for the patient, but the healthcare professional must commit to the act of listening (Benbenishty & Hannink, 2015:1359).

4.4.1.7   *Sub-category 7: Educate*

Educating the patient includes educating the family. The participants mentioned that through effective communication patients could be educated to better understand what is wrong with them. Discharge information is also an important part of the journey through the ED. The participants agreed that educating the patient is essential to improve patient satisfaction.

Quotes to support the importance of Educate:

> • *"Not sufficient information given to the patient… patient was left in the dark a bit about the cause and further treatment…"* (Observation 7)

- *"… they said tomorrow if you feel a pain in the arm you can rub, don't scratch you can rub…"* (Patient 11)
- *"… she (healthcare professional) told me I must go for physiotherapy and she explained it is going to take long so she is taking me to physiotherapy that those 3 weeks of pain can be less…"* (Patient 13)
- *"… she (healthcare professional) said I must sleep with this thing (wrist brace) to heal properly, 6 weeks…"* (Patient 2)

- *"… the patient got the script and then asks; 'when must I come back?' but patients are not listening…"* (Interview 14)
- *"I do see doctors (healthcare professional) explaining medication specifically on the prescription with the patient... You do see that communication but you do not see the participation in making the decision regarding discharge. I'm going to discharge you because this and this and this are normal…"* (Interview 8)
- *"We (healthcare professional) just rules orientated. Tell the patient to go is like there's a script for 2 days and what then… There is no discussion around the lifestyle and if there is stairs and…we just orientated to do our job…."* (Interview 2)
- *"… we (healthcare professional) give them (patient) discharge sheet to say if you have a problem this is the numbers you can call, it is free of charge and you can call if you have a medical question. So if there is family members around, we do and the doctor do explain to them and the family members. Sometimes you have to explain a few times before they get it, but you explain. So yes we do…"* (Interview 5)

Education to patients is especially important when they are discharged from the ED with medication and instructions to follow at home. Gallahue, Betz, Druck, Jones, Burns and Hern (2015:879) describe discharge as handing off from the healthcare professional's responsibility to the patient's responsibility of care and a complex process for the patient. The discharge process is dependent on the healthcare professional's ability to communicate effectively and with the patient's understanding of discharge instructions, for the transfer of responsibility to be successful (Gallahue et al, 2015:879). According to a participant, the discharge information given was not that clear in the ED,

- *"… yes he (healthcare professional) did explain to me that day but he did tell me to come back but didn't say for what…"* (Patient 13)

There is often a gap in the discharge information given to patients in the ED. McCarthy, Engel, Buckley, Forth, Schmidt, Adams and Baker (2012:1) found that 78% of patients did not fully understand discharge information given by the healthcare professional. Moreover, communication upon discharge is very important and affects the

quality of patient care, the patient's safety and healthcare outcomes (McCarthy, Waite, Curtis, Engel, Baker & Wolf, 2012:277).

The healthcare professionals do give discharge information and patients are educated yet communication is inadequate. The quality of communication is inadequate and patients are not allowed to ask questions so ineffective patient-healthcare professional communication leads to errors in the discharge process in the ED (Gallahue et al, 2015:879). Participants agreed there was a gap when healthcare professionals discharged patients out of the ED. For example,

- *"… we (healthcare professional) will see patients coming back for follow-up saying: 'I still have abdominal pain… yes there is a prescription sheet but I haven't went to fetch it' … so we (healthcare professionals) have quite a lot of patients coming back with the same problem…"* (Interview 12).

Many patients struggle to recall information after the healthcare professional has instructed them. Patients' knowledge decreases within a 15-minute period, especially older patients (McCarthy et al, 2012:278). To recall spoken information is a challenge for many patients, particularly if they are not feeling well and the information was given in the form of a list (McCarthy et al, 2012:279). Individuals can process only small amounts of new information at a time, but can recall the information best that was given in the closing statements (McCarthy et al, 2012:280).

The ED is a chaotic environment and it is difficult to give effective discharge information to patients (Engel, Buckley, Forth, McCarthy, Ellison, Schmidt & Adams, 2012:E1042). A big challenge is that patients leave the ED without the proper knowledge and incomplete understanding of their care and instructions given (Engel et al, 2012:E1036). The discharge process is influenced by the challenging environment and getting the patient out of the ED as soon as possible, and this affects the communication.

McCarthy et al (2012:280) emphasise that understanding their discharge instructions and home care is the most difficult part of the journey through the ED for patients. One participant pointed out,

- *"I (healthcare professional) think it is done the patient doesn't always take it in… giving them a pamphlet in hand and to reintegrate what you have said… head injury pamphlet to explain it to them (patient) and they can go and read it at home... But many of those pamphlets actually end up in the rubbish bin before the patient reads it… they also forget quite a lot and some patients are under medication that can also make them forget and then later not know that the doctor communicate certain things to them… where we should actually also involve the family and the friends, so that they can remind the patient…"* (Interview 4)

Patients frequently do not understand the information given to them. According to McCarthy et al (2012:280), there is a gap between the patient's learning needs and the healthcare professional's teaching method. One participant stated,

- *"… having written information on a piece of paper, you would think that patients will sit down and read it but it doesn't really help… I think word of mouth type of communication is still the best…" (Interview 13).*

Written information to support what was said during discharge can be provided to improve patient-centred communication in the ED (McCarthy et al, 2012:281). The written information needs to be visually attractive and literacy-appropriate together with consistent verbal communication (Engel et al, 2012:E1041). In addition, limited information should be provided to maximize the probability of patients' understanding what is communicated (McCarthy et al, 2012:2). Patients are more informed about their medication and diagnosis than about the reasons to return to the ED, therefore patients need to understand the reasons why and when they need to return to the ED (Engel et al, 2012:E1041). Effective communication is essential to provide safe and quality care to patients, and that is why understanding will lead to better health outcomes, better patient experiences and improved patient satisfaction (Engel et al, 2012:E1042).

4.4.1.8   *Sub-category 8: Regular updates*

The participants identified regular updates as part of how healthcare professionals should communicate in order to keep patients informed and updated about their journey through the ED.

Quotes to support the importance of Regular updates:
- *"… there was suppose to be a male doctor but he (healthcare professional) was busy with another emergency so the other doctor to come see me, a female doctor, they (nursing staff, healthcare professional) gave me advice in stages like where she was… and how far along she is…"* (Patient 10)
- *"… they (healthcare professional) did come back and say they are waiting for the blood results, the doctor will look at the blood results…"* (Patient 12)
- *"… the waiting period, they (healthcare professional) say it will take an hour, but I think the delay came with the blood test, but it was much longer than an hour when the results come back, the doctor did come and attend to me and said there is some sort of hiccup I must not worry…"* (Patient 5)

- *"… we (healthcare professionals) go while we still waiting for blood results back to them (patient) and we tell them: 'mr X we still wait for your blood results, hence there is a delay, but as soon as the doctor is available with the blood results he will definitely come and explain everything to you' so yes we do…"* (Interview 12)

- *"… reason is that he doesn't know the reason why he is waiting. If the patient knows why he is waiting, and understands the steps that must happen before a result can come out, the report can come out then they understand. So waiting long is one thing but if they know why they waiting, they might not be so agitated about it… communicate to the patient what is the next step that is going to happen and why things need to happen in a certain way."* (Interview 4)

- *"… where they (healthcare professional) just go and communicate and say, just wait for the doctor they (healthcare professional) are currently busy with somebody. The moment they (patient) understand that they are more patient to wait. But I think in my experience, the number one reason why patients are a bit upset is that they don't understand why the doctor takes so long to come back and sometimes you are just stuck with somebody else…"* (Interview 6)

Keeping patients updated includes telling them what is going to happen. Patients go to the ED and expect to wait but not without being updated on how long they will wait, because that makes them feel abandoned and insecure (McConnell et al, 2016:32). Regular updates should be a communication transfer that should be uncomplicated, specific, some repetition, minimal jargon and making sure the patient understands (King & Hoppe, 2013:386). Communication with patients should have a patient-centred approach with an interpersonal interaction and regular updates (King & Hoppe, 2013:386). Patients who receive information about their treatment and reasons for waiting are more satisfied than patients who are not informed of their expected path in the ED (Lovato et al, 2013:491). Keeping the patient updated will lead to patient satisfaction and moments of patient-centred communication in the ED.

4.4.2   Category 2: Body Language

The stressful, fast-paced and complex environment of the ED has a lot of challenges for patient-healthcare professional interactions and very often communication fails to meet patients' expectations (McCarthy et al, 2013:442). Body language or non-verbal communication plays an important role when communicating with the patient and patient's family. Through body language trusting relationships can be formed and help to improve patient outcomes and improve patient-centred communication (Benbenishty & Hannink, 2015:1360).

Quotes to support the importance of Body language:

- *"In triage… Healthcare professional stood with her back to patient while reading vitals to other healthcare professional…"* (Observation 3)

- *"All healthcare professionals are standing at the nursing desk, turned with their backs to the patients and facing each other…"* (Observation 18)

Benbenishty and Hannink (2015:1359) state that during communication body language counts for 55%, voice tone 38% and actual spoken words 7%. Body language is thus essential to enhance patient-centred communication in the ED. According to Benbenishty and Hannink (2015:1359) body language builds trusting relationships, and consists of:

- Belief that our good will be taken care of by the healthcare professional.
- Attitude bound to time and space and a person (patient) relies on another person (healthcare professional) with confidence.
- Willingness to engage in a relationship with the acceptance that you as a person (patient) are vulnerable.

Through body language trusting relationships can be formed and help to improve patient outcomes and patient-centred communication (Benbenishty & Hannink, 2015:1360). The quality of communication between patient and healthcare professional has a great impact on patient outcomes, especially in patient healthcare education, treatment adherence and patient satisfaction (O'Hagan, Manias, Elder, Pill, Woodward-Kron, McNamara, Webb & McColl, 2014:1345). Communication is a significant component of patient care because patients' perceptions of good healthcare professional communication lead to experiences of patient-centredness (O'Hagan et al, 2014:1345). Patient-centredness is vital to patient-healthcare professional interactions and is effective communication that includes engagement and relationship building with the patient (O'Hagan et al, 2014:1353). Patients value healthcare professionals who care, are present and fully engage in them as patients (McConnell et al, 2016:43).

The participants of this study identified five (5) sub-categories relating to body language, namely attitude, eye contact, facial expression, pull up a chair, and touch.

4.4.2.1 Sub-category 1: Attitude

Positive and negative attitude is part of how you communicate. The participants agreed that healthcare professionals' attitude is an important part of body language to communicate effectively.

Quotes to support the importance of Attitude:

- *"… the doctor (healthcare professional) was like he don't care… after my x-rays that doctor again was like I'm wasting time, like there is nothing wrong with me… like he don't care … the doctor (healthcare professional) of today was very nice, she took long but she did explain to me…"* (Patient 13)
- *"… most of the people come to work because of the money, but it is so good to see people that are passionate about what they do, because you dealing with the community, you dealing with people, you dealing with lives' of people so it is always challenging it is always nice to see people that are doing their work… "* (Patient 9)

- *"I (healthcare professional) think the other thing is attitude. Just have a positive attitude. The thing is you can't bring your issues with you just got to leave it behind. The thing is people come here 3 in the morning because they need to come here, just as much as we don't like it..."* (Interview 3)
- *"... because if we really can change our attitude and change the way we talk to the patient..."* (Interview 2)
- *"Good communication, positive attitude, basically in a nutshell, positive, polite, good communication, it will lead to an atmosphere that we (healthcare professional) want."* (Interview 1)
- *"And the problem becomes when we (healthcare professional) a bit harsh, I've noticed sometimes we a bit harsh when we collect data from them."* (Interview 7)

Attitude includes healthcare professionals' positive and negative attitude and plays a significant role in enhancing patient-centred communication. Patients experience healthcare professionals' response as nonchalant and irritated sometimes (McConnell et al, 2016:32). Patients also recognise if healthcare professionals are passionate about their work.

4.4.2.2 *Sub-category 2: Eye contact*

Eye contact is part of body language that plays an important role in effective communication. Healthcare professionals identified the need to make eye contact with patients to practise patient-centred communication in the ED.

Quotes to support the importance of Eye contact:
- *"In triage makes it difficult for eye contact (layout, logistics) and can come over as unprofessional..."* (Observation 11)
- *"Patient come into the ED, the healthcare professional didn't made any eye contact at the book... No eye contact made by healthcare professional when admit patient and don't really speak to family member... healthcare professional keep on writing and silence again..."* (Observation 9)
- *"... the sister (healthcare professional) went to the patient to do vital signs, she explained the procedure of doing vital signs and she did make eye contact with the patient. She explained to the patient that they waiting for the doctor..."* (Observation 16)

Lack of healthcare professionals' eye contact makes patients feel invisible which, sometimes makes patients feel uncared for and hesitate to ask questions (McConnell et al, 2016:34). Eye contact enhances the healing relationship between patient and healthcare professional (Pinto et al, 2012:86). Eye contact is part of how you communicate and contributes to effective patient-healthcare professional communication.

4.4.2.3   Sub-category 3: Facial expression

The participants identified friendliness as an important facial expression and part of body language. How healthcare professionals communicate is important and being friendly towards patients is included in that communication. Facial expression portrays to the patient how the healthcare professional is feeling while communicating with the patients and facial expression speaks louder than words.

Quotes to support the importance of Facial expression:

- *"Healthcare professional is friendly towards patient…"* (Observation 3)
- *"Night doctor is very friendly and greets the night nursing staff..."* (Observation tool 18)

- *"… the lady from the doctor's reception was very very rude…"* (Patient 8)
- *"You (patient) are greeted with a smile, the doctors are friendly, you get told exactly what they going to do to you, what is going to happen and what is the steps forward…"* (Patient 3)
- *"Nice doctor (healthcare professional), talking to me nicely, in a joking way and make me feel at home, made me feel as if everything is alright, even that anger part washed away because the way he treated me…"* (Patient 9)

- *"We often have comments where you absolutely just friendly, your normal self and you go the extra mile then you get that feedback, where the people was just overwhelmed by the friendliness. Talking nicely to someone. Then you get positive feedback…"* (Interview 3)

Benbenishty and Hannink (2015:1359) point out that psychological studies since the 1980's found that facial expressions correspond to six definite emotions: happiness, sadness, surprise, disgust, anger and fear. Being friendly and smiling is seen as a marker for patient-centred communication because the healthcare professional is concerned about the patient's needs and feelings (O'Hagan et al, 2014:1351).

4.4.2.4   Sub-category 4: Pull up a chair

The expression 'pull up a chair' was introduced to the participants by a doctor (another participant) who had attended a workshop. Participants agreed that 'pull up a chair' may be a way to remember to spend time with the patient. Healthcare professionals should spend time with patients and all their attention should be on the patients. It is an essential part of creating a moment of patient-centred communication.

Quotes to support the importance of Pull up a chair:

- *"Sometimes you (healthcare professional) don't even have the time to sit with them and show them this is your prescription and this is the medication you need to take… I think that we could do it more often to sit with patients…"* (Interview 13)
- *"… it creates a perception to the patient that you care and that you listening. You pull up a chair and you sit. If you don't interrupt the patient you hear the whole story. In the first minute they give you the whole story. In the 6 months since I've been doing it, the majority of patient appreciate if you just take a decent history and listen to their story…"* (Interview 11)
- *"You don't have the time to properly pull up a chair and actually sit down and tell them everything that they need to hear to be reassured…"* (Interview 10)

Patients regard healthcare professionals who are too busy to spend time with them as un-empathic (O'Hagan et al, 2014:1351). 'Pull up a chair' is important to spend time with the patient and build rapport even if the ED is chaos and falling apart. Giving the impression to the patient the healthcare professional do not have time for the patient indicate a lack of patient-centred communication (O'Hagan et al., 2014:1352). Pulling up a chair is a patient-centred approach to improve effective communication between the patient and healthcare professional.

4.4.2.5 *Sub-category 5: Touch*

The participants identified touch as an important component of body language to effectively communicate with patients.

Quotes to support the importance of Touch:

- *"When speaking to patient, no touch to display a caring nature…"* (Observation 11)
- *"Specialist (healthcare professionals) ask patient about comorbidities, touch the patient and reassure the patient… the sister (healthcare professional) touch the wife and explain what was done, dressings, chest x-ray and pain medication…"* (Observation 1)

There is power in touching the patient and touch reduces the patient's anxiety (Benbenishty & Hannink, 2015:1359). Touch is the universal language of caring and is used to show comfort, emotion, response, reassurance and understanding between patients and healthcare professionals (Benbenishty & Hannink, 2015:1360). Touching the patients reassures and comforts them (O'Hagan et al, 2014:1351) and shows that the healthcare professional regards them as an important part of the care.

4.4.3   Strategies for key touch point 2: Communication

The participants suggested the following strategies relating to verbal language that could be implemented in future to ensure patient-centred communication in the ED every day:

- Patients should communicate their expectations at triage; for example, wanting a prescription or x-ray.
- Healthcare professionals should speak in a well-mannered tone to the patients.
- Healthcare professionals should speak clearly and be specific to their patients.
- Respect and provide privacy to the patients at all times during the patient's journey.
- Attentive listening when the healthcare professionals concentrate on listening and not only answering.
- At triage colours needs to be explained to patients, don't say yellow or 45 minutes. Also explain how triage works like for instance that a patient from a car accident will get prioritised and will skip the queue to ensure their safety.
- Give the patient a printout of their blood and x-ray results when the patients are discharged.
- Listen and try to understand the patient without interfering or interrupting while the patient are talking and telling their stories.
- Be positive when communicating with the patients in the ED to promote patient-centred communication.

The participants suggested the following strategies relating to body language that could be implemented to ensure patient-centred communication in the ED every day:

- Maintain an approachable, friendly posture when communicating or working with the patients in the ED.
- Walk with confidence as this non-verbal communication method says a lot about your competence.
- Healthcare professionals should be patient (show patience) at all times.
- Be proud of what you are doing and what you are (healthcare professional).
- The healthcare professional should always connect with the patient, make eye contact and touching the patients where applicable to show care and support to the patient.

4.5   Key touch point 3: Daily Focus

Patient-centred communication should be a daily focus in the ED. Daily focus was the third key touch point identified by the participants. The focus of patient-centred communication is effective communication. The positive outcomes linked to patient-centred communication include ultimately improved patient satisfaction and patient outcomes. Since the late 1990s patient-centred communication has been identified and promoted as the ideal communication style with patient-centredness as the core (Saha & Beach, 2011:390).

A daily focus to improve patient satisfaction in the ED should include listening to patients' and their families' stories and experiences of care experienced – specifically relating to communication - in the ED. Levinson, Lesser and Epstein (2010:1311) maintain that healthcare professionals need to understand patients' needs,

values and preferences, provide patients with information to participate in their own healthcare, and build trusting patient-healthcare professional relationships. Effective communication should be a daily focus to constantly remind healthcare professionals and to promote and enhance moments of patient-centred communication experienced by patients in the ED.

Epstein, Franks, Fiscella, Shields, Meldrum, Kravitz and Duberstein (2005:1517) stress four elements in the daily focus of patient-centred communication, namely:

- Try to understand patients' perspectives, values, needs and preferences.
- Understand patients within their individual psychosocial context.
- Shared understanding of patients' illness and treatment options that respect their values, needs and preferences with shared decision-making.
- Power sharing and active participation to the level of patients' preferences.

Power sharing and collaboration between patient and healthcare professional is part of patient-centred communication and should be practised daily (Saha & Beach, 2011:386).

The participants in this study identified four categories relating to daily focus, namely holistic approach, consideration, privacy and equality.

4.5.1   Category 1: Holistic approach

The participants identified holistic approach as one of the categories of daily focus to improve patient-centred communication in the ED. A holistic approach needs to be a daily focus in the ED. Healthcare professionals must adopt a holistic approach towards their patients and by making it a daily focus it might become second nature and the way things are done in the ED.

Quotes to support the importance of Holistic Approach:

- *"No opportunity for patient to ask questions. One-way communication…"* (Observation 9)

- *"… when it comes to communication, when I (patient) came and they (healthcare professional) just took me through to that side, maybe if they can just monitor that they can limit the time they keeping a patient, so at least you can see a patient without any complications make sure everything is on point…"* (Patient 9)

A holistic approach should be a daily focus in the ED. The daily focus should be to work so that patient-centred communication is lived out and puts the patient at the centre of care in the ED (McConnell et al, 2016:38). A holistic approach in the ED acknowledges the patient as an individual with specific needs (Zandbelt et al, 2007:330). The patient's problem and illness is fully explored and understood by the healthcare professional to

make an accurate diagnosis with quality treatment (Zandbelt et al, 2007:330). To involve the patient may give the patient a sense of shared 'ownership' and by involving the patient the daily focus of working holistically can easily be achieved to improve patient-centred communication (Zandbelt et al, 2007:330). The patient as a person wants to be acknowledged as a 'whole person' and have a human connection with the healthcare professional (McCormack et al, 2011:1090). Another element of patient-centred communication is a 'whole person' orientation to patient communication that includes the biological, psychological, social and behavioural dimensions of health and illness (Saha & Beach, 2011:386). This fact was emphasized by one of the healthcare participants with the following quote:

- *"Remember as we say getting better – bio –social – psycho. We can treat bio but if you don't get the social and psycho right then you only 33% better. So you can give the best antibiotic but it is just not working because you have a bad house and are depressed and you not going to get better."* (Interview 3)

Patients need to be involved in their care and information needs to be shared to create a holistic approach in the ED.

The participants in this study identified five (5) sub-categories relating to holistic approach, namely balance, patient expectations and misunderstandings, hidden truth, participate and consent.

4.5.1.1   Sub-category 1: Balance

The participants agreed there should be a balance between time keeping and talking to patients. The balance between treatment and communication in the ED should be a daily focus. Both the patient and the healthcare professional have an expectation and therefore a balance need to be reached: a balance between the patient's expectations and their misunderstandings.

Quotes to support the importance of Balance:

- *" I (healthcare professional) came back with all the Robert Jones (type of dressing for knee injury) things, my point was just to put the Robert Jones and get it over, the patient was furious. So you see the communication part of it, there was a break between the doctor, the patient and us (nursing staff, healthcare professional) because for me I was just going to put the Robert Jones – what is it for and why is it necessary, I was not there – I was work orientated and time orientated …"* (Interview 2)

- *"Each healthcare professional do his/her 'job'… very task-orientated…"* (Observation 9)

Patients that engage with healthcare professionals during their management enable the healthcare professionals to be responsive towards their needs, values and preferences and improve patient care and create a balance between the treatment and communication (Bucknall, Hutchinson, Botti, McTier, Rawson, Hewitt, McMurray, Marshall, Gillespie and Chaboyer, 2016:2). Patient engagement involves patient participation in decision-making and patients take responsibility for their care at home and then provide suggestions for improving the care (Bucknall et al, 2016:3). Power sharing and shared knowledge and mutual understanding are part of the patient-healthcare professional relationship and components of patient-centredness to create a balance in the ED (Bucknall et al, 2016:3). Providing explanations to patients helps to establish empathy and opens the door for patients to share their concerns. Patients will then participate and engage more in their treatment discussions, which also results in a decrease in returns to the ED (Chandler et al, 2015:7-8). The holistic approach that is collaborative and patient-healthcare professional relationship focused (McConnell et al, 2016:39) is not part of daily focus in the ED and should be practiced if a balance is to be maintained.

4.5.1.2 *Sub-category 2: Patient expectations and misunderstandings*

The participants agreed that explaining to the patient will lead to patients having realistic expectations. Avoiding patient misconceptions is all about explaining everything beforehand, such as: how long the waiting times are; what will happen after the doctor has seen the patient, and what will happen when admission is necessary.

Quotes to support the importance of Patient expectations and misunderstandings:

- *"Nurse (healthcare professional) asked patient to come with her, without explaining where… patient asked where she is going and then RN (healthcare professional) replied inside unit to be seen…"* (Observation 3)

- *"… unfortunately when I come that day they though I was for a review, while I got injured so they had to take me straight to that side for review and when I got there now the lady was busy filling in my papers 'like are you coming for a review? And I'm like 'no I didn't come for review, I came here for to be treated because I got injured today' so the papers don's say you got injured today the papers say you here for review, I say just check properly. I was a bit disturbed and a bit angry because I had to sit for a while and now I need to come back in, they want me to come back to this side to do my BP and check all those things but they had to do it over that side… but the doctor was already coming to see me …"* (Patient 9).

- *"… you get told exactly what they going to do to you.. and what the steps forward is..."* (Patient 3)

- *"I didn't expect that it is going to take long because I came for a review…"* (Patient 9)

- *"…but I was surprised because I waited for so long, but the doctor when she come to me she told me that they were busy with another patient that they shooted…"* (Patient 6)

- *"They (patients) come with a perception you (healthcare professional) are going to fix it all. The other thing is the procedure. Coming from the outside world and referred by a GP at the outer sector that told the patient you are going to get a lumbar puncture and you going to be admitted and then we don't do any of that and then you are again the worst… we not doing what they being perceived. When they come here they must be admitted, they can choose to be admitted and really they can't choose to be admitted." (Interview 3)*

- *"You'll (healthcare professional) find that maybe the patient waited for an hour, or more than an hour, before been seen by the doctor but they (patient) will understand, especially when you interacting with them and explaining to them the unit is busy… explain to the patients there are no beds available, but the patients know he will still wait. But the patient automatically knows they have to wait but they will attend to me…" (Interview 1).*

- *"… And it is about meeting expectations. Communicating what the expectations that the parents have or the family has or the patient has, understanding those, listening to those and meeting that is required …. they (patients) come with expectations, of the emergency department will be a 1-stop centre of care, because it is an emergency department they will be seen quickly…"* (Interview 11)

Very often patients' expectations are that they are going to the ED to see a doctor within minutes of arrival and that is not the reality. In a study in Finland, Forsgärde, Attebring and Elmqvist (2016:34) found that patients do not know the expected path of the ED and that makes them feel powerless. Patients and relatives were dissatisfied with the ED because of lack of knowledge and communication. Patients feel powerless because they do not know what is going to happen next and how serious their condition is and that leads to a feeling of not being in control of their journey through the ED (Forsgärde et al, 2016:35). Patients' expectation of perceived waiting time is one of the key determinants of patient satisfaction in the ED (Shah et al, 2015:32).

When patients are given very little information about how the ED works or are not informed about their expected path through the ED, they find it difficult to accept that higher priority patients are helped before them (Burström et al, 2013:1). Waiting times become a challenge when patients feel that nothing is happening in the ED and this leads to angry and frustrated patients (Burström et al, 2013:1). To improve patients' ED experience and patient satisfaction, the focus should be to manage patient expectations and communicate the expected waiting time when they arrive in the ED (Shah et al, 2015:32). A good example is when one patient remarked:

- "… I am a yellow patient and they will attend to me within 45 minutes…" (Patient 5).

Patients' expectations are not met when knowledge and information is lacking on how serious their condition is, and the reasons for waiting, and when healthcare professionals treat patients like objects and not as individuals (McConnell et al, 2016:34). Patients would be more satisfied if the expected journey through the ED was explained because then they would have realistic expectations (Forsgärde et al, 2016:35).

The patient is the one receiving the healthcare, therefore, it is important to identify what the patient wants or expects from the interaction with the healthcare professional (King & Hoppe, 2013:387). According to Kent and Reyes (2016:17), patients' and healthcare professionals' expectations differ greatly. Kent and Reyes (2016:17) found that patients' biggest complaints were that they were misdiagnosed and the healthcare professional did not spend enough time with them. Chandler et al (2015:8) found that healthcare professionals underestimate the amount of information patients want and overestimate the time spent explaining information to the patient. This was also the case in this study as one participant (healthcare professional) stated:

- *"… that if you (healthcare professional) sit and try to explain things to them (patient), to alley their fears, that it becomes very time consuming…"* (Interview 13)

Patients want more information about their ED journey, to be participants in their own healthcare, and to feel that they are being listened to (Chandler et al, 2015:8). Patients seek help at the ED and leave their health in the hands of healthcare professionals who will care for them in a safe and optimal way (Burström et al, 2013:4). Moreover, patients have expectations of what is an acceptable waiting time in the ED but when nothing happens, the waiting becomes non-acceptable (Burström et al, 2013:4).

4.5.1.3   *Sub-category 3: Hidden truth*

The participants identified the hidden truth as a sub-category of a holistic approach that should become a daily focus in the ED. Hidden truth means to explain the hidden truth to the patients, including the hidden costs so that if the patient receives a bill after two weeks which the medical aid rejected that the patient is aware of the hidden truth. Costs involved in the ED should be transparent to the patient.

Quote to support the importance of Hidden truth:

- *"Sometimes we are getting a lot people that are unhappy about it because they didn't know they went for a scan and then get this account. Or they didn't know the doctor is going to test so many bloods, because we have few new doctors in the unit and then she will tick of everything on the list just to make a diagnosis for the patient. "Sometimes we are getting a lot people that are unhappy about it because they didn't know they went for a scan and then get this account. Or they didn't know the doctor is going to test so many bloods, because we have few new doctors in the unit and then she will tick of everything on the list just to make a diagnosis for the patient."* (Interview 8)

King and Hoppe (2013:387) maintain the healthcare professional should disclose specific information to the patient to avoid misunderstandings, including:

- Discuss the cost of the different treatments like blood tests, x-rays, and what the patient's medical aid will cover if the patient belongs to medical aid.
- Be responsive and understand the patient's household and living circumstances and support structures.

4.5.1.4   Sub-category 4: Participate

The participants agreed that patients need to participate in their healthcare. Patient-centredness increases patient satisfaction, patient involvement and participation in the patient's treatment (Chandler et al, 2015:1). Patient participation improves communication between the patient and healthcare professional that leads to a healing relationship and enhance patient empowerment and there is an opportunity for shared decision-making that increase patient satisfaction (Mavis, Holmes, Rovner, Jorgenson, Coffey, Anand, Bulica, Gaulden, Peacock & Ernst, 2015:1828). Healthcare professionals see patient participation as a daily focus in ED to create moments of patient-centred communication.

Quotes to support the importance of Participate:

- *"Communication is a two-way path between patient and nursing staff (healthcare professional) and if any misunderstanding or by facial expression, it is explained again to ease concerns…"* (Observation 16)

- *"Big burnshield put on patient's face without explanation… only eyes, nose and mouth open, but healthcare professionals not talking to patient and also not kind…" (Observation 1)*

- *"But I really don't think they involve the patients at all in the decision-making. Because they tell them I'm going to give you this medication and going to do this x-rays, I'm going to do this blood. They do not tell the patient the indication thereof. So no I really don't think they involve the patients."* (Interview 8)

In 1978, the WHO advocated for patients' right and responsibility to participate in their own healthcare (Mavis et al, 2015:1828). Terms used for patient participation include collaboration, patient engagement, patient empowerment and patient satisfaction (Mavis et al, 2015:1828). Patients feel empowered to engage as active participants in their healthcare and improve patient outcomes (Mavis et al, 2015:1828). The patient's needs, values and preferences need to be considered to get the patient involved in patient participation (Verlinde et al, 2012:10). According to Mavis et al (2015:1828) patient participation involves four (4) attributes:

- Patient-healthcare professional relationship that forms the healing relationship.
- Sharing of power and control between patient and healthcare professional.

- Information sharing between patient and healthcare professional, including patient's preferences, and shared decision-making.
- Active engagement of patient and healthcare professional.

Patient participation is key to patient-centred communication and is influenced by the patient's personality, social class and education and also the healthcare professional's communication style and the setting, like the chaotic ED environment (Verlinde et al, 2012:10). The patient is a more active participant when the healthcare professional practises partnership building and is involved in supportive communication (Verlinde et al, 2012:10). Patient participation is influenced by the amount of information given by the healthcare professional and the patient's personality and communication style (Verlinde et al., 2012:11). Patient involvement is seen as a key element of patient-centredness and is important to enhance patient-centred communication in the ED (Flynn et al, 2012:960). Involving the patient to participate in decision-making leads to patient cooperation with treatment and reduces the rates of readmission to the ED (Chandler et al, 2015:8). Patients that actively participate in their healthcare decisions have better patient outcomes and their experience of care is positive (Bucknall et al, 2016:2).

4.5.1.5   *Sub-category 5: Consent*

The participants identified confirmation together with consent to be a daily focus in the ED to follow a holistic approach. All procedures in healthcare require that patients give their permission (Pera & van Tonder, 2007:47). The patient needs to be fully informed about the procedures with explanation of possible risks and disadvantages and also alternatives to the treatment suggested (Pera & van Tonder, 2007:47). Informed consent displays respect towards the patient's autonomy and right to self-determination (Pera & van Tonder, 2007:47).

Quotes to support the importance of Consent:

- *"Healthcare professional asked for patient's consent for an IV line and patient agreed… the healthcare professional that went to insert the drip (intravenous therapy) did not introduce herself but procedure of IV is explained well…"* (Observation 14)

- *"… the concept of it becomes a consensual discussion, of asking consent to sent the bloods away and the explanation of why I'm (healthcare professional) doing the tests, because I'm obtaining consent to do that but the patient can't say yes or no unless they have the reason behind it. I think from a personal perspective I do try to engage the patients especially with investigations…"* (Interview 11)

  "… we (healthcare professional) do inform the patient about the medication prior to giving the medication and also obtaining consent…" (Interview 12)

- *"… some people will go and do whatever they are doing and without consent and not telling them (patient) what they (healthcare professional) are going to do. Sometimes we do it right…"* (Interview 14)

> • *"… when the patient enters the unit you (healthcare professional) greet the patient, you asks what's wrong and take a patient to triage and you need to get consent from the patient. Like when we do it, we do not ask consent, it is as if we are telling the patient: 'I'm going to triage you I am going to do your blood pressure and that'. In that way you not asking consent, you are telling the patient… that is why I say we need to get consent, give them the reason why you doing that…"* (Interview 9)

Lamont, Jeon and Chiarella (2013:2388) identify four domains of consent, namely understanding, appreciation, reasoning and communicating a choice:

• *Understanding* relates to the ability to comprehend information related to diagnosis, recommended treatment by asking the patient to repeat or summarise the information back to the healthcare professional.

• *Appreciation* refers to how the patients understand the diagnosis and treatment information and then relates it to their individual values and beliefs. Appreciation can be used to determine the truthfulness of facts and information and the patients' perspective on the likely outcome of treatment.

• *Reasoning* is the ability to provide logic and rationality in terms of evaluating treatment options and identifying benefits, risks and reason for patients' choice.

• *Communicating a choice* is the least complicated and involves giving the message about the treatment decision.

Determination of patient capacity to consent for any procedure or treatment is a continuous process and is relevant for all healthcare professionals especially those working in the ED (Lamont et al, 2013:14)

4.5.2 Category 2: Consideration

The participants identified consideration as a category of daily focus. Consideration towards the patient and the patient's family is part of patient-centred communication. The participants indicated it is important to consider the different age groups of patients.

Quote to support the importance of Consideration:

> • *"… explained to patient but forget the children although not the age or the patient, they were curious about what is happening… maybe to explain shortly to children what is going to happen to mom (patient)…"* (Observation note 7)

Consideration is part of patient-centred communication. Healthcare professionals can consider patients through understanding patients' values, needs and preferences, respond to patients' psychosocial context, and promote patient involvement by understanding their illness and how decisions will affect them as individuals (Epstein et al, 2005:415). According to Levinson et al (2010:1311), there are various advantages in considering the patient as an individual, namely:

- Patients' knowledge about their illness increases.
- Better informed decision-making.
- Better patient adherence to treatment.
- Improved patient outcomes.

Consideration is all about considering the patient as a 'whole person' by the healthcare professional delivering care that is guided by the patient's values, needs and preferences (Saha & Beach, 2011:386). The patient should be an equal partner in the care and shared decision-making and patient participation with mutual understanding forms part of the relationship between patient and healthcare professional (McCormack et al, 2011:1086).

The participants identified two (2) sub-categories relating to consideration, namely patient and family, and healthcare professional.

4.5.2.1 *Sub-category 1: Patient and patient's family*

The participants identified the patients and their families as important role players that need to be taken into consideration by healthcare professionals during communication.

Quotes to support the importance of considering the Patient and Patient's Family:

- *"Family member (daughter) involved by doctor (healthcare professional) to give history about patient's condition…" (Observation 9)*
- *"Doctor (healthcare professional) ask to get a family member… one sister (healthcare professional) not sure who family is so the other sister went to call the family… when the family is present, specialist (healthcare professional) explain shortly situation of patient, not really giving a lot of attention to the family… they were just standing there…" (Observation 12)*

- *"… the husband was there and even the other family members was there. We (healthcare professionals) talk to them and explained to them, what we going to do on the patient, and the doctor is also still coming to the patient. But because I immediately upgraded her as a P1 I immediately call the doctor and the doctor (healthcare professional) come, and she also talks to the family…" (Interview 1)*
- *"… they (patient) want the family member with them, we (healthcare professional) don't have a problem with that, even if they didn't ask us, we treat them quickly and call in the family members so that they can be with their patient. We know they are sick and need someone close to them…" (Interview 9)*

The more procedures and treatments are explained to patients, the more they are informed, emotionally stable and the more empathy is established (Pun et al, 2015:10). It is important for the patient to have a family member during the patient's journey through the ED for support (Forsgärde et al, 2016:32). In today's healthcare the

presence of family is becoming a more acceptable practice and it has been found beneficial for both patient and family (Duran et al, 2007:278). Family members are concerned about the expected waiting time, immediate medication if patients experience pain, and good and effective communication with the healthcare professionals (Forsgärde et al, 2016:32). According to Forsgärde et al (2016:35), it is important to include the family because half the complaints come from the family. Miles and Mezzich (2011:425) maintain that only through engagement with the patient and the family will patient-centredness happen and lead to patient satisfaction.

Families have a need to talk to a healthcare professional, especially a nurse, to explain in words they can understand and be updated often because good and effective communication reduces stress and anxiety (Botes & Langley, 2016:5). The authors Vermeir, Holley and Lipman (2016:446) refers to a patient's wife who wrote of her experience as a family member of healthcare professionals' communication with her, saying, "behind a bed number there is also a person, a family and a community". Healthcare professionals need to remember that all the attention is on the patient and to acknowledge and recognise the importance of family because the family member is the one that suffers in silence (Vermeir et al, 2016:4036).

4.5.2.2   *Sub-category 2: Healthcare professional*

The participants identified the importance of considering the healthcare professional while delivering quality care to the patient in the challenging and chaotic ED environment.

Quote to support the importance to consider the Healthcare professional:

> • *"… a cellphone ring and she (patient) answers while nurse (healthcare professional) is taking history from the patient…"* (Observation note 11)

In a Middle Eastern tertiary care centre, Batleyh, Nasreddine, Chami, Zebian, Bachir and Abbas (2016:1) found that healthcare professionals displayed cynicism and other attitudes towards patients because they experienced family being present in the ED as intrusive, interrogative, and disrespectful with no situational awareness. Batley et al (2016:1) acknowledged, however, that the presence of family has a positive effect on patient outcomes. The patient with a family member is more satisfied and the presence of a family member gives the patient a sense of safety (Forsgärde et al, 2016:35). According to Towle (2016:6), healthcare professionals should:

• Respect the level of education and knowledge of the patient and family. Use medical terminology that is easy to understand and ask the patient and family to repeat what was explained to them

• Respect and acknowledge the fear, anxiety and the unknown the patient and family is experiencing by giving full attention to the patient, listening actively and making eye contact.

• Respect the privacy of the patient and family but also share and communicate important information to each other.

• Build trusting relationships with the patient and family by mutual understanding and open discussion.

4.5.3   Category 3: Privacy

The participants identified privacy as an important category of daily focus. The ED physical environment and high volume of patients make patients' privacy and confidentiality difficult (Lin et al, 2013:2). The lack of privacy leads to healthcare professionals making wrong diagnosis and patients not receiving the correct treatment, and prevents trusting patient-healthcare professional relationships being built (Lin et al, 2013:1). Lack of privacy contributes to patients' negative experience in the ED and being dissatisfied (McConnell et al, 2016:43).

Quotes to support the importance of Privacy:

- *"Everyone can hear what is wrong with each patient. No privacy in the ED…"* (Observation 18)
- *"Lack of privacy, especially in casualties… I (healthcare professional) was able to hear other patients private conversations with the doctor (healthcare professional)…"* (Observation 11)
- *Doctor (healthcare professional) very loud, everyone can hear what is wrong with patient…"* (Observation 4)

- *"… maybe a little bit more privacy like with the curtains being drawn not only when doctor (healthcare professional) come in to see you maybe it should just be drawn a little…"* (Patient 10)

- *"Some of the doctors (healthcare professionals) are talking loud; you can hear what the doctor is saying in Casualties bed 8 if you stand in casualties bed 2. There is no privacy. When I want to see a doctor and he ask me: "when was my last menstrual period?' I mean, everyone in casualties can hear, there is no privacy…"* (Interview 15)
- *"Maybe communication from when they (patient) walk into the door should be I (healthcare professional) think a little bit more confidential. I don't know if we maybe can, the patient can write it down, and they can still put it in the book, because the book is confidential, and they can still put it in the book without the patient screaming what is wrong with them."* (Interview 10)

The healthcare professional is responsible for the patient's privacy and patient's confidentiality (Lin et al, 2013:1). In the ED, however, there is a lack of privacy. There are treatment bays that are not sound proof and only curtains to use with examinations. In the resuscitation area the beds are separated by curtains and screens due to the layout of the ED. Patients are placed close to each other and the lack of privacy and confidentiality makes communication difficult between patients and healthcare professionals, especially discussions about treatment options and sensitive medical conditions (Lin et al, 2013:1).

The participants in this study identified one (1) sub-category relating to privacy, namely disturbances.

4.5.3.1   *Sub-category 1: Disturbances*

The ED has a lot of disturbances and is a chaotic environment. Disturbances happen daily in the ED and affect patient-centred communication. The ED environment is a complex environment with a lot of interruptions when healthcare professionals communicate with patients (Werner & Holden, 2015:244).

Quotes to support the importance of Disturbances:

- *"A lot of noise and disturbances…"* (Observation 7)
- *"Unit is extremely busy and a lot of visitors at Bed 4 and very noisy…"* (Observation 12)
- *"ED is busy… a lot of noise and a lot of people, patients, family in the unit… and healthcare professionals walking around, each healthcare professional on a mission… "* (Observation 18)

- *"… also "butting" in when you (healthcare professional) busy. Especially some staff members (healthcare professionals) loves to come in when you with a patient. He (Nursing staff, healthcare professional) will come in while you talking to the patient… especially when you examine someone and someone pop in there, first you are distracted, because you see them there, must I carry on or listen to you… Distraction, its distraction!"* (Interview 3)

The disturbances in the ED lead to poor communication between the patient and healthcare professional and affect the quality of care delivered to the patient. Noise is another disturbance in the ED. The noise sources in the ED come from patients and healthcare professionals and among healthcare professionals who communicate with each other (Ortiga et al, 2013:48). Noise leads to ineffective communication in the ED. Noise in the hospital, specifically ED noise, is a worldwide problem (Ortiga et al, 2013:50). The WHO recommends that noise levels should be 30dB with a maximum of 40dB (Ortiga et al, 2013:48). Elevated noise levels in a busy, chaotic ED environment lead to annoyance, disruptions, ineffective communication and increased stress levels (Ortiga et al, 2013:45).

Quotes to support the importance of noise:

- "*Monitor alarming and not addressed immediately although 10 people around the bed now…"* (Observation 1).

The ED is a critical care unit and patients and healthcare professionals are both under stress (Ortiga et al, 2013:49-50). The noise impacts on the quality of care delivered to the patient, because sound has an effect on communication between people and interferes with hearing (Ortiga et al, 2013:50).

4.5.4 Category 4: Equality

The participants identified equality as part of the daily focus to enhance patient-centred communication in the ED. Participants described equality as equal everything for patients and healthcare professionals: equal sympathy, equal respect, and it should be a daily focus.

Quotes to support the importance of Equality:

> • *"… they (healthcare professional) tell them (patient), we going to put up a drip instead of you have pain, do you rather prefer something oral or an injection or do you want a drip. We do not give our patients options, we just tell them… So I really think we should involve them more… we carry out the orders and without involving the patient in decision care… Without questioning what the patient want. Sometimes some patients don't want a drip they want an injection or something orally but yet we do not give them that option at all."* (Interview 8)

Equity is defined as equal care for people in equal need of care (Verlinde et al, 2012:1). Miles and Mezzich (2011:424) refer to the Patient-Centered Outcomes Research Institute (PCORI) definition of the aim of patient-centredness as "to provide patients and their healthcare providers, family and caregivers, with the information required to make choices that are aligned with their desired health outcomes and where such choices are consistent with their values and preferences". According to Miles and Mezzich (2011:424) the healthcare professional should ask four (4) questions to promote equity :

1. According patients' personal characteristics and preferences what can they expect to happen to them?
2. What are patients' options and what are the benefits and disadvantages of those options?
3. What can patients do to improve the outcomes that are important to them?
4. How can the healthcare system improve patients' chances of achieving the outcomes they desire?

Patients want to be equal partners and therefore want healthcare professionals that involve them in decision-making through communication and provide them with different treatment options for their specific needs and preferences (Phillips et al, 2015:2622). However, that is not always a reality in the ED. Kanzaria et al (2015:1438) found that treating the patient as a equal partners involving shared decision-making is difficult to apply in a busy, chaotic and challenging environment. In a trilingual ED in Hong Kong, Pun et al (2015:8) found that several factors affected communication and healthcare professionals working in the ED were seen as fast decision-makers and did not give attention to patients mental needs but only to their physical discomfort. According to observation notes,

- *"Nursing staff (healthcare professionals) is much task-orientated and not involve the patient in decision-making…"* (Observation 16)
- *"… the patient was not involved in her treatment. The doctor (healthcare professional) was decision-maker and her decision was final..."* (Observation 10)

Shared decision-making is part of patient-centred communication to reach mutual understanding. Decision-making should be guided by patients' values and reaching a mutual understanding of the patients' illness (King & Hoppe, 2013:386). Facilitating shared decision-making and power sharing is essential to make patient-centredness a reality in the ED and improve the delivery of patient-centred communication (McConnell et al, 2016:44). At the same time, however, not all patients want to be part of decision-making and not all medical situations allow a shared decision-making approach (King & Hoppe, 2013:389). Pun et al (2015:2) emphasise that more patient involvement with positive patient-healthcare professional relationships lead to mutual understanding and improved patient outcomes. Patient-centred communication is a collaborative process where patient and healthcare professional make healthcare decisions together and consider the patient's values, needs and preferences (Kanzaria et al, 2015:1438). According to a participant,

- *"… So I (healthcare professional) really think that patients should be involved more. And more should be explained especially diagnostic tests and then cost comes into it as well. Because theoretically a patient, every test that is been done and every procedure that is done, there should be a quote, communicate to the patient at least what cost could be even if it is a cost estimate. But it must be done and I'm not sure if it is done correctly in the manner we do it every day…"* (Interview 4)

The ED visit is an unique journey that is an acute visit to an unfamiliar place without an on-going patient-healthcare professional relationship (Dudley, Ackerman, Brown & Snow, 2015:e255). Patients who engage in their care treatment and have a relationship with the healthcare professionals bring valuable knowledge about the impact their illness or condition have in their life and influence the decision-making positively and improve patient adherence to treatment (Phillips et al, 2015:2622). The quality of the patient-healthcare professional relationship is part of the effectiveness of care and is related to improved patient satisfaction, better patient compliance and optimal patient outcomes (Verlinde et al, 2012:1-2). Patient-centredness allows the patient's preference of level of involvement with the aim of improving healthcare delivery and patient-centred communication in the ED (Phillips et al, 2015:2627).

Patients are individuals with different preferences and desires of involvement. Some patients find it too much responsibility to engage in their healthcare and decisions while some healthcare professionals dismiss patients' sharing their story and experience of illness (Phillips et al, 2015:2626). Shared decision-making in the ED where

time is limited and establishing good patient-healthcare professional relationships is important to enhance effective communication (Kanzaria et al, 2015:1443).

4.5.5   Strategies for daily focus

The participants suggested the following strategies for daily focus that could be implemented in the future to ensure that patient-centred communication happens in the ED every day.

- Patients should be prepared at all times when coming to the ED, bring chronic medication with.
- Patients should have a paper with the history of chronic medicine and medical history.
- Have the medical aid card available.
- Patients and healthcare professionals should be calm when communicating.
- Healthcare professionals should focus on values and make it a daily drive in the ED
- Healthcare professionals should be nice to everyone.
- Daily communication should be part of the daily focus and handing out daily thoughts for inspiration among healthcare professionals.
- Ensure that the patient understands the expected journey and healthcare professionals should listen to the patients' stories.
- Use one language namely English in the ED so that everyone can understand.
- Healthcare professionals should practise tolerance be accommodative towards the patients and colleagues.
- Healthcare professionals should always be patient-centred and explain procedures to the patient.
- Healthcare professionals should explain everything to the patient like expected journey through the ED.

4.6   SUMMARY

Patient-centredness is all about patients' experience of the illness and is equal to the patients' treatment of their health complaint and establishing of empathy between patient and healthcare professional through interpersonal communication to improve the relationship. Patient-centredness can be defined by the quality of the interactions between patients and healthcare professionals combined with communication that is the key component of care that forms healing relationships, mutual understanding, trust, patient participation and informed decision making.

This chapter discussed the data analysis and findings in detail with reference to the literature reviewed. The discussion focused on the key touch points, namely professionalism, communication and daily focus and their categories and sub-categories.

Chapter 5 concludes the study, briefly describes its limitations, and makes recommendations for further research.
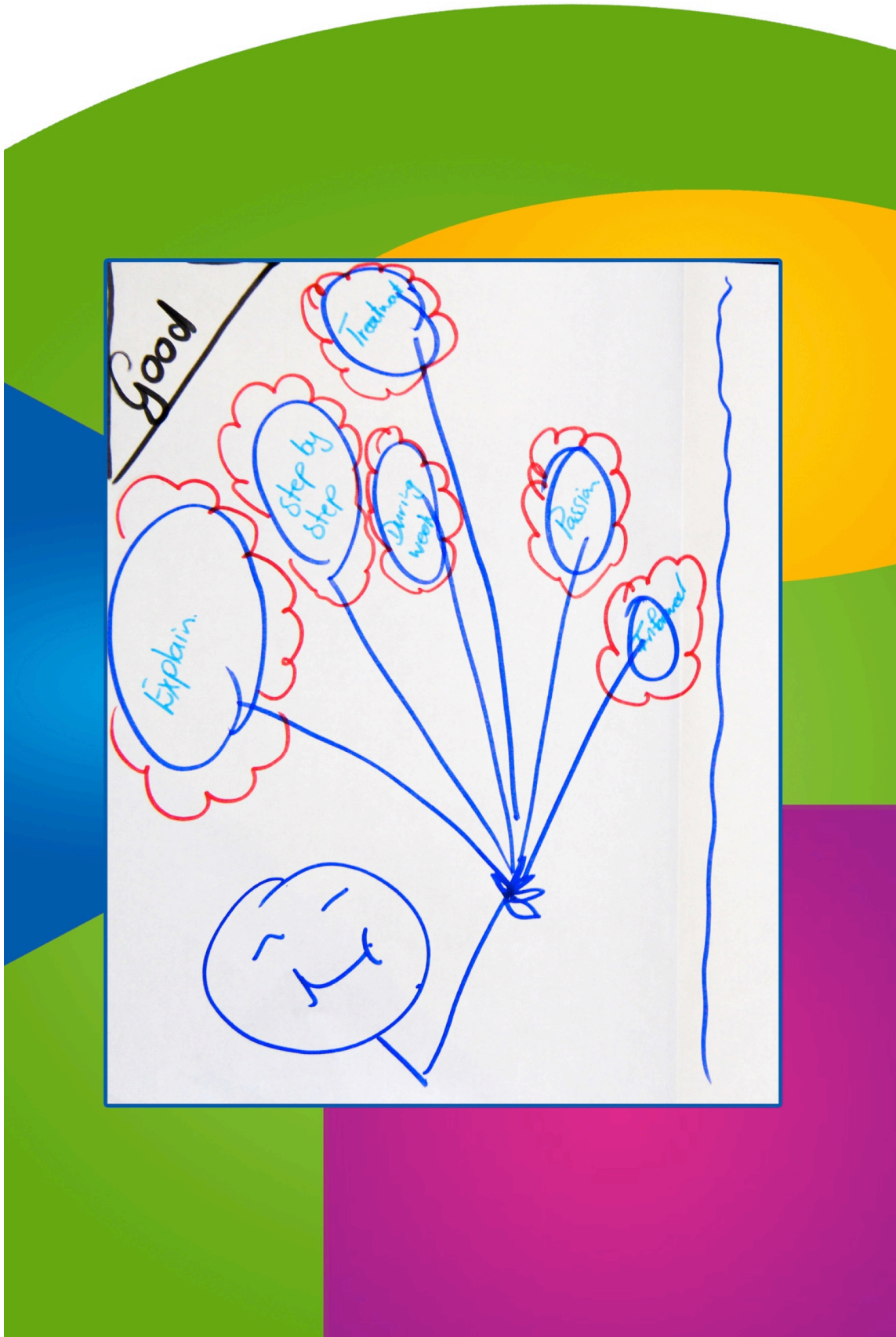
Illustration by participant at Co-design event, July 2016.

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CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

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"The most important concept to grasp is that all experiences are important and that we can learn from them." –
Nathan Shedroff

5.1 INTRODUCTION

Chapter 4 discussed the data analysis and research findings and an in-depth review of the applicable literature. The research findings were based on the collaborative data analysis conducted by the participants and the researcher from the data obtained during the observations of existing communication in the ED, narrative-based film interviews with patients and interviews with healthcare professionals. This chapter presents the conclusions and recommendations related to the two aims and objectives identified for the study, the limitations of the study and a personal reflection from the researcher.

5.2 AIM AND OBJECTIVES

The aim of the study was to co-design patient-centred communication in an emergency department. In order to achieve the aim, the objectives of the study were to:

- Explore current communication in an emergency department as experienced by patients and healthcare professionals.
- Collaboratively co-design strategies to enhance patient-centred communication in an emergency department.

The conclusions relating to current communication as experienced by patients and healthcare professionals and the strategies identified to improve patient-centred communication in the ED will be discussed simultaneously to simplify the discussion. Recommendations relating to the key touch points and related categories and sub-categories identified during the data analysis session will then follow.

5.3 CONCLUSIONS AND RECOMMENDATIONS

The researcher and healthcare professionals observed existing communication in the ED in 18 unstructured observation sessions, for a total of 343 minutes (see chapter 3, section 3.3.2). A total of 13 patients' narrative-based film interviews, where the participants shared their experiences of communication in the ED, were conducted (see chapter 3, section 3.3.3). Fifteen (15) healthcare professionals were interviewed and shared their experiences of communication in the ED, for a total of 221 minutes and 58 seconds (see chapter 3, section 3.3.4). The data obtained was analysed by means of the hermeneutic data analysis method (see chapter 3,

section 3.3.5) during the co-design event. Twenty three participants, namely the researcher and two supervisors, eighteen healthcare professionals and two patients, attended the co-design event. An experienced supervisor, who guided the data analysis and strategy planning processes, facilitated the co-design event. The participants subsequently collaboratively developed strategies for each identified key touch point (see chapter 3, section 3.3.5).

The conclusions reported are based on the data obtained during the unstructured observation, patients' narrative-based film interviews, and healthcare professionals' semi-structured interviews and the creative hermeneutic analysis of the data at the Co-design event. The participants identified three (3) key touch points, namely professionalism, communication and daily focus of patient-centred communication.

5.3.1   Key touch point 1: Professionalism

Professionalism is a pre-requisite of patient-centred communication in the ED. Professionalism has become one of the six core competencies in healthcare today. To achieve patient-centred communication in the ED, it is vital to be professional at all times and respect the patient as an individual with specific values, needs and preferences. Trust, competence, respect and communication skills form the core of professionalism.

Empathy, respect and patience are another three core values of professionalism that improve patient satisfaction and lead to better patient outcomes. The most important element of respect is the patient's involvement in shared decision-making. Healthcare professionals that involve the patient in shared decision-making that is guided by the patient's values, needs and preferences are respecting the patient as a person. Empathy is made visible to the patient through effective communication and mutual understanding between patient and healthcare professional. Effective communication leads to quality care in the ED.

The patient's perception of quality care plays a role in quality improvement strategies. The healthcare delivered becomes more about the patient's experience. The overcrowding in the ED and long waiting times influence the quality of care in several ways. In the busy chaotic ED environment there is no time to listen to the voice of the patient. Time will always be a topic of conversation in an ED. The healthcare professionals are under pressure to treat patients in the shortest time possible so they become more task-orientated affecting the professionalism values expected by the patient. The more satisfied the patient, the more the patient adheres to treatment and plays an active role in the treatment. The patient's role in become more involved in the healthcare is still not clear. Healthcare professionals feel positive about the idea that patients need to be more involved but the idea is not well known by patients in South Africa and therefore not practiced in all EDs yet. Patients will need to realise and be made aware that there is an opportunity to become an equal partner in designing their healthcare. Involving the patient in decision-making and achieving mutual understanding leads to better patient outcomes.

Patients are satisfied in general with the healthcare they receive. Healthcare professionals are task-orientated and not always aware that the patient-healthcare professional relationship plays an important role for the patient. Listening to the patient's story is more valuable than focusing on getting the job done and getting the patient out of the ED. Spending time with the patient and understanding the patient as a holistic person is a valuable element of patient-centredness. Trusting healing relationships between patient and healthcare professional will lead to patient engagement. Collaboration is needed to form those trusting healing relationships. To move towards patient-centred communication a voice needs to be given to the patient to improve patient satisfaction. The patient needs to become the centre of communication to create patient-centred communication in the ED.

5.3.1.1   Recommendations

Healthcare professionals should be professional and that includes co-constructing values and living out those values to enhance patient-centred communication and consequently professionalism; providing quality service delivery, good time management and a team approach. The researcher and participants made the following recommendations regarding professionalism that will enhance patient-centred communication in daily practice, management, education and future research.

Clinical practice

- Patient-centred communication should be re-evaluated on a continuous basis and feedback given to healthcare professionals working in the ED.
- Collaboratively do a value-and-belief clarification relating to patient-centred communication in the ED, which should include respect, empathy and patience.
- Reach consensus amongst all healthcare professionals working in the ED on values and beliefs that would guide patient-centred communication.
- Provide opportunities to have reflective conversations on the realisation of the set values and beliefs relating to patient-centred communication in the ED.

Management

- Engage all healthcare professionals in the management of patients as this may lead to a healing patient-healthcare professional relationship.
- Enhance teamwork, which may enable healthcare professionals to spend more time with individual patients.
- Encourage patients to engage during decision-making as this will enhance the incorporation of patients' values, needs and preferences to establish a trusting and healing relationship between healthcare professionals and patients.
- Keep patients continuously up to date with what the expected path is and waiting times, such as for diagnostic test and specialist referrals.

- Allocate a dedicated healthcare professional to explain what can be expected during their journey through the ED.
- Regularly update patients on their current point in this journey and the expected time it could take before being discharged.

Education

- Continuous improvement of quality care in the ED, the healthcare professionals need to be part of the team.
- In-service training about professionalism and how to it promotes patient-centred communication.
- Provide in-service training about effective communication that promotes professionalism, which in turn may enhance trust between healthcare professionals and patients.
- In-service training about patient-centred communication, the concept and how to apply it in practice in the ED every day.

Future Research

o Explore effective teaching strategies to stimulate patient-centred communication skills that should be used in the ED.
o Explore how to involve patients to participate in the decision-making process and consequently become equal partners in healthcare.

5.3.2 Key touch point 2: Communication

Communication is the core of patient-centred communication. In the fast paced and complex environment the healthcare professional is challenged to effectively communicate with the patient. Communication often fails to meet the expectations of the patient. Patients come to the ED as strangers. When the healthcare professionals introduce themselves to the patients and orientate them to the ED, the patients are put at ease. One of the challenges of the healthcare professional in the chaotic ED environment is to treat the patient as a person and not just a number.

The concept of the patient as a person and not the person as a patient is part of the core of patient-centred communication in the ED. Healthcare professionals state that it is important to introduce themselves when patients come into the unit and to make eye contact to reassure them from the beginning of their journey in the ED, but in the observation notes eye contact and introducing themselves to patients was lacking. The healthcare professionals see effective communication as important, but effective communication is not carried out in practice. The patient is not treated in a patient-centred way and the humanisation principle is not always applied in practice. Healthcare professionals in the ED are task-orientated and work in a challenging environment where communication often fails and seldom are patient-centred. Healthcare professionals do not always communicate with the patient in layman's terms and use terminology that the patient does not understand. Respecting the

patient's values, needs and preferences and treating the patient as a human being is getting lost in the chaotic ED environment. Healthcare professionals are rushed for time and therefore do not spend enough time to reassure the patients throughout their journey in the ED.

Explaining the ED processes to patients is vital because the more informed the patients are about the journey through the ED, the more they will adhere to and be involved in their treatment. Patient involvement leads to patient engagement, which is a component of patient-centredness. There is still a gap in shared decision making between patient and healthcare professional in the ED. Patients will engage and participate in their own healthcare and be involved if they are informed and are given enough information to feel in control and feel able to make decisions regarding their healthcare plan. Patient involvement and participation leads to improved patient outcomes, but it was found that patients have incomplete understanding of important aspects regarding their care upon discharge from the ED.

Patients are discharged out of the ED without properly understanding information given to them regarding when to return to the ED and care instructions at home. Patients have difficulty recalling what had been said after healthcare professionals had given verbal information alone. Explaining the procedures in the ED is important to get patients involved in their treatment and decision-making. The ED environment is of such a nature that the focus is to get the patient out of the ED as quickly as possible without ensuring that the patient understands discharge information. Effective communication is crucial at discharge to ensure patients adhere to treatment and to improve patient outcomes and can be strengthened by also giving the patient written information regarding follow up and home care.

Communication is vital in the chaotic and challenging environment of the ED and body language plays a key role in effective communication. Building trusting healing relationships is based on effective communication and body language that portrays patient-centredness. Touch is a universal language of caring and eye contact is important to portray a caring attitude and make patients feel important and at ease. Eye contact also enhances listening and makes the patient feel important enough and cared for by the healthcare professional. The healthcare professionals who pull up a chair are showing patients they want to listen to the patients' story. Touch, eye contact, pull up a chair, positive attitude and friendliness contribute to building trusting patient-healthcare professional relationships and create moments of patient-centred communication in the ED. The patient as a person is the core of patient-centred communication and regular updates, reassuring and informing the patient of the journey through the ED is essential to improve patient outcomes and patient satisfaction.

5.3.2.1 *Recommendations*
Healthcare professionals should focus on how to effectively communicate in the ED, which includes verbal language and body language. The following recommendations were made regarding the key touch point

communication to enhance patient-centred communication in daily practice, management, education and future research.

Clinical practice

- Re-focus the way every healthcare professional communicates with a patient.
- Ensure that the patient understands what was communicated.
- Communicate in a way that the patient's values, needs and preferences are incorporated.
- Use layman's terms when communicating with patients in order to enhance their understanding.
- Determine the patient's level of education to enhance understanding when communicating to the patient.
- Patients should be acknowledged as individuals and not numbers or conditions, particularly during triage.
- Reassure patients from the beginning of the ED journey until the end with discharge from the ED to relieve their anxiety.
- Explain the expected journey through the ED as well as all procedures, because the more the patients are informed, the more they will participate in their own healthcare and adhere to prescribed management.
- Listen actively to the patient's story as the patient then experience effective communication form healthcare professional

Management

- Re-visit documentation practices in the ED to identify areas for improvement.
- Re-enforce and have critical conversations with healthcare professionals about acceptable attitudes towards patients.
- Address undesired and inappropriate attitudes of healthcare professionals.
- Collaborate with healthcare professionals to enhance their understanding of the importance of communicating with patients in a patient-centred way.
- Collaboratively design innovative approaches together with healthcare professionals and patients to improve discharge information, written and verbal communication.
- Revise discharge information leaflets and ensure that the information is relevant and understandable to enhance the patient's understanding.

Education

- Patient education, specifically before discharge, is vital to enhance management compliance.
- Patient education should be emphasised as it promotes an understanding of discharge information and directly influences patient care, experiences and healthcare outcomes.
- Healthcare professionals should actively learn patient-centred communication skills to improve their confidence in communication and to improve patient satisfaction.

Future research

o   More developed and widespread understanding of the concept of patient-centredness and awareness within the healthcare systems, namely medicine *of* the patient, *for* the patient, *by* the patient and *with* the patient.

o   Patient-centred communication in the ED, which is a challenging environment where life-saving interventions take priority over communication, is not well understood and should be further explored.

o   Explore whether communication factors such as autonomy, competence and shared decision- making would play a role in strengthening the healing patient-healthcare professional relationship.

o   Explore the extent to which patients can be involved in the shared decision-making process when admitted to the ED.

o   Co-construct the key components of patient-centredness for the unique ED setting, specifically in the South African context.

o   Investigate the complex relationship between the patient and healthcare professional and communicative behaviour of the healthcare professional and how this influences the patient's way of communicating.

5.3.3   Key touch point 3: Daily focus

Patient-centred communication is the daily focus in the ED. The patient is the centre of all communication in the ED. Healthcare professionals should have a holistic approach towards their patients. A balance between talking (communicating), time-keeping and waiting times in the ED is an important daily focus to improve the patient experience. Healthcare professionals recognise that effective communication plays a vital role in delivery of quality care, especially in the ED because of the complex and challenging environment. To communicate care is just as important as delivering care to patients in the ED and is crucial to create moments of patient-centred communication.

Patients come to the ED with expectations and know they are going to wait. Healthcare professionals need to identify opportunities to inform and explain the expected path in the ED. There are hidden truths that cause misunderstanding mainly about costs involved. To avoid misconceptions and misunderstandings, it is necessary to inform the patient about all possible hidden truths in advance and not withhold information from the patient. The better informed the patient, the calmer the patient is and a balance is maintained.

Consideration of the patient's values, needs and preferences will enhance the moments of patient-centred communication. Consideration of the patient's family is part of patient-centredness and should be a daily focus. Healthcare professionals underestimate the value of the family member presence in the ED to support and reassure the patient and could lead to a better ED experience. The patient also needs to consider the healthcare professional while being treated and communicating in the ED. To consider the patient, patient's family and the healthcare professional are essential to build trusting relationships.

Trusting relationships are affected by lack of privacy and could contribute to a negative patient's experience in the ED. Privacy should be a daily focus in the ED, as well as to limit the disturbances that are almost unavoidable. Elevated noise levels in a busy, chaotic ED environment is the reality and regrettably leads to annoyance, disruptions, and ineffective communication. Effective communication is vital for patient-centred communication in the ED, but lack of privacy and frequent disturbances affect patient-centred communication in the ED.

Equal treatment, equal respect for patients and their families, equal respect for healthcare professionals, thus equality, should be a daily focus to enhance moments of patient-centred communication in the ED. Mutual understanding, shared decision-making between patient and healthcare professional and patient participation are elements of patient-centred communication. Decision-making should be guided by the patient's values, needs and preferences. Shared decision-making and power sharing are essential components of patient-centredness in the ED and improve patient-centred communication. Effective communication between patient and healthcare professional is essential to deliver quality healthcare and increase patient satisfaction.

5.3.3.1   *Recommendations*

Healthcare professionals should have a daily focus that includes a holistic approach, consideration, privacy and equality to patient care and communication. The following recommendations were made regarding daily focus to create moments of patient-centred communication in daily practice, management, education and future research.

Clinical practice

- Patient-centred communication should be a daily focus in the ED.
- All healthcare professionals should be aware that they should listen attentively to patients' stories during interaction.
- Understand patients' needs, values and preferences during patient management.
- Allow for power sharing which, in turn, may enhance mutual understanding as well as active participation.
- Involve patients in their care to give them a sense of shared ownership of their healthcare.
- Acknowledge the patient as a 'whole' person and have a human connection with the patient rather than just recognising to patient as a number.
- With the patient's consent, family members should be seen as a valuable part of support during the patient's ED journey.

Management

- It should be a top priority for patient-centredness to renovate or build an ED that gives more privacy to patients.
- Install a video, internet link and/or information brochure that will explain to the patient/family what the journey through the ED entails.
- Expand quality care to re-look and improve operational efficiency like workflow and being a patient-centred ED.
- Healthcare professionals need to be made aware of the noise they create in the ED and its effect.
- Use an appreciative feedback approach when giving feedback to healthcare professionals.
- Address noise levels in the ED through increasing awareness among healthcare professionals, patients and family members.

Education

- Schedule formal workshops for healthcare professionals to learn how to communicate clearly at the "bedside" with patients' families.

Future Research

o Shared decision-making and patient self-management is a less studied area that needs to be researched in the future.

o The role of the healthcare professional with regard to family care in the ED and how to meet the needs of family members, specifically in the South African context.

5.4   RECOMMENDATIONS

Based on the findings of the study the following general recommendations are made:

- The findings of this study should be shared with all healthcare professionals working in the ED so as to raise awareness of current communication in the ED. Raising awareness of the challenges may contribute to implementing the suggested strategies to enhance patient-centred communication in the ED.
- All healthcare professionals should implement the strategies identified by the participants to improve patient-centred communication, related to the key touch points, collaboratively.
- Patient-centred communication should be re-evaluated on a continuous basis and feedback on the findings given to healthcare professionals working in the ED.

It should be acknowledged that the ED is a chaotic and challenging environment and patient-centred communication has not been widely researched in the setting. Therefore the ideal ED patient-centred communication is not realistic because of the chaotic and challenging environment. Patients with life-threatening

conditions and injuries will always get priority above patient-centred communication in the ED. The healthcare professionals working in the ED will always strive to be professional and make patient-centred communication a daily focus. The ultimate ED would strive to create moments of patient-centred communication to shape the experience of the patient and healthcare professional.

5.5   LIMITATIONS

The study explored existing communication in the ED, patients told their stories about their experience of communication in the ED and healthcare professionals shared their experiences of communication in the ED. Data analysis was done collaboratively with patients and healthcare professionals to co-design patient-centred communication in the ED.

Of the 22 patients who were invited to the Co-design event to co-design patient-centred communication in the ED, only two (2) attended and both left before strategies were identified. The strategies were identified by the healthcare professionals with no input from the patients. The data was analysed by 18 healthcare professionals and two patients. Except for the 12-minute video of the patient interviews, the patients' voice was limited to just the two (2) who attended the event. Moreover, the study was limited to the ED of one selected private hospital. Accordingly, it may not be possible to generalise the findings to other hospitals in other parts of the country.

5.6   PERSONAL REFLECTION

"Eat better. Run more. Squat more. Sleep earlier. Wake up earlier. Make a good breakfast. Drink water. Eat fruits. Read books. Adventure. Talk less. Listen more. Feel deeper. Love better. Open your eyes. Experience life. Be happy." –Unknown

Communication is part of us and without communication we cannot survive. In the ED communication is vital and I work in the chaotic ED environment and know communication is the air we breathe to survive. What I realised is that the challenge is to give patients a voice in the ED and an opportunity to tell their stories of their experience in the ED. Healthcare professionals are task-orientated and not aware of patients' needs and preferences. The gap we identified was to make the healthcare professionals more aware of patient-centred communication in the ED and give patients a voice. The ultimate goal was to improve patient outcomes and patient satisfaction. That is how we decided on patient-centred communication in the ED. While my supervisor and I were still playing around with the concept of patient-centred communication, she mentioned the term "Experience-based co-design". She advised me to go and read up on EBCD because she had come across it at a conference she had attended. I started reading up on it and basically fell in love with EBCD and the way research was being done when using such a method. I read and read and almost became an expert on EBCD. From the very first article I read I just knew this was what I wanted to do. Experience-based co-design is a new concept in healthcare and the future of research to obtain patients' experience through stories and make them equal partners in healthcare. This study

is the very first EBCD study done in South Africa and only the second study of EBCD done in an ED. We have used EBCD to enhance patient-centred communication in the ED, and that is where my journey started more than a year ago.

My journey consisted of learning new concepts and terms and working out just how we were going to pull this EBCD off. With the brain power and years of experience of my supervisors we slowly started to get the bigger picture and how all the puzzle pieces would fit and not fit together but I learned with time that everything eventually worked out how it should work out. After all the ethical approvals we could start doing the real work. I kept a short dairy of when and what happened. This was my research journey.

29 April 2016

I did my Stage 1: setting up. I showed a power point presentation of my research project at the unit meeting. That included all the permanent registered nurses, enrolled nurses and enrolled nurse assistants working in the ED. Two of the deputy nursing managers were also present for the presentation. My unit manager was very supportive and encouraged everyone to take part and to ask questions. I was a little nervous to show the presentation to the nursing staff. I was not sure that they would understand and want to be part of the project. Afterwards I got a lot of feedback during the course of the week. More nursing staff want to participate in observation than to take part in the interviews. One registered nurse verbalised that she could see that I am enthusiastic about my project and explained it very well. The two deputy nursing managers were also very impressed about the project and told me afterwards that it is a very good project. I was very happy to receive such feedback at the beginning of my project. The next step was to involve the doctors who work in the ED.

5 May 2016

Stage 1: Setting up. I showed my power point presentation to the four (4) directors of the doctor's practice of the ED. My unit manager accompanied me for moral support. She was really very supportive of my project in the ED. The four (4) doctors were very positive about the project in the ED. One of the doctors said it is very much needed to improve patient satisfaction in the ED. They were willing to help me get some of the other doctors as volunteers and be part of the observation and interviews. They asked me to please present my presentation to the other 8 permanent doctors working in the ED at their next meeting on 20 May 2016. I was very excited that everyone I approached was willing to be part of this study. When I gave feedback to my supervisor after meeting with the four (4) directors, she said she is very proud of me and that it is the first study that has a multi-disciplinary approach where both doctors and nursing staff will participate. That motivated me even more to make a success of this research project. Next up was showing the presentation to the other 8 doctors working in the ED.

20 May 2016

I did Stage 1 with all the doctors working in the ED at their monthly meeting. It was very informal and interactive while I presented my power point presentation. The feedback was positive and few questions arose that my supervisor answered. I was very thankful for their positive feedback and they would support my research project. Then the big work started. I was very thankful for my unit manager's support throughout the research thus far. She was also present the morning when I presented the power point to the remaining eight doctors and it helped a lot to know she supported me. Then I needed to get ready for Stage 2 that was observation in the ED.

25 May 2016

I was almost done with my Stage 2: observation in the ED. It was very interesting to hear what the nursing staff observed about existing communication in the ED. I think after they had done an observation, they were made aware of how we communicate with our patients and that we don't really communicate with our patients in a patient-centred manner. I was very glad we did observation, because we excluded observation when submitting my proposal to the post-grad meeting at the university, but the evaluator suggested that observation needs to be part of the study. I think my supervisor and I were relieved because I read that observation was the part of EBCD that people easily do not do, although the literature shows it is a very valuable data-collection method.

I was getting a bit anxious about Stage 3: interviewing of patients. I started to identify possible patients that I would contact. I think my biggest concern was that the patients won't be interested, but I needed to get positive and send out positive vibes to get my patients involved. Then I started preparing for Stage 3 and 4.

8 June 2016

I have started with Stage 4: interviewing of healthcare professionals. I have done (2) healthcare professional's interviews and I was a bit nervous while doing the first two interviews. I have learned a new skill how to use a voice recorder and that the more I am relaxed and stay calm, the better. I was looking forward to the rest of the healthcare professionals' interviews. When I phoned my supervisor to share my experience with her she was very proud of me and asked if something specific stood out in both interviews and I realised that I could identify more than one 'key touch point" already. I liked doing research and it makes me happy.

21 June 2016

I have done about 8 healthcare professionals' interviews at that point and gathered good data. I did not like transcribing at all. It was definitely not my favourite activity but it was good to do it because I started analysing the data and could see some triangulation of data between what I have observed and what the healthcare professionals' state in their interviews. Transcribing was extremely time-consuming but the more I transcribed, the easier and quicker it became. Most of the healthcare professionals where positive about the research project and asked me how it was going. The doctors were especially interested and one of the directors was very keen to take part in an interview.

I think the healthcare professionals liked doing the interviews because after the interviews most of them verbalised that it felt like a therapeutic session and they could debrief a bit. I think we, as healthcare professionals, do not often get the chance to speak our minds and share how we feel and have someone truly listen. I felt as though I started to have a better relationship with the doctors I have interviewed and felt like there was some trust between us. Some of the other nursing staff was also asking about doing a masters degree and how it worked and what it entailed. They found it is interesting and actually listened and saw when I did my research. I was really surprised when especially one sister asked me about my masters.

I look at things in the ED differently. The way I approach a patient is different, I try to have more time and listen to the patient and not be just task-orientated. I tend to be more relaxed in my work and try to show more respect to my colleagues and patients.

22 June 2016

I have started with Stage 3: interview patients. I did my first 2 patient interviews yesterday. I was really unsure and nervous about it. But after I'd showed the 2 narrative-based film interviews to my supervisors I felt much better and knew what to correct and how to conduct the other narrative-based film patient interviews. My supervisors' advised me to use less medical terminology and keep the questions simple and keep myself dumb. I am positive about the next narrative-based film interviews and looking forward to the data that I am going to collect. I still need to work hard to get patients to come to the Co-design event.

The event was going to be the highlight of the research project. I cannot believe I am so far in my study and that the end of data collection is approaching! I am looking forward to the Co-design event and the difference it will make in our ED. I have realised that you need to be very accommodating with the patients and healthcare professionals to get their cooperation to conduct interviews.

8 July 2016

I really enjoyed Stage 3 to hear the patients' stories. I was surprised how positive the patients were about the research project. Patients were very surprised about the research design to involve them and hear what needs to be changed in the ED from their point of view and be given a voice. I learned a new skill, how to use a camera and do video recordings. I was very angry with myself one day, because due to a technical problem the last patient video went missing and it was my favourite patient story! Life happens. In-between I was still busy transcribing the healthcare professionals' interviews. I'm so glad that I did not need to transcribe the patient stories.

13 July 2016

Today I had breakfast with my 2 supervisors and my personal film editor. I still cannot believe that I am done with the data collection. I am very excited to share the data with the participants at the Co-design event and curious to know what key touch points of patient-centred communication will be identified. I think the biggest part was putting the 13 patient videos into a 20-minute film. We showed the 28-minute film to my supervisors and they said it needed to be less than 10 minutes. I was a bit disappointed because it was such hard work to get patients to tell their stories on the video. At last we managed to get the final patient stories film to 12 minutes. Everything was now in place and ready for the Co-design event

15 July 2016

Finally the big day has arrived! The venue looked very impressive with a happy atmosphere, baroque as background music and yellow, purple, green and blue helium balloons floating. The coffee was brewing with delicious chocolate cake and a sweetie table because it is a celebration. Everyone was happy and excited for the day. To my disappointment, only 2 patients came to the event. I worked extremely hard to invite patients to the Co-design event and sent a lot of emails, phoned patients and sent text messages a few days before the event. We think that the main reason that patients did not attend was that they cannot get off from work but would like to come to the event. I was really nervous and stressed out about the event.

In my welcome, I asked everyone to make the most of it even if we just changed one small thing today it will be worth it. Everyone enjoyed analysing the data and collaboration. My personal touch was at the end when we went outside and let the balloons up in the air. The feedback was very positive and everyone said it was the best training day they had ever attended. A very big thank you to Tanya for facilitating the whole Co-design event with the help of Ilze and my husband for keeping the coffee pots full and almost everything else.

To summarise the feedback: the participants said it was fun; they could sit together and talk and learn about communication. Some were disappointed that the only feedback from patients was the video and would have liked to hear patients' voice and views in person. The other participants shared that it was nice to see each other's thoughts about communication and there was no judgment. The presence of the doctors was seen as positive and collaboration took place between the patients, doctors and nurses. One participant mentioned that approach is important, how you approach a person can either build or break a person and that is so true. Mutual respect was a topic that needs to be raised more often in the ED. Some participants said they were forced to do some introspection during the course of the morning. Most of the participants said that they did not know each other on a personal basis and maybe we should do it more often in a social capacity. Everyone enjoyed the Co-design event and felt it was the best training day ever. The big question is 12 patients said they were coming and only 2 patients came. This Co-design with patients is not a common practice in South Africa but needs to be researched further. I was delighted to hear such positive feedback from all the participants! It is true the "how" of communication is important. How do I make other people feel when I communicate with them?

The collaborative data analysis to identify the key touch points was a bit of a surprise for me. While I was writing chapter 4 and 5 I could see how the 3 key touch points fit together and form the core of patient-centred communication in the ED. To my surprise, the literature I used to support my findings was like puzzle pieces fitting together to create moments of patient-centred communication in an ED.

5.7   CONCLUSION

This study was presented in five chapters. Chapter 1 gave an orientation to the study, focused on the problem statement and provided background information in support of its formulation.

Chapter 2 presented an in-depth literature review. The chapter provided a theoretical underpinning based on current literature relating to the research topic: patient-centred communication in an emergency department. Topics discussed included communication, patient-centredness and patient-centred communication.

Chapter 3 discussed the research design and research methods used in detail. Experience-based Co-design (EBCD) was used in the study to co-design patient-centred communication in an ED. The five stages in which the EBCD were conducted were discussed in terms of the research methods, namely the population, sampling, data-collection techniques and data analysis, and the strategies to enhance the trustworthiness of the research were discussed.

Chapter 4 discussed the research findings. The key touch points were identified at the Co-design event using the hermeneutic data analysis method. Key touch points, categories and sub-categories as well as strategies for implementation to improve patient-centred communication in the ED were identified namely, professionalism, daily focus and communication. Ten (10) categories that supported the research findings together with the sub-categories and each theme were also identified. References were made to relevant existing literature that supported the discussions and strategies were discussed related to each identified key touch point.

Chapter 5 provided an overview of the conclusions, strategies and recommendations related to the identified key touch points. The limitations of the study were noted and recommendations made for future research. A personal reflection on the study by the researcher concluded this chapter.
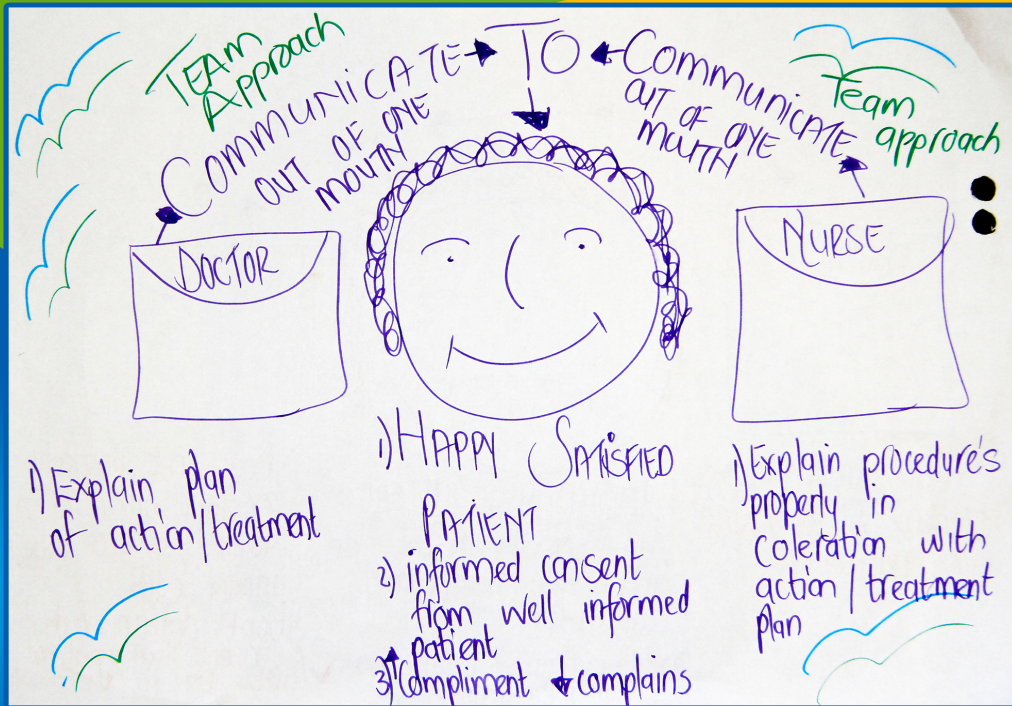
Illustration by participant at Co-design event, July 2016.

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