Information and communication in the emergency department

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ABSTRACT

Background: Effective communication between healthcare providers and patients represents an important caveat in healthcare, both nationally and internationally. Providing information to patients about their care and condition can be challenging, particularly in demanding, time-pressured environments such as the Emergency Department (ED). Understanding the process of communication and information between patients and staff in the ED is essential to ensuring patients are satisfied with their treatment and care.
Aim: This study aimed to develop a holistic understanding of the informational and communicational requirements of patients and staff in the ED.
Methods: Action Research involving patient qualitative interviews and a staff focus group were used.
Results: Fifteen patient and family interviews identified four main themes associated with information and communication in the ED. Six ED staff participated in the focus group, which identified three emergent themes echoing some findings from the patient qualitative interviews.
Discussion: Meaningful and informative interactions between patients and healthcare providers are an imperative and pragmatic component of a positive patient experience. Establishing communicative procedures that are practical, functional and reflective of the service can improve communications between patients and staff and have implications for practice on a local, national and international level.

1. Background

Communication between healthcare providers and patients is important for patient-centred care and a positive patient experience [1] and represents an important caveat in healthcare, both nationally and internationally. Patient-specific information, particularly in the ED, is an essential component of the patient pathway, patient-physician relationship and nursing practice [2]. It is essential to effective team working [3], and enabling patients to make informed decisions [3]. Ineffective communication has been associated with dissatisfaction and frustration [4] and feeling ill informed at discharge is a commonly reported consequence of substandard information amongst ED patients, particularly regarding condition-specific symptoms or medications [5]. This is important, as being ill informed may contribute towards a negative experience, unnecessary readmission or patient anxiety. Indeed, Ackerman et al. [6] examined the patient-physician communications at discharge following chest pain in a hospital in Switzerland and found that effective communication empowered patients to feel positive and confident about their care.

The importance of effective communication and information has

been recognised by the development of several Government initiatives [7–9]. However, information delivery is largely environmentally dependent [1] and demanding, time pressured and target driven environments such as the ED, can be disadvantaged to deliver information to patients. ED attendance is inherently stressful and anxiety provoking, with patients typically requiring urgent care [10]. This can exacerbate inadequate communications, with some patients being discharged without fully understanding their treatment [11], leading to dissatisfaction, negative health outcomes and increased readmission [12–13].

Poor communication can have an extensive negative impact on a patient's health and wellbeing, with research both nationally and internationally indicating that aggressive behaviour towards health care professionals can be attributed to miscommunication [14]. Angland et al. [15] used thematic analysis to examine nurse's perceptions of violent and aggressive behaviour in the ED in Ireland and found waiting times and poor communication were regarded as key factors, particularly in triage. Staff also felt that the operational setting of the ED presented difficulties communicating information to patients. Aggressive behaviour can negatively impact staff. In a systematic review

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and meta-analysis examining the factors involved in aggressive or violent behaviour, Edward et al. [16] found female nurses experienced higher levels of verbal abuse from patients and relatives than male nurses, with nurses working in psychiatric or mental health settings experiencing significantly increased levels of physical assault than in other settings.

Effective communication strategies are fundamental to empowering patients to feel involved in decisions about their care [17] and the evidence points to an obvious need to improve communicative systems within the ED [18]. Examining these mechanisms from a holistic perspective could help to identify how communication systems could be improved to inform future practice and develop procedures that are practical, functional and reflective of the service.

2. Aims

The overall aims of this study were to understand the informational requirements of patients and their families attending the ED and how best to deliver this to meet their needs. This study also aimed to understand how to apply these findings to inform future practice around information provision within the ED.

3. Methods

Action Research (AR) was used to understand the experiences and requirements of communication and information exchange within the ED. Exploring the lived experience of the ED from a patient perspective, whilst also understanding the needs of staff is central to establishing a service that reflects the reality of the ED. AR is a holistic, collaborative qualitative approach that is useful in healthcare research [19]. The perspectives of ED staff, researchers, patients and their families were brought together, to provide a holistic understanding of how communications could be improved. Through a cyclical process of exploration, feedback and modification, an understanding of how informational resources, focusing on the requirements of patients and their families in the ED, could be developed to evolve current working practices. The design incorporated individual patient qualitative interviews and a staff focus group.

3.1. Patient qualitative interviews:

A purposive sample of 15 patients who had attended the ED and been admitted to the ward were invited to take part in a one to one semi-structured interview.

3.1.1. Inclusion criteria

- Patients aged 18 years or above and admitted to a ward following an ED referral.
- Patients considered clinically well to participate by the lead ED nurse.
- Family member of a patient aged 18 years or above.

3.1.2. Exclusion criteria

- Patients who lack mental capacity at the time they are approached (as defined under the Mental Capacity Act 2005).
- Patients considered to be very weak, frail or with an infection risk.

Fifteen individual interviews with patients who had attended the ED for treatment were undertaken by the lead author. At the time, she was a 34-year-old female with a PhD in Psychology, working as a research fellow at Barnsley Hospital NHS Foundation Trust, with previous experience of undertaking qualitative research. An interview schedule was designed with open ended questions to guide the interviews. To ensure the patient interviews focused on issues pertinent to the subject

area, the topic guide was developed with input from an ED research nurse who had significant experience of working in the ED.

Potential participants were identified from the daily ED attendance records or by reviewing the previous days admissions by the research team during a three-month period. Participants were approached by the lead author in the ward environment, and invited to take part in a semi structured interview about their experiences of information and communication in the ED. The invitation took place once the patients had left the ED to ensure they had experienced the complete journey from ED to the ward area. This was believed to provide greater insight into the multifaceted informational needs of patients throughout their ED visit. Participants were provided with information sheets and given time to decide whether or not they wished to take part. Written consent was obtained prior to interview to participate in the study and for the interviews to be audio taped. The interviews took place at the patient's bedside over a range of days and times to capture a varied sample. Interviews were audio recorded then transcribed verbatim in readiness for analysis. Interviews lasted between 20 and 45 minutes. Due to the nature of the convenience sampling, it was only possible to include one family member's experience. Data was collected between April and June 2017.

3.1.3. Staff focus group

The focus group aimed to understand ED staff views of the informational and communication needs of patients. Six senior nursing staff working in the ED, of varying roles and grades, were recruited through advertisements on the department's social media page and word of mouth. The group was facilitated by the lead author utilising a topic guide developed using data collected during the patient interviews. Participants were provided with information sheets and given time to decide whether or not they wished to take part. Written consent was obtained prior to the focus group to participate in the study and for the focus group to be audio taped. The discussion was audio recorded and transcribed verbatim.

4. Ethics

This project was considered a Service Evaluation, not requiring ethical approval from the Health Research Authority (HRA). The project was reviewed and approved by The University of Sheffield Ethics Committee in the School of Health and Related Research (ScHARR). The Research and Development Department at Barnsley Hospital NHS Foundation Trust reviewed the protocol and supporting documents and provided governance assurance for the study to proceed.

5. Data analysis

5.1. Patient qualitative interviews

The interview data was transcribed in full by the research team. Data analysis drew upon the principles of the 'Framework' approach to qualitative analysis [20], involving a systematic process of sifting, charting and sorting material into key issues and themes through the following stages: familiarisation, developing a thematic framework, indexing, charting, mapping and interpretation. Regular consistency checks were carried out where a sample of transcripts were independently coded by all analysts ensuring consistency in coding and interpretation across the team.

5.2. Focus group

Themes from the patient interviews were communicated to staff and discussed at length to understand how their needs could be better incorporated into current working practices.

6. Results

6.1. ED patient and family qualitative interviews

The patient and family interviews identified several common themes associated with information and communication in the ED including the main themes of *Communication* (including the sub-themes of 'Feeling informed' and 'How long will I have to wait?'), *Explanations of treatment and care* (including the sub-themes of 'Explanations of treatment' and 'Explanations of triage'), *Expectations of the ED* and *Written communication*.

6.1.1. Theme 1: Communication

Patient experiences were mixed, with positive and effective patient-nurse interactions being identified, as well as instances of being ill-informed and not involved in decision making. This often had an impact on the patient's mental health and wellbeing.

6.1.1.1. Feeling informed.
Positive communication was associated with regular interactions with staff, ensuring patients felt informed about their care pathway, condition and treatment. Patients who had a nursing background or repeated ED attendances described 'knowing the system' and their discourses pointed to past experiences assisting their understanding of the operational processes in the ED. This prior knowledge reduced anxieties and enabled them to feel more involved in their care. Some took a passive approach and were confident in the expertise of staff to not need significant information about their condition. These patients were unquestioning and were happy taking on the role of 'the patient'.

I'm one of these that if they are going to help me, I'll put myself in their hands,

Others felt they were being 'listened to' when staff asked questions about their ED journey, enabling them to feel they were receiving individualised care.

…they were absolutely superb, they asked me all the questions about what had happened

the nurses kept coming to see me and saying are you ok, how is your pain, all that lot and then doctor err, he was a nice young man, he went through it all again,

Interactions between different health care professionals was often confusing for patients, particularly when they were being treated by several different nurses and doctors and this sometimes resulted in them being unconfident about their treatment. Sometimes, patients were unaware of who they were being treated by or why, whilst others recognised the multidisciplinary working environment of the ED. Effective communication was central to increasing this confidence.

there was two paramedics, and a nurse err they took a load of information, gave me some morphine, and then they left, and then I was taken to, the care was taken over by a nurse and a doctor, and they just carried on that care

Well you get one or two nurses that are not helpful, you know but most of them are very good. You always seem to get you know one or two, that, are they are very forgetful. I mean I've been going to get something to be able to use this all morning and I still haven't got it so, I think that they have got too many things to do,

6.1.1.2. How long will I have to wait?.
Acquiring information about their condition empowered patients to understand why certain tests or procedures were being undertaken. Here, information was essential and some reported that staff could do more to inform them about the specifics relating to them, particularly regarding waiting times.

they said I'm just going to find a doctor or somebody to come and do this, they didn't say it was going to be 10 min, 15 min

erm we didn't know how long we were going to wait, they said like, the nurses told us that the doctor was going to come next and then the doctor said that erm that you would go to a ward, but they didn't tell us how long we would have to wait,

Overall, patients benefitted from having knowledge and understanding about their care, whether through being informed by staff, or through prior knowledge and experience of the ED system. Although some patients described wanting more information, their discourses described how they were reluctant to question staff due to perceived staff pressures and demands. Importantly, patients were conscious of not adding to this stress, remaining silent when they felt staff were too busy to communicate with, adding to their anxieties.

so we didn't really get communicated through that until about 5 min before, when she was like you shouldn't be waiting,

…they seemed to have enough on their plate

6.1.2. Theme 2: Explanations of treatment and care

Patients preferred to understand their condition and treatment but many described staff explanations as being inadequate.

6.1.2.1. Explanations of treatment.
Environmental challenges in the ED were regularly accepted as influencing communications. Patients who described having limited information about their condition elicited explanations including time pressures and demands.

I wanted more information of what were happening to me,

Many patients wanted simplified explanations about their condition and treatment and it was common for staff to deliver complicated medically focused explanations of care that were of little value.

I think maybe explain stuff, you know a bit more, simplified rather than in medical terms cos we don't all know them, erm but yes, it was just the main, like obviously you can't prevent cos it got really busy, it's just that we waited here 5 h for a bed to become available after A&E,

I was kind of just going with the flow a bit, but I felt like it would have been a bit more helpful if they would have explained like what's in the nebulisers and stuff so I actually knew,

6.1.2.2. Explanations of triage.
Being ill-informed about ED waiting times was also significant in the patient's accounts. The environmental challenges in the ED prevented some patients from asking the nursing staff questions about their care or waiting times. Patients seemed apprehensive about adding to the staff's stresses and were conscious of 'being a pain' in an already demanding setting.

Interviewer: did you feel that you could ask questions?

Patient: I did with a few people, like at the beginning because it was quite quiet, but then it got really busy and I felt like it was, just irritating and stuff'

Patients narrated how their experiences could be improved through explanations about the operational environment in ED and how their care could be impacted by patients in other areas of the hospital.

…that was a long one that was 5 and half hours, enormously long, for some reason that day. Well, they didn't seem, you can't tell emergencies, is a funny thing isn't it, cos there is people coming in from everywhere

6.1.3. Theme 3: Expectations of the ED

Patients expected that staff were time pressured and waiting was inevitable.

yes, and I know that everybody is so busy, you are kind of run off your feet

They were understanding of these challenges, expecting to wait significant lengths of time for treatment, with some describing being pleased when their wait was shorter than expected.

no but you do expect, you do expect to wait you know a long, but I was amazed at how quick it was

This suggests that although patients expected to wait to receive treatment, their care experience could be improved through regular communications and interactions with staff.

6.1.4. Theme 4: Written communication

Patients noted a lack of written information in the ED and some believed this would improve understanding of the ED processes and expectation management.

I think it, it's about the process you really need to know because, you know in A&E you are left for long periods aren't you? Waiting for doctors to see you, and just that information as to why, they think that you are ignoring them some patients don't they, or you have forgotten them or just that sort of information, I think would help, enormously really

Written communication about who patients might be treated by or their expected journey through the ED was considered advantageous but patient-dependent; some felt they were too ill to read and process information, others felt it would be useful, particularly when staff were under significant pressures to communicate effectively.

A good question. I'm quite happy to be given a piece of paper, that says, this is what is going to happen to you, this is the medication we are suggesting at the moment, this is what we expect the outcome to be, this is how long we expect you to be in here, that's great I can do that, that's not a problem

However, some patients reported being too poorly to read any written information and felt that face to face communication was more effective.

No, I wasn't in a position to read it, I was too ill to be bothered it wasn't something that we were looking at to be honest

Despite the differing patient needs, it was apparent that all patients felt increased communication and information would enhance their ED experience.

6.2. Staff focus group

Six senior nurses participated in the focus group, which echoed some of the emerging themes from the patient interviews, including *Staff-patient interaction*, *Explanations of treatment* and *Written information*.

6.2.1. Theme 1: Staff-patient interaction

Staff recognised inconsistencies in the transmission of information between patients and staff and acknowledged how limited communication increased patient anxieties. Despite this, staff described how significant time was used directing patients around the department, or answering questions about waiting times, procedures and length of stay.

…especially cos we walk through the waiting room, we get stopped, we were walking through, you'd be called a patient through and you get stopped all time

Receptionist will say go and ask them on the department and you walk onto the main department and there is just all these people and half of them don't work in the department they could be specialities so they are

stopping people and that waste time doesn't it. So if they need any information, I think if there was an information point, that has come out of previous questionnaires hasn't it,

Staff discussed how patients *'do not listen'*, particularly if they were anxious or stressed. This suggests that whilst staff did understand that patients required information about their care, many of their interactions were 'wasted' providing patients with less treatment-specific information and more related to the environmental factors in the ED.

6.2.2. Theme 2: Explanations of treatment

Staff acknowledged that patients sometimes received inadequate explanations of treatment. Staff concurred that in-depth explanations of why tests were being undertaken could prove useful in reducing patient anxieties. Staff discussed what this might look like in practice and it was felt that providing patients with more specific information about tests or procedures could prove useful for improving the communicative experiences of patients in the ED.

yes I would agree with that, yes I think we just automatically go on auto pilot don't we, we are going to your bloods and then, that's all they know is that they are getting their bloods done but, odd ones will ask you what are you looking for,

I know to some extent, some patients don't listen, and even when you do explain sometimes, but I think there needs to be better, maybe some better information around for the ones who are interested, cos if you do sit in waiting room and look around some of it's really outdated, cos again who is responsibly is that to give that information,

6.2.3. Theme 3: Written communication

A common theme in the staff interviews was that written information could prove useful in improving the patient experience. Here, written information in the form of leaflets or posters, providing detailed information of ED processes and treatment areas was considered to be particularly useful. Improved signage was also felt necessary to help patients navigate their way around the department, meaning staff could spend less time verbally directing patients and visitors, releasing more time to spend with patients during consultations and assessments.

I think that there should be patient information things that they are given err when they arrive about explaining the department or some posters or something round which there should have been for years shouldn't there?

A leaflet containing information regarding the patients' ED journey, types of staff in the ED (including what colour uniform each member of staff wears and job role) and common tests and investigations, was also considered useful. Posters, displayed in the waiting room and other ED areas, were also considered a valuable method of providing succinct, pertinent information to patients.

that would be good just so that they knew exactly what sort of area they would be looking at going, then if we told them that they were going to minors and there is a little brief sentence you should be seen by a nurse practitioner or whatever

…like what their journey is, as in so you are going to get seen by an assessment nurse who is going to decide where you are going to go, any plans that you are going to have done so that will be planned that you are going to have your bloods done and ECG done

Some staff recommended a TV screen in the waiting room to keep patients updated with waiting times and the pressures that the department were facing at any given time. Staff felt patients were not aware of the other areas in the department and often perceived the waiting room as the only area where patients are waiting to be seen. This particularly increased patient frustrations when they perceived the department to be quiet.

yes and then your kind of different areas, cos you will get people sat in the waiting room as well, that will get called through by say EMP service, so there is somebody else say there thinking well I've been here before them and they don't understand it's a different process to depending where you are in triage

Staff also discussed whether patients could be informed of delays in other areas of the department, which could impact the ED (for example, when there was an emergency in the resuscitation room and extra doctors and nurses were required), in order to ensure patients were more aware of how hospital pressures may have an impact on their treatment and care pathway.

…they can't have been there two minutes and they are already, some of them are on the ceiling and sometimes rightly so cos obviously their anxieties are high aren't they, they've either got a relative or themselves are not feeling great so yes I do think that, if there is something either that reception tell that they are waiting for this and then they do go into there and then when they are handed over there is some kind of welcome to department when they finally hit majors, for what they've had done and what they are waiting for or whatever

7. Discussion

Communicative interactions that are meaningful and informative between patients and healthcare providers are an imperative and pragmatic component of a positive patient experience. Determining the fundamental components that encapsulate these experiences are central to improving the patient-nurse relationship, reducing anxieties and enhancing the patient experience. Through examining these practices in the ED using AR methodology, this study identified several common themes amongst patient and staff experiences, which are important for improving future practice.

Effective communication, resulting in feeling informed and knowledgeable about their condition was essential and facilitated empowerment. Through a pre-existing awareness of the healthcare system, or informative interactions with staff, knowledge permitted patients to be active agents, rather than passive recipients of care. Indeed, communication and information have been shown to be essential for empowering patients to feel involved in decisions about their care [17]. Consistent with previous research [4], poor interpersonal exchanges were associated with frustration and dissatisfaction, resulting in ostensible inferences about the patient-care trajectory. For example, patients felt frustrated when they perceived the waiting room to be quiet, despite significant waiting times. Managing expectations through effective communication has a significant impact on the patient experience and Shah et al. [21] found that effectively communicating with patients at triage, specifically regarding waiting times, improved the patient experience of the ED in general. The staff in this study felt that informing patients about their wait and how it could be impacted by hospital demands was important for improving the patient experience and that the assessment nurse and reception staff were best placed to provide a mechanism for managing expectations by providing patients with this initial information. Displaying written information in the waiting room about the operational complexities of the ED was also considered an effective communicative method, specifically the triage process, which many patients were unaware of. Consistently, research internationally has highlighted the importance of providing patients with information about waiting times and the triage process in reducing frustration and anxiety [22]. Technology was considered a useful tool for communications. A TV screen in the waiting room displaying information regarding tests and procedures, staff groups, waiting times and statistical information (for example, number of patient attendances at certain time points) was considered important. This has previously been shown to have a demonstrable effect on patient satisfaction and feelings of control [18] and patients and staff felt that this would improve the patient experience.

8. Recommendations

Attributable to the findings in this study, several methods for improving the information and communication in the ED were introduced. For example, a poster was produced, to enable patients to understand their patient journey and the operational complexities of the ED including how the ED may be impacted by different areas in the hospital. This detailed information about where patients might receive treatment depending on their specific condition. A leaflet was also developed, containing information about the different areas of the hospital in general and the ED and where patients might receive treatment. It also contained information regarding the different types of staff working in the ED, enabling patients to recognise the differing roles and responsibilities of those providing treatment and care. It was felt that this information would improve the ED patient experience and satisfaction with care. The assessment nurse and reception staff were also encouraged to inform patients of the ED waiting time on arrival, in order to improve communications and manage patient expectations.

9. Limitations

This study aimed to develop a holistic understanding of the informational and communicational requirements of patients and staff in the ED, to inform future practice. Due to the nature of convenience sampling, only one family members experience was included in the sample. It is therefore possible that family member's experiences of attending the ED with a patient may have required information that was specific to them that was not captured in this study.

10. Conclusion

Communication and information are essential for empowering patients and improving patient satisfaction with care. This study has demonstrated that by incorporating the perspectives of patients and staff, a holistic understanding of how current systems of communication could be reformed can be established to develop communicative procedures that are practical, functional and reflective of the service. This has implications for practice on a local, national and international level.

11. Conflict of interest statement

No conflict of interest has been declared by the authors.

12. Ethical statement

This project was reviewed and approved by The University of Sheffield Ethics Committee in the School of Health and Related Research (SCHARR). The Research and Development Department at Barnsley Hospital reviewed the protocol and supporting documents and provided governance assurance for the study to proceed.

13. Funding statement

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References

[1] Morgan S, Yoder LH. A concept analysis of person-centred care. J Holistic Nurs 2012;30(1):6–15.

[2] Jones DE, Carson KA, Bieich SN, Cooper LA. Patient trust in physicians and adoption of lifestyle behaviours to control high blood pressure. Patient Education and Counselling 2012;89(1):57–62.

[3] Department of Health. Patient experience overall measure: 2012 accident & emergency survey update. National Statistics; 2012 [Accessed 4th April 2018].

[4] Frank C, Asp M, Dahlberg M. Patient participation in emergent care- a phenomenographic study based on patients' lived experiences. Int Emerg Med 2009;17:15–22.

[5] National Accident and Emergency Patient Survey (Care Quality Commission, 2014. https://www.cqc.org.uk/sites/default/files/20141201_accident_and_emergency_survey_2014_key_findings.pdf [Accessed 4th April 2018].

[6] Ackermann S, Heierle Anette, Bingisser MB, Hertwig R, Padiyath R, Nickel CH, Langewitz W, Bingisser R. Discharge communication in patients presenting to the emergency department with chest pain: defining the ideal content. Health Commun 2016;31(5):557–65.

[7] Department of Health, 2011. Hard truths: the journey to putting patients first equality analysis. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/259651/34660_2901463_Equality_Impact_Assessment_accessible.pdf [Accessed 4th April 2018].

[8] Department of Health, 2015. The Government's mandate to NHS England for 2016–17. https://www.england.nhs.uk/wp-content/uploads/2015/12/05.PB_.17.12.15-Annex-A-Mandate-to-NHS-England.pdf [Accessed 4th April 2018].

[9] Department of Health, 2014. Personalised health and care 2020: a framework for action. https://www.gov.uk/government/publications/personalised-health-and-care-2020/using-data-and-technology-to-transform-outcomes-for-patients-and-citizens [accessed 4th April 2018].

[10] Bongale S, Young I. Why people complain after attending emergency departments. Emerg Nurse 2013;21:26–30.

[11] Engel KG, Heisler M, Smith DM, Robinson CH, Forman JH, Ubel PA. Patient comprehension of emergency department care and instructions: are patients aware of when they do not understand? Ann Emerg Med 2009;53:454–61.

[12] DeWalt DA, Dilling MH, Rosenthal MS, Pignone MP. Low parental literacy is associated with worse asthma care measures in children. Ambul Paediatr 2007;7:25–31.

[13] Morrison AK, Myrvik MP, Brousseau DC, Hoffmann RG, Stanley RM. The relationship between parent health literacy and paediatric emergency department utilization: a systematic review. Acad Paediatr 2013;13:421–9.

[14] Kamchuchat C, Chongsuvivatwong V, Oncheunjit S, Yip TW, Sangthong R. Workplace violence directed at nursing staff at a general hospital in southern Thailand. J Occup Health 2008;50(2):201–7.

[15] Angland S, Dowling M, Casey D. Nurses' perceptions of the factors which cause violence and aggression in the emergency department: a qualitative study. Int Emerg Nurs 2014;22(3):134–9.

[16] Edward KL, Stephenson J, Ousey K, Lui S, Warelow P, Giandinoto JA. A systematic review and meta-analysis of factors that relate to aggression perpetrated against nurses by patients/relative or staff. J Clin Nurs 2015;25(3–4):289–99.

[17] Marshall A, Kitson A, Zeitz K. Patients' views of patient-centred care: a phenomenological study in one surgical unit. J Adv Nurs 2012;68(12):2664–73.

[18] Forsgarde ES, Attebring MF, Elmqvist C. Powerlessness: dissatisfied patients' and relatives' experience of their emergency department visit. Int Emerg Nurs 2016;25:32–6.

[19] East L, Robinson. Change in process: bringing about change in health care through action research. Journal of Clinical Nursing 1994;3:57–61.

[20] Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, editors. Analysing qualitative data. 1994. p. 173–94.

[21] Shah S, Patel A, Rumoro DP, Hohmann S, Fullam F. Managing patient expectations at emergency department triage. Patient Exp J 2015;2(2):31–44.

[22] Cohen EL, Wilkin HA, Tannebaum M, Plew MS, Haley Jr. LL. When patients are impatient: the communication strategies utilized by emergency department employees to manage patients frustrated by wait times. Health Commun 2012;28(3):275–85.