AN EMERGENCY DEPARTMENT PATIENT’S PERCEPTION OF SAFETY

A

DISSERTATION

Presented to the Faculty of
The University of Texas Health Science Center at San Antonio
Graduate School of Biomedical Sciences
in Partial Fulfillment
of the Requirements
for the Degree of
DOCTOR OF PHILOSOPHY IN NURSING

By

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San Antonio, Texas

May, 2010
AN EMERGENCY DEPARTMENT PATIENT'S PERCEPTION OF SAFETY

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DEDICATION

To my life,
My love,
My God:
Father, Son, and Spirit.
As well as to two devoted servants and
Faithful models of Gospel living:
Francis of Assisi
and
Clare of Assisi
ACKNOWLEDGMENTS

Much gratitude to Dr. Kelly Dunn whose gentle guidance led this process forward with accuracy that is required for doctoral education, experience that mentored me beyond my expectations, and cheerleading that kept my spirits up and focus sharp.

I am indebted to my doctoral committee. For the encouragement I received from Dr. Mickey Parsons and Dr. Nancy McGowan from my time as a staff nurse in the Emergency Department, to the doctoral application process, through five years of Masters and Doctoral education culminating in their service as advisors for this dissertation, I am grateful. The guidance and education in ethnographic methods provided by Dr. Juliete Langman at University of Texas San Antonio was vital for this research. Dr. Jan Patterson’s generous offer of time and direction as a medical professional and academician was equally necessary.

To my fellow Franciscan friars who supported me in this process by praying with/for me, carrying me in times when I was more invested in the life of a doctoral student than in the life of a friar. I am especially appreciative of the friars and postulants at San Damiano Friary.

The assistance I received from my family in Louisville and spread across the southern US and northern Indiana was essential. Your prayers, letters, emails, phone calls, and words of encouragement moved me along. I am particularly indebted to my grandmother, Mary Louise Spitznogle Graf, and mother, Christine Ann Graf Clark, who modeled nursing for me.

My colleagues in the Emergency Nurses Association, notably in the San Antonio and Texas chapters, have been relentless in challenging me to be a better nurse and professional for the patient and for those (of us) caring for the patient.

Dissertation research can not be completed without funding. The Baptist Health Foundation and the Michael and Louise Beldon Living Endowment provided that funding.
which assisted me in completing this work. They are the giants on whose shoulders I stand.

Finally, love to Jennifer Collins, Patti Grota, and Katherine McDuffie, my doctoral colleagues and cohort.
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Publication No. _____________________

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Purpose: Because the patient’s perception of safety in the healthcare system has not been adequately examined, the purpose of this study was to discover an Emergency Department patient’s perception of safety so as to add an element currently absent in safe patient care provision.
Background: That there is a real and significant problem in the United States healthcare system of providing safe, efficient care to patients is not in dispute. Many agencies, academic researchers, and experts in their fields have studied preventable healthcare errors and proposed and implemented solutions. Yet a careful review of current solutions reveals that patients are not adequately empowered to take an active role in their care, and this fact puts them at greater risk of experiencing a poor outcome due to preventable error. Specifically, patients have not been asked how they, from their role and view as patient, perceive safety.

Methods: This study was undertaken using a qualitative, ethnographic methodology. Eight female and six male participants (six Hispanics, five whites, and three African Americans) with an age range of 22 to 85 years (mean age of 48.5) completed one focused, ethnographic, in-person interview. Content analysis was used to analyze the data.

Results: One main theme, Competent Caring emerged supported by three domains (Accurate Caring, Protective Caring, and Communicative Caring). Examples of patients’ perceptions help define several sub-domains which underlie the three domains.

Implications: Safe care for patients is patient involvement in their care as well as making decisions with their healthcare providers. Healthcare providers can meet these expectations by: (a) communicating care information using language understandable to the patient and allowing adequate time for questions to be answered; (b) updating patients about their care on both a scheduled and as needed basis; and (c) not allowing healthcare staff “insider knowledge” to discount patient concerns. Safe care provision
also involves meeting physical comfort needs (such as pillows, blankets, food, water, and medicine for noxious symptom control), meeting psychological comfort needs including empathy, and protecting patient physical safety by removing obstacles in their care area, following hand washing guidelines, and identifying the patient through such practices as arm band checking and name / birth date verification.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>i</td>
</tr>
<tr>
<td>Copyright Notice</td>
<td>ii</td>
</tr>
<tr>
<td>Approval</td>
<td>iii</td>
</tr>
<tr>
<td>Dedication</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>v</td>
</tr>
<tr>
<td>Abstract</td>
<td>vii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>x</td>
</tr>
<tr>
<td>List of Tables</td>
<td>xvii</td>
</tr>
<tr>
<td>List of Figures</td>
<td>xvii</td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>A. General Problem Area</td>
<td>1</td>
</tr>
<tr>
<td>1. Patient safety issues in general</td>
<td>2</td>
</tr>
<tr>
<td>2. Solutions</td>
<td>4</td>
</tr>
<tr>
<td>B. Specific Statement of the Problem</td>
<td>10</td>
</tr>
<tr>
<td>C. Background and Significance of the Problem</td>
<td>10</td>
</tr>
<tr>
<td>1. Measuring healthcare safety</td>
<td>12</td>
</tr>
<tr>
<td>2. What has the patient to offer?</td>
<td>13</td>
</tr>
<tr>
<td>3. What have patients already revealed?</td>
<td>15</td>
</tr>
<tr>
<td>4. Significance of this study</td>
<td>16</td>
</tr>
<tr>
<td>D. Hypothesis and Research Aims</td>
<td>18</td>
</tr>
<tr>
<td>E. Summary</td>
<td>19</td>
</tr>
</tbody>
</table>
II. REVIEW OF LITERATURE AND OVERVIEW OF THEORY .......................... 20

A. What is Known about the Problem ............................................... 21
   1. Patient safety: What is missing? ............................................. 21
   2. Active involvement of patients in their care ............................. 22
   3. Patient’s active role: Programs and research ............................ 27
   4. An under-considered patient safety piece: A patient’s perception
      of safety .................................................................................... 30

B. Summary of Literature Review .................................................. 38

C. Gaps or Shortcomings to Date .................................................... 39

D. Theoretical Framework ............................................................. 40
   1. Influence of Kurt Lewin ......................................................... 41
   2. Bronfenbrenner’s ecological theory ......................................... 42
   3. Interconnecting environmental elements of the ecological theory .... 44

E. Bronfenbrenner’s Ecological Model in Patient Safe Care Provision .... 46
   1. Specific application of the ecological theory in healthcare ............ 47
   2. The patient in the ecological healthcare system .......................... 49

III. METHODS .................................................................................. 53

A. Introduction .................................................................................. 53

B. Study Design: Ethnographic Case Study ........................................ 53

C. Setting, Sample, and Participant Data ........................................... 55

D. Study Variables and Reflexivity Check .......................................... 60

E. Procedure ..................................................................................... 61
1. Recruitment and inclusion/exclusion criteria .............................................. 61
2. Measures ..................................................................................................... 63
3. Data Collection ............................................................................................ 64
   a. Observation ............................................................................................... 64
   b. Interviews and medical records review ................................................ 66
   c. Media accounts ......................................................................................... 71
F. Data Analysis and Coding Plan ................................................................. 71
G. Reliability and Validity ................................................................................ 74
H. Privacy and Confidentiality ......................................................................... 74
   1. Human subjects protection ...................................................................... 74
   2. Consent ..................................................................................................... 75
   3. Data management privacy and security ..................................................... 76
I. Limitations .................................................................................................... 76
J. Summary ........................................................................................................ 77
IV. FINDINGS .................................................................................................... 78
A. Research Questions ..................................................................................... 78
B. Research Question One ............................................................................... 79
   1. Communicative Caring .............................................................................. 79
      a. First sub-domain: ED MD Interaction .................................................... 81
      b. Second sub-domain: Providing Sufficient Information ....................... 84
      c. Third sub-domain: Empathy ................................................................ 90
      d. Fourth sub-domain: Responsive Listening .......................................... 92
2. Accurate Caring ............................................................. 95
   a. First sub-domain: Diagnostic Precision ............................. 95
   b. Second sub-domain: Efficiency ......................................... 100
3. Protective Caring .......................................................... 104
   a. First sub-domain: Comfort Measures .................................. 105
   b. Second sub-domain: Proficient Caring ............................... 109
   c. Third sub-domain: Anticipatory Caring ............................. 115
   d. Fourth sub-domain: Collaborative Caring .......................... 119
   e. Fifth sub-domain: Assuring Security .................................. 123
4. Summary of Competent Caring domains ................................ 131
C. Research Question Two .................................................. 132
   1. Communication issues ................................................... 132
   2. Accuracy issues .......................................................... 142
   3. Protection issues ......................................................... 145
D. Research Question Three .................................................. 159
   1. Patient safety definition ................................................ 159
      a. The patient care room ................................................. 160
      b. Hand washing and glove use ...................................... 163
   2. Patient views on safety ................................................ 163
E. Research Question Four .................................................... 164
   1. Safe actions and their characteristics ................................ 164
      a. Condition of patient care room ..................................... 164
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Glove use</td>
<td>165</td>
</tr>
<tr>
<td>c. Comfort needs</td>
<td>166</td>
</tr>
<tr>
<td>d. Communication</td>
<td>166</td>
</tr>
<tr>
<td>e. Accurate diagnoses</td>
<td>168</td>
</tr>
<tr>
<td>2. Summary of patients’ safety perceptions</td>
<td>168</td>
</tr>
<tr>
<td>F. Member-Checking</td>
<td>169</td>
</tr>
<tr>
<td>G. Patient Safety Media Stories</td>
<td>172</td>
</tr>
<tr>
<td>1. Communicative Caring</td>
<td>174</td>
</tr>
<tr>
<td>2. Accurate Caring</td>
<td>176</td>
</tr>
<tr>
<td>3. Protective Caring</td>
<td>178</td>
</tr>
<tr>
<td>4. Significance of media review</td>
<td>182</td>
</tr>
<tr>
<td>H. Summary</td>
<td>183</td>
</tr>
<tr>
<td>V. DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS</td>
<td>184</td>
</tr>
<tr>
<td>A. Summary and Discussion of Findings</td>
<td>184</td>
</tr>
<tr>
<td>B. The Theoretical Framework: Bronfenbrenner’s Ecological Model</td>
<td>184</td>
</tr>
<tr>
<td>C. Theoretical Model as Data Collection and Analysis Guide</td>
<td>185</td>
</tr>
<tr>
<td>D. The Emerging Framework: Competent Caring</td>
<td>190</td>
</tr>
<tr>
<td>1. Communicative Caring</td>
<td>190</td>
</tr>
<tr>
<td>a. ED MD Interaction: First sub-domain of Communicative Caring</td>
<td>193</td>
</tr>
<tr>
<td>b. Providing Sufficient Information: Second sub-domain of Communicative Caring</td>
<td>196</td>
</tr>
<tr>
<td>c. Empathy: Third sub-domain of Communicative Caring</td>
<td>198</td>
</tr>
<tr>
<td>Sub-domain</td>
<td>Page</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
</tr>
<tr>
<td>d. Responsive Listening: Fourth sub-domain of Communicative Caring</td>
<td>198</td>
</tr>
<tr>
<td>2. Accurate Caring</td>
<td>199</td>
</tr>
<tr>
<td>a. Diagnostic Precision: First sub-domain of Accurate Caring</td>
<td>200</td>
</tr>
<tr>
<td>b. Efficiency: Second sub-domain of Accurate Caring</td>
<td>202</td>
</tr>
<tr>
<td>3. Protective Caring</td>
<td>203</td>
</tr>
<tr>
<td>a. Comfort Measures: First sub-domain of Protective Caring</td>
<td>203</td>
</tr>
<tr>
<td>b. Proficient Caring: Second sub-domain of Protective Caring</td>
<td>204</td>
</tr>
<tr>
<td>c. Anticipatory Caring: Third sub-domain of Protective Caring</td>
<td>207</td>
</tr>
<tr>
<td>d. Collaborative Caring: Fourth sub-domain of Protective Caring</td>
<td>208</td>
</tr>
<tr>
<td>e. Assuring Security: Fifth sub-domain of Protective Caring</td>
<td>209</td>
</tr>
<tr>
<td>E. Summary</td>
<td>213</td>
</tr>
<tr>
<td>F. Ethnographic Methodology</td>
<td>214</td>
</tr>
<tr>
<td>G. Implications</td>
<td>215</td>
</tr>
<tr>
<td>1. Nursing practice</td>
<td>215</td>
</tr>
<tr>
<td>2. Nursing education</td>
<td>219</td>
</tr>
<tr>
<td>H. Research</td>
<td>220</td>
</tr>
<tr>
<td>I. Policy</td>
<td>221</td>
</tr>
<tr>
<td>J. Researcher Perspective</td>
<td>223</td>
</tr>
<tr>
<td>K. Limitations</td>
<td>225</td>
</tr>
<tr>
<td>L. Strengths</td>
<td>226</td>
</tr>
<tr>
<td>M. Conclusion</td>
<td>227</td>
</tr>
</tbody>
</table>
# APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>Researcher Record of Emergency Department Patient’s Visit History</td>
<td>228</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Letter of Introduction</td>
<td>229</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Interactive Question Guide</td>
<td>230</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Informed Consent Form</td>
<td>232</td>
</tr>
</tbody>
</table>

REFERENCES ................................................................. 238

VITA ............................................................. 248
LIST OF TABLES

Table 1  Sample Demographics, Presenting Complaint, Discharge Diagnosis, and Final Disposition .............................. 59
Table 2  Number and Duration of Ethnographic Observation Activities ........ 65
Table 3  Ethnographic Interview Length and Refusal Data ...................... 67
Table 4  Domains of the Theme Competent Caring with Definitions and Exemplars ......................................................... 80
Table 5  Sub-domains of Communicative Caring with Definitions and Exemplars ................................................................. 82
Table 6  Sub-domains of Accurate Caring with Definitions and Exemplars . . . 96
Table 7  Sub-domains of Protective Caring with Definitions and Exemplars . . 106
Table 8  Positive and Negative Media Case Examples by Domain ............ 173
Table 9  Taxonomy of Domains and Sub-Domains of Patients’ Sense of Safety in the Emergency Department ............................ 191
Table 10 Taxonomy of Patients’ Sense of Risk and/or Diminished Sense of Safety in the Emergency Department .................... 192

LIST OF FIGURES

Figure 1  Impact of Emergency Department (ED) System Factors on the ED Patient ................................................................. 186
I. INTRODUCTION

A. General Problem Area

Patient safety, viewed as the product of the interaction between the individual patient and multiple aspects of the healthcare environment, is a focus for those involved in healthcare safety at all levels. A variety of agencies and researchers have attempted to define patient safety. The National Patient Safety Foundation (NPSF) understands patient safety in the process of healthcare as the prevention, avoidance, and amelioration of adverse outcomes along a continuum from accidents, near misses, dangerous situations, and errors/deviations (NPSF, 2000). Patient safety involves all of system’s components, not just a single person, machine, or process (NPSF, 2000). The Agency for Healthcare Research and Quality (AHRQ) defines patient safety as, “Freedom from accidental or preventable injuries produced by medical care” (AHRQ, 2008). The Institutes of Medicine (IOM) recognizes patient safety as freedom from accident and injury (Kohn, Corrigan, & Donaldson, 2000). For the purposes of this dissertation, patient safety will be defined as freedom for a patient from actual/potential adverse outcomes during the provision of healthcare. This includes the plans or actions implemented by the entire system during the process of healthcare provision dealing directly with the patient’s underlying disease or injury to prevent errors from occurring.

The patient safety focus has been more keenly developed as studies over the last decade suggested that the United States healthcare system is not of the safety, quality, or efficiency that it needs to be. The underachievement of safe patient care caught the public's attention with the year 2000 publication by the IOM which noted that
between 44,000 and 98,000 patients in the United States die every year as a result of medical errors (Kohn et al., 2000). This startling account awoke in healthcare researchers, providers, and administrators the realization that they were failing to successfully complete their laudable and self-sacrificing mission of caring for patients without doing harm. As a result, patient safety improvement research has vastly increased since the year 2000. However, what this research has uncovered is disturbing.

1. **Patient safety issues in general**

   Many studies have noted the lack of patient safety in healthcare. In a study of the quality of patient healthcare, Davis et al. (2004) learned that over twice the number of patients in the United States as in the United Kingdom reported a medical or medication error that led to serious consequences (18% vs. 9%). In addition, patients in the U. S. experienced more duplicate testing along with failure to send test results to the appropriate provider (Davis et al.). From the patient’s perspective, U. S. healthcare providers perform poorly on five of six domains of the IOM’s quality care framework (patient safety, patient centeredness, timeliness, efficiency, effectiveness, and equity). Finally, while U. S. healthcare spending outstripped all other countries in terms of gross domestic product, the U. S. is not in the list of top thirty countries that provide safe, reliable healthcare (Davis et al.).

   Other studies and healthcare journal editorials continue to note safety issues. A chart audit at a Wisconsin hospital revealed 233 actual or potential errors for every 100 charts reviewed (two to three errors per patient) (Morrissey, 2004). More than one study found poor or insufficient communication contributing to patient errors and poor patient
outcomes (Vincent & Coulter, 2002; Wolosin, Vercler, & Matthews, 2005, 2006). What is clear is that the lack of sufficient patient safety is not only dangerous to patients, but holds the U. S. back from providing premier healthcare.

Print, broadcast, and electronic media have not ignored this problem. Stories regarding patient injuries and deaths from healthcare errors have been reported widely. Judith Graham (2007) of the Chicago Tribune reported a story about a physician whose wife’s common bile duct was damaged during a routine gall bladder procedure. This damage, an unintentional and serious surgical mishap, left his wife unable to conceive more children. Also, their children born before this surgical error were each injured by healthcare errors (Graham). A March 2008 segment on the television news magazine 60 Minutes detailed the near fatal heparin overdose of the twin infant children of actor Dennis Quaid and his wife Kimberly (Fager, 2008). The twins, in the hospital for medical treatment, had their intravenous lines flushed with heparin that was 1,000 times the strength of heparin normally used. The twins survived but this experience of healthcare error left Mr. Quaid and his wife deeply shaken.

These examples of insufficient patient safety are a direct result of a paradigm shift in healthcare. The IOM report mentioned earlier was actually a follow up to a seminal patient safety study carried out by Harvard Medical School. Researchers examined more than 30,000 randomly selected patients and found that 3.7% were harmed by preventable healthcare errors (Leape, Brennan, Laird, Lawthers, & Localio, 1991). This study led to the realization that there were significant numbers of patients being harmed unnecessarily. Research on patient safety followed, but the publication of the IOM’s To Err is Human brought the patient safety issue to the public’s attention.
Public concern combined with continued research demonstrating the preventable harm patients incur while receiving healthcare caused a shift in the healthcare system.

No longer could preventable healthcare errors be considered a normal part of healthcare. Just as the aviation and nuclear industries learned after several very public preventable accidents involving potential or actual loss of human life (including the 1977 Tenerife airline disaster and the 1979 Three Mile Island Nuclear Power Plant accident), the healthcare system began to examine how healthcare errors were viewed. The paradigm shifted from accepting and treating healthcare errors as a part of healthcare provision to realizing the severity, frequency, and preventability of healthcare errors and seeking processes to reduce and eliminate them.

2. Solutions

Realizing the severity of the patient safety crisis, the healthcare system, including researchers, government institutions, healthcare consultants, and providers and administrators from hospitals and outpatient offices began searching for and implementing solutions. Essentially, those from within the system began searching for problems and implementing solutions (Brennan & Safran, 2004; Wolosin et al., 2005). The National Patient Safety Foundation was among the first to begin this work.

A nonprofit organization founded in 1997, the NPSF carries out its mission to improve patient safety in the delivery of healthcare through research and education. They continue to produce patient safety studies and documents that create a core body of knowledge used to develop patient safety solutions. Most recently in 2007, the Lucian Leape Institute became a part of the NPSF. The Leape Institute is a think tank that
develops action plans and provides focus, vision, and context to patient safety research and solution development (NPSF, 2008).

The Institute of Healthcare Improvement (IHI) initially began a 100,000 lives campaign, dedicated to reduce morbidity and mortality in US healthcare caused by healthcare errors (IHI, 2008). After having met the goal of saving and protecting 100,000 lives through healthcare safety improvement, the IHI has now instituted a five million lives campaign. This campaign, while having a greater scope than the 100,000 lives campaign, has the same mission (IHI, 2008).

Individuals inside healthcare affected by healthcare errors are also becoming actively involved. An example of an individual who is now actively involved in patient safety issues is Lenore Janecek. Ms. Janecek is an insurance and healthcare consultant who received an unnecessary operation. Test results that were not her own were used to diagnose cancer she did not have (Graham, 2007). After many months of pain and worry, the issue was resolved, but left her emotionally scared. As a result of this experience she founded the organization Save the Patient in 2001 to support and educate individuals on healthcare safety matters (Janecek, 2008).

The hard work of private institutions, governmental agencies, and researchers has led to an explosion of information in the patient safety area. The patient safety knowledge base has grown tremendously as a result. The NPSF (2000, 2003) has noted that safety does not come from one person, or from a device to prevent errors, or from the wisdom of one section of the hospital. Rather, patient safety comes from the interaction of these healthcare components. Solutions are rendered when these component interactions are better understood and different parts of the system are
allowed to contribute their unique perspectives. Just as the nuclear and aviation industries have developed, pilot tested, implemented, and evaluated approaches to safety in their industries, so must healthcare do the same to maintain patient safety as an integral part of healthcare delivery culture (NPSF, 2000).

Another area of the expanded patient safety knowledge base includes fostering an environment in which errors can be reported without fear of unstructured retribution. Those involved in errors must be encouraged to report these errors and receive sanctions appropriate to the level of error. Without going into detail regarding the sanction system, suffice to say that if providers could report errors so that the system focused on solving the issues leading up to the error rather than directed toward punishing the person(s) committing the error, then the errors themselves and what led up to them could be better considered. Causes of errors can be understood and corrected (Hatlie, 2004; Morrissey, 2004).

This nonpunitive error reporting system is a necessity for a hospital or any patient care provider (institution or individual). In a nonpunitive error reporting system environment, errors are reported, the report examined, and solutions developed to prevent them from recurring (Anthony et al., 2005; Marx, 2001).

Beyond catching errors after they occur, much of the focus of research and patient safety solutions has shifted to an “upstream approach.” The upstream approach focuses on identifying and recognizing events leading up to errors to stop them before an error occurs. A second, more important upstream approach comprehends why these pre-error events occur to prevent them from recurring in the first place. The emphasis of
the upstream approach is on preventing harm and poor outcomes before an error occurs (Morrissey, 2004).

Upstream approaches have been noted in research such as that carried out by Schoen et al. (2007). By way of background, a medical home is defined as regular care with a specific provider and clinic, clear and timely communication from the provider/clinic, and coordinated care between the provider/clinic and other outside providers. Patients who had a medical home had more responsive and efficient care and were less likely to encounter errors (Schoen et al.).

Communication is another significant piece of upstream error prevention. Patients with whom providers and administrators in the healthcare systems communicate are more likely to perceive higher levels of patient safety and experience fewer errors (Hobgood, Peck, Gilbert, Chappell, & Zou, 2002; Press Ganey Associates, 2007; Vincent & Coulter, 2002).

Probably one of the most significant and important ways to prevent harm and poor outcomes is through the active patient involvement in their care (Gandhi et al., 2003; Gibson, 2007; Hatlie, 2004; “Most ED patients feel safe, but many fear errors,” 2005; Vincent & Coulter, 2002). Patients are not passive recipients of care, despite perhaps being treated in this fashion. The healthcare system needs to provide a context and opportunity for increased communication so that patients can be actively involved in their care and prepared to take more responsibility in their own care (Leonhardt, 2007; Michaud, Davis, & Gaines, 2007; Vincent & Coulter, 2002)

How do patients take a more active role in their care? Initially, upon entry into a healthcare system, patients can contribute diagnostic information, medical history, and
an accurate description of their current complaint. They can participate in their
developing care through choice of providers, by responding to treatment plans by
carrying out these plans (medications, therapy, testing), and by monitoring for adverse
events (Vincent & Coulter, 2002). Most patients who are not cognitively impaired are
fully functional adults that comprehend the risks in the world (Hatlie, 2004). Because
they are the ones who will most benefit from good care and suffer the poor outcomes of
healthcare errors, and because they assume a critical role of evaluating their quality of
care, their participation needs to be actively elicited as they receive healthcare (Brennan
& Safran, 2004).

This active involvement of the patient is labeled “goal 13” of the 2009 Joint
Commission patient safety goals. This goal, one of nine patient safety goals for 2009,
encourages patients’ active involvement in the healthcare they receive by defining their
role in planning and implementing this care. Activities include patients’ marking their
own surgical sites, patients verifying their identity before medication administration, and
processes for and encouragement of patients and family members to voice concerns
about their healthcare. Most important, providers and institutions must communicate
more effectively to better educate patients and family members on this role (The Joint
Commission, 2009). Care providers and institutions are encouraged to develop
strategies to meet this goal.

There are cautions, however. Providers carry the burden of responsibility for
impacting safe care as they are ultimately responsible for it. They must not rely on the
patient beyond what is reasonable in monitoring for adverse events and providing care.
There is an expectation patients will not take responsibility for knowledge beyond their capacity (such as medication incompatibilities) (Leonhardt, 2007; Lyons, 2007).

Yet excluding patients from becoming actively involved in their care not only removes a source of vigilance, but may be unethical (Entwistle, 2007). Ethical questions could be raised if care was provided to patients without explanation, rationale, or chance for input. The NPSF 2003 report included this very theme in the title of its safety report: Nothing about me without me (National Patient Safety Foundation Patient and Family Advisory Council, 2003).

Preventing a patient from becoming actively involved in his/her care is not only unethical, it decreases patient safety. When the healthcare system fails to allow patients to play an active role in their care activities, then behaviors which patients could adopt on their own behalf that would make patient care safer are not identified, valued, or learned (Brennan & Safran, 2004). However, when patients are included on the healthcare “team” and take an active role in their care by being involved in that care, they may be able to spot activities leading up to an error and/or be able to identify that an error has occurred (Brennan & Safran, 2004; Gibson, 2007). Preventing patients from offering input to their providers that may positively impact their care and discouraging them from identifying errors, leaves the patient uninvolved. In this scenario, and, at best, errors remain unaddressed. At worst if an error occurs, the patient has a poor outcome with an increased likelihood that a similar error will recur.

The bottom line is that care provision needs to include the patient. Incorporating patients into the healthcare team, listening to their input, responding to that input, and clearly defining their roles in providing their own care will provide them with better, safer
care. Including patients in their own care may demonstrate healthcare providers’
respect to the patients as people, may underline the provider’s desire to provide safe
care, and may display a willingness to empower the patient to help themselves and their
families (Entwistle, 2007). As researchers and healthcare policy experts learn how to
undertake this paradigm shift, one significant way to actively involve patients in their
own care is to determine their perspective of safety.

B. Specific Statement of the Problem

The purpose of this study is to discover an Emergency Department patient’s
perception of safety. Patient safety is a primary focus of those supplying healthcare, yet
many patients are unnecessarily injured or killed during their care. Safety solutions
come from an analysis of the entire healthcare system, yet one part of this system has
not been adequately studied: the patient’s perception. Safety solutions have been
developed by those within healthcare, and often do not rely on input from patients and
family members who are outside the healthcare system.

Thus, to better understand what patients perceive as safety in their active role as
“patient” and to more clearly research what patients discern as safe in their role outside
healthcare, the proposed, novel study seeks to research the patients’ perceptions of
safe care delivery and uncover missing data vital to building patient safety solutions.

C. Background and Significance of the Problem

Even with the many research dollars invested into the patient safety examination,
a lack of knowledge exists regarding the patients’ safety perceptions. Not only are
patients left with a less than active role in their own care, the people, places, and
processes considered safe by patients have not been inadequately examined. As
Wolosin et al. (2005) observed, patients' perceptions of safety are necessary when designing safety initiatives. Yet, many in healthcare along with healthcare research communities remain unaware that this perspective is under considered, leaving a knowledge gap that is more canyon than crack (Brennan & Safran, 2004; Burroughs et al., 2005; Gibson, 2007; Hatlie, 2004; “Most ED patients feel safe, but many fear errors,” 2005; Press Ganey Associates, 2007; Vincent & Coulter, 2002; Wolosin et al., 2006).

This lack of research leading to the patient safety perception knowledge gap has developed because an examination of the patient safety problem has come primarily from those within the healthcare culture: hospital administrators, quality improvement/assurance and risk management professionals, and providers such as physicians, nurses, and other staff. This makes intuitive sense. Those from within the system know the system. They understand it. When the system fails, those who know the system are best positioned to study what went wrong and fix it. When an automobile has engine trouble, the car is taken to an automotive mechanic who looks within the engine to determine the problem. When heating and air conditioning services stop functioning, a heating/cooling repair worker is dispatched to diagnose and fix the unit. When the healthcare system is broken, healthcare experts and researchers look for reasons within the system to find problems and repair them.

The problem with this analogy is that the patient’s perspective is excluded. Automotive mechanics and heating and air conditioning technicians will make an initial assessment of the problem by listening to the complaint by the customer and asking questions to elicit further information. In healthcare, patient safety experts often discount patient perceptions of their illness and care provision. These experts have not been as
forthcoming in asking the patient what they see and experience as problematic. This omission prevents patients who have a front row seat to their own healthcare treatment from sharing knowledge they have of this treatment. This knowledge includes insight into safe care provision.

1. Measuring healthcare safety

Those from within the healthcare system have their work cut out for them. That a healthcare safety issue exists is not in dispute. So to begin to solve the problem, those within healthcare needed to search for the problems. Initially these healthcare experts defined safety in a number of ways. One researcher characterized patient safety as encompassing all the events that occur (admissions, meals, tests or treatments, and discharge) provided by personnel (nurses, MDs and technical staff) in the physical surroundings (room, treatment area, hospital), and the interpersonal aspects of the stay (Wolosin et al., 2006).

Other ways of measuring healthcare safety include medicine administration errors, equipment malfunctions, infection rates, morbidity & mortality rates, sentinel events, root cause analyses, and wrong site surgery rates (Pronovost, Miller, & Wachter, 2006). These operationalized definitions of patient safety can be found in hospital incident reporting systems and by searching for certain drugs and treatments known as “markers” in the patients’ medical records. These marker drugs or treatments are typically used to correct a medical error (for instance, the use of vitamin K for heparin overdose or naloxone for a midazolam overdose) (Pronovost et al., 2006).

Yet these measurements of healthcare error lack trustworthiness (Pronovost et al., 2006). Hospital incident reporting systems rely on those making the errors to report
them, and in the current punitive environment in which providers work, errors are under reported (Pronovost et al., 2006). Markers that point to healthcare errors may not indicate an actual error. In these research studies, there is no further investigation to determine if the marker drug was used to correct an error or to treat the patient. Because it is not clear why the marker was actually used, this “marker” methodology is not a reliable technique for detecting errors. Reliable and valid patient safety measures are still lacking.

Further complicating the reliability and validity of defining and uncovering patient safety issues is the missing patient perspective. Can patient safety solutions be considered reliable and valid when their source is primarily from within the healthcare culture? In other words, are safety solutions which lack patient perspective valid and reliable? Solutions missing vital components would seem to be less than complete, which is the case for patient safety solutions missing the patient’s perspective.

2. **What has the patient to offer?**

The question can be raised: Why would the patient be considered? The patient is an outsider to the system. Therefore, healthcare professionals have assumed patients lack an understanding of and the training in the healthcare system. The assumption is that their perspective would offer little if any insight into solutions.

However, patients, as “outsiders” to the healthcare system, develop unique perspectives of their care as they receive healthcare. This distinctive patient view of safety exists because patients experience and understand safety issues differently from those within the healthcare culture. Precisely because they have little if any professional healthcare training, patients can discern safety gaps that providers within the system
may miss (Hatlie, 2004). Unfortunately, this very perspective has been under studied leading to the current patient safety knowledge gap (Hatlie, 2004).

It may be helpful to examine an example outside the realm of healthcare that highlights the importance of the outsider’s perspective. Bill James, a worker at a manufacturing plant in Kansas, and an avid baseball fan, had been employed at various jobs outside the sport of baseball. He never professionally played or coached the game. As an outsider, he noticed some interesting aspects of the game. For example, traditional statistics used as benchmarks for measuring success at offensive actions, such as batting, or defensive actions, such as pitching, did not match up with outcomes. He determined that pitching success could not be gauged solely by the traditional, gold-standard “win-loss record.” Rather, a better analysis of his success was how many home runs or walks a pitcher gave up and how many strikeouts a pitcher recorded. Batters, James found, could not be judged as flourishing by the “batting average” benchmark, but more exactly by how many pitches they caused a pitcher to throw. Batters who made fewer hits but drew more balls and hit more foul pitches would wear a pitcher down, causing the pitcher to throw pitches that were more likely to be hit by subsequent batters (Naphin, 2008).

James recorded his theory, known as sabermetrics, in a 68-page paper. Sabermetrics outlined some methodologies for determining success or failure of hitting, pitching, and other aspects of the game of baseball. These theories were ground breaking and often went against conventional baseball practices. His theories were applied by teams in Major League Baseball (MLB). Almost overnight, MLB teams with
losing records who put sabermetrics into practice, such as the Oakland (California) Athletics began to enjoy winning seasons (Naphin, 2008).

James was eventually hired by the Boston Red Sox in 2002. In 86 years, the Red Sox had not won the coveted MLB championship, the World Series. However, since putting sabermetrics into practice the Red Sox have won two World Series. Professionals familiar with baseball note that Mr. James has provided a fresh look at the game and how it is played (Naphin, 2008). He has used his outsider’s perspective to help under achieving teams enjoy success.

This example is not meant to be glib. What could healthcare accomplish if it were able to hire an outsider, such as someone like James, who could bring fresh perspectives to the safety issue? Would two “World Series” in healthcare terms equate to the elimination of all deaths and significant morbidity due to healthcare errors? This study hopes to find information similar to what outsider Bill James provided to baseball by researching what patients as outsiders perceive as safe care. This information could then be used to assist healthcare in the same way that James used his sabermetrics to assist baseball: to debunk myths and reveal new ways of thinking about safety to bring about “success” in terms of improving patient safety.

3. What have patients already revealed?

Patient perspectives have already been examined in a few studies and have revealed missing pieces in the patient safety knowledge gap. Two studies revealed that a significantly high number of patients (88%) reported their safety as good, very good, or excellent (Burroughs et al., 2005; Wolosin et al., 2006). While patients in a study of Emergency Department (ED) safety in Great Britain, 65% felt the physician may
overlook a problem significant to their care, only 4% of this group was “extremely concerned” that this would actually happen (Byrne & Heyman, 1997).

Despite these good numbers, there are some disappointing results as well. In a 2005 study of ED patients, Burroughs et al. (2005) noted that 38% of patients surveyed had at least one concern about an error during their ED visit. This may be due in part to poor communication. In many studies and reports, when information regarding their care or regarding broader care issues such as end-of-life options (e.g., living wills) or existing safety practices are not communicated adequately, patients report experiencing less safety (Press Ganey Associates, 2007; Vincent & Coulter, 2002).

Patients have reported needs not being met. Such needs span multiple realms including psychosocial (a lack of knowledge regarding how their current medical condition will affect the life they knew before illness or injury), emotional (fear of the unknown due to poor or nonexistent provider and staff communication), spiritual (no connection with a chaplain or spiritual source), and physiological. These unmet needs were associated with a lack of safety (Byrne & Heyman, 1997; Hupcey, 2000). While they may not have fallen, may have not been infected with a hospital-acquired microbe, nor experienced a lack of any safety benchmark established by those inside healthcare, they still experienced a lack of safety. If further research of these perceptions occurred, could a fresh perspective into safety be obtained? Could new approaches to the challenge of developing safer patient systems be developed?

4. Significance of this study

Many authors noted that the patient’s perspective of healthcare safety has not been considered as fully as it should be (Brennan & Safran, 2004; Gibson, 2007; Hattie,
Of particular note is the lack of qualitative research of the patient’s perception of safety (Burroughs et al., 2005; Hupcey, 2000). Additionally, a review of the literature revealed very few qualitative or quantitative studies that examined patients’ safety perspectives. Thus, there is a lack of knowledge regarding the patients’ view of healthcare safety. This study begins to bridge this knowledge gap.

Patients, because they are not within and are not members of the “culture” of healthcare, have a unique outsider’s view of the healthcare system. This focused ethnographic case study approach will uncover the outsider’s perspective. By focusing the patient interview on the patient’s safety experience in the healthcare setting (for the purposes of this study, the ED), the researcher was able to enter into the culture of the patients as they interact with healthcare (Hodgson, 2001), allowing patients to express to the researcher what is important to them.

The outsider’s perspective (how the patient reacts and thinks in the patient culture) can reveal to the researcher the patients’ positive and negative experiences of patient safety. Aspects of their care, definitions of safety, and causes of their unsafe experiences heretofore unseen by those who work from within the culture of healthcare will be revealed (Hatlie, 2004). By investigating the patient perspective, this study goes beyond the surveys, summaries, studies, and analyses of the healthcare system (indeed, the healthcare culture). This study will get at the heart of unmined safety data that has the potential to uncover a significant and unmined source of data for error reduction and safety improvement.
Using the data from this study to build on previous studies, newer mechanisms for building safer patient care systems might be found. This is the true importance of this study. Interventions could be developed based on the fresh perspective, new insights, and heretofore uncovered knowledge of the patient’s perspective. The rationale is to include one more perspective on providing appropriate, safe care. By examining the patient perspective, this study illuminates sources of error missed by those who are a part of the healthcare culture. These sources can be further examined or processes can be developed to prevent them from recurring, all of which improves patient safety.

D. Hypothesis and Research Aims

Qualitative research in general and ethnographic research in particular uses, among other tools, research questions to guide in-depth interviews with participants. At the heart of qualitative research is the development of research questions that lend themselves to the specific qualitative processes (Munhall, 2007). While the researcher will guide the process, the interview will be flexible enough to allow participants an opportunity to express and clarify their safety experience in the ED.

In this study, a focused ethnographic approach was used to examine the participant in his/her culture as patient. The aim or purpose of this study was to uncover the participant-as-patient’s perception of safety. In order to provide the participant an opportunity to reveal this information in the ethnographic process, the following questions were used to guide the researcher.

For patients who have visited the ED:

1. What are perceptions of safe practices and processes in the ED?
2. What are perceptions of unsafe practices and processes in the ED?

3. How do patients define patient safety?

4. What are the most important safe actions and their characteristics in the ED?

E. Summary

Patient safety has always been a problem in healthcare. The IOM’s 2000 report made the public more aware of this issue. Research not only revealed gaping holes that were causing problems, but solutions that helped improve the situation. There is a long way to go in completely solving the unacceptable lack of patient safety in healthcare settings.

One approach to closing the knowledge gap is to examine the patient’s perspective of safety. Patients, as outsiders to the healthcare system, have a unique view of all elements of their care, including safe and unsafe provision of this care. Using a focused ethnographic case study method, this investigator examined the patients’ perspective of care. The data generated affirmed data generated in other studies and provided new insights and fresh perspectives into the patient safety problem. The data also have the potential to be used in developing new safety solutions that make care provision much safer.
II. REVIEW OF LITERATURE AND OVERVIEW OF THEORY

No society can long sustain itself unless its members have learned the sensitivities, motivations, and skills involved in assisting and caring for other human beings.

-Urie Bronfenbrenner

Patient safety considerations in patient care are a driving force in healthcare. However, despite good efforts, patient safety is not what it could be. It is hypothesized that through a more thorough understanding of patients’ perceptions of safety, the patient safety knowledge gap can be narrowed and interventions can be developed that will improve patient safety.

This chapter focuses on one of the greatest problems driving insufficient patient safety: that a lack of knowledge about how to actively involve patients in their healthcare blocks the discovery of comprehensive patient safety solutions. Specifically, patients’ perspective of their care (as part of this active role) has been under-considered at the cost of patient safety. A literature review of expert opinion articles, patient surveys, and research studies will highlight this problem.

Additionally, theory will be presented to better contextualize the importance of patients’ safety perceptions. Dr. Urie Bronfenbrenner’s ecological theory of psychological development will be applied to the healthcare setting. This theory will emphasize the importance of the active role patients take in the care provision system and the importance of studying their perceptions of this environment, all to improve the safety of their care.
A. What is Known about the Problem

1. Patient safety: What is missing?

That there is a serious problem with patient safety is not disputed. The Institute of Medicine’s (IOM) report highlighting tens of thousands of patients who are injured or killed every year by healthcare errors was the wake-up call for a problem that has been and continues to be a serious issue in healthcare (Kohn et al., 2000). Insufficient patient safety has been documented by researchers, healthcare professionals, and news and media outlets. The United States in particular has a significant problem with healthcare safety. U. S. patients experience more errors and receive and perceive poorer care despite a healthcare system that is among the most expensive in the world (Davis et al., 2004)

Like most complex problems, no one answer that will solve this healthcare safety crisis; multiple solutions are needed to solve this vast problem. Despite solutions that have been applied which have saved tens, if not hundreds, of thousands of lives, there are still more responses that have yet to be discovered to solve this issue.

Missing patient safety solutions have developed as the result of a knowledge gap in healthcare safety. To verify this knowledge gap, a literature search of the data bases Medline (OVID), HealthStar (OVID), CINAHL (EBSCO), and PsycINFO (EBSCO) from 1995 to 2007 was undertaken. These databases contain nursing, medicine, and other healthcare-related journals, along with psychological literature pertinent to this topic. The goal of this literature search was to find research studies on patients’ perceptions of safety. Search terms were sought using CINAHL’s Headings, Medline’s MeSH®
(Medical Subject Headings) terms, and keywords appearing in journal articles on this particular topic. The following terms were found and used: patient, perspectives, perceptions, beliefs, hospital, emergency department, consumer attitudes, consumer perspectives, patient satisfaction, healthcare safety, healthcare errors, adverse healthcare events, emergency service, medical errors, safety, and healthcare safety. The search produced a number of editorial and opinion articles on the topic of patients’ safety perceptions, but only four actual studies of patients’ perception of safety were found.

Literature unearthed in the above search includes research studies, conference reports, and editorials generated by researchers and healthcare professional advocates. Healthcare advocates have been especially vocal in professional opinion journal articles. These advocates have used their positions as healthcare safety experts to emphasize missing pieces of the puzzle. One of the missing patient safety solution pieces these bellwethers have noted is the shocking lack of active patient involvement in their care. What follows is a review of salient non-research, professional healthcare advocate articles highlighting the patient safety problem and some missing elements.

2. **Active involvement of patients in their care**

The Picker Institute, a nonprofit healthcare research and consulting firm dedicated to improving the quality and safety of patient care, holds an annual conference on topics dedicated to this mission (Gerteis, 2001). The 2000 symposium, *Through the Patient’s Eyes*, offered several patient-centered conferences. These conferences focused on including the patient in care decisions and care provision models in redesigned health care systems. Provider-patient communication must
improve, and providers must work constantly to find barriers blocking effective communication (Gerteis, 2001). One conference in particular described how patient input was used to improve care when system improvements were designed (Gerteis, 2001).

The Agency for Healthcare Research and Quality is an organization dedicated to “supporting research designed to improve the quality of healthcare, reduce its cost, address patient safety and medical errors, and broaden access to essential services” (AHRQ, 2000, p. 1). The AHRQ was one of the first organizations calling for active patient involvement in the provision of safe care by producing a patient fact sheet. This short, easy-to-read article outlined how patients could be more active in their care to prevent errors (AHRQ, 2000). Tips for patients included asking healthcare professionals directly involved in their care to wash hands, asking for clarification of discharge plans, and insisting that all questions be answered in ways that the patient understands. The AHRQ points out in this fact sheet that, “The single most important way you can help to prevent errors is to be an active member of your healthcare team. That means taking part in every decision about your health care” (AHRQ, 2000, p. 1).

Heeding the call for a more active patient care role, the Joint Commission (2009) has begun to provide guidance in this area. The Joint Commission has included the active patient care role in their patient safety goals. Since 2006, its 13th goal has been to find strategies to empower patients’ active involvement in their own care. This goal is focused on improving patient safety (The Joint Commission). As of 2009, this goal continues to be a part of the Joint Commission’s National Patient Safety Goal program.
Good communication between patient and provider not only is a part of patients’ active role in their care, but it can also decrease errors. Sue Gaard, RN (founder of a patient communication improvement firm) and Sarina Schrager, MD (Associate Family Medicine Professor at the University of Wisconsin School of Medicine) pointed out that the patient of today is “engaged, activated, adherent, self-managed, vigilant and empowered, a transformation of the passive role of the traditional patient” (Gaard & Schrager, 2007, p. 449.). Patients who are active participants in their care positively impact the efficiency and safety of their care (Gaard & Schrager, 2007). Advocating for improved communication, Gaard and Schrager (2007) supported providers who encourage patients to write down their primary complaints and issues so as to more adequately address their concerns. When patients are clear in what their problems and issues are, providers are better able to listen completely to their patients. Accordingly, they are better able to catch important issues that put patients at risk for errors and poor outcomes.

Another communication improvement approach which actively involves patients in their care is educating staff on specific patient care communication techniques. Often staff assumes that patients understand complex issues and terminology when in fact, they don’t. When patients don’t understand their discharge instructions or treatment information, they are less involved in their care and more prone to errors. The Franciscan-Skemp hospital system surveyed their nurses regarding nurse-patient communication. Nurses reported being least proficient at a competency in which they needed to demonstrate high levels of proficiency: “Determines patient’s ability to read, understand, and act on healthcare information (healthcare literacy) and adjusts teaching
methods accordingly” (Fleishman & Doherty, 2007, p. 453). In other words, nurses were not assessing patients’ healthcare literacy and adjusting their explanations to improve patient comprehension.

As a result, registered nurses (RNs) were provided specific patient communication training. This patient and family communication skills program developed by the American Medical Association helped develop RN’s healthcare literacy and assessment skills to improve patient communication. A second wave of RN and medical doctor (MD) education has been instituted to further improve communication. This program is based on the Mayo Healthcare System’s Three Function Model of Communication, as well as a three fold patient communication approach called Simplify, Verify, Clarify, and repeat (Fleishman & Doherty, 2007). While no post-intervention measures determining whether providers were communicating more clearly or if patient’s comprehension of the information they were provided was reported in the article, the significance of actively involving patients in their own care to prevent errors through better communication is clear.

Patient centered care and improving patient communication is also part of the patient safety system at the Lehigh Valley Hospital (LVH). The LVH, located in eastern Pennsylvania, has implemented a program with several legs. Driven by their “tricycle model” with patient safety as the “front tire” of the tricycle, and education and research as the two “rear tires,” LVH strove to improve patient safety and the quality of care through active patient engagement (Anthony et al., 2005).

One of their biggest active patient engagement efforts was to include the patient in essential communication during patient rounding (Anthony et al., 2005). Bringing in
families to the patient rounding process enabled families and patients to be a part of the information sharing process that informs care giving decisions. Additionally a program called Bienvenidos (Warm Welcome) assists those patients who do not speak English as their primary language with translation services so that they better understand their situation and can participate in making care decisions affecting them. All of these programs have been successes, largely due to improved teamwork and communication (Anthony et al., 2005).

At LVH, improving patient care through a more thorough, clear communication does not end with discharge. After discharge, patients can participate in focus groups or take patient satisfaction surveys. Follow up with patients once they are back in their primary care setting assists LVH in providing consistent care and in developing better care processes (Anthony et al., 2005).

However, further analysis of this American Hospital Association McKesson Quest for Quality Prize® award-winning article reveals that this intervention is not research. Only one safety perception survey that could be considered as a measurement for the interventions at LVH was reported. In two short sentences, this measurement of the improvements at LVH was spelled out (not nearly enough information on which to make a decision). While perceptions are important, the success of these programs would carry more weight if they could be shown to make measurable differences in patient safety benchmarks such as medication error decreases or decrease in number of patient falls.

Communication is but one aspect of promoting patients to take an active role in their care. A second aspect is patient centered care, a concept supported by the IOM,
AHRQ, the Joint Commission, and World Health Organization. Patient centered care is a belief that actively involving patients in their care requires patient empowerment (Leonhardt, 2007).

Kathryn Leonhardt, MD, Patient Safety Officer for the Aurora (Wisconsin) Health System, defined patient empowerment in terms of the “patient as an active member of the healthcare team, engaged as a contributing constituent in the process of addressing his or her own healthcare needs” (Leonhardt, 2007, p. 447). Dr. Leonhardt noted that empowering patients to take an active role in their healthcare requires that both patients and providers be educated on their team roles and how to more effectively communicate with each other. Patients who are part of the team providing their care take a more active role in their healthcare and have better outcomes than patients taking passive roles (Leonhardt, 2007).

3. Patient’s active role: Programs and research

Beyond professional opinion and insight, there have been studies directed toward improving patient satisfaction, communication, and patient care processes. However, in all of them, the prime focus has been on improving patients’ active role in improving healthcare safety. The studies which follow deal with the actual improvement of the active role a patient takes in his/her care. In these studies, measurements included a decrease in errors or change of behavior. Some studies do measure how a patient perceives improvement in the ability to take an active role in his/her care; measurement of these studies usually involves satisfaction surveys and other perception-based measures.
An educational intervention that involved increasing the active role senior adults play in their care was recently undertaken. A two-part educational intervention was conducted to determine if (as a result of the intervention) seniors would become better health advocates and thus be more involved in their care. This intervention consisted of a group training session on healthcare errors followed by a one-on-one session teaching the PACE (Present detailed description of the issue, Ask questions, Check understanding of confusing terms or statements, and Express concerns regarding care). A pre and posttest were given consisting of the Seniors Empowerment and Advocacy in Patient Safety (SEAPS) survey (Elder et al., 2008). The SEAPS would help determine if the intervention assisted seniors in becoming better health advocates. Quantitative analysis was undertaken. Paired t-tests were used to compare pre- and post-intervention SEAPS survey results. Interviews were undertaken to measure patients' attitudes after the intervention.

The results of the paired t-tests analysis indicated that all areas of demographics except those seniors with educational levels above high school (with a significance or p value greater than 0.01) had higher SEAPS scores after the intervention in the form of better attitudes toward behavioral examples of self advocacy for patient safety (Elder et al., 2008). Almost all of the 61 patients involved in the survey reported carrying out new self-advocacy behavior even after the first educational intervention. The improvement in SEAPS scores illustrates that seniors can change their behavior when they are educated to become better safety self-advocates (Elder et al., 2008). A patient safety education intervention such as this one which actively involves patients in their care may prevent errors and poor outcomes (Elder et al., 2008).
The study included some shortfalls: the outcomes were centered on patients’ self-report; thus, the patient safety improvement was not objectively measured. There was no power analysis to determine how many patients would be needed for a valid study although the authors did report that this was a “pilot” study (Elder et al., 2008). However, there was, according to the demographics table, a good mix of ages, races, genders, levels of marital status, and various educational levels.

A study of how the healthcare system actively engages the patient by Schoen et al. (2007) considered how the *medical home* concept made a difference in patient care outcomes. A medical home was defined as a patient having (a) a regular doctor or place of care; (b) doctor(s)/staff who always or often know important information about the patient’s medical history; (c) a provider clinic that is easy to contact during regular office hours; and (d) primary care doctor/staff always or often coordinating care received from other doctors or sources of care. Adults who answered “no” to any of the four definitions of medical home were classified as without a medical home (Schoen et al.).

Having a medical home was associated with lower rates of patient-reported errors and with making a positive difference for patients (Schoen et al., 2007). Active involvement in the patients’ care beyond providing a face-to-face visit made a difference for these patients. Providers who know or can access a patient’s history in a reasonable amount of time, who encourage clear, uncomplicated communication with patients, and who actively seek healthcare diagnostic information provided by an outside source, supply better care with lower numbers of errors (Schoen et al., 2007). This active provider involvement decreases errors and improves positive outcomes.
In the study, Schoen et al. (2007) did not describe how the survey, administered to patients in seven countries, was developed, nor was there any information on reliability testing. The medical home concept was developed by the researchers but not by any statistical process such as a factor analysis. The results point to promising outcomes, but future studies need to confirm the reliability, generalizability, and role of the medical home in improving patient care and reducing healthcare error.

In summary, patient safety agencies and experts are all calling for patients to take an active role in their care. Studies that examine the effects brought about when patients play an active role in their care found resulting healthcare safety and quality improvements. One specific way of actively including patients in the improvement of their care is by determining their perception of safety.

4. An under-considered patient safety piece: A patient's perception of safety

Very little research has been undertaken to determine the patients’ perceptions of safety despite calls for exploration in this area (Brennan & Safran, 2004; Gibson, 2007; Leape, Berwick et al., 2009). A few patient safety surveys and research studies have been undertaken, and the information contained therein is highlighted here.

Press Ganey, a national organization which surveys patient satisfaction for hospitals, has included patient safety questions in their surveys since 2004 (Wolosin et al., 2006). In the 2006 Press Ganey survey of 2.3 million patients at more than 1,700 acute care hospitals throughout the U. S., the patient’s perception of safety was among several topics examined.
Communication of information and attentiveness to patients’ needs were two of the top ways to improve patients’ safety perceptions (Press Ganey Associates, 2007). By providing patients with the information about their care, patients then had the data that aided their decision-making process. Being especially attentive to patients’ needs (such as answering call lights promptly, bringing comfort items such as pillows, or summoning spiritual support personnel such as chaplains), improved patients’ perceptions of safety by easing concerns that they were not being cared for (Press Ganey Associates, 2007). In the latest Press Ganey survey, regular communication (especially updates on delays) delivered respectfully continues to be a patient expectation (Press Ganey Associates, 2009).

Some problematic issues of design and analysis are evident. Completion of the Press Ganey survey was voluntary; there is no way to examine differences between those who filled out a form and those who didn’t. In addition, response rates were not documented. Unanswered questions included “What were patients’ motivations for completion or non-completion?” Also, there is no statistical analysis of the data beyond descriptive statistics. Reliability analysis of the scale in the form of a coefficient alpha, is not discussed; this would help convey the quality of the scale. This survey points to interesting directions and is worth using to develop new patient perception studies, but it would be difficult to make conclusions from this data without further addressing some of these design and analysis issues.

Wolosin et al. (2005) analyzed a 2004 Press Ganey survey; this was the first year that Press Ganey included patient safety and patient perception questions in their surveys (Wolosin et al., 2005). Individual patient surveys that met the following criteria
were included in the analysis: (a) demographic questions were answered; (b) the patient was 18 years or older; (c) the Medicare provider number was included. Patient safety was perceived as either good or very good in 87.8% of the cases. Older men (50 - 79 years) felt safer during their care than younger ones; younger women (18 - 34 years) felt safer than older women. Hospitals which provided information about patient rights and related topics during the registration process were perceived by patients as having greater safety; in addition, the longer the hospital stay and the larger the hospital, the lower the safety perception.

The study also revealed that the following increased the patient's perception of safety: (a) attending to the patient's emotional and spiritual needs; (b) being sensitive to the patient's hospitalization; (c) offering information about life support, patients rights, and organ donation; (d) using private rooms; and, (e) keeping length of stay short (Wolosin et al., 2005). The study reported that communicating the existence of safety systems such as electronic medication dispensing and hand washing practices will improve a patient’s safety perception (Wolosin et al., 2005); however, data from the Press Ganey survey were not used to support this assumption.

The Wolosin et al. 2005 study could have been strengthened had the following issues been addressed: (a) exclusion of those facilities contributing less than 30 surveys (no reason for this number was given); (b) failure to discuss reliability and generalizability of the data; and, (c) lack of a coefficient alpha to convey the scale’s quality. Additionally, the specific data manipulation and interpretation that support the conclusions of this analysis were not discussed. Yet, despite these weaknesses, results
point toward promising outcomes by involving patients in their own care through analysis of their perceptions.

Byrne and Heyman (1997) undertook a nonexperimental, quantitative analysis of patients’ perceptions on a variety of topics in an emergency department in Great Britain. Ninety-six patients were interviewed and asked to identify sources of anxiety while in the ED. The structured interview process included 29 potential sources of anxiety which the patients could rate as does not apply, not at all anxious, slightly anxious, moderately anxious, or extremely anxious (Byrne & Heyman, 1997).

The survey found that 65% of ED patients felt the physician may overlook a problem significant to their care. However, only 4% of this group was extremely concerned about this (Byrne & Heyman, 1997). Younger, female patients expressed more anxiety, which is a slightly different finding than in the Wolosin et al. (2005) study noted above. Based on these results, nurses and physicians need to assess and address anxiety and the patient’s emotional condition as well as the patient’s physical condition (Byrne & Heyman, 1997).

While this research adds perspective regarding the treatment of the patient, design flaws decrease the study’s significance. The sample size was arrived at arbitrarily. A power analysis needs to be completed before generalizability and strength of the results can be ascertained. Also, the process for arriving at the 29 potential sources of anxiety was not discussed. As with the surveys listed above, these findings indicate that new information regarding a patient’s perception of care can be found. However, study design and analysis issues must be addressed.
In a qualitative study of Intensive Care Unit (ICU) patients, grounded theory methodology was used to uncover patients’ perceptions of their care during their ICU stay (Hupcey, 2000). Forty-five patients were interviewed in an unstructured, open-ended discussion. The study’s aim was to answer the following questions: (a) what are the psychosocial needs of the ICU patients; (b) what happens to patients when these needs are not met; and, (c) how families and nurses can intervene to meet these needs.

The overwhelming need of the ICU patient was to feel safe (Hupcey, 2000). Those factors implicit in a patient’s feeling of safety included (a) knowing about their condition and what was being done to care for them; (b) gaining control; (c) having hope; and, (d) trusting. The patient’s perception of feeling safe was increased by the presence of family and friends during the ICU admission, by confidence in the ICU staff (especially the nurses caring for the patient), and by possession of religious beliefs (Hupcey, 2000).

The Hupcey (2000) study breaks important ground by revealing important patient care aspects through the study of their perceptions. Good information is created to provide impetus for future studies, noting which patient safety perception factors were adequately studied and which required further studies. Additionally, the results of this study provide information that is helpful for designing and implementing changes in care that would increase the ICU patient’s actual and perceived safety.

Critiques of the Hupcey (2000) study include (a) minimal description of subject’s protection; (b) length of each interview not recorded (interview length would assist the reader in determining the strength of the conclusions); (c) lacking description
of data collection procedures including interviewer training and consistency in
interviewing process (reduces confidence that the same patient would provide the same
data to different interviewers); (d) rigor not adequately addressed, including the process
for theme development (rationale, decision trees), journaling and memoing to address
reflexivity, and preliminary theoretical concepts (Munhall, 2007).

Patient safety surveys seem to be a more popular way of querying and
understanding a patient’s perception of safety. In a recent survey carried out in Swiss
hospitals, Schwappach et al. (2008) developed an instrument from a pre-existing survey
utilizing qualitative feedback. The new instrument delved into patients’ perceptions of
their care by asking them to report any undesirable experiences during their hospital
stay (Schwappach et al.).

There was a 31% return rate on the finalized questionnaire. Seventy-five percent
of patients reported definitive safety problems, while 27% of patients reported uncertain
safety problems. Serious events were reported by 14% of those responding. The
highest percentage of reported definitive and uncertain events were phlebitis, missing
hand hygiene, allergic drug reaction, unavailability of documents, and infections
(Schwappach et al., 2008). Twenty-three percent of patients reported serious concerns
about their safety. Overall, this survey found that many patients experienced
undesirable events during their hospitalization, and many were seriously concerned
about their safety. During qualitative interviews, which were not analyzed using a
specific approach (ethnographical or phenomenological), patients revealed that safety is
an “unsaid word” between patients and their care providers (Schwappach et al., 2008).
The article of Schwappach et al. (2008) revealed two important pieces of information: (a) patients are concerned about the safety of their care, and, (b) patients’ perceptions are not being adequately considered by the healthcare system (for this study in Switzerland). Despite a lack of a power analysis to determine an appropriate N and a questionable survey development process (leaving room to question reliability), this study pointed to a need to consider the patients’ perceptions.

By far, of the studies and surveys reviewed, the most rigorous and salient study of the patient’s safety perception was undertaken by Burroughs et al. (2005). This quantitative study utilized 767 participants from 12 Midwestern hospitals who were patients in an Emergency Department. After several qualitative iterations, an 8-item instrument which assessed patient safety perceptions was developed. This instrument was added onto an existing 23-item instrument assessing patient satisfaction with their ED experience. The entire 31-item instrument was administered by an independent research firm via telephone.

Burroughs et al. (2005) noted a surprisingly high percentage (88%) of patients reporting their safety from medical errors as good, very good, or excellent. These results mirrored those of the Press Ganey survey, even though most of those surveyed were non-ED inpatients. However, almost 38% stated they had experienced at least one of eight concerns during their ED stay. Of the eight concerns, 22% were fearful about misdiagnosis, 16% expressed unease with mistakes by physicians, 16% had trepidation about medication errors, 12% were concerned with mistakes made by nurses, 10% were disquieted by the thought of having the wrong test/procedure, 8% were concerned
they would be mistaken for another patient, and 6% were alarmed by the prospect of falls.

This study also linked patient satisfaction with the patients’ safety perception. The perception of patient safety and frequency of safety concerns were significantly correlated with patient satisfaction and willingness to return to the hospital (Burroughs et al., 2005). Perceptions of safety also were correlated with the willingness of patients to recommend the facility to family and friends (Burroughs et al., 2005). Regression analysis was used to analyze the joint impact of perceptions of safety on the willingness to recommend or to return to the facility. The analysis pointed toward a significant positive relationship: the higher the patient’s safety perception, the more willing they would be to return and the more likely they would be to recommend the facility to others.

This study (Burroughs et al., 2005) is important and, in some ways, groundbreaking. After an extensive review of the research regarding patient safety, this specific study is one of the very few focusing specifically on patients’ safety perceptions in the ED. Furthermore, how these perceptions impact patient satisfaction is vital in understanding how safety perceptions can affect a facility. Patient safety perceptions affect patient satisfaction. While it was beyond the scope of this study, the economic impact patient perceptions can have must not be ignored. Improved patient safety perceptions increase a patient’s support for the facility in terms of return visits and recommendation of the facility to future patients. Both factors would seemingly affect the facility’s bottom line in terms of increased customer base.

Criticisms of the Burroughs et al. (2005) study include several areas. Subject protections were not adequately described. No power analysis was undertaken to
determine how many subjects were needed for this study. Internal validity is threatened by selection bias: the study participants were chosen in a non-random convenience sample, thus generalizability would be difficult to assess. The reliability of the 31-item instrument that was created is questionable: adding eight patient safety perception questions onto a preexisting 23-item satisfaction survey even with demonstrated reliability and validity does nothing to add to the reader’s confidence that the resulting 31-item instrument has appropriate validity and reliability. However, a strong statistical approach adds confidence to the results of the study: (a) a one-way ANOVA (analysis of variance) determined if key patient and hospital characteristics impacted overall safety perception concerns, and (b) the average number of safety concerns was determined. This quantitative investigation demonstrates that patient perceptions are important. It also indicates that the healthcare system has not adequately considered them. Burroughs et al. (2005) noted that additional concerns beyond these eight specific items could have been missed. To remedy this, qualitative research of patient safety perceptions should be implemented in the search for additional medical safety issues, fears, and concerns (Burroughs et al.).

B. Summary of Literature Review

Two articles have examined how to improve patients’ safety perceptions (Press Ganey Associates, 2007; Wolosin et al., 2005) and four others have examined what patients’ perceptions of safety are (Burroughs et al., 2005; Byrne & Heyman, 1997; Hupcey, 2000; Schwappach et al., 2008). These research studies do have weaknesses in study design and gaps in addressing the patient safety concept fully. None of these studies alone point definitively to a need for incorporating the patients’ safety
perceptions into the system for safe care provision. Yet as a body of studies they point to a need for understanding how a patient’s safety perception can bridge knowledge gaps in the quest for improved patient safety.

C. Gaps or Shortcomings to Date

Professionals in healthcare safety have drawn the research and healthcare professional community’s attention to the importance of active inclusion of patients in their care. However, there currently exists a real lack or gap in the area of a patient’s active care role. This gap is the lack of knowledge regarding how patients perceive their care. As can be seen in the studies above, there are several advantages in knowing patients’ perceptions of their care, not the least of which is the real possibility of improving patient safety. When patient safety perceptions are studied and included in patient safety interventions, they have been shown to improve patient safety. Yet much more needs to be learned. Given the real problem of insufficient patient safety, the patient’s safety perception knowledge gap is problematic.

There has been some work in uncovering patients’ safety perceptions, as noted above. However, the number of these surveys is small, and survey development often relied on healthcare providers asking patients about safety issues that were of interest or importance to the healthcare providers. This seems to beg the question of whether patients’ safety perceptions are really known. This was precisely the point brought up by Burroughs et al. (2005) when calling for a qualitative study of a patient’s safety perception.

Because of the small number of existing research studies concerning this issue, and because the survey of safety perceptions often contains perceptions important to
healthcare providers and not necessarily of concern to patients, a qualitative study of ED patients’ safety perception seems warranted. By investigating the patient perception, this study goes beyond the surveys, summaries, studies, and analyses of the healthcare system (indeed, the healthcare culture) and examines what the patient perceptions are from their position “outside” of the healthcare process. This is a potentially significant and an unmined source of data for error reduction and safety improvement.

D. Theoretical Framework

Patient safety, the patients’ perception of their care, and the perception of safety within the care they receive are driving factors in this study. A case is being built both for the importance of and need for this study. Background on patient safety and the role of the patients’ perception of safety has been presented. A practical structure would be exceedingly helpful which clearly situates patients in the care provision system (for the benefit of this study, in the Emergency Department) and also highlights the necessity for the patients’ perception of safety. Such a practical structure exists in Bronfenbrenner’s ecological theory (Bronfenbrenner, 2001).

What follows is a brief overview of this significant theory. Bronfenbrenner’s ecological theory provides a system in which patients are placed in the context of the care-providing environment of the Emergency Department. This theoretical context will demonstrate how patients are affected by the various elements of the Emergency Department. However, the importance of the patient’s unique perception (including the perception of safety) will be shown to be significant, unique, and necessary to know. The real benefit of using this theory is that it emphasizes the importance and necessity of the patient’s perceptions.
1. **Influence of Kurt Lewin**

Dr. Urie Bronfenbrenner developed his ecological theory after extensive work with developmental theorist, Dr. Kurt Lewin. Dr. Lewin, a German-born psychologist escaped from Nazi Germany during World War II. Providing assistance to the U. S. Government in the assessment of candidates for secret service duties overseas, Lewin worked with many psychologists, including Bronfenbrenner (Bronfenbrenner, 1977).

During their time together, Bronfenbrenner was impressed with Lewin’s study of and focus on the environment in which people developed psychologically. Specifically, he was intrigued by Lewin’s understanding of space as not physical but psychological. This psychological environment is a complex of differentiated, interconnected, embedded aspects that impact the psychological development of the individual (Bronfenbrenner, 1977, p. 44). Individuals perceive this environment differently than others because it impacts them subjectively.

Lewin originally published this theory in an article entitled “*Kriegslandshaft*” (“War Landscape”), appearing in *Zeitschrift für Angewandte Psychologie* in 1917 (Bronfenbrenner, 1977). This article outlined a practical application of the importance of the individual’s subjective environmental perception. Lewin applied his concepts and explained them in the context of a “war landscape,” an easy demonstration for this World War I veteran.

A soldier placed in a bucolic farm landscape close to a World War I battle field would see this situation very differently than the farmer who lives amidst this landscape. For the soldier, a green hilltop becomes an observation post, an unexposed hollow becomes a battalion aid station, a wooded area becomes camouflage for the enemy,
and a farmhouse becomes a field headquarters. In other words, an individual’s reality changes as the perceived environment changes (Bronfenbrenner, 1977).

2. Bronfenbrenner’s ecological theory

Bronfenbrenner built on Lewin’s line of thought in creating his ecological model. This model is a theory of environmental interconnectedness and how environmental forces affect an individual’s psychological development (Bronfenbrenner, 1979). For Bronfenbrenner, the ecological environment influences human development because of the complex and reciprocal interactions between the individual and the persons/objects/symbols of the environment (Bronfenbrenner, 1979). The individual is affected by these interactions and psychologically develops over time.

However, the individual is not simply impacted by these environmental persons/objects/symbols. Human development, according to Bronfenbrenner is driven by both objective and subjective elements. Objective elements are those aspects of the environment that have an impact on the individual. Specifically, in child psychology (an area in which he later specialized), he described objective elements as parent talking to the child, toys for child’s play, physical abuse of child, others who support the child’s self esteem (Bronfenbrenner, 1979).

Subjective elements consist of the phenomenological experience of the individual: how the environment is perceived by the individual. This subjective experience includes feelings people develop over time as they interact with the environment. He described these subjective feelings as anticipation, hope, and/or foreboding (Bronfenbrenner, 1979).
The development of subjective feelings over time is an important aspect of the ecological theory. An individual encounters his/her environment and experiences it subjectively. These experiences are linear, occurring one after the other. Thus, the individual subjectively experiences his/her environment over a period of time. This period of time in which the individual encounters the environment is called the chronosystem (Bronfenbrenner, 1979).

This chronosystem is important because, as a concept, it defines a period of time in which the individual identifies the impact of prior life events/experiences either singly or sequentially (Bronfenbrenner, 1979). For Bronfenbrenner, the identification of the environmental impact on one’s life is the foundation on which human psychological development occurs. The significance here is that behavior and development occur as the environment is perceived rather than as it may exist in objective reality (Bronfenbrenner, 1979). Perceptions are different for each person. As will be seen, the rationale for considering the patient’s safety perception lies within this chronosystem.

Objectively and subjectively interacting with and perceiving their environment sets the stage for Bronfenbrenner’s notion of interconnectedness. As will be outlined in the upcoming paragraphs, the environment contains four elements with which the individual connects. This interconnectedness contains forces that directly affect the individual. Not only are objective forces affecting the individual, but the individual subjectively perceives these forces. This subjective/objective interaction is the grist for psychological development.
3. **Interconnecting environmental elements of the ecological theory**

To demonstrate how the environment and individuals interact and are interconnected, Bronfenbrenner developed a system of four interconnecting elements. These elements impact on and are perceived by the individual, and consist of the *microsystem*, *mesosystem*, *exosystem*, and *macrosystem*. The microsystem is any system in which the developing individual interacts within a particular physical or material setting. These patterns of interactions include activities, roles, and interpersonal relationships experienced by the developing person in this face-to-face setting (Bronfenbrenner, 1992). In Bronfenbrenner’s child psychological development world, a microsystem could be a child at school interacting with teachers and classmates, or a child at home interacting with family and pets.

The mesosystem is the system that exists when two or more microsystems interact. Interactions in the mesosystem consist of the linkages and processes that directly include the individual. Bronfenbrenner understood a mesosystem as the interaction of a child’s microsystems: child with family interacting with child at school, family interacting with child in community activity such as Girl Scouts. Interaction requires a child to undertake normal activities with her two microsystems. In the above instance, interaction would require the young girl to finding a parent or sibling of driving age to take her to a Girl Scout meeting.

An exosystem is any interaction of the individual's microsystem with a system that does not contain the individual. The interactions in the exosystem consist of linkages and processes between the systems that influence the individual's world (Bronfenbrenner, 1992). An example of this would be a child's family microsystem
interacting or being affected by the parent’s work world or being affected by changes in local, state, or federal laws. In this case, the child’s family microsystem is affected by two systems (parent’s work or the legislative process) which do not contain the child.

The macrosystem is the “grand scheme” or overarching pattern of micro-, meso-, and exosystems in a broad social context (such as culture or subculture). This broad social context contains the belief systems, resources, hazards, lifestyles, opportunity structures, life courses, options, and patterns of social interchange embedded in these systems (Bronfenbrenner, 1992). An example of a culture is a race-based culture such as the African Bemba tribal culture (in Zambia), or one not based in race or ethnicity, such as the United States-based healthcare system with its providers (doctors, nurses), care provision system, quality assurance, and reimbursement system. Bronfenbrenner likened the macrosystem to a social blueprint for the culture/subculture of the individual’s environment (Bronfenbrenner, 1992). For the child, the macrosystem in Zambia would consist of the Zambian culture, plus the subculture of the “Bemba” tribe to which the child belongs. In upcoming sections, a specific ED application of the micro-, macro-, exo-, and mesosystem ecological theory elements will be provided.

The interconnectedness of these interactive systems directly impacts the individual by affecting his/her psychological development. Both between persons within settings (the microsystems) and between systems (meso-, exo-, and macro-), the individual is objectively affected by and subjectively perceives these interactions (Bronfenbrenner, 1979). As a developmental psychologist, Bronfenbrenner understood psychological development occurring over time between the systems that are grandly interconnected (Bronfenbrenner, 1979).
Necessarily, then, all of the systems involved in an individual’s world must be identified, queried, studied, and observed to determine how they affect his/her psychological development. Leaving one system out would provide an incomplete psychological development picture.

In the next section, Bronfenbrenner’s ecological system will be applied to the provision of safe patient healthcare. A shift from a psychological development system to a patient safe care perception system will occur so as to understand the patients’ role in the healthcare system by examining their micro-, meso-, exo-, and macrosystems of the healthcare environment. Using this model, the rationale for the necessity of studying the patient’s subjective perceptions to improve healthcare safety was elucidated.

E. Bronfenbrenner’s Ecological Model in Patient Safe Care Provision

From the outset, it must be stated that this model does not directly apply to the safe patient care provision, or to a rationale for including the patient’s perspective. This theory was created to help understand how people, specifically children, undergo psychological development (Dr. Bronfenbrenner was a cofounder of the United States Head Start program, geared toward addressing children’s psychological needs as they prepared for school). This theory is a model that predicts behavior and success of children situated in specific environments. Understanding the environment helps clarify the child’s role in that environment.

Yet, this model is very useful in this study. This ecological model applied in the healthcare setting supplies a clear picture of the patient within a specific environment (the healthcare environment), thus a structure and a model to understand the patient’s role in this environment. Specifically this model highlights why a patient’s perspective is
relevant in arriving at patient safety solutions. In the paragraphs that follow, the application of the ecological model will be applied to the healthcare safety improvement system to show the patient’s role both in the system and in improving healthcare.

1. Specific application of the ecological theory in healthcare

As stated above, the specific issue is not of psychological development, but of the provision of safe healthcare to patients. Patients enter the healthcare system seeking healing. They are suffering, typically, from a physical or psychological issue (traumatic injury, medical problem, psychiatric illness) and they are treated in an environment that addresses their physical, psychological, sociological, and spiritual issues. This process occurs through the complex and reciprocal interactions between the patient and the persons/objects/symbols of their environment (Bronfenbrenner, 1979). In other words, patients seek healing by interacting with doctors, nurses, respiratory therapists, technicians, registrars, and/or diagnostic studies staffs, who examine, diagnose, and treat the patient.

Healing begins and continues as the patient encounters both objective and subjective elements of the healthcare environment. Objective elements are those activities completed with patients: diagnostic studies, vital signs and treatments (including use of equipment) administered by nursing (RN), providers (medical doctors [MD], physician’s assistants [PA], nurse practitioners [NP]), technicians, respiratory therapists (RT), and other ancillary staff. Objective elements also include those systems not directly involving the patient but which impact their care (Unit Clerks ordering diagnostic tests, housekeepers who clean the area), and those systems that operate outside the direct patient care environment (such as unit and hospital management,
human resources, hospital nursing quality improvement professionals, and performance measurement and improvement staff).

Subjective elements of the healthcare environment are a phenomenological experience of the patient. These would include feelings that the patient develops over time while interacting in this environment: trust or lack of trust with staff, fear of mistakes, confidence in procedures or staff, and assurance that patient education provided by staff is not too complicated or too simple.

Similarly, as in the Bronfenbrenner ecological system, these feelings are developed over time. The chronosystem develops in the healthcare setting as the patient encounters the system and then develops subjective feelings and perceptions linearly (during the course of time). Thus, feelings can be reinforced (consisting of good experiences or feelings of confidence with a provider) because they are encountered repeatedly in this chronosystem.

These evolving feelings develop as the patient perceives his or her environment. These perceived feelings and emotions are important for two reasons. First, these patient perceptions are different from those trained in the healthcare system. Because their ecological system is very different from that of those within healthcare, patients perceive things differently. As outsiders, they have unique perceptions enabling them to see things that those within the system cannot. Thus, patients are positioned to see errors that the healthcare providers are unable to see because of their insider perspective.

Secondly, patients will form judgments based on these perceptions that will then form the basis for future interaction with the healthcare environment. The patient may
not undertake specific treatments or provider follow-up as directed based on negative feelings and perceptions. For instance, if the provider was perceived as rude, the patient may not follow up with the treatment because of a loss of confidence in the provider’s knowledge and/or decision making capability. If the patient experiences an unclean environment (bloody gauze visible in an open waste can or a full urinal on a counter top) the patient may feel unsafe and perhaps not come back to that facility.

The important application of the ecological theory to healthcare is this: the patient’s objective and subjective encounters with this environment over time will impact not only the physical, psychological, sociological, and spiritual healing, but also the patient’s perceptions in this environment. For Bronfenbrenner, knowing the objective and subjective impact of the environment on the individual was necessary to understand psychological development. Similarly, when the objective and subjective impact of the healthcare environment on the patient is studied, how the patient forms perceptions about that care is better understood. The patient’s (subjective) perceptions are crucial in finding missing pieces of data that point to patient safety issue and are vital in completely understanding the provision of safe care.

2. The patient in the ecological healthcare system

As noted in the theory section, several interconnecting systems in the environment influence an individual’s psychological growth. These include the micro-, meso-, exo-, and macrosystems. In the healthcare environment, there are similar systems. For the purposes of this doctoral study, the Emergency Department (ED) will be the specific healthcare environment in which these systems are accentuated.
The many microsystems with which the patient interacts are those care process systems in which the patient is directly involved. They include interactions of patients with RNs, MDs, ED technicians (EDT), RTs, registrars, diagnostic testing staff (Computed Axial Tomography [CT] tech, Magnetic Resonance Imaging [MRI]) tech, transporters, and paramedics (EMT-Ps).

There are also a number of mesosystems. The processes and linkages of mesosystems occur between the various microsystems. When the MD orders the RN to provide the patient with a treatment or medication, this is an example of a mesosystem at work. The patient is interacting directly with both the MD and the RN, and those two microsystems interacting form a mesosystem.

The exosystems at work in the healthcare environment involve those microsystems interacting with other systems in which the patient is not directly a part. A few of the systems that do not directly include the patient are pharmacy, management (unit and hospital level), laboratory testing of specimens, and various hospital-level systems including process and quality improvement and human resources. An example of an exosystem in action occurs when pharmacy sends a medication to the RN after receiving an order from the MD; the RN then administers the medication to the patient. The RN and MD are two microsystems involved with the patient. The pharmacy is a system in which the patient is not directly involved (face-to-face). Interaction of pharmacy with the MD (direct patient involvement) and the pharmacy with the RN (direct patient involvement) is an example of an exosystem.

The macrosystem in the ED is the overarching pattern of the micro-, meso-, and exosystems that exist in the belief systems, resources, hazards, lifestyles, opportunity
structures, life courses, options, and social interchange patterns of the healthcare environment cultures and subcultures. The macrosystem for this model is the culture and the interpretation of the experiences of the US Healthcare System. One specific hazard of this macrosystem is the lack of appropriate safety in this healthcare environment (as outlined in the literature review above).

As can be seen in this simplified application of the ecological system to the healthcare environment, there is much interconnectedness. The patient enters the environment and immediately is a part of several microsystems. These microsystems have to interact to make the care system work. RNs and MDs (and other providers) rely on each other to steer the patient’s care, forming a tight mesosystem. ED management, which may never see the patients in that environment, trains staff and provides staffing (among myriads of other functions) which can positively impact the patient in this exosystem. A tightly interconnected environment consisting of the specifics of U. S. healthcare culture and other subcultures, such as the safety subculture, forms the macrosystem.

Bronfenbrenner’s ecological theory holds that knowing each part of the system and how these systems relate with each other in the individual’s environment would provide an understanding of the individual’s psychological development. Similarly, knowing the elements of the micro-, meso-, exo-, and macrosystems that form the healthcare environment and how they relate with each other would provide keener insight into the patient in this environment. First and foremost, the insight that patients are subjectively affected by the environment and thus perceive it uniquely is of great importance. This provides the rationale for understanding why a patient’s perception is
important and essential. With it, a unique view of the healthcare provision system can be noted and perhaps new insights into patient safety gaps can be learned. Secondly, this theory provides insight into how a patient fits into and is impacted by this system.

The patient is a key element in the healthcare system. Patients are interconnected with persons and processes in other microsystems as well as systems not directly involved with patient care. Patients are influenced by forces of these systems that affect their physical, psychological, sociological, and spiritual healing. Not only are they influenced upon by the interactions and interconnectedness of this system, they perceive subjectively the interactions and interconnectedness of this system. That is why it is vitally important to (a) include the patient in developing solutions to problems in healthcare (specifically the patient’s safety perspective) and (b) study their perspective of safety to discover, from their subjective perception, what issues are present and not currently perceived by those involved in healthcare (who by fact of being an insider to the healthcare culture have a different perception).
III. METHODS

A. Introduction

The purpose of this study was to uncover patients’ perceptions of safety. Patients who are outsiders to the healthcare system have a unique, under appreciated, and under studied view of their healthcare and associated safety issues. By interviewing a group of participants (Emergency Department or ED patients) about a specific setting (ED) using qualitative, ethnographic methods including in-depth interviews, observation, and visit record and incident report reviews, patients’ ideas about safety in the ED were elicited and compared with provider reports of untoward incidents. Sources of the patients’ safety perception included (a) observations of the Emergency Department; (b) review of patient records (ED visit history and incident reports of those interviewed); and, (c) collection of patient safety issues from popular media and broadcast & print news sources. By detecting themes of the patient’s safety perspective from more than one source, confidence increased that these themes and supporting domains represented the patient’s safety perception.

B. Study Design: Ethnographic Case Study

For exploratory purposes a qualitative, focused ethnographic case study with ED patients in south Texas allowed patients to recall and reflect on details of their ED stay. This method was ideal because it allowed the patients to discuss their perceptions of their care, revealing strengths and weaknesses of the system not currently perceived by those within the healthcare system. Discovering, understanding, and correcting these deficiencies will improve existing patient safety.
This ethnographic case study provided the means for studying a specific aspect of the participant’s culture, thus exploring a specific area of his/her experience, using his/her descriptions and explanations (Spradley, 1979). By learning about patients’ experiences in healthcare, from their perspective, culture, and role as patient, additional aspects of the safety of their care were revealed. This information was important because information from patients’ perspective regarding their care has been under considered by formal healthcare systems. Thus, the focused ethnography used in this study was a means for discovering how the patient and healthcare provider perceptions were similar or different and what can be learned from the patient (Hodgson, 2001; Silverman, 2006).

Triangulation in ethnographic studies involved examining several different data sources to discover if themes from one source (e.g., observation) appear in other sources (the interview and/or media sources). Triangulation provided a more complete definition of themes, reinforced reliability, validated interview findings, and strengthened confidence in conclusions (Roper & Shapira, 2000). In this study, triangulation included the patients’ perspective of safety from their ethnographic interview, safety issues as recorded in their emergency department visit records and incident reports, observations of the ED care setting, and media news stories of patient safety problems.

The first source of ethnographic information generated was observation. Observation involved the researcher observing the patient care environment: how staff, providers, and administrators worked together, and how inanimate objects such as stretchers, medication carts, and cleaning items were used in the environment. The ethnographic interview was the second source of ethnographic data. The interview
involved a dialogue with patients within two weeks of their ED visit to capture as much of their perceptions of their recent ED visit as possible (Löf, 2006). The third ethnographic source involved examining articles on patient safety perspectives from media sources, such as newspapers and television and radio programming. The data from these media sources were examined for common themes in a manner similar to the analysis of the interviews. More detailed methods for gathering those data are discussed in the following sections of this chapter.

To assist the researcher in more completely understanding the context of the visit, a copy of the emergency department visit record and related documents dealing with the patient’s visit were obtained. The primary investigator (PI - Paul Clark) made handwritten notes on a form created for this purpose (Appendix A). Additionally, if a safety incident occurred during the visit, that report was examined. Handwritten notes were recorded on the same form. To maintain confidentiality of the patient medical record and incident report, no copy of the medical record or incident report was made (other than the handwritten notes).

C. Setting, Sample, and Participant Data

Bexar County, in which most patients reside, consists of a population of 57% Hispanic (49% male), 32% Anglo (approx. 49% male), 7% Black (approx. 49% male), and 3% other (approximately 46% of whom are male) (Texas State Data Center and Office of the State Demographer Institute for Demographic and Socioeconomic Research, 2006).

The theologically-based Christian healthcare system consists of five inpatient facilities with more than 1,500 inpatient beds. The specific purpose of this hospital
system is to promote and support the healthcare of the community by improving how healthcare is delivered to patients and to provide charitable care to people of this region of southwest Texas. The value system and management philosophy used by this system is built on the W. Edwards Deming management philosophy. One specific facility was chosen: a hospital with the 356 licensed inpatient beds with a 34-bed Emergency Department. This ED has a wide variety of psychiatric and medical patients.

Entry into this system was enhanced by this researcher’s professional relationship with several gatekeepers: the Chief Nursing Officer, Director of Emergency Services, and Vice President for Research and Education and Research. Face-to-face meetings were conducted with the Vice President for Research and Education to review protocols and explain and answer questions about the study’s purpose. Upon approval from this hospital system’s Institutional Review Board, the official stated that they would provide resources and people to help in setting up Emergency Department observations, recruitment of participants, and medical record/incident report review (Vice President for Research and Education, personal communication, September 9, 2008).

Purposive sampling allowed the researcher to intentionally select participants, sites, documents, and media that provided the data to answer the research questions (Creswell, 2003). Initially a purposive sample of three participants was used as a pilot study. The interactive question guide, interview process, and data analysis were trialed and refined during this pilot study.

ED patients were chosen because expanding knowledge of ED patients’ safety perception was a clinically important area to the researcher. In a study of ED patients in
St. Louis, Missouri, researchers arrived at conclusions about ED patients’ healthcare safety perceptions (Burroughs et al., 2005) that were relevant to the conceptualization of this study. Upon completion of this quantitative review of ED patients, researchers undertaking that study called for a qualitative study of ED patients to discover if there were other perceptions missed by their study (Burroughs et al., 2005). The intention of this specific qualitative study was to expand on previous studies of healthcare systems and patients perspectives.

In qualitative research, sample size was defined by data saturation rather than a power analysis as in quantitative research (Munhall, 2007). Participants were sought until no new themes or information were found from additional participants (data saturation) (Munhall, 2007). The minimum qualitative study sample size is six to seven one-hour interviews (Spradley, 1979) and can require up to 40 in a more broadly defined study (Munhall, 2007).

Patients recruited into the study reflected the ethnic (Caucasian, Hispanic, and African American) and gender demographics of Bexar County. Patients aged 18 to 100+ were eligible to participate. Fourteen patients agreed to participate in these ethnographic interviews. Eight females and six males took part. Six of those interviewed were Hispanic, five were white, and three were African American. The age range was from 22 to 85 with a mean age of 48.5 years. Six of the patients were in the 18- to 39-year-old range, five of the patients were in the 40- to 59-year-old age range, and three patients were aged 60 years or older.

These patients had a variety of reasons for seeking emergency care at the ED. Medical issues included abdominal or chest pain or systemic infections. Traumatic
injuries included pain to upper or lower extremities after falling or being struck by falling objects. Nine patients were discharged to home, and five were admitted to the hospital for further testing and treatment. The rationale for including these types of patients was to include patients who interfaced with several different aspects of the ED (nurses, physicians, ancillary departments such as radiology, respiratory therapy, or pharmacy) and thus had exposure to a greater number of staff and procedures in the ED. Table 1 lists participant sex, ethnicity, and age range as well as ED admission, discharge diagnosis, and whether they were sent home or admitted as a hospital inpatient.

Study participants were either discharged to home/community or admitted to the hospital after their ED stay. Since the ED is an outpatient department, discharge to home/community or admission to the hospital completely removes the patient from the care of the ED (unless the patient re-accesses the ED for additional or recurrent illness/injury). This clear break allowed the researcher to distinguish between events and perceptions in the ED and those events and perceptions that occurred in the hospital at the patient’s home after discharge. The participants were asked to focus specifically on their ED experience.

Interviews primarily took place in the patient home with the following exceptions: one interview at a local café and four interviews at the patients’ hospital admission (inpatient) room. Each interview was a single instance. When no new data emerged from the interviews (indicating that data saturation had been reached), interview recruiting was halted (Munhall, 2007). Data saturation was reached with the 14th participant.
### Table 1
Sample Demographics, Presenting Complaint, Discharge Diagnosis, and Final Disposition

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>57%</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>43%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>14</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>3</td>
<td>21%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6</td>
<td>43%</td>
</tr>
<tr>
<td>White</td>
<td>5</td>
<td>36%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>14</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Age Range</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 – 39 years old</td>
<td>6</td>
<td>43%</td>
</tr>
<tr>
<td>40 – 59 years old</td>
<td>5</td>
<td>36%</td>
</tr>
<tr>
<td>60 years and older</td>
<td>3</td>
<td>21%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>14</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### Admitting Complaint / Discharge Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>High blood pressure at MD office, dizzy, blurred vision / Hypertension</td>
<td>Home – f/u¹ with PCP²</td>
</tr>
<tr>
<td>2</td>
<td>Severe right lower quadrant abdominal pain / Acute abdominal pain, no specific cause</td>
<td>Home – f/u with PCP</td>
</tr>
<tr>
<td>3</td>
<td>L shoulder pain after fall / contusions: left shoulder, left anterior chest</td>
<td>Home – f/u with PCP</td>
</tr>
<tr>
<td>4</td>
<td>Lower abdominal pain / Pelvic pain, unknown cause</td>
<td>Home – f/u with PCP</td>
</tr>
<tr>
<td>5</td>
<td>Diarrhea, nausea-vomiting, dehydration / Acute dehydration, acute diarrhea,</td>
<td>Home – f/u with PCP</td>
</tr>
<tr>
<td>6</td>
<td>Joint pain &amp; left knee pain / Left knee pain</td>
<td>Home – f/u with PCP</td>
</tr>
<tr>
<td>7</td>
<td>Chest Pain / Painful respiration and chest pain; anemia</td>
<td>Home – f/u with PCP</td>
</tr>
<tr>
<td>8</td>
<td>Coughing up blood / Pneumonia and pleurisy</td>
<td>Admitted – history of kidney transplant</td>
</tr>
<tr>
<td>9</td>
<td>Chest pain &amp; back pain / Angina pectoris, coronary atherosclerosis, cardiac dysrhythmias, back pain uncertain origin</td>
<td>Admitted – cardiac work up &amp; back pain management</td>
</tr>
<tr>
<td>10</td>
<td>Rectal pain &amp; diarrhea / Diarrhea, anal fissure, blood in stool</td>
<td>Admitted – pain management</td>
</tr>
<tr>
<td>11</td>
<td>Left foot pain / Foot contusion</td>
<td>Home – f/u with PCP</td>
</tr>
<tr>
<td>12</td>
<td>Shortness of breath / Sepsis, septicemia</td>
<td>Admit – treat infection</td>
</tr>
<tr>
<td>13</td>
<td>Ankle Joint Pain / Poly arthritis, gout</td>
<td>Home – f/u with PCP</td>
</tr>
<tr>
<td>14</td>
<td>Right ankle pain, fever / Joint effusion, ankle pain, acute renal failure</td>
<td>Admit – treat joint pain &amp; manage kidney failure</td>
</tr>
</tbody>
</table>

**TOTALS** 9 or 64% DC Home 5 or 36% Admitted

*Note.* ¹PCP is the patient’s primary healthcare provider. ²f/u = follow up.
D. Study Variables and Reflexivity Check

Unlike quantitative studies, qualitative research is not usually conceptualized as having dependent and independent variables, and neither do qualitative studies control nor manipulate any aspect of the participants or their environment (Polit & Beck, 2008). Also, unlike quantitative studies, the only instrument used in this study is the researcher. The skill of the researcher qua instrument and of the team working with the researcher thus ensures, as Morse and Richard (2002) note, “quality and scope of the data, the interpretation of the results, and the creation of the theory” (p. 168).

Because the researcher was the instrument used to collect study data, care was exercised to prevent the researcher from imposing his own input onto the data. To prevent the researcher's prior knowledge, biases, suppositions, and information from a literature review from affecting the data, bracketing, a central process of any qualitative research, occurred. Bracketing was the process of making these biases, suppositions, and prior knowledge overt by writing them in a journal. For Morse and Richards (2002), bracketing was important because it allows the researcher to “see the research problem, the setting, and data with fresh eyes and work inductively creating understanding from the data” (p. 170).

Bracketing occurs by keeping a research journal. This journal recorded personal feelings, philosophical positions, felt biases, impressions of the participant's participation, feelings the researcher had about interviewing the participant, and decisions made regarding directions in research (Buckner, 2005). Such activity revealed apriori understandings the researcher brings to the project. When noted and reviewed with co-researcher and faculty advisor Dr. Kelly Dunn, PhD, APRN, BC, this checking
and counterchecking process prevented the researcher from infusing his views on the participant data and interview content (Buckner, 2005).

This researcher was an Emergency Nurse from 2001 to 2005 at another ED in this hospital system. He also was an Emergency Technician from 1988 to 1991 at a level one trauma Emergency Department (treated patients with catastrophic traumatic injuries) in St. Louis, Missouri. He is the treasurer of the Texas Emergency Nurses Association (ENA), and was president in 2006 and 2007 of the San Antonio ENA. This researcher played a part in two research projects, both involving data collection in a participatory action research program at the University of Texas Health Science Center at San Antonio. However, no other research projects have been undertaken by this writer.

E. Procedure

1. Recruitment and inclusion/exclusion criteria

A purposive sample was taken from Emergency Department patients at this specific hospital. Patients were approached by their nurse or provider (Physicians/Physician Assistants/Nurse Practitioners) in the Emergency Department private patient care area or in the ED triage area and asked to participate in the study. The researcher was at the Emergency Department observing the patient care setting with approval from the Internal Review Boards (IRB) of the University of Texas Health Science Center at San Antonio (UTHSCSA) and of the healthcare system of this ED for the purposes of research.

If the patient asked for clarification or questions the staff couldn’t answer, the researcher was available to respond. This researcher identified himself to the patient,
explained that he knew of the patient’s condition as part of the “observation” piece of this research, clarified that this study was approved by this healthcare system, and relayed that he was not part of the patient’s treatment team. If the patient was not comfortable with the situation in any way, contact was terminated.

A letter (Appendix B) was given to the patients explaining the purpose of the study. At the bottom of the letter was the phrase, “Thank you for considering being a part of this important study. If you have any questions about this study, you may call Paul R. Clark RN, MSN, MA at (210) 789-6031” followed by three blank lines marked name, phone, and Best Time to call (circle): Morning, Afternoon or Evening. A fourth line for a signature and the day’s date was also included. The patient filled them out and handed them to the researcher.

This researcher followed up with a phone call. During the phone call, the researcher determined eligibility, provided a complete explanation of the study, received the participant’s permission to continue, and determined a date, time, and place to conduct the initial interview. Additionally, if, during the phone call, the patient decided (s)he no longer wished to participate in the study, the patient was thanked for his/her interest and contact was terminated. At the time of the interview, written consent was obtained by the researcher.

Participants were Emergency Department (ED) patients aged 18 to 100, who were English speaking, cognitively unimpaired, able to recall their personal history of healthcare events, treatments, and medications, alert and oriented to person, place, and time, and who could express their thoughts and ideas through verbal/audio and/or visual communication. They were conscious for the majority of their ED stay.
Patients less than 18 years of age (considered minors or children) were excluded because children cannot provide consent, and their perceptions would be different from those of adults. Because this researcher is limited to English and was the primary data analyst, patients who did not speak English were excluded. Patients had to have good recall of their visit so that the details and perceptions they had could be discussed. Patients who had a poor recall of their health history, treatments, and medications, and those who had dementia or other condition that limited their orientation to person, place, and time were not invited to be a part of the study. In addition, so that patients would be able to recall the details and perceptions of their visit, they needed to be conscious for most of their visit. Women and minorities who speak English were included.

Patients directly admitted to the hospital but who waited in the ED until a bed became available and patients who were both transferred from a lower level of care who have been diagnosed/treated and awaited an inpatient bed were excluded. These direct admit patients typically spend a short time in the ED as “boarders.” They would not have accessed the variety of services that EDs offer, which were required to provide the patient experience on which to build perceptions.

2. Measures

As with all qualitative studies and with this ethnographic case study, there were no instruments (aside from the researcher) used to collect data. No other instruments were used to make any patient assessment. Demographic information acquired from patients’ records included their age, gender, ethnicity, marital status, education level, income, type of insurance coverage, length of stay (in hours), treatment day of week, and time of day. Day shift treatment was defined as ED treatment between 7 am and
3 pm, evening shift treatment was defined as ED treatment between 3 pm and 11 pm, and night shift treatment was defined as ED treatment between 11 pm and 7 am.

3. Data Collection

Data collected for this study included observations of the ED and ED patient care rooms, patient interviews, patient visit history (medical record), incident report reviews, and media patient safety story analyses.

a. Observation. Observation of the patient care environment was undertaken at the ED of this facility. These observations allowed the researcher to watch the entire patient care environment, view how staff, providers, and administrators work together, and note how inanimate objects such as stretchers, medication carts, and cleaning items were used in the environment. These observations provided the researcher with a view of the environment in which the patient received care.

Observations occurred during all patient care shifts (7 am - 3 pm, 3 pm - 11 pm, and 11 pm - 7 am). This researcher anticipated that observations would be made an equal number of periods in all shifts over a two to four month period. Because of scheduling conflicts, the day and evening shifts were the shifts most frequently observed, accounting for about 90% of the observation times. The period of months over which the observations were made was March to September for a total number of 39 observation days. Table 2 lists the number of total hours of observation on each shift along with the percentage of hours on each of the three shifts.

As with patient interviews, observations occurred until data saturation was reached. Data saturation occurred when no new observations occurred. Observations made by the researcher along with subjective feelings and perceptions of the
Table 2

Number and Duration of Ethnographic Observation Activities

<table>
<thead>
<tr>
<th>Shift</th>
<th>Observation Days</th>
<th>Observation Time Duration</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7 am - 3 pm (day shift)</strong></td>
<td>17 days</td>
<td>57.75 hours</td>
<td>44%</td>
</tr>
<tr>
<td>Observation Days</td>
<td>17 days</td>
<td>57.75 hours</td>
<td>44%</td>
</tr>
<tr>
<td>Observation Time Duration</td>
<td>57.75 hours</td>
<td></td>
<td>47%</td>
</tr>
<tr>
<td><strong>3 pm - 11 pm (evening shift)</strong></td>
<td>18 days</td>
<td>54.5 hours</td>
<td>46%</td>
</tr>
<tr>
<td>Observation Days</td>
<td>18 days</td>
<td>54.5 hours</td>
<td>44%</td>
</tr>
<tr>
<td>Observation Time Duration</td>
<td>54.5 hours</td>
<td></td>
<td>44%</td>
</tr>
<tr>
<td><strong>11 pm - 7 am (night shift)</strong></td>
<td>4 days</td>
<td>11.75 hours</td>
<td>10%</td>
</tr>
<tr>
<td>Observation Days</td>
<td>4 days</td>
<td>11.75 hours</td>
<td>10%</td>
</tr>
<tr>
<td>Observation Time Duration</td>
<td>11.75 hours</td>
<td></td>
<td>9%</td>
</tr>
<tr>
<td>TOTAL OBSERVATION DAYS</td>
<td>39 days</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>TOTAL OBSERVATION TIME DURATION</td>
<td>124 hours</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>
researcher were recorded in the field notebook of this researcher (called the “Research Journal”). Making observations during multiple times enhances reliability of the data (Roper & Shapira, 2000).

b. Interviews and medical records review. Patient interviews were scheduled within two weeks of their ED visit, so as to capture as much of their recent experience as possible (Löf, 2006). Typically patients, who accepted an invitation to be interviewed, were contacted within four to five days of their discharge, or within one to two days of their hospital admission. This researcher discovered that patients needed a few days to get home (if discharged) to recover before being contacted. However, if too much time elapsed between discharge and second contact (to establish an interview time), the patient would either decline or not respond to phone calls. Additionally, patients admitted to the hospital were contacted relatively quickly after leaving the ED (within 2 days). Patients contacted after that time were either discharged or began to include their inpatient experience with their ED experience (requiring additional questioning to separate out their ED experience from their hospital experience).

Interviews took place at a location convenient to the patients: in the participants’ homes, their inpatient hospital rooms, or at a local café. Interview length varied, with the shortest interview lasting 23 minutes and the longest lasting 72 minutes. Over 60% of the interviews lasted between 30 and 60 minutes. Table 3 delineates interview length by span of time.

As stated earlier, 14 patients participated in the study. However, a total of 26 agreed to become participants, but 12 of those declined for a variety of reasons. Two-thirds of those initially agreeing but declining were female. The majority of those
**Table 3**

Ethnographic Interview Length and Refusal Data

**Participant Interview Length by Span of Time**

<table>
<thead>
<tr>
<th>Time</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 31 Minutes</td>
<td>3</td>
<td>22%</td>
</tr>
<tr>
<td>31 - 60 Minutes</td>
<td>9</td>
<td>64%</td>
</tr>
<tr>
<td>61+ Minutes</td>
<td>2</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Patient Interview Refusals**

**Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4</td>
<td>33%</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>67%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Reason for no interview**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not return calls</td>
<td>9</td>
<td>75%</td>
</tr>
<tr>
<td>Did not keep appointment</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Refused</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>100%</td>
</tr>
</tbody>
</table>
who declined to become participants did so passively by not returning phone calls. This researcher called participants three times over a period of a week. After leaving a message for a third time, the researcher ceased contacting the patient. Table 3 outlines participant gender and reason for refusal.

For the interview itself, Spradley (1979) proposed that broad questions be used to elicit the participant to report the parts of their perspective most important to them. Located in an interactive question guide (Appendix C) these questions helped patients frame their ED experience and elicit their healthcare safety perceptions. The questions used during an ethnographic interview were: (a) descriptive (participant use of terminology and meaning); (b) structural (participant describes events and activities that provide their view of characteristics of the ED); and (c) contrast questions (participant sorts out similarities and differences between activities, events, and people in the ED) (Spradley).

The interactive question guide contained descriptive and structural questions. Descriptive questions were grand tour questions (Spradley, 1979). For instance, “Can you tell me what it was like being a patient in the ED at hospital x?” Specific grand tour questions focused the person on specific aspects of his/her experience. “Could you walk me through some of the things you can remember about the staff and their interactions with you during your stay?” Structural questions were asked concurrently with descriptive questions to more deeply probe the details (Spradley, 1979). Often they were dependent upon answers provided by the participants. “You mentioned a medication error. What happened and was it discussed with you?” Contrast questions directed the participant to define events, activities, and people in greater detail and were
dependent upon information the participant shared. A contrast question in this study might be, “You said you felt unsafe when that patient in police custody was in the stretcher next to yours. How is this different from when you didn't feel safe after the nurse made the medication error?”

As the interviews progressed, the quality of the data obtained improved. Initially this researcher asked very structured questions according to an insider’s understanding of the ED visit. Questions started at the triage desk (or if the patient came in by EMS the patient care room) relating to what the researcher assumed would be the patient’s first perceptions of the ED. After reviewing several recorded interviews with the doctoral committee chair, the questions became more general in nature. While still Grand Tour questions, the patient could choose where to start (instead of the interviewer). By the last interview, patients were better able to answer the Grand Tour questions beginning with what was important to them.

All interviews were audiotaped with a digital voice recorder and transcribed by a transcriptionist. Minimal notes were taken during the interview, i.e., a quick note to remind the researcher to follow up with a specific question. The only follow-up interviews that were undertaken to verify results were with the patients who had been interviewed. This process is known as “member-checking.”

As soon as possible following each interview and follow up (if necessary), the researcher wrote field notes that included details not recorded at the time of the interview, such as participants’ reactions (crying, smiling, fidgeting), physical setting, and researcher impressions (Spradley, 1979). Subjective feelings and perceptions of the interview, participant, and environment were noted and reviewed later.
The Emergency medical record generated during the patient’s stay was an important source of data. While not containing the patient’s perceptions and direct experience, the information noted by healthcare staff was an important adjunct to the patient interview. Information either corroborated or refuted information provided by the patient. Of the 14 records reviewed, 12 records supported the details reported by the patients. In two cases, details provided by the patient were countered by data in their medical record. One patient reported not being given any pain medicine while the medical record noted three instances of the ED MD ordering the pain medicine while the ED RN administered it.

The medical records were accessed and examined at the Health Information Management offices at the institution. Handwritten notes on a form designed by the researcher were taken based on information from the incident report (Appendix A). The records were checked to determine if any unsafe actions not noticed by the patients occurred; none were noted. In addition to the patient’s triage information, lab and radiological testing results, MD and RN progress notes and discharge information were noted.

Incident reports filed by staff related to the ED visit would have been examined; however, of the 14 patients taking part in the study, none filed an incident report nor were any incident reports regarding these 14 patients filed by staff. The medical record as well as incident reports regarding the patient’s care, reports of error, or omissions of errors were important to examine to more clearly understand the patient’s ED visit and provide the researcher with a measure complementing the patient’s perceptions.
c. **Media accounts.** The third aspect of an ethnographic approach involved examining patient safety perspectives from media sources such as newspapers and both television and radio programming. Internet web sites such as CBS.com as well as the Newspaper Source data base of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) were searched for patient safety stories. Sixteen case examples were uncovered and about 90% of them reported a lack of patient safety. Only two of these case studies dealt with safe patient care.

The data from these media sources were examined and analyzed for themes. The rationale for including these stories in the analysis was for triangulation. Media stories revealing themes and domains similar to those themes and domains emerging from patient interviews and patient care area observations would be a third source confirming the study results. Use of these three sources, called triangulation, provides a more thorough definition of themes and domains, strengthens trustworthiness, validates interview findings, and strengthens confidence in conclusions (Roper & Shapira, 2000).

F. **Data Analysis and Coding Plan**

The findings of this ethnographic case study were enhanced by using content analysis. Content analysis is commonly used to analyze data derived from an ethnographic methodology (Munhall, 2007). Content analysis examines the raw, unanalyzed product of the interview to uncover themes important to the participants. By exploring examples across several participants derived from content analysis, pertinent themes can be discovered (Mishler, 1986).

So that constant interaction with the data could occur, the researcher analyzed data concurrently. When the interview was received from the transcriptionist, analysis in
the search for themes began. In this way, the data were analyzed immediately (and concurrently with other data collection) to discern common themes, outliers, and other information common or unique across the participant’s perceptions.

Upon completion of the digitally recorded interviews and verbatim conversion into a typed transcript, content analysis began. A specific method of content analysis coding was employed that involved organizing similar issues in participants’ stories into sub-domains (categories) that could then be organized into a few domains from which a theme or themes were expected to emerge.

Content data analysis began with reading participant interviews to discover examples of safe and unsafe caring which were important to them. As more patient interviews were gathered and analyzed, similar examples of safe and unsafe care began to emerge. These examples coalesced under specific categories (sub-domains) which included as few as nine and as many as 85 references in each sub-domain. Examples from the patients’ stories became cases in these sub-domains. These examples further defined and clarified the relationships between sub-domains. Similar sub-domains were grouped under a larger domain. The verbatim transcripts, coding schema, and themes were analyzed, reviewed, and discussed with Dr. Kelly Dunn, RN, PhD, who is a qualitative and ethnographic researcher, and this researcher’s faculty supervisor at the UTHSCSA School of Nursing (SON). This process was undertaken to check for misnamed domains or sub-domains.

The process of extracting patients’ words, phrases, or paragraphs from their detailed story and organizing them into sub-domains and domains is the process of content analysis (Munhall, 2007). The organizational process is called coding, which
involves classifying and interpreting data to uncover the bigger picture. This “bigger picture” makes explicit the implicit meanings and symbols that were implicit in the patients’ stories (Munhall, 2007). The explicit pieces were sub-domains and domains that make up the theme or themes of the study.

Sub-domains are more concrete, and domains are less concrete as they are attached indirectly to the patient stories that make up the sub-domains. Themes, because they are the most abstract, are not immediately apparent (DeSantis & Ugarriza, 2000). However, by coding the common threads of experience present in multiple interviews into sub-domains and domains, the theme becomes more apparent. Content analysis allowed for the process of coding which revealed a theme that adequately summed up the patient-as-participant’s perspective of safety in the ED. To verify the trustworthiness of this coding process, researcher field notes along with media stories of unsafe and safe patient care were similarly analyzed to determine if equivalent sub-domains and domains existed in those sources.

By undertaking an ethnographic methodology that employed a content data analysis, a thick, rich description of a patient’s perception of safety was achieved. This description consisted of themes culled from triangulation of observations, interviews, records review, and media story analyses. These themes formed the backbone of the patients’ safety perceptions that could then be put to use developing safer healthcare practices in the patient safety solution process. The long term goal is to use this data to limit morbidity and mortality due to healthcare error.
G. Reliability and Validity

Reliability in qualitative research is not achieved in the same way as it is in quantitative studies where variables are controlled (Roper & Shapira, 2000). However, reliability is possible to attain. Strategies for collecting consistent, stable, and repeatable data include multiple interviews by the same interviewer, data collection from one type of participant (ED patients), and establishing that interviewees are cognitively intact prior to interview (Roper & Shapira, 2000). The variety of patients’ ages, genders, and ethnicities, data collection from different shifts (7 am - 3 pm, 3 pm - 11 pm, and 11 pm - 7 am) and including patients who have dealt with complex medical or trauma issues (thus having a complex ED experience) increased the richness of the patients’ collective descriptions. This process enhanced the strength of this study’s reliability.

Sampling until saturation occurred improved validity. Including participants in the study until the data generated was repetitive (began to appear in the perceptions of patient safety of new participants, with no new data appearing) led to a “thick and rich” description of the phenomenon studied (Morse & Richards, 2002). As mentioned above, this study recruited participants until data became repetitive. The content of these interviews was analyzed seeking themes from their care description. This provided a rich, full picture of their perception of safety.

H. Privacy and Confidentiality

1. Human subjects protection

Approval for this study was obtained at two levels. The UTHSCSA IRB reviewed the research for scientific merit and approved the study protocols before participant
recruitment and data collection begins. Additionally, the IRB of this hospital system also provided approval of study protocols.

2. Consent

Once the patient agreed to participate, the researcher set up an in-person interview with the patient. Before the focused-ethnographic, in-person interview began, this researcher handed the patient a typed consent form (Appendix D). A second copy was signed and provided to the patient to take with him/her for his/her records. This researcher verbally reviewed each section of the consent form. The consent was signed by the participant, and was kept in a locked file cabinet in the office of the researcher.

The participants were given the option of ending the interview if they did not agree to any part of the consent. The researcher explained that he was not a part of their Emergency Department patient care team, and that the patient’s participation or lack of participation was in no way related to medical services provided by this hospital system.

The consent itself contained information about the study, contact information of both the researcher and the researcher’s faculty supervisor, the study’s purpose, the rationale behind inclusion, what was asked of the participant, risks, benefits, alternatives, how participants and data confidentiality were maintained, and permission to access protective health information (medical records and incident reports). The purpose, as explained to the participants, was to improve patient safety through discovery of their insights and perceptions of their ED care. Risks included the experience of mental stress that could occur when patients recount their story, especially if the story involves a healthcare error. Benefits included advancing the
patient healthcare safety improvement process, although little if any benefit was directly noticeable to the individual participant. There was no cost to or compensation for participants.

3. Data management privacy and security

Interview data were recorded on a digital recorder; digital audio files of the interview were stored only on CD or DVD ROM disks kept in a locked file cabinet to which only this researcher has a key. The de-identified digital audio files for transcription were sent to the transcriptionist via secure electronic transfer to her website or sent via US Post Office Registered Mail (which is kept under supervision or is securely stored during shipment). The transcriptionist was bonded and had signed a confidentiality agreement to ensure confidentiality of data transcription. Transcribed data had all identifiers removed and assigned an alphanumeric identification. The digitally recorded audio files and paper transcription copies were kept in a locked file cabinet in this researcher’s office. A written research journal and observational data were kept in the same locked file cabinet. The de-identified information sheet that contained data from the patient’s Emergency Department visit record and incident report record were kept in the same locked file cabinet. The typed sheet with names and associated identifying number of the participants were kept in a second, separate, locked file cabinet. Public media accounts were stored electronically in a password-protected computer.

I. Limitations

This study was undertaken by a novice researcher who is completing an ethnographic study for the first time. Narrow experience may cause the researcher to miss some obvious data points or to mishandle the process. To address these issues,
an experienced doctoral committee consisting of qualitative researchers who are experienced in ethnography, Emergency Nursing, qualitative research, qualitative data analysis, and patient safety issues coached and provide supervision for this researcher.

Perceptions of care and of safety of that care expressed by these patients were limited to South Texas; other parts of the country may have different concerns/issues. This study was applicable only to ED patients. Patients in other departments or units (Intensive Care Units, medical-surgical departments) may have different perceptions. Thus, other patient cultures need to be studied. Finally, other ethnic groups not represented here may have other issues.

**J. Summary**

This methodological overview outlines the ethnographic methodology used to help uncover an Emergency Department patient’s perception of safety. Patients from this large southwestern city who access an ED of this healthcare system had an opportunity to be interviewed. This interview, along with observations of the ED care area, analysis of medical records and incident reports, and patient safety media news stories were used to discover the healthcare safety perception of the patient. This data that could be used to inform other, additional data collected by those within the healthcare system to produce more comprehensive and complete patient safety solutions will be discussed in the next chapter.
IV. FINDINGS

The purpose of this study was to uncover the participants-as-patients’ perceptions of safety during their Emergency Department visits. A focused ethnographic methodology was used to arrive at study data culled from 14 patient interviews after their ED visits in one hospital in a large city in the southwest United States. Patients’ perceptions of their ED visit revealed new insights and were confirming of findings from other studies. Research questions for patients who visited the ED:

1. What are perceptions of safe practices and processes in the ED?
2. What are perceptions of unsafe practices and processes in the ED?
3. How do patients define patient safety?
4. What are the most important safe actions and their characteristics in the ED?

The following sections will address each of these research questions using the patients’ own words. Patient quotes build rich descriptions further defining and clarifying domains of a main theme that emerged from the data. Member-checking and an examination of patient safety perspectives in the media are used to strengthen validity of the study.

A. Research Questions

Three of the four research questions were answered not by asking patients directly of their experience of safety or lack of safety, but by following their lead during the interview when they discussed pertinent aspects of their care. An interactive interview guide was used in this process, modeled from an ethnographic interview guide developed by Spradley (Appendix C). Thus, research questions were answered
indirectly from this researcher’s coding and presentation of patient responses. What follows are the patients’ actual words regarding perceptions of their care as it relates to their experience of safety or lack thereof.

B. Research Question One

What are perceptions of ED safe practices and processes?

Patients revealed interesting perspectives during individual interviews which lasted anywhere from 23 to 72 minutes. Interview length by time span was noted earlier in Table 3. These perceptions were novel and remarkable because they revealed new information that could come only from people who are outside the healthcare culture. Other information shared by some patients reinforced the necessity of safety practices that are currently being used in the healthcare system.

As the interviews were analyzed for content, patterns began to emerge that seemed to parallel patterns that were also evident in the description of unsafe practices (see Research Question 2). The patterns that emerged were organized conceptually into three mutually exclusive domains: (a) Communicative Caring; (b) Accurate Caring; and (c) Protective Caring. Table 4 notes each of these domains along with a definition and exemplar. Within each of these domains were several sub-domains. The content of each of the three overarching domains is essential in answering the first two research questions.

1. Communicative Caring

Patients are sensitive to communication that occurs in the ED. Consistently, patients desired sufficient information about diagnoses, options for diagnostic testing
Table 4
Domains of the Theme Competent Caring with Definitions and Exemplars

COMMUNICATIVE CARING

**Definition:** Communication between ED personnel or directed to the patient providing sufficient, clearly understood information. When directed to the patient, information was provided about options for medications, diagnostic testing, treatments, and trajectories of care toward solving their health problems.

**Exemplar:** Wherever they take the x-ray, they took me all the way there, and they helped me off the bed. And he helped me on the thing where they x-rayed it, and they were very nice. Even him, he explained everything to me. Everything that was going to happen he explained it. He said, “When it goes through, I’ll tell you to hold your breath, and you hold it. Then I’ll tell you to turn loose.” It was very, very nice. And it didn’t scare me at all, you know, when I went in.

ACCURATE CARING

**Definition:** Effective and timely testing, treatment, and medication administration providing healthcare that adequately addresses the underlying illness and/or presenting symptoms.

**Exemplar:** I had gotten back from CT and I ended up going to the bathroom and she could hear me vomiting in the bathroom. . . And then she was I guess working on getting an order for me for nausea while I was in the bathroom. . . And then by that time I had made it back to the room, and she had assessed, you know, talked to me, and then got an order for the nausea medication. . . Yes, it was not a long wait at all. It wasn’t like I was vomiting or retching for a long time or anything like that. It was taken care of.

PROTECTIVE CARING

**Definition:** Expressing concern for protecting patients’ physical safety, health condition, and privacy. Nurses and physicians provide protection collaboratively and skillfully, they anticipate potential problems or educational needs, and they supply comfort measures.

**Exemplar:** So [the RN] told me that. And even said to me, “Oh, you’re going to feel like you’re floating about 10 feet above yourself,” and you do! I don’t know if she had experienced that or not, but I don’t know that I would have ever been able to have explained it like that. I mean but her explaining it to me as she’s pushing this medicine, and I truly did feel about 10 foot above myself.
and treatments, and trajectories of care necessary to resolve their health problems. This data are adequately captured in the domain titled Communicative Caring. Communicative Caring consists of four domains that include communication witnessed by patients between ED personnel as well as communication from hospital personnel directly to the patient (Table 5). These four domains are (a) ED MD Interaction; (b) Providing Sufficient Information; (c) Empathy; and, (d) Responsive Listening.

a. **First sub-domain: ED MD Interaction.** Several patients were particularly impressed with the level of communication coming from the ED MDs (medical doctors). Because of the high quality of communication from the ED MDs, patients perceived that the proficiency, accuracy, and level of care were safe and of high value. Patients desired high-quality interaction with the ED MD that includes the following qualities: having the full attention of the ED MD, having the MD completely answer questions to their satisfaction, conveying to the patients an understanding of their symptoms that provided them a confidence that they would be treated appropriately, and using terms in their explanations that patients could understand.

A 38-year-old female patient with lower abdominal pain very clearly understood the importance of having the ED MD listen to her and interact directly with her about specific symptoms:

I would say that I feel like the emergency physician listened to me, and I think that maybe a lot of times when you go to a physician, I don't know that they're necessarily hearing you, but I felt like he did hear me, he listened to me and treated appropriately by what my symptoms were, or what I told him my symptoms were... because he had interaction with me. It was a question and answer session; it wasn't okay (if the physician looked) at this piece of paper, and this is what you know, by this triage note, this is what I'm going to treat. It was asking me specifics about my symptoms.
Table 5

Sub-domains of Communicative Caring with Definitions and Exemplars

| ED MD INTERACTION | Definition: High quality interaction between patient and the ED MD that demonstrates full attention of the MD, who answers patient questions completely and satisfactorily in language understandable to patients conveying an understanding of symptoms which builds confidence that appropriate treatment will be provided. | Exemplar: He was very prompt in coming back to tell me that, “I’ve called Dr. W. He’s going to be your attending physician for the (admission). We're putting you under his care.” He came back in and was very informant of letting me know what was going on. Like I said, one of the very few, because a lot of them don’t. A very nice man, and he looked me straight in the eye, didn’t beat around the bush, and told me what was going on. |
| PROVIDING SUFFICIENT INFORMATION | Definition: Enough information conveyed to and understood by the patient so that they could make decisions about their care and that alleviated their worry. | Exemplar: Yes, he gave me updates. He was like we’re just waiting for this lab result to come back, this lab result to come back, you know. He was pretty verbal. I mean he told me what he thought was possibly wrong with me, and what, you know, the possibilities as to what was going on with me. He was just going to double check just to make sure, so. |
| EMPATHY | Definition: Communication acknowledging patients’ feelings and concerns. | Exemplar: Oh yes. Especially the male nurse, when I was telling him about all the soap, and he said, “I have very less hair,” and I thought to myself, “With your looks, you don’t need any.” [Laughs] I wasn’t going to tell him that, but I’m just thinking there, you know. So that tells you I wasn’t so terribly sick! [Laughter] No, he was very good. |
| RESPONSIVE LISTENING | Definition: Understanding the patient’s communicated message followed by connecting the patient with another resource (person, requested article, or medicine). | Exemplar: A patient’s family member comes to the desk and addresses the RN-C stating that a family member needs to walk to the bathroom but can’t because she is hooked up to an IV pole that doesn’t roll. ZF RN-C walks to the patient room, disconnects the patient from the IV. The patient ambulates to the toilet. |
An 82-year-old female patient who complained of knee pain described issues important to her that were similar to the previous patient: the ED MD interacted with her in a manner that demonstrated understanding of her symptoms, not just writing on a paper and then leaving without any follow-up:

You know, he didn’t come in and say, “Dah dah dah,” you know how they do. . . He talked to me very, very nice. And then he went out, he said I want to take an x-ray. So when I went and took the x-ray, came back, and he explained everything to me. . . At least he sits and talks to you. Some of them come in and they write and you’re through. But even like Dr. C, Dr. C sits and he talks to you. First he asks this or this, you know, what’s wrong? And then you tell him, but then he sits and talks to you. That really is nice, when a person talks to you.

This particular patient was impressed by the level of detail that the physician covered as he examined her and as he explained her test results.

Speaking in terms that are clearly understood by patients so that they can understand the aspects of their care was perceived by them to be personally important. One patient observed that the ED MD explained his care clearly, using terms familiar to the patient.

He goes, “So yeah, I’m going to try to get you a preventative, and I’m going to give you some like a steroid for the inflammation.” He explained himself very clearly to where I could understand. You’ve got some doctors that go in there and they start talking all this medicine, and I’m like, “Whoa! Hold on,” you know. Speak in my terms, you know, patient terms. But yeah, he went ahead and explained everything as far as the medication, but, yeah. (33-year-old male with joint pain)

A similar instance occurred during the care of a 40-year-old male patient with hypertension who felt that, because the ED MD used “layman’s terms,” he didn’t need to ask for additional explanation:

He came back in and was very informant of letting me know what was going on. Like I said, one of the very few, because a lot of them don’t. A very nice man, and he looked me straight in the eye, didn’t beat around the bush, and told me
what was going on. A lot of the doctors really won’t look you eye to eye when they’re telling you stuff. They refuse to come right out and tell you. They want to beat around the bush. And that again, goes back to speak to me in laymen’s terms. Please. . . [Interviewer: Did they use layman’s terms?] They spoke to me pretty well to where I understood. I didn’t need a whole [lot] explained to me.

This patient expressed anxiety when information was not timely or communicated to him in a manner which helped him understand. He called this “being kept in the dark.” However, he described confidence in his care because of the high quality of ED MD communication he received.

In the field notes that the researcher kept during observation in the ED, there was an example of direct, clear, and sufficient information from the ED MD to the patient. In this instance, a patient who had come to the ED complaining of pain in his thumb was shown his x-rays by the ED MD after his thumb had been reduced (from its previous dislocated state) to demonstrate how his condition had changed after he underwent a procedure: “Patient had dislocated thumb that was reduced by the MD. MD states to patient, ‘Look what your finger looked like before.’ Patient looks at x-ray and states, ‘Shoot, no wonder that hurt.’ MD states, ‘Now look at it afterward.’ Patient states, ‘That looks good.’”

b. Second sub-domain: Providing Sufficient Information. Beyond perceiving that they were listened to and, therefore, heard and understood, and being spoken to in plain language that they could understand, patients described feeling safe about their care when they had enough information to make decisions about the direction of their care. Sufficient information helped patients make decisions about their care, alleviated their worry, and clearly identified who was their care provider. When patients were told the rationale for or against diagnostic testing, when they received
timely and clear communication of test results, when they understood the physician’s
decision-making about the administration of medicines to alleviate noxious symptoms,
when they perceived they were given complete discharge instructions, and when they
were told the names and roles of staff providing direct care to them, they reported
feeling comfortable with the care they received.

A patient who had been treated for significant pain in her lower abdomen felt she
had enough information from the ED MD to make a decision regarding further testing.

I guess what was explained to me in a little bit greater detail is that since the CAT
scan was negative, the next step to do is an ultrasound, and he asked me if I
wanted to get it done, and I felt like I guess that was almost my thing that I could
say no I don’t want to get it done at this point, or no I want to investigate this a
little further? I do feel like it was a question of me-did I want to investigate this
further. He felt like it was necessary, but did I want to do this? Because the only
thing left unturned would be missing something in the ovary, and the ultrasound
would prove that. (38-year-old female with lower abdominal pain)

This patient went on to describe that the ED MD had a plan of action, but that she could
have changed the plan based on her preferences.

Other patients felt that, based on what the ED MD had communicated, they were
informed enough to make decisions that would have taken their care in a different
direction. A 50-year-old male patient with back pain noted:

Oh yes, I could have probably gone off into another direction if not, but what I
saw and the way I saw everything being handled, I felt like I was in adequate
hands and I trusted fully whatever decisions they were going to make at that
point.

Sufficient information was provided when patients were told by the ED MD why
they were receiving medicines to alleviate their noxious symptoms like vomiting or pain.
A patient with symptoms of nausea and vomiting was being treated with IV rehydration.
After being asked if ED personnel had communicated enough information regarding her
care, a 32-year-old female patient with intractable vomiting stated she understood the rationale for the care she was receiving.

Actually, yes. I feel like I knew what I wanted. I think at that point I knew I was just really dehydrated, and I knew that there wasn’t anything they were going to do. It was probably some virus, although it was more likely that it was food poisoning because she [the patient’s infant daughter] didn’t get sick.

This patient felt that sufficient information was provided to her so she could understand that the IV fluids would help the dehydration that was the source of her nausea.

Pain control was an important aspect for nine of the patients in this study, and communication from the ED RN to patients regarding how often pain medicine could be taken was an important part of pain management. One patient, who received pain medicine for foot ulcer pain who had hypertension secondary to renal failure, noted that after receiving the medicine from the RN, the RN’s instructions regarding re-administration of pain medicine put him at ease and was helpful in making a decision regarding when to ask for it again.

She said, and was able to let me know which was good that I was very appreciated of, “If it still hasn’t gone all the way I can give that to you again within four hours.” So again, communication. Yes. Now I know that within four hours from the time she gave me, I can have it again. . . . But if you’re aware of it, then you can calm yourself down, try to let the pain medicine take its course, and realize that, “Oh, it’s almost four hours. I can take it again.” (40-year-old male with hypertension)

For this patient, having sufficient information about when to ask for pain medication reduced his sense of uncertainty and helped give him a sense of control.

Another aspect of a sub-domain of Communicative Caring, Providing Sufficient Information, prepared patients for procedures. When patients were told what to expect and given an opportunity to ask questions, they felt better prepared. Because they
wanted to understand the reasons for testing, when they were told the rationale behind diagnostic tests, they felt that the tests were important, reasonable, and necessary.

Prior to an additional test (ultrasound) following a CT scan to determine the source of her lower abdominal pain, a 38-year-old female patient described the importance of information given to her by the ultrasound technician regarding the methods used to in during her pending ultrasound. “They were-- the ultrasound tech told me, you know, all that they were going to do, because they ended up getting a transvaginal ultrasound also, so she explained that procedure before that even happened.”

Sufficient information given to patients not only helps them make decisions and understand why certain tests are done, but it also helps alleviate their fears. An 82-year-old female patient with knee pain noted that explanations of an x-ray she received helped her feel less frightened.

Even him, he explained everything to me. Everything that was going to happen he explained it. He said, “When it goes through, I'll tell you to hold your breath, and you hold it. Then I'll tell you to turn loose.” It was very, very nice. And it didn’t scare me at all, you know, when I went in . . . . . You know, when you don’t know what’s going to happen, you’re a little scared, too, but he explained everything. He explained everything to me.

Researcher field notes indicated several instances of patients receiving sufficient information about their care from hospital personnel. One field note record described communication during the care of a very sick patient. “RR [the nurse in charge] went in to work with critical patients. She explained the medicines she was going to give the patient, gave the medicines, answered some of the patients’ questions, and deferred other questions to the MD.” Another entry notes that the RN (BB) explained to the
patient why he was being given medicine for hypertension and provided him with his 

blood pressure reading before and after medicine administration.

BB RN introduced me to him. She stated she was going to give him some 

medicine to bring his blood pressure down. “Is my blood pressure high?” he 
asked. BB said yes. “How high?” he asked. BB told him exactly how high. The pt 

stated, “Is the medicine going in my IV?” BB said that yes it is going in his IV. A 
bit later, BB re-entered the room to give another dose. The patient asked if his 

blood pressure had dropped. BB said it had and she gave him the exact 

numbers.

These patients received information that helped them understand why medicines 

were being given, how they have been affected by treatments, and how to care for 

themselves at home. During the patient interviews, patients discussed receiving 

communication from ED personnel (that was also noted during researcher observations 

and recorded in field notes) which helped them feel that safe care was being delivered.

Providing sufficient information in the form of discharge instructions is an 

important aspect of a patient’s care. Two patients in particular noted how important 

sufficient information was at discharge. A 35-year-old female patient with chest pain 

noted that she was given discharge instructions that left her with some concerns about 

a steroid prescribed to alleviate her symptoms. After asking the nurse about the 

medicine she noted, “I was kind of scared about it, because the prescription was a 

steroid, I’m like, you know? He told me, he said, ‘Don’t worry, you’re not going to look 

like Arnold,’ and I was like okay. [Laughter].” This information, delivered with humor, 

alleviated this patient’s concerns and ultimately enhanced her perception that she had 

received safe care.

A 38-year-old female patient with lower abdominal pain also received discharge 

instructions from the physician that included her test results.
He was closing up the stay. I mean he came back in, reviewed all the labs that had happened, the x-rays, et, the CAT scan and ultrasounds that were done. And just offered for me to follow up with my physician. If there continued to be any problems, then just as a follow up, you know.

Her sense of this complete review of her stay helped her feel safer about her care.

Communicating sufficient information to patients is also vital so they can care for themselves at home. As noted from an entry in the researcher’s field notes, the RN carefully explained to a patient who had second degree burns from a grease fire how to care for his wound after discharge.

She introduced herself and me and then explained she was going to dress his wounds. She started by having the patient wash his hands and the burn on his hands, explaining that he was to use Hibiclens [cleaner] and wash his hands since the skin that is burned is a primary barrier against bacteria and is not currently able to do its job. She explained that he is to dry his hands with a clean towel. She dressed his wound [with Silvadene burn cream], explaining not to “double-dip” the blade into the jar of burn cream to prevent bacteria from the wound from making its way into the jar. She wrapped a bandage around the dressed wound explaining that the burn cream will “melt” and the bandage will absorb excess cream. She explained that the dressing needs to be changed twice daily. She provided him discharge instructions, explaining his medications and diagnosis.

A final aspect of this sub-domain of Communicative Caring, Providing Sufficient Information, is the importance of ED personnel identifying themselves to the patients. Patients not only want to know the names of individuals providing them care, but they want to know their roles. They want to know if someone is an RN, MD, or technician so they could better understand the purpose of their interactions with them. A 40-year-old patient with hypertension noted:

Identify yourself when you walk in. “Look, I am not your nurse. I am your CPA tech. I am only here to take your vital signs.” Or identify yourself as, “Yes, I’m your registered nurse... This is where I say it’s very valuable not to keep the patient in the dark. Let them know exactly what’s going on, because if a patient is in the dark, it’s very scary. [Interviewer: Do you feel in the emergency
department they identified themselves?] I feel in this session that I’ve been in this hospital, my nurse identified herself very well. She came and told me who she was. My doctor that saw me in the ER identified himself.

Introducing oneself by giving a name and title allowed patients to feel safer because they were clear about the purpose of staff who were present in the patient care room. Badges and other external forms of ID are an important aspect of this. One patient noted:

I always look at their badges. . . . Well the two that came in first, they identified themselves as nurses, and I checked out their badges and said, “Yeah, yes you are.” [Chuckles] And the doctor had his little coat on and said he was a doctor. (58-year-old male with ankle pain)

Badges and clothing as well as external identification are important to the patients in understanding who is caring for them and at what capacity.

c. Third sub-domain: Empathy. In addition to providing sufficient information, Empathy emerged as an important sub-domain. Empathetic care was care provided when ED personnel acknowledged patients’ feelings and concerns.

The first instance of empathetic care was described by an 83-year-old female patient who had slipped and fallen at home. The patient had been in the middle of washing her hair before the fall and the paramedics brought her to the hospital before she could rinse the soap from her hair. Feeling self-conscious about this, she explained it to the ED RN, who responded empathetically.

Oh yes. Especially the male nurse, when I was telling him about all the soap, and he said, “I have very less hair,” and I thought to myself, “With your looks, you don’t need any.” [Laughs] I wasn’t going to tell him that, but I’m just thinking there, you know. So that tells you I wasn’t so terribly sick! [Laughter] No, he was very good.
When asked how she felt when she was cared for by a nurse who responded to her with empathy, she responded, “Safe, safe, very safe. Extremely safe.”

A second patient was assisted by an ED RN who helped the patient undress, sit on the toilet, and urinate. The patient described how her potential embarrassment was eased by the ED RN.

And then she helped me on the commode, and she helped me go, you know, sit on the commode, and then she pulled my pants out, and I was tinkling, you know. I was just a little bit embarrassed, but still in all she was very nice about it. After she started working with me on the commode I didn’t feel so embarrassed. So I felt really at ease, you know, because if somebody helps you like that you get embarrassed. But after a while I didn’t. She was so nice.

Nurses’ empathic responses required sensitivity to the feelings and thoughts of the patient. As a result of expressions of empathy either through RNs’ actions or behaviors, patients felt at ease and better about their care.

During field observations, the researcher noted several instances of empathy from the ED RNs. One RN initiated an IV on a patient who was a self-described “hard-stick,” or one with whom starting an IV was extremely difficult. After not finding a site that she felt confident with, one ED RN (YY) obtained an order from the ED MD to start a lower leg IV.

Patient is again tearful and YY acknowledges this. “I know these things hurt. Have you ever had one in your foot before?” Pt nods yes. “They hurt don’t they? I won’t put any needles in without telling you. See? I don’t have any needles on me.” Shows pt her lab coat pockets. “No needles.” YY puts a tourniquet on the left calf then the right. She looks for a vein. “I’ve found a good vein. Since I need to get a blood sample from you, it makes sense to put an IV in and keep it in.” Pt begins to cry. “I know. I’m sorry.”

The nurse’s offer of understanding demonstrated she was sensitive to the patient’s feelings of concern and fear.
Another patient who received empathetic nursing care also required a blood draw. The patient was having leg cramps, and the ED MD had ordered blood tests to help determine their cause. When the ED RN (ZH) attempted to start the IV, the patient experienced serious cramping that caused her to move so much that it was impossible to draw blood.

After searching for a vein, she stated, “Here’s a good one.” As she was attempting to insert a butterfly needle, the patient began cramping and crying again. As ZH RN attempted access, the patient moved a lot. Eventually ZH RN gave up, removed the needle, the tourniquet, and applied a bandage and Band-Aid. She removed her gloves and apologized for not getting the needle in the vein for a successful blood draw.

In a frustrating situation, instead of expressing that frustration (which would have been professionally inappropriate), ED RN demonstrated concern for the patient’s feelings, stopped the procedure, apologized, and asked a phlebotomist (who was able to draw the blood) to complete this care.

d. **Fourth sub-domain: Responsive Listening.** Responsive Listening involves understanding the patient’s communicated message followed by connecting the patient with another resource (person, requested article, or medicine). This usually involved several steps including finding the patient’s primary nursing and/or medical provider, and making additional phone calls or inquiry. However, the amount of work that goes into this is not lost on the patient. Patients who were responded to with resources described feeling more cared for or feeling better about their care and, as a result, perceived their care as safer.
One patient in particular was impressed with the level of concern expressed by the ED MD after telling the MD that her hypertension was not adequately addressed by her private-care MD. The patient knew she had the full attention of the ED MD.

It was really positive. I could tell that I was on his mind, and that’s all that he was doing right at that moment. [Clears throat.] Um, he asked questions that I could answer. He asked me where I’d been and why I had come here. And, uh, and then I had referred to my primary care doctor, not wishing to belittle her, but I said, “My primary care doctor has not been real interested in my high blood pressure,” and he, he was very vehement about, “Why not?” and you know, what, “What’s the problem? . . . Well, this is something that really needs to be addressed.”  (76-year-old female with hypertension)

The patient went on to state that, because of the ED MD’s emphasis on the importance of this problem, she had since found another private-care physician to help her deal with chronic hypertension issues.

A second patient had a perplexing set of symptoms which pointed to joint inflammation that was different from the diagnosis of gout for which the patient was currently being treated. The physician listened to the patient, examined his tests, looked at the patient’s medical records, and realized that this particular instance was pseudo gout.

He [the ED MD] goes “So I don’t know why it would, why would they rule it as gout?” He goes, “Maybe it’s something else.” He goes, “Have you ever tried putting a cold pack on it?” I said, I’ve tried cold, hot, elevating it. He goes, “What I’m thinking is it’s probably a different sort of gout, which is a pseudo gout, and that usually attacks different part of your joints, different joints at the same time.” He goes, “And that’s what I’m seeing here. . . . Well, I’m going to go review your records again, and see what [private-care] doctor [who] saw you and what they gave you. (33-year-old male patient with joint pain)

By listening to the patient’s symptoms, listening to the patient’s responses, and checking laboratory tests and medical records, the physician could arrive at a diagnosis that had a very different treatment route than the patient’s previous misdiagnosis of
gout. This was important for the patient, especially because he earned a living driving a truck and could not drive while experiencing these symptoms.

Field notes taken during the researcher’s observations contained several examples of responsive listening. One patient, who had psychiatric issues and whose personal effects were stored at the desk during her ED stay, requested her CD player.

A patient walked to the staff area. “Where’s my doc?” she asks. EE [unit secretary] tells her the doctor is seeing another patient and asks if he can help. She asks to see her nurse. DD RN approaches her asking how he can help. She asks for her compact disc player. He states he is busy labeling blood tubes and he’ll check with the doctor as soon as he has completed his current task.

The patient returned to her room, and DD eventually obtained permission to give the patient her compact disc player.

Another particularly complicated instance of responsive listening occurred when a patient sent a family member to ask for more pain medicine. This interaction involved MM, an RN at the desk, ZZ, the patient’s RN, and Dr. ZE, the patient’s admitting MD.

Patient’s family member stops at desk to ask for pain medicine for patient. MM RN asks if Tylenol, which has been ordered by the patient’s admitting physician, will be enough. Patient’s family member states, “No.” MM finds ZZ RN, the actual patient’s nurse, and asks if she [MM] can page Dr. ZE, the patient’s admitting physician to ask for additional pain medication orders. ZZ replies in the affirmative. MM pages.

The patient received sufficient pain medicine when new orders were called in by the admitting physician. This interaction is a typical example of the responsive listening involving multiple resources to provide patients what they need.

A final instance of this from the field notes occurred as a suicidal patient came from the triage area back into the main ED treatment area. TT, the RN who was in the hallway, had to attend to this particularly distressed patient.
Patient walked to the back stating, “Help me. No one will help me.” TT RN walked up to the patient and asked, “What room are you in? Who are you?” Patient stated “I’m suicidal and no one will help me.” TT responded, “What room are you in?” The patient responded, “I’m in the waiting room and I can’t wait anymore.” TT stated, “All of our rooms are full.” The patient turned and walked up the hallway with TT walking with him talking.

TT was able to secure a spot for this patient and involve the psychiatric RN specialist there in the ED until they could get the patient into a treatment room. Typical responsive listening involved making phone calls, involving other providers (RNs and MDs), and other activities to provide patients with resources they needed.

Communication issues are very important to patients in gauging the safety of their care. Whether it is an ED MD who clearly listens to the patient with undivided attention or whether it is hospital personnel using clearly understood terms to help the patient understand upcoming procedures, pain management, and course of treatment, several patients felt empowered to participate with personnel in their treatment and have their fears alleviated. Empathetic responses from personnel along with responsive listening build positive feelings and increase the patients’ perceptions of safety.

2. Accurate Caring

Patients who experienced a high level of accurate care which is efficient (quick and effective) or diagnostically precise (diagnoses which adequately addressed the underlying problem behind the symptoms and were provided accurate treatments and medication administration as a result) had perceptions of safe care. Accurate Caring is made up of two sub-domains: Diagnostic Precision and Efficiency (Table 6).

   a. First sub-domain: Diagnostic Precision. Diagnostic Precision involved accurate questioning and interpretation of symptoms to bring about a correct,
# Table 6

Sub-domains of Accurate Caring with Definitions and Exemplars

## DIAGNOSTIC PRECISION

**Definition**: Accurate questioning and interpretation of symptoms to bring about a correct, timely diagnosis.

**Exemplar**: I guess what was explained to me in a little bit greater detail is that since the CAT scan was negative, the next step to do is an ultrasound, and he asked me if I wanted to get it done, and I felt like I guess that was almost my thing that I could say no I don’t want to get it done at this point, or no I want to investigate this a little further. I do feel like it was a question of me-did I want to investigate this further. He felt like it was necessary, but did I want to do this? Because the only thing left unturned would be missing something in the ovary, and the ultrasound would prove that.

## EFFICIENCY

**Definition**: Quick, organized, and prioritized care attentive to patient needs.

**Exemplar**: She was just asking me what I was in for, so she just brought me basically to the back to the little, I guess it’s a little room. It’s covered with a curtain, you know. And then she just asked me to change into the hospital robe, and that they’d be with me shortly. They came in there, asked for a urine sample, then drew blood and everything. I mean it was pretty quick.
timely diagnosis. Patients who described experiences of Diagnostic Precision related experiences of ED MDs distinguishing symptoms of the patient’s illness from symptoms related to medications side effects, understanding why certain tests were required to arrive at a diagnosis, determining the most critical issues requiring immediate attention, and distinguishing between similar diagnoses that have different treatment routes.

Patients want to know what is causing their symptoms and perceived they were receiving excellent care when their diagnosis or rationale for further testing was explained to them. In one instance, a 50-year-old male patient came to the ED complaining of severe back pain. However, a serious cardiac issue was discovered. The patient was impressed that the cardiac issue became the primary focus even though the back pain was still being treated.

You know what I thought? I couldn’t have been in better hands. That’s the honest truth there. I don’t think I could have been in any better hands at that point. You know, I didn’t know at that point that— I thought mainly I was just suffering back pain and this and it seemed like I had some type of cardiac event and stuff also. Well, I had tied it all in to just my back pain, and he found it and knew it. He’s the one that let me know that I had some type of cardiac event that had happened, I guess. [Interviewer: Did you think they managed your back pain even though they were working on your heart because you did have a lot of pain in your back?] Oh absolutely. They got me comfortable with my back pain, but they were more concerned with my heart pain and what was going on with my chest at that point, yes. My back became secondary.

This patient clearly understood the implications of having cardiac problems and the importance of finding and treating the cause. Yet, his back pain was still an issue. Both problems were being treated, and the patient’s confidences in these accurate diagnoses lead him to feel safe.

A 33-year-old male patient with joint pain, a man with a wife and three children aged 10 and younger, who had gout like symptoms came to the ED because of
unmanaged joint pain. As he and the ED MD discussed his case, it was clear that the colchicine medication prescribed for the presumed diagnosis of gout was not preventing flare ups. This was perplexing to the patient, but the ED MD noted the patient needed not colchicine (to neutralize an attack that was in progress) but a medication to prevent these flare-ups of pseudo gout.

He goes, “What I’m thinking is it’s probably a different sort of gout, which is a pseudo gout, and that usually attacks different part of your joints, different joints at the same time. He goes, “And that’s what I’m seeing here. But your uric acid levels weren’t high.” He goes, “They weren’t that high.” . . . And that’s when I explained to him, “Well, I had been taking the colchicine.” And that’s when I let them know I need a preventative, something to prevent this from happening, because I would hate to just get it, and then start taking the colchicine, and then what if that doesn’t…” He goes, “Yeah.” He goes, “You know what? You’re right, because a lot of times you can miss it.” It’ll hit you and once you start taking the medication [colchicine], well the gout’s already attacked, so you can’t neutralize it because you’ve passed it. And the colchicine or medication is not going to catch it in time. He goes, “So yeah, I’m going to try to get you a preventative, and I’m going to give you a steroid for the inflammation.”

The patient was energized while discussing this part of his care. The most important part of his care was finding out why the medicine he was currently using was not working. The ED MD accurately diagnosed a different kind of gout. Since the physician explained to him why he needed something to prevent the attacks (because the patient now had a new diagnosis), this led the patient to feel he was accurately treated and provided safe care.

Patients want confidence that new symptoms they are having in addition to ones that brought them to the ED are accurately diagnosed. A 38-year-old female patient who had significant lower abdominal pain developed vomiting after being given pain medicine. She wasn’t sure if the new onset vomiting was related to her current symptoms or a side effect of the pain medicine.
When I started vomiting I was a little concerned. I didn’t know if it was something going on with my abdomen that was making me sick. And then, like I said, whenever the physician had come back in and thinking I was having like a rebound headache from the pain medication that I had been given, that he felt like that was probably why I was vomiting. You know, so the uncertainty in my head is why am I [chuckles] vomiting now? Or is this a new symptom? Or is this a change in something? Then what’s given me, the Benadryl and the . . . I don’t know what anti-nausea medicine they actually gave me, but they gave me some nausea medication and those symptoms went away, so I’d have to say that that’s probably [chuckles] what happened.

Her concern was that her condition was worsening. The MD’s accurate diagnosis of rebound headache and treatment with Benadryl and an antiemetic gave her confidence that she was experiencing pain medicine side effects.

RNs were also involved in making accurate diagnoses. The field notes from the researcher’s journal noted several instances of nurses collecting patient information that assisted in developing an accurate diagnosis. One field note described the process of charting assault details by a Sexual Assault Nurse Examiner (SANE). “When charting, chart facts: appearance, measurements, size, shape, color, direct statements, NO INTERPRETATIONS! Tattoos, birthmarks.” This RN was underscoring a basic tenet of charting taught to RNs and MDs alike: no subjective remarks which decrease accuracy and limit the value of the charted information.

Vital signs were collected from the patient by the techs and RNs. This is data vital to an accurate patient assessment and diagnosis. Oftentimes, if a patient’s mental status is in question, the nurse will perform a mental status exam as well. Field note entries on this topic included, “Vital signs were taken (blood pressure, pulse, temperature, respiratory rate, oxygen saturation), and a mental status exam (pupils, hand grips, foot pushes and foot pulls, patient stated where she was, the date, and her
name).” These data are charted and then used by MDs and other nurses to make either an accurate diagnosis or to note changes in mental status or vital signs.

Testing protocols are another way of ensuring an accurate diagnosis. During the initial onset of novel H1N1 flu (known in the media as Swine flu), patients flooded the ED. Initially, cultures taken from patients were being sent to the Centers for Disease Control (CDC) in Atlanta, GA for further testing. At that time, an entry from the field notes indicates that hospital protocols to allow the samples to be sent to the CDC were being enforced.

Hospital supervisor came through and asked that the protocols for flu symptoms (which include the collection of a swab from the patient’s throat for a rapid flu test and the collection of a tube of blood to be placed on ice that would be sent to the Centers for Disease Control in Atlanta for further testing if the patient were positive for the flu) be instituted. She also noted the waiting room should be segregated so that patients with flu/respiratory symptoms could be cordoned off from others.

Not only was an accurate diagnosis this supervisor’s concern but so was safety for the patients who may not have had the flu. Segregating patients with flu symptoms from other patients seeking emergency healthcare would limit the spread of the flu to these patients.

b. Second sub-domain: Efficiency. Efficient patient care contributes to a patient’s perception of safety. Efficient care is quick, organized, prioritized, and attentive to patient needs. The patient perceives efficient care as being provided in a timely manner when (a) multiple tests are completed, requests (for patient belonging bag, food, water) are fulfilled, or transfer to another unit/facility in what is perceived by patients as a reasonable and short period of time is completed; (b) nursing or medical responses are quick, accurate, and alleviate pain or concerns; (c) resources are
provided regardless of time of day (MDs present during night shift); and (d) staff respond quickly to care provision orders from other ED personnel.

Several patients noted how quickly personnel responded to them when getting them into an ED treatment room in a short period of time or when reacting to symptoms perceived by ED personnel as serious and potentially life threatening. One patient noted that when she walked up to the ED triage desk and stated her symptoms, the triage nurse responded immediately. “They weren't chatting or anything, just let's go get this done.” (76-year-old female with hypertension.) She was immediately moved to a patient care room. A second patient had a similar experience, “Oh, I thought it was pretty fast. Like they were ready to receive me, I thought. . . So they took me to the closest emergency room to the door so that I wouldn't have to walk so far.” (5-year-old male with ankle pain.) A 42-year-old male patient who was experiencing worsening abdominal pain noted that he, too, was taken back into the ED treatment area in a short period of time and was assisted immediately by ED RNs.

The nurse that came out. She was very, very nice. She took me in right away. And then there was the nurse that she spoke to. And they took me into one of the rooms. Again, she was very sweet. They were very helpful. They told me to just go ahead and lay on the bed and go ahead and change into the gown and so forth. And they came in right away, and they were assisting me. . . They came right away, and they had to do what they needed to. They were asking me questions. They had me fill out some forms.

Because of the immediate response of ED personnel to their healthcare issues, these patients had positive impressions of their care that led to an increased perception of safety.
Patients present with a variety of symptoms drawing immediate action from the triage nurses. This next patient came to the ED because he was coughing up blood. He did not feel this was a dangerous issue, but the RN at triage treated it as an emergency.

I was impressed that when I showed them the blood they got me in right away. And health wise, I wasn’t distressed anyway; I was just concerned about the blood. And apparently they saw a priority to get me back, and I felt the need. I wasn’t really concerned about the blood per se. I mean I wanted to get it fixed. I didn’t see it as an actual emergency. But I was impressed how quickly I got seen. I mean once I got back to the ER the doctor was in the room in like three minutes to see what was going on. . . . And from my previous experience, I mean that’s probably one of the fastest response times I’ve had from a doctor. (27-year-old male with bloody cough)

Not only was the patient placed in a patient care room quickly, but he was impressed with the short period of time it took the ED MD to initially assess him.

Other patients were impressed with how quickly they received their care. This patient stated that she felt the initial assessment occurred in a short period of time.

She was just asking me what I was in for, so she just brought me basically to the back to the little, I guess it’s a little room. It’s covered with a curtain, you know. And then she just asked me to change into the hospital robe, and that they’d be with me shortly. They came in there, asked for a urine sample, then drew blood and everything. I mean it was pretty quick. (35-year-old female with chest pain)

A 38-year-old female patient who had a lower abdominal work up for significant pain in the same region felt positively about the brief period of time that it took for tests to be completed and a diagnosis to be made. When asked for an overall description of her stay, she replied:

Brief, which I was more than happy that it was brief. And it got the job done that needed to get done. I needed to get some scans and lab work done today and now, not later or on an outpatient [basis]-- You know, at least I felt like it needed to be done on a now basis or an emergent basis. So it did get that done. I believe I was there from like 8:00 to 1:00, which was to get all those tests done, that was a positive piece out of it.
This perception of efficient care was mirrored in the comments of patients who noted that ED personnel “were attentive to their business” (76-year-old female with hypertension); “worked quickly” (50-year-old male with back pain); and were very prompt in relaying information to the patient (40-year-old male with hypertension). One patient, who had a dry mouth as a side effect of narcotic pain medicine he had received, asked for a glass of water. Moments later the RN brought it, and he was impressed by this quick response.

Your mouth gets kind of dry, and you don’t have like a water fountain right there, you know, at your reach to get water. So I think that right there was like, I appreciated that. . . . because of my experience in going into the emergency room, like I said, you’re always waiting. And you try to find a certain person, “Oh, okay. I’ll be right with you.” The next thing you know, and here it is 30 minutes later, there’s another nurse there. So you really don’t know who to, “Hey, I spoke to,” such and such. And they’re like, “Oh, well let me get them.” Now that’s another 30 minutes. So to me, all in all, I really appreciated and liked that she was easy to find. I don’t know, because she was so busy that she would always walk by there and, “Hey,” you know, but it was that she was easy to find, and she did get my water, and she did what I actually needed to try to get rid of this pain and swelling.

Not having to wait, having an RN who was easy to find, and expeditiously receiving an item which met his needs, left this patient with a positive perception of his care.

Examples of efficient care provision can be seen also in entries in the researcher’s field notes. Two nurses (PP and QQ) prioritized the care they were about to give not only to complete the most important care first but also to provide for the comfort of patients:

PP RN and QQ RN confer on the number of [patients] that need treatment and in what order. QQ states, “One at triage needs a mouth swab. She wants to eat. I need to get this urine sent [for lab testing]. Would you swab the mouth? I’ll get an [evidence] envelope; you sign it off to VV RN. Then finish your current exam.
Expedited patient transfers occurred quickly because of a computerized reporting system. Information specific to a patient’s care was reported by the patient’s ED RN to the unit/department RN via electronic reporting. The transferring RN filled out a computerized template, answering questions regarding patient care, and sent it to the receiving nurse.

[The patient’s RN, FF] called up the screen called a patient transfer sheet and filled it out with the patient’s data including tests ordered and the results, vital signs, and patient’s treatment outcomes. She then sent this to the printer on the floor where the patient was going. The sheet would be given to the admission floor charge nurse and the patient’s receiving nurse or RN responsible for the patient’s care on the admission floor. FF RN called the admission floor 15 minutes later to make sure the sheet had printed and was reviewed by the receiving RN. Upon receiving an affirmative answer and hearing that the receiving RN was ready for the patient, FF RN thanked the receiving RN and sent the patient to the admission floor. FF commented that this computerized patient transfer form greatly improves communication between the ED RN and the receiving RN.

Computerized patient reporting appears to improve the consistency of patient care information shared between RNs and increases the speed by which patients are transferred out of the ED.

Patients who perceived that their diagnosis was reached with great concern and precision and who experienced care that was efficient, perceived their care to be safe. Interestingly enough, nine of the 14 patients interviewed described their care in terms of efficiency. Quick, accurate care and treatment greatly impacted these patients.

3. Protective Caring

As patient interviews were analyzed, the research consistently found that patients reported examples of being protected during their ED treatment. Specifically, this domain involved patients witnessing protection of their physical health and privacy
by staff, possessing a sense that staff worked together to provide care, perceiving that staff prepared them for potential problems or upcoming aspects of their care, having an impression that staff were highly skilled and capable in their roles as MDs, RNs, techs, respiratory therapists, or describing the importance of comfort measures that were supplied to them. Five sub-domains of this domain of Protective Caring emerged: Comfort Measures, Proficient Caring, Anticipatory Caring, Collaborative Caring, and Assuring Security. Table 7 contains definitions and exemplars of each of the five sub-domains of Protective Caring.

a. **First sub-domain: Comfort Measures.** When patients enter the ED, they are driven by concern for their health, life, or limb. The symptoms which drive them to the ED point to at least one if not multiple diagnoses leading the patient down several treatment avenues. ED personnel work to stabilize the patient and treat the life-threatening issues first. However, most patients don’t enter the ED with problems that are immediately life threatening. Several hours are taken to arrive at a diagnosis, and patients’ bodily needs must be met during that time: toileting, food, water, pain control, and temperature control. Warm blankets, water, and pain meds were consistently discussed as important comfort measures.

Patients used a variety of terms when describing the staff after they helped meet patient’s bodily needs. “Helpful,” “cared for,” and “comfortable” were some of these terms. This was especially true when staff supplied patients with blankets. A 76-year-old female patient with hypertension described how she felt when ED personnel were attentive to her request for a blanket: “And then somebody brought me a nice warm blanket. [Interviewer: How did that make you feel when you got the
Table 7

Sub-domains of Protective Caring with Definitions and Exemplars

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<tr>
<th>Sub-domain</th>
<th>Definition</th>
<th>Exemplar</th>
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<tr>
<td>COMFORT MEASURES</td>
<td><strong>Definition</strong>: Meeting bodily needs: toileting, food, water, pain control, and temperature control.</td>
<td><strong>Exemplar</strong>: Well, they took me-- oh, my mouth went dry, you know. I think during the fall I might have gotten an anxiety attack because my mouth went dry, but completely dry. So I got there and I asked, and it was the male nurse, he brought me some ice and water. And so I drank it.</td>
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<td>PROFICIENT CARING</td>
<td><strong>Definition</strong>: Skills and behaviors which increased confidence in the professional abilities of the ED personnel.</td>
<td><strong>Exemplar</strong>: And especially the male nurse. He called this thing he put here a butterfly, and they never used the butterfly. And now I wanted to be upset about not using that thing when-- It didn’t hurt that bad because the guy was so careful not to hurt me. Because I did tell him, “I’ve gone to places that they actually hurt.”</td>
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<td>ANTICIPATORY CARING</td>
<td><strong>Definition</strong>: Foreseeing positive and negative outcomes during patient care and adjusting practice behaviors to prevent negative and support positive outcomes.</td>
<td><strong>Exemplar</strong>: [Interviewer: So they asked you if you were allergic to any medicines before they gave you pain medicine. Did . . . it matter to you that they did that?] Yeah, it mattered because they could’ve gave me that dye, iodine, that’s what I’m allergic to. So they could’ve swabbed on my foot or whatever. Again it would’ve been complications, and no, they inquire before they make a move. They ask you.</td>
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<td>COLLABORATIVE CARING</td>
<td><strong>Definition</strong>: Safe patient care which is the result of several staff working together.</td>
<td><strong>Exemplar</strong>: I noticed that the attending physician there in the emergency room could almost, without even being able to really do full examinations, he could tell what was going on. I noticed one of the patients, and it was a female patient in one room. He said something that there was something going by and he could tell by the smell that was in there, and he sent another one of the physicians that was on duty in there with him and told him, “If you will go in there and smell that smell,” and that is a direct result of whatever it was he was talking about. He asked him when he came back out, “Did you smell it?” “Yes.” They had it nailed down. They were really, really good, really good.</td>
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<td>ASSURING SECURITY</td>
<td><strong>Definition</strong>: Maintaining the patient care environment and using patient and personnel protective equipment to prevent patient injury or compromise of confidentiality.</td>
<td><strong>Exemplar</strong>: [The RN] placed her sharps in the sharps container, trash in the trash can, and told the patient she’d be back shortly. As we walked to the hallway she stated that she saw blood on the bedside table, “I didn’t have time to check my rooms this morning, and I noticed blood on the bedside table. I need to go back and clean that up.” She obtained a sanitizing wipe at the lab draw supply cart, returned to the room, and cleaned the blood. She wiped down the two other bedside tables.</td>
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blanket? Oh, so cared for.” A second, 27-year-old patient who came to the ED because he was coughing up blood described feeling “comfortable” after receiving a blanket.

The nurse stayed after, make sure I was settled and comfortable, asked me if I needed anything. [Interviewer: And settled and comfortable, can you describe to me what that means to you?] In that situation, I guess in the bed. Those rooms are kept rather chilly. She made sure I had enough blankets. I asked for another one; she got me another blanket. That’s what I would call in the ER settled and comfortable, in the bed. Of course they put the safety rails up.

It is difficult to tell if the “safety rails” comment was part of feeling comfortable. An interesting speculation is that side rails may lead the patient to feel more comfortable and therefore “safe” (and worth probing in future studies).

Either to address the chill experienced by the ED environmental temperatures or to attend to thirst that was the result of a medication side effect, patients expressed appreciation and satisfaction when staff addressed these bodily needs. An 82-year-old female patient with knee pain observed, “And we were freezing, and she brought us blankets… She did everything that should’ve been done, you know. I didn’t know anything. I just let them do what they wanted, but she was very, very nice. I’d like to have that all the time.”

Another patient pointed out that staff brought her water for dry mouth.

“Well, they took me-- oh, my mouth went dry, you know. I think during the fall I might have gotten an anxiety attack because my mouth went dry, but completely dry. So I got there and I asked, and it was the male nurse, he brought me some ice and water. (83-year-old female with fall injuries)

These instances of providing comfort measures were not just incidental reports. Patients described comfort measures as contributing to their overall sense of safety. In
this instance, a patient who was given a narcotic pain medicine and had dry mouth was describing how important it was for him to have access to water.

So she was gone, and when I woke up my cup of water was there, so that right there is honestly, was a, “Wow!” to me, because a lot of times patients are sitting there and in pain, and some are there, like I was, huffing and puffing. Your mouth gets kind of dry, and you don’t have like a water fountain right there, you know, at your reach to get water. . . . I don’t know, because she was so busy that she would always walk by there and, “Hey,” you know, but it was that she was easy to find, and she did get my water, and she did what I actually needed to try to get rid of this pain and swelling. (33-year-old male with joint pain)

Provision of comfort measures provided this patient and others with the perception that their bodily needs were being met and symptoms being addressed. This led to an overall sense of safe care provision.

Another comfort measure found “helpful” by a patient who was being treated for back pain and a cardiac issue was pain medicine.

They ran my vitals, ran EKG, made sure that I was comfortable, and at that point there, they were trying to see-- getting me some pain medication to relieve some of my pain right off the bat. [Interviewer: When you said they were making sure you were comfortable, what did they do specifically . . . ?] Oh yes, they certainly did. They went right on ahead and administered pain medication and stuff to get me a little more comfortable because I was very, very much in pain. (50-year-old male with back pain)

This patient was initially impressed that the back pain which brought him to the ED was discovered to be not his most significant diagnosis (he was having episodes of cardiac ischemia that were far more serious). However, he was also impressed that the significant back pain he experienced was being treated and was not lost in the concern for his cardiac issues.

The researcher’s field notes also carry indications that patient comfort measures were a priority. There were notations that call lights were answered within 45 to 60
seconds of being activated. Call lights, which when triggered in a patient’s room, provided an audio and visual signal alerting ED personnel at the main staff desk that a patient required assistance. Many times RNs, unit secretaries, and techs who answered the call lights returned to the patient’s rooms with pain medicines, water, or blankets from a warmer.

**b. Second sub-domain: Proficient Caring.** Patients were impressed with the level of skill and intellectual acumen of the ED personnel. Patients described this type of proficient caring as adept care which increased confidence in the professional abilities of the ED personnel. Specific types of proficient caring included both attitudes and skills or practice actions such as gaining IV access on the first stick, reduced pain or pain free procedures/treatments, or multitasking.

Attitudes of ED personnel were quickly picked up by patients and contributed to their sense of safe care provision. The first patient interviewed in this study set the tone for how positively she felt about the attitude of those who provided her care when she stated, “No concern at all. I just, uh, I felt like it was primarily a good hospital, and clean. And the people that worked there were attentive to their business.” (76-year-old female with hypertension.) When describing an example of what this patient meant by her comment, she noted, “Because sometimes you go in there and you’re either hurting or half dying, and the doctor comes in, ‘Well, going to do this and that. Got to run and do this other thing.’ But when he was in there, his time was all mine.” Having the undivided attention of the ED MD was important for this patient to feel that she was receiving skilled care.
Several patients used the terms “nice” or “sweet” when they described the care they received. When pressed further about what he meant, one patient described the interactions he had with ED RNs as he initially entered the patient care room:

She was very, very nice. She took me in right away. And then there was the nurse that she spoke to. And they took me into one of the rooms. Again, she was very sweet. They were very helpful. They told me to just go ahead and lay on the bed and go ahead and change into the gown and so forth. And they came in right away, and they were assisting me. [Interviewer: And when you say she was really sweet and nice, just her attitude or…?] Her attitude, her approach. She was very, very friendly. I wish I could remember their names, and I just don’t remember. But she was very, very nice. And then when she introduced me to the other nurse, the nurse was also real nice. They came right away, and they had to do what they needed to. They were asking me questions. They had me fill out some forms. (42-year-old male with lower abdominal pain)

A quick response, introducing other ED personnel, completing necessary tasks, and focusing on the patients’ needs all were important aspects of the adept care he received.

Sometimes, professional behavior extends beyond discharge. One patient described how safe she felt when, unable to reach family members after arriving in the ED after midnight, the ED RN stated he would get the patient a cab voucher.

That’s when I wanted to hug him again. I mean like do you realize, well, picture yourself 83-years-old and having to walk that far, and a little angel comes out and says, “No, I’m going to carry you home.” . . . It was-- the main thing was incredible, it’s like a little angel coming out, saying, “I’m going to carry you home and put you at home.” Then you can just relax and know they’re doing good for you, and you feel good. I did. (83-year-old female with fall injuries)

For this octogenarian patient, not having to worry about transportation and knowing that ED personnel were taking care of this allowed her to “relax” and feel cared for.
The professional and expert treatment provided to patients was perceived not only of ED staff. One patient, whose medical care had been handed off to a hospital cardiologist, was impressed with the level of service provided when this cardiologist followed the patient outside of the ED proper and downstairs to the Radiology Department to continue his assessment.

As soon as I got to the room, the cardiologist came and sat down right here in the room with me and was asking me questions. He went back out toward the nurses’ station there in the emergency room, and he did not leave. When they went to transport me to take me downstairs to have the CAT scans done, he told them just to hold on for a second. He took my charts with him, and he stayed with me the whole time. The cardiologist actually walked with transportation down there with me and was present the whole time. (50-year-old male with back pain)

For these patients, the attitude of ED personnel when addressing both patient needs and their symptoms provided patients with a sense of care that was expert and capable.

ED personnel attitudes and behaviors were not the only perception of competent, proficient care of patients. Being skillful at tasks such as IV starts and blood draws also provided patients with a sense of receiving safe care. One patient noted the importance of the nurse not causing her undue pain during a blood draw.

Well, they were so warm. They were so like, truly, we want to help you. They showed me they really wanted to help me. . . . . He called this thing he put here a butterfly, and they never used the butterfly. And now I wanted to be upset about not using that thing when-- It didn't hurt that bad because the guy was so careful not to hurt me. Because I did tell him, “I've gone to places that they actually hurt.” [Really emphasized the word “hurt.”] (83-year-old with fall injuries)

A different patient noted a sense of proficient care perceived when a phlebotomist demonstrated concern and exercised skill when drawing blood from the patient.
They got it on the first stick. The person that did the blood in the hand got it on the first stick. She was concerned about doing it in my hand, because I asked her to do it in my hand. She was concerned that was going to be more painful than trying in my forearm again. My forearm was already pretty sore from the first stick with the dig, so I was hoping to do my hand, because then it would be . . . But yeah, she was worried about bruising, but it didn't hurt when she did it. So she was A-okay with me. (32-year-old female with intractable vomiting)

Another patient, a 24-year-old female with upper abdominal pain, questioned some aspects of her care (see Research Question Two below) but did express confidence in the nursing care she received. Her trust in this care was the result of the attention the RN paid to her symptoms as well as the ED RN’s skills as a practitioner:

Um, I felt like she took her time to, you know, see really what was wrong, and just, you know, asking questions about what I ate. You know, doing her job, drawing blood, and you know, I guess getting vitals and things like that. So she was pretty friendly as well, lots of pleasantries. Yeah, she was good. (24-year-old female with upper abdominal pain)

Practice activities and skills demonstrating a high level of proficiency impressed patients when ED personnel were able to effectively multitask. A 50-year-old male patient with back pain and cardiac problems, who had a good view of the staff working area, noted how impressed he was watching ED personnel work on several activities at once.

I also know that I’m sitting there looking at the board and I can tell how many other patients are in there. I’m seeing that this doctor that was attending at that point, not only was he taking care of my case and staying on the phone and making phone calls to get specialists and other people in for me, that he was on top of everybody else’s case that was in the other rooms also. Yes, it was-- I guess you could say he was very good at multi-tasking. . . . I also even noticed and it was right there through lunch. The attending physician there in the emergency room, I noticed that he did not even leave to have his lunch. He stayed, and I was sitting right there. He had him a sandwich right there at the desk. You know, right there in the emergency room he had a quick sandwich, and during the time that he was eating his sandwich, he was still answering questions and talking to other nurses and directing healthcare for the other patients.
When asked if the patient felt it was appropriate to see the ED MD eating while conducting patient care, the patient noted, “I think it was very gracious of him to sit there and cut into what little time he could have had, you know, to sit there and keep going like he was going and keep healthcare going for the patients within the room, the facility.”

Patients felt that the high level of care they received demonstrated safety on many levels. One patient even discussed his thought that ED personnel have safety ingrained in their practice, activities, and behaviors:

because the way I see it, from my standpoint, the safety, it’s taught to them. And like they worked there, and that’s what they practice everyday, and that’s what they do everyday is safety. And so, you know, anybody that goes to an emergency room, that wants to be their least worries to be honest, is a safety. So when I was back there, you know, I really felt at ease, comfort, and knew that I was going to be taken care of. (33-year-old male with joint pain)

Safe care provision is present in the minds of these patients, and safe care provision was perceived as occurring in the practice and skills of the ED personnel in this ED.

The researcher field notes recorded several instances of proficient, professional caring. The SANEs who care for victims of sexual assault provided interesting insight into the care of these patients. One particular SANE pointed out, “Medical over forensics. Treat the medical problems that are most urgent first, then collect evidence of the assault.” This puts the patient’s life and health as a priority over collecting facts of the assault. The SANEs recall practice knowledge specific to this area of caring that an RN or MD not trained in forensics nursing might forget. The SANE noted in an interview that
Survivor exam - chaplain and rape crisis center person are offered to the survivor. They can remain with the patient during the exam but can only get so close (usually from the shoulders up) so that any part of their DNA does not get mixed up in the evidence collected.

SANEs not only have to remember specialized skills and training as nurses, but how to protect the evidence collected from the patient. This specialized knowledge prevents evidence contamination that could potentially harm the case of the patient during a criminal or civil trial.

Another field note entry points out that, when patients have a diagnosis involving cardiac instability necessitating admission to a telemetry floor, specialized equipment and licensed personnel are used when transporting patients to their admission room. “CC RN reported that patients who go to the telemetry floor [admission floor where a patient’s heart is constantly monitored], are transported from the ED by an RN, but not with any other personnel, connected to a portable heart monitor.” Licensed personnel can monitor the patient’s heart rate and oxygen level and can respond immediately if the patient experiences an emergent deterioration in condition.

A final field note records an interaction between an RN and a patient during the insertion of an IV. The RN demonstrated safe care during IV insertion as well as utilizing professional humor to help ease the patient’s concerns.

FF RN and I entered the patient room. She explained that the pt required an IV and what the IV would do for the patient. She introduced herself and me, eased the mood of the room with some humor (the family member asked if she could leave and FF stated “For $1 you can!” Both laughed). She also rubbed the patient’s arm stating, “You have beeYOUtiful veins.” The patient grinned. She talked through the IV process, what happens when the needle goes in, that the needle comes out, but only a plastic catheter remains, that it will be firmly taped down, that a “flush” will be used to move the blood out of the line and prevent a blood clot from forming.
By her explanation of the IV insertion process and use of humor to gain patient and family member confidence, the RN demonstrated professional care that provided patients with a sense of safety.

For patients, attitudes and actions provide a sense of safe care provision. When staff treat the patients’ concerns as important by listening to them, demonstrating attentiveness to their symptoms, and revealing a high level of skill when carrying out procedures, patients understand this high level of skill. Patients know the difference between a high level of care which they perceive as safe and a limited or low level of care which is not perceived as safe.

c. Third sub-domain: Anticipatory Caring. ED personnel, especially RNs and MDs, practice with an eye toward anticipating positive and negative outcomes. To head off potential negative outcomes, ED MDs and RNs ask questions about what is occurring currently with the patient. They then adjust practice behavior to prevent errors and reduce the time from ED admission and discharge to home or inpatient admission. Patients’ perceptions of Anticipatory Care contributed to feelings of safety.

Specifically defined, Anticipatory Care is foreseeing potentially harmful outcomes of treatments, medicine administration, or other care provided to patients. This includes (a) anticipating allergies to medications; (b) controlling symptoms (asking about recurrence of noxious symptoms like pain and nausea so as to preemptively medicate); and (c) educating patient about effects of medication (pain medicine, contrast media) prior to administration of medications.
Patients frequently recalled that during their time in the ED, staff consistently asked them about allergies to any medication the patient was to receive, which included allergies to contrast media given during CT scans or Magnetic Resonance Imaging (MRI). One patient remarked that “it mattered” that ED personnel asked him about contrast media allergies.

First they ask you are you allergic to anything, you know. And I told her I was only allergic to that dye they put in your kidneys to see your kidneys. And she asked me when was the last time I had had some dye used on me, and I had just had a stress test done. And so I told her they put that dye in me then to see my heart, and it didn’t bother me, so. And then he ordered the medicine. . . Yeah, it mattered because they could’ve gave me that dye, iodine, that’s what I’m allergic to. So they could’ve swabbed on my foot or whatever. Again it would’ve been complications, and no, they inquire before they make a move. They ask you. (59-year-old female with foot injury)

This patient was impressed that a staff member worked to prevent complications by asking about these allergies. Patients were also asked about allergies to pain medicines. As one patient observed, “And then when I came up to the room, a doctor came in and he said, ‘What’s the problem?’ and I repeated myself again to him. And he said, ‘Well, are you allergic to anything?’ I said no, so they gave me a pain pill.” (58-year-old male with ankle pain)

The researcher’s field notes also carried entries such as this one of staff inquiring about patient allergies, in this case, to contrast media.

She told the pt he would be going down for a CT; she explained “. . . a CT is a cat scan; you’ve had one of those before?” The patient answered that he had, and ZH asked if he was allergic to iodine or shell fish. She explained that a medicine given (contrast media) during the CT contained iodine and if he was allergic to it that this could be a problem. He stated, no I’m only allergic to penicillin but not to iodine or shell fish. He did admit to breaking out in a rash when he ate shrimp. This was reviewed with the doctor who later stated to give the patient 25mg of Benadryl so as to dampen any allergic reaction the patient might have.
In this case, the physician ordered Benadryl, a histamine blocker and standard medication used to preempt any allergic reaction. However, the important piece is that the ED MD or RN has to ask the patient so as to anticipate the allergic reaction (poor outcome). In another instance, an RN prevented a patient from receiving a medication to which the patient could be allergic.

Dr NN, MD to YY RN: “Please give room eight 2 Lortab.” YY RN walks off, returns, and states “You know, she’s allergic to Vicodin” [Vicodin contains the same narcotic medication as Lortab, thus the patient may be allergic to the Lortab just ordered by Dr. NN.] Dr. NN changed the medication to a different one to which the patient may tolerate better.

Anticipating pain and its recurrence is another anticipatory practice which ED RNs and MDs undertook. After administration of pain medicine, RNs would reassess the patient to determine if the pain medicine was enough. One patient commented, “They made it a point to keep asking me what my pain level was and if I needed any more pain medication or if I was comfortable and exactly how I was feeling.”

(50-year-old male with back pain.) Pain control is important to all patients, and reassessment of pain is an important anticipatory practice that patients observe.

But she was a very good nurse, because she did come back and ask me, “How is your pain level?” A lot of times they don’t come back and ask you that. They want to know what your pain level is before they give it to you, they give you the medication, and they leave you alone. This nurse, she did come back, and ask me what my pain level was now that she gave me the pain medicine. I told her.

(40-year-old male with hypertension)

This patient noted experiences during previous visits when his pain was not reassessed. During this visit, he did recall that the RN came back and noted how important this was. Another patient also remembered having been reassessed so as to achieve “symptom relief.”
Yes, my nurse came in to check on me, check on my pain levels, and check on what my symptoms were at that point. You know, because like I said, whenever I came back from CAT scan I started vomiting, so she was on top of it as far as symptom relief, trying to get me some symptom relief. (38-year-old female with lower abdominal pain)

Anticipating return of symptoms is an important part of care provision which contributes to a patient’s safety perception.

ED personnel also anticipated a patient discharge and the implication discharge may have for family members. One patient who arrived in the middle of the night was encouraged by the ED RN to call her son. “But he was extremely nice, all the way through. Like he even said, ‘Aren’t you going to call your son? Because if you were my mother, I’d like to know!’” (83-year-old female with fall injuries.) Not only was this RN anticipating that family would want to be with their mother, but since this patient also had arrived by ambulance, she would need a ride home. Family could provide that ride.

Field notes from the researcher revealed other instances of anticipation. In one instance, a suspected drug abusing patient who was a flight risk required a blood draw. The ED RN could put an IV in, anticipating future medicine administration, but was concerned that the patient may elope (depart without informing staff). An IV in a patient who has left the hospital poses a variety of health risks to that patient. The nurse ZH anticipated this possibility and conferred with the ED MD, Dr. ZJ: “ZH RN to ZJ MD: ‘I have a patient who is an IV drug abuser. I’m afraid he’s going to bolt [leave the ED without formal discharge] when I put in his IV. Can I just straight stick him to get his blood?’ ZJ: ‘OK, that’s fine.’”

Another RN (KK) explained to a patient the rationale for placing an IV instead of drawing blood with a phlebotomy needle.
KK noted that she was starting the IV because she had to draw blood (and thus put a needle in anyway) and with a patient having abdominal pain, the chance of administering fluids or medicines that would require an IV is high enough that she would put the IV in and left it in.” Anticipating the administration of IV meds, KK placed an IV through which she could draw blood and administer meds, saving the patient a second (painful) needle insertion.

Another entry from the field notes occurred at the time that novel H1N1 (swine) flu was making a first appearance in the US in April. ED personnel anticipated an onslaught of patients and were reviewing how to keep both patients and staff safe. Upon entry into the ED one morning the following was observed. “ZZ RN was reviewing respirators [n-95 respirators are used to prevent inhalation of biological agents]. He was also reviewing with staff the use of a hood with a HEPA [high efficiency particulate air] filter, which provides a higher degree of protection from biological agents.” Since it was unknown at that time how novel H1N1 flu was spread, this RN anticipated the highest level of protection and reviewed this with ED personnel, thus displaying a high level of anticipatory care.

d. Fourth sub-domain: Collaborative Caring. Patients were aware of the amount of staff collaboration and noted how collaborative care positively impacted their health and well being. Collaborative care is defined as safe patient care which is the result of several staff working together. This involves ED personnel with multiple roles working together to coordinate care on the same patient.

Several patients expressed that nursing and medical personnel consistently worked well together. One patient stated, “And once again, I’m going to go off the impression and how I was impressed, how quickly something got done once the doctor told the nurse to do it.” (27-year-old male with bloody cough.) This patient suffered from
a severe cough and bleeding from his lungs (hemoptysis), which were the consequence of a chronic illness. He repeatedly noted how impressed he was with the speed of his care delivery and with the cooperation between ED personnel during his treatment.

A second example of cooperation between the ED MDs and RNs occurred during discharge instructions for this 33-year-old male patient who came in with a case of pseudo gout. The ED MD gave the patient discharge instructions, and then the ED RN gave almost the same instructions a few minutes later which reinforced the previous instructions from the MD. “That’s when [the ED RN, a female] also said, ‘And if your ankle starts to swell up again within this period of time before you start actually taking the medication, you need to come back. . .’ [Interviewer: So that helped your learning process?] Right, exactly.” Having new information on a more accurate diagnosis of pseudo gout reinforced by the RN exemplified to this patient a high level of teamwork between the MD and RN.

Collaboration between MDs was another factor in patients’ perceptions of protective, safe care. Because the MDs have the authority to diagnose and treat, patients pay special attention to the level of care they receive from them. When MDs work well together, it reassures the patients that they are receiving a high level of care. A 40-year-old male patient with hypertension had expressed frustration over having to answer what he perceived as the same questions over and over from different staff. However, this was not a problem when the ED MD handed his case off to the admitting MD.

They communicated what they had to, and showed each other the charts. Without having to explain again, like I said, “Okay, where does it hurt?” and having to explain the whole thing, he told him exactly everything when the doctor
came. He said, “They’re already going to be taking you. You’re under my care. Blah blah blah. I’ll be seeing you.” And my admitting doctor is the one that said you’re going to be dialyzed. He started telling me everything that he had planned for me, and again, communication that was very good, because he’s communicating with me and telling me things.

Knowing that MDs communicate with each other reassured this patient that he was receiving safe care.

A second patient who was dealing with a significant cardiac issue observed that the ED MD had secured a specialist (a cardiologist) with whom he had coordinated the patient’s care. The speed with which the patient was transferred and with which his cardiac issue was dealt was impressive to this patient.

At that point, the attending physician there said that they were calling in, and I had not seen a specialist yet. He had conferred with specialists over the telephone and yes, he told me after speaking with a specialist that they were going to have me transferred here to this facility and that they were already sitting here waiting and they were already waiting on me to get here to run the different procedures that they had set up for me, yes. (50-year-old male with back pain)

This patient understood that it was because the ED MD had coordinated his care so well with the cardiologist, that the cardiac issue could be resolved quickly. The only wait for the patient was on transportation. As the patient noted, “It was just a matter of time of waiting on an ambulance to get there and get me and get me over here and bada bing, it was on!”

Collaboration was noted by the researcher during observations of the patient care environment. Often phone calls would come in from admitting MDs to RNs who were treating ED patients awaiting a hospital admissions bed. Taking these phone calls required a quick response by nursing as the admitting MD would hang up if the call wasn’t answered promptly. RNs worked with each other and with the ED MDs to take
these calls quickly, even if the RN answering the call was not the RN for that specific ED patient.

Dr. I MD, overheard on the phone to an admitting MD, “Let me get a nurse.” To the staff area, “Where’s YY [the patient’s RN]?” 13 seconds. “Can someone take phone orders?” TT [a second RN] states, “Yes,” and grabs the patient’s chart. An additional 10 seconds elapse. TT can’t find the phone line on which the admitting MD was on hold. “Where’d he go?” Dr. I MD: “He must’ve hung up.” TT, to SS [the unit secretary]: “Can you please call Dr. X back again for admission orders?”

A second example exists also demonstrating that the ED MD interrupted care of another patient to talk with an admitting MD about an admitted patient’s care.

ZJ MD enters an ED patient care room for a procedure; another patient’s private-care MD called to receive a report from ZJ MD who interrupted the procedure on which he was working to take the phone call. He then asked for an RN so that the patient’s private MD could take admission orders on the patient. ZK RN found LL [the charge] RN who took the orders. She read these orders back to the MD for verification.

LL the charge nurse practiced an additional layer of security, reading the orders back to the admitting MD so that the admitting MD could check the orders for accuracy and omissions.

Collaboration between ED personnel during direct patient care is also an important aspect of safety provision. One RN noted that his patient, who was scheduled for an MRI, had a titanium rod in his arm. Knowing that metal in body parts or organs is prohibited in MRIs, she consulted with the MD.

YY RN asked Dr. NN MD about the possibility of an MRI for a patient with a titanium rod in the patient’s arm. YY RN explained that an MRI involves the use of a magnet and any metal in a patient’s body could be affected by the magnet. If a patient has metal in his/her body, that usually prevents them from receiving an MRI. Dr. NN MD called an MD in the radiology department for a consult, discovered that titanium rods are not affected by an MRI, and communicated this to YY RN. She then sent the patient via transporter to the MRI.
Other ED personnel, such as respiratory therapists (RTs), also were observed collaborating with MDs and RNs. “Prior to initiating patient treatment, the RT comes to the ED staff area to consult with the emergency MD and RN so as to receive critical information about the patient’s respiratory need. He receives information from both to help him with treatment administration.” RTs also assisted a patient with better placement of an endotracheal tube that was placed in a patient’s lungs to help the patient breathe on a ventilator. The RT conferred with the MD.

The RT reviewed the x-ray of the endotracheal tube inserted into the critical patient’s lung and noted to the MD that the tube was inserted too far into the lung, into the “right main bronchial tube.” He stated to Dr. NN that he would “fix it” or adjust the tube so that it was in the main bronchial tube.

These are but a few examples noted by the researcher that affirm that ED personnel confer with each other and reinforce good practices because of their patient-directed professional activities and behaviors. Without collaboration, care can be missed, delivered inaccurately, or delivered erroneously.

e. Fifth sub-domain: Assuring Security. Patients discussed several subjects that have been placed in this sub-domain. In general, assuring security involves maintaining the patient care environment and using patient and personnel protective equipment to prevent patient injury or compromise confidentiality and to assure cleanliness. Specific details include making certain that protective devices such as sharps boxes, restraints, side rails, specimen labels, patient identification and patient allergy wrist bands, and alarm equipment are in place and used, inquiring about
medication use and medication allergies, and preparing IV and syringe injection medications in front of the patient.

Cleanliness of the patient care area was described by several patients as important to them. When asked what they remembered about their room in the ED, many described finding them clean. The first patient interviewed in this study asserted her appreciation for this “I noted the hospital was really nice and clean, which I really appreciated. . . Well, the curtains around the rooms were hanging nice and weren’t wrinkled or dirty or anything. And the floor was nice and clean, shiny.” (76-year-old female with hypertension.) When asked at the end of the interview if she had any concerns, this same patient affirmed, “No concern at all. I just, uh, I felt like it was primarily a good hospital, and clean.” A second patient noted similar room conditions. “Yeah, the room was clean. The room was clean. I did ask them for a bag to put all my personal belongings in, because I just didn’t like just leaving my clothes out, just sitting there. She came in right away and she gave us a bag to put my clothes in.” (42-year-old male with lower abdominal pain.) During the interview of an 82-year-old female patient with knee pain, when asked what she remembered about her ED care room, her sister who was present during the interview, noted the cleanliness of the room.

In the researcher field notes, several instances of ED personnel cleaning rooms were noted. Housekeepers with cleaning carts were observed emptying trash, cleaning patient toilets, and mopping floors. At the request of the charge RN, housekeepers also “deep cleaned” a patient care room after a patient who had a diagnosed contagious infection was discharged.
Patient has chicken pox. Was discharged to home after given medications and discharge instructions. Housekeeping was paged to come to the ED and deep clean the room. A “deep cleaning” as defined by ZH RN is a thorough disinfecting of floor, beds, walls, and counter tops by housekeeping.

In between patients, RNs and the unit secretary-techs, would clean the rooms. Cleaning a patient care room involved several steps.

YY RN discharged a patient. After the patient left the room, YY RN wiped down the stretcher mattress, pillow, and side rails with anti-septic. She placed a fitted sheet onto the mattress, a pillow case on the pillow, and a top square sheet on the mattress with a folded sheet on the bed. The anti-septic used to clean the bed is called Sani-cloth and has bactericidal, tuberculocidal, and virucidal properties.

The by-products of this attention to room cleanliness was directly noted by the researcher when observing direct patient care. “ZZ took her vital signs and then walked out of the room. In room condition: all supplies were in their place; no loose trash on floor or counter tops. Room had a fresh, neutral smell.” ED personnel were observed to clean up after themselves when completing procedures. “She collected the blood, removed the tourniquet, removed the needle, applied a bandage, and placed the blood in the blood culture vials. She cleaned her trash, placed the sharps in the sharps box, and exited the room.” Occasionally ED personnel would note problems with cleanliness of the room, and immediately addressed these problems themselves.

KK placed her sharps in the sharps container, trash in the trash can, and told the patient she’d be back shortly. As we walked to the hallway she stated that she saw blood on the bedside table, “I didn’t have time to check my rooms this morning, and I noticed blood on the bedside table. I need to go back and clean that up.” She obtained a sanitizing wipe at the lab draw supply cart, returned to the room, and cleaned the blood. She wiped down the two other bed side tables.
The comment about checking the rooms in the morning to assure cleanliness was interesting because another RN also pointed out that he checked and cleaned ("set up") his rooms early in the shift.

ZZ continued the triage interview. He took the pt’s vital signs. Several cords from the monitor (cardiac 5 lead cord, BP cord, pulse oximetry cord) were entangled by the pt’s bed. ZZ stated, ‘If these were my rooms, I wouldn’t have ‘macramé.’ I like to set up my rooms.

The use of ED personnel protective equipment such as gloves was also mentioned by patients. When asked if he noticed any safety practices by staff, despite noticing that he did not see ED personnel wash their hands, a 59-year-old female patient with a foot injury did notice that they used gloves. “Well, they had on rubber gloves. I’ve never seen them wash their hands. But they put on rubber gloves when they came in.” Another patient noted ED personnel safety practices which also included glove use.

I think that’s pretty much covered a lot of well with this hospital, the safety gloves that they use, the masks that they use to cover themselves, any type of germs that they might be spreading to a patient, I think their safety issues are pretty much covered because they use the latex gloves, they use the mask, they use the booties, they use the lab coats that they need to. I think they pretty much have that covered very well. Sanitary wise, every time they walk into the room, they spray sanitizer when they touch the patient. I think that’s a big safety issue, because you’re not spreading germs to the patient from where you just may have come from another one.

This patient had chronic kidney disease and had spent a lot of time in and out of the hospital. For him, use of this equipment was important to prevent the spread of infection between patients.

Researcher field notes contain entries of staff glove use as well. “BB wore gloves, prepared her supplies, applied the tourniquet, found a vein, inserted the
catheter, collected the blood in specimen tubes, taped the IV, and flushed it with normal
saline.” In another entry, glove use was noted during IV placement. “KK RN washed
her hands, donned gloves, applied a tourniquet, and began looking for a venipuncture
site. Finding one, she cleaned the site with Chlorhexidine, and inserted the needle.”
Glove use is more of an ED personnel protective issue but is perceived by patients as
an important aspect of their safe care provision.

An additional feature of receiving safe care that was perceived by patients is the
use of wrist bands for patient identification and for the recognition of medication
allergies. When asked if ED personnel demonstrated any patient safety practices, one
58-year-old patient with ankle pain noted that ID band placement was used. “They put
on the wrist band, that ID band. And I still had my University band on. And I said, ‘No,
don’t take that one off yet.’ So they’d know where I came from. And then after they took
it off.” When asked if ID band checking provided him with a sense of security or if he
thought ED personnel were just doing their job, one patient remarked,

Well, I mean, I guess it was more a sense of security knowing that, at least they
were checking to find out exactly that I was the right person that they were doing
the testing for. And not doing something that they shouldn’t have been doing.
(42-year-old male with lower abdominal pain)

This patient was aware that staff was checking his ID band ensuring that the correct
procedure or medication was being given to or completed on the correct patient. Other
patients also made this connection.

They put a white band with my name and my doctor’s name and the date I was in
there. This one had some numbers on it. [Interviewer: Did they look at that at all
after they put it on? Did they ever refer to it again, before they did any
treatments or gave you any medicines?] They would come in and ask me my
name and my birthday. Yes, because they have your birthday on there, too, and
they had to match up. (59-year-old female with foot injury)
Similar experiences occurred with patients as additional bands were placed on them noting their allergies to medications. Before she related to the interviewer that ED personnel placed an allergy band on her wrist, this same patient explained why she felt it was important that she be asked about her medication allergies.

First they ask you are you allergic to anything, you know. And I told her I was only allergic to that dye they put in your kidneys to see your kidneys. And she asked me when was the last time I had had some dye used on me, and I had just had a stress test done. And so I told her they put that dye in me then to see my heart, and it didn’t bother me, so. And then he ordered the medicine. . . . Yeah, it mattered because they could’ve gave me that dye, iodine, that’s what I’m allergic to. So they could’ve swabbed on my foot or whatever. Again it would’ve been complications, and no, they inquire before they make a move. They ask you.

This patient not only made the connection that iodine in the contrast media used in the radiographic imaging of her kidneys is the same iodine that in the past was used as a skin cleanser prior to phlebotomy or wound cleaning (“could’ve swabbed on my foot), but also made the connection that complications arise when patients do not have an opportunity to talk about their allergies.

Researcher field notes reveal instances of ED personnel verifying patient information. ID bands are usually placed on the patient by the registrars, as this field note entry points out: “Registration places patient ID band on the patient.” ED RNs verify patient identity by asking patients for their names and birth dates and comparing the answers against data on lab labels or ID bands. This usually occurred during collection of blood and urine for lab testing:

Example 1: She inserted the IV and drew the blood into collection tubes. She asked for the pt’s name and birth date to verify the label--correct pt. She labeled the tubes and then walked the urine and blood specimens over to the lab.
Example 2: ZH RN asked the patient to tell her name and birth date before putting the labels on the blood tube at the bed side.
Example 3: Blood was drawn and placed in collection containers. She had the patient state his name and birth date before placing labels on the tubes. Asking for identification or allergic medication reaction is an important healthcare safety action.

A final yet important discovery of this study was that three patients stated their preference for ED RNs to open and prepare in front of the patient in the patient care room IV- and syringe- administered medication. When the tubing and needles used for the medication administration are opened in front of the patients, they are assured that the equipment is sterile and/or not reused. One patient, who potentially has Lupus, was very concerned about contracting any type of infection because her immune system is challenged.

The only concern, now I watch carefully to make to sure they use a brand new needle on me. I don’t want them coming in there with the tip off the needle, and say, “Oh, Mrs. [patient states her name] we’re going to give you this,” because I will refuse it. I like the way they prepare everything in front of you. They bring in all the gauze and the tape and the needles and everything, and you can see that it’s fresh and it’s clean. And most of the time they tear it open out of the sterile bags, so you know it’s been sterilized or supposedly had been sterilized. But like I said, the only thing I’m concerned with is catching a communicable disease, because I have-- They don’t want to say I have Lupus. They don’t really know if I have Lupus or not, but my immune system is down, and I’m subject to. . . . But my only concern is contacting a disease that I know I didn’t have from the nurses or the doctors. (59-year-old female with foot injury)

This patient was assured that equipment which is “sterilized,” “fresh and clean” will protect her from any further infections which could be worsened by her Lupus. When the equipment was brought into her room in the packaging and prepared in front of her, she received this assurance. A 24-year-old female with upper abdominal pain made similar observations.
And the thing I don’t like about needles, I get concerned a lot because things are transmitted through blood and needles and things like that, and I’m always afraid that if a nurse doesn’t clean a needle good enough or something like that, you know, I’m like I don’t know what kind of stuff they’re going to give me [laughs]. So like that’s kind of a little bit of a concern. So I made her show it to me in the package, and she showed it to me, and that was fine. [Interviewer: Did you feel like that helped your confidence a little bit when you asked her to show you the package and she was able to do that?] Yeah, it helped out a little bit more. You know, I don’t really like needles period. I don’t like the idea of being stuck with anything. But it made me feel a little bit more comfortable when she actually showed me the package and stuff.

While describing his satisfaction with an IV insertion, a 33-year-old male patient with joint pain mentioned how safe he felt watching the RN prepare his IV set up in front of him.

But no, yeah, everything was nice, closed, even the medication that come in the little vials like that, she came and she did everything there. Once I saw that to where she was already opening the pack, then I was like, “Okay, let me relax.” Because I know they’re going to go ahead and fix me up. [Interviewer: Watching her open all that equipment, you know, and opening those packages, did that give you any kind of reassurance?] Yes. Again, the safety, and I think— I guess once I saw that again, you know, it kind of like gave me the assurance that it’s good, because I didn’t want her coming here with this. I’m like, “Man, I don’t know where she got that.” Or she opened it over there and it could’ve fallen, and she could’ve, okay, brought it. You know what I mean? She brought the little table, and put everything up there. I saw her open the package and stuff like that. But that gave me a more at ease, you know, more safe.

The topics of greatest concern to all three of these patients were reuse of needles, needles and tubing that could have been soiled because they fell on the floor, and needles that weren’t “cleaned well.” The concern about reuse of needles and the cleaning of needles is interesting because that fact indicates patients are not aware of some of the safety practices in place and used by staff, especially the use of disposable, single-use needles, syringes, and IV tubing. Regardless of this fact,
preparation of IV and injectable medications in front of the patients reassures them on a number of levels and helps them feel safer about their care.

Assuring Security is the last of five subsections of protection issues. Patients who perceived their care as being safe noted that their comfort measures were provided for, that staff practices anticipated outcomes, that ED personnel worked together, and that their physical safety and security was assured. The domain of protection issues is also the part of the section used to help understand patient perceptions of safe practices and processes in the ED.

4. Summary of Competent Caring domains

Patients noted many safe aspects perceived during the provision of their care. The variety of these aspects can be grouped into three domains: Communicative Caring, Accurate Caring, and Protective Caring. Communicative Caring consists of several sub-domains including how well ED MDs interacted with patients, provision of sufficient information to patients, and expressions of empathy toward patients. Accurate Caring involves precise diagnostic practices including patient questioning and interpretation of symptoms to bring about a correct diagnosis that could be explained to the patient and also involved efficient, organized, and prioritized care. Protective Caring involves ED personnel supplying comfort measures (like water, pain medicines, and blankets), assuring the security of the patient by preventing injury (cleaning the room, using gloves or stretcher side rails), collaborating with each other so as to bring about satisfactory patient care, anticipating potential poor outcomes for patients (like allergic reactions to medicines), and demonstrating a sufficient level of skill and practice that demonstrated proficiency. These three domains provide a helpful structure to situations
and to how patients understand the safe aspects of their care. The following section will
discuss, using the same domains and similar sub-domains, the next research question
dealing with perceptions of unsafe ED practices and processes.

C. Research Question Two

What are patient perceptions of unsafe practices and processes in the ED?

Patients were encouraged to discuss their entire visit with the interviewer,
beginning with entry to the unit and ending with discharge. When patients discussed
topics important to them pertaining to their ED visit, the interviewer would probe more
deeply to determine if this constituted a perceived decrease in or lack of safe care for
the patient. Interestingly enough, a little under two thirds of the data coded was
perceived as safe actions taken in the ED. A little over one third of the coded data noted
patient perceptions of unsafe aspects of their ED care. What follows are data indicating
patient perceptions of unsafe practices. Interspersed are notes taken from the
researcher’s field notes of the patient care area. Data analysis revealed that unsafe
practice perceptions fell into three categories: (a) communication issues; (b) accuracy
issues; (c) protective issues.

1. Communication issues

Some patients perceived that the initial process of entry into the ED, which
includes the registration process and their initial triage, had problematic elements.
Patients want their disposition (diagnosis, treatment, and discharge to home or inpatient
hospital admission) to make sense to them in terms of how it alleviates the symptoms
that brought them to the ED. If communication from RNs, MDs, technicians, and other
ED staff members does not communicate why a disposition is made, if patients aren’t
updated about the progress of their care, if their concerns aren’t taken seriously, or if patients otherwise perceive communication is not occurring regarding their care, their perception of care as “safe” fails to materialize.

Patients want to feel they are being listened to and given the proper attention. A 32-year-old female patient with nausea and vomiting symptoms noted that there was more attention paid to paperwork than on the initial triage process:

Yeah. The nurse’s-- The door to the triage was, you know, 10 feet from where we were sitting perhaps, so he just opened the door, and called my name. I went back in the triage behind the door behind the window. And I think he took some vital signs. He filled out-- I thought it was a little peculiar that he was handwriting things on forms, and then in duplicate he was filling them out on the computer. So doing a lot of form filling, not too many question asking.

A 24-year-old female patient with upper abdominal pain felt that the process of determining patient preferences, such the use of cardiopulmonary resuscitation (CPR) or cardiac medications in the event of cardiac or pulmonary arrest, was not explained adequately. At this specific facility, the registrar attains this information during the initial registration process. The patient seemed unclear on what was being asked, which led her to think that perhaps these preferences were being asked of her because of her symptoms:

Although the paperwork, they’re like, “Okay, do you want to…” Uh, I think she asked me something about what they wanted to do if I had to be on life support of something like that, like would you want us to keep you on life support or would you like us to remove you? And I was just kind of like… You know, I guess it’s just one of those things that she had to ask, but you know, I was like, “I’m hoping it’s nothing serious!” So I was like do I really need to sign anything right now? [Laughs]

This patient was asked about end-of-life care preferences for an advanced directive which could make a considerable impact on her health and life. The personnel
(the registrar) who asked the questions was not prepared to answer patient questions about the meaning of the decisions that the patient was being asked to make. More explanation could have been given to the patient by ED personnel who were better positioned to have the knowledge to answer this question (i.e., ED RNs and MDs). This outcome suggests that patients can be made to feel vulnerable if non-nursing or non-medical personnel, such as registrars, are responsible for presenting difficult information to patients so that end-of-life decisions can be documented. Policies that support MDs and RNs presenting this information and which present standardized training on how this information is presented may allow the patient to be better informed and provide answers reflective of their wishes.

Patients also expressed concern about the timing of payment information collection. Patients want their healthcare issue to be treated first, especially when they are in pain. They expressed concern and wonder about the quality of their care when payment information is perceived as more important than being treated medically. The 24-year-old female patient with upper abdominal pain mentioned above felt there was more importance placed on payment information than on her healthcare issues:

You know, and I just think it’s kind of really crappy to go into the emergency room and have people badger you about your health insurance information before you ever get to see anybody. It’s like, you know, what if-- I could have something serious, you know, that could have been life-threatening or something. They’re going to make sure they get my insurance information before they even look at me.

This patient was between health insurers (having just recently started working for a company) and felt some pressure because of a potentially expensive ED bill. Compounding her worry was the registrar’s request to provide payment information
before being seen by ED personnel. Perhaps changing the order in which information is collected (healthcare information collected first by ED RNs and MDs followed by collection of payment information) may provide a more appropriate model for patients who want their serious health concerns to be the priority.

The level of professionalism in staff verbal communication was noted by patients. In general, staff communication was perceived by patients as appropriate and as contributing to a feeling of safety during their care. However, patients’ experiences of multiple providers (medical and nursing) asking similar questions contributed to a perception of decreased safety.

Specifically, there was a concern or perception that patient care information was not passed on either verbally or in written format (charting) between multiple providers. A 40-year-old male patient with hypertension had the experience of several physicians and nurses entering the room and asking similar questions. The patient perceived a serious communication problem between the healthcare staff caring for him, leading him to feel aggravation and a sense of being ignored.

Because what’s aggravating also about being in the ER, the minute you come in is you have the first doctor and the nurse that walk in, they get the information from you, and when they get that information from you they take it all in and everything. Well, then guess what? You have another doctor that might walk in and say, “Okay, so what’s wrong with you? What do you have?” And you explain it to him. . . . And you have to explain yourself about five times before they finally all understand, that whole staff, what went wrong with you. . . . And you have to explain it over and over again. It gets pretty annoying, and it gets pretty aggravating, because you’re having to explain to them, and then for them not to listen to you and ignore you, and they want to come back and hear the information again. . . . Write everything that they just finished telling you, because to repeat this over and over and over again becomes very aggravating, and for people that are in pain or are already agitated because of the pain or whatever they’re in for, it’s just useless. It’s aggravating. And it gets more angry, your blood pressure goes up, and guess what, you’re in a worse condition than
when you came in just because of the aggravation and the stress they've put on you.

Information not being shared between providers is a safety issue for this patient because he perceived that specific information pertinent to his care could be missed leading to error.

So I believe it is a safety issue because they need to understand that when you speak to somebody, that person either needs to transfer all that information to everybody that’s going to see you or write it down and put it there for when the person walks up they can read it. And that way everything is understood if you can not speak, if you can not talk, if you’re having an attack, if you’re having some kind of seizure, they understand. They’ve already read it. You don’t have to repeat it over and over again.

Similar questions being repeatedly asked by nurses and doctors was perceived as a safety issue for a 32-year-old female patient with nausea and vomiting symptoms.

In fact, I noticed a lack of communication with that first nurse and the doctor where he asked me questions and then left, and then she repeated some of the questions and asked me questions, and then wrote it down, and then left. So clearly she wasn’t talking to him about it if she had questions that he didn’t have or . . . . It seemed to me like they weren’t on the same page.

Perceived unsafe communication issues arise when patients directly experienced a lack of communication from healthcare staff regarding their care. Patient frustration built when staff failed to update them on the status of their tests, relaying their diagnoses, or facilitating their discharges. One patient continually described this feeling as being “left in the dark.” A particular instance occurred for a 40-year-old male patient with hypertension as a second ED patient experienced a seizure requiring complete attention from this patient’s ED RN.

I feel that they tended to the patient as best as they can, and I understood that it is an emergency. The woman is having a seizure and she does need medical attention immediately, but when you have other patients in an emergency room, to leave them unattended and just run away from them, give them some
acknowledgment of what’s going on. People that are left in the dark are often confused, disoriented, don’t know what’s going on. Then the nurses come back, staff comes back, and act like nothing happened, don’t tell you what’s going on. I feel people are at least acknowledged and told what, you know, “I’ll be right back. There’s a patient having a problem.” I think it calms people down if they understand what’s going on. And I’m sure if it was a family member of their own they would understand, but when they don’t know what’s going on and they leave the room, it’s rather disturbing.

This patient went on to discuss another concern: information needs to be communicated to patients at regular intervals. Regular communication would lead him to feel safer, not being “left in the dark” or “unattended.”

Again, coming in, maybe at least, like I said, every 10 minutes or just even passing by, and telling you we’re waiting to admit you or we’re waiting for the doctor to call us back. Or we know you needed the pain medicine. We’re waiting for our pharmacy to go ahead and bring it to us. Once it gets here, we’ll go ahead and give it to you. Instead of just leaving you alone. At least every 10 minutes, if not 10 minutes maybe even 15 minutes. But when they leave there over an hour and a half with no communication. You’re in the dark, you don’t know what’s going on.

A 32-year-old female patient with nausea and vomiting symptoms expressed concern about the lack of information shared with her regarding her care. After blood had been drawn for laboratory tests, a second test was required that had not been ordered at the time of the initial laboratory blood tests. So after waiting over an hour for the second test results and receiving no information from the staff, the patient finally sought information herself.

Yeah, so we waited for a long time for the test results to come in. Finally after about, you know, an hour I think, I went out in the hall and I found that male nurse. And I asked him, “Are the test results back?” And he’s like, “I’ll go check.” And then there was a lot of waiting, and there was like maybe another hour of waiting, like a long time. . . . We were there most of the day for a bag of fluids. So there was a lot of waiting after. Again, after a long time had passed, in my perception, I went and asked him again like, “Hey.” “Oh, we have the results. We’re just waiting for the doctor to come in.” Or something. There was some
waiting they were doing again. So, you know, the doctor came in and said everything was fine, and gave me some paperwork.

This patient had several concerns regarding the care she received in the ED (some chronicled in other sections of this chapter). These issues, including the lack of follow-through from staff with test results and diagnosis from her ED MD, left her feeling that the staff provided substandard care.

Communication problems specifically related to inadequate responses from both RNs and MDs in the ED contributed to a sense of unsafe care. When patients communicated symptoms, the presence of pain, anxiety, and basic questions to ED personnel, they expected responses that answered their questions, addressed their issues, and all delivered in a reasonable amount of time. There were many examples of appropriate responses reported by patients. However, four patients noted specific concerns with the responses they received from ED personnel.

Patients expressed a desire not only to be listened to but understood. Sometimes patients explained specific symptoms to their RNs and MDs, but the responses they received led them to believe that they weren’t being adequately understood. One patient, a 24-year-old female patient with upper abdominal pain, noted that she felt her symptoms of nausea, vomiting, and stomach pain related more to problems in her upper abdomen. The ED MD focused his medical examination on the patient’s lower abdomen, specifically looking for an ovarian cyst. This patient explained that she perceived the MD did not listen to what she was saying and did not take time to understand what was actually going on.

He was like, “I’m just going to push around and see where it’s hurting you, see if it’s something that’s going on down here.” But I felt like he just gave me a
random answer. He was like, “You might have had an ovarian cyst that burst.” So it wasn’t very conclusive, number one, the answer that he gave me, so that kind of made me feel a little unsafe. And I felt like he was wrong from jump as soon as he told me that answer, I didn’t feel like it had anything to do with what was going on down here; it was more up here. [Interviewer: Upper abdominal?] Yes, upper abdominal.

She was discharged to home feeling that she had not receive an adequate diagnosis and that her care was substandard.

Other patients felt like they did not have an opportunity to relay specific information to the ED staff that would help them provide better care. One patient, a 40-year-old male patient with hypertension who had visited the ED several times over the years for kidney issues, expressed frustration that he could not direct staff in ways that would help them care for him. This lack of interest in responses from him resulted in a loss of confidence in the staff:

First of all, find out from the patient, uh, if you’re able to draw blood from them. “Can I draw blood from you?” . . . . Then find out where the patient would they prefer you to draw the blood from. If you listen to the patient, nine out of ten, the patient might be able to help you a lot more than you poking around six or seven times trying to find their vein. . . . . “My left arm has an artificial vein, but can hit me on my right arm. My right arm has a good vein. They always hit me right below the elbow or they hit me right below the wrist.” . . . . So if you talk with them, calm them down, let them explain to you where you can draw the blood. Where is the best place? And you get your information, everything goes well, they’re confident, you’re confident, and you’re done.

Untreated pain or perceived slow responses to pain medicine requests caused frustration and built perceptions of inadequate, unsafe care provision. A 24-year-old female patient with upper abdominal pain patient complained of upper abdominal bloating, and she was frustrated that the narcotic pain medicine administered to her did not treat her bloated feeling.
Actually the medicine the doctor gave me, it didn’t even affect me at all, not at all. When the doctor finally got to me, and he gave me a pain killer. I was kind of bloated... They just kind of gave it to me. And see, the thing was it wasn’t like a pain like that. I was bloated, so them giving me pain medicine didn’t help. [Laughs] You know? I mean it really didn’t help at all.

Other patients expressed a desire to understand why their pain medicine was not administered in a timelier manner. A theme of the 40-year-old male patient with hypertension was “being left in the dark.” He used this image several times when describing frustration that he was not receiving information about his care, and in this case, why his pain medicine was delayed.

All she said was that they had already finally talked to the doctor and he did prescribe some pain medicine, and that’s what they were going to go ahead and administer to me. Still no word if I was going to be admitted. Still no word on what was going on. Being left in the dark if you’re in an emergency room and you’re a patient is very discomforting, because if you do not know what’s going on it gets you anxious. It gets you pretty emotional, because you want to find out what’s going on with you. You want to know and not be left in the dark.

Even when the pain medicine is administered in a short period of time, patients can still perceive that the time between the request and actually receiving pain medicine is too long.

[Interviewer: How long did it take the nurse to come in?] Umm. It took maybe a couple of minutes before she came in there. [Interviewer: Did you feel like that was a reasonable amount of time?] Well, at that point, no [laughter]. [Interviewer: Because you were in a lot of pain?] Yeah, because I was in pain. But, again, they were very friendly. It’s not that they were rude or anything. And I know they were probably busy. So when you’re at that point, a minute can seem longer. (a 42 year-old male patient with lower abdominal pain)

The perception of ED staff being “busy” by this 42-year-old male patient was noted by other patients as a problem in the ED. The perception that there is inadequate staff for the number of patients in the ED led some to perceive that safe care was not being
administered. One patient felt that her concerns were not responded to because the MD wanted to discharge her quickly.

But I felt like if it had been more serious, my life would have definitely been in more danger, because he didn’t listen to what I was saying, he didn’t take the time to try to understand what was going on really. It was just like “I need to get you in and out of here because I have plenty of people to look at.” And that’s understood, but I think the solution to that is to have more doctors on the floor rather than to skimp around on care.

The 42-year-old male patient with lower abdominal pain who was not convinced that his diagnosis and pending discharge from the ED was well thought-out called his private-care MD and expressed his concerns. The private-care MD spoke with the patient’s ED MD who then changed his diagnosis and had the patient admitted. This change led the patient to wonder if his concerns and high pain level were not responded to in a way he considered appropriate because of the busyness of the ED which he perceived.

So that’s the only concern that I have . . . . Is I don’t think sometimes they don’t take into account exactly what’s going on. And it could be that maybe they are so busy. But I think they just need to take time and look back, and look and see what’s actually happening.

A lack of clear, appropriate communication that does not respond to patients’ concerns and does not convey to the patient an understanding of their symptoms and concerns leads patients to believe their care is inadequate and ultimately unsafe. Patients want communication from staff that assures them (a) that their care is the most important part of their ED visit; (b) that ED personnel understand their chief complaint; (c) that they will receive timely updates during their stay; and (d) that their concerns, symptoms, and preferences will be responded to appropriately.
2. Accuracy issues

Accuracy is the second domain related to this research question about patient perceptions of unsafe care and processes. Accuracy is defined as effective and timely testing, treatment, and medication administration which provides diagnoses that adequately address the underlying illness and symptoms. Two sub-domains regarding these accuracy issues are (a) Diagnostic Precision and (b) Efficiency. What follows are patients’ perceptions of the accuracy of their care that did not meet safe care provision expectations.

Two patients had difficulties with the diagnosis and ED disposition that they received after their initial work-up by the ED MD. The first patient was discharged to home. The second patient called his private-care MD who contacted the ED MD, and he was eventually admitted to the hospital. In both cases, the patients struggled to understand the lack of care they felt they received.

A 24-year-old female patient with upper abdominal pain complained of nausea, vomiting, and a bloated feeling after ingesting some soap that remained in a cup from which she drank a short time earlier. Despite stating these symptoms clearly and relating to the ED MD that she felt they were related to drinking from the soapy cup, the ED MD focused the diagnosis on a gynecological work up. The patient noted her frustration with this direction.

But the doctor, I don’t feel like he diagnosed me at all. And you know, I got this huge bill for going to the emergency room, and I was in pain, and I just felt like a number, like he was trying to get me in and out. . . So I was like if you would just listen to what I’m saying, you might have been able to diagnose me better. Instead he said, “Well, I’m going to order a Pap smear on you.” He ordered a Pap smear and started pushing around at things, and I was really uncomfortable. And I felt like he was in the wrong area, you know, to even be looking at because
it was more gastrointestinal than a problem with my female anatomy. . . He was like, “You might have had an ovarian cyst that burst.” So it wasn’t very conclusive, number one, the answer that he gave me, so that kind of made me feel a little unsafe. And I felt like he was wrong from jump as soon as he told me that answer. I didn’t feel like it had anything to do with what was going on down here; it was more up here.

There are times that symptoms do not match up with the actual healthcare problem.

The ED MD sensed that this patient’s pain was of a gynecological nature. According to this patient, the MD was unable to help the patient understand his rationale for focusing more on an ovarian cyst as a diagnosis. Because the work up and diagnosis did not fit the patient’s perception of what care should be given her symptoms, the patient felt her care was unsafe.

The 42-year-old male patient with lower abdominal pain also felt his diagnosis (and pending discharge) was not correct. This patient had chronic health issues. After experiencing similar symptoms with intense pain a few months earlier, and at that time having visited the ED three separate times before being admitted as an inpatient, he decided that discharge was not safe for him. After calling his private-care MD and convincing the MD to talk to the ED MD, the patient was admitted for pain management and to determine the source of the pain. He was disturbed because originally he was to be discharged from the ED without care he perceived he needed.

Again, I mean, I was upset at that point. Because, like I said, I was in so much pain. I just couldn’t tolerate the pain anymore. I knew there was something wrong. I knew it wasn’t something minor. You know, I can tell on my own body when I’m feeling real ill. So that was the only thing with me. It was like, “Well, why the change of mind now? Why am I being admitted after I had to contact my own doctor?” Which I shouldn’t have had to have done that. So sometimes I just wonder if emergency rooms are just so busy that they just want to see people and then just let them go. And then they come back, and they get ten times worse.
There are similarities between this patient’s perceptions and the 24-year-old female patient with upper abdominal pain. Both patients felt they did not get the work up they needed based on their symptoms. As with the case of the 24-year-old female patient, the MD for the 42-year-old male patient with lower abdominal pain either did not make the case that no further work up was needed or did not help the patient understand why he was going to discharge him given his level of pain. Regardless, the patient was left wondering about the safety of his care.

Efficiency in care is also an issue with patients’ accurate care. Some instances have already been chronicled: (a) the wait of more than two hours beyond what a 32-year-old female patient with nausea and vomiting symptoms expected because a test was not ordered, followed by a delay of getting the results to the ED MD; (b) the 42-year-old patient’s perception that his eventual admission was delayed because his pain was not given the consideration he felt it should have been given, and because he had to contact his private MD, who then had to talk to the ED MD (was the ED too busy for him, he wondered?); and, (c), a 40-year-old male patient with hypertension who noted ED personnel asked similar questions leading to the perception that ED personnel were not coordinating the patient’s care: “And you have to explain yourself about five times before they finally all understand, that whole staff, what went wrong with you.” The 32-year-old female patient mentioned above had a similar issue. “So clearly she [the RN] wasn’t talking to him [the MD] about it if she had questions that he didn’t have or . . . It seemed to me like they weren’t on the same page.” Patients expect that the communication between ED personnel is clear, ongoing, and that the data obtained from staffs are charted and read by other members of the healthcare team. When tests
are delayed, communication breakdowns are perceived, symptoms are not managed, and the patient’s perception of the efficiency of their care is cast in doubt. This contributes to a decreased sense of safe care provision. The next section of this chapter discusses how patients defined safety directly when asked to do so.

3. Protection issues

The third domain that emerged during data analysis revolves around protection issues. These particular concerns center on (a) effective collaboration between staff; (b) personal security that includes activities to prevent bodily harm such as maintaining cleanliness of the furniture and floor in the patient’s room, removal of unsafe items to prevent patient harm, use of appropriate cleaning methods, and use of protective equipment (gloves, call lights); (c) care of their body in terms of comfort measures (blankets if feeling cold, timely administration of pain medicine); and (d) perception of staff proficiency through experience of professional behaviors and skills. There were no examples of concerns with ED personnel providing Anticipatory Caring. What follows is a discussion of each of these four particular concerns.

Collaboration between staff is vital in the care of patients. ED personnel cooperation is discussed frequently when describing how ED personnel work together best in providing care. Patients are aware of this teamwork and when it breaks down. Two patients in particular noted a lack of collaboration between staff and felt that this was a safety issue.

This next patient, a 40-year-old male patient with hypertension who earlier discussed concerns with staff communication, noted that when ED personnel don’t collaborate on a patient’s care, it endangers the patient’s safety.
So I believe it is a safety issue because they need to understand that when you speak to somebody, that person either needs to transfer all that information to everybody that’s going to see you or write it down and put it there for when the person walks up they can read it. And that way everything is understood if you can not speak, if you can not talk, if you’re having an attack, if you’re having some kind of seizure, they understand. They’ve already read it. You don’t have to repeat it over and over again.

For this patient, a perceived lack of collaboration between staff occurs because vital patient information is not communicated between staff. This perceived reality puts him at risk, especially in a medical emergency when the patient can’t communicate what is wrong.

A second patient who noted safety concerns with communication also explained that when staff enter the room and ask questions that a previous staff member has asked, it leads her to believe that they are not coordinating care. During a specific instance in the care of this 32-year-old female patient with nausea and vomiting symptoms, the RN (a female) asked almost the same questions after the MD (a male) had just completed his assessment and left the room. This situation led the patient to perceive that no collaboration was taking place. She noted, “So clearly she wasn’t talking to him about it if she had questions that he didn’t have or . . . . It seemed to me like they weren’t on the same page."

Patients discussed a variety of issues that dealt with their personal security. They had issues about cleanliness of the rooms or furniture, the designs of the ED stretchers, the use of gloves and masks, and the lack of functioning call lights within reach. All of these experiences dealt with their perception of how the environment, equipment, or furniture would prevent patient injury and maintain privacy by protecting patient confidentiality.
Three patients noted cleanliness problems with the ED environment. This mirrored the observations of this researcher of the patient care environment. An important fact to note: more observations of cleanliness relating to safety were coded in the analysis of researcher observations. There were three different cleanliness entries noted in the researcher's field notes:

(a) After the EKG, I reentered the room. I noted there was a 2x2 gauze on the floor with blood on it, but it was not visible to the patient. (b) On the floor in the room of the patient above, I noted some dried blood and a paper clip beside the patient bed. (c) The room’s floor had several pieces of trash (discarded IV supplies, gauze, tongue depressor, thread, and/or dirt)

Observations similar to the ones recorded in the field notes were made by patients in their care rooms and in the triage area. A 24-year-old female patient with upper abdominal pain encountered a chair in triage with blood.

One thing that kind of bothered me was I sat down and there was like blood on one of the chairs, so they need to clean a little bit better. [Laughs] . . . . That was kind of a little disturbing, especially because things are transmitted, you know, through bodily fluids. So that kind of was like “eww.”

A 38-year-old female patient with lower abdominal pain encountered an Opsite or plastic covering that is placed on top of an IV insertion site for infection control. The Opsite had been removed from a previous patient, stuck to a sheet, gone through the laundry, and then remained on the sheet unnoticed as the laundered sheet was placed on this patient's bed.

Uh, it was clean, except for the sheet [Laughs]. The sheet wasn’t clean. It was probably clean as far as had just come out the laundry, but there was a big old hairy IV thing that someone probably stuck on the . . . and then it went through the laundry. So they changed the sheet before I came in there, but somebody had put that on there and I saw it, and I asked if they could change the sheet. . . . I would think that it would have been on a man’s hairy arm or something like that, and it was all hairy. I was like I am not going to sit on that! [laughs]
A 32-year-old female patient with nausea and vomiting symptoms noted “detritus” on the floor after an IV start. This patient not only perceived that the safety of her care was jeopardized because of the lack of disposal of a used IV catheter that was on the floor, but it also led her to wonder what else was on the floor that had not been cleaned.

So she takes her gloves off, and the needle out. I don’t remember seeing where they were put until later when my mom came in, and there was blood and the needle that she was using on the floor. And also, the tourniquet was on the floor, which was particularly disturbing to me because I don’t remember seeing her leave with the needle, but how do I know that was the needle she was using on me, and I was barefoot. So it was just really gross. And then I was thinking, “Oh my God! I’m barefoot, and I’ve been off and on standing up for one reason or another on this floor. And who knows what’s on the floor.” I know you can’t walk on the floor and get something, but it’s just icky. But the idea of stepping on the needle was to really important to me.

Compounding the problem for this same patient was the approach the nurse used when the patient brought it to her attention. The RN did not share the concern of the patient, stating that the “needle” was only a catheter, implying that the physical danger of being penetrated by the plastic catheter was limited.

She said, “Oh, it’s no big deal. That’s not really a needle, it’s plastic.” But it had blood on it, and it was the butterfly, so it had that square tab of plastic, and whatever it was made out of it, it was a sharp object that had blood on it that was on the floor. And there’s kind of a smear of blood on the floor now.

The RN also did not use an antibacterial cleaner to clean up the leftover blood on the floor.

[Interviewer: When she wiped up the floor, was there anything on that paper towel? It was just a dry paper towel? Yes?] In fact, no, she was sitting on a stool of some sort or some sort of chair, I think, and I think she threw it down and did it with her foot. And then picked it up. She was wearing gloves, so maybe that makes it better. I don’t know. Again, patient culture, doctor culture. Maybe it’s better if you do it with your foot, but to me it was just smearing around a mess that already occurred.
Two things stand out for these patients in these encounters: (a) the current concern (blood, an Opsite, a bloody needle on the floor) could endanger their health; and (b) (more importantly) poorly cleaned and maintained rooms do not reassure the patient that there are not unclean portions of the room from previous patients that could harm the current patient. When asked if she thought her safety was compromised in a cluttered and otherwise unclean room, a 38-year-old female patient with lower abdominal pain noted, “Yeah, I think it could have definitely, if it not being clean, you know, what was happening before that or after that, or is this the way it always is, you know?” A 32-year-old female patient with nausea and vomiting symptoms emphasized the same point, that an unclean room left her feeling unsafe because inadequate cleaning may leave room surfaces with dirt and microbes from previous patients.

If this is what we’re seeing, and this is the kind of concern for what we were seeing, for the way things were tossed on the floor, the way things were cleaned, what happened before I was in this room that I’m not seeing that I’m being a part of? People with, you know, flu or something serious and touching the bed, and maybe the bed hadn’t been cleaned. I don’t know how touchy transmission of diseases are, but I know that a hospital is probably one of the better places to contract such things, and I would expect them to be particularly vigilant about cleaning up. My expectations weren’t met.

Having this knowledge reduces their sense of being provided safe care.

Another area of concern that left patients feeling less safe about their care involves protective equipment. Protective equipment includes gloves, masks, bed side rails, call lights, and any other equipment meant to protect, or perceived to protect, the patient. Broken or inappropriately used equipment contributed to a sense of decreased safety.
The nurse call lights were an issue for two patients. In both cases, the call lights were inoperative. In the first instance, the call light was not given to a 27-year-old male patient with a bloody cough.

I couldn't find a nurse call button on my side. I don't know if it was disassembled or wasn't there, I didn't find it is the only thing I could say. I would think something like that would stick out more. But I could have just missed it completely. I mean I've missed things right in front of my face before, but I didn't see it. [Interviewer: It sounds from your description that a staff didn't point to it and say, “Hey, this is your call button.”] No. And I'm used to that, the little red switch or like the string that you pull. But yeah, no one brought that to my attention.

This was witnessed in at least one instance by this researcher. In journal notes taken during patient room observations, the following was noted: “The room was well lit, and the nurse call light was on the wall.” This is of importance because the nurse call light was not on the patient's bed but on the wall, out of the reach of the patient, and thus unavailable for use by the patient.

In this next example, the pain medicine of a 42-year-old male patient with lower abdominal pain was delayed because he was given a call light, but it did not work. The patient's pain level increased, and eventually the patient's brother had to find the nurse to ask for pain medicine. This researcher asked what he was told to do if he experienced pain:

Yes, they told me to press the button. And I kept pressing the button, and it wouldn’t work. [Interviewer: It wouldn't work?] Nm-hmm. So then my brother was there with me, and I told him, “Can you go tell the nurses I’m in a lot of pain?” So then he went to go find someone to tell them. And then the nurse came in there. And she goes “Did you press the button?” And I said, “Yeah, we did. And the button wasn’t working.”

A third patient who was bedridden due to an amputation was left without a call light. When staff ended up in an emergency with another patient and out of earshot, this
particular patient was left feeling anxious and upset. He needed a urinal and was unable to leave his bed.

Inside the emergency room the only thing that you can do is yell out for a nurse. I was not given a call button. I was not pointed to a distress button that I could send a signal or something, nothing. [Interviewer: Did you have to get in touch with staff during that 15-minute period that we’ve talked about?] Yes. [Interviewer: And were you able to get in touch with a staff member?] No. [Interviewer: How did that make you feel?] Anxious, disturbed, a little upset, but at the same time I’m not a very cold hearted person. I understand that there was a woman getting medical help because she was having a seizure on the floor. But I needed attention for something I needed, and who was I to call? Nobody’s around.

All three patients were unable to reach the nurse when they needed to, and in two instances patients had needs that were unfulfilled.

Glove use was another issue that patients touched on. A 32-year-old female patient with nausea and vomiting symptoms noted an inappropriate use of gloves. This patient felt unsafe when she saw nurses entering a room with gloves which she wasn’t sure were “clean.”

They would leave with gloves, they’d come back with supplies, and I didn’t know what they’d touched, and they were still wearing the same gloves. It grosses me out. It just does. I know when I go to the airport, and I had the baby when we were traveling, we were flying here, and there’s like bottles of formula or frozen breast milk that had been thawed. And I see the person in the airport with gloves, and they go to unzip it and grab it to open it, and I think, “No, those gloves aren’t to protect you. They’re to protect both of us, and you’re touching my baby’s formula.” And I made a big scene in the airport about her using those awful purple gloves that had touched everyone’s stuff for who knows how long.

This patient was aware that gloves are used to primarily protect staff, but she was also aware that gloves protect the patient. Her perception that exiting and entering a room without changing gloves is the same as a staff member entering a room and not washing his/her hands.
Another equipment issue occurred with beds and side rails. ED stretchers, because of the need to move them to other treatment areas of the hospital, are smaller, narrower, and have thinner mattresses. Patients, however, find this an issue. The discomfort of a 24-year-old female patient with upper abdominal pain was magnified by having back pain (as a chronic condition) and feeling cold in the ED.

You know, just physically. Like I already have back pains and stuff like that, so I need to sleep on something comfortable whenever I can. So like I was just kind of uncomfortable lying there . . . . And the bed was just really hard and things like that. It was kind of cold too. I never like hospitals, so I made to be sure to bring a blanket this time, so I was a lot more comfortable than previous times that I've been in the hospital, because it's just really cold. I know they probably do that to keep it clean, but it's freezing.

A 59-year-old female patient with a foot injury was concerned that the beds were so narrow that she could accidently roll out and fall to the floor. She also had a chronic back condition and was worried about what a fall would mean to her already frail back.

Everything was all right, except for I don’t like those little thin beds they have you on. I don’t feel safe on those . . . . You can’t turn over, and half the time they don’t put the sides up. If the sides are up, then it’ll be a little better. You’ll feel a little more secure, but with both of the sides down, and it’s so narrow. And I’ve had four back surgeries, so if I fall off, you know, I could be paralyzed. I try to be as still as possible when I’m on them, but I really don’t care for those.

This patient went on to say that say that side rails were her main safety concern. For her, having both side rails raised on a “narrow” ED stretcher would allow her to feel much safer in the ED.

Protection issues for patients also involve timely administration of comfort measures. Specific instances of comfort measures include pain medicine provision that relieves a patient’s specific pain symptoms. Two patients felt that inappropriate
administration or non-administration of pain medicine led them to question the safety of their care.

A 24-year-old female patient with upper abdominal pain was provided a narcotic pain medicine that did not address her specific symptoms. She complained of bloating in her stomach area related to nausea and vomiting. Her ED MD prescribed a narcotic pain reliever which did not address the bloating issues. “They just kind of gave it to me. And see, the thing was it wasn’t like a pain like that. I was bloated, so them giving me pain medicine didn’t help. [laughs] You know? I mean it really didn’t help at all.”

Another patient in the ED was being treated for lower abdominal pain. This 42-year-old male patient with lower abdominal pain went for several hours without pain medicine and without an explanation from the ED staff. His pain was reported as a 10 on a 10-point scale. The patient reported that staff stated they were unable to reach his private MD and consequently were unable to give him pain medicine.

[Interviewer: Did they offer you any pain medicine?] No. [Interviewer: There was no offer of pain medicine at all?] No. [Interviewer: Where was your pain?] I had my pain in my lower rectal area. I had constant pain that it wouldn’t go away. And they asked me, “Well, from the scale of one through ten, what’s your pain level?” And I said, “Ten.” But, at that point, nothing was given to me for the pain. [Interviewer: There was no Tylenol or narcotics or…?] And I guess maybe because they wanted to find exactly what it was first. That’s what I’m assuming. . . . [Interviewer: Did you question anybody in the emergency department to say, “You know, I’m in a lot of pain. I need something. I need some pain medicine”?] Yes, I did. [Interviewer: And what was their response?] I think they said that they hadn’t heard anything back from the doc yet to see what could be administered.

A complicating factor involved with this story is that the patient’s medical record indicates he was given two doses of morphine (4 mg per dose) IV and then Dilaudid 2 mg IV to control his pain. What this patient remembers and the care that was charted as being given to him is very different.
His pain issues and management aside, this particular patient had been admitted to the hospital for a similar issue a few months prior to this current visit. During the present ED visit, he was going to be discharged, but after conferring with his private MD and talking about his concerns with the ED MD, he was admitted to the hospital. His concern about not originally being admitted to the hospital along with a memory of poor pain management left him feeling unsafe.

A second patient also had to wait a long time for a comfort measure, in this instance a urinal, so he could urinate. This bed-bound patient was without a call light, and thus unable to get the attention of ED personnel, who were occupied with an emergency involving another patient. When staff finally did attend to him again, there were further delays:

I felt it could've been quicker, because from what I observed from the moment when I told her what I needed, she went into an area where I could see her through a glass wall, talk to another nurse, talk to a doctor, wrote something down in the chart, then went and got what I needed and brought it to me. So. Umm . . . . And if we want to be specific, what I really needed was a urinal. To be specific, I needed to use the restroom, and there was no way of getting out of bed to go use it, and I asked her for a urinal. So I felt she could've gone and got the urinal, came back, and gone back to do whatever she needed to do. So this is why I say it could've been faster rather than seven to eight minutes.

This patient felt a lack of safety because of several delays in attending to his pain and discomfort. In fact, it may have been that the number of delays caused this patient to have the perception that certain parts of his care were not safe.

Patients look for high levels of staff proficiency when they come to the ED as demonstrated by staff professionalism and skill. Two patients in this study had such high confidence in the professionalism of the staff that they said safety concerns weren't
even a consideration. They stated that they knew ED personnel were committed to the safe care of their patients in the ED.

However, a few patients perceived lapses in professionalism that led them to believe their care was less safe. The following brief stories provide insight into how staff professional behavior, actions, and attitudes can negatively impact a patient’s perception of his/her care.

One patient observed a nurse handling a urine specimen without gloves. Nurses may know that urine can be sterile, although that is not always the case. When this particular nurse carried out a full, capped urine specimen cup from a patient’s room with ungloved hands, a 24-year-old female patient with upper abdominal pain felt that the nurse was not using enough care for her own protection.

But you know, I had to, you know, pee in a cup so that they could test it, and she came in there, she used her like bare hands to you know, test it, so I was kind of like freaking out. But I have heard that urine is sterile, so I mean, but still, it’s gross! [Laughs] . . . I was just like how does she know it’s not on the side of that cup? I don’t want to touch it! If it was me, I would have put some gloves on first. [Laughs]

This patient wondered what else this nurse had handled without gloves, and whether it could it have contributed to the spread of germs. This patient noted that the nurse came into the room without washing her hands (in front of the patient). This left her wondering what the nurse had handled before entry into the patient room and whether her hands were clean.

Another patient, unfortunately, had several problems during her care which, taken as a whole, led her to have a poor perception of staff professionalism. As mentioned in a previous section, the 32-year-old female patient with nausea and
vomiting symptoms pointed out a bloody “needle” on the floor that was accidently dropped and not seen by the nurse. When this was pointed out to the nurse, the patient stated, “She said, ‘Oh, it’s no big deal. That’s not really a needle, it’s plastic.’ But it had blood on it, and it was the butterfly, so it had that square tab of plastic, and whatever it was made out of it, it was a sharp object that had blood on it that was on the floor.” The patient felt that the nurse was not taking her concerns seriously. This made the same patient reflect further:

I think about my job, but I think about how detail oriented I have to be, and how people’s safety is something that we’re constantly discussing. And if we think that anything we’ve done compromises safety, that meant I had to stay late. I mean I’m a stay-home-mom now, but this is relatively new to me. So, you know, in my job crossing all the Ts and dotting all the Is, because you don’t want to be responsible for whatever happens. And I’m thinking, you know, it just frustrates me that other people don’t think that that’s necessary for their job or it doesn’t appear that they think that. It didn’t appear that way. You’re right. I don’t know what’s safe or what’s not, but it didn’t look safe to have bloody gauze on the floor or to throw things down like that. Yeah, just not what I would’ve expected.

It is apparent that this patient felt the nurse was not demonstrating enough detail orientation to provide the patient with confidence that safety was the RN’s concern. This encounter left the patient feeling apprehensive. “Oh. I just didn’t want to feel like I couldn’t touch anything.”

This same patient encountered two further practice issues which contributed to a poor perception of staff professionalism. The first example occurred when the tests were not ordered in a timely fashion (as noted above in the communication section). After the initial test results were back, a second set of tests were ordered which staff stated to her should have been ordered with the first set. After waiting an hour, the
patient asked about the results of the second test. The RN stated he would check. After an additional hour passed, the patient had to ask about the results again. She noted,

So there was a lot of waiting after. Again, after a long time had passed, in my perception, I went and asked him again like, ‘Hey.’ ‘Oh, we have the results. We’re just waiting for the doctor to come in.’ Or something. There was some waiting they were doing again.

The combination of waiting on test results that were not ordered initially, a lack of follow-up from staff, and the long wait contributed to the patient’s diminishing confidence in her care.

Patients indicated that a lack of perceived ED personnel professionalism could be caused by ED processes. During this researcher’s observations of the patient care environment, communication was made out loud from staff to staff without a verbal acknowledgment. During one observation period, the following was witnessed:

ZJ MD states out loud to the staff “Here are some medicines on 9.” He places the chart in the unit secretary chart rack so that test orders and medicines can be taken off. His pronouncement was meant to call attention to his medication orders for the patient.

What is unique about this interaction is that no RN acknowledged this verbal communication. The ED has since changed the process for making the RN aware of pending orders. However, not having a verbal response from an RN acknowledging the presence of these orders and implying a follow-up could be one cause for this patient’s missed test. A poor process could contribute to this patient’s perception of poor professional behavior and decreased safety perception.

The last problem regarding professionalism which this patient encountered was at her discharge after she was given verbal and written instructions. After staff had left
the room and the patient was leaving her room, she realized she still had an IV in her hand.

[Interviewer: What about the IV?] Exactly, that’s where we’re going. So it’s still in my hand. So then I went up and went to the desk again and said, “Hey, can someone come take the IV out of my hand, so we can go?” That was— Who ended up doing it? I think the woman nurse came back at that point.

This patient is unique in some ways. She had a child who was born premature with whom she spent several months in the hospital. Her knowledge of care, although not measured, was fairly high. Her mother, accompanying her, is a CEO of a healthcare system, and helped point out issues that were of concern to the patient. Lastly, this patient experienced a high number of issues during her stay. Her perspective is significant because it reveals concerns that staff do not perceive.

The last example of patient’s perception of poor professionalism comes from a patient who noted what he described as “horseplay” between security guards and housekeeping staff. Most of the patient discussion regarding staff professionalism centered on RNs, MDs, techs, and others providing direct patient care. As this patient pointed out, patients note the behavior of other employees as well.

On that point, there’s too much horse playing, which is a big safety issue. Too much horse playing and… [Interviewer: Between staff or patients?] Between staff . . . . This hospital has security guards. Security guards were roaming around in the emergency room. You have housekeeping that is down there either clearing the floors, cleaning the restrooms, or whatever, but you have the security guards that are talking with them, laughing with them, joking with them, pushing the cart and hiding it from the housekeeper. . . . So also, horse playing around with the wet floor signs or pushing the carts out of the way and stuff like that. You have too many people running down there, when you actually need the nurses and doctors to be doing that.

This patient further explained his concerns that some of the carts which were being moved by the security guards may in fact have been medicine carts. He believed
that nurses who knew where the carts were at the time may not have been able to locate them because they had been moved, and this could cause significant problems during a patient emergency. “Now she has to walk maybe four more feet way, because she couldn’t see it where she was. I just feel there’s a lot of that going on in the ER when there shouldn’t be.” Regardless of whether the carts being moved carried medicine or cleaning supplies, this patient described this behavior as undermining his sense of staff competence and ultimately weakening his sense of safe care provision.

D. Research Question Three

1. Patient safety definition

Patients discussed various aspects of their care and this researcher followed up their perceptions and experiences with questions designed to further deepen the understanding of the patients’ perceptions of their care. For litigation reasons, as was suggested by faculty at the University of Texas Health Science Center at San Antonio as well as a researcher at another university who had undertaken a mixed-methods study on patient safety, care was taken not to directly focus patients on unsafe aspects of their care (L. Powel, personal communication, February 13, 2008; T. Burroughs, personal communication, July 14, 2008).

However, once interviews were underway and it was clear patients wanted to talk about issues of safety important to them, they were asked directly how they characterized or defined patient safety. The last eight of the 14 patients interviewed were asked this question. Their responses fell into five categories: personal safety, equipment issues, comfort issues, hygiene, and their patient care room.
Most of the responses from these patients had to do with conditions preventing them from experiencing bodily harm: securing equipment in their rooms, use of protective equipment (gloves, side rails), and hand washing. Only one person, who worked as a clerk in an inpatient setting, defined patient safety in terms of medication errors. When asked to define patient safety, this 35-year-old female patient who had chest pain stated, “Um, I can’t think of what that deal is called. I see it at the hospital all the time, ‘make sure it’s right patient, right site, right . . . .’” All other patients’ safety definitions were related to protection from bodily injury.

a. The patient care room. Several patients noted specifically that patient safety was related to conditions in their patient care room. Specific issues included in-room patient diagnostic and treatment equipment. A 42-year-old male patient with lower abdominal pain defined patient safety as an environment free from harmful obstacles and personnel to watch over him.

Well, just to make sure that things are safe for that individual. Nothing around there that they could harm themselves or do something to themselves. Making sure that it’s safe. Knowing that they’re there and that they’re under their care that nothing can happen to them while they’re there.

When asked what his definition of patient safety included, one 33-year-old male patient with joint pain specifically discussed use of bed brakes and making sure equipment is properly placed to prevent injury.

That of course the bed that you’re laying in had its brakes on. Because maybe you’re trying to scoot on there to get on it and it’s going to roll back, you can actually hurt yourself or anybody else. So that’s one thing, the kind of safety I always want to try to move the bed, okay, then lay on it. And cords, or if they have a machine to take your vitals, I kind of look at all that, that I don’t want to disconnect anything, that I don’t want to bump it or push it out of the way. And the sheets, I want them clean. You know, you kind of look at everything. To me, those are the things that I look for, my surroundings.
Other patients also defined safety not in terms of bumping into equipment but in terms of having necessary items within reach so they would not injure themselves when reaching for them. The 50-year-old male patient with back pain noted,

They make sure that I’m comfortable enough to where I’m not going to be reaching for something else, you know, that I’m very, very comfortable and I have everything that I need within where I can reach it and get hold of it. [Interviewer: Right. Not make some awkward reach across the room and have some kind of accident.] Right, right. Exactly right.

Expounding on the patient safety issues related to the patient care room, the patient with chronic back pain, a 59-year-old female patient with a foot injury, discussed the necessity of having an in-room toilet. This patient had a swollen foot (from an injury for which she was being treated) that was too big for a shoe, and she was concerned about walking unshod down the hall to the patient restroom.

I think they need to put the restrooms closer to the cubicles that you’re in, so you don’t have to go out and go down the hallway. Plus, half the time you’re barefooted or you have to try to get your shoes on, and if your foot is swollen, you can’t get your shoe on, and if you could just go right next door or down maybe two cubicles and go into the restroom that would, you know, help with patient care.

A clean patient care room was an aspect of safety for a 33-year-old male patient quoted above. Not only desiring “clean sheets,” he went on to say, “But you know, I’m laying there looking at everything. I look at the sink to see if it’s clean. . . . My wife would tell you I’m kind of like a clean freak, I look at everything. But as far as the safety, that’s what I look at.”

A final aspect of the patients’ safety definition regarding their patient care room was having private rooms for the sake of confidentiality. A 42-year-old male patient with abdominal pain and a new (January, 2009) diagnosis of HIV was concerned about the
confidentiality and hearing about others’ care in a semi-private room. During the ED stay for which he was interviewed, he had a private room and stated that it made a difference in his feelings of confidentiality and, therefore, safety.

But this past time, I was in a private room, which I was pleased to be more in a private room, because I didn’t want anybody to know exactly what I had and what was going on or what I was experiencing. I guess, to me, that was the only difference.

However, he had noted that during a previous stay when he was in a semi-private, inpatient hospital room, his experience left him feeling less safe.

And again, to me, it’s just for the safety and for the confidentiality of that individual. I mean, because when I was there in January and I was in a double room, the person next to me was going through cancer and was throwing up every night and was very, very ill. I was sick, but it was making me even worse by hearing them throwing up and going through what they were going through.

Somewhat related to safety issues in the patient care room is patient bed side rail use. Two patients discussed their desire to have stretcher side rails used appropriately to prevent them from injuring themselves. A 50-year-old male patient who came in with back pain and cardiac ischemia had injured his back a few days before and was very concerned with the use of bed side rails. While describing his definition of patient safety, he noted: “That’s just like when I was coming in and they put me within a bed, I also noticed that they made sure that the rails are up on my bed, that I’m not going to be able to roll off and hit the floor.” Another patient, a 59-year-old female patient with a foot injury and chronic back pain, when asked for aspects of patient care stated, “Putting the sides up on the rails up on their beds is one of them.” She had specifically spoken to a concern of falling off her bed and further injuring her back. Side rails would prevent this from occurring.
b. **Hand washing and glove use.** One last dimension of the patients’ safety definition was hand washing and wearing of personal protective equipment like gloves, masks, booties, and lab coats by ED personnel. A 58-year-old male patient with ankle pain discussed these issues in his patient safety definition.

And a lot of times they’ll wash their hands or they wear their gloves. And I saw a lot of changing of gloves up here. And the doctor had his gloves on, and then when he’d step out and come back in, he’d put some other gloves on. [Interviewer: Fresh, clean gloves?] Yes. And I figured well that’s to keep the guy from bringing in any kind of external infection, because they are inside the room and he’s not getting them from another room. So I figured that’s kind of a protection.

A 40-year-old patient who required dialysis and was suffering from hypertension described similar aspects during his patient safety definition discussion.

I think that’s pretty much covered well with this hospital, the safety gloves that they use, the masks that they use to cover themselves, any type of germs that they might be spreading to a patient, I think their safety issues are pretty much covered because they use the latex gloves, they use the masks, they use the booties, they use the lab coats that they need to. I think they pretty much have that covered very well. Sanitary wise, every time they walk into the room, they spray sanitizer when they touch the patient. I think that’s a big safety issue, because you’re not spreading germs to the patient from where you just may have come from another one.

Both patients recognized that, from their perception, glove use and hand hygiene were important to prevent spread of infection from other patients to themselves. While glove use is primarily used for the protection of healthcare personnel, patients recognize this as another layer of protection for them.

2. **Patient views on safety**

Clean rooms, equipment out of harm’s way, patient care items located within reach of the patient, the presence of certain amenities like toilets and private rooms, and side rail use were aspects of safety in the patient care room. Further aspects of
patient safety involved hand washing and use of personal protective equipment like gloves. These aspects were mentioned specifically by patients when they were asked directly to define patient safety. The information provided by these definitions has provided a unique glimpse into a patient’s definition of safety. This information can support data culled from the patients’ perceptions of safety as described during the discussion of their ED visit. The next section of this chapter will combine information from this section with the patients’ perceptions of safe and unsafe care (the previous two sections of this chapter) to explore the most important safe actions and their characteristics in the ED.

E. Research Question Four

What are the most important safe actions and their characteristics in the ED?

In the previous three sections, patients’ perceptions of safe and unsafe care were described, and patients’ definitions of safety have been examined. The purpose of this section is to discuss the most important aspects of these three previous sections. Aspects of care were considered most important if they were mentioned in the patient safety definition and discussed in patient perceptions of safety/lack of safety or if there were two or more direct references about this aspect discussed in the patient perceptions of safety and/or lack of safety.

1. Safe actions and their characteristics

   a. Condition of patient care room. Patients spent most of their time in the patient care room of the ED. So it is not a surprise that many comments about safety were related to their room. When asked to define patient safety, patients discussed the arrangement of their patient care room in a way that would prevent bodily
injury. This included stowage of equipment to prevent it from becoming a tripping hazard, locked bed wheels and raised bed side rails up to prevent falls, items within reach to prevent falls, and room cleanliness that indicated the room had been cleaned after previous patients.

When discussing their safe/unsafe care perceptions, similar themes about their patient care room emerged. In several instances, patients noted that their rooms were clean, organized, and arranged. Field notes revealed examples of ED personnel cleaning up messes and bodily fluids according to protocol. In addition, patients felt less confidence about safety in their care when they found “detritus,” blood on a chair, and a used IV “Opsite” stuck to a sheet. Clean rooms led patients to feel they had been given safe care; patients felt less safe when their environment was not clean. Regarding in-room equipment, patients desired their bed rails raised and nurse call lights to be working and within reach to feel safe. When their call light was out of reach or when it was unusable, patients felt less safe about their care.

b. Glove use. The use of protective gloves and hand washing was mentioned both in patients’ definitions of safety and as they described their perceptions of safe care. In defining patient safety, patients noted that glove use and hand washing were key aspects of their definition of patient safety. Patients noted when staff used hand gel and/or wore gloves when they were caring for the patients. Likewise, when describing their care perceptions, patients expected glove use as a way to ensure their safety. They also perceived a lack of safety when staff did not use gloves (when carrying a full specimen cup) or when gloves were not changed as a staff member came into the patient care room while wearing gloves from a previous procedure. Use of clean
gloves and cleaning hands with alcohol gel or soap and water provides the patient with a sense of proper hand hygiene etiquette.

c. **Comfort needs.** When discussing important aspects of their care, having comfort needs met was mentioned frequently. Patient safety definitions only discussed comfort measures in terms of maintaining privacy or having items within reach. However, when describing their care, several comfort-related issues were discussed. Patients especially felt a high level of care and safety when they were supplied with warm blankets. Water and medicines to control noxious symptoms like nausea and pain were comfort measures mentioned frequently by patients that helped them feel that they were receiving excellent care. When patients did not receive expected comfort measures, it diminished their sense of safe care. A 42-year-old male patient with lower abdominal pain did not receive pain medicine (that he remembered, as ED RNs charted the administration of pain medicine in his medical record), and described his uncontrolled pain as an unsafe aspect of his care. A 24-year-old female patient with upper abdominal pain received pain medicine that did not address the bloating that she was feeling. This experience diminished her sense that her symptoms were understood and that she received an accurate diagnosis. Other patients described relief when their pain was controlled and nausea reduced by intravenous medicines. Comfort measures certainly played a role in perceptions of safe patient care.

d. **Communication.** Communication plays an important role on a number of levels with patients. While patients did not discuss communication in their patient safety definition, when describing their perceptions of safety/lack of safety, many
patients discussed several types of communication that played a fundamental role in feeling safe during their ED visits.

Good communication increased the quality of interaction with the ED MD for many patients. A 38-year-old female patient with lower abdominal pain described how important it was that the ED MD listened to her. An 82-year-old female patient who complained of knee pain felt the MD went to great lengths to talk to her and understand her symptoms. Both a 33-year-old male patient with joint pain and a 40-year-old male patient with hypertension noted how the ED MD spoke in layman’s terms, helping both of them better understand their care. Given the central role that the ED MD has in caring for patients who come to the ED, physician communication is an important aspect of perceiving safe patient care.

Other essential safe communication components included receiving explanations about why treatments would be carried out, how medications would affect and help the patient, and how treatment results related to patient symptoms. Patients’ sense of safety increased with good communication when they felt they had sufficient information to make decisions, and decreased when problematic communication prevented them from receiving enough information to understand their care and make decisions about it.

When communication was not clear, patients noticed. Problematic communication included no explanation about delays in care, a lack of regular communication of care, not being understood, a sense that ED personnel did not respond to communication from the patient regarding their preferences or concerns. Three patients noted that they were asked similar questions by multiple MDs and RNs. They would respond, and then another provider would come in and ask the same
questions. As a result, patients felt aggravated and ignored, wondering if their care and resource needs would be appropriately responded to or if their information was being recorded in their medical record. These instances of unclear or poor communications left patients questioning the safety of their care.

e. **Accurate diagnoses.** Finally, patients realized when their diagnoses did or did not address the symptoms and concerns they possessed. In most cases, despite some delays in care, patients were satisfied that their diagnoses addressed the problems that drove them to seek emergency care. One 33-year-old male patient with joint pain was particularly pleased that his diagnoses distinguished between two types of gout, and that newly prescribed medication could control his pseudo gout. A 50-year-old male patient who came to the ED with severe back pain was pleased that the cardiac ischemia he was concurrently experiencing was diagnosed and that both his back and cardiac issues were addressed. Patients also felt frustration when their symptoms were not addressed. A 24-year-old female with upper abdominal pain felt her symptoms were ignored as the ED MD ran tests and focused his exam on the lower abdomen. The patient was discharged from the ED feeling that she had received testing that did not pertain to her symptoms and, therefore, did not trust the diagnostic tests would be accurate.

2. **Summary of patients’ safety perceptions**

The data generated in this study are vital for understanding patients’ safety perceptions. Information in this section included the more salient aspects of this study discussed during patients’ perceptions of safety/lack of safety and/or also mentioned in the definition of patient safety. Safety of the patient’s ED care room, glove use and hand
hygiene, comfort needs, communication issues, and diagnostic accuracy were all
discussed in depth by patients as they described their care or defined safety.

The next section of this paper describes member-checking that was carried out.
Member-checking provided participants an opportunity to provide feedback when data
from the study were shared with them.

F. Member-Checking

After the interviews were completed and the data analyzed, participants were
contacted and provided with the results of the study. Examples of safe and unsafe care
used in examples of the emerging model of competent caring were shared with the
participants. Participants were asked for reactions, feedback, or other input. This
provided patients an opportunity to add details, make corrections if they disagreed with
the results, and/or provide additional comments.

Nine of the 14 patients were contacted. One phone number was no longer in
service, and three patients did not respond to two phone calls made on two separate
days.

Five patients agreed to participate in the member-checking process. Four
patients provided feedback over the phone and a fifth patient provided input from his
hospital room, all affirming input of the study.

Overall, patients had no major disagreements with the emerging model or with
the outcomes of the study. Three of the participants, the 38-year-old female patient with
lower abdominal pain, the 50-year-old male with back pain, and the 42-year-old male
with lower abdominal pain all stated agreement with each section and did not offer any
additional feedback. Examples of their comments included, “I agree with all three
areas,“ (42-year-old); “That all sounds good to me, I have nothing further to add,” (38-year-old); and “I agree with the other patients” (50-year-old).

The 42-year-old male with lower abdominal pain did add startling additional information. This patient was originally discharged to home by the ED MD. The patient, whose pain was not in control, did not feel he could go home in such pain. He called his primary care doctor who called the ED MD treating the patient, and the two agreed to admit the patient. The patient stated that the source of his pain was cancerous growths found during his hospital admission. He stated that the growths were caught early, but had he not pushed to be admitted and gone home with the pain he was experiencing, treatment for the cancer would have been delayed. He wondered why he had to advocate for himself and push to get admitted.

The 50-year-old patient with back pain restated how good he thought his care was from the ED MD. When asked if the multitasking that he described during his original interview dealt more with a perception of safety or with increased confidence in his care, he stated that he felt both safer and more confident in the care. His impressions were built on watching the ED MD satisfactorily manage his care while simultaneously managing others’ care.

The 33-year-old with joint pain, who was diagnosed with pseudo gout and who had his medicines changed as a result, expressed a lot of satisfaction at his visit. Prior to his ED visit, his gout had been treated solely with colchicine. After his ED visit, Allopurinol was added. Allopurinol prevents gout from occurring. The patient stated this new drug did a great job “attacking” the gout and getting to the heart of the matter: preventing the gout from occurring. He went on to say that ED personnel took good care
of him, from the cup of water brought for his dry mouth to the clean room he had. He stated that when the nurse dropped a piece of the IV set up on the floor, she threw it away and retrieved a replacement. He reiterated how this kind of practice behavior made him feel safe.

Finally, feedback from the 40-year-old male patient with hypertension was received during an interview in his hospital room where he was being treated for chronic conditions. He agreed with the study data and restated some of the points important to him: updating the patients frequently and regularly on the progress of their care; use of non-technical, laymen’s terms; and taking time with patients to understand their illness. He did underscore the importance of the ED MD spending time with the patient to understand symptoms so as to make an accurate diagnosis. He also noted that his experience of protective caring in terms of cleanliness of the rooms and the presence of security officers was very impressive, leaving him feeling very safe about his time in the ED. He also felt collaboration among staff was very good.

Member-checking provided an important opportunity for the study participants to assess the data of the study. No new data surfaced during these member checks. Patients had no corrections for the data, lending strength to the trustworthiness of the study (Brantlinger, Jimenz, Klingner, Pugach, & Richardson, 2005). This was a valuable exercise that helped the researcher verify the study results.

To further affirm the validity of the study, another source of input is needed. Media reports of patient safety issues are a valuable source of patient safety stories. As a method to help verify the data found in this study, this next section will examine patient safety issues found in the media as described by patients and family members.
If similar domains are found in these stories, trustworthiness of the current research would be strengthened.

G. Patient Safety Media Stories

The number of stories found in the media on the topic of patient safety problems has, within the last 11 years, exploded. The number of newspaper stories alone reporting patient safety problems has increased exponentially since 1999. This is the same year that the groundbreaking work by the Institute of Medicine, *To Err is Human*, was published which chronicled the substantial harm patients were undergoing in the U.S. hospital system (Kohn et al., 2000). A search of newspaper sources in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) from 1900 to 1999 using the search terms medical errors, healthcare errors, doctor errors, and nurse errors found 64 entries. Using the same search criteria in CINAHL but changing the date range to 2000 to 2010 brought up 1156 entries.

Many of these entries chronicle how patient safety has changed and what methods healthcare systems are implementing to stop the occurrence of preventable healthcare errors. Other entries chronicle stories that relate the experiences patients or patients’ families had during and after a preventable healthcare error.

This section on patient media stories is vital to this study. Demonstrating links between data that comprise domains found in this study and data found in similar stories in a second source (outside media) strengthens the trustworthiness of the findings in the current study (Lincoln & Guba, 1985). As is demonstrated in Table 8, the case studies found in the media stories fit into all of the domains and most sub-domains of the emerging Competent Caring framework. It is no surprise that, given the
Table 8

Positive and Negative Media Case Examples by Domain

<table>
<thead>
<tr>
<th>MEDIA CASE EXAMPLES BY DOMAIN</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEGATIVE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicative Caring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing Sufficient Information</td>
<td>2</td>
<td>13%</td>
</tr>
<tr>
<td>Responsive Listening</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Empathy</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Accurate Caring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Precision</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Protective Caring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proficient Caring</td>
<td>7</td>
<td>39%</td>
</tr>
<tr>
<td>Anticipatory Caring</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Assuring Security</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td><strong>POSITIVE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protective Caring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assuring Security</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total Negative Case Examples</strong></td>
<td>16</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Total Positive Case Examples</strong></td>
<td>2</td>
<td>11%</td>
</tr>
</tbody>
</table>
sensational nature of patient safety errors, almost 90% of the case studies reported by the media detail instances of errors. What follows are stories about patients’ perceptions of safety as well as the reporting of patient outcomes of preventable healthcare errors as they relate to the domains found in this study.

1. **Communicative Caring**

A story airing on *60 Minutes*, a television news program of the Columbia Broadcasting System (CBS) network, in March 2008 chronicled the near overdose of the twins of actor Dennis Quaid and his wife, Kimberly (Fager, 2008). The Quaids’ twins, daughter Zoe and son Thomas, were admitted to Cedars-Sinai Hospital in Los Angeles shortly after their birth because of an infection. During their care, they were inadvertently given the wrong dose of heparin by the RNs during routine maintenance of their IV lines. The overdose, which was 1,000-times stronger than the dose they were ordered to receive, caused uncontrolled bleeding and nearly killed both twins. Both twins recovered and were discharged without any noted residual problems.

One of the problems the Quaids noted was poor communication from the staff. The Quaids called the hospital to check on their twins around 9:00 pm; about the time RNs began to discover the problem with the twins. The Quaids were told their twins were fine. It was not until the next morning, when the Quaids went to visit their twins, that they were told of the life-threatening situation that was unfolding. According to the *60 Minutes* story,

But the hospital never called the Quaids and they didn’t find out that anything was wrong until the next day when they showed up at the hospital early the next morning and went to the twins’ room. “We were met at the door by our pediatrician, the nurse - head nurse that was on duty,” Dennis Quaid recalls.
“Risk management,” his wife adds. “Risk management, which is basically the liability division of a hospital, which is lawyers,” he explains.

Poor communication was the lesser of the Quaids concerns; however, did it contribute to their perception of safe care provision? Had the hospital contacted the Quaids about the worsening health of their twin children, even if it were in the middle of the night, would this have lessened or increased their perception of unsafe care? While the hospital wanted those with the latest information (the pediatrician and the head nurse) in the unit to inform the Quaids of their twins’ condition, the presence of risk management, “the liability division of the hospital which is lawyers,” as Mr. Quaid pointed out, apparently raised Mr. Quaid’s suspicion of a coverup, leading him to believe, as the following quote points out, that staff attempts to cover for each other pointed to unsafe care provision.

Quaid calls it a conspiracy of silence, where doctors protect nurses, nurses protect hospitals, and insurance companies protect drug manufacturers. Almost no one, he says, is aggressively trying to find ways to eliminate medical mistakes. So the Quaids are in the final stages of launching a foundation they hope will help remedy a situation that almost destroyed their lives.

A 2009 Sunday Times (London, United Kingdom) story chronicles the struggle of a daughter who copes with the death of her mother after several errors were committed (Jackson, 2009). After entering the hospital in 2001 for a fractured femur, Catherine Jackson’s condition deteriorated and she eventually died. Her daughter, Alison, who narrated the story, discussed several errors that occurred during her mother’s care. Information vital to the care of her mother’s leg was not communicated between the hospital where her mother was initially seen and the admitting hospital where her mother had surgery. Secondly, a drug, Baclofen, used to control muscle spasms was
not continued. When the patient’s daughter discussed this with the nurses, they refused to bring this to the attention of the doctor. As Alison Jackson notes, “The drug, which she had been taking for 12 years, had been forgotten, but when I pointed this out to the nurses, they would not give it to her because it had not been noted by the doctor who admitted her” (Jackson, 2009). In this instance, the nurses did not use responsive listening, a sub-domain noted in this study. Dropped communication contributed to the patient’s daughter’s perception of missed opportunities to protect her mother’s safety.

A final story of patient safety problems caused by poor communication occurred in Sydney, Australia. The *Sunday Telegraph* (Sydney) reported a story of Jehan Nassif, an 18-year-old female who was brought to the emergency department via ambulance with flu-like symptoms (Markson, 2008). Several problems occurred during her care, but the paramedics (ambulance officers) relayed confusing information to staff which caused part of the misdiagnosis. Miscommunication from paramedics was blamed, in part, for the patient not receiving antibiotics in a timely fashion (Markson, 2008). This caused her death. The father of the patient noted, “All people in Australia deserve better from the government, from the health department, better from ambulance officers” (Markson, 2008). Miscommunication of information was partly to blame for this grave healthcare error.

### 2. Accurate Caring

In this study, accurate caring had two sub-domains of Efficiency (care provided that was quick and effective) and Diagnostic Precision (diagnoses which adequately addressed the underlying problem behind patient symptoms and provided accurate
treatments and medication administration). Examples of Accurate Caring found in the media dealt primarily with inaccurate diagnoses.

In an example described above, the Sunday Telegraph reported the story of Jehan Nassif, an 18-year-old female patient with a rash and meningococcal symptoms. Miscommunication from paramedics was partly to blame for her death (Markson, 2008). However, the article further reported that medical and nursing personnel missed important aspects of her history, including a recent exposure to a friend recovering from meningococcal disease. She was misdiagnosed, not given antibiotics, and when medical personnel realized she was suffering from bacterial meningitis, she was beyond the point where antibiotics could adequately fight the infection to which she eventually succumbed (Markson, 2008).

A New York Times article reported that misdiagnoses happen more often than is safe. This article reports on a study demonstrating that appendicitis, meningitis, and broken arms are the most commonly misdiagnosed conditions in pediatric patients (Tarkan, 2008). Another New York Times article raised the issue of whether patients have a role to play in missed diagnoses. Physician Pauline Chen chronicled the story of a patient who unsuccessfully tried homeopathic remedies after a physician had cautioned her about a probable breast cancer diagnosis. The patient stated, “I thought I could take care of it, but I guess not” (Chen, 2009). Dr. Chen asked a vital question: Were both physician and patient to blame? The patient ignored the advice of her physician to get a mammogram after finding a pebble-sized lump in her breast. However, she didn’t return to her physician because every time she mentioned homeopathic or herbal remedies to the physician, the physician “shut down” (Chen,
Responsibility for this missed diagnosis belongs both to the patient who never returned to her physician after attempting homeopathic remedies and to the physician whose attitude toward the patient’s initial preferences led the patient not to return for follow-up (Chen, 2009).

### 3. Protective Caring

Several media accounts convey instances of a lack of protective caring. In this study, a lack of protective caring is perceived by patients when their security is put at risk, when personnel do not anticipate allergies or medication reactions, when they do not provide adequate comfort measures, and when care is not perceived as proficient. Poor protective caring in particular seems to be the cause of unsafe patient care.

Proficient caring, defined in this study as skills and behaviors which increased confidence in the professional abilities of the ED personnel, was lacking in several stories found in the media.

The story about the heparin overdose given to the twins of Dennis and Kimberly Quaid described elements of poor staff proficiency. Nurses inadvertently gave the twins the wrong dosage of medication because there were very similar labels placed on the drug with a 1:1,000 dosage (the dosage for procedure used for the twins) and the drug with the 1:10,000 dose (the wrong, stronger dosage given to the twins inadvertently). The similar color and layout of the label of two very different dosages of heparin led many, including Mr. Quaid, to believe that the nurses relied on the layout rather than the dosage on the label. “But this mistake occurred right under our noses, that the nurse didn’t bother to look at the dosage on the bottle” (Fager, 2008). A similar instance occurred in Indianapolis where nurses misread the label, relying perhaps on layout and...
color rather than the actual words, administering the wrong (higher) dose of heparin to two infants who subsequently died (Higgins, 2008). In both instances, nurses did not provide proficient care to these patients.

Proficient care lapses occur when a lack of skill causes pain, suffering, and even death. A 2008 *New York Times* article on the consequences of medical mistakes in pediatric patients gave an account of a 6-year-old surgical patient, who experienced undue pain and suffering because of a misplaced IV (Tarkan, 2008). After coming from the surgical suite, his mother recalls, “He was crying hysterically, vomiting, and kept saying, ‘I wish I was dead” (Tarkan, 2008). When his nurse became upset with the mother for failing to calm her child, the mother asked another nurse to check him. This nurse found his IV was not “inserted correctly” and upon successful insertion, the patient felt relief in a matter of seconds (Tarkan, 2008).

In another instance reported in the Adelaide, Australia *Observer*, a patient was intubated incorrectly during a cardiac arrest, suffered hypoxia, and developed brain damage that led to his death. The physician inadvertently inserted an artificial airway into his esophagus (leading to his stomach) rather than into the patient’s trachea (leading to his lungs) which prevented oxygen from reaching the patient’s lungs and bloodstream (Schriever, 2010).

A nurse in London (United Kingdom) overdosed a premature infant on glucose causing the patient’s death. The *Evening Standard* (London, United Kingdom) reported that a machine that was supposed to be used during glucose administration was given to another patient, and the nurse incorrectly set up the tubing that was manually providing glucose to the neonatal patient. The nurse also had three weeks of
experience in this particular unit, which made the patient’s father wonder, “I don’t know why a nurse with just three weeks experience was looking after [my daughter].” (Davis, 2009).

In the Republic of Fiji, the Fiji Times reported that a four-day-old infant died after the nurse did not follow a policy prohibiting injections during feeding. The nurse injected the infant with prescribed medications three times while the child was breastfeeding, leading to an instance of choking that led to his death (“Report shows nurse at fault,” 2008).

In the Sunday Times story above narrated by Alison Jackson, other errors were recounted regarding proficient caring that led to her mother’s death. These errors included her mother contracting Methicillin Resistant Staphylococcus Aureus (MRSA), a bacteria that is resistant to many antibiotics, as well as an omitted feeding tube causing her mother to be malnourished and dehydrated (Jackson, 2009).

Lapses in Anticipatory Caring also demonstrate a lack of protective caring. The Philadelphia Daily News (Philadelphia, Pennsylvania) reported the story of Dolly Garber, a comedian who was given an injection of heparin during a hospitalization. Mrs. Garber cannot have heparin because she has a congenital birth defect in her hand called cavernous hemangioma (Bykofsky, 2008). Despite having noted in her chart that she could not have heparin and posting a note above her bed with the same information, she was injected twice in her sleep when she was unable to refuse medication. This led to a deterioration of the condition in her hand and subsequent amputation of the hand (Bykofsky, 2008). Had the nurses anticipated allergies or medication reactions to heparin, Mrs. Garber would still have her hand. As Mrs. Garber states, “I had a horrible
hand for 60 years, but it worked. It was ugly and it hurt, but it worked. And now I've got
nothing” (Bykofsky, 2008).

Protective caring also involves assuring security, which is defined in this study as
maintaining the patient care environment and using patient and personnel protective
equipment (such as sharps boxes, restraints, side rails, specimen labels, patient
identification and patient allergy wrist bands, and alarm equipment) to prevent patient
injury, compromise of confidentiality, and to assure cleanliness. Examples abound in
media stories about the lack of assuring security. Incorrectly identifying patient
specimens which subsequently lead to test results being erroneously assigned to the
wrong patient, and then completing procedures based on the misidentified data is a big
issue, especially in surgery.

The Modesto Bee (Modesto, California) reported a story about a physician who
completed a cardiac bypass procedure on the patient using the angiogram video of
another patient. While the physician immediately disclosed the error and felt the
erroneous procedure should repair the patient’s cardiac damage, the patient continued
to have symptoms and required an additional cardiac procedure six months later
(Carlson, 2009). The patient remains in poor health despite the second procedure and
notes, “It is something that should have never happened. It could have been and should
have been prevented. I hope that this never happens to anybody else” (Carlson, 2009).

Another patient identification mix-up was reported by Newsday (Melville, New
York). Patient Janelle Trenchfield’s breast biopsy results were labeled with another
patient’s biopsy label leading to an incorrect diagnosis of cancer (Kerr, 2009). Ms.
Trenchfield then underwent an unnecessary lumpectomy and removal of lymph nodes,
which left her breast scarred, her lymph system compromised, and her psyche so stressed that she required psychological counseling (Kerr, 2009).

In all of these patient misidentification instances, shortcuts were taken or policies not followed that caused the mix-ups. One hospital, as reported by the *Lancaster New Era* (Lancaster, Pennsylvania) is working to prevent patient misidentification. The hospital system met with 11 other regional hospitals and decided on standardized colors for patient identification bands (red for allergy, white for identification, purple for “do not resuscitate”) (Stauffer, 2008). The policy will allow hospital personnel, who may work in more than one facility, to know that a red “allergy” band in one hospital means the same in another hospital. Standardizing the information signified by wrist band colors is one method to prevent inappropriate medicines or treatments from being given or carried out on patients (Stauffer, 2008). An article in the *New York Times* notes that identification bands are an important guard against being misidentified during a hospital stay (Tarkan, 2008).

4. **Significance of media review**

The purpose of this media review was to inquire if patient safety issues reported in this study were similar to patient safety issues in a second source (the media). An important point to note is that media reports make cases of patient safety appear black and white so as to clearly demonstrate what went wrong. However, patient safety violations caused by nursing and medical errors are never simple or committed by one person.

With that in mind, while media stories report outcomes of healthcare errors that patients in this current study have not experienced (death, loss of limb, infections,
anxiety related to life threatening or error-induced conditions, and unnecessary treatments and/or surgeries), data in these stories are similar to data culled from the patient safety interviews. Communicative Caring issues (poor communication in the Quaid twin’s heparin overdose, dropped communication in the Jackson and Nassif deaths), Protective Caring issues (nurses misreading heparin labels in the Quaid twin’s overdose and the death of pediatric patients in Indianapolis, Indiana), incorrect IV insertions, medicines given to patients at the wrong dose, procedures completed against hospital policy or incorrectly, and mislabeling specimens or misidentifying patients), and Accurate Caring issues (inaccurate diagnoses being made on patients) are all domains of this study which exist in stories outside this study. Sufficient similarities between domains discussed in this study and domains noted in the media are found. This strengthens the trustworthiness of this study’s data.

H. Summary

The purpose of this chapter was to review the study results in terms of the research questions. Data were presented in raw form. The next chapter will provide further insight into the data together with an examination of implications.
V. DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

This chapter contains a review of the research findings reported in Chapter IV with accompanying discussion about how these results relate to current research findings and other related literature. The chapter continues with a brief examination of the effectiveness of the Ethnographic Methodology employed, study implications for nursing education and practice, healthcare policy, and future research. Final sections include researcher perspective, limitations, and strengths.

A. Summary and Discussion of Findings

The purpose of this study was to uncover Emergency Department patients’ perspectives of safe and unsafe care as they described being treated during an ED visit. Patients’ subjective perceptions as they were influenced by the elements of the healthcare system (micro-, meso-, exo-, and macrosystems as defined by an adaptation of Bronfenbrenner’s (1979) Ecological Model for the ED healthcare setting) could be recorded and analyzed using a qualitative, ethnographic methodology. Analysis revealed an emerging theme, Competent Caring supported by three main domains and several sub-domains.

B. The Theoretical Framework: Bronfenbrenner’s Ecological Model

Bronfenbrenner’s Ecological Model was introduced in Chapter II as a theoretical model that situates the patient in the healthcare environment. For the purposes of this study the healthcare environment is the ED. Understanding the patient’s place in this environment provides a rationale for considering the patient’s perspective. Patients experience the various elements of the ED providing them with a unique perspective,
a perspective different from that of the healthcare providers who work within the ED. This patient perspective can reveal helpful information that may then be used to make the ED environment safer.

C. Theoretical Model as Data Collection and Analysis Guide

The patient encounters ED personnel directly in their various roles (ED MD, ED RN, ED technician, Respiratory Therapist). These encounters occur in a microsystem. The many different microsystems that interact directly with the patient (ED MD and patient, ED RN and patient, CT technician and patient) are called a mesosystem. Personnel that indirectly interact with the patient (pharmacist, ED manager) are parts of an exosystem. The cultural milieu that exists both inside and outside the hospital that influences and is influenced by the three previous systems is called a macrosystem. Figure 1 contains a visual graphic of the patient situated among these four systems.

Patients, over time, experience a variety of input from these various systems in the ED. The experience of this input is unique for patients because they experience the system’s impact subjectively. Thus, each patient experiences the system differently. Having patients share this experience through their perceptions of the ED is important because it reveals this unique view which is different from the views of those who are a part of the system (like ED personnel). Therefore, this view can bring to light new information not apparent to those who are a part of the system. The theoretical model situates the patient in the ED and highlights why a patient’s perspective is important.

Patients shared many insights as they reported their ED experiences that related to how the various systems interacted with them and affected their perceptions.
Impact of Emergency Department (ED) system factors on the ED patient that represents an adaption of Bronfenbrenner’s Ecological Model to the social and bi-ecological ED environment. This figure signifies the ED along with ancillary systems (such as pharmacy).
Communication, responding to their bodily (comfort) needs, perceiving efficiency and precision in diagnoses, and observing how their security was assured by a variety of ED personnel were aspects of patients’ observations of their microsystems. Observing ED MDs and RNs working together collaboratively and perceiving safety when their care was communicated well by ED personnel were two ways patients directly experienced several microsystems within a mesosystem. Patients were not always aware of the indirect interactions they had during their care (such as with pharmacists who prepared their medications or radiology MDs who interpreted their x-rays and CT results directly to the ED MD). However, some of the exosystem’s impact on patients were recorded in the researcher’s field notes and were evidence of patients’ safety perceptions.

Even the macrosystem’s impact was felt by a few patients; for example, the patient who perceived that her care was altered by a lack of health insurance. While beyond the scope of this study, recording patients’ perceptions regarding how race, gender, and age affected their care would have provided further insight into how the macrosystem positively or negatively affected patients’ care.

This theory was not only helpful in providing a rationale for studying the patient’s care perceptions and in helping to situate the patient in the ED environment, but it was helpful in arriving at the emerging theme, Competent Caring. As data began to emerge from the patients' interviews, a picture of the patients' safety perception began to emerge. Having a framework to understand how patients’ perceptions were affected directly and indirectly by the micro-, meso-, exo-, and macrosystems assisted in the organization of data under the sub-domains. For instance, when the sub-domain Responsive Listening emerged, understanding how ED personnel reacted directly with
patients (in micro- and mesosystems) and how resources outside the ED like a pharmacist or private-care MD (in the exosystem) were also involved assisted in better defining this sub-domain and realizing its depth.

What became clear to this researcher in applying Bronfenbrenner’s model of Ecological Model was the importance of the experiential/perceptual aspect and not the psychological aspect. Bronfenbrenner’s model dealt with psychological and behavioral development. However, for this study, space was not psychological, as it was in Bronfenbrenner’s model, but experiential. The adapted model used in this study was more of a bio-ecological model, demonstrating how, through biological and sociological interaction, the patient formed perceptions over time in the ED space. For Bronfenbrenner, the Ecological Model helped frame how and why children developed psychologically over time in their environmental space. For this study, the bio-ecological model demonstrated how patients developed their perceptions: the patient experienced issues in the ED space but developed perceptions, not behaviors, over time. These perceptions emerged as data in this study.

One patient stands out as a significant exemplar of how this framework demonstrates the impact of various elements on the ED patient. The 24-year-old female with upper abdominal pain had several encounters with the system that helped form her perceptions that her care was not very good. She entered the ED without health insurance, which was part of the underlying U. S. healthcare milieu of the macrosystem. Being negatively impacted by the macrosystem caused her concern about finding the means to pay her hospital bills, which was expressed in her frustration of having to pay for substandard care. In the triage area, she encountered blood on the seat of the
waiting room care, an impact of the exosystem on her care. The housekeeper, who had indirect contact with the patient, by (inadvertently) not cleaning the blood-stained chair continued to worsen the patients’ safety perception. These impressions did not improve following two strongly negative encounters of poor care in the microsystem. While her interaction with one or two of the nurses was positive (safe), the interaction with the registrar (the patient felt she was treated rudely) and the ED MD (the patient felt she was given the wrong tests for her complaints and was not given correct medicine to manage her symptoms) helped further form her poor perceptions of care. These two microsystem encounters (the ED MD and registrar) helped the patient form an overall decreased sense of safety with the mesosystem.

What is important to understand is that in the ED space and over a period of time, the patient formed overall poor perceptions of time. This bio-ecological framework assisted in understanding how the patient formed the perceptions she did. Not only did the patient reveal aspects of her care that need attention so as to increase safe care provision overall, the model assisted the researcher in understanding how her decreased perceptions of safety were formed.

The Ecological Theory adapted for this study was helpful on a number of levels. This framework was useful in the creation of the emerging theme with its domains and sub-domains. The adapted framework also demonstrated how patients form their perceptions over time as they are impacted by the various systems in the ED. In the next section, the domains and sub-domains that are the foundation and building blocks of data of this theme will be described and discussed.
D. The Emerging Framework: Competent Caring

Competent Caring emerged as the overall theme from the data. Competent Caring is caring that (a) provides a correct diagnosis in a timely manner through the proficient activities and behaviors of ED personnel working collaboratively and anticipating negative outcomes; (b) provides comfortable care that is free from injury and adequately communicated; and (c) supplies the patient with sufficient information and resources to understand their care and make decisions with ED personnel. Three domains emerged that further explained this theme: (a) Communicative Caring; (b) Accurate Caring; and (c) Protective Caring. Each of these three domains is further subdivided into several sub-domains that add clarity to each domain. Table 9 indicates the number of safe codings by sub-domain, and Table 10 notes a patient’s diminished sense of safety by sub-domain. Each sub-domain is ranked according to the number of codings attributed to it. These tables will be used in the following discussion of the three domains.

1. Communicative Caring

As data surfaced during the analysis of the patient interviews, it became clear that communication was an important aspect of the safe patient care perspective. As seen in Table 9, 30 codings of safety were recorded in the four Communicative Caring sub-domains, the second highest number of codings of all three domains. In studies of ED patients, communication is one of six domains patients mentioned as important during their ED care (Cooke, Watt, Wertzler, & Quan, 2006; Press Ganey Associates, 2007, 2009) Good communication is important because it provides information that empowers patients to participate in and make decisions about their own care.
Table 9
Taxonomy of Domains and Sub-Domains of Patients’ Sense of Safety in the Emergency Department

<table>
<thead>
<tr>
<th>Domain Name</th>
<th>Sub-domain Name</th>
<th># of reports by ED patients</th>
<th>% of all safe excerpts</th>
<th>Rank order of Patient Reports of each Sub-Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicative Caring</td>
<td>Providing Sufficient Information</td>
<td>14</td>
<td>11.02%</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>ED MD Interaction</td>
<td>8</td>
<td>6.30%</td>
<td>7&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Empathy</td>
<td>6</td>
<td>4.72%</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Responsive Listening</td>
<td>2</td>
<td>1.57%</td>
<td>11</td>
</tr>
<tr>
<td>Protective Caring</td>
<td>Assuring Security</td>
<td>23</td>
<td>18.11%</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Proficient Caring</td>
<td>21</td>
<td>16.54%</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Anticipatory Caring</td>
<td>9</td>
<td>7.09%</td>
<td>5&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Collaborative Caring</td>
<td>9</td>
<td>7.09%</td>
<td>5&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Comfort Measures</td>
<td>8</td>
<td>6.30%</td>
<td>7&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Accurate Caring</td>
<td>Efficiency</td>
<td>20</td>
<td>15.75%</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Precision</td>
<td>7</td>
<td>5.51%</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td><strong>127</strong></td>
<td><strong>100.00%</strong></td>
<td>–</td>
</tr>
</tbody>
</table>

*Note.*  
<sup>1</sup> Tie.

Sub-domain excerpt percentages represent the proportion of excerpts in each domain. Sub-domain rank order is determined by ordering the number of sub-domain codings from greatest (1) to least (11).
Table 10
Taxonomy of Patients’ Sense of Risk and/or Diminished Sense of Safety in the Emergency Department

<table>
<thead>
<tr>
<th>Domain Name</th>
<th>Sub-domain Name</th>
<th># of sub-domain codings</th>
<th>% of all diminished safety codings</th>
<th>Sub-domain rank order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicative Caring</td>
<td>Providing Sufficient Information</td>
<td>1</td>
<td>33.33%</td>
<td>1[^1]</td>
</tr>
<tr>
<td></td>
<td>ED MD Interaction</td>
<td>0</td>
<td>0.00%</td>
<td>4[^1]</td>
</tr>
<tr>
<td></td>
<td>Empathy</td>
<td>0</td>
<td>0.00%</td>
<td>4[^1]</td>
</tr>
<tr>
<td></td>
<td>Responsive Listening</td>
<td>0</td>
<td>0.00%</td>
<td>4[^1]</td>
</tr>
<tr>
<td>Protective Caring</td>
<td>Assuring Security</td>
<td>1</td>
<td>33.33%</td>
<td>1[^1]</td>
</tr>
<tr>
<td></td>
<td>Proficient Caring</td>
<td>1</td>
<td>33.33%</td>
<td>1[^1]</td>
</tr>
<tr>
<td></td>
<td>Anticipatory Caring</td>
<td>0</td>
<td>0.00%</td>
<td>4[^1]</td>
</tr>
<tr>
<td></td>
<td>Collaborative Caring</td>
<td>0</td>
<td>0.00%</td>
<td>4[^1]</td>
</tr>
<tr>
<td></td>
<td>Comfort Measures</td>
<td>0</td>
<td>0.00%</td>
<td>4[^1]</td>
</tr>
<tr>
<td>Accurate Caring</td>
<td>Efficiency</td>
<td>0</td>
<td>0.00%</td>
<td>4[^1]</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Precision</td>
<td>0</td>
<td>0.00%</td>
<td>4[^1]</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>3</td>
<td>100.00%</td>
<td>–</td>
</tr>
</tbody>
</table>

Note. ¹ Tie.

Sub-domain excerpt percentages represent the proportion of excerpts in each domain. Sub-domain rank order is determined by ordering the number of sub-domain codings from greatest (1) to least (11).
As patients discussed how communication positively or negatively impacted their care, the following definition was developed to describe the domain Communicative Caring: communication between ED personnel or directed to the patient providing sufficient, clearly understood information. When directed to the patient, information was provided about options for medications, diagnostic testing, treatments, and trajectories of care toward solving their health problems. This definition captures the significant pieces of the four sub-domains that underlie this domain: (a) ED MD Interaction; (b) Providing Sufficient Information; (c) Empathy; and, (d) Responsive Listening.

a. ED MD Interaction: First sub-domain of Communicative Caring. Patients want physicians to listen to and respond to them both verbally and nonverbally as an indication that they were heard. Patients who were satisfied with the responses from the ED MD perceived the ED MD made and maintained eye contact, took enough time to explain care, and answered questions so that patients understood what would be happening to them.

Patients appreciated the question and answer sessions during the MD assessment, and were grateful that the MD paid attention to them and not to something else like the patient chart.

The ED MDs appear to place priority on maintaining the relationship with the patient through good communication. As the 82-year-old patient noted, “And then you tell him, but then he sits and talks to you. That really is nice, when a person talks to you.” Some described this level of connection as high quality interactions or having the full attention of the ED MD. Because ED MDs place an emphasis on patient
communication, patients indicate overall satisfaction with the information that was provided to them from the ED physicians.

Other positive aspects of the ED MD/patient interaction are explanations that use terms familiar to patients. Patients noted that they understood best when the MD used language they could understand. The 33-year-old patient with gout pain noted that because the ED MD spoke in his terms, he could understand. “He explained himself very clearly to where I could understand.” Other patients also were appreciative that staff used “laymen’s terms” so that they better understood the ED MD’s communicated message. This not only helped them understand their care but reduced their anxiety.

Patients who were communicated to in terms understandable to them had better knowledge of what was happening to them and took a more active role in their care by making decisions about their care (Longtin et al., 2010). Patients in other studies who clearly understood vital information received communication from their ED caregiver in language which they could understand (Cooke et al., 2006). When patients clearly understand their care, they are empowered to be in control of and take part in the planning of their care, providing another protective element that reduces the possibility of errors in their care (Gaard & Schrager, 2007; Leape, Berwick et al., 2009).

No system is perfect, and two patients’ experiences provided excellent negative case examples of communication with the ED MD. A 24-year-old female patient complained of upper abdominal pain but did not understand why she was treated for an ovarian cyst. This example provides insight into what happens when the message from the ED MD is communicated but not understood. “But I felt like he just gave me a random answer. He was like, “You might have had an ovarian cyst that burst.” So it
wasn’t very conclusive, number one, the answer that he gave me, so that kind of made me feel a little unsafe." The physical exam this patient received did not make sense to her based on her symptoms. She either did not ask for additional discussion or was not supplied with an opportunity to discuss this treatment course, which is a common occurrence (Buetow et al., 2010). An additional example of insufficient communication regarding a treatment course occurred with a 42-year-old patient who had uncontrolled pain. After initially discharging this patient, the ED MD had the patient admitted to the hospital through his private-care MD after the patient called to complain to his private-care MD. The patient recalled feeling that the staff might have been too busy to take into account the entire patient picture and communicate it to the patient.

Neither of these patients received communication that helped them understand their plans of care. Had the patients been able to make clear their lack of understanding and had the ED MD better explained the treatment routes prescribed for the patients, they may have perceived better and safer care with the ED MD. Providing the patients an opportunity to ask questions and assuring that they understand their treatment prevents error and improves their perception of safety (AHRQ, 2000).

Communication lapses sometimes occur because the personnel involved in the patients’ care (especially, ED MDs, RNs, other personnel) (a) feel they are the experts and are, therefore, the only ones who can make treatment decisions; (b) desire to maintain control; (c) do not or cannot take sufficient time to educate or explain themselves completely; and, (d) are not trained well in how to help patients participate in their care (Longtin et al., 2010). When patients received clear communication in
language they understood, they better understood and became active participants in their care. This was not the case with the two previously mentioned patients.

b. Providing Sufficient Information: Second sub-domain of Communicative Caring. Patients want to know what is being done with them and why. This is true of patients in a study of ICU patients as well as patients in this study (Hupcey, 2000). When provided sufficient information about the illness which underlies their symptoms, about what treatments could be used to diagnose this illness, and about what medicines can be used to treat both the immediate symptoms (like pain) as well as the overall illness, patients can make informed decisions about their care. Being provided with sufficient information is important for patients in one ED study so that they know what ED MDs are going to do, why it is being done, how it will address their health problem, and what they can expect during their ED stay (Cooke et al., 2006).

There is no surprise that this sub-domain is ranked fourth of all sub-domains with 14 safe codings (Table 9). This sub-domain also received one of only three diminished safe codings in this study. Communication is an important aspect of safe care. Patients feel less uncertainty when they are supplied with more information. In this study, patient anxiety generated from the uncertainty surrounding their ED visit was modulated when they were provided with sufficient information, such as clearly explained test procedures and discharge instructions. Having this information reduced the fear of the unknown and helped patients know what to expect when starting new treatments or medicines. Other patients described feeling more anxious when they did not receive certain information, like the names and roles of ED personnel who were supplying them care or the rationale for the care they were receiving (as in the case of the 24-year-old female
patient who did not understand the lower abdominal treatment she received for her upper abdominal pain).

Sufficient information must be of good quality. One patient described how his anxiety was reduced when the RN communicated to him how often he could request pain medicine. Another patient expressed frustration because she did not understand why the bloated feeling she had in her stomach was treated with a narcotic pain medicine that did not relieve this feeling. In the first case, the patient received good quality, personally-conveyed communication in plain terms that helped him understand how his pain would be treated. In the second case, the patient received poor quality information because it did not help her understand why she received the medication, given her symptoms.

Sufficient information also requires delivery at regular intervals. Several patients in this study expressed frustration or concern (being “left in the dark”) when updates were not delivered frequently. Overall, patients understand that emergencies occur which can occupy ED personnel. However, patients do want to be reassured that they are not being lost in the shuffle and that their treatment results and pain medicine were not forgotten. In previous studies, patients expected frequent updates during all stages of their care, including explanation of delays, investigations, results, and treatments (Press Ganey Associates, 2009; Watt, Wertzler, & Brannan, 2005; Wolosin et al., 2005). Specific time frames for basic care updates indicated by patients in one study are every 30 minutes (Cooke et al., 2006). Delays happen frequently in an ED. Acknowledging delays along with providing updates and assuring that tests are completed within the
time frame parameters established by the hospital laboratory were important aspects of patient caring and safety for these patients.

c. **Empathy: Third sub-domain of Communicative Caring.**

Patients entering the ED have a variety of concerns and anxieties. Some are worried about specific changes in their health (such as a bloody cough) or a high level of pain or nausea. Some have been plucked from very normal situations, such as being in a shower before a fall, and then being taken to an ED in a condition they had not planned on (such as having soapy hair). They desire to be treated with care and concern in a way that alleviates this anxiety. They want to know that ED personnel are sensitive to their emotional needs such as feelings of concern, fear, and embarrassment.

Patients want their emotional needs as well as their immediate healthcare needs attended to. Emotional needs, as with comfort needs (discussed later in the Protective Caring domain section), are not suspended when patients come to the ED. Being treated with empathy is one way to address these emotional needs and improve patients’ safety perceptions (Wolosin et al., 2006). Patients in other studies likewise desired empathy during their ED stay (Breeze & Repper, 1998; Watt et al., 2005).

ED personnel helped alleviate the anxiety and concern that come with being an ED patient by providing empathetic communication. ED personnel drew attention away from patients’ concerns about their appearance or dealt with potentially embarrassing or painful situations by focusing on patient care and acknowledging patients’ feelings. Patients described having their anxiety or embarrassment reduced as a result.

d. **Responsive Listening: Fourth sub-domain of Communicative Caring.** Emergency Departments have evolved to provide a great number of resources
for patients during a health crisis: access to additional medications, rationale for their care, incentive to address chronic health issues, specialists who can deal with specific health problems, or comfort measures like food, water, and pain measures. Access to these resources is provided with responsive listening. Responsive Listening occurs when ED personnel understand the patient’s communicated message and then connect the patient with other resources (person, requested article, or medicine).

Responsive Listening goes beyond treatment for a current healthcare issue, but is not exclusive from it. Examples included strong encouragement to have the patient’s primary care MD provide more aggressive treatment of a chronic health condition or ED personnel contacting several other personnel in person or by phone to provide the patient with the resources they need.

2. **Accurate Caring**

Concern, worry, fear, pain, and other emotional and physical feelings swamp most ED patients as they enter the ED. Because of the heavy weight of this burden, patients do not want to experience additional concern about their treatment. When patients experience accurate care, this alleviates their concerns.

While consisting of only two sub-domains, this domain had 27 safe codings (zero diminished safety codings), which is almost the same number of safe codings as the domain Communicative Caring, which has four sub-domains (see Tables 10 and 11). Most of these safe codings are accounted for in the sub-domain Efficiency, which had the third highest number of safe codings at 27. This number of codings indicates the importance that patients place on accurate, efficient care.
Accurate care involves effective and timely testing, treatment, and medication administration that provides diagnoses adequately addressing the underlying illness and symptoms. Two sub-domains of Accurate Caring that emerged from patient interviews about their care were Diagnostic Precision and Efficiency.

a. Diagnostic Precision: First sub-domain of Accurate Caring.

Patients seek an accurate diagnosis to treat the serious symptoms that drove them to seek emergency assistance. Patients desire precision in the ordering of tests and completion of a physical exam that leads to an accurate diagnosis. One of ED patients’ top concerns is that those caring for them be precise so as to order the correct tests and make the accurate interpretations of their entire exam to arrive at a correct diagnosis (Press Ganey Associates, 2009). The importance of a correct diagnosis is underscored by study findings, which reveal that the main concern of ED patients is not receiving an accurate diagnosis (Burroughs et al., 2005).

A key component of Diagnostic Precision involves an explanation to patients about how the treatment plan will deal with the illness which produced their underlying symptoms. Three patients had clear impressions of how precise they felt their care provider was when (a) heart problems were discovered concurrently with back pain; (b) a more specific diagnosis of joint pain was made; and (c) symptoms of medication side effects were separated from illness symptoms. A clearly-stated diagnosis followed by an explanation about how the treatment plan would address the symptoms eased patients’ anxiety and helped them deal with a reality of illness rather than the mystery of symptoms.
Similarly, patients who felt their diagnosis and/or treatment did not match their symptoms or went against their intuitions were left wondering if they had received good care. One patient with uncontrolled, strong lower abdominal pain was discharged to home. Only through his insistence and the help of his primary-care MD was he admitted as an inpatient; this hospital admission uncovered the source of his pain: early colon cancer. Another patient’s diagnosis of a ruptured ovarian cyst did not address the bloating and upper abdominal symptoms she felt, and left her feeling uncared for.

Patients expect a definitive diagnosis, and occasionally the diagnosis provided to them does not point to the direct cause of the problem. In a study of ED patient expectations, study findings note that patients sometimes have expectations, including a definitive diagnosis, that cannot be met for a variety of reasons (Watt et al., 2005). In the case of the patient with uncontrolled, strong, lower abdominal pain, an entry from the researcher’s field notes from the ED RN who was taking care of this patient makes this very point.

As we left the room, KK explained to me that, given the nature of his complaints which in her professional judgment indicated a problem that was chronic and not an immediate, critical issue, she wanted to prepare him for a diagnosis that might not point out directly his problem. She said, “so many people leave here mad because we don’t give them the diagnosis that might not point out the specific problem.”

While patients may not be given a definitive diagnosis, the following processes may ensure that patients still feel cared for: (a) a clear explanation as to why a definitive diagnosis cannot be made; (b) an opportunity for the patient to ask and have answered any remaining questions about why there is no definitive diagnosis; and, (c) illustrating the next steps in treatment to continue to search for the cause of their health problem.
b. Efficiency: Second sub-domain of Accurate Caring. In a society where there are many “instant on” amenities (instant movie rentals through cable, instant food delivery, instant information through the internet), people have been conditioned to quick responses to their wants and needs. Patients expect quick responses to their symptoms and healthcare needs as well. They understand the limitations of the ED: that staffing levels can vary, that the number of patients requiring treatment can go beyond available bed space and staffing, and that there may be short-term limitations of many of the ED resources so as to provide care for an emergent patient. However, when their care is provided efficiently (quick, organized, prioritized, and attentive to their needs), they are left feeling safer. The importance that patients place on Efficiency is noted in Table 9. This sub-domain has the third highest number of safe codings at 27.

Patients in this study described efficiency in terms of being taken quickly to their care rooms from triage, of quick response to symptoms that caused them (or the ED personnel) concern, and of receiving attention from the ED MD and RN regarding treatments, medications to alleviate their symptoms, and diagnoses that were arrived at in a reasonable amount of time. They did not want to wait beyond what they perceived as a reasonable amount of time on medicines, test results, or to be seen by the ED MD. A few patients had long waits; one patient’s concern about her long wait occurred because a test not ordered initially had to be ordered after the other test results were returned and because she had to follow up twice with the ED RN to facilitate an MD evaluation of the test results. Her overall sense of safe care was not very high partly because of this lack of efficient care.
3. Protective Caring

When describing their care during the research interview, patients noted many actions carried out by ED personnel that provided them a sense of safety. Many of these aspects have been bundled into the domain of Protective Caring. Protective Caring is defined as expressing concern for protecting patients' physical safety, health condition, and privacy.

Nurses and physicians provide protection collaboratively and skillfully; they anticipate potential problems or educational needs; and, they supply comfort measures. Maintaining this level of protective care supplies patients with safe care. Not surprisingly, 70 of the 124 safe codings noted in Table 9 occur in this domain. This domain also has five of the top seven sub-domains. Similarly, Table 10 notes that two of the three diminished sense of safety codings are noted in this domain. Patients, while wanting good communication and accurate caring, desired and noticed protective caring the most. Protective Caring is best described through its five facets or sub-domains: Comfort Measures, Proficient Caring, Anticipatory Caring, Collaborative Caring, and Assuring Security.

a. Comfort Measures: First sub-domain of Protective Caring. The human beings that enter the ED as patients bring a variety of needs with them, but the chief need is immediate attention to a pressing health concern. However, once settled in the ED with care underway, their bodily needs continue to require attention. Patients need food, water, comfortable bedding, and temperature control among other needs. Comfort Measures, such as warm blankets and water seem like insignificant pieces of patient care, but comfort measures were significant for patients. Often, simply meeting
these bodily needs left patients feeling much safer. That comfort measures provide a sense of safety for patients is found in other studies. ED personnel who attend to these needs provide patients with the feeling of safe care (Press Ganey Associates, 2007).

Patients have other needs that also require attention. Response to their emotional needs is important, and staff meet this need with Empathy as discussed above under the Communicative Caring domain. Another emotional need is the desire to be treated respectfully and with kindness. Patients entering this ED described ED personnel as “sweet,” “nice,” and “helpful.” Patients felt cared for and comfortable because staff attitudes were attentive, professional, and because staff activities put patients at ease and made them comfortable.

Additionally, patients mentioned the management of their pain and nausea as important comfort measures. This was especially important when the patient was experiencing high levels of pain, or, as in the case of one patient who was experiencing a more serious issue (cardiac ischemia), that pain management was still a priority.

Conversely, when patients’ bodily needs were not met, they felt uncared for and unsafe. Patients who continued to experience their symptoms (such as bloating) because medications were administered which did not address their symptoms, or because there was a delay in administering the medication, felt they were not cared for safely. Patients who were not given care items (such as a urinal for a bed-bound patient) that allowed them to care for their bodily needs (such as toileting) had similar perceptions.

b. Proficient Caring: Second sub-domain of Protective Caring.

The professional skills and intellect of the ED personnel were assessed by patients.
Patients were concerned with mistakes that could potentially be made by RNs and MDs; and when patients witnessed a high level of professionalism, it helped them to feel more secure about their care (Burroughs et al., 2005). Patients were impressed by the skills and behaviors of the ED staff. This is reflected in the number of safe codings (21) noted in Table 9, which is the second highest number of codings among sub-domains. The experience of staff proficiency increased both the confidence in the professional abilities of the ED personnel and the perception of being cared for safely.

Initial impressions were very important, and patients stated that the friendly attitudes of the staff combined with prompt service helped them feel safely cared for. Some patients wondered (prior to their ED visit) if they would be treated as just a diagnosis or a complaint on a sheet of paper. Their experience of receiving satisfactory nonverbal and verbal responses of their ED MD and RN through direct eye contact and question and answer sessions left patients with a strong impression of staff professionalism and safety.

How well ED personnel demonstrated healthcare skills was another determination of staff proficiency. RNs who were able to draw blood and initiate IVs on patients with relatively little pain and with good professional mannerisms (explaining the procedure and following patient preferences) were perceived to have a high level of proficiency. MDs who multitasked to provide full care to the patient while continuing to provide care to other patients lent credence to patients’ perceptions of proficiency and safety.

Poor staff skills diminished the sense of the proficiency of ED personnel. One patient noted that a staff member carrying a full urine specimen container without gloves
left her questioning whether the specimen was contaminated. ED personnel possess knowledge about patient care. When used inappropriately, this knowledge leads them to take patient concerns less seriously. This in turn leads patients to perceive that ED personnel act in unsafe ways. The example of the ungloved RN carrying a full specimen cup is one such example. RNs know that gloves protect the wearer and that ungloved hands do not necessarily increase the chances of contaminating the specimen. Nevertheless, beyond the fact that the RN opened herself up to a potentially harmful body fluid exposure, the patient’s perception that the RN could contaminate the specimen led her to feel care was administered unsafely. Simply wearing gloves (according to protocol) would have provided the patient with a better perception that safe care was being carried out. Another example of insider knowledge used inappropriately by ED personnel occurred when a bloody IV catheter was discovered on the floor by the patient. Instead of acknowledging the patient’s concerns, the RN shrugged off the concern, noting that the absence of a metal needle and small amount of blood limited the chance of patient harm. Had the nurse acknowledged the patient’s concern, apologized, and cleaned up the blood according to protocol instead of trying to brush off the patient concerns with an explanation that seemed rational to the RN, perhaps the patient would have perceived greater proficiency and safety in the care she received from the RN.

Patients also perceive a lack of professionalism when actions that should be staff responsibilities have to be carried out by the patient. Patients should not have to follow up with staff on aspects of their own care. Discharge instructions need to be supplied, IVs need to be discontinued, and staff should not have to be frequently reminded to
check on test results. Patients want updates and test results reported in a reasonable amount of time (Cooke et al., 2006).

c. **Anticipatory Caring: Third sub-domain of Protective Caring.**

With the worry of symptoms, an interrupted life schedule, a possible diagnosis that may lead to further life alterations, and other concerns, patients want to know that they are not only being cared for in the present, but that future negative outcomes are being managed as well. Anticipatory caring is foreseeing positive and negative outcomes during patient care and adjusting practice behaviors to prevent negative and support positive outcomes. Patients were impressed with the anticipatory care that they received.

Patients are aware of some negative outcomes of their care, including the consequences of receiving a medication to which a patient is allergic. Patients know which medications they should not receive, and they know the consequences of receiving them. So when ED personnel anticipate the outcomes for patients before administering medications for pain or before patients receive IV medications during testing procedures like CT scans, patients realize the benefit of this. Patients know the importance of having their allergy bands checked and/or being asked if they are allergic to any medications prior to medication administration.

Patients also want to have their pain managed well. This involves an initial administration of pain medicine and reassessments of pain levels along with readministration of pain medicine as needed. ED RNs who were attentive to providing patients with follow up pain medicine protected the patient’s health and contributed to the patient’s sense of receiving safe care.
d. **Collaborative Caring: Fourth sub-domain of Protective Caring.**

Staff collaboration for the benefit of the patient requires a set of skills and behaviors that are learned over time. According to the patients interviewed for this study, a high level of collaborative care was in evidence. Collaborative care is safe patient care which is the result of several staff working together. Patients noted that staff worked well together and acted promptly to carry out treatments and medication administration. MDs and RNs also worked well together to provide information to patients that they would be able to recall after discharge.

Good collaboration occurs when ED personnel work in concert, and maintain an awareness of the tasks and personnel who are to carry out these tasks during patient care (Reader, Flin, Mearns, & Cuthbertson, 2009). Patients noticed when ED RNs followed up on ED MDs medication and treatment orders and discharge instructions (and when they didn’t). ED personnel were aware of patient’s care plans and of the personnel involved in it, and reminded other personnel to complete tasks to expedite care. Patients felt safer as a result.

Patients want to have certainty that the information derived during their care in the ED will be passed onto the next set of caregivers at a receiving floor or facility. Four of the patients interviewed in this study were admitted to the hospital immediately following their ED treatment. They felt that the tests, diagnosis, and other pertinent aspects of their visit were communicated well to the receiving unit. This includes patient transfer communication from the ED RN to floor/unit RN who would care for the patient initially upon admission. Good collaboration between personnel is important because it ensures that information would not be lost as one provider took over care from another.
provider. Good collaboration as one provider passed care to another reduced mortality levels and raised patient satisfaction (Reader et al., 2009).

One issue of concern for patients involved the perceived lack of collaboration between the ED MD and the ED RNs, ED personnel, and admitting physicians caring for some of the patients. This perception developed when several ED personnel asked patients similar questions about their symptoms, medical history, and other care information. Patients perceived that ED personnel were not on the same page or that the information was not recorded in the patient’s medical record since it was being asked for so frequently. ED personnel can be trained to develop strategies to check information in the patient record before entering the patient care room and then verifying it with the patient, or to “round” on patients so that all questions could be asked at one time rather than repeating the patient interview (Anthony et al., 2005; Fleishman & Doherty, 2007).

e. **Assuring Security: Fifth sub-domain of Protective Caring.**

Assuring that patients remain safe in their care environment seems like an obvious aspect of patient safety. However, the obviousness is confirmed in Table 9, which notes that the assuring security sub-domain is ranked number one of all sub-domains in the number of codings (23). Without a doubt, patients believe that when staff undertake all of the aspects of this sub-domain, their care is safe. Table 10 also notes that this sub-domain received one of three diminished sense of safety codings, which affirms the fact that when security is assured, patients feel safe (and when it is not assured, patients do not feel safe).
After patients have entered the patient care area of the ED and the initial care has been initiate, they then spend a considerable amount of time in their patient care rooms awaiting results. During this time, patients pay attention to the condition of the room. What they notice in these rooms begins to affect their perception of safety. Observations of the room condition, activities of staff in maintaining the patient care environment, and staff use of patient and personnel protective equipment to prevent patient injury or compromise of confidentiality combine to form the foundation of this fifth Protective Caring domain.

Cleanliness is one of the most often-mentioned items in this sub-domain. When asked what they remembered about their physical surroundings, patients often discussed the cleanliness of their beds, floors, walls, and curtains. They also were very specific about problems with cleanliness: blood on a chair in triage, a used IV “Opsite” stuck to a clean sheet, and a bloody IV catheter on the floor. Room cleanliness was important because it indicated an interest in protecting them from contamination from previous patients. If the room was clean, it reassured them that bacteria and viruses carried in body fluids and trash were eliminated and would not affect them. If the room was not clean, patients fear they may contract an infection from bacteria or viruses from a previous patient (one patient observed an RN clean a bloody spot on floor by using her shoe and a dry paper towel). Additionally, a room free of items such as glass, needles, and other sharp objects assures patients that they will not injure themselves.

Placement of equipment in rooms is another element of the patient safety perception. When asked to define patient safety, several patients expressed concern that equipment in the room be placed out of the way so it would not provide an obstacle...
that could cause an injury. Patients expect equipment to be placed against walls and cords to be secured so they do not become a tripping hazard or become disconnected from it (as in the case of a heart monitor). Additionally, items such as call lights, patient care tables, and other items need to be placed within reach. Patients are vigilant about their own health, and when patients cannot easily access items like call lights, reaching for these items places the patient at risk of a fall or accident. Emergency Departments are foreign places filled with patient care equipment that creates a foreign environment for patients. Falls are among the top concerns of patients in the ED (Burroughs et al., 2005). In this unfamiliar environment, patients want to feel that the risk of tripping over equipment or falling when reaching for something is kept to a minimum.

A lack of side rail use on the stretchers in the ED care rooms contributed to a reduced perception of safety by patients. A few patients had chronic back problems. Concern that a fall from the narrow stretcher mattress to the floor could cause additional problems or exacerbate existing ones led many patients to notice when side rails were not used. Patients desire to have these side rails used so that they are assured of one more layer of protection preventing them from injuring themselves in the ED care environment.

Issues related to nurse call lights concerned several patients. Patients are often too sick, injured, or simply physically incapable of leaving their bed. When left with no way to contact staff, either because they have not been given a call light or because the call light was not in service, patients were unable to make requests to ED personnel. Patients went without pain medicine and items like urinals, which increased their anxiety and pain levels. In general, when patients are left without a way to contact ED
personnel, they felt less safe. Prompt response to a functional call light within patient reach is very reassuring to patients (Press Ganey Associates, 2007).

Glove use and hand washing by staff was another layer of protection from which ED patients felt they benefitted. Patients remembered when gloves were used and also reported feeling safer watching ED personnel wash their hands. While gloves are worn primarily to protect those who wear them, patients perceive them as an additional layer of protection for them. A few of the patients had chronic conditions that could be affected by hospital-acquired infections, and they appreciated when staff took the time to don gloves and wash their hands as these activities protected them from contracting an infection. ED personnel who wear clean gloves left patients with a better assurance that they were better protected from infections that could be transmitted by staff.

One negative case example of glove use occurred when a patient noted a staff member entering the room to care for her with gloves she wore from another room. The patient was not reassured that the gloves were clean. ED personnel could wash hands and don gloves once they enter a room to prevent patients from perceiving their hands are not clean.

Patients did appreciate the use of ID bands and allergy bands in identifying them and preventing harmful medicines from being administered to them. Patients in other studies expressed concern about being misidentified (Burroughs et al., 2005). ID bands provided confidence to patients that treatments were being completed on the right patient. An additional layer of protection was verbal identification that backed up ID bands and patient specimen labels verification. Staff asked patients their dates of birth and names to verify their identity before labeling specimen containers, giving them a
Patients noted increased perceptions of safety and security as a result. Allergy band checking to verify that patients were not allergic to medicines also provided them with reassurance that medicines which were harmful to them would not be administered. Patients were also asked if they were allergic to medications before the medication was administered.

A final, yet important, revelation by patients in this study is the perception of safety when equipment for injections (gauze, tape, syringes, and needles) or IV set up (IV tubing, extension sets, IV catheters) are removed from the packages and set up directly in front of the patients. Patients noted feeling better and safer when witnessing this directly for several reasons. Witnessing equipment being removed from its package provided confidence that needles were not being reused. Having IV supplies removed from the sterile packaging assured the patient that the equipment was clean and free of contamination that could lead to patient infection. Certainty that IV supplies were not dropped on the floor or otherwise contaminated was another reason cited by a patient for wanting the supplies set up in front of him. With patients more aware of their chronic conditions and how their health can be negatively impacted if they contract an infection from contaminated supplies, there is a greater desire for assurance that equipment remains clean or sterile up to and during patient use.

E. Summary

Patients supplied many insights into what they found safe by sharing their perceptions. One main theme with three domains supported by several sub-domains helped organize and better understand the study data. Many of the safety perceptions organized under the Competent Caring theme affirmed data that were noted in other
studies. However, some new data emerged adding to the current patient safety knowledge base that could potentially help develop new processes to better protect patient safety. The next section of this chapter will discuss how useful the ethnographic methodological approach was in developing and analyzing patients’ safety perceptions.

F. Ethnographic Methodology

The ethnographic methodology was specifically chosen for this study. As discussed in Chapter II in the Theoretical Framework section, Bronfenbrenner’s Ecological Theory was employed. The Ecological Theory as adapted for this study demonstrated that patients subjectively experiences the various ED systems employed to care for them. Because of this subjective experience, each patient possesses a unique perspective as a member of a culture different from those working within the healthcare culture. Utilization of the ethnographic methodology gets at the heart of the unique perspective of the participant’s culture. Their descriptions and explanations (perceptions) are analyzed to reveal specific areas of their experience (Spradley, 1979).

The ethnographic methodology and Spradley’s interactive question guide used during the interview was a successful tool that facilitated a discussion of patient experiences and revealed their unique, credible perceptions of their care. The data and study findings demonstrated that the patient does experience the ED care environment in ways not anticipated by ED personnel within the healthcare system. Ethnography was thus a useful qualitative methodology that made possible the revelation of this unique patient view.
G. Implications

Patient perceptions supplied this study with valuable insight into the confidences and concerns patients have about their care. The data that emerged provided perceptions of both safe and less safe caring that have multiple implications. Implications of these research findings fall into four areas: nursing practice, nursing education, research, and policy.

1. Nursing practice

Patient care supplied by nursing practice is not just support of the patient during the search for a diagnosis. Patients rely on nursing care to meet a variety of needs for their physiological, psychological, sociological, and spiritual health. The first way this is met is through accurate, clear communication with patients.

RN communication is one source that connects patients with the healthcare system treating what is for them a serious health concern. Therefore, nurse-patient communication must (a) clearly convey information stated in words patients can understand; (b) provide time for the patient to ask as many questions as needed to understand their care; and (c) be delivered both on a scheduled basis and when the patient requires it (PRN: as needed). Nursing practice must, therefore, be attentive to developing and maintaining good communication practices.

Nurses who practice good communication with patients provide the them with the information they need that helps them participate in their care. This includes the initial assessment of the patient, answering questions about the prescribed treatments and medications, updates on their test results, estimated wait times before procedures, information on delays, and approximate times before the patient is admitted or
discharged. Patients who receive this level of communication report both reduced anxiety and increased perceptions that safe care has been provided.

RNs also need to be aware of patients’ psychological needs. When patients’ emotional needs, such as acknowledgment of and sensitivity to their feelings, were acknowledged, patients felt their care was better and safer. This is especially true when patients find themselves facing a serious health concern or find themselves making an unscheduled, sometimes emergent ED visit. Empathetic communication will address these needs, reducing patient anxiety.

A second area of nursing practice that is important for patients is the accuracy of the care they receive. Much of the data in this section affirms the importance of current healthcare safety practices already in place. However, as an incentive to continue their implementation, practices that contributed to the accuracy and safety of patients care need to be highlighted. Patients remember and appreciate that their ID bands are checked, that they are asked their names and birthdays, that their lab labels are checked and placed on the appropriate specimen containers, and that their allergies bands are checked as well as when they are asked verbally about allergies to medicine, food, and contrast media (used in CT scans).

Additionally, nurses need to pay special attention to patients who do not receive a definitive diagnosis. As one of many ED patient advocates, they need to ensure that patients who do not have an accurate diagnosis do feel that there is a plan in place when they are discharged. A plan reassures the patient that, despite a lack of certainty, there are resources to which they have access that will help them discover the source of their health problem.
A third area of nursing practice that patients both in this study and others stated improved their safety perception was the maintenance of their bodily comfort. Pillows, blankets, urinals, call lights, and patient tables all within reach helped patients feel that their care was important to ED personnel, and thus improved their perceptions of safety. Practicing some rudimentary aspects of nursing will go a long way for patients.

Continuing with the theme of bodily comfort, maintaining and protecting the patient from harm is a fifth area of nursing practice vital to contributing to patient safety. Proper hand hygiene etiquette (hand washing, glove use), cleaning bodily fluids from surfaces according to policy, moving equipment out of the way to prevent patient injury, putting up stretcher side rails, placing call lights within reach, and assuring that the call light is operational are all basic practices that not only provide the patient with a perception of safety, but also assure their safety by preventing injury.

An interesting finding of this research not encountered in the literature was the patient preference that IV and syringe medication be prepared in front of them. Setting up IVs and preparing syringe administered medications in front of the patient assured the patient of the sterility of the equipment (that it was not reused, dropped on the floor, or otherwise unclean). This is a no-cost practice change that can be implemented to improve patient safety.

A sixth practice that could be implemented is acknowledging patient concerns and preferences. RNs and other professionals possess knowledge that provides them with rationale of which patients are not always aware. However, if patients have concerns that are raised and which are not acknowledged because the RN thinks the concern is unfounded, the patient feels that unsafe care is being given. Acknowledging
these concerns and following up with ways to address those concerns is a safety practice that acknowledges the patient role in care, delivers safer care, and increases the patient’s perception of safe care delivery.

A seventh and final practice involves collaborative care. Attention was paid by ED patients to the amount of collaboration that went on during their stay. However, patients mentioned feeling that staff were not all on the same page or that healthcare information was not being recorded in the patient medical record when RNs, MDs, and other staff asked them similar questions about their healthcare issues. ED personnel need information from patients that will help care for the patient, but reducing or eliminating the amount of data that is repeatedly asked of patients needs to occur. Practice changes that could incorporate “rounding,” in which all those caring for the patient are present with the patient so that information is shared may provide a solution to the independent gathering of information one staff member at a time. ED personnel reviewing the notes already recorded in the patient “chart” during the patient’s current stay is another solution. This finding also requires further study to determine how widespread a concern this is. However, simply reading the patient’s chart to determine what information has already been gathered would appear to be a no-cost solution that would provide personnel with vital information without decreasing the patient’s perception of diminished caring.

These practice issues have implications in the realm of education. The next section briefly reviews how nursing education can be responsive to some of these research findings important to patients’ safety perceptions.
2. Nursing education

Teaching new knowledge being generated along with the current nursing knowledge base is a challenge to educators. New pieces of nursing knowledge vital to patient care have to be inserted into nursing education so that current knowledge is not edged out. However, both clinical education and nursing leadership education seem like arenas where the knowledge generated from this and other, similar studies can be placed.

Clinical instructors, who teach and assess nursing practice skills, can be briefed on topics to review with their students and then followed up to see how these topics are used in practice. These topics include appropriate, professional communication with patients to ensure that communication is clear, timely, and accurate, provides time for questions, and is made on a scheduled as well as on a PRN basis.

Secondly, clinical instructors can provide the rationale for attending to patients’ comfort needs (blankets, pillows, pain medicine, food, and urinals). The skills of nursing (tube insertion, monitoring equipment) are important, but assessment of all of the patients’ needs is a more important professional nursing action.

Finally, patient safety should be a precondition, not a priority (Leape, Berwick et al., 2009). Educating nursing students early on safe patient practices during the didactic portion of their training, reinforcing these practices during their clinical training, assessing how well they practice what they have learned, and correcting conditions and unsafe practices will provide the ground necessary to precondition future RNs for safety. Safe practices ingrained early will create safer conditions for patients.
Leadership courses would also provide excellent additional opportunities in nursing education to implement some of the findings in this study. Practicing good communication skills such as the use of layman’s terms and empathetic response, reviewing scheduled versus PRN communication, and emphasizing the necessity of providing time for patients to ask questions are good skills that all nurses as leaders need to possess.

H. Research

The research findings from this current study revealed novel data that require further inquiry to determine if there is sufficient evidence for across-the-board practice changes. Additionally, when patients were asked to define patient safety, their definitions concentrated on ways to prevent bodily injuries such as falls and use of protective equipment. Healthcare-driven patient safety research centers on many different areas (such as medication safety, teamwork, and critical stops for verification). Thus, future research should examine novel data emerging from this study to determine if practice changes are warranted. Future research on patient knowledge deficits regarding patient safety would also be helpful.

Patients revealed novel data during this study that were not found in existing patient safety perceptions studies. ED personnel who asked patients similar questions about their health history and information multiple times left patients feeling less safe. Patients wondered if this data were being recorded or if personnel were on the same page with their care. Patients also noted feeling secure when IV and syringe medication administration sets were prepared in front of them. Guarantees of sterility and non-reuse of equipment were the issues cited by patients as important to their safety.
Future research could further investigate these areas. Qualitative studies could include specific questions about these two areas, examining patients’ perceptions of equipment reuse and other related safety topics. Quantitative studies could include the development of an instrument similar to the one used by Burroughs et al. (2005) to determine if this is a concern for a larger group of patients.

Additionally, patients defined safety in terms of what could be done to protect them from bodily harm, such as equipment placement, side rail use, and hand washing. Medication safety which is one of the most closely studied patient safety initiatives driven by the healthcare culture was not mentioned by this group of patients. This lends credence to findings of recent surveys demonstrating that those within healthcare and those outside of the healthcare culture (patients, the general public) view healthcare safety through different lenses (Kuzel et al., 2004). Further research clarifying the elements of patient safety that are important to patients would provide not only a measure of how aware patients are of safety initiatives pertinent to healthcare, but also reveal topics on which patients need to be educated to help them maintain their safety.

Finally, this ethnographic methodology was able to delve into patients’ perceptions of safety. However, patients were not always clear in defining what safety issues were and what quality issues were. Future research could develop a methodology which more clearly distinguishes safety issues from other areas. Such a methodology would provide a clearer picture of what patients perceive as safety issues.

I. Policy

Since the publication of the Institute of Medicine’s seminal work To Err is Human (Kohn et al., 2000), the entire healthcare system has been developing policies and
methodologies to improve patient safety. Healthcare policy that is much more patient-centered has evolved. The Agency for Healthcare Research and Quality has led the way, among other agencies and patient safety groups, in making patients full partners in healthcare (AHRQ, 2000). This current research study has demonstrated that patient perspective is important: without the patients’ perspective, current data can not be clarified and a source of novel data would be omitted.

However, healthcare culture fights a tendency to allow the “experts” (MDs, RNs, techs, other health professionals, healthcare researchers, and safety experts) to drive the healthcare provision and safety process. This paternalistic approach which is ingrained into healthcare providers omits the patient’s valuable views and perspectives (Longtin et al., 2010). When all of those involved in healthcare (including patients) are not involved in providing safety solutions, there will be gaps that prevent safety from being fully implemented.

During a 2009 emergency landing of a US Airways jet into New York’s Hudson River after a bird strike caused both engines to fail, all of those involved (including the passengers) were responsible for a safe evacuation of the plane (Porto, 2009b). Passengers knew what to do in that situation because the aviation industry engaged passengers in the safety process. Prior to flights, passengers were provided safety briefings that assisted them in completing an evacuation after the emergency landing. Had the passengers not been engaged in the safety process, and had the entire responsibility of plane’s evacuation been up to the crew, a different, more tragic outcome may have occurred (Porto, 2009a).
As the aviation industry has engaged passengers in safety, so must healthcare engage patients in safety. The National Patient Safety Foundation has been a leader in developing policies that engage patients in the development of safety solutions. "Nothing about me without me," is one guiding principle for patient engagement: when healthcare is involved, then patients and families must be involved at every level (Leape, Berwick et al., 2009; National Patient Safety Foundation Patient and Family Advisory Council, 2003).

Current and future policies must fully involve patients in their own care and in the development of safety solutions in healthcare. As the findings from this current research study have uncovered, patients have valuable information to share. Patients have insight into their care and the environment where they receive this care that must be given due attention by safety experts. Patients want to be engaged in their care so that their healthcare concerns are efficiently, accurately, and safely resolved.

J. Researcher Perspective

One of the most interesting and exciting parts of this research was listening to the patients’ stories during the interview process. Patients want to share, and they want to be a part of the provision and assessment of their care. These participants were impressed by the level of personal, professional, competent service they received from the entire ED staff. This is a perspective not often heard (sadly) by those providing care; perhaps processes for making these comments of praise made available to staff need to be developed! Oftentimes, the voices heard more often are those spoken when care is not as professional, personal, competent, and/or safe. Critiques are valuable sources of data and need to be heard. Patients who shared critiques had interesting
perspectives and added valuable data to this study, although at times it was painful to hear such critiques as they pointed to system failures. However, amid the critiques and the kudos, the most important part of this study was providing the patients an opportunity to share their stories.

The greatest concern possessed by this researcher was not allowing his perspective as an insider (Emergency Nurse) to cloud the patient’s perspective. As patients told their stories, it was difficult not to stop them and explain why aspects of patient care were good or not good. Creating an environment in which the patients were able to tell their stories without feeling the researcher was the “expert,” or in which patients did not feel they had to please the researcher and tell him what they thought he wanted to hear, or what would be the most culturally polite and appropriate response was a challenge. Reflexive journaling and discussing these issues with the doctoral committee chairperson were valuable tools for maintaining some important boundaries.

Finally, taking part in a research study was a revelatory process. Witnessing in real time the fruits of processes (qualitative methodologies including Ethnography, thematic analysis, reflexive journaling and discussion, learning what was already studied, and arriving at a novel study) that brought about data was fascinating. During classroom course work, learning the research process was a valuable theoretical exercise for understanding how knowledge is created. Taking part in actual research is far more interesting. Realizing how much is still unknown and learning the processes that bring that knowledge to light creates an enthusiasm in this novice researcher to continue the research process.
K. Limitations

The most obvious limitation is the population from which this sample was chosen. This study was completed in one hospital of one hospital system in a large southwestern Texas city. Transferability of these findings to patients in other (non ED) departments in the hospital, in other EDs in different facilities or hospital systems in the city, and in other EDs in different parts of the United States or in other countries (where there is a different mix of race, economic levels, and other social differences) is limited.

This researcher is a novice to research in genera, and to qualitative research in particular. While being coached by experts in this field, the actual interview process and analysis was a work in progress. Early interviews were not as sharp as later interviews. Data quality was probably somewhat affected as a result.

This researcher entered the research process with some biases. Knowing that there is a patient safety problem, believing in the necessity of including patients’ perspectives to solve this problem, and being an insider in the ED were among the most obvious biases that probably affected the research. Despite reflexive journaling and peer debriefing with the doctoral committee chair and committee members, the researcher’s perspective could have provided unintentional guiding or leading during the interview process.

Challenges during the recruiting process including recruiting enough men to achieve the desired 50% men/women balance for the study. The first six participants agreeing to the purposive sampling were women, despite the attempt to recruit a number of men (who said “no” to the follow up interview). Research slowed a bit as purposive sampling focused on recruiting men. Many of the men interviewed for this...
study were inpatients in the hospital and were visited in their hospital rooms. Attempts to make appointments with men outside the hospital setting proved very difficult.

L. Strengths

The study findings are robust because several measures contributing to credibility were used. Data triangulation was employed in this study. Findings from this study were found to exist in sources outside of the study (newspaper and television stories about patient safety). Researcher reflexivity was employed through journaling. The researcher attempted to understand his assumptions, beliefs, values, and biases so as to minimize his impact on the data collection and analysis (Brantlinger et al., 2005). Second level member-checks (reviewing research findings with participants for feedback) were utilized to confirm accuracy of study results. Five individuals in the study were contacted, and the researcher reviewed the study results as well as the theme and domains with the participants. Their feedback affirmed the results and added additional details that supported the results. Peer debriefing was applied to help diminish the researcher influence on the data. Peer debriefing occurred when the researcher discussed feelings and biases he experienced during interviews and sought feedback by playing back actual interviews with the doctoral committee chair, Dr. Kelly Dunn PhD. Dr. Dunn’s responses were used to improve the researcher’s interview abilities. Thick, detailed descriptions were employed in the results section along with enough participant quotes to support the evidence of the research findings and conclusions (Brantlinger et al., 2005). Finally, the use of ethnographic methodology was an appropriate methodology to bring to light the patient’s experience of care in the ED. Patients encounter the healthcare environment subjectively as a cultural entity different from
those personnel who work within the healthcare culture. The ethnographic methodology allowed the researcher insight into this cultural reality and valuable data from the patient’s cultural perspective.

M. Conclusion

This study provided an excellent opportunity for the researcher to practice research skills and provide patients an opportunity to discuss their care. The results generated knowledge about patients’ safety perceptions that point to future research and affirm current findings in other research studies. No research is truly definitive, but in the process of completing this study, the researcher is aware of generated knowledge revealing important findings. Additionally, the researcher is attentive to the need for further research to broaden and deepen the patient’s perceptions of safety for use in the development of healthcare safety solutions.
Appendix A

Researcher Record of Emergency Department Patient’s Visit History

<table>
<thead>
<tr>
<th>Chief Complaint</th>
<th>Patient ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage Note</td>
<td></td>
</tr>
<tr>
<td>Number and Name of Departments which Patient Visited During Treatment</td>
<td></td>
</tr>
<tr>
<td>Lab Results</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Study Results</td>
<td></td>
</tr>
<tr>
<td>Progress notes: MD, RN, RT, SW</td>
<td></td>
</tr>
<tr>
<td>Healthcare Error(s) Recorded</td>
<td></td>
</tr>
<tr>
<td>Incident Report (event, outcome, follow up)</td>
<td></td>
</tr>
<tr>
<td>Disposition at Discharge</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

Letter of Introduction

Paul R. Clark, RN, MSN
University of Texas Health Science Center School of Nursing

Dear Sir or Madam,

You are invited to participate in a research study. I am interested in talking to patients about their experience as a patient in the Emergency Department. This is part of a research program sponsored by the School of Nursing at the University of Texas Health Science Center here in San Antonio in cooperation with [blank].

The purpose of this study is to understand your experiences of care and safety during your stay as a patient here in the Emergency Department today. I am interested in knowing what you have to say and what you experienced as a patient. I am studying your perspective as a patient because patient’s insights are important in improving the quality of care. By interviewing you about this topic, I hope to uncover new information that will lead us to improve health care.

You are eligible for this study because you are an Emergency Department patient, over the age of 18, able to communicate in English, and were awake and aware during your Emergency Department visit.

By participating in this study you will be asked to participate in a face to face interview with the researcher at a later date and time convenient to you. Any information you provide will be kept confidential.

If you are interested in participating, please complete the information below and hand this form to your doctor or other health care provider. Please keep a blank copy of this form for your information. The researcher will contact you within a week and arrange a time, convenient to you, for an interview. The interview will take anywhere from 45 minutes to 2 hours, depending upon how much information you would like to share. I may contact you in the future, if you give permission, to follow up with any questions I may have about what you shared during the interview.

Thank you for considering being a part of this important study.

If you have any questions about this study, you may call Paul R. Clark, RN, MSN, MA at [blank]

Name: ____________________________________________

Phone Number: (           ) ____________________________

Best time to call (circle) Morning Afternoon Evening

Signature ____________________________________ Today’s Date: _____________
Appendix C

Interactive Question Guide

Typical Grand Tour Questions
Tell me about your most recent visit to the ED on (date)
Tell me what happened while you were there
Tell me about any concerns you had while you were receiving care

Specific Grand Tour Questions
Tell me how you were feeling when you came to the ED
- anxious
- frightened
- unsettled
- concerned
- in pain
- Did the staff do anything to make you feel better? What feelings did you experience as they cared for you?

You mentioned earlier that you spent a lot of time on your stretcher. How was that for you?
During your recent visit, was there a delay of your care? Can you tell me about that?
During your recent visit, did you have to wait to be seen? Can you tell me about that?
- Would you describe how you felt with the more time you spent in the ED?
- Did this affect you in any way?
- Can you please tell me how you perceived your care as the amount of time of your stay increased?

Guided Grand Tour Questions
Explain to me what the ED looked like to you. the waiting room, the lobby, the main department, your patient care room.
- Private Rooms
- Level of Noise
- Cleanliness
- Level of activity
- Distance from central desk
- Door open/closed

Mini-tour Questions
During this last visit, could you describe how the doctors, nurses, techs, and or other staff talked to each other? Can you provide me some examples of communication between...

- Did the level of communication make you feel safe?
- Were you given information about your care?
- Were you able to make decisions regarding your care based on this information

(Continued)
Experience Questions
What was your experience in the Emergency Department?
During your ED care, did you experience any concerns?
  • Do you feel that your concerns were taken seriously (marginalized)
  • To whom did you express your concerns?
  • If not, why didn’t you express them?
Did you experience any activities by the ED staff that you questioned?
  • What was it about that specific activity that made you question it?
If concern/if voiced:
What did the staff do to correct those issues?
Can you tell me how that change/correction/apology/explanation was for you?
Was it your experience that you were included in decisions regarding your care?
During your time in the ED on this last visit, did the staff tell you directly what practices were being done for your care?
  ∙ Hand washing
  ∙ ID checking
  ∙ Electronic med dispensing

Native Language Questions
How would you define patient care?
Could you describe patient care?
Appendix D

Informed Consent Form (Institutional Review Board, UTHSCSA)

The University of Texas Health Science Center at San Antonio (UTHSCSA)
To be conducted at

Information about this form
You may be eligible to take part in a research study. This form gives you important information about the study. You will be asked to sign in more than one place in this document.

Please take time to review this information carefully. You should talk to the researchers about the study and ask them any questions you have. You may also wish to talk to others (for example, your friends, family, or a doctor) about your participation in this study. If you decide to take part in the study, you will be asked to sign this form. Before you sign this form, be sure you understand what the study is about, including the risks and possible benefits to you.

Please tell the researchers or study staff if you are taking part in another research study.

Taking part in this study is completely voluntary. You do not have to participate if you don't want to. You do not have to participate in this study in order to get standard medical treatment. You may also leave the study at any time. If you leave the study before it is finished, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

General Information – “Who is conducting this research?"

Principal Investigator
The Principal Investigator (PI) is the researcher directing this study; the PI is responsible for protecting your rights, safety, and welfare as a participant in the research. The PI for this study is Paul R. Clark, RN, MSN, MA, a graduate student of the University of Texas Health Science Center San Antonio, School of Nursing, advised by School of Nursing graduate faculty member Dr. Kelly Dunn RN, PhD, CNS-BC.

Purpose of this study – “Why is this study being done?”

The reason this study is being done is to discover new ways to improve patient care and safety. Many programs have been developed by health care professionals to improve the care and safety of patients while they are being cared for in the hospital. However, patients have not had an adequate opportunity to share with healthcare professionals their insight on the important parts of their care and safety. By having an opportunity to share your thoughts on your care and safety, we hope to learn other ways to improve care and safety.

You are asked to participate in this research study of An Emergency Department Patient’s Perception of Safety. Because you’ve been a patient in the Emergency Department, you’ve experienced first hand how care is given. We would like to know about your experience through your eyes and in your words. In this way your perspective can shed light on how we can do better.

The researchers hope to learn how to improve patient safety through your stories. As a patient you have seen the way care is provided in ways we can not see. Your perspective is unique. By sharing this unique perspective we hope to develop new ways of making care safer.
Information about Study Participants – “Who is participating in this research?”

You are being asked to be a participant in this study because you have been a patient in the Emergency Department.

How many people are expected to take part in this study? This study will enroll approximately 30 study participants.

Information about Study Procedures – “What will be done if you decide to be in the research?”

If you decide to take part, you will be asked to sign this consent form.

While you are taking part in this study, you will be asked to attend one interview with the researcher. A follow up interview may be necessary to clarify some of your points of view.

As a participant in this research study you will be able to participate in an interview with the Primary Investigator, Paul Clark, a registered nurse who has worked in an Emergency Department and a graduate student in the University of Texas Health Science Center School of Nursing. During this interview you will be invited to talk about your care in the Emergency Department. You will also be able to discuss any concerns you had and be able to fully describe any ideas regarding your care. The interview will last anywhere from 45 minutes to 2 hours depending on how much information you would like to share.

If at any time you wish to end the interview, you may do so. The researcher respects your time!

Risks – “What are the risks of participation in the research?”

Risks from the specific research procedures
There are risks to taking part in this research study. There is a chance that you will experience some emotional discomfort while recounting your Emergency Department visit. If this occurs we can talk about the reasons for your discomfort, if you choose. You may also choose to end the interview. I will provide you with names and contact information of counselors if you wish.

Benefits – “How could you or others benefit from your taking part in this study?”

You may not receive any personal benefits from being in this study. We hope the information learned from this study will benefit other people through improved safety in hospital care.

Alternatives – “What other options are there to participation in this study?”

Not participating in this research is an option. You may choose not to participate in the interview, or decide to end the interview at any time.

Compensation – Will there be any compensation for participation?

You will not receive any compensation for participation.

Costs – Will taking part in this study cost anything?
You will not receive any compensation for participation, and you will not need to pay any money to participate in this research. You will be paid for any parking expenses incurred at the University.

### Confidentiality – How will your records be kept confidential?

Information we learn about you in this study will be handled in a confidential manner, within the limits of the law. If we publish the results of the study in a scientific journal or book, we will not identify you. The Institutional Review Board and other groups that have the responsibility of monitoring research may want to see study records which identify you as a subject in this study. More information concerning confidentiality is described in the "Authorization to Use and Disclose Protected Health Information as part of a Research Study."

### Contact Information – Who can you contact if you have questions, comments or complaints?

If you have questions now, feel free to ask us. If you have additional questions, comments or complaints later or you wish to report a problem which may be related to this study please contact:

**Primary contact:**
Paul Clark, RN, MSN, MA can be reached at (cell) [contact information] and (home) [contact information].

**If primary is not available, contact**
Dr. Kelly Dunn RN, PhD, CNS-BC can be reached at (office) [contact information] and (cell) [contact information].

The Healthcare System committee that reviews research on human subjects (Institutional Review Board) will answer any questions about your rights as a research subject, and take any comments or complaints you may wish to offer. You can contact the IRB by calling [contact information] or by mail to [address].

You may also contact the University of Texas Health Science Center IRB by calling [contact information].
Research Consent Signature Section
If you agree to participate in this research sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE
- You have read the above information.
- Your questions have been answered to your satisfaction.

Adult Signature Section
You have voluntarily decided to take part in this research study.

<table>
<thead>
<tr>
<th>Printed Name of Subject</th>
<th>Signature of Subject</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name and Title of Person Obtaining Consent</td>
<td>Signature of Person Obtaining Consent</td>
<td>Date</td>
<td>Time</td>
</tr>
</tbody>
</table>

This section describes the use of your health information. If you agree to allow the researcher to use your private information, you will be asked to sign at the end of this section.

Confidentiality – Will your health information be protected?

Research policies require that private information about you be protected. This is especially true for your health information.

However, the law sometimes allows or requires others to see your information. The information given below describes how your privacy and the confidentiality of your research records will be protected in this study.

What is Protected Health Information (PHI)?
Protected Health Information is information about a person's health that includes information that would make it possible to figure out whose it is. According to the law, you have the right to decide who can see your protected health information. If you choose to take part in this study, you will be giving your permission to the investigators and the research study staff (individuals carrying out the study) to see and use your health information for this research study. In carrying out this research, the health information we will see and use about you will include information from your Emergency Department visit:
- Official notes about your care written by the registered nurses, doctors, respiratory therapists, social workers, Emergency Department Technicians, and any other hospital personnel.
- Your final diagnosis and plan of care (called a "disposition") written by the Emergency Department Physician(s), Physician's Assistant(s) or Nurse Practitioner(s) who cared for you.
- The reason you came to the Emergency Department (called a "chief complaint")
- The original note describing the details that led you to go to the Emergency Department written by the Registered Nurse who first interviewed you, (called a "Triage note")
- Laboratory results that were completed as part of your care in the Emergency Department
Other tests (called “diagnostic studies”) such as x-rays, MRI (Magnetic Resonance Imaging) results, CT (“CAT scan”) results and other diagnostic studies carried out during your care so the doctor could determine how to treat you.

Other reports that were written by staff during your care.

We will get this information by accessing your medical record from the [redacted] (medical records) department.

How will your PHI be shared?

Because this is a research study, we will be unable keep your PHI completely confidential. We may share your health information with people and groups involved in overseeing this research study including:

- The committee that checks the study data on an ongoing basis, to determine if the study should be stopped for any reason.
- The members of the local research team
- The Institutional Review Board and the Compliance Office of the University of Texas Health Science Center at San Antonio, and [redacted] that oversees how research studies are carried out.

The researcher will hand copy parts of your PHI. Your name will not be recorded, and instead a code will be assigned to you. No part of your medical record will be photocopied or photographed.

The research team receiving your health information may not be obligated to keep it private. They may pass information on to other groups or individuals not named here, but your name will never be associated with any information the research team reviews. Only the PI will have been able to associate your data with your name.

If you decide to participate in this study, you will be giving your permission for the people named above, to collect, use and share your health information. If you choose not to let these people collect, use and share your health information as explained above, you will not be able to participate in the research study.

How will your PHI be protected?

In an effort to protect your privacy, the study staff will use code numbers instead of your name, to identify your health information. If the results of this study are reported in medical journals or at meetings, you will not be identified.

Do you have to allow the use of your health information?

You do not have to allow (authorize) the researchers and other groups to see and share your health information. If you choose not to let the researchers and other groups use your health information, there will be no penalties but you will not be allowed to participate in the study. After you enroll in this study, you may ask the researchers to stop using your health information at any time. However, you need to say this in writing and send your letter to [redacted] If you tell the researchers to stop using your health information, your participation in the study will end and the study staff will stop collecting new health information from you and about you for this study. However, the study staff will continue to use the health information collected up to the time they receive your letter asking them to stop.

Can you ask to see the PHI that is collected about you for this study?
The federal rules say that you can see the health information that we collect about you and use in this study. Contact the study staff if you have a need to review your PHI collected for this study. You will only have access to your PHI until the end of this study, at the latest June 2010. At that time your PHI will be destroyed.

How long will your PHI be used?
By signing this form, you agree to let us use and disclose your health information for purposes of the study at any time in the future. There is no expiration date because we do not know how long it will take us to finish doing all of the analyses and we will need to use your health information for as long as it takes.

Authorization Signature Section
If you agree to the use of your protected health information in this research, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.
SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:
- You have read the above information.
- Your questions have been answered to your satisfaction about the collection, use and sharing of your protected health information.

Adult Signature Section
You authorize the collection, use and sharing of your protected health information as described in this form.

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<tr>
<th>Printed Name of Subject</th>
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<td>Date</td>
<td>Time</td>
</tr>
</tbody>
</table>
REFERENCES


Higgins, W. (2008, September 13). Parents sue over babies' heparin overdoses; infants were given too much heparin at Methodist hospital. *Indianapolis Star*, Retrieved from


VITA

Paul R. Clark was born in Louisville, KY to John W. Clark Jr. and Christine Ann Graf Clark (19[ ]). Paul received Bachelor of Arts (Biology-1989) and Bachelor of Science (Nursing-1999) degrees from St. Louis University (St. Louis, MO). Paul became a Franciscan Brother in the Roman Catholic Conventual Franciscan Religious Order in 1993, and was awarded a Master of Arts degree (Theology) from the Washington (DC) Theological Union (1997).

After being accepted into the BSN to PhD program at the University of Texas Health Science Center in San Antonio School of Nursing in 2005, a Master’s Degree in Nursing was awarded in December, 2006. He received several scholarships including the Emergency Nurses Association Foundation Doctoral Scholarship (2006), Michael and Louise Beldon Living Endowment Scholarship (2007, ‘08, & ‘09), Baptist Health Foundation Scholarship (2007, ‘08, and ‘09), and the Advanced Education Nursing Grant, St. Vincent (Indianapolis, IN) School of Nursing, Alumnae Association (2008).