PATIENTLY WAITING?

a report of research into waiting time at King George Hospital Accident and Emergency Department – patient and staff views

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Contents

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Coral Booth. January 1999.

Summary

Part I - Why and how the study was undertaken

During 1996 Redbridge Community Health Council (CHC) became aware of increasing dissatisfaction from patients using King George Hospital Accident and Emergency services. Many of these patients cited waiting times as a contributory or the main factor for their dissatisfaction; some of these delays contravene guidance issued by the Department of Health. Accident and Emergency staff cite these waiting times as the cause of some of their difficulties. Redbridge CHC believed that the level of complaints was disproportionately high, even taking into account the increase in patients seen each year (currently 63,000), and wished to understand the factors contributing to lengthy waits and the effects they have on both patients and staff.

The study into this situation was undertaken over a one year period from 1997-1998. Due consideration was given for the need of the A&E department to function as usual and for the confidentiality of patients, those accompanying them and the staff.

Both quantitative and qualitative data were gathered. Quantitative data was collected from both patients and staff using three questionnaires. Qualitative data was gathered from a number of observations and interviews carried out by the researcher. Also, a number of patients were tracked from arrival to leaving (or to placement on a ward).

Before production of this final report the department was revisited.

Part II - What the patients said

141 questionnaires were completed by patients using the Accident and Emergency department. These responses were from two separate questionnaires, the first acting as a pilot to test the suitability of the questionnaire.

The responses showed that people using the department for less serious accidents, not requiring admission, tended to wait up to a maximum of about 4 hours to be treated. However some people who required investigations such as x-rays or blood tests reported waiting considerably longer. Responses indicate a good deal of dissatisfaction with information around waiting time combined with a belief that the information provided was inaccurate. Perhaps unsurprisingly people would be treated more quickly when the department was less busy.

Very few people indicated dissatisfaction with the treatment that they obtained in the department.

Part III - Waiting for admission - The patient experience

Nineteen patients were tracked through A&E on two separate days in February 1998. On one of these days thirteen patients agreed to be tracked by the researcher from 7a.m; all had arrived before midnight. These patients had already undergone tests and were accommodated two to a cubicle, despite which few made overtly negative comments. During this time the A&E department bore more resemblance to a ward. By the time all thirteen patients had been tracked to admission, the shortest time one of them had waited for admission was 15 hours, with one patient admitted after waiting for over 29 hours.

A&E cubicles were occupied, it would seem, by people who had been dealt with by the A&E staff and who were simply waiting for a bed to become available on a ward.

Other issues uncovered by the two days observation were as follows.

- Staff had difficulties on one observation day on communicating with two patients who did not speak English.
- Some patients and those accompanying them were uncertain as to whether or not the patient would be admitted.

- A relative of one patient expressed anger that there was no provision for privacy between patients who were very possibly about to die and their relatives, who were about to see them for the last time in the middle of a busy A&E department.

Part IV - Staff views

The researcher spoke to staff about their feelings during the period when patients were tracked. Some expressed a firm view that waiting time was a problem. Further difficulties were usually associated with lengthy waiting times. Nurses expressed concern that they sometimes worked in a way that they felt was unacceptable. Both nurses and reception staff described incidents of violence and verbal abuse, reception staff describing the latter as an almost daily occurrence. A questionnaire completed by the staff during October 1998 revealed that 86% of those responding had experienced either physical or verbal abuse, with 97% of these feeling that lengthy waiting times contributed to these incidents - but only 35% feeling that they had been adequately supported by their management as a result of these incidents. Only one respondent believed that there were adequate systems in place in the Trust to minimise the risk of such incidents recurring.

The respondents to the questionnaire who had not experienced physical or verbal abuse all regarded it as a potential risk.

Part V - Revisiting the A&E Department

An interim report, with recommendations, was submitted to a number of Trust staff who had been involved with the study from its inception. They discussed their responses to this report with the researcher, believing that they were aware of a number of issues raised in it and were already trying to address some of them. Detailed information on the strategies of the Trust regarding these issues is, however, outside the remit of this report.

The researcher revisited the A&E department during April 1998 and found that some issues had been addressed; for example, the cubicle situation was improved, as were staffing levels. However, the staff security issue was still unresolved - the comments in part IV of this report are from staff questionnaires returned after the revisit.

Part VI - Discussion of the study - with recommendations

Summary of recommendations

1. That Redbridge Health Care Trust should consider the employment of staff with a clear role of patient liaison/communication.

2. That patient/staff interaction should be integral to the training of staff.

3. That the evening GP service be maintained.

4. That consideration be given to the provision of a Minor Injuries Unit adjacent to the department.

5. That a separate enquiry point be provided (ideally staffed by the person(s) in recommendation 1).

6. That nurses staffing the A&E department be given the authority to order x-rays and that consideration be given to nurses having the authority to administer pain relief.

7. That the geographical location of patients attending be monitored and if patients are continually appearing in KGH rather than other A&E departments nearer to their address, the reasons for this be investigated.

8. That honest communication with patients concerning waiting time be undertaken.

9. That an appraisal of the level of compliance with Patient Charter standards be undertaken.

10. That the difficulties arising from 'blocked beds' be tackled in conjunction with other agencies.

11. That the needs of patients who do not speak English be addressed.

12. That the morale and safety of staff be improved.

Part VII - Researchers reflections

Finally the researcher provides some reflections upon the research in part VII of this report.

The researcher reflects that in the A&E situation there are both objective facts and the perceptions of patients (and their accompanying friends or relatives) and staff.

The researcher reflects upon the subjective impression that staff and patients have of each other and suggests further study into issues relating to patient anxiety.

Finally the researcher concludes that there are simply too few beds in KGH and elsewhere in the local area to accommodate patients entering hospital through the A&E department and acknowledges that this problem has no easy short term solution.

PART 1- Why and how the study was undertaken

1.0 Background Information

During 1996, Redbridge Community Health Council (CHC) became aware of increasing expressions of dissatisfaction from patients using King George Hospital Accident and Emergency services[1]. Many patients stated that lengthy waiting times for treatment contributed to, or were responsible for, their feelings of dissatisfaction. Complainants asserted that they had experienced overnight trolley waits within the department, a situation deemed unacceptable by the NHS Executive.[2] Further evidence of dissatisfaction around waiting time emerged from the "Complaints Audit Committee'[3], Report of complaints by category for a directorate - acute services division"[4], and from local media reporting[5].

There were indications that staff working within the department attribute some of their own working difficulties to the time that patients wait to be seen and that this may be a factor in acts of aggression towards staff from patients[6]. This assertion has been supported elsewhere[7].

The Accident and Emergency department at King George Hospital currently treats in excess of 63,000 patients each year. The number of patients seen and treated in the department has increased each year. This trend conforms to those seen within other A&E departments[8]. However, it was the view of Redbridge CHC that even with the increased activity the level of complaints was disproportionately high and that lengthy waiting time was both the direct reason for some complaints and a contributing factor to others.

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[1] Redbridge CHC complaints 1996
[2] Accident and Emergency Departments, NHS Executive. Department of Health 1994
[3] CAC April-Sept 1996. 24th January 1996
[4] Redbridge Health Care Trust - almost one third of complaints related to A&E, 01.4.96-31.3.97.
[5] Ilford Recorder Newspaper 13.3.97 and 23.1.97.
[6] Ilford Recorder Newspaper 29th May 1997.
[7] Dix, A.. Health Service Journal 30.01.97
[8] District Audit. 1997

This view that waiting times were relatively long is supported by Redbridge CHC's participation in 'Casualty Watch' (see reference 14) a snapshot survey of activity, including lengths of waits, on a monthly basis. Participation confirmed that people using the hospital experienced long waits on a regular basis (see reference 14 on page 58, and appendix 4 for further information).

Redbridge CHC wished to understand the factors which contributed to the lengthy waits; perhaps more importantly there was a wish to understand the **effects** of this waiting time - on both patients and staff. This was believed to be particularly important within a context of increasing shortages and difficulties in recruitment and retention of qualified nurses together with increasing media accounts of violence towards health service staff. It was important also when taking into consideration the expectations that patients have when using the NHS together with increasing awareness of Patients' Charter standards and the aim of openness and accountability within NHS structures and services.

1.1. Planning the study

There were a number of factors to take into account when planning the research. Paramount was the need to ensure that the work did not interfere with the department undertaking its daily activities. It was also important that the researcher maintained as much objectivity as possible to present a view that was not distorted.

There were issues to consider when attempting to elicit the views of patients using the department; it was important not to add to their distress or interfere with any diagnosis or treatment.

The confidentiality and sensitivity of patients, relatives accompanying them and staff were considered of fundamental importance.

The impact of the research on the department was considered in some detail by the researcher and a number of key staff prior to commencing. Together they agreed access, protocols and other issues related to the study.

1.2 Methods used to gather information for the study

Data was gathered in a number of different ways. Quantitative data was gathered using three separate questionnaires. Two of these were addressed to patients, one in the form of a pilot survey. The third was addressed to staff. These questionnaires are reproduced as appendices 1-3.

Qualitative data, used to elicit greater depth and understanding of the experience of being a patient/relative/staff member in the department, came from two main sources: observation and interviews. A number of observations were undertaken in order to experience the department at both busy and quiet periods. Many interviews were undertaken with both staff and patients; prior agreement to interview was sought and the interviews were structured around a theme of waiting time and its impact.

In order to gather quantitative and qualitative data which would offer insights into the process of being a patient waiting for a bed following admission into A&E, a number of patients were 'tracked' on their journey through the department. This meant following the trajectory of individual patients' A&E contact from the time of arrival until eventual placement on a ward (or other outcome). Patients who would be likely to meet the requirements for this analysis of process were identified with help from staff. If permission was obtained they were observed and interviewed during their time in the department.

The methods described above resulted in the primary data source for this study.

1.3 The findings

Following data collection an interim report was produced and circulated to those who were closely involved with the study. This was to provide an opportunity to reflect upon the process of data collection and the findings which arose.

It also allowed an opportunity to discuss the recommendations that had arisen from the interim report.

It was agreed that an opportunity to look at any changes that had been made since the data had been gathered would help to produce a final report that would be more up to date. This was seen as a useful dimension to the report, therefore opportunity to revisit the department was taken. The findings of that visit are included within this report.

1.4 Scope and limitations of the study

Given the nature of Accident and Emergency Departments it was felt that little would be achieved in undertaking a 'snapshot' type study. This is already done routinely each month as part of 'Casualty Watch' and was unlikely to yield the data required. Because the study attempts to elicit people's attitudes, experiences and perceptions, intangible human qualities which may be difficult to access, or may change from day to day, a more considered approach to data collection was required which combined qualitative and quantitative methods. The longer term approach helped to overcome the effect of having a researcher in the environment, which may alter the behaviour of those being observed. It was hoped that this effect would be minimised as people became more comfortable and familiar with the researcher.

For the reasons outlined above the study incorporates a number of data collection methods. These methods are seen as complementary, each offering a different dimension.

The extended study period has allowed for variations over time in factors which may impact on the perceptions and experiences of patients and staff. Therefore, findings over time are compared to eliminate the possibility that an unusual event affected the data.

The staff survey was left until the end of the period of study in order to attempt to gauge the effect of security measures which had been put in place to remedy concerns that were evident from staff at the time of the interim report.

The project methodology allows some insights into the dynamic between patients and staff using the department. This may yield useful insights into communications, actions and responses to lengthy waiting time. Furthermore, if it is accepted that the perceptions that individuals have will influence the way that they act in the world, then understanding more about these perceptions may in itself be informative and useful.

In summary the project aims were to find out further information about the following:

- A greater understanding of 'waiting time' as a source of dissatisfaction
- Identification of the elements of waiting which cause particular distress / discomfort to patients and staff
- Possible consequences of lengthy waiting time to patients and staff
- Understanding of the impact of GP referrals on patient expectation.
- Factors which contribute towards variance in waiting time
- Evidence, if any, of statistically significant associations between key variables other than clinical priority (specifically gender, ethnicity and age) and length of wait

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1.5 Project Timescales

December 1997	Distribution of pilot patient survey.
December 1997	Initial observation period - 4 hours (evening)
January 1998	Feedback with A&E manager
January 1998	Observation 12 hours (weekday am and pm)
February 1998	Observation 24 hours (nights and weekends)
February 2nd 1998	"Tracking patients" - 8 hours and follow up.
February 6th 1998	"Tracking patients" - 8 hours and follow up.
April 1998	Main patient survey 250 copies distributed.
April 1998	Interim report and meeting with department managers.
October 1998	Staff survey distributed
October 1998	Draft final document to CHC Members for comment
November 1998	Analysis of staff survey
December 1998	Production of final report

1.6 Context of the study

Following several months of planning, the initial pilot survey of patients was undertaken during December 1997. Brief findings of this are recorded within this report. This pilot study was undertaken to test the effectiveness of the questionnaire and to compare the results with the main survey which was undertaken during April 1998.

December is one of the busiest times of the year within an A&E department. Peak attendance usually coincides with the winter months.

At the time of the initial phase of the study, the A&E department was in the process of adding and fitting out a further four examination cubicles.

Nursing staff levels throughout the period of the study were considered by the manager to be adequate and considerably more stable than they had been a year previously. However, it was noted that on the occasions the researcher visited the department there was usually at least one member of nursing staff absent. The use of the in-house agency LPNS helped to overcome staffing shortages but was unable to always meet the demand.

Junior Doctors change their residences during February and October which may feasibly contribute towards some delays whilst new staff familiarise themselves with the department. Part of the study was undertaken at a time when the new Junior Doctors arrived.

PART II - What the patients said

2.1 Pilot patient survey

The questionnaire was distributed during December 1997. It was offered to attendees at A&E reception. Distribution was successive and non selective and was offered to the first 100 people arriving. The questionnaire is reproduced as appendix 1.

Of the 100 questionnaires offered, 43 were completed and returned sealed in the envelopes provided to a box at the reception desk.

Following the pilot survey the information was shared with the department manager. No indications were given that practice would be altered as a result of this pilot survey.

The two main purposes of the pilot survey was to test the adequacy of the questionnaire, and the method of obtaining responses. It was evident from the responses that two of the questions would benefit from rewording to make the meaning clearer. This adjustment was made to the questionnaire prior to the main survey being undertaken.

The response rate of almost 50% was considered to be adequate. It is possible to maximise response rates to questionnaires by a number of means but when the time and cost of such methods are considered, this trade-off of a lower response rate was felt to be reasonable. The main difficulty experienced by the researcher was the lack of control retained over giving out the questionnaires, there was no way of knowing whether those giving out the questionnaire would offer one to each walk in attendee.

2.2 Characteristics of the respondents

Gender:

Male 47%

Female 53%

Age distribution:

18-25 years 28%

26-40 " 40%

41-60 " 28%

61-75 " 0

over 75 " 4%

Ethnic identity (self defined) of respondents: British: 34% White: 14%

Asian: 9.0% Sri-Lankan: 4.0% Irish: 2.0% Chinese: 2.0%

Mixed race: 2.0% No ethnicity defined: 33%

Postal Region:

Almost half of the respondents came from the following areas:

IG1, IG3, IG11, RM6.

The remaining respondents were distributed amongst other IG and RM postal regions.

2.3 Responses to questions

Question 1 asked whether respondents knew which treatment category they had been assigned, following triage assessment[9].

[9] Categories are assigned by appropriately trained clinical staff and indicate a clinical priority based on a clinical assessment at the time of the patient presenting to the A&E department. Categories are as follows:P1 = serious illness requiring immediate attention. P2 =severe injuries or serious illness requiring rapid medical attention within 10 minutes. P3 = Non-life threatening conditions requiring medical attention within one hour. P4 = Medical problems that can safely wait more than 2 hours without medical attention. P5 = Non urgent problems that do not appear to be accidents or emergencies. Source: King George A&E Patient information July 1997. These categories were implemented within a reorganised Triage system on 1st September 1997.

Yes 51%

No 46%

Comments made in relation to this question were as follows:

"not told - but read the category on the form" (2 people)

"asked after reading the questionnaire" (2 people)

Question 2 asked respondents who knew which category they had been allocated to indicate this on the form. Of the 22 respondents who indicated that they did know, 40% were in category 3 and the remaining 60% were in priority category 4. For an explanation of this and other categories please read footnote 9 above.

Question 3 asked respondents whether they had been given information about how long they could expect to wait before being seen by someone who could examine or treat them. 41 of the 43 respondents answered this question as follows:

Yes 58%

No 42%

comments made were as follows:

"told four hours, more doctors are needed"

"I was told that the wait shouldn't be too long as the department was quiet"

"I wasn't told anything but there was a notice on the wall"

"The triage nurse told me how long I would have to wait"

"The receptionist told me how long I would have to wait"

"No - I wasn't told anything - why?"

"I was told it would be a long time - but what does that mean?"

"Information was given, but it wasn't accurate and I thought that I had been forgotten"

"The staff were polite but unhelpful. I had no idea why I had to wait for so long"

Question 4 asked respondents to estimate the time they spent overall in the department, before either going home, or being allocated a bed. The majority of respondents (almost 70%) estimated that they spent between 1 and 4 hours in the department. Less than 5% estimated that they spent over 4 hours in the department.

Question 5 asked respondents if they experienced further delays after seeing a doctor who could treat them. Just under half of these respondents indicated that they did experience further delays. They were asked to identify the reasons for the further delays if known (question 6). Most of the respondents (almost 75%) did not indicate that they knew the reasons for further delays. Those who did attribute a factor, cited the following:

- waiting for a prescription
- GP letter
- further treatment or assessment
- medication
- x-ray
- blood test results

Question 7 went on to ask those who had experienced delays whether they had been kept well informed about the reasons for the delays.

Yes 36%
No 64%

Some respondents included comments that they had received no information at all, even when they asked.

Question 9 asked respondents whether they had experienced any personal discomfort as a result of the time spent waiting. Of the 28 people that answered this question, 64% responded that they had not experienced personal discomfort as a result of time spent waiting. Several very positive comments were made, indicating that people

expected to wait and did not mind this. Of those that did experience personal discomfort as a result of waiting the comments cited in response to question 10, below, give insights into how this made respondents feel.

Question 10: asked "How did the waiting time make you feel"?

"very upset"

"fed-up"

"worried"

"angry"

"I was in a lot of pain"

"I thought that the staff had a very bad attitude and didn't care"

"my wife was seriously ill and staff didn't seem very caring or sympathetic, I suppose they see it all the time, but it was very upsetting for us"

"I thought that young children were always a priority but my child wasn't seen for three hours .. got worse and worse, I was so annoyed"

Respondents were also asked about ways in which waiting time could have been made easier. Many of the responses related to the physical environment. The drinks machine did not work and there were no snacks available; a change machine was suggested to enable telephone calls. More than one respondent complained about the children of other patients/relatives. Some suggestions were made that magazines would be helpful, also that information and posters on the wall would be welcomed.

One respondent who claimed to wait for over 20 minutes before seeing a triage nurse suggested that a visual alert be attached to the ticket machine to alert staff that people were waiting for triage.

Question 12 asked respondents to judge the overall helpfulness of staff. 37 people responded to this question. The majority (83%) indicated that they felt that, overall, the staff attitude was helpful. Several respondents indicated that reception staff had been particularly helpful.

Questions 13-15 Asked respondents whether they had contacted their GP or attended a Minor Injury Unit prior to attending the Accident and Emergency department. The majority of people had not contacted any other agency prior to attending A&E (65%).

Following this pilot survey the information was shared with the manager of the department. There were no indications that any changes would be made as a result of the pilot survey.

The pilot survey indicated by the responses given that some of the questions required refining and that the questionnaire was probably too lengthy for some people to bother completing. The main survey amended and shortened the questions and is attached as appendix 2.

3.0 The main patient survey

The questionnaire was distributed to all walk-in attendees to the department on the 22nd April 1998. In total 96 completed questionnaires were returned from the 150 that were distributed.

3.1 Characteristics of respondents

Totals may not add up to 100% because of missing responses (for example, some people did not indicate their age group, or define their ethnicity).

Gender:	Male	60%
	Female	40%

Age distribution:	18 - 25	37%
	26 - 40	34%
	41 - 60	14%
	61 - 75	10%
	over 75	0

Ethnic identity (self defined):

White 29% British 10% Asian 18% African 8% Mixed race 4% Irish 6%

Moslem 6% No definition offered: 19%

Postal region:

The majority of respondents indicated either an IG or an RM postal region.

3.2 Responses to questions

In response to the question which asked whether the respondent knew the triage category to which they had been assigned:

Yes 58% No 39%

Those respondents who had indicated that they knew which category they had been assigned all indicated priority categories 3 and 4 and were divided fairly evenly between these two categories.

Question 3 asked if the respondent had been given information about how long he / she could expect to wait before being seen by someone who could treat them.

Over two thirds of the respondents (68 %) said that they had been given information about how long they could expect to wait before being seen by someone who could treat them. However, included in this figure are those respondents who obtained this information from the visual display on the wall of the department.

Several respondents commented that the information given was misleading (in particular the LED visual display was criticised). Others commented that the information given was probably accurate at the time it was given but that it became very inaccurate and no explanation was offered when circumstances changed.

Question 4 asked about the length of time that people spent waiting to be seen by a doctor. The majority of respondents indicated that they spent an amount of time that was consistent with the triage category that they had been assigned. Those who were assigned priority category 3 waited approximately 1-2 hours, and those assigned priority category 4 waited approximately 2-4 hours. In a number of cases some respondents indicated that they waited for a substantially shorter period. These respondents attended during the early hours of the morning, at a time when the department was, presumably, less busy.

Questions 5, 6 and 7 asked respondents to reflect upon the amount of time spent in the department overall. Had they experienced further delays once being seen by a doctor? And if so were they kept informed of the reasons for delays?

Perhaps unsurprisingly, many of the respondents indicated delays experienced because of waiting for blood test results, dressings, stitching of wounds etc. In many responses people indicated that they expected delays and therefore were not concerned at the length of the wait experienced. However almost ¾ of respondents indicated that they were not given information about the reasons for waiting. A number of comments made suggested that where information had been given it was vague and non - specific. Some others asserted that information was not offered but that staff had been helpful when responding to queries around time delays.

Those respondents who waited for x-ray results were particularly unhappy at the length of the wait experienced, indicating in several responses that they thought that nursing staff should be able to "order an x-ray" as it seemed fairly obvious one was needed. One responded commented:

> *" I don't know why I had to see a doctor when the nurse had already said it would probably need an x-ray. I waited two hours, saw the doctor...who said we need an x-ray, then I saw him again once that was done....in total I was there for about six hours...it seems really inefficient"*

Question 8 asked whether respondents felt that they experienced any personal discomfort whilst waiting in the department. Similar responses to those in the pilot questionnaire were forthcoming. There were comments about the poor environment of the department, together with the lack of adequate catering facilities (particularly when the outpatient facilities were closed). There were a small number of comments which parallel those made above regarding waiting to see a doctor:

> *"Why did I have to wait nearly three hours before being offered pain relief? I was in terrible pain and the nurse kept saying sorry but we can't give you anything until the doctor has seen you."*

The next question asked about the attitude of staff in the department. Again there were parallels with the earlier questionnaire which indicated that the majority of respondents felt that staff were helpful.

3.3 Summary of patient survey

Comparison of the two surveys of A&E attendees show a high degree of consistency in the responses which have been elicited. The similarities in the responses are of interest because the two surveys were carried out at different periods of the year (December and April). Respondents are adequately representative of the geographical location served by the hospital. It is not known if the ethnic diversity is representative of those attending the hospital because the Trust does not currently collect data on the ethnicity of attendees to the A&E.

A slightly higher number of respondents indicated that they knew which triage category they had been assigned in the later survey; similarly there was an increased number of respondents indicating that they had information about how long they could wait to be treated. The increase is encouraging, but any conclusions drawn can only be tentative without looking at other expressions of user satisfaction.

Where an attempt was made to find out if people were kept well informed about reasons for delays, where these occurred, results from both surveys are very similar. This could indicate that no improvement has occurred in information given to patients.

In both surveys the question which asked about whether staff were perceived as helpful elicited similarly favourable responses. In hindsight this question was probably phrased in a way that was too vague to allow useful insight. It is however encouraging that overall this figure remained high.

The negative comments which were made in both of the surveys do illustrate that there are areas of dissatisfaction around waiting time. Particular sources of concern appear to be misleading or inaccurate information and not being able to obtain pain relief before seeing a doctor. The environment is clearly regarded as in need of improvement. A number of comments indicated that even when initial information has been given there are information needs at other points during the patient episode that are not adequately addressed and contribute towards negative patient perceptions.

The survey looked at the personal characteristics of respondents and was unable to identify any significant correlation between particular characteristics and negative responses. It can therefore be assumed that people do not experience the department differently because of their age, gender or ethnicity. However, one of the shortcomings of the questionnaire was its reproduction only in written English. Therefore those who do not use written English have not been able to respond to the questions. Their experience of the department in the context of survey responses is unknown. Qualitative data described elsewhere in this document will suggest that people who do not speak English may indeed experience the department differently from those who do.

4.0 Observation of the department

All observations were unannounced with the exception of the first. Staff knew that such visits were to take place and that they would be at any period of the day or night. The researcher did let staff know once in the department and wore identification. Observations were carried out during the period indicated in the previous section. Below is a brief account of the first observation.

The waiting area had ten people in it; the object of the observation was to monitor reactions and responses when people came into the department. The intention was to note whether they showed any reaction to waiting e.g. seeking or reading information. Observed behaviour on this and subsequent observations have been integrated into the report.

During this initial observation the opportunity arose to carry out two interviews simultaneously with women who had brought their children into the department and were leaving the department to return home. Both had children who had been admitted to a ward.

The women were made aware by the researcher of the reasons for the researcher's presence and had been told that "waiting time" was the subject that she would like them to talk about. One woman told how she had made an active decision to attend King George Hospital rather than Whipps Cross which was slightly closer to where she lived. She was asked to talk about the reasons for this.

> *"I've been here before - I think the staff are excellent, they really know what they are doing and they do explain things to you. They're really good at Whipps too but I just think that they are better here……To be honest I hate waiting, I've got another one (child) at home and I'm too busy to spend hours waiting about. I phoned here and I phoned Whipps….here they said the wait was fairly short and that it wasn't busy, so I came here …that's the main reason"*

The other woman agreed and said that she had also 'phoned ahead in the past', she said that she had to attend KGH now because her child was under the care of a Consultant at KGH, but that she would attend KGH anyway because the care was so good and that she had confidence in the staff.

Both of the women felt that they had been seen and attended to very quickly. One of the women said that in her experience this was unusual and an unexpected surprise. She said that she usually came with food, drink and reading material, prepared for a lengthy wait. She said that she had spent a lot of time in the A&E recently because of the health problems of her child. She told the researcher that tonight was very unusual…she suggested that they had put on extra staff because of the researcher's presence. She said..

> *"The last time I was here I waited nine hours just to see the paediatrician.....I knew why, she was busy with an emergency, and I didn't mind, but when the little one's not well it does make you worry and waiting just makes you even more worried. I think that if the baby had got worse then they would have done something.....I think they treat people according to how bad they are and you can't moan about that"*

She went on to say that the first time the child attended was best because the child was admitted in a different way because of being under three months old; this reduced dramatically the waiting time. She also said…..

> *"It's a shame that they haven't got a proper nurse for children here, at least it would set your mind at rest if someone who specialised in children saw them before the paediatrician was available"*

Later that evening there was an opportunity to talk to a man who had been treated and was waiting to go home; he was asked about the wait….

"They are great here, they even made me a cup of tea, the receptionist just phoned my wife for me to tell her I was on my way home, and she's called a cab for me..... the only wait I had was for blood test results, they said it would take a couple of hours and it did, I was a bit bored but you can usually find someone to talk to."

He agreed that the department was exceptionally quiet, and that as a fairly frequent visitor he had rarely seen it so quiet.....

"You're joking, it can be pandemonium in here...the staff are always good though, I feel sorry for them.... you hear people getting very irate and rude...well it's not the fault of the nurses is it, they haven't got enough space...it gets packed out in there (treatment area) sometimes, it's like a war zone!"

The comments recorded above where made during a time when there were just four people in the waiting area, who were being called for treatment very shortly after triage assessment. The treatment room was similarly quiet and by 2.30 am there were just two people in the treatment area waiting for admission to wards. Both of those people were asleep.

The following comments were made during a substantially busier observation which took place during the same week but during the daytime:

"It's a nightmare in here.... One delay after another, but you don't know what the reasons for the delays are because no-one bothers to tell you and even when you ask they don't seem to know. I have been here for over eight hours just getting my child's broken leg sorted out, and I've got to come back again tomorrow.....I think that X-ray is one of the biggest problems, you wander about with your films, I asked a nurse what I should do with them and she just sort of pointed to the desk, then I noticed other people coming along after with their x-ray and putting them on top of the films that I had put there....so I suppose it's a case of last in first out, and that the first one to place the films there is the last one to be seen...it just doesn't make any sense to me, they are just not organised."

"I have been waiting for several hours, my doctor said to come here, The board says a two-three hour wait and it's been a lot longer than that and now I am going home without being seen because I am starving hungry and totally pissed off"

This person was asked if there was any particular reason for the delay

"I wouldn't know, I have tried to find out but nobody seems capable of giving any information, I was told they are very busy but I haven't seen a single person go into there (treatment area) for over half an hour....I suppose they are on a dinner break or something"

Another person who claimed to have been waiting for a considerable length of time expressed similar views, but did not intend to leave before being treated, the person told the researcher how they felt at being kept waiting longer than expected with apparently no understanding of why the wait should be so long....

"You don't like to moan but this is terrible, I won't come here again, I'll go to Oldchurch next time, I really feel that I could shake someone, I'm diabetic but they tell you not to eat or drink before seeing the doctor, it would help If I had something for the pain"

4.1 Comments on observations

The views above all come from people who were either waiting for treatment or who were in the process of being treated, and had seen a doctor but were awaiting test results or dressings etc.. The last comment came from someone who a short time later walked out of the department without receiving treatment. The comments represent the more extreme examples which the researcher elicited, and have been selected from many similar but less extreme comments which have not been included.

These comments illustrate that waiting time can indeed have a considerable impact on the way that the public using the department perceive it. Clearly the public perception is more favourable when waiting time is shorter. It seemed that when the department was least busy then communication between staff and patients was at its best, and perhaps unsurprisingly when the department was very busy patient information relating to waiting time was not passed on. The electronic display which advised on waiting time was observed to read the same as it had on previous, quieter occasions. There was no information on the whiteboard that was up-to date, and no members of staff orally gave any information to those in the waiting area.

On the busier occasion the difference in patient behaviour was observed, there were many approaches to the reception desk, and to the triage assessment nurse, also to nurses who may be walking through the department. Similarly when a doctor came to the waiting area to call a patient, invariably two or three people would go up to him and speak to him.

Of course it would have been obvious to anyone very familiar with the department that it was extremely busy; on entering the treatment area this was immediately obvious by the numbers of occupied treatment rooms. It was also evident from the number of frequent ambulance arrivals (indicated by a specific audio alert) that the department was becoming increasingly busy. Because of the physical layout of the department it is unlikely that any patient sitting in the waiting area would be aware of this.

During one observation period when the department was busy a woman was observed entering the department alone, she was literally doubled up in pain and did not take a ticket, just spoke to the reception staff and sat down. It was observed that the people entering the department behind her did take a ticket. It was noticed that when the woman's turn would have been she appeared unaware of this but the receptionist spoke to the triage nurse who then approached the woman and took her in to the triage room. Although the department was very busy this woman waited only a few minutes before being taken to the GP in an adjoining area.

Later during this busy period there was further observation of the treatment area; a young father come up to a doctor at the nurses station, he could be overheard asking when his child was likely to be seen. The doctor responded that he was only doing his job and that if the man did not like it he should go to his GP instead (it was almost 11.00pm). The man became quite irate and raised his voice to the doctor who then walked away. This doctor had been observed for about half an hour whilst he spoke to other staff members and looked through the patient cards at the Nurses Station, no interactions between patients and this doctor were observed during this time, but a senior nurse had told him on several occasions that the waiting area was very full. Later an opportunity for the researcher to speak with this doctor arose, he offered the view that people misused the A&E department, treating it as an alternative to the GP surgery and not for accidents and emergencies.

4.2 Summary of general observations of waiting and treatment areas

Following several disconnected periods of observations of these two areas, where there was a concentration on interaction between staff and patients as well as the individual behaviours of each group, the following points were noted:

Many patients do not appear to seek information when they use the department. There is often an inclination to sit and wait until approached by a member of staff. Most people observed entering the department who had arrived by their own mechanisms, rather than being transported by ambulance, approached the reception staff before taking a numbered ticket.

Following triage people would by necessity return to the receptionist for registration. Many people were observed to ask for explanation of waiting time from reception staff. Throughout the period of waiting prior to treatment, people were usually observed sitting and talking to other patients in the waiting area. Overheard conversations indicate that there is some discussion about waiting time during this period, with informal use of patients who had been waiting longer as sources of

knowledge about waiting time. Some people were seen to approach the receptionist at intervals for information, and others would sometimes approach the triage nurse, staff walking through the department, or the doctor who approached the entrance from the treatment area to call a patient. Some patients or those accompanying them would enter the treatment area before being called but this was not observed frequently. Comments were overheard about the inadequacy of information in the waiting area pertaining to waiting time. The visual LED display seemed to be viewed as inaccurate by some. Some people were observed to leave the department following registration, and then return later.

Many people were heard to express discontent that the drinks machines in the waiting area did not work, and that there was no evidence of drinking water being available in this area. This was particularly evident on the occasions when the facilities in the adjacent outpatients area were closed.

To some extent similar behaviour was viewed in the treatment area, a notice on the entrance requesting that people accompanying the patient be restricted to one person was rarely observed. Once inside the treatment area it was usually those accompanying the patient rather than the patient themselves who approached staff for information. A good deal of the information being requested related to waiting time, but a considerable majority of people did not make any evident attempt to seek information.

When the department was not very busy and waiting time was relatively short it was possible to hear staff offering information to patients and their relatives. This information was given without being requested and related to waiting time, e.g. what would happen next and how long this was likely to take. Staff were heard also to offer information to patients about the A&E process, e.g. if an admission was thought possible then the patient would wait in A&E until a bed became available on a ward, together with information about the current bed state.

However, when the department was busier, which on most occasions it was, patients or their relatives seemed more anxious to have information, but less likely to be offered it. To explain this in greater detail; the researcher observed a number of patients' friends/relatives approach the nurses station in the treatment area to request information about length of time waiting, or to express concern about their relative/ friend. Often they approached the desk with some hesitancy, It was observed that on these busier occasions staff were less likely to indicate responsiveness by their body language, looked busy and often quite tense, were likely to be writing or looking at something and did not appear very approachable. Eye contact was often minimal and the staff would be facing away from those approaching the desk, giving powerful non-verbal signals that they were very busy.

The effect of this on patients' friends/relatives was observed to be as follows: A number of people became more hesitant for example some were observed to approach the desk, were not asked what they wanted, and walked away after a short period of time without having spoken to anyone. Others were observed to make a more assertive effort to attract attention - sometimes with success and sometimes without. A further number of people were observed to be looking quite angry, speaking loudly and sometimes swearing. This type of behaviour unsurprisingly would often receive attention, provoking a defensive or angry reaction from staff.

This was not always the case and there were observations where some staff responded in a positive way to fairly unpleasant demands for their attention. In some cases sympathetic explanations were given for lengthy waits, and this seemed to successfully dissipate the anxiety or anger evident in the enquirer. Such observations contribute to the researcher's impression that good 'customer relations' and an ability to defuse difficult behaviour depend on the personality and ability of the individual staff member with little evidence of a coherent, systematic or uniform approach towards the 'customer'.

PART III - Waiting for admission - The patient experience

5.0 Tracking patients through A&E

Nineteen patients were tracked on two separate days in February 1998. Because the purpose of this part of the field work was to understand the process experienced by patients who were admitted to the hospital, staff assisted the researcher by identifying those people who in their experience were likely to be admitted. Almost all of them eventually were admitted to wards.

On one particular day it was evident that there were likely to be lengthy delays. At 7.00 a.m. when the tracking exercise was commenced, there were thirteen patients who were approached by the researcher, all of whom agreed to be tracked. Many of these people had already been in A&E for a considerable length of time; all had arrived before midnight, thereby having the status of 'overnighters'. There were seventeen 'overnighters' in the department at that time, with no available beds. This meant that the department was very full, with many of the cubicles accommodating two people; newly built cubicles were being used but were not completely ready for use which meant that they did not have piped oxygen and suction equipment. There was no major or minor trauma cubicle space available for incoming patients for several hours, with room for treatment available only in a shared cubicle, or in a paediatric or resuscitation cubicle.

These patients, some of whom were accompanied by a relative or friend, had already undergone a series of tests, observation and assessment of their physical health. Many were feeling very unwell, anxious and tired. Many spoke stoically of the experience of being in the department and only a few made overtly negative comments. On the contrary, many indicated that they felt they had been cared for very well under circumstances that were probably difficult for staff. Some made very scathing comments and located blame in government policies rather than in the practices of the hospital. Relatives were likely to be less generous in their comments and some demonstrated considerable anger, particularly at the lack of privacy and inability to

rest experienced by their relative. However, it was evident that some people did not know why they were still in the Accident and Emergency department. Even though it was clear to the researcher that most were likely to be admitted, since this information had been conveyed by senior nursing staff, patients themselves seemed unaware of this.

It was evident that for these patients, a number of efforts had been made to ensure their comfort: extra mattresses on trolleys, additional blankets, provision of food and drink and of toiletry packs. Patients had been placed in cubicles alongside patients of the same sex and where possible of a similar age group. The staff undertaking the provision of this care were the Accident and Emergency staff. It appeared that they were unable to use the Accident and Emergency treatment area space for those patients in the waiting area until cubicles had become available. During this time the Accident and Emergency department resembled a ward, not an Accident and Emergency department.

By the time that all of the thirteen people seen at the beginning of the shift had been tracked through to admission (all except one had required admission) they had waited in A&E for the periods indicated in the table on the following page

PATIENT	TOTAL LENGTH OF TIME IN A&E
A	21+ hours
B	22+
C	21+
D	29+
E	16
F	20
G	22+
H	23+
I	16+
J	17+
K	18+
L	16+
M	15

It can be seen from the length of waiting times above that many of the cubicles in A&E were occupied by people who were waiting for beds to become available on wards. It seemed in particular that there was a shortage of beds on medical wards. Nursing staff who were asked said that they were waiting for beds to become available, but that they did not know if there were specific reasons why beds were unavailable. It seemed that nursing staff viewed this as fairly routine.

5.1 Patient Charter Standards

The patient charter standards from April 1996 state " Patients should not wait longer than two hours from assessment to decision to admit to a bed". Through involvement in the "Casualty Watch" exercise, the CHC is aware that "time of decision to admit" is usually not recorded on the patient's A&E treatment chart.

Questions arise around the current data collection methods operational at King George Hospital A&E. When the researcher was given access to "track" the above patients, the staff helpfully explained how to interpret the status board within the department. This board informed the researcher that all of the above people were waiting for beds, which is indicated in a particular way on the board. When a bed becomes available, this is written in the appropriate space on the board and the patient is transferred when a porter and nurse escort are available for this.

The researcher was aware at a little after 7.00 a.m. that these people had undergone all necessary tests and assessment; and in most cases were likely to be admitted to a ward when a bed became available. However, most people did not begin to be transferred to beds until during the afternoon. Moreover, it became evident when talking to these patients and their relatives that more than half of them were not aware of whether there was a plan to admit them or not. Therefore the following questions arise:

- Do A&E doctors themselves make a decision to admit?
- If not - who makes this decision?
- Why do patients often appear not to know whether there is a plan to admit them or not? The patients interviewed expressed that this uncertainty caused a good deal of anxiety.
- How is the hospital able to claim an average failure to meet this standard of just under 30% (Quarterly Monitor Report)?
- Is the "decision to admit" a theoretical rather than a practical measure, i.e. retrospectively recorded by somebody?
- Is this Patients Charter standard meaningful to patients?

It may be seen that a number of uncertainties and questions arise from the "decision to admit" process, further complicated by the fact that written notices within the department remind doctors to record this time on patient notes. It is doubtful that any conclusions can be drawn from the way in which data is currently manufactured, but the Redbridge Health Care Trust "Quarterly Monitoring Report", which publishes performance indicators, is undermined by the above observations.

A further observation during this period of tracking was of the difficulties encountered with two patients who did not communicate using spoken English, and were unaccompanied by friends or relatives for part of their time in the department.

5.2 The experience of patients who did not speak English

The researcher observed obvious difficulties as staff tried to communicate with two elderly people who were unable to speak English. Some attempts were made to identify other staff in the department who may be able to speak the appropriate languages. One member of staff was able to guess that the first language of one of the individuals was Bengali. The nurse was able to guess this through knowledge of the individual's name (which later turned out to have been incorrectly recorded). Since nobody was located who spoke Bengali, nurses asked an individual nearby, who was accompanying someone else, if she might be able to help. She agreed to try and the researcher witnessed this person and a nurse attempt to reassure a bewildered looking elderly person that she was to be assisted with personal hygiene and offered some food.

The researcher later spoke to relatives who joined this individual. She asked them whether they were aware of any communication difficulties that had arisen. They explained to the researcher that their elderly relative had been incontinent whilst in the department, and that they felt this was probably because of communication difficulties, since it would not usually occur. They also said that their relative had been offered food that they would usually not eat and which was unacceptable to them. The researcher spoke with them about translation and interpretation needs. They expressed the view that it was unrealistic to expect that these needs would be adequately met and that it was important for members of the family to be available to assist in translation. The impression of the researcher was that they blamed themselves for having been unavailable.

5.3 Effects of lengthy waits in A&E whilst waiting for a bed to become available

It has been indicated that some patients and their relatives claimed uncertainty of knowing whether they would be admitted or not This was cited by relatives as causing enormous distress.

When looking at the above figures indicating that some people waited more than 20 hours before being admitted, one can only imagine that tiredness, anxiety and uncertainty would combine to create real distress.

Some patients complained that they were not being adequately observed whilst in A&E. One patient, attached to a cardiac monitor, expressed the intention to leave if a bed did not become available soon. He claimed that even if the monitor showed unusual activity no-one was "keeping an eye on him" so, in his view, there was no point to being in the department.

Patients and their relatives were asked who or what they felt was responsible for the delays. In most cases people thought that they were probably waiting for an available bed, some people were aware that they were, and some others thought that they may be waiting for more tests, or to see more medical staff. Many people expressed the view that King George Hospital had a shortage of beds - with some people believing that even if they needed admission they would be discharged home because of this.

People expressed a high degree of satisfaction with the treatment that had been received so far, and many stated that they thought that nursing staff had gone out of their way to ensure the patient's comfort whilst in A&E . Many people expressed disbelief that they had been in A&E for so long and felt that the NHS was in decline.

One relative expressed high levels of dissatisfaction and was very angry. This person was accompanying an elderly person who was very frail. She claimed that she had been led to understand by medical staff that there was a strong possibility that the

elderly relative would die. The relative felt that there was no privacy for family members to see their relative, possibly for the last time, and that the environment was busy and noisy, making it impossible to talk to the person in the way that they would wish. The relative expressed the view that to die in this way was particularly undignified and reflected badly on NHS provision. This person felt that elderly people were not treated as a priority, which was understandable, particularly in the A&E department, but that a ward bed should be found.

This person, as well as others, expressed concerns that the A&E environment was not the right place to provide the "tender loving care" required by dying people, did not believe that the staff were the right ones to do this, and was concerned that the trolley and cubicle would be better occupied by an 'emergency'.

Some of the above person's concerns were associated with a perceived lack of dignity and privacy afforded to the ill person, there were many such concerns expressed from other patients, relatives and staff. At a time when the department was extremely busy, and the smaller "minor" trauma cubicles were each occupied by two people, this was illustrated by a patient who told the researcher that he was "desperately trying not to go to the toilet" since this would have to take place in the cubicle because of an attached drip. The patient was "mortified" at the thought of undertaking this personal act in a cubicle approximately six feet wide, with another occupant within touching distance.

The researcher's observations during this time were that these people waiting for admission, many of them with two or three relatives accompanying them, created a blocked environment where it was difficult to move around effectively, and difficult to treat people because of the lack of space. In effect the impression was of chaos.

PART IV -Staff views

6.0 Views elicited during observation and tracking

The researcher spoke to staff about their feelings during the period when patients were tracked. Some expressed a firm view that waiting time was a problem. When waiting time increased the patients and relatives were perceived as being less satisfied and this in turn was generally seen as having a negative effect on morale. One nurse stated how the previous shift had been very difficult, with many expressions of anger at lengthy waiting times. This nurse said that she was unable to communicate with anybody by the end of the shift because of feeling very fed-up and low.

There were further difficulties which usually went hand in hand with lengthy waiting times, as in the situation described in the "tracking" observations above. These difficulties were centred around a shortage of space resulting in an inability to work efficiently. Several nurses expressed concern that they sometimes worked in a way that they felt was unacceptable. Examples given were administration of wrong medication due to enormous workload pressure, almost missing a reaction to medication being given intravenously to a child, and treating people in new cubicles not equipped with appropriate equipment.

Nurses talked of their fears of personal assault and of repeated incidents of verbal abuse which undermined their ability to effectively treat somebody. Some said that they did not believe that these issues were taken seriously by managers.

Reception staff who spoke to the researcher talked about several incidents of violence and potential violence. They felt that verbal abuse in particular was an almost daily occurrence. They believed that they were quite vulnerable to attack and some felt that screens above the reception area would make them feel safer. In terms of strategies to deflect aggression and violence they felt that it was an individual matter and that it was in many ways perceived as the individual's problem. Staff working at night were seen as being even more vulnerable because there was only one member of reception

staff at night and the department was open to anybody with no method of screening visitors.

Management was not seen as addressing the matter adequately or as treating it seriously which fed into the viewpoint that it was the problem of the individual. Staff described some recent incidents that they believed had contributed to the resignation of some reception staff.

The researcher witnessed some potentially violent situations. On one occasion a patient was escorted off the premises by police. This person had apparently been expecting to be seen quickly because the GP had telephoned the department in advance.

Staff were offered an opportunity to complete a questionnaire which was developed in order to elicit their views about the effects that they felt lengthy waiting time had on patients and on themselves. The next section discusses these responses.

6.1 Staff views elicited from survey

The staff survey was distributed to staff in the department during November 1998. In total 40 copies were distributed with a covering letter which explained the purpose of the questionnaire, and that respondents identities would be anonymised. The questionnaire included a stamped addressed envelope for return to the Community Health Council. Fifteen completed responses were returned. The questionnaire is reproduced as appendix 3.

6.1.1. Which type of staff completed the questionnaire? (question 1)

Nursing:	66%
Medical:	13%
Clerical/administrative:	13%
Other:	7%

6.1.2. Length of time working in the department (question 2)

Less than one year	20%
Over 1 year but less than 2 years	20%
Between 2-5 years	26%
Over 5 years	34%

6.1.3. Have you ever experienced an assault or threat, either verbal or physical, whilst at work in this A&E department? (question 3)

Yes	86%
No	14%

6.1.4. The following question asks those who had responded YES to question 3 for details; the following responses are a sample of the information given. More detailed and specific information was given which has not been included since it may enable identification of the informant. The information which has not been reproduced are descriptions of physical assault.

"The usual alcohol induced abuse - one young boy (17 years) friend calling me a slag and telling me to piss off because I asked him to switch off his mobile" (Nurse)

"Many verbally abusive patients, on one occasion a father backed me against a wall and started swearing to try to get his child seen -situation defused" (Nurse)

"unable to detail specific events as verbal threats and abuse are almost a daily occurrence in department, by both patients and relatives/friends" (Nurse)

"Many incidents of patients and relatives being verbally abusive about: 1. Expecting to be seen immediately when referred by the GP. 2. Waiting for a bed to become available. 3. Waiting to be seen when low priority as an inappropriate A&E attendance" (Nurse)

"Majority are verbal, usually 2-3 times a day, sometimes 1-4 people all at once. Usually all regard waiting times and people's perception of their own condition and priority. Never really experience abuse from emergencies and the very critical. One experience of physical abuse due to waiting time and considering must be a higher priority - a condition a GP could have treated" (Nurse)

"I have experienced physical abuse on two occasions, both patients were drunk, one caught my arm and punched me in the shoulder, the other pushed me against a wall in one of the rooms" (Nurse)

"I have experienced verbal abuse in A&E more from family than from patients - usually due to the length of time that people have to wait to see a doctor, or the fact that there are no beds available and their relative has to stay on a trolley overnight in A&E" (Nurse)

"Luckily only once in the last eighteen months has an attempt at physical assault been successful...and that was in the presence of two police officers. .....As for verbal abuse and threatening behaviour, it's a daily event, I don't believe that anyone will document verbal abuse, it's too frequent" (Nurse)

"Physical attack by a psychiatric patient who attempted to reach across reception desk to hit me, when thwarted by desk height, he pushed the VDU at me" (Reception staff)

"Too many incidents for me to list..." (Reception staff)

"Stressed patients, Psychiatric patients, long waiting time……strong words on many occasions. Often local security or the police have to be called" (Medical staff)

6.1.5 The 86% of staff who had experienced threat or assault were asked if they felt that lengthy waiting time had contributed to the incident/s? (question 4)

Yes 97 %

No 3 %

Those who did not feel that lengthy waiting time contributed towards threatened or actual aggression cited factors such as : alcohol, psychiatric symptoms and unreasonable expectations of patients.

6.1.6 Question 5 asked if the experience of assault or threat had affected the ability of the individual to do their job.

Of the 86% of staff who had experienced threat or assault just over half (64%) stated that they had felt that the events *had* affected their ability to carry out their job in the way that they usually would. Additional comments about the effects ranged from discomfort and upset which remained whilst the patient was in the department to an inability to concentrate on the job adequately. One member of the medical staff stated "*considering giving up the job*". The remaining respondents who did not feel that their ability to carry out their job was impeded made comments which indicated their acceptance of such events:

"Regrettably this kind of thing happens too often and we've learned to work through it" (Nurse)

6.1.7 Question 6 asked if there were any longer term effects following the incident/s and for a small number (one quarter of the total who had experienced assault or threat) of respondents there were:

"A desire to leave the department, the Trust, the job.. if I could find an A&E department that didn't have it that's where I would go" (Nurse)

" Psychological effects ...you don't enjoy the job" (Nurse)

"It made me a nervous wreck" (Medical staff)

"The physical assault stays with one long term as does the verbal abuse" (Nurse)

6.1.8 Question 7 asked these 86% who had experienced threat or assault whether they felt that they were adequately supported by their management as a result of the incident?

Yes 35%

No 65%

Some of those who did not feel adequately supported made the following comments:

"Management do lack in their support of staff, this includes immediate support, i.e. caring!. When incidents are reported also fail to follow up and check on welfare and effects the incident may have on the individual concerned. As a whole management is very slow to introduce and improve security. Cost seems important. (Nurse)

"Whilst management puts physical barriers etc. into the department they have very little personal contact with people after an incident" (clerical staff)

"Abuse and aggression seem to be accepted and the department has inadequate security back-up despite some recent improvements" (Nurse)

"Sisters yes, above A&E - no" (Nurse)

As well as the comments cited above, many of the respondents identified improvements in recent months, suggesting that the issue was taken more seriously by management now that it had been a few months previously.

6.1.9 The following question, again directed at those who had experienced threat or assault asked if the respondent believed that there were adequate systems in place, in the Trust, to minimise the risk of a similar incident happening again (Question 8)

Yes 1% (equivalent to one respondent only)
No 99%

Once again respondents were invited to put comments, the majority of these comments asserted the need for better systems such as close circuit television (CCTV), adequate security personnel, police in the department, screening to desks and other physical methods of alleviating risk. One nurse asserted that the triage room allowed no means of escape for staff who were threatened Again over half of the comments indicated that improvements had been made but that they did not go far enough. Almost a quarter of the comments included reference to action being taken following assault - with an assertion that this was currently lacking and thus giving "the wrong message" to offenders. A number of comments suggested that even with security systems in place, some patients and their relatives would present a risk to staff and that this was a known part of the job. The following comments have been selected as illustrative examples of the views of the respondents:

"We need a screen in the A&E reception to make us feel safer" (reception staff)

"We should have more CCTV, more security personnel. A proper security system for staff i.e. one that works! We should have the right to refuse potentially violent people in the department" (Nurse))

"When incidents are reported no follow up is taken. I feel that the Trust should write to the offenders and possibly use a 'red card' system. More legal action should be taken" (Nurse)

6.2 The remaining questions, nos. 9 and 10 were directed to those 14% of respondents who had not experienced physical assault or threat. They asked whether the respondents regarded it as a potential risk in the department and if so, which factors could they identify that contributed towards this risk.

100% felt that it was a potential risk and identified the following factors:

"Waiting times to see a doctor"

"Lack of hospital beds"

"Easy public access to the department - especially at night"

(Nursing staff)

"Drunkenness and verbal aggression" (other staff)

PART V - Revisiting The A&E Department

An interim report, with recommendations, was submitted to a number of staff of the Trust who had been involved with the study from its inception. Following the interim report, staff at the Trust contacted the researcher to discuss their responses to the report.

This meeting provided an opportunity to reflect upon the way in which the work had been undertaken, its scope, the findings and the interim recommendations. The interim recommendations which had been made may be seen in part VI of this report. This final report contains more and fuller recommendations than those included in the interim report, but those which appeared in the interim report are clearly differentiated from those added later to the final report.

It was agreed that since some time had passed since the fieldwork phase of the research was undertaken, there would be benefit in revisiting the department. The Trust staff felt that they were already aware of a number of issues that had been raised within the report, and that they had been attempting to address them, in some cases, prior to the research being undertaken. Trust management staff gave the researcher detailed information on the ways that some of the issues were being addressed which have not been included in this report. The researcher was encouraged by some of the positive changes that were planned or had already been implemented, but felt that it was more properly the place of Trust management to respond to this report upon its completion, and that inclusion of management views were outside of the scope of the report.

The researcher re-visited the department during April 1998, the following headings in this section briefly describe some of the changes which had occurred since the fieldwork was undertaken.

Cubicles

The new patient cubicles which were in the process of being completed during the fieldwork phase have now been completed. They compared favourably to the smaller cubicles used in the department. The intention was that smaller cubicles would no longer be used to accommodate two people. It has been documented in this report that sharing a small cubicle was experienced as a source of discomfort to patients, negatively affecting dignity and privacy.

One of the cubicles had been equipped with a comfortable bed and specifically designated for use by elderly people who were remaining in the department overnight. Unfortunately, the researcher was informed that this effort to ensure patient comfort had resulted in a decision by Local Authority Social Services to regard this bed as a respite bed. The consequences of this meant that an elderly person using the bed would not be regarded as the same high priority as when occupying a trolley and may experience an even longer wait because of delays in assessment by a social worker.

Staffing levels

Some of the people interviewed during the course of data collection had expressed their concern at the apparent lack of staff who had a particular interest and knowledge of sick children. Trust staff detailed how, at the time of the revisit, there were two RSCN's employed within the department with a third undergoing accelerated training.

Since undertaking the fieldwork the following additional staff had been employed:

- 2 extra playleaders (for the children's area in A&E)
- 1 evening administration staff

The nurse manager involved in the recruitment of these staff had been involved in the study. Being aware of some of the findings which indicated that there were issues of communication that had been raised, this manager informed the researcher of her attention to communication skills in the interviewing process when she had been

interviewing for the post of the evening administrator. She looked for evidence of good communication skills with patients as a criterion of the successful applicant.

Geographical location of patients attending the department

It has been documented within this report that the majority of those attending the department who completed a questionnaire and indicated their postal code were from the Romford and Ilford areas. However, it was evident that a small but significant number of people came from areas in Ilford and Romford that were closer to either Whipps Cross or Oldchurch hospital, both of which have Accident and Emergency Departments. It would appear that some people make an active choice to attend King George A&E.

From both 'Casualty Watch' and the tracking of patients awaiting admission (the majority of whom were ambulance admissions), it is apparent that ambulances bring people to King George A&E who may reside closer to other A&E departments. The reasons for this are unknown. London Ambulance Service have been asked whether they were requested to avoid certain A&E departments on particular days when the fieldwork was being undertaken, but this was not the case.

The researcher asked Trust staff if they were aware of ambulance personnel choosing to bring patients to King George A&E rather than to an alternative A&E department. It was felt that this may be a possibility, and that if this were the case then the availability of trolleys which could be used to transfer patients, releasing the use of the LAS trolley, might be a factor. This is only conjecture, with no evidence to back it up, but would be an interesting area to investigate further.

Information and communication

A decision had been made to switch off the visual electronic display which informed people of expected waiting times. It was not easy to programme this unit in order to adjust it when needed, to ensure that the information which it gave was accurate. It was felt that an ordinary noticeboard, which could be easily updated, would be a

preferred alternative. This had been implemented soon after the re-visit to the department.

Environment

Extra trolley mattresses had been purchased to ensure that when patients, particularly those who are most vulnerable, remain on a trolley for a long period, they would be more comfortable.

A fresh water system had been installed in the A&E treatment area for those patients requiring a drink. tea and coffee were available free of charge to patients and their accompanying friends/relatives in the main treatment area of the department.

Acts of aggression towards staff

The researcher was informed that this issue was being monitored prior to the commencement of the research and that a working group had been set up to address this issue. Responses from staff highlight the need for such a group, and for it to be able to take effective action to minimise risk to staff safety.

A new security system which was seen as being sensitive to the needs of patients and did not intrude on their privacy, had been installed at the time of the re-visit. It did not appear to be fully operational at this time. The staff questionnaires which were returned a considerable time after the re-visit suggest that security is still regarded by some staff as inadequate, and that the security system introduced is not fully functional.

PART VI - Discussion of the study - with recommendations

Some of the recommendations which appear within the summary below were included in the interim report and have been partially or wholly addressed by the Trust. If a recommendation appeared in the interim report then this is marked with an asterisk (*). Some of the recommendations appear for the first time in this final document.

6.1 Patient surveys

Interpretation of the patient questionnaires indicated the need for more effective communication between patients, their relatives/friends and staff. This communication appears to be particularly poor when the department is busy. Moreover the communication, when offered, is sometimes inaccurate, inconsistent and not sustained throughout the patient's 'journey' through the department.

From the patient surveys three main areas of dissatisfaction stand out:

- The environment
- Provision of up-to-date, accurate information relating to waiting time.
- A need for continued information, such as how long one might expect to wait for blood test or x-ray results, together with information about the process of being in the department.

6.2 Observation

Clearly there were some people who chose to attend King George Hospital rather than another A&E department. This is supported by both interviews and analysis of postal regions of those attending.

Observations allowed an opportunity to experience the department in a range of situations; from very quiet to very busy. It was evident that patient information and communication are excellent when the department is quiet. It is perhaps unsurprising that when the department is extremely busy this communication very often appears to be lacking. It is understandable that staff working under considerable pressure will be less able to communicate effectively.

The observations lend support to recommendation 1.

***Recommendation 1**

The Trust should consider the employment of staff with a clear role of patient liaison/communication, specifically for the A&E department, together with other means of ensuring better communication to patients. These could include information about the department and how it processes patients and should include information about the clinical priority assessed at Triage.

In revisiting the department it was made clear that the Nurse Manager had taken seriously the issue of patient communication and attempted to employ a member of staff with good communication skills. The misleading visual display which advised people of waiting time had been disconnected and replaced by up-to-date, accurate waiting times written on a board. These are positive measures towards better communication which suggest that improvements have been made.

Recommendation 2

Patient/staff interaction should be integral to the staff training agenda. If it is not already undertaken staff should be encouraged to find effective ways of coping with working in such a stressful environment. Management should consider ways in which some stress which may be unnecessary can be minimised.

Recommendation 3

The evening GP service appears to be very useful,[10] not only to those registered with a GP subscribing to the service, but on occasion to others (see example in text on page 23). It is recommended that this service be maintained and be expanded/developed.

[10] This service operates adjacently to the department during the evening up until 11 pm. During the winter the service was extended to accept any patients regardless of whether they are registered with one of the GP's participating in the service. The extension was funded from 'winter pressures' money.

Recommendation 4

A Minor Injuries Unit adjacent to the A&E should be considered. This would be of particular value to patients requiring treatment which could be administered by nurse practitioners. This may have the effect of enabling patients to be treated quickly where they might currently be waiting for treatment which they cannot receive because the department has run out of minor injury treatment cubicles.

Recommendation 5

In the main treatment area an enquiry point separated from the nursing and medical staff station could be considered. This would reduce interruption to staff and give patients a clear access point for their enquiries. Ideally this would be staffed by the person suggested in recommendation 1.

Recommendation 6

Patients have identified factors such as waiting to see a doctor before being offered pain relief and waiting to see a doctor before being prescribed an x-ray as sources of discomfort and delay. Nurse Practitioners in the Accident and Emergency department have been asserted as having a positive impact elsewhere.[11] Therefore it is recommended that consideration be given of triage nurses having the opportunity to extend their role and prescribe x-rays and pain relief for patients within agreed protocols.

Recommendation 7

Monitoring of the geographical area of patients attending. If there do appear to be patients from outside of the expected area on a regular basis, investigation into reasons for this should be undertaken.

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[11] A&E Services-A guide to good practice. (NETRHA.) "*North East Thames supports the role of the nurse practitioner as a provider of patient care without reference to a doctor and sees this as being an integral part of the Nurse's role within the department*" Newey, Jackie. Senior Clinical Nurse, Western Area Health Trust. Specification of Emergency Nurse Practitioner.

6.3 Tracking

It is recognised that considerable efforts have been made since the fieldwork was undertaken to promote greater comfort and privacy of patients. These improvements are discussed in Part V-Revisiting the Department. Recommendation 8, below, appeared in an abbreviated form in the interim report.

***Recommendation 8**

Patients and their relatives did not know why they remained in the A&E department for a considerable period of time. Many said that they would prefer to know as this would promote a reduction in the anxiety experienced. It is strongly recommended that honest communication with patients concerning waiting time is undertaken. This recommendation reinforces that of better communication which has been discussed earlier.

***Recommendation 9**

For the reasons explained within the text, (page 33) the researcher is left with a number of uncertainties around the production of the Patient Charter standards which pertain to 'waiting for an available bed following a decision to admit'. If the Trust is experiencing difficulties meeting these standards then it is recommended that an honest appraisal is undertaken. If the Trust is able to meet the target approximately 70% of the time, as suggested within the 'Quarterly Monitoring Report', then a fuller explanation of the current system of data collection and analysis would be helpful to both the CHC and other interested parties.

Recommendation 10

Effective links with other agencies should be developed and maintained, to tackle the difficulties of 'blocked beds' where they arise, particularly when these beds are blocked because of the continuing care or social care needs of the patient occupying the bed. It is recognised that the Trust is limited in its scope for improvement and that some responsibility rests with other agencies.

***Recommendation 11**

It is strongly recommended that the needs of patients who do not speak English are recognised and addressed. It is acknowledged that this is a challenge for many agencies within the Borough and is not exclusive to the Trust. It is also recognised that of all the clinical areas of a hospital it is possibly most difficult to implement interpretation facilities in an A&E department. However, an initiative from the 'Practice Managers Forum' (R&WFHA) might be a useful template for adoption in an A&E department.[12]

***Recommendation 12**

Some staff spoke of their low morale and fears for their personal safety. It is recognised that during the revisit considerable effort had been made to promote better security arrangements but the system was not fully functioning. The morale and personal safety needs of agency staff as well as permanently placed staff should be considered if they work within the department.

It is recommended that the security system is implemented fully as soon as possible together with additional measures to promote positive staff morale and personal safety.

It is also recommended that staff exit interviews are undertaken when staff leave the department; this may help identify issues important in retaining staff.

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[12] This initiative was circulated during October 1998 and comprises a series of 'cards' featuring a number of common questions and phrases used in GP receptions. Translations are available in: Bengali, Bosnian/Croatian/Serbian, Turkish and Somali. Circulated by Lynne Macintosh, Locality Manager, Redbridge and Waltham Forest Health Authority.

PART VII Reflection

This study had the overall objective of understanding more about the effect of lengthy waiting time on patients and staff at King George Hospital Accident and Emergency Department. The combination of qualitative and quantitative methodologies was used because it was felt this would enable complementary insights together with an understanding of the interpersonal dynamics between patients and staff.

In section 1.4 of this report the usefulness of exploring these dynamics is asserted in relation to the action of individuals being partly determined by their perceptions, rather than by an objective reality. Many examples of such behaviour have been witnessed and reported during the course of this project. In particular nursing staff have cited patients' overestimating the clinical priority of their condition and patients have spoken of staff underestimating their discomfort. It is difficult to imagine that such a situation could easily change.

The researcher has tried to maintain an objectivity during the course of this study, which was helped by looking at the views and experiences of both staff and patients. Reflecting upon the characteristics of each 'group', it was possible to identify a specific attitude amongst many A&E staff. This attitude related to the validity of patients attending the department and manifested itself in a judgement of whether or not patients were using the department appropriately. It is not suggested that this judgement is either right or wrong and it is easy to see how it might serve a very useful purpose where changing clinical priorities need to be managed effectively.

However, although not a cohesive group, patients too had some similar attitudes in relation to their attendance at the department. Many were very passive and seemed hesitant in seeking information about waiting time. Others behaved very assertively or aggressively, particularly those who were concerned about young children. The reasons for such behaviours is unknown, and there are many probable factors, but there may be some value to further exploration of patient attitudes in relation to their

own anxiety and its causes, or of patient expectations, or of media reporting and its effects upon patients.

A research report which looks at "Inappropriate attendance at Accident & Emergency" [13] includes verbatim accounts of the reasons for attendance from the attendees. Throughout the report there are references to the anxiety experienced - particularly from the parents of young children. If further research were to illustrate a relationship between the anxiety levels of patients and violence to staff or inappropriate attendance then undoubtedly measures to address this could be devised.

In addition to a recognition that perceptions affect attitudes and behaviour there is an objective reality that can be asserted from evidence in this report, in particular from 'tracking patients waiting to be admitted'. There are simply too few vacant beds on the wards and elsewhere in Redbridge to accommodate the needs of patients entering the hospital through A&E. Demand frequently exceeds supply and the consequences are sometimes an A&E department that is unable to function effectively or allow throughput because of a lack of available space to treat patients. The results of the 'Casualty Watch' exercise undertaken by Community Health Councils fully supports the evidence that came from the 'tracking' observation. [14] King George Hospital is frequently one of the hospitals which appears in the "top twenty longest waits" (see appendix 4). Such a problem has no easy short term solution.

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[13] "Inappropriate attendance at Accident & Emergency - Users Views and Perceptions. Sheila Egan, (Practical Resourcing) July1994

[14] Casualty Watch is a 'snapshot' of waiting times in A&E departments throughout London and the South East. The project is undertaken by Community Health Councils and occurs on the last Monday of each month. The relative position of King George Hospital is summarised as appendix no. 4

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Appendices

King George Hospital Accident and Emergency Department Survey

This questionnaire is part of some research which is being carried out in A&E over the coming weeks by Redbridge Community Health Council. You do not have to fill it in but it will be appreciated if you can. It is being given to all A&E attenders who are over 18, and do not arrive by emergency ambulance.

Your answers are confidential and you are not asked to give your name. However if you wish to contact the Community Health Council about this research please do so on 0181 518-5736.

When you have completed the form please seal it in the envelope provided and place it at the reception desk in the Accident and Emergency department.

For completion by the patient or the patient's representative (friend, relative etc). Please tick the box next to the answer you agree. Space has been left for your comments.

1 Priority Classification

Do you know which category of treatment priority you were placed in when you were first seen by a nurse?

Yes [go to next question] ☐

No [go to question no. 3] ☐

comments?

2 Priority Classification

If you answered yes to Q1 above, can you please say which category you were placed in ?

category P1 (red) ☐
category P2 (orange) ☐
category P3 (yellow) ☐
category P4 (green) ☐
category P5 (blue) ☐

3. Waiting time

were you given information about how long you could expect to wait before you would be seen by someone who could examine or treat you?

Yes ☐

No ☐ comments?

King George Hospital Accident and Emergency Department Survey

4. Waiting time

Can you tick the box which indicates roughly how long you had to wait before being seen by a doctor for your illness / injury?

Less than 10 minutes ☐

More than ten minutes but less than one hour ☐

Between one and two hours ☐

Between two and four hours ☐

More than four hours. ☐

5. Waiting time

Once you had been seen by a Doctor did you experience any further delays

Yes [please move on to question 6] ☐

No [please go on to question 7] ☐

6. Waiting time

You have answered to Q5 above that you **DID** experience further delays once you had been seen by a Doctor. Could you please explain in the space below why you think that you experienced these delays. Could you please also state whether you were given any information about the delay.

_____

_____

_____

_____

_____

7. Waiting time

Can you give your opinion of whether you feel that you were kept informed of any factors which may have affected the length of time you would wait for treatment.

Comments?

Yes - kept well informed ☐

No - not kept well informed ☐

King George Hospital Accident and Emergency Department Survey

8. Waiting time

Is it possible for you to say roughly how long you spent in the department in total before leaving the Accident & Emergency Department . Could you also say whether you were returning home, being transferred, or being admitted to a ward?

_____

_____

_____

_____

9. Waiting time

Overall, do you feel that waiting in the Accident and Emergency Department caused you any personal discomfort.

Yes [please go to Q.10] ☐

No [please go to Q.11] ☐

10 Waiting time

Could you please try and explain how you felt about waiting, can you suggest ways that the waiting time may have been made more comfortable?

_____

_____

_____

_____

_____

_____**please move on to question 12**

11. Waiting time

Can you say why you did not feel that waiting time was a problem e.g. happy to wait, comfortable waiting area, drinks available, children's play area available etc.

_____

_____

_____

_____

_____**please move on to question 12**

King George Hospital Accident and Emergency Department Survey

12. Waiting time

Did you feel that overall the attitude of staff was helpful?

Yes ☐

No ☐

comments?

13. About your injury or illness.

Did you contact your family Doctor (G.P) or a Minor Injury Unit, before you came to the A&E dept.

Yes [go to Q.14] ☐

No [go to Q.16] ☐

comments?

14. G.P. Contact

If you did contact your G.P. before coming to A&E, did the G.P. contact the A&E Department to let them know that you would be coming along?

Yes [go to Q.15 ☐

No [go to Q.16] ☐

comments?

15 G.P. Contact

Do you believe that the contact with the G.P. helped you get attention more quickly than you would otherwise have done?

Yes ☐

No ☐

comments?

King George Hospital Accident and Emergency Department Survey

16 About you

Are you

Male ☐

Female ☐

17 Your age

Please tick which box includes your age

18-25 ☐

26-40 ☐

41-60 ☐

61-75 ☐

over 75 ☐

18 Ethnic Identity

Please write in the space below how you describe your ethnicity.

_____

19 Postal Region

Could you please write your postal code in the space below.

_____

Thank you for taking the time to complete this questionnaire, please seal it in the envelope and hand it to the reception as you leave. If you would be willing to be interviewed, either on the telephone or in a group with other A&E attenders, would you please leave contact details below, and a researcher will get in touch with you shortly.

APPENDIX II

King George Hospital Accident and Emergency Department Survey

This questionnaire is part of some research which is being carried out in A&E by Redbridge Community Health Council. You do not have to fill it in but it will be appreciated if you can. It is being given to all A&E attenders who are over 18, and do not arrive by emergency ambulance.

Your answers are confidential and you are not asked to give your name. However if you wish to contact the Community Health Council about this research please do so on 0181 518-5736.

When you have completed the form please seal it in the envelope provided and place it at the reception desk in the Accident and Emergency department.

For completion by the patient or the patient's representative (friend, relative etc). Please tick the box next to the answer you agree. Space has been left for your comments.

What is the date and approximate time of your arrival? _____am / pm

1 Priority Classification

Do you know which category of treatment priority you were placed in when you were first seen by a nurse?

Yes [go to next question] ☐

No [go to question no. 3] ☐

comments?

2 Priority Classification

If you answered yes to Q1 above, can you please say which category you were placed in ?

☐ category P1 (red)
☐ category P2 (orange)
☐ category P3 (yellow)
☐ category P4 (green)
☐ category P5 (blue)

3. Waiting time

were you given information about how long you could expect to wait before you would be seen by someone who could examine or treat you?

☐ Yes

☐ No

APPENDIX II

King George Hospital Accident and Emergency Department Survey

4. Waiting time

Can you tick the box which indicates roughly how long you had to wait before being seen by a **doctor** for your illness / injury?

☐ Less than 10 minutes

☐ More than ten minutes but less than one hour

☐ Between one and two hours

☐ More than four hours.

5. Waiting time

Once you had been seen by a doctor did you experience any further delays

☐ Yes [please move on to question 6]

☐ No [please go on to question 7]

6. Waiting time

You have answered to Q5 above that you **DID** experience further delays once you had been seen by a Doctor. Could you please explain in the space below why you think that you experienced these delays.

_____

_____

_____

_____

_____

_____

7. Waiting time

Do you feel that you were kept informed about any of the reasons that meant you would be delayed ?

☐ Yes - kept well informed

☐ No - not kept well informed

comments?

APPENDIX II

King George Hospital Accident and Emergency Department Survey

8. Waiting time

Overall, do you feel that waiting in the Accident and Emergency Department caused you any personal discomfort ?

☐ Yes

☐ No

comments?

9. Waiting time

Did you feel that overall the attitude of staff was helpful?

☐ Yes

☐ No

comments?

13. About your injury or illness.

Did you contact your family Doctor (G.P) before you came to the A&E dept.

☐ Yes

☐ No

comments?

14. **About you**

Are you

☐ Male

☐ Female

Please continue over the page.....

APPENDIX II

King George Hospital Accident and Emergency Department Survey

AGE

Please tick the box that indicates the patient's age:

☐ under 18

☐ 18-25

☐ 26-40

☐ 41-60

☐ 61-75

☐ over 75

Ethnic Identity

Please write in the space below how you describe your ethnicity

_____

Postal region

Could you please write the first three characters of your postal code in the space below (if known)

_____

Thank you for completing this questionnaire, please seal it in the envelope provided and leave at the reception desk. If you have any other comments at all that you would like to make about the Accident and Emergency department, please make your comment in the space below.

_____

_____

_____

_____

_____

_____

_____

1. Could you please indicate whether you are:

☐ Nursing staff
☐ Medical staff
☐ Clerical / administrative staff
☐ Porter
☐ Volunteer
☐ Other staff (please indicate)

2. Could you please indicate approximately how long you have worked in King George Hospital Accident and Emergency department:

☐ less than 1 year
☐ over 1 year, but less than 2 years
☐ 2-5 years
☐ over 5 years

3. Have you ever experienced an assault or threat, either verbal or physical, whilst at work in *this* A& E department.

☐ yes
☐ no

If you have answered yes to the last question could you please give as much detail as possible in the space below. If you have experienced more than one incident please give as much detail as possible about all of the incidents that you have experienced. (all of this information will be treated as confidential). Please use an additional sheet of paper if you wish.

_____
_____
_____
_____
_____
_____
_____

If you have answered that you HAVE experienced either assault or threat please answer questions 4-8 please do not complete any further questions.

If you have not experienced either assault or threat please move on to questions 9 & 10.

4. Do you feel that lengthy waiting time contributed to the incident that you experienced?

☐ yes

☐ no

comments?

5. Did the assault/threat affect you ability to carry out your job in the way that you usually would?

☐ yes

☐ no

comments?

6. Did the assault/threat have any longer term effects upon you?

☐ yes

☐ n o

comments?

7. Did you feel that you were adequately supported by your management as a result of the incident?

☐ yes

☐ no

comments?

8. Do you believe that there are adequate systems in place, in the Trust to minimise the risk of a similar incident happening again?

☐ yes

☐ no

comments?

9. Even if you have not personally experienced assault or threat, do you regard it as a potential risk when working in the Accident and Emergency department?

☐ yes

☐ no

comments

10. If you have answered YES to the above question. Can you please identify the factors **within the department** that contribute towards the threat of violence to staff .

_____

_____

_____

_____

_____

Thank you for filling in this questionnaire. Please return to CHC using the pre-paid envelope provided.

Casualty Watch - Redbridge Community Health Council and King George Hospital Accident and Emergency Department.

(Participating hospitals usually London and the South East unless stated otherwise)

Month/year	Relative position of KGH
30th March 1998	2 positions in the "top twenty longest waits" Both patients waiting over 11 hours
27th April 1998	16 patients waiting on trolleys. 1 out of the top twenty longest waits. Patient waiting over 8 hours
18th May 1998	Redbridge CHC unable to participate
June 1998	7 positions in the top twenty longest waits These patients waiting between 11-19 hours
27th July 1998	16 patients waiting on trolleys. 3 out of the top twenty longest waits these being the top three waits of the watch - 7,8 & 10 hours.
24th August 1998	20 patients waiting on trolleys. 4 out of the top twenty longest waits including the top 2 longest. (17 & 18 hrs)
28th September 1998	21 patients waiting on trolleys. 5 out of the top twenty waits ranging from 8-20 hours.
26th October 1998	16 patients waiting on trolleys. None of the waits in the top twenty longest waits. Longest wait over 7 hours
30th November 1998 (Nationwide CW)	2 out of the top twenty longest waits 21&22 hours.
21 December 1998	1 out of the top twenty longest waits. Almost 22 hours