Vol. 7. No. 3. 2020.
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Contents available at:

www.crdeepjournal.org

Global Journal of Current Research (ISSN: 2320-2920) CIF: 3.269

Full Length Research Article

Patients' and Relatives Experiences in Accident and Emergency Department in a Private Hospital, Kisumu County, Kenya: A Qualitative Descriptive Study

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ARTICLE INFORMATION

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Article history:
Received: 01-09-2020
Revised: 15-09-2020
Accepted: 22-09-2020
Published: 28-09-2020

Key words:
Patient Experience, Private Hospital, Relative, Accident , Emergency

ABSTRACT

Over the last few decades, service provision in accident and emergency departments in the County of Kisumu has been of great concern. Although this phenomenon is not unique to the County of Kisumu, and many other Counties, authors have given suggestions on the causes and management strategies to deal with those crises. The aim of this qualitative study was to describe the experiences of patients and their relatives who happened to have spent 12 hours or more at the Accident and Emergency Department (ED) before admission to the wards in one of the private hospitals. A descriptive qualitative design was adopted that followed the fundamentals of naturalistic phenomenon in its natural settings based on an occurrence and experiences from the study participants. This study had 4 patients and 4 relatives who voluntary participated in the study. A thematic inductive approach was used for analysis. Study Participants gave a description of the accident and emergency department as a disaster zone or a hospital scene that needed help, and a needs assessment ought to have been done to find out the root cause of the disastrous situation affecting its services. Thematic findings of this study indicate that 75% of the patients and their relatives were not happy with the experience of visiting the ED. Study participants (25%) were positive towards the care and attitude they received, however some descriptions were not ideal nor were they guided by guidelines or evidence based practice. Majority of the study participants (87.5%) described the ED environment as being similar to what would be encountered after a major disaster had occurred. From descriptions on the quality of care and interactions (88%) of the study participants verbalized that there is a gap on quality of care that needs improvement. From this study the researcher recommends that additional investigation is necessary to further characterize ED patient experience themes and identify interventions that effectively improve these domains.

Introduction

Patient experience with Emergency Department (ED) care is an expanding area of focus, and recent literature has demonstrated strong correlation between patient experiences, care for relatives accompanying patients to and from ED and meeting several ED and hospital goals (Wesson et al 2015).Over the last few decades, delays in accessing emergencycare in an ED is not a new phenomenon and neither is it encountered in one country (Wesson *et, al,*2015).Accidents, injuries and acute illnesses do happen at any time and people require urgent health care services.More often, the first contact service is the ED (McCoy *et, al* 2012).Access to emergency care in Kenya is challenging, but can be improved by encouraging recognition and initial emergent treatment in the Counties. Health care is changing rapidly with the demand to create more collaborative working environments, keep pace with demographic pressures and meet complex care needs for patients seeking care at the ED areas (Ham et al 2012).Delays in the treatment of acute illness and injury are known to cause increased morbidity and mortality (McCoy *et, al* 2012).According to studies that have been done in various countries , various authors have addressed ways to manage delays and overcrowding that has been present in the past particularly during winter periods, weekends and off peak hours, this delays have majorly led to nursing strikes especially in the government institutions to address the crisis through industrial actions for the government to intervene (Bradley, 2005).However little has been studied or done to find out the experiences patients and relatives have had while waiting for care at the Accident and Emergency department.

Due to the rise in patient and relative complaints at the Emergency and Accident departments in most hospitals in Kisumu County, the excessive lengths of time spent waiting

before treatment in the emergency department may negatively impact on their experience and perception of the care given to them. Therefore it is against this background that the study aims at determining patients/relatives description on the experiences for the long waiting time while receiving care at the Accident and Emergency department in a private hospital in Kisumu County.

Main Objective

The main objective of this study was to describe the patients/relatives experiences while receiving care at the accident and emergency department before admission to the wards/transfer to discharge.

Specific Objectives

To explore the patients/relatives perceptions on the quality of care offered to them at the point of accessing care at the ED

To establish the effects of long waiting time on the study participants at the ED

To determine the conditions at the accident and emergency in which the patients had to wait for admission to the wards/transfer/discharge for over 12 hours

To assess as to what would be done to reduce the patients/relatives waiting time at the accident and emergency department

Materials and methods

Study Area

The study was conducted in one of the private hospitals in Kisumu County in western region of Kenya.

Research Design

A qualitative descriptive approach was used to minimize interpretation or interference from the study participants.Qualitative studies are more focused on reporting the facts of experience rather than meanings from the statements said by the study participants, qualitative studies are least encumbered with philosophical or theoretical principles (Wilson, 2014).This study further follows the fundamentals of naturalistic phenomenon in its natural settings and describes the findings without using an abstract framework (Wilson, 2014).According to Wilson 2014 qualitative studies can be associated with phenomenology or grounded theory.

Sample

Literature reveals that most patients who visit the accident and emergency area have conditions that can be critical, acute or chronic and can complicate than in the recent past (McCoy, 2012). Due to the acute illnesses, emergency accidents, injuries and medical emergency conditions, the researcher felt it appropriate to approach these patients and relatives at this potential crisis to get the information. During the period of study only 4 patients and 4 relatives of the patients who were at the Accident and Emergency Department consented to participate in the study.

Target Population

Four patients and four relatives who voluntarily accepted to participate in the study having waited for 12 hours or more at the accident and emergency department

Inclusion Criteria

Patients and relatives who had waited for 12 hours or more at the accident and emergency area and had volunteered to participate in the study. Patients/relatives who were interested were given a letter with an in-depth explanation of the purpose of the study. Study participants were 18 years and above and were fluent in English language.

Exclusion Criteria

Patients and relatives who did not volunteer to participate in the study and had waited for less than 12 hours at the accident and emergency area. Relatives or significant others who had patients who had passed away within the last six hours of waiting at the accident and emergency area

Ethical Considerations

Prior to conducting the study, approval was sought from the Institutional Ethical Review Committee (IERC) of the University Of Masinde Muliro University Of Science and Technology, where logistical and ethical considerations were included, as well as from the executive administrative team at the facility in which the study was conducted. In compliance with the outlined regulations brought forth by the facility, the principal investigator provided contact information to each study participant in lieu of questions regarding participation in the study. The participants were assured of anonymity in joining the study; they were also informed of it's voluntary to participate and that there was no penalty for those not willing to participate.The researcher avoided strategies that would compromise the patients' values or put them at risk. Informed consent and maintaining confidentiality were the ethical issues considered in this study. The researcher accurately represented what the study participant reported without biases.

Informed Consent

Consent refers to the process of giving respondents an opportunity to decide whether to participate in a particular study or not. Adequate information and opportunity to enquire was availed before study participant were asked to fill in the informed consent forms. The study participants were given all the relevant information about the study that was to be undertaken. This was important for the study participants to give consent without coercion, pressure or undue enticement. The researcher ensured that the study participants' anonymity was maintained, and this was to allow them to choose to either participate in the study or not.

Confidentiality

The material and information provided by the respondents would be destroyed upon completion of the study period to protect their confidentiality. The researcher had no intention whatsoever to use the study participants' names in any publication.

Privacy

This was safeguarded where no disclosure of information was done by researchers to others at any point during the study.

Beneficence

In this study the study participants involved were given information on what the study was about and a debriefing after the study. This gave the study participants involved in the study

room to ask questions and clarifications about the study. This ensured that the risks incurred will not be greater than the normal.

Non maleficence

This would entail the duty to benefit others and prevent any harm in the study.

Justice

In this research fairness and equity was observed, where a procedure of selecting the study participants to be involved in the study was done using an inclusive criteria.

Data Collection and Analysis

Data was collected using a semi-structured interview which was conducted with the help of an interview guide. The guide consisted of a number of open ended questions that were useful for both stimulating conversation and insuring that all areas of interest were included. Once the conversation was initiated more focused questions were utilized to clarify experiences. Interviews varied in duration from thirty to forty-five minutes and were conducted either in the participant's home or in a venue arranged by the researchers, whichever was most convenient for the participants. Data were recorded, with the participants' permission, using a tape recorder and field notes were also made during the interviews. Data collection and analysis were performed concurrently. The recordings were reviewed in conjunction with the field notes as the researchers became familiar with the data before transcribing it verbatim. The transcribed interview was then subject to content analysis in an attempt to summarize the data as recommended by Long &Johnson*et, al* (2000). The aim within the analysis was the re-presentation of the participants' experiences with minimal interpretation of their descriptions.

Results and Discussion

Four patients and four relatives/ of patients, who had waited for at least 12 hours in an ED for admission to the wards following medical review, participated in the study. Patients' conditions included suspected stroke, suspected pulmonary embolism, organophosphate poisoning, chronic obstructive pulmonary disease, road traffic accident and febrile illnesses. The patient who waited longest was in ED for 12 hours before being transferred out to a ward.

These long waiting times are not unusual as was demonstrated by the annoyed patients and their relatives more than any other issue when visiting the emergency department, and the observations they make while in the facility. This was confirmed by (Syshowski et, al 2017)who states that long waits and overcrowding in ED increases feeling of being unattended to for treatment and this can lead to patients leaving the department without being seen by the medical team. One patient in the present study described delaying going to ED rather than face the long waits and only faced these delays when the situation worsened: ''I had been feeling quite unwell up to that point so, I had delayed to go to the EDand wait with those conditions, it was a warning for me ... but it got quite bad over the weekend, it got quite debilitating so i said right i have got to address it. So that's what brought me to the ED.'' [Patient 3]

Description of the Accident and Emergency Department

Theme 1: Description of the Emergency Department

- *The environment is far from an expected private hospital*
- *An overcrowded department that is unmanned*
- *A chaotic environment*
- *A disastrous area*
- *An area lacking privacy and security to patients and relatives*
- *A noisy environment*
- *Dirty and filthy environment*
- *A department that has lack of resources like vomitus bowl, screens for patient 's privacy*
- *An area that has a shortage of beds to an extent of patients using trolleys and some sleeping on the floor.*

The descriptions offered by the patients and their relatives of the accident and emergency departments was of an environment far removed from what was expected of a private hospital in Kisumu County.''It was horrible to see everybody just squeezed and piled together. It was as if some catastrophe had happened in the country, you know, some major catastrophe and the whole place is in chaos. You know, it's what you'd imagine if a plane crashed or a bus crashed or something and everything is just chaotic you know.'' [Patient 1] ''You were literally on top of everybody, no privacy. It was just terrible and unbearable. It was like a scene out of a third world country or you know somewhere where a huge disaster had taken place – everyone was crowded into the one area.'' [Patient 2]. ''I was left on the corridor on the trolley. Now I say a corridor, but it was part of the unit and it was wide open so I could see everything that was going on at the nurses' station and all the movements in and out of all the cubicles. It was a wide open space, there were no barriers offered so I had to try and sleep in that situation. It was difficult obviously because there were bright lights and lots of action and people walking all night and then suddenly your trolley would be moved somewhere else.'' [Patient 3]. According to Rumsey *et, al* 2016 nurses are thus regarding these patients as in transit rather than inpatients of the departments. Yet some patients were described as spending there as a holding area awaiting for admission to the wards. Another patient who was febrile as a result of cytotoxic medication described how she was cannulated for intravenous antibiotics. ''... the doctor needed to get a line in, and given my veins were pretty bad and as he had nowhere to put me, he had to get down on the floor beside me. The dishes he was using were put on the floor, and it was like everyone in the department was jumping over them.'' [Patient 2].

Emergency departments were not designed for the long term management of patients but for patients with critical physical needs that can be managed and transferred out within a few hours of stabilization(Graham, 2019). ''...there were people who got the whole of their inpatient treatment in casualty'' [Relative 1]. The environment in the respondents' ED departments were also described as unhygienic and filthy in appearance. There also appeared to be a lack of resources which created potential infection control hazards, especially as one patient's family developed flu like symptoms of which they believed was hospital acquired. ''I was reluctant to get up on the couch to be examined. The place was quite dirty.'' [Patient 2] ''It was very untidy, the walls appeared quite dirty. It hadn't been cleaned, there was rubbish thrown around...Generally the environment wasn't at all comforting. It was unkempt really.'' [Patient 3] ''There were 2

screens only on the whole corridor and they were exceedingly dirty. They were taped together with cello-tape.'' [Relative 3] ''Then she started to vomit and they had no vomit or sputum containers so they [the nurse] told her to get out and sleep on the floor.'' [Relative 2]

Theme 2: Quality of Care

- *Complaints from study participants (patients and relatives)*
- *Study participants perceptions on the care received at the emergency department*
- *Staff attitude towards care provision to patients at the emergency department*
- *Staff workload at the emergency department was high*
- *Leadership and co-ordination at the emergency*
- *Department not adequate*
- *Working conditions for staff at the emergency department need improvement*
- *Communication gap among patients and staff at the emergency department*
- *Nursing care provision to patients at the emergency department from arrival to admission/transfer/discharge not adequate*
- *Patient experiences at the emergency department*
- *Environmental issues at the emergency department*

Study participants were positive in their attitudes towards the nursing and medical staff, where they accepted the care they received because they felt the staff were overworked and undermanned.

''I think the staffs were, considering the conditions they work in, doing their best for everyone. You can only do so much... I believe the essential was done for me. I don't believe there was any–it wasn't a comforting experience let's say.'' [Patient 3]A similar finding was reported by Hess et al 2015 on the state of an emergency department. The study participants both patients and relatives to patientsfelt that, there were other patients who were more in need of attention than themselves and this added to those guilt feelings of complaining despite being made aware of the difficult situation the staff were working under. A relative in the present study expressed it thus: ''You feel guilty because you are shouting and there is someone else there in a bed – the old woman in the bed beside mammy seemed a lot worse and she had to be resuscitated on the trolley ... and you feel that maybe she's worse than mam and deserves it [a bed in the hospital] more ... and she has no one to fight her case.'' [Relative/ 2] ''The admitting nurse wasn't very pleasant, I have to say. She told me to undress, to put on a blue paper gown and to sit up on a high bench, even though I had pain. It was very much about sorting herself out.'' [Patient 3] In another situation the attitude of the nurse was distressing for both the patient and her family. The patient, an elderly lady, was incontinent but having difficulty micturating and had attempted to use a bedpan a number of times. However, due to position and surroundings she was unable to urinate. '''Oh, I can't be bothered with this' she [the nurse] said 'I'm putting a nappy on you' and I was shocked. I -it really destroyed me, it really did destroy me. It had an awful effect on me. It had a terrible effect on me. The thought of having toput a nappy on and be told to go [urinate] in that. I mean they can't make you -here they are making you go in a nappy ... it still upsets me and it still has an awful effect on me.'[Patient 4] One patient's relatives described the development of pressure sores from lying on a trolley over a long period. ''Five days mammy was on a trolley and it was just disgusting ... She had bruises and blisters all over her arms and from the trolley she had blisters on her backside and all over her back.'' [Relative 2] ''I remember at one stage [during the night] actually calling for a nurse because ... the gentleman in the cubicle who had apparently taken a stroke, must have pulled the rug up and the covers came off his feet and I could see him trying, in vain, to make an attempt to cover his feet ... the poor man hadn't the energy ...'' [Patient 2] ''She wasn't getting washed or cleaned or whatever. We were trying to wash her under her arms or whatever to give her a basic clean.'' [Relative 2] ''I said she was in pain and needed to change her clothes ... we needed to take her out of the clothes to get her dry and I had asked one or two [nurses]. 'Oh somebody will come to you.' They seemed to be passing it on-they didn't seem to take responsibility you know. 'The other nurse down there is in charge of this' ... and actually it wasn't very busy ... it seemed they were just chatting to each other and walking up and down.'' [Relative 3] For some of these patients the experience was so traumatic that they stated they would dislikethe thought of ever returning to accident and emergency. ''I needed to go [back] to hospital and I said 'no, I'm not going. I would rather ... die here than to go down to the hospital'. That's how bad I feel about it ... It terrifies me, absolutely terrifies me.'' [Patient 4] ''To me it's just such a depressing place to go into and i have to say it'll be the last place i will go into again.i have, you know, an absolute horror of going back into it now to be honest with you.'' [Patient 2]Hess et al 2015 continues to state that this findings appear to reflect an acute hospital audit or a needs assessment. In his study on patient satisfaction with primary healthcare services it concurred with our study showing that depressedand anxious patients had a negative opinion about healthcare services, and that was visible from the study participants' narratives.

Theme 3: Waiting in Accident and Emergency Department

- *Noise at the emergency department*
- *Lack of sleep and rest at the emergency department*
- *Movement and commotion at the emergency department*
- *Continuous lighting at the emergency department at night*
- *Lack of privacy and security at the emergency department*
- *Lack of attention from staff taking care of patients at night*
- *Communication breakdown between nurses, doctors, patients and patient relatives*
- *Abandonment and neglect of patients at the emergency department for long hours*
- *Space constraint at the emergency department*
- *Lack of enough rooms at the emergency department*

Participants described a number of difficulties they encountered while waiting in ED. They stated how difficult it was to get a proper night's sleep because of the noise and the lights:

''I got no sleep... it's quite impossible to sleep ... you have people you know coming back and forth all the time you have the constant noise.'' [Patient 2]

''The only thing they do at night time is dim the lights down, but the lights are bright for night time and they dim them down a bit, but otherwise there's noise going on all the time you know what I mean, you don't sleep you dose off, but no way do you sleep.'' [Patient 4]

A secluded area away from everybody, so I was very frightened because obviously the two men they may as well literally have

been in the bed with me. If it was a bed they would have been in the bed.'' [Patient 1]

''I went into this little room where the doctor had brought me, but I had to bring my husband in because I was terrified somebody would pull the curtains back again. So I tried as best I could to give myself a bit of wash in there.'' [Patient 2]

''If you were trying to change a top or change the curtains did not even fit around totally, you know. So there was never any privacy to do anything.'' [Patient 1]

''She had her leg put in the cast ... then they put her on the corridor ... she was in terrible pain then at that stage though she didn't want to be there because there was 2 other people -a lady and a man -and they were very drunk and they said to her what happened to her and she said 'I got knocked down' and they kept saying to her 'you're very stupid oh you stupid girl' and she was saying to me 'mom take me home I'm not staying I'm not staying.''' [Relative 3]

''You're not getting any feedback, you don't know what's going on. If you need something... you have to make the effort to get out of the bed to find a nurse to ask her ... It's just being totally isolated ... And you're delighted when a
nurse comes near you or comes in or pops her head in or whatever but very few and far between I think have the time to do that.'' [Patient 1]

''Somebody did actually give me information in the morning about the hospital, a little booklet, but what would have been useful I think is if somebody was available during the night time that could stop and talk.'' [Patient 3]

Wong (2007) states that patients are afraid of the unknown and need to know what has, is and will happen in relation to their care. Wong in her study continued to say that patients complained of feelings of abandonment and neglect when left unattended in the ED.

Recommendations from patients and relativesat the ED

- *Reducing the waiting time from 12 hours to 6 hours at all stages of care*
- *Improving communication within emergency department*
- *Improving particular emergency department facilities in relation to privacy and safety for patients, staff and relatives accompanying patients to the hospital*
- *Interpersonal communication with patients and relatives in relation to care by the medical teams*
- *Uniform care to all patients and relatives irrespective of whatever challenges or conditions they may present with*
- *Treatment of all patients with care and respect*
- *Customer relations and patient centered care be embraced*
- *Improvement on real time communication to the anxious patients and relatives on the progress of care*
- *Environmental awareness and vigilance by the caregivers*
- *Maintenance of privacy and security within the hospital premises*

The recommendations from patients and relatives at the ED is as per table 4 above.

''... ideally people spending 6 hours maximum in casualty, but to be realistic they're spending a lot more.'' [Relative 1]

''There was no liaison person. It possibly would have been nice if somebody had come to me at some point during that time to chat to me and tell me this is what you should anticipate.'' [Patient 3]

''I do think if space was created it would be more possible to keep men in one area and women in another area or something like that. There would be a bit more privacy in that respect.'' [Patient 1]

''And I do think there is the need for a particular ED sectionfor those with drug addictions or alcohol addictions. They deserve to be treated with care and respect, as we all should be, but I do believe that it adds to the chaos.'' [Patient 1]

The recommendations generally appeared to focus on the issues that were regarded as being the most distressing for the participants.

Hess and Thomson *et, al* 2015, acknowledge that shared decision-making in the emergency department, and respecting patient autonomy in relation to communication of information to patients about their treatment, care and their progression through the ED creates trust in patient care management.Greater recognition of the psychological and communication needs of patients in the ED by nursing and medical staff also needs to occur (Thomson, 2015). Care has to be regarded as more than just managing acute physical needs and ought to include the development of therapeutic relationships (Hess *et al*, 2015).

Limitations of the Study

In qualitative studies, results would not be generalized due to the small sample size of the study participantsand as a result data saturation was probably not achieved. Another limitation is that participants in a volunteer sample may have an entrusted interest in the phenomenon being studied (Wilson, 2014), and this may have influenced their participation. However, despite this, it is important that all patients' experiences are heard and acknowledged.

Conclusion

The findings of this study appear to indicate that patients and their relatives were, to a major degree, unhappy with the experience of visiting the ED. Some participants described the ED environment as being similar to what would be encountered after a major disaster had occurred. The descriptions of the quality of care and interactions also left room for improvement. Also the design and structure of the departments were clearly not suitable for the patients who were expected to wait for long hours for admission to the wards. Graham 2019 states that, patients seeking emergency care at the EDs understand the need to wait in an emergency and understand that sicker patients need to be seen first. However Graham further states that waiting room anxiety is increased significantly by the lack of information available for timely information mitigation by the departmental leaders.The most commonly identified drivers of ED patient experience include communication, wait times, and staff empathy; however, existing literature is limited. From this study the researcher recommends that additional investigation is necessary to further characterize ED patient experience themes and identify interventions that effectively improve these domains.

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