Barriers to Change Hindering Quality Improvement: The Reality of Emergency Care

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Purpose: The aim of this study was to investigate physicians' and nurses' perspectives and prerequisites for quality improvement in the emergency department based on results from a previous patient survey.

Method: The study used an explorative design with a qualitative approach and was conducted at the main emergency department of a Swedish university hospital. Interviews were conducted with 5 focus groups. In total, the groups comprised 22 respondents.

Results: The respondents suggested goals and quality improvements, such as more patient-centered care, reduced waiting times, and better pain management. However, barriers to quality improvement also were identified and represented 3 themes: the patient is looked upon as an object or a problem; the physicians and nurses belong to different organizational cultures; and the hospital's organization hinders the optimal flow of patients and improvements to quality.

Discussion: When assigning priority to the topic areas, most of the focus groups ranked "information, respect, and empathy" as most important to improve. Adequate information, proper care, and treatment within a reasonable time in the emergency department were cited as the goals for patient care, but the health care professionals perceived barriers to change in the hospital culture and organization. To ensure quality care and patient safety, these barriers should be addressed by leaders on all levels in the organization, including the hospital board. Health care professionals' perspectives of quality of care are valuable and should be included in quality improvement work.

Key words: Barriers to change; Focus group interview; Emergency department; Quality improvement; Health care professionals' perspective

"I am satisfied with the qality of care provided." These are the words that health care institutions strive to hear from patients today. Several studies indicate the importance of listening to patients to achieve improvements in the quality of care.[1-3] Waiting times are often seen as a key factor to patient satisfaction in the emergency department,[4] but there also is a need to improve other aspects of ED care, such as information, respect, and patient safety.[5,6]

The implementation of new routines and evidence into practice is one of the most challenging aspects of quality improvement work. It is therefore necessary to adopt a systematic approach. The Model for Improvement has been successfully used in different care environments[7,8] and consists of 2 parts. The first is to answer 3 key questions: "What are we trying to accomplish?" (goal), "How will we know that a change is an improvement?" (measurement) and "What changes can we make that will result in improvement?" (improvement). The second part of the model is the Plan-Do-Study-Act (PDSA) Cycle, where "Plan" stands for planning the change in the clinical practice, "Do" for trying the change, "Study" for observing the results, and "Act" for acting on what is learned.[9] The PDSA-cycle represents a systematic

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approach to quality improvement work with a focus on making small steps and evaluating them before continuing.

The importance of context (culture, leadership, evaluation) in this work is widely recognized. An understanding of the beliefs and values in the culture (ie, that of the individual, team, and organizational system) and a learning organization may facilitate changes. Transformational leadership and effective teamwork also are essential. Feedback should be given on performance (of the individual, team, and organizational system), and different methods of evaluation should be used.[10] Furthermore, it is important that the implementation process be multidisciplinary from the beginning and integrated into the clinical practice.[11] The perspectives of health care professionals regarding the quality of care may be useful in the quality improvement work but is an area that is not well explored.[11,12] This study addresses the results of a previous study conducted at a Swedish emergency department, in which 200 patients who visited the emergency department responded to the Quality from the Patient Perspective (QPP) questionnaire.[6] The QPP questionnaire evaluates the perceived quality of care and the subjective importance of each question addressed.[13] The results of the QPP survey showed that patients generally perceived the emergency care as of good quality. However, 5 areas for quality improvement were identified: (1) information, respect, and empathy; (2) pain relief; (3) nutrition; (4) waiting time; and (5) general atmosphere.[6]

Aim

The aim of the present study was to investigate physicians' and nurses' perspectives and prerequisites for quality improvement in the emergency department based on the results from the QPP survey.

Method

DESIGN AND DATA COLLECTION

The study used an explorative design with a qualitative approach. The focus group interview is a method used in qualitative research in a wide variety of fields. It is an appropriate method when investigating a previously unexplored topic.[14]

A moderator conducts interviews with the selected focus groups, usually with the aid of an interview guide. The groups are made up of 4 to12 respondents, and the dynamic interaction of the group interview situation inspires the respondents to come up with new ideas and views on the topic.[14]

SETTING

The study was conducted in 2005 at the main emergency department of a Swedish university hospital. At the time of the study, the emergency department treated about 50,000 patients per year and covered 3 medical specialties: general surgery, internal medicine, and orthopedic surgery. In total, work shifts (day/evening/night) in the emergency department were staffed by 3 to 5 physicians, 5 to 7 registered nurses (RNs), and 5 to 8 licensed practical nurses (LPNs). There were no specialist emergency physicians working in the emergency department and only a few RNs with special training in emergency care.

PARTICIPANTS AND PROCEDURE

All physicians and nurses (RNs and LPNs) working in the emergency department were invited to participate in the study. Written and oral information about the study was provided by the first author. The days of interviews were scheduled in advance. The health care professionals who were interested in participating and were available on the predefined day were included. Five focus groups were conducted. To facilitate unstrained discussions, each focus group consisted of only one category of health care professionals: 3 groups with physicians from general surgery (n = 4), internal medicine (n = 6) and orthopedic surgery (n = 2), one group with RNs (n = 5), and one group with LPNs (n = 5). In total, the groups comprised 7 men and 15 women, with a mean age of 40.9 years and a mean work experience in the field of 5.5 years. The physicians were employed by the hospital in their respective specialties and worked on call at the emergency department according to a rotating schedule (day and/or night shifts).The nurses were employed by the hospital and worked day, evening, and night shifts in the emergency department, rotating between the department's 3 medical specialties.

The focus group interviews were led by a moderator (the first author) and lasted about 90 minutes. The interviews were tape recorded and an assistant moderator also took notes as a back-up in case of technical problems. The moderator presented the main results from the patient survey (the QPP survey previously described). Each respondent ranked the 5 areas for quality improvement, assigning them an order of priority according to what he or she believed was most important. It was decided that the area that received the highest ranking would be the first topic for group discussion. An interview guide was developed for the study by the first author. The structure and content of the interview guide followed the 3 key questions of the Model for Improvement: "What are we trying to accomplish?" (goal), "How will we know that a change is an improvement?" (measurement) and "What changes can we make that will result in improvement?"[9] At the end of the interview session, the moderator made an oral summary of the interview, which was confirmed by the respondents. Immediately after each focus group interview, the moderator and assistant moderator had a debriefing regarding the interaction and discussion.[15]

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