

Original
Contributions



TALK-TIME IN THE EMERGENCY DEPARTMENT: DURATION OF PATIENT-PROVIDER CONVERSATIONS DURING AN EMERGENCY DEPARTMENT VISIT

Danielle M. McCarthy, MD, MS,* Kirsten G. Engel, MD,* Barbara A. Buckley, RN,* Annsa Huang, BA,†
Francisco Acosta, MBS,‡ Jennifer Stancati, BA,§ Michael J. Schmidt, MD,* James G. Adams, MD,* and
Kenzie A. Cameron, PHD, MPH‡

*Department of Emergency Medicine, Northwestern University, Chicago, Illinois, †Feinberg School of Medicine, Northwestern University, Chicago, Illinois, ‡Division of General Internal Medicine and Geriatrics, Department of Medicine, Northwestern University, Chicago, Illinois, and §Loyola University Chicago Stritch School of Medicine, Maywood, Illinois

Reprint Address: Danielle M. McCarthy, MD, MS, Department of Emergency Medicine, Feinberg School of Medicine, Northwestern University, 211 E. Ontario Street, Suite 200, Chicago, IL 60611

Abstract—Background: Analyses of patient flow through the emergency department (ED) typically focus on metrics such as wait time, total length of stay (LOS), or boarding time. Less is known about how much interaction a patient has with clinicians after being placed in a room, or what proportion of their in-room visit is also spent waiting. **Objective:** Our aim was to assess the proportion of time that a patient spent in conversation with providers during an ED visit. **Methods:** Seventy-four audio-taped encounters of patients with low-acuity diagnoses were analyzed. Recorded ED visits were edited to remove downtime. The proportion of time the patient spent in conversation with providers (talk-time) was calculated as follows: (talk-time = [edited audio time / {LOS – door-to-doctor time}]). **Results:** Participants were 46% male; mean age was 41 years (standard deviation 15.7 years). Median LOS was 126 min (interquartile range [IQR] 96 to 163 min), median time in a patient care area was 76 min (IQR 55 to 122 min). Median time in conversation with providers was 19 min (IQR 14 to 27 min), corresponding to a talk-time percentage of 24.9% (IQR 17.8%–35%). Multi-

variable regression analysis revealed that patients with older age, longer visits, and those requiring a procedure had more talk-time: total talk-time = 13 s + 9 s × (total time in room in minutes) + 8 s × (years in age of patient) + 482 s × (procedural diagnosis). **Conclusions:** Approximately 75% of a patient's time in a care area is spent not interacting with providers. Although some of the time waiting is out of the providers' control (eg, awaiting imaging studies), this significant downtime represents an opportunity for both process improvement efforts and innovative patient-education efforts to make use of remaining downtime. © 2014 Elsevier Inc.

Keywords—emergency medicine; communication; patient-physician interaction

INTRODUCTION

Attempts to characterize patient flow within the emergency department (ED) typically focus on metrics of timeliness (wait time), throughput (length of stay [LOS], boarding time), and look at outcomes related to patient satisfaction (1–3). One influence on these metrics that has not been explored with respect to time data is the face-to-face patient–provider interaction. Little is known about how much a patient interacts with

Presented at the Society for Academic Emergency Medicine Annual Meeting, Oral Presentation, Chicago, Illinois, May 2012 and the International Conference on Communication in Healthcare, Oral Presentation, St Andrews, UK, September 2012.

Institutional Review Board approval was obtained.

clinicians after being placed in a room, or what proportion of their in-room visit is also spent waiting. Many tasks other than direct patient communication demand caregiver attention and understandably may take the caregivers away from the patient. However, the proportion of the time that caregivers spend in direct conversation with patients in the ED is not completely understood, and neither is the impact that the time can have on other outcomes.

Researchers previously focused on discrete actions in the ED, such as time-motion analyses for interruptions or discrete tasks (eg, hand washing, documentation) (4–6). These studies provide a rich description of the time flow of the physician, including detailed time metrics; however, they do not show the interaction or timing from a patient's perspective. One study by Slade and colleagues was conducted with an ethnographic approach to characterize the network of care, number of discrete interactions, and linguistic features of conversations from a patient perspective (7). However, this study did not report any time metrics related to conversation. Although these studies increase our understanding of the individual patient and individual physician experience in the ED considerably, data regarding the intersection of these two groups are lacking. The objective of this study was to assess the proportion of time that patients with select low-acuity complaints spent actively in conversation with members of the health care team during an ED visit.

METHODS

Study Design

In this descriptive study, the time-related metrics from audio recordings of complete patient visits are used to describe the duration of spoken interactions between emergency medicine providers and patients. The study took place at an academic medical center (>85,000 annual patient visits) with data collected in two time periods: May to July 2011 and March to August 2012. Institutional Review Board approval was obtained for all study procedures.

Study Population

Clinician participants. All ED care providers (ie, attending physicians, resident physicians, nurses, and technicians) were approached to provide informed consent approximately 1 month before study initiation. Other ED personnel (eg, patient registration personnel, security, patient transporters, x-ray technicians) were not included as care providers for the purposes of this study. If a provider declined to participate, patients were not recruited in clinical areas where that provider was working. If a provider had been missed in the preconsent process

(due to vacations or other obligations), the provider was approached at the time of patient enrollment and written informed consent from the providers was obtained before entering the patient room.

Patient participants. Patients with one of four chief complaints (ie, ankle sprain, back pain, head injury, and laceration) were eligible for inclusion. These conditions provided a high likelihood of the patient being discharged and a range of throughput times. This study was performed along with another study evaluating the content and type of doctor–patient communication, using the same study population (8). Exclusion criteria included age younger than 18 years, non–English-speaking, significant history of psychiatric disease or cognitive impairment, medically unstable patients, or patients being seen by nonconsenting providers. If an alternative diagnosis was made that did not fit into the four diagnosis categories mentioned, patients were excluded at that time (eg, chief complaint of ankle sprain that was found to be an ankle fracture after x-ray study).

Patients were recruited based on research assistant availability (day and evening hours of weekdays). Patients were approached in triage or upon room placement, at which time the study was explained to them and, if the patient indicated interest, written informed consent was obtained.

Study Protocol

After patient and provider consent, digital audio recorders were positioned in the patient room with “sound-grabbers” to enhance the quality of the recordings. Audio recording started at the time of patient consent and was stopped after patient discharge. The audio recorder did not leave the room with the patient (eg, when the patient went to studies, such as x-ray or computed tomography [CT]), therefore, only conversations that occurred within the patient room were captured. If a patient was moved from a patient room to a hallway bed or other more public care space, the recording was stopped and patient was excluded. The specific four diagnoses targeted were noncritical patients and the patients were seen primarily in the urgent care section of the ED, where there was less likelihood of being pulled to a hallway space; however, some patients were also seen in the main ED. After completion of the patient's visit, the ED arrival time, total ED LOS, door-to-doctor time, and total daily volume were abstracted from the medical record.

Audio editing was then performed on the digital recordings using Audacity® Software (version 1.3). Research team members (JS, FA, AH, BB) trained in the use of Audacity listened to the digital recordings

Download English Version:

<https://daneshyari.com/en/article/3246988>

Download Persian Version:

<https://daneshyari.com/article/3246988>

[Daneshyari.com](https://daneshyari.com)