What Parents Want: Does Provider Knowledge of Written Parental Expectations Improve Satisfaction in the Emergency Department?

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ABSTRACT

OBJECTIVE: Satisfaction is an important measure of care quality. Interventions to improve satisfaction in the pediatric emergency department (ED) are limited, especially for patients with nonurgent conditions. Our objective was to determine if clinician knowledge of written parental expectations improves parental satisfaction for nonurgent ED visits.

METHODS: This randomized controlled trial was conducted in a tertiary-care pediatric ED. Parents of children presenting for nonurgent visits (Emergency Severity Index level 4 or 5) were randomized into 3 groups: 1) the intervention group completed an expectation survey on arrival, which was reviewed by the clinician, 2) the control group completed the expectation survey, which was not reviewed, and 3) the baseline group did not complete an expectation survey. At ED disposition, all groups completed a 3-item satisfaction survey, scored using 5-point Likert scales (1 = very poor, 5 = very good). The primary outcome was rating of "overall care." Secondary outcomes included likelihood of recommending the ED and staff sensitivity to concerns. Proportions were compared by chi-square test.

RESULTS: A total of 304 subjects were enrolled. The proportion of parents rating 5 of 5 for overall care did not differ among the baseline, control, and intervention groups (74.8% vs 73.2% vs 69.2%, $P = .56$). The proportion of parents rating 5 of 5 also did not differ for likelihood of recommending the ED (77.7% vs 72.2% vs 70.2%, $P = .45$) or staff sensitivity to concerns (78.6% vs 78.4% vs 78.8%, $P = .71$).

CONCLUSIONS: For nonurgent pediatric ED visits, clinician knowledge of written parental expectations does not improve parental satisfaction.

KEYWORDS: emergency department; parental expectations; satisfaction; survey

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WHAT'S NEW

This is the first study to describe parental expectations and satisfaction for nonurgent visits to a pediatric emergency department. Though clinician knowledge of written parental expectations does not improve satisfaction, parental satisfaction is high overall for nonurgent visits.

PATIENT-CENTEREDNESS IS AN essential component of quality health care.[1] The 2007 Institute of Medicine report *Emergency Care for Children: Growing Pains* suggests that failure to deliver patient-family centered care in the emergency department (ED) setting can result in numerous untoward effects.[2] Specifically, lack of patient-centeredness can lead to inadequate understanding of diagnoses and treatment by families, preventable morbidity and mortality, and ultimately patient and family dissatisfaction with care.[2,3] Methods to improve patient-centered care include the presence of family members accompanying their child at all times, the availability of interpretation services to overcome communication barriers, and the incorporation of family and patient preferences and input into management and treatment decisions.[3,4] Ultimately the goal of patient and family-centered approach to care is to establish a physician–patient partnership to facilitate open communication, shared decision making, and the delivery of high-quality care that is satisfying to the patient and family.[2,3]

There are many barriers to effective patient-centered care that are unique to the ED setting. High patient volume, overcrowding, and high acuity can lead to significant delays in care and many disruptions to the patient encounter.[3,5] The inherent lack of a previous relationship between the provider and family can make involvement of the family difficult due to system-imposed time constraints as well as those imposed by the time-sensitive nature of ED situations.[3] Given these challenges, the

incorporation of patient expectations into the routine flow of ED care is a possible intervention to better engage the provider with the family and patient and to enhance the patient–provider relationship.[6] Prior studies have demonstrated that awareness of a patient's expectations can allow for providers to address specific needs important to the patient and family[7] and that unmet expectations with health care affects patient satisfaction.[7,8] However, measures of the effect of patient or parental expectations on ED care are limited. Previous studies have not demonstrated improved satisfaction when previsit expectations were met[9] or with use of a written expectation survey,[6] though it was unclear if the majority of surveys in the intervention group had been reviewed by the provider.[6]

In the ED, nonurgent visits comprise more than half of all pediatric visits.[10] Parental decision making for bringing children to the ED for nonurgent conditions is often unclear, as opposed to children with more emergent or critical illness.[11–15] Additionally, parental satisfaction for these visits has not been previously evaluated. Therefore, we sought to examine the potential effect of parental expectation on satisfaction for nonurgent ED visits. Specifically, our objective was to determine the effect of physician knowledge of written parental expectations before ED evaluation on parental satisfaction for nonurgent pediatric visits.

METHODS

STUDY DESIGN

We conducted a 3-arm prospective randomized controlled trial to assess the impact of provider knowledge of parental expectations on parent satisfaction for children with nonurgent visits to the ED. The Human Investigations Committee of Yale University approved this study.

STUDY SETTING AND POPULATION

The study was performed in an urban tertiary-care pediatric ED (annual census 35,000) over a 1-year period from February 2014 to February 2015. A convenience sample of parents or guardians (hereafter referred to as parents) of children triaged as a nonurgent visit (Emergency Severity Index [ESI] level 4 or 5)[16] were approached for enrollment upon arrival to the ED examination room. The ESI is a 5-level triage algorithm from 1 (most acute) to 5 (least urgent) based on patient acuity and anticipated resource needs, with levels 4 and 5 considered to be low-acuity visits.[16] Parents were eligible for participation if their child was <18 years old and presenting for a nontraumatic chief complaint (eg, fever, cough, emesis). Parents were excluded if the child's chief complaint was health maintenance related (eg, vaccination), or if the parent was non–English speaking and/or could not read the English-language surveys.

STUDY PROTOCOL

Eligible parents were enrolled by trained research assistants (RAs) during predetermined study blocks distributed throughout the 24 hours of the day and 7 days of the week, dependent on RA availability. Study packets were distributed to potentially eligible parents on arrival to the ED. An information sheet explained that consent was implied if the parent completed the enclosed surveys. Using block randomization, parents consenting for participation were randomly assigned using blocks of 80 into the 3 study groups: baseline, control, or intervention (Fig. 1). RAs were blinded to the group assignment at the time of enrollment.

Parents assigned to the baseline group followed routine care, and no study procedures were conducted except completion of a satisfaction survey after the ED visit. Parents in the control and intervention groups were given an expectation survey immediately after enrollment. Upon survey completion, the RA collected the expectation survey. The control group expectation survey was placed back in the study packet, and the medical providers caring for the patient were blinded to survey responses. For the intervention group, the expectation survey was reviewed by the first treating provider (pediatric or emergency medicine resident, nurse practitioner, physician assistant, pediatric emergency medicine fellow, or attending physician) before his or her initial evaluation of the patient. The first treating provider initialed the expectation survey to acknowledge review of the survey responses and returned the survey to the RA. We did not record whether a nonattending physician provider subsequently discussed the survey with an attending physician. Not every patient evaluated by a nurse practitioner or physician assistant in the ED is staffed with an attending physician, so an attending physician did not see all patients. Treating providers were not provided any further information about the study or outcomes being evaluated, and they were not instructed as to how to consider the expectation survey responses. Parents in all groups were blinded as to whether the provider received written knowledge of their expectations.

OUTCOME MEASURE

Once the patient was ready for discharge, as decided by the treating medical provider, the RA provided parents in all groups with a satisfaction survey that was completed

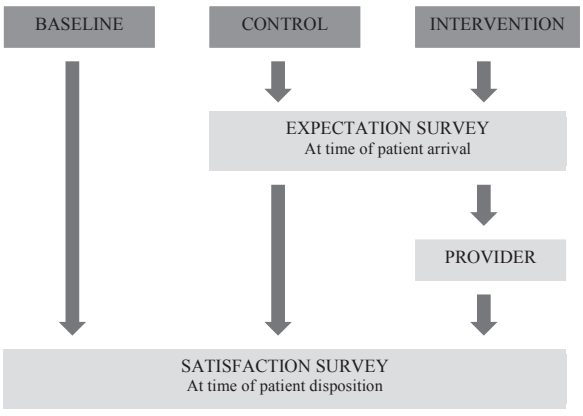

Figure 1. *Study flow diagram.*