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Implementation of a Patient Care Specialist Role to Enhance the Patient Experience in a Pediatric Emergency Department

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Implementation of a Patient Care Specialist Role to Enhance the Patient Experience in a Pediatric Emergency Department

A DNP Project Submitted to the
Graduate Faculty
of Jacksonville State University
in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Nursing Practice

By

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Abstract

Background*:* Patient-centered care (PCC) has been an emerging trend in healthcare for the past two decades (Walsh et al., 2022). PCC and the patient experience have become essential measures of the quality of care provided and are linked to reimbursement dollars and improved patient outcomes (Rapport et al., 2019).

Purpose: The purpose of the Doctor of Nursing Practice (DNP) project was to improve the patient experience in the Emergency Department (ED) of a metropolitan hospital. The DNP project focused on the benefit of a patient advocate in the ED to improve the patient experience. The project sought to improve patient experience scores to the facility goal of >70%; the current overall score for 2022 is 68.9%.

Methods: The project followed the plan-do-study-act and Lewin's change theory as a foundation to guide the project.

Results: The patient care specialist role improved patient experience scores weekly on weeks one through six. The overall scores for the eight-week period were not >70%; however, an electronic medical record change in week seven directly affected scores.

Conclusion: The patient care specialist role proved to be a valuable resource and liaison for families in the ED. Patient experience scores improved weekly and met or exceeded the agency's goal except during the last two weeks of data collection; there was a significant change within the organization during this time frame, including changing electronic medical record (EMR) operating systems.

Keywords: emergency department, patient satisfaction, patient advocate, patient experience

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Implementation of a Patient Care Specialist Role to Enhance the Patient Experience in a Pediatric Emergency Department

The term patient experience has emerged within the healthcare setting over the last two decades following a landmark study that linked Patient-Centered care (PCC) with improved healthcare utilization and health outcomes (Larson et al., 2019). While the terms patient satisfaction and patient experience are often interchanged, the terms discuss two different categories of person-centered measures of quality of care (Larson et al., 2019). Patient satisfaction has been defined as a patient's evaluation of the care provided relative to their expectations of the healthcare system (Larson et al., 2019). In contrast, the patient experience is a sum of patients' interactions with the health system (Larson et al., 2019) and a sum of specific moments and encounters during the patient's care (Sze et al., 2019). Focusing on the patient experience over patient satisfaction ensures the care provided is evidence-based and has been shown to give a more objective response in surveys (Golda et al., 2018). Focusing on the patient experience allows an objective assessment of the patient interaction with the healthcare system while guiding the organization for quality improvement (Rapport et al., 2019). While Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores are used to assess patient satisfaction in adult hospitals, pediatric hospitals do not use or require these scores (Hospital Consumer Assessment of Healthcare Providers and Systems, 2021). A positive patient experience impacts the healthcare organization by increasing patient engagement, enhancing the organization's revenue, and improving the organization's reputation (NRC Experience Portal 2022). A positive patient experience is about more than money; the patient experience has been linked to better patient outcomes, decreased litigation risk, and increased compliance with a treatment plan (Golda et al., 2018). The ED is a high-stress environment for patients due to

unplanned visits, lack of established relationships and trust with providers, and limited resources in the ED (Byczkowski et al., 2018). Improving the patient experience improves family loyalty to the organization, but most importantly, treating patients well and doing what is best for the patient is the right thing to do (Sze et al., 2019).

Background

The culture of the ED contributes to high anxiety and confusion for patients and families due to uncertainty, long wait times, and fear of illness (Feuerwerker et al., 2019). The ED can also be stressful for families due to intense circumstances, a lack of communication between providers and families, and a poor understanding of care coordination (Byczkowski et al., 2018). The metropolitan pediatric hospital where the DNP project was implemented uses National Research Corporation (NRC) health surveys to track patient satisfaction and identify areas of improvement. The NRC is an independent organization that conducts patient experience surveys for healthcare facilities to help organizations understand their clients (NRC Experience Portal 2022). To date, they have partnered with 75% of the largest healthcare organizations nationwide to send surveys about their experience, organize the data, and give real-time feedback to the organization (NRC Experience Portal 2022). The surveys provide real-time feedback from all hospital and emergency department discharges, intending to understand better the population of patients we serve in the ED. The survey consists of 15 questions focused on confidence and trust in the healthcare team, education and information provided to the parents, communication with the child, coordination of care, and physical comfort. The most valued response on the survey is the numerical ranking 1-10 on the question ‘likelihood to recommend the facility to others’; this is known as the net promoter score (NPS) (NRC Experience Portal 2022). The NPS is used in healthcare to simplify reporting, evaluate patient experience scores, and allows for comparison

between hospitals (Adams et al., 2022). Patients and families receive NRC surveys by email, phone call, or text typically within 24 hours of leaving the facility, and data can be retrieved in real-time (NRC Experience Portal 2022). Since January 2021-January 2023, the facility has explored various strategies to improve the patient experience and provide quality care. Patient experience scores have decreased from 71% to 56% during this 2-year time frame (NRC Experience Portal 2022). Improving the patient experience in a pediatric ED is challenging due to parents completing surveys while needing to engage parents and children in medical decision-making (Byczkowski et al., 2018).

For the DNP project, the intervention was implementing a patient care specialist in the ED. The term care specialist refers to what is commonly known as a patient advocate. A patient advocate in the healthcare setting can be defined as one who promotes patient safety and quality, including being the patient's voice and improving the interpersonal relationship with patients (Nsiah et al., 2019). The patient care specialist position requires a bachelor's degree in social work who dedicated his/her time to rounding on families to improve the patient experience. A vital responsibility of the patient care specialist was to round on all patients boarding in the ED. Other essential tasks included rounding on patients and family members who have been in the ED room for four hours or more and rounding on families whose healthcare providers reported having increased anxiety or agitation. In addition, the role served as a liaison between families and the healthcare provider. The goal was to create an environment to improve patient care, alleviate the non-medical burdens placed on busy healthcare staff, and enhance patient satisfaction scores while improving communication between providers and patients (Feuerwerker et al., 2019).

Needs Analysis

For the year 2022, the average patient experience score was 67%, with the facility goal greater than 70% (NRC Experience Portal 2022). The patient experience score varied as real-time data was consistently analyzed. For example, in September 2021, the patient experience score was 59.4%, with the goal still being >70% (NRC Experience Portal 2022). In June 2022, the score improved to 72% (NRC Experience Portal). Variability in data typically coincided with the volume of daily visits in the ED. Currently, the average visit per day is >200/day. In June 2022, the average volume was around 170/day. With increased volume comes the increased length of stays, reduced staff morale, and worsened patient-to-provider communication (Moskop et al., 2019). A SWOT analysis was performed to assess strengths, weaknesses, opportunities, and threats, as seen in Appendix A.

The facility where the DNP project was implemented is the state's only independent, free-standing children's hospital and ED. Therefore, comparable data from "like" facilities were unavailable at the state level. However, two other hospitals in the state have pediatric areas within the ED. In addition, two other hospitals in the state have designated pediatric treatment within their ED; however, the facilities are not free-standing pediatric facilities. Therefore, the two facilities participate in the HCAPS survey. One of those hospitals is rated at 4/5 stars, and the other is rated at 3/5 stars using HCAPS scorecards (Medicare.gov, 2023).

Compared to other pediatric emergency medicine departments in the nation, the facility where the project was implemented ranks above average in every category except one. The only NRC category falling below the national benchmark would recommend this facility to others where the current ranking is 67%, and the national average is 71.3% (NRC Experience Portal 2022). However, the size of these facilities and the annual volume to compare equally is unclear.

Problem Statement

Within the organization where the project was implemented, the organization desired to improve the patient experience by implementing a patient care specialist. Therefore, the following PICOT question was developed for the DNP project: Among patients and families in the emergency department (ED), do consumers of healthcare in a pediatric emergency department (P) who interact with a patient care specialist (I) compared to consumers who do not interact with a patient care specialist (C) have improved patient experience scores (O) over eight weeks (T)?

Aims and Objectives

The overarching goal of the DNP project was to: (a) Improve the net promoter score on the patient experience surveys, (b) improve the patient experience in the emergency department, and (c) provide real-time service recovery to dissatisfied patients and families.

Review of Literature

A literature review was performed with the following primary considerations: defining the patient experience, the importance of the patient experience, what families and patients expect while in the ED, using a patient care specialist in the ED, and various ways to improve patient experience through survey results. Supportive literature and evidence to strengthen the DNP project are presented below.

The databases used in the literature review were CINAHL, PubMed, Medline, and Cochrane Library. Keywords included in the search were emergency department, patient experience, patient satisfaction, patient advocate, patient experience scores, and pediatric emergency department. The initial search yielded over 400 articles on each database; the results were narrowed to include academic journals and peer-reviewed articles publications in the last

three to five years. Finally, an evidence table was used to sort the articles which supported the evidence-based intervention selected for the DNP project.

Defining The Patient Experience

The patient experience is similar but different from patient satisfaction (Golda et al., 2018). The patient experience has been broadly accepted in the healthcare community as reflecting the interpersonal aspects of the quality of care received and clinical effectiveness (Larson et al., 2019). The patient experience provides a comprehensive picture of the healthcare quality and interactions, whereas patient satisfaction is about a patient's expectations of the healthcare encounter being met (Cadel et al., 2022). The emergency department provides a unique environment to address the patient experience due to a lack of established relationships with the patient, overcrowding, chaotic environment, understaffing, and space shortages; however, there is no patient experience tool specifically designed for the needs of the ED (Oyegbile & Brysiewicz, 2020). In a scoping review conducted by Oyegbile and Brysieqicz (2020) to identify gaps in the literature related to patient experience in the ED, the search revealed limited data in low to middle-income countries (Oyegbile & Brysiewicz, 2020). At the same time, nine different tools were used to measure patient experience in the United States, Iran, the United Kingdom, and the Netherlands, making a linear comparison of data complex (Oyegbile & Brysiewicz, 2020). Another systematic review and meta-analysis identifying determinates of adult patient experience in the ED revelated patient's perceived needs during the visit, including communication, competent care, emotional needs, physical/environmental, and waiting needs all affected patient experience; patients needed to know the provider cared about them (Graham et al., 2019).

Importance of the Patient Experience

A cross-sectional study by Park et al. (2022) investigating the relationship between patient experience, patient satisfaction, and willingness to recommend a hospital identified that the patient experience directly influenced the patient's willingness to recommend a hospital where patient satisfaction had an indirect effect on the willingness to recommend a facility. Healthcare has shifted from disease-centered to patient-centered, and a positive patient experience correlates with patient safety, treatment adherence, and clinical effectiveness (Park et al., 2022). The Centers for Medicare and Medicaid Services (CMS) requires Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys to be collected, with survey results accounting for 25% of hospital reimbursement based on the value-based purchasing system (Hospital Consumer Assessment of Healthcare Providers and Systems fact sheet, 2022). The HCAHPS surveys are standardized questions that evaluate a patient's experience during a visit. The survey results allow for accurate comparison to other hospitals (Hospital Consumer Assessment of Healthcare Providers and Systems fact sheet*,* 2022). NRC surveys are used in place of HCAHPS in the pediatric healthcare setting. In addition, the Net Promoter Score (NPS) gives a straightforward, actionable approach to assessing patient satisfaction; the NPS also assesses the likelihood that the family will recommend the practice to others (Sze et al., 2019). Addressing patient experience is an integral part of evidence-based patient care. Another retrospective study by Alexandrovskiy et al. (2022) at a five-ED health system in the US revealed four possible responses to survey questions: positive, negative, neutral, or mixed, where responses were primarily related to how the patient felt about their provider. Higher patient experience scores have decreased litigation for providers, improved the

clinician's job satisfaction, improved compliance with health recommendations, and improved patient health outcomes (Alexsandrovskiy et al., 2022).

Factors Influencing Patient Experience Scores

Many studies have focused on what matters most to patients during an ED visit to guide patient experience scores (Golda et al., 2018). For example, Hermann et al. (2019) conducted a semi-structured interview guide based on HCAHPS survey to elicit qualitative data on patients seen in the ED where common themes emerged, including staff communication, courtesy, and respect from the healthcare workers. The quality of the information provided by the healthcare team and the communication between staff also positively affect survey scores (Rapport et al., 2019). A retrospective study conducted by Abidova et al. (2020) of 382 patients in Portugal aimed to identify key predictors of patient satisfaction and perceived quality of care; themes included age, gender, marital status, education level, income, and expectations. A randomized study conducted by Dunsch et al. (2018) found that the phrasing of a question positively or negatively easily manipulated survey results, causing bias, which may not accurately reflect the actual patient experience. For example, a survey question worded "the waiting time was appropriate" is more likely to get a positive result vs. a question worded "the waiting time was too long" (Dunsch et al., 2018). Both questions assess the patient's view of the wait time, but a positively worded question yields an extremely high level of satisfaction on patient surveys (Dunsch et al., 2018). Factors linked to lower patient experience scores include a patient's view of an unclean environment, long wait times, lack of privacy, pain control, and ED overcrowding (Sonis et al., 2018); therefore, scores may not give a comprehensive review of the patient care provided.

Patient and Family Expectations During an ED Visit

According to Emerson et al. (2021) and Sonis et al. (2018), several points have been identified that improve the patient experience: (a) improved communication, (b) leadership rounding, (c) wait times, and (d) staff empathy. Emerson et al. (2021) improved patient experience scores by assembling a multidisciplinary team to address wait times, staff sensitivity, and communication about delays, improving scores by 3%. Effective communication from staff includes general knowledge and practical information about the hospital: where to park, food accommodations, wi-fi, wait times, and identifying staff (de Steenwinkel et al., 2022). Sonis et al. (2018) conducted a literature search focusing on ED patient experience and concluded that the most important drivers of patient experience scores included communication, wait times, and staff empathy. The pediatric ED has different challenges than other emergency departments, mainly because the patient does not complete the surveys (Barbarian et al., 2018). Parents have reported that wait times do not necessarily result in an adverse patient experience if communication about wait times and activities for the children is available (Barbarian et al., 2018). Providers sitting down at any point during the visit improved the patient experience scores by 8% on survey questions about the provider listening or feeling like the provider cares (Orloski et al., 2018). Provider communication which includes smiling, making eye contact, shaking hands, acknowledging wait times, apologizing to the family, making a non-medical gesture, overestimating the length of stay, and asking open-ended questions, were all shown to have positive impacts on the patient's perception of their ED experience (Finefrock et al., 2018).

Use of a Patient Advocate to Improve the Patient Experience

Interchangeable terms exist for a patient care specialist, including patient advocate, liaison, and navigator (Emerson et al., 2021). Research has shown effectiveness in using a patient

advocate role to improve communication between providers and patients (Emerson et al., 2021). For example, in a retrospective, mixed methods study by Lopez-Soto et al. (2021) on the use of a family liaison team to communicate with families who had loved ones in the ICU, the patient liaison was shown to improve the family perception of care by improving communication among families in the Intensive care unit by over 40% of the families surveyed. A qualitative inductive design by Sjöstedt et al. (2022) evaluating the effectiveness of a patient liaison in Sweden to support families better and patients transferring from an ICU setting to a regular floor yielded positive results from families. Patients reported this role as helpful, meaningful, and valuable to help navigate the hospital setting and communicate their needs to the medical team (Sjöstedt et al., 2022). In a similar role, a liaison for psychiatric patients was implemented in an emergency department, improving patient and healthcare worker satisfaction, and lowering hospital costs by making dispositions faster from the department (Okoronkwo, 2019).

Review of Literature Summary

Key findings from the literature review concluded that communication, respect, and courtesy are important to patients and families. A patient liaison or care specialist to improve communication with families and address non-medical needs benefits patients and families. Communication about wait times, addressing concrete needs, conversations about what to expect while at the hospital, and the medical plan of care improves the patient experience and can reflect on the patient experience survey results (Golda et al., 2018).

Theoretical Model

The IHI Model for Improvement-Plan Do Study Act (PDSA) and Lewin's change theory guided the project. Lewin's change theory (1951) served as the underlying theoretical framework for the project, while the PDSA served as the guiding framework for the DNP project's

development, implementation, and evaluation. Lewin's change theory examines human behavior, driving forces, restraining forces, and equilibrium (Petiprin, 2020). Applying Lewin's change theory creates a well-defined basis for argument as it is well-studied and well-accepted for change guidelines, especially within healthcare (Burnes, 2019).

Lewin's theory emphasizes democratic participation, meaning all parties must be involved on an equal and open basis for the change to be effective (Burnes, 2019). Lewin's theory of change provides a three-step change model: unfreezing, moving, and refreezing (Abd el-shafy et al., 2019). The first step involves unfreezing or breaking the status quo and breaking old habits (Abd el-shafy et al., 2019). In practice, the unfreezing phase was illustrated by performing the gap analysis and recognizing the need for change within the organization. The second step involved the actual change and guided the project toward the end goal (Abd el-shafy et al., 2019). The second step was illustrated with stakeholder meetings, staff education, and implementing the patient care specialist role in the ED. Finally, the third step involved setting a new standard to avoid returning to the old ways or "refreezing" (Abd el-shafy et al., 2019). The third step was evident in integrating the patient care specialist role into everyday practice and providing the administration with the evidence or data to support the sustainability of the role. In the DNP project, Lewin's theory was reflected by prioritizing the patient experience to the healthcare workers in the unfreezing phase. In the change phase, the healthcare workers learned why the patient care specialist role was created and how to use the new role. Finally, in the refreezing phase, the healthcare workers would feel the benefits of satisfied patients during their shifts.

Lewin's change theory provided structure and guidance for the DNP project by considering the human aspect of making lasting organizational change. A leader must step up,

examine organizational behaviors, look at the group's values, identify driving and restraining forces, and plan for change before a change occurs (Petiprin, 2020). Part of the leadership role was creating buy-in to create the change desired within the department. Abd el-shafy et al. (2019) suggested that effective communication, a well-defined plan to create change, administration support for the desired change, and working through the carries to change are all needed to define the change needed. An example of this approach would be if hospital administration agreed to fund a role designated explicitly within the emergency department to improve the patient experience for patients and staff.

The PDSA model guides the test of change to determine if the change is an improvement from current practice. The PDSA model examines three fundamental questions: What are we trying to accomplish? How will we know that a change is an improvement? Finally, what change can we make that will result in improvement? (Institute for Healthcare Improvement*,* 2022). The model provided a theory-driven approach to the DNP project by testing a change, observing the results, and acting on what was learned (Institute for Healthcare Improvement*,* 2022). An example of the PDSA model in the DNP project was the patient care specialist focusing on families with wait times of four hours or more. Following the PDSA model in the project's initial phase, the PI evaluated if real-time service recovery was effective after implementing the patient care specialist role.

The IHI Model for improvement explains the study's significance and validity by allowing several cycles of the PDSA to drive improvement. Each cycle of data collection and change allows for learning, growth, and improvement to achieve the end goal of creating best practices. In addition, data can be reviewed after each cycle to allow for further learning and adjustments for growth (Henry et al., 2021). Finally, the PDSA cycle allows for predicting the

outcome of a change over time to assess the impact of an intervention (Christoff, 2018). Application of the model can demonstrate a gap in practice by identifying stakeholders, setting goals, establishing quantitative measures, and looking at ideas for change. For example, for the DNP project, the organization identified a problem of decreased patient experience scores and allowed the stakeholders and change agents to develop potential solutions to the problem.

The PDSA model provides broader guidelines and ideas for expanding the project by testing the potential solutions on a small scale, learning from that testing cycle, and then implementing the change on a larger scale (Institute for Healthcare Improvement, 2022). Guidelines can be established through the various cycles of PDSA and looking at the data to see what improved, what did not improve, and what gets the organization closer to its goal. The model also allows learning from others through literature review and collaboration with other organizations. An example of this was using outcomes of the DNP project to consider the sustainability of the DNP project and integration of a care specialist role 24hrs per day and in another department within the organization.

Methodology

Patient experience is a quality indicator of patient care, affects patient outcomes, has financial impacts on the organization, and affects employee satisfaction and a patient's loyalty to the organization (Agency for Healthcare Research and Quality (AHRQ), 2017). The patient experience differs from patient satisfaction; patient satisfaction is more subjective, while patient experience assesses if specific behaviors occurred and how often and is thought to be more objective (Golda et al., 2018). The patient experience is defined as understanding the human experience while engaging in healthcare services (Oben, 2020). The overarching goal of the DNP project selected was to improve the patient experience in an academic pediatric emergency

department. The project followed the Plan-do-study-act (PDSA) framework. The PDSA model promotes small-scale testing of interventions to enable rapid assessment and flexibility to ensure solutions are developed (Christoff, 2018). The primary purpose of selecting the PDSA framework was to establish a relationship between process changes and outcome variation and to learn from those results (Knudsen et al., 2019). The PDSA framework improves the rigor of the quality improvement project and strengthens the foundation for a more convincing justification for the study results within healthcare (Knudsen et al., 2019).

The DNP project intended to improve net promotor scores on the patient experience survey and reduce the number of dissatisfied families in the department. The net promotor score is a question on the NRC survey that asks, "Would you recommend this facility" and is an indicator of the likelihood for a patient to return to the organization for care or to recommend the facility to others for care (National Research Corporation Experience Portal, 2022). This project's primary intervention was implementing a patient care specialist in a pediatric ED. The patient care specialist focused on addressing the immediate needs of families, managing expectations, and providing real-time service recovery. Service recovery is the art of correcting what went wrong and allowing for process improvement for future care (National Research Corporation Experience Portal, 2022).

An evidence-based quality improvement project was developed using the IHI's PDSA as a framework to guide the project. NRC quantitative data were collected pre and post-implementation. An extensive literature review revealed best practices to improve patient experience scores, including real-time service recovery when needed, improved communication in the emergency department, and decreased wait times (Golda et al., 2018). In addition, collaborative meetings were held with comparable pediatric hospitals in the United States, which

offer similar services to pediatric patients and families. Administrators in these organizations shared anecdotal comments revealing an improvement in patient experience scores after implementing a similar role within the organization.

Setting

The DNP project was conducted in an academic pediatric ED in the Southeast United States (US). The department was part of a Level I trauma center with 49 beds, with four additional trauma beds allocated as dedicated trauma beds. The organization is the only health system in the state dedicated solely to the care and treatment of children. The ED averages more than 70,000 visits annually, with an average daily census of around 200 visits per day. The patients presenting to the ED have a variety of chief complaints as the hospital is a tertiary care center. Currently, there was no process to address dissatisfied patients and families or a way to implement real-time service recovery. In addition, there was not currently a care specialist in the ED.

Population

The population of interest was families and patients presenting to the emergency department, specifically those without psychiatric or urgent care level complaints. The patient's age range was from birth to 19 years of age. The largest payor for patients presenting to the ED was the Alabama Medicaid program. Often patients presenting to the ED have complex medical histories and need specialty care or have poor access to care and low health literacy (Oben, 2020). The estimated sample size for the project was 150-200 families based on the time of day, the feasibility of one person seeing families, and the number of people that complete patient experience surveys.

Inclusion/Exclusion Criteria for the Population

Inclusion criteria for the project included patients presenting to the ED, specifically between 3 pm-11 pm, Friday-Tuesday weekly. In addition, the age ranges for patients presenting to the emergency department for a visit included birth to 19 years of age. Exclusion criteria for the project are patients presenting with a chief psychiatric complaint and patients with low acuity chief complaints that are triaged to go to the urgent care area of the ED.

Recruitment

A convenience sample of secondary data was used for the DNP project; therefore, a recruitment strategy was unnecessary. Secondary data was used for the project as the NRC conducts the surveys from which data was retrieved. The population of interest had clearly outlined inclusion and exclusion criteria.

Consent

Secondary data was collected from patients and families presenting to the ED between 3 and 11 pm Friday – Tuesday weekly. Due to the nature of the project, the secondary data collection process, and how data was collected and analyzed, informed consent was not required from the patient, families, or patient care specialists.

Design

The identified gap for the DNP project was based on trended data of the patient experience scores over the last year in a pediatric ED. The PDSA framework guided the DNP project's planning, development, implementation, and evaluation. The PDSA framework is established for developing, testing, and implementing change through a continual improvement approach (Bianchini & Copeland, 2020). The primary purpose of the framework was to establish a relationship between process changes and variation in outcomes and to learn from those results

(Knudsen et al., 2019). The framework design improves the rigor of the quality improvement project and strengthens the foundation for a more convincing justification for the study results within healthcare (Knudsen et al., 2019).

The PDSA model served as a foundation to guide the DNP project. The “Planning” (P) phase of the PDSA framework was used during the planning phase of the DNP. The planning phase included identifying gaps in practice, developing a job description, creating goals for the role, establishing how the role will be used in the department, the job announcement posted on the hospital website, on-site interviews conducted, and metrics established to be studied. The “Do” (D) phase included educating the healthcare staff on using the newly formed role. The project timeline, as seen in Appendix B, was used when implementing the DNP project. After educating the staff, the patient care specialist began working in the department and interacting with waiting families. Expectations of the role are for the care specialist to check in with families waiting more than four hours, families boarding in the department for an inpatient bed, and any dissatisfied families identified by the healthcare providers. In addition, the patient care specialist created a document in the electronic medical record (EMR) to track data and family needs from a visit.

Benchmarks are goals set by the organization; there are also national benchmarks set for similar organizations by the NRC (National Research Corporation Experience Portal, 2022). For example, facility benchmarks for the emergency department are based on the NRC question, "Would you recommend this facility to others" this is termed the net promoter score, and the benchmark is set at >70% (National Research Corporation Experience Portal, 2022). Patients are sent these surveys within 24 hours of discharge from the emergency department to get a more accurate reflection of the visit. The pre-DNP project's annual net promoter scores are 67%

(National Research Corporation Experience Portal, 2022). After the 8-week data collection period, the data were analyzed per the “Study” (S) aspect of the PDSA model to identify if the project met the metrics. After the data were analyzed, the PI identified what worked well for the department and patient experience to develop the next cycle of PDSA better. During the “Act” (A) phase, the PI can work with the ED administrative team and organization to develop a sustainability plan based on the data obtained during the DNP project.

The NRC patient experience surveys evaluated pre-and post-intervention experiences, and specifically, patients' answers to 'would recommend this facility to others.' NRC deploys and manages survey results for the facility. All data obtained for the project was reflective of and pertained only to the ED visits. A statistician was consulted to assist with data analysis. Quantitative data was used to evaluate the family experience. Data were analyzed using the t-test to look at families that interacted with the care specialist, and families saw that the care specialist did not see. A graph was used to disseminate information. Other data analysis included paired t-tests to evaluate patient experience scores pre and post-implementation of the care specialist role and the continuous variables, including the average census in the ED during implementation. The PI collaborated with the information technology department to obtain access to average census data and data for the number of patients seen by the patient experience staff member.

Data Review Process

Outcome measurement was measured using NRC health survey results from the ED. Results were measured for specific questions to include good communication between nurses and providers, having enough input/say in care, whether providers explain things, and would recommend this facility overall. The pre-implementation and post-implementation scores were compared for this project.

Risks and Benefits

There are no risks to patient care or healthcare providers. The benefits of engaging with the care specialist and completing the patient experience surveys include improving current and future ED experiences. In addition, the project adhered to all ethical and privacy standards per the organization's policies to protect patients and families in the ED.

Compensation

No monetary compensation was provided to patients or families who completed the NRC survey. Healthcare providers in the ED were compensated at their usual salary/hourly rate; however, they did not participate in the data collection process. In addition, the patient care specialist's salary received compensation from the organization, which is clarified in the Budget and Resource section of the manuscript. The principal investigator (PI) did not receive in-kind compensation for implementing the DNP project.

Timeline

A letter of support from the organization was provided to the PI and is attached to the manuscript in Appendix C. CITI training was completed with the certificate attached in Appendix D. Institutional Review Board (IRB) approval was obtained through the university in October 2022; no IRB was needed per the organization's guidelines as this was a quality improvement project. IRB approval is attached in Appendix E. The eight-week project was implemented in January 2023 and ended in March 2023. Data were analyzed, and outcomes were evaluated in April and May 2023. The manuscript was finalized in the summer of 2023, with dissemination in July 2023.

Budget and Resources

The project had minimal to no cost to the PI; however, funds were provided by the organization for the care specialist position. Through multiple stakeholder meetings, funds were reallocated from the patient and family services division to the social services division to support the identified need in the ED. The budget supported 1.0 Full Time equivalency (FTE) or one full-time personnel. In addition, the stakeholders approved two part-time, 0.5 FTE, benefit-eligible positions. The budget for the patient care specialist position of 1.0 FTE was around $56,000 annually.

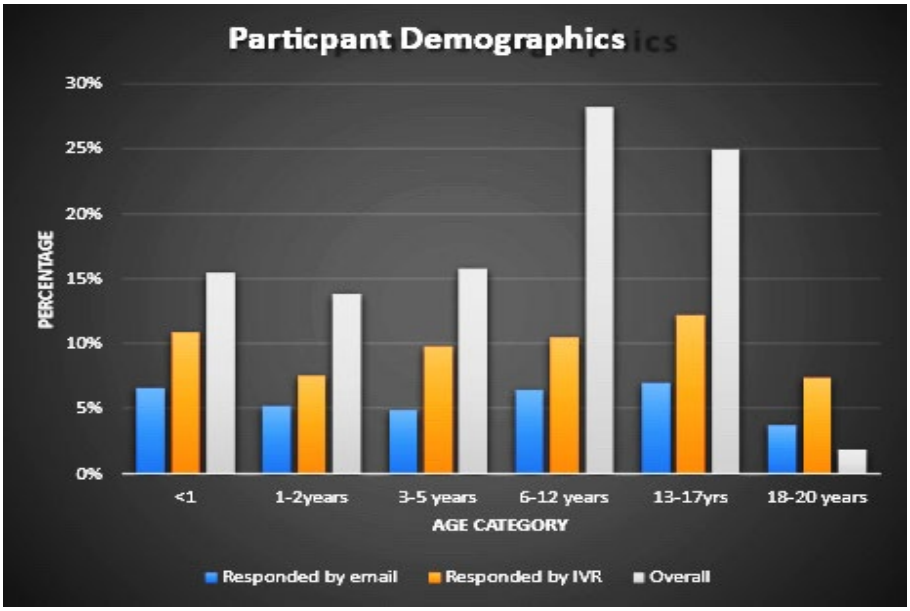
Evaluation Plan

Statistic Considerations

A QI project was conducted to determine if patient experience scores can be improved by implementing a patient care specialist role in a pediatric emergency department. There were 2,016 survey responses from January 16 through March 13, 2023; all patients were pediatric (ages 0-20). The results are shown in Figure 1. Most respondents accessed the survey by Interactive Voice Response (IVR) (58.3%), and others responded by email (33.8%).

Figure 1

Participant Demographics



There were 1,626 responses observed for the age category; results by age are displayed in Table 1.

Table 1

Participant Responses by Age

Age Range	Frequency
<1	251
1-2years	225
3-5 years	256
6-12 years	459
13-17yrs	405
18-20 years	30

Figure 2

Survey Responses Broken Down by Age

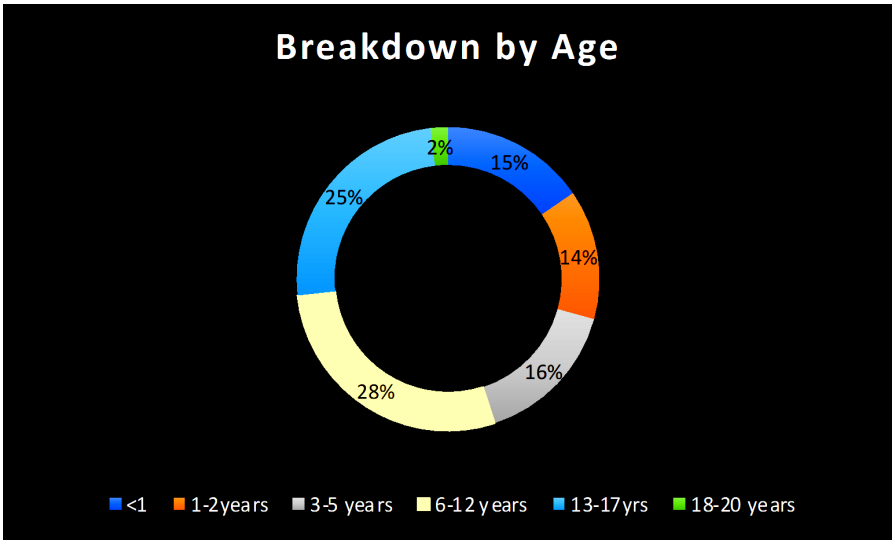


Figure 2 shows the patient response rate by age category.

The survey results indicated that for 1,661 who responded, the majority of patients were white (61.6%), 570 were Black (32.5%), 7 were Hawaiian/Pacific (0.4%), 4 were Native American (0.2%), 1 was Middle Eastern (0.06%), and the remainder were unknown or declined to respond (3.3%). In addition, roughly half the patients were female (49.4%), half were male (50.6%), and most (91%) spoke English, while the remainder (9%) spoke Spanish. Figure 3 illustrates the proportion of races represented in the sample.

Figure 3

Survey Responses Broken Down by Race

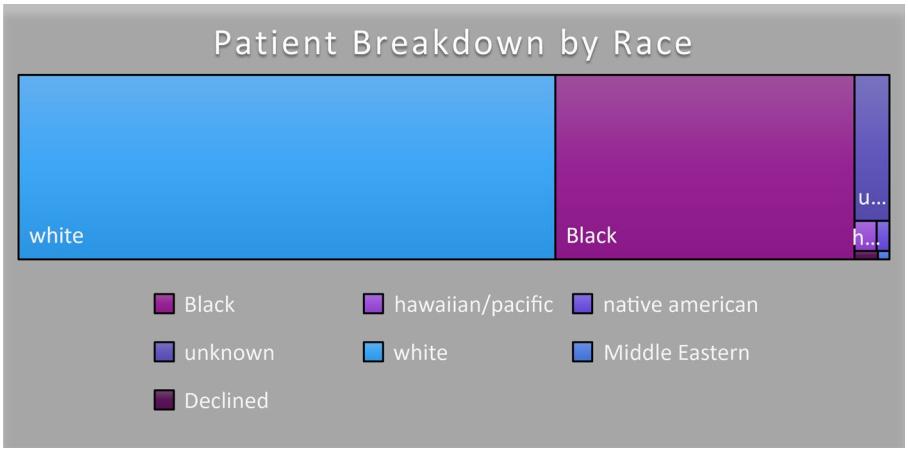


Figure 3 displays the survey respones broken down by patient race.

For the eight weeks observed in 2023, the patient experience scores were collected each week. The average score was 59%. All weeks resulted in scores higher than average except for weeks seven and eight. Figure 4 shows how the scores varied by week. The patient care specialist intervention did decrease the number of dissatisfied families in the ED on a daily basis.

Figure 4

Average Patient Experience Scores

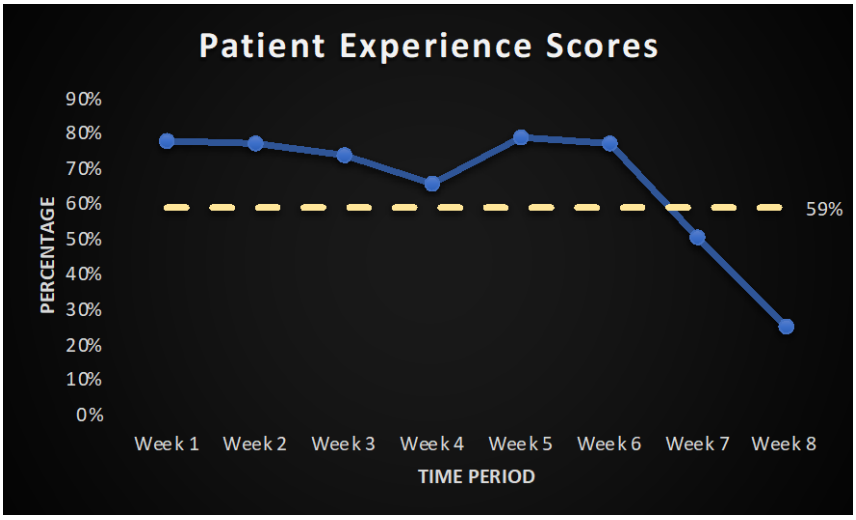


Figure 4 shows the average patient experience score broken down by week with the average being 59%.

Additionally, scores were examined by age category, race, gender, marital status, and language. The average score by age category is reasonably consistent. The highest score was 8.65 for ages less than one year, while the lowest was 8.00 for ages 18 to 20; results can be found in Figure 5. Differences appear when the scores are examined by race, as shown in Figure 6, but this is most likely due to the underrepresentation of certain races. The average score when comparing genders was nearly identical; the results were 8.5 for males and 8.62 for females. Only one patient observed a score of 10. Similarly, since almost all patients were unmarried (99.8%), the increase in score observed for married and unknown is not statistically valid. The average score for Spanish-speaking patients was higher than for English-speaking; Spanish-speaking patients gave an average score of 9.4, whereas English-speaking patients gave an average score of 8.5.

Figure 5

Average Score by Patient Age

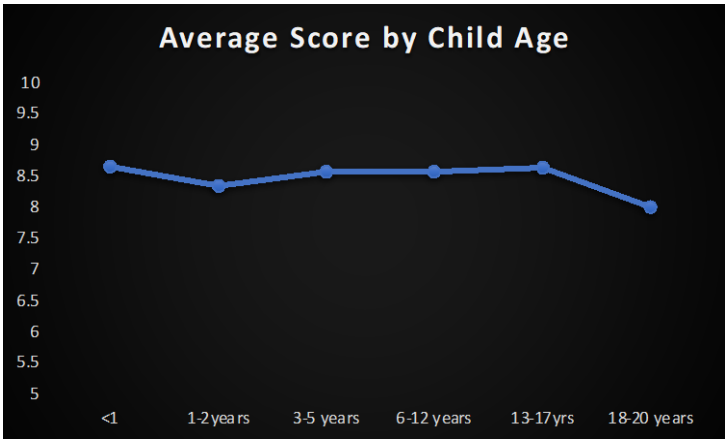


Figure 5 displays the average score on patient experience surveys based on patient age.

Figure 6

Average Score by Race

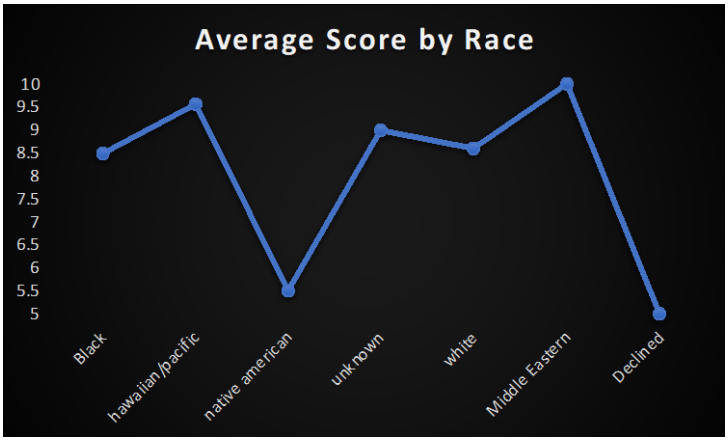


Figure 6 displays the average survey score broken down by patient racee.

Data Maintenance and Security

The patient experience survey data was obtained and secured on the NRC database website, which is username and password protected. In addition, the patient care specialist and family encounter information was secured using the electronic medical record (EMR), which is also username and password protected. All data will be automatically deleted two years after project completion.

Results

Results of Data Analysis

The experience scores and the acuity level were recorded over three different periods to evaluate for variation. The three-time periods were January 1 – March 30 of 2021 and 2022 and January 16 – March 13 of 2023; results are found in Table 2. A total of 37,608 patients were assessed during the three time periods. The most frequent acuity level was ESI 4.

Table 2

Average Census by Acuity

Acuity:	ESI 1	ESI 2	ESI 3	ESI 4	ESI 5	Totals
Jan 16th -March 13th, 2023	15	2193	3112	4373	1332	11025
Jan 1-March 30, 2021	26	2247	**2152**	5158	1352	10935
January 1 -March 30, 2022	22	2986	4282	6149	2209	15648
Totals	63	7426	9546	15680	4893	37608

Table 2 displays the volume of patients broken down by ESI category for the same time period in previous years.

Figure 7

Acuity Level by Year

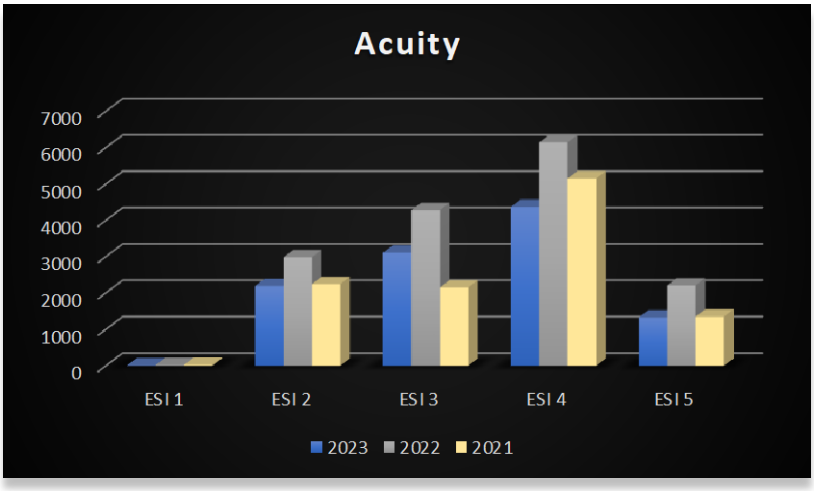


Figure 7 displays the frequency of each acuity level by year.

A Chi-Square test of independence was conducted to test if any association exists between acuity level and timeframe. The test results indicated a statistical association between

acuity and time period ($\chi^2 = 348.84$, df = 8, $p < 0.001$). This implies that the incidence of acuity differs overtime periods. Further investigation indicates that ESI 3 cases are significantly lower than expected in 2021.

Discussion

The DNP project addressed the decreasing patient experience scores from the ED. A review of the literature for the DNP project was conducted. Evidence supported implementing a patient care specialist role to address the need for real-time service recovery in the pediatric ED. Evidence also supported that the role could improve relations between healthcare providers and patients/families during the ED visit. The patient care specialist role proved to be an appropriate intervention to improve the organization's benchmark scores.

After reviewing the literature, it was evident that implementing a role to improve communication with families from the medical staff improved the patient experience. Implementing a patient liaison yielded positive patient experience results in an ICU setting during the COVID pandemic (Lopez-Soto et al., 2021) and in an ED to improve communication and patient experience with psychiatric patients and their families (Okoronkwo, 2019). Improving the patient experience directly correlates to decreasing litigation risk for healthcare workers, improving patient loyalty to the organization, and improving patient outcomes (Agency for Healthcare and Quality, 2017).

The objectives and goals of the DNP project were partially met. The patient care specialist made real-time service recovery and improved scores during weeks one through six to >70%. On week seven, an internal variable influenced the outcome of the results. A new hospital electronic medical record was implemented, temporarily affecting patient flow through the hospital and hospital processes; this change directly affected patient experience scores. Families

and staff gave positive feedback on the new role, reflected in the patient experience scores for most of the project.

Implications for Clinical Practice

Implementing a patient care specialist in the ED proved beneficial in improving the patient experience. Weekly scores were improved from pre-intervention, although scores drastically decreased in the project's last two weeks. The PI believes an uncontrolled variable influenced the lower patient experience scores. In addition, the organization implemented a new hospital electronic medical record system during the last two weeks of data collection, which directly affected all aspects of patient care and hospital flow. The project's overall goals were met by decreasing the number of dissatisfied families in the ED. Based on the results of the DNP project, the patient care specialist's role in the ED can significantly impact clinical practice and the patient experience. For example, the healthcare providers in the ED used the patient care specialist as a proactive, pre-escalation intervention to diffuse tense situations.

Implications for Healthcare Policy

Prior to the implementation of the DNP project, there were no policies or processes in place related to improving the patient experience in the ED. The value of the patient care specialist role is sustainable in the department due to the organization's commitment to improving the patient experience. Based upon the statistical findings of the DNP project, there are several implications related to the development of policy and processes regarding using a patient care specialist to improve the patient experience. For example, a policy could be developed to expand the role to all ED patients and address escalating parents in the waiting area before entering a treatment room. The organization and healthcare staff desire to decrease the number of distressed patient experiences in the emergency department to improve patient care.

Using the patient care specialist makes improved patient experiences a reality as they can intervene before escalating behaviors.

Implications for Quality/Safety

The DNP project focused on quality improvement to improve the patient experience for patients and families in the ED. Evidence supports the use of a patient care specialist role to improve the patient experience, which is directly linked to quality and safety by improving patient outcomes, compliance with treatment, and provider and patient relations. Tracking the patient experience can help evaluate quality improvement efforts while holding the health system accountable and identifying gaps or evaluating the need for policy change (Larson et al., 2019). The patient experience scores can also help evaluate the quality of care provided and are often used on targeted interventions towards improving patient care (Larson et al., 2019).

Implications for Education

Implications for education involve addressing the current ED staff to include education on the patient care specialist role, why the patient experience is essential, what the patient experience entails, and when to seek help from this new role. Other implications for education include implementing education related to the patient care specialist role to all new employee orientation and annual unit-based competency sessions. Healthcare staff education refreshers have been shown to improve retention and use of the information in an ED setting for similar projects (Amberson et al., 2020). Education refreshers are cost-effective using already established platforms such as staff huddles (Amberson et al., 2020). Educating on using this newly formed role can influence the sustainability of the DNP project.

Limitations

This project's limitations include the project being conducted at an academic tertiary care pediatric emergency department. As a result, resources, demographics, patient needs, and visit expectations may be difficult to apply to all hospitals. Other limitations include implementing the project during a hospital electronic medical record change which increased wait times, length of stays, and staff frustration. In addition, the healthcare worker environment, including turnover rates, staffing, hospital efficiency, and hospital policies, have been shown to affect the patient experience directly (Winter et al., 2020).

Dissemination

The findings of this DNP project went through poster, presentation, and paper. In addition, the project findings were presented to agency stakeholders and peers in the ED for academic review per the American Association of Colleges of Nursing (AACN) recommendations for the implementation of DNP projects (*The American Association of Colleges of Nursing (AACN) homepage*, 2023). The DNP project was also presented to the university faculty and peer group on July 13, 2023 and included a poster and virtual presentation of the project details and findings. Finally, the finalized manuscript was submitted to the University digital commons repository and made available for viewing by those internal and external to the college.

Sustainability

The sustainability of all evidence-based interventions is a cornerstone of improving patient care; sustaining a project over time indicates project success (Hailemariam et al., 2019). Sustainability related to a DNP project has been defined as the extent to which an evidence-based intervention can continue to deliver its intended benefits over an extended period after the

external support has ended (Hailemariam et al., 2019). Stakeholder support and creating "buy-in," anticipating challenges early in the project, and careful planning to apply findings from the evidence-based project all help sustain the project in a real-world setting (Hailemariam et al., 2019). The patient care specialist's role continued after the project's conclusion. The role is still present in the department and continues to use the same established guidelines used during the project for daily operations. The goal is that the healthcare workers and families feel more supported and engaged with the newly formed role and will expand to other areas of the organization and with expanded hours in the ED.

Plans for Future Scholarship

A further scholarship could focus on awareness and use of the patient care specialist role in the ED. Research indicates that improving communication and patient experience improves treatment compliance and patient outcomes (Golda et al., 2018). Future projects could focus on how the patient experience affects burnout among healthcare providers and the effects of the patient care specialist to decrease burnout. The Maslach tool can assess burnout among healthcare providers (Carthon et al., 2020). Future studies can also investigate the link between patient experience and staff satisfaction or between staff job satisfaction and using the patient care specialist role. Further scholarship is needed to increase the awareness and use of the patient care specialist role.

Conclusions

The patient experience in the hospital setting has been a focus for all organizations over the last two decades. The project findings indicated that implementing the patient care specialist role improved the patient experience, with patient experience scores averaging>70% during weeks one through six. The value of this role to the healthcare providers in the ED and families

seeking care in the pediatric ED was substantial. Challenges with changing electronic medical record systems during project implementation did affect results. However, the newly formed role allowed for better communication between providers, patients, and families, improving the overall patient experience in the ED. The patient care specialist's role is a feasible evidence-based intervention to overcome anxious and dissatisfied families.

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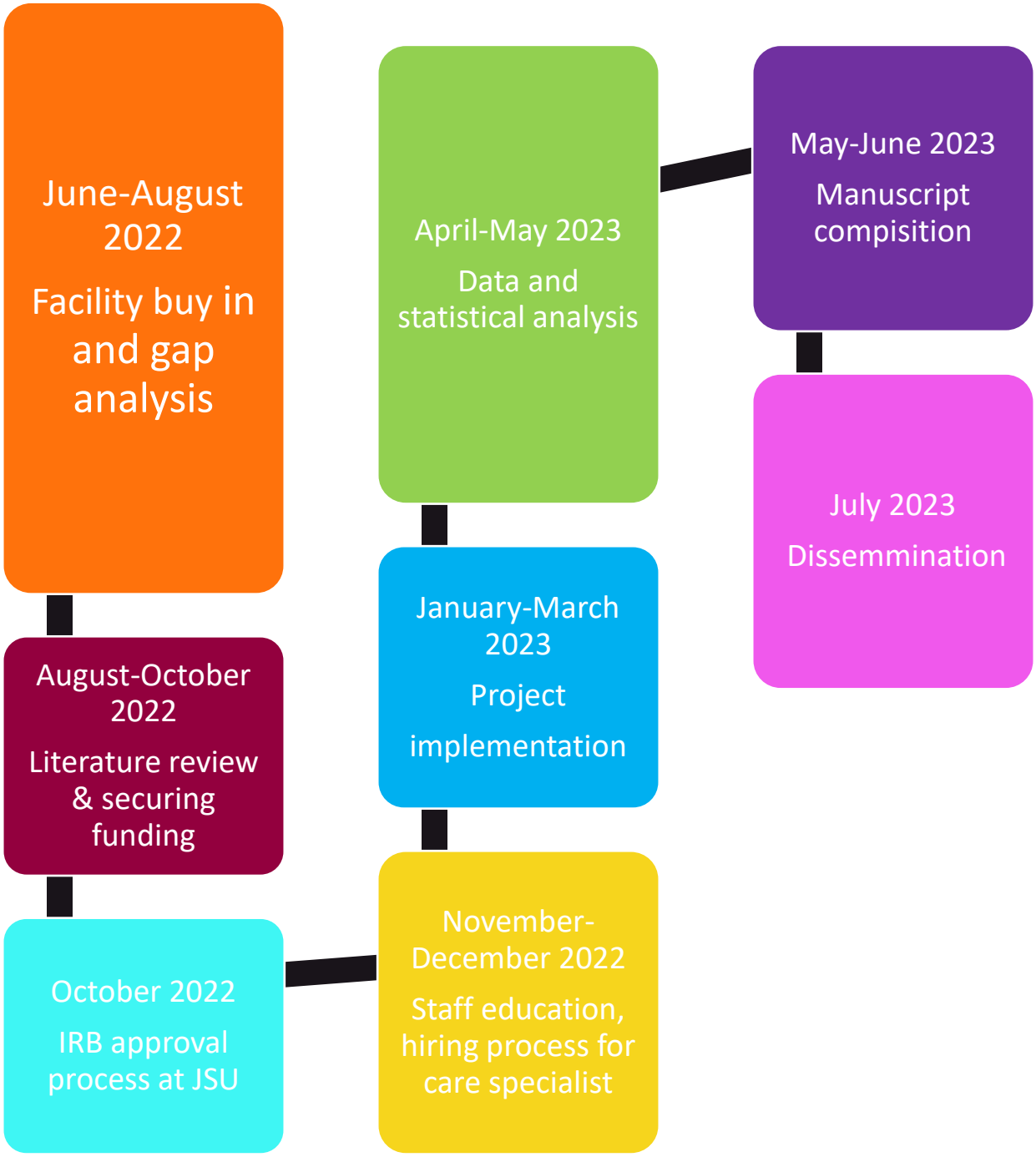
Appendix A

SWOT Analysis

Strengths	**Weaknesses**
• Personalized role • Needed role to bridge the gap between families and healthcare workers • Supportive and enthusiastic staff • Decreases the number of dissatisfied families in the ED • Improved patient experience • Leadership support • Financial support • EBP literature support	• Limited hours and day of week coverage • Not previously used in the ED, new role • Additional resources may be needed • The number of surveys returned do not reflect the in-person response to the new role.
Opportunities	**Threats**
• Improve patient and family expectations of the ED visit • Limit the dissatisfied family interactions with the healthcare workers • Expand the role to 24/7 coverage to better support the healthcare staff	• Limited resources • Expected to be a high turnover role • Lack of staff engagement or inappropriate use of the role • Difficulty hiring for the position

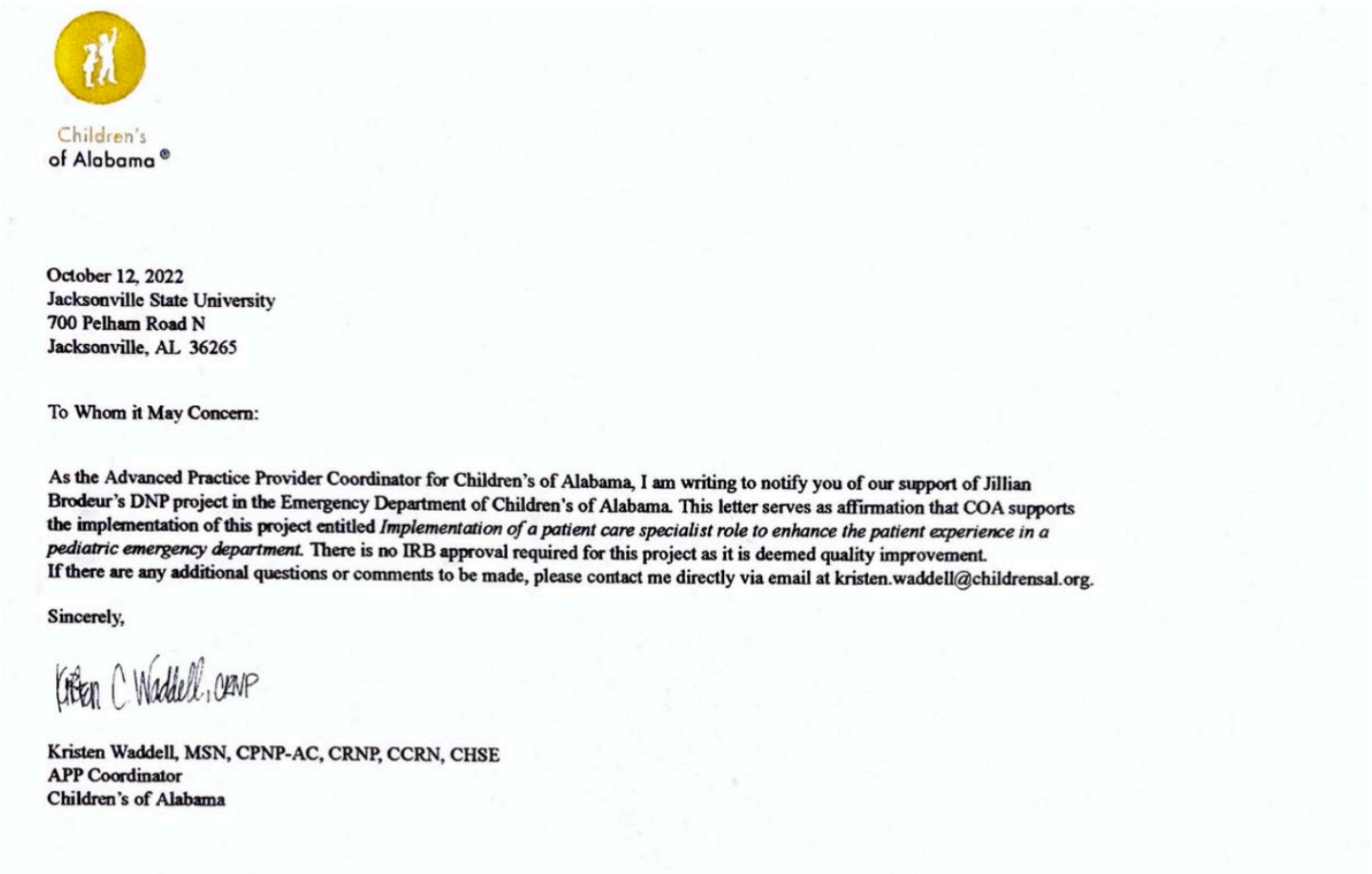
Appendix B

Project Timeline



Appendix C

Agency Letter of Support



Children's
of Alabama®

October 12, 2022
Jacksonville State University
700 Pelham Road N
Jacksonville, AL 36265

To Whom it May Concern:

As the Advanced Practice Provider Coordinator for Children's of Alabama, I am writing to notify you of our support of Jillian Brodeur's DNP project in the Emergency Department of Children's of Alabama. This letter serves as affirmation that COA supports the implementation of this project entitled *Implementation of a patient care specialist role to enhance the patient experience in a pediatric emergency department.* There is no IRB approval required for this project as it is deemed quality improvement. If there are any additional questions or comments to be made, please contact me directly via email at kristen.waddell@childrensal.org.

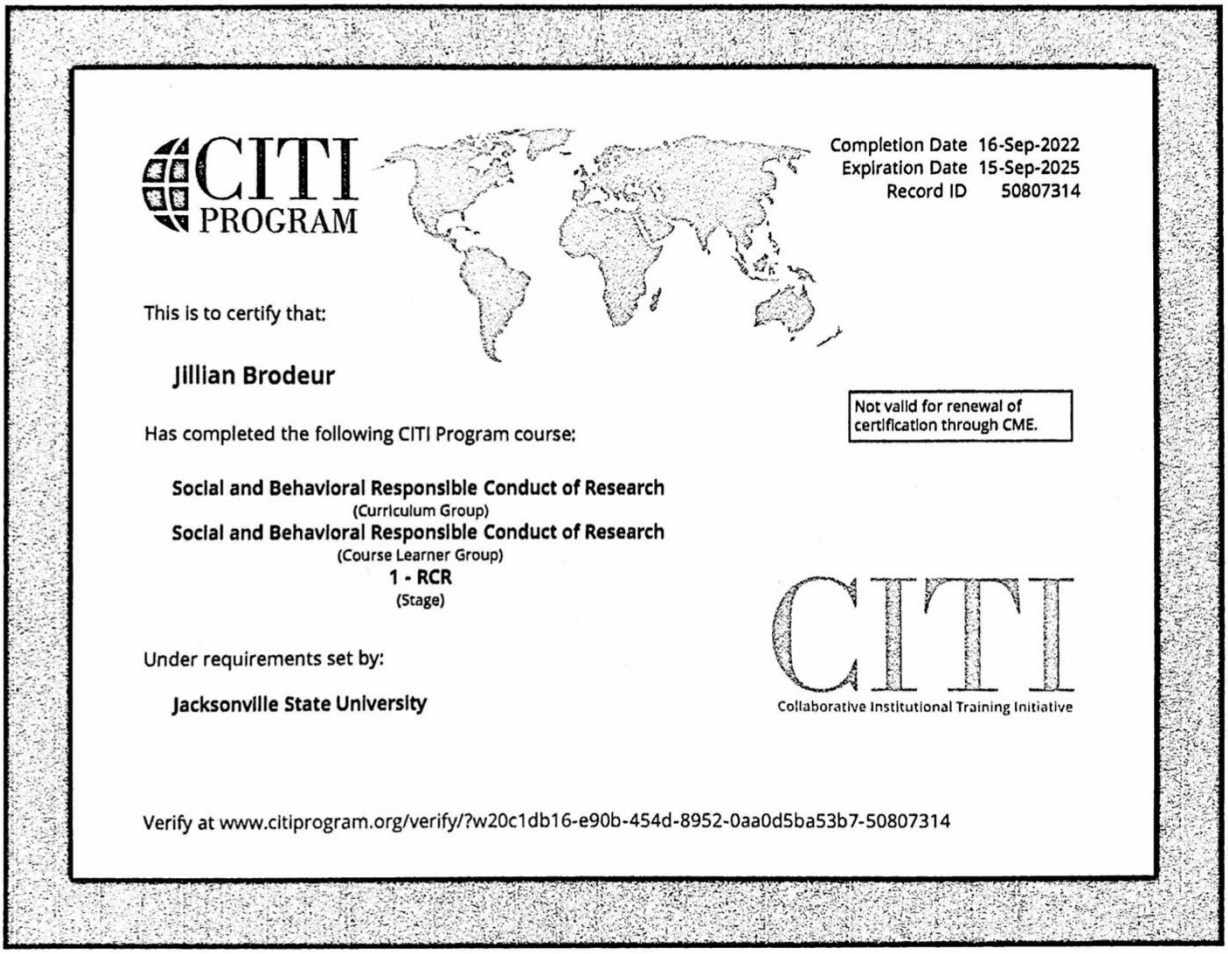
Sincerely,

Kristen C Waddell, CRNP

Kristen Waddell, MSN, CPNP-AC, CRNP, CCRN, CHSE
APP Coordinator
Children's of Alabama

Appendix D

CITI Training Certificate



CITI PROGRAM

Completion Date 16-Sep-2022
Expiration Date 15-Sep-2025
Record ID 50807314

This is to certify that:

Jillian Brodeur

Not valid for renewal of certification through CME.

Has completed the following CITI Program course:

Social and Behavioral Responsible Conduct of Research
(Curriculum Group)
Social and Behavioral Responsible Conduct of Research
(Course Learner Group)
1 - RCR
(Stage)

Under requirements set by:

Jacksonville State University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w20c1db16-e90b-454d-8952-0aa0d5ba53b7-50807314

Appendix E

IRB Approval letter

Institutional Review Board for the Protection of Human Subjects in Research
249 Angle Hall
700 Pelham Road North
Jacksonville, AL 36265-1602

November 2, 2022

Jillian Brodeur
700 Pelham Rd. North
Jacksonville, AL 36265

Dear Jillian:

Your project "Implementation of a Patient Care Specialist to Enhance the Patient Experience in the Emergency Department" 11022022 has been granted exemption by the JSU Institutional Review Board for the Protection of Human Subjects in Research (IRB). If your research deviates from that listed in the protocol, please notify me immediately. One year from the date of this approval letter, please send me a progress report of your research project.

Best wishes for a successful research project.

Sincerely,

Lynn Garner
Associate Human Protections Administrator, Institutional Review Board