

Dyad rounding on inpatients admitted from Emergency Department: Rehumanizing the patient & clinician experience in a post pandemic world

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Abstract

Emergency departments (ED) across the country were stretched to the breaking point as a result of the COVID-19 pandemic. The chaos, fear, and uncertainty impacted the emotional, physical, and spiritual well-being of not only the patients and families but also nurses, providers, and the myriad of other clinical and non-clinical staff providing care in the ED. Compounding these challenges was the dehumanizing effects of providing care in personal protective equipment (PPE). The burnout ED teams experienced left them feeling defeated and unsure of how to reconnect with patients and families. The purpose of this narrative is to share the story of two clinical leaders, Christine M. Walden, Ph.D., R.N., NE-BC and Leigh A. Patterson, M.D., MAEd., who partnered to rehumanize the patient experience in the ED after the height of the COVID-19 pandemic and to share their learning and ultimate success in improving the patient experience. Equally as important was how feedback gathered through their conversations with patients personally reconnected them back to their passion and their practice, reassuring them that they could lead the way forward by listening to the voices of their patients.

Keywords

Emergency department, dyad leader rounding, patient experience, COVID-19 pandemic

A Tale of Two Clinicians

Dr. Walden, Senior Administrator for Emergency and Hospitalist Services at ECU Health Medical Center, and Dr. Patterson, a board-certified emergency medicine physician and Department Chair and Associate Professor at ECU Health, serve as the ED nursing/physician leadership dyad and provide oversight for the care provided to over 75,000 patients per year in an 89-bed ED in a Level 1 Trauma Center in eastern North Carolina.

Dr. Walden, a nurse for over 35 years, channeled her experiences as an operational leader and change agent to help navigate and innovate during the challenging time of the pandemic.

An ED physician for 20 years, Dr. Patterson acknowledged that the COVID-19 pandemic upended every aspect of ED care but found solace in the chaos and figuring out how to make the environment in the ED better for patients and the care team.

Their shared passion, expertise, and commitment throughout the pandemic strengthened their dyad partnership. It also provided a solid foundation to continue to lead as the worst of the pandemic receded.

Background

East Carolina University Health (ECU Health), formerly Vidant Health, serves eastern North Carolina and includes nine acute-care hospitals with full-service emergency departments. The ECU Health Medical Center (formerly Vidant Medical Center) is a Level I Trauma Center. The service area is primarily rural. Pre-pandemic, community members frequently visited friends and loved ones in the hospital to offer assistance and provide comfort or companionship. Unfortunately, protocols during the COVID-19 pandemic prohibited visitation, leaving nearly all adult patients to experience much of their ED and hospital stay isolated and alone. Masks and infection prevention protocols made it difficult for clinicians to express visible emotion and connect with patients in a personal and heartfelt way. As the pandemic wore on, ED patients often spent extended amounts of time in the waiting room surrounded by a sea of unfamiliar masked faces. As they progressed through the ED phases of care to admission, patients found themselves waiting alone in hallways or ED rooms for an inpatient bed to become available. What was lost was what many value the most about small-town living: that connection, sense of community, and belonging.

Dr. Walden and Dr. Patterson knew they had to find ways to rehumanize the ED experience. They wanted to hear firsthand what mattered most to patients as they moved through the phases of care in the ED. At the height of the pandemic and again during the Delta and Omicron surges, the ED care team was overworked, exhausted, and overwhelmed, experiencing some of the same feelings of isolation and loneliness as their patients. This was compounded by national and local negative sentiments about the pandemic, long waits in the ED, and visitor restrictions. The team felt blamed and disconnected from their patients and their practice.

ECU Health Office of Experience, responsible for capturing and responding to patient concerns and analyzing patient feedback, identified a significant gap between the experiences of inpatients admitted through the ED versus those directly admitted to an inpatient bed.^{1,2} As measured by Hospital Consumer Assessment of Providers and Systems (HCAHPS), inpatient units caring for a higher percentage of patients admitted through the ED received lower ratings than units that cared for patients who were not admitted through the ED. In fact, many of these inpatient units failed to meet the HCAHPS achievement threshold of 50th percentile for Value-Based Purchasing. The ED leadership dyad and the Office of Experience became a partnership, with a shared goal to understand and improve the experience of the ED patients.

Dyad Leadership Rounds Process

The ED leadership dyad agreed to round on ED patients admitted to inpatient units within one day of admission. Available research and best practices were explored with limited findings. While the effects of hourly rounding on inpatient units and in the ED were identified in the literature, no information was found on ED leaders or leadership dyads rounding on inpatients who were admitted from the ED.^{3,4}

The leadership dyad rounding was based on the framework of hassle mapping with the purpose of discovering all the inconveniences and aggravations a patient experiences in the ED by asking questions.⁵ Feedback gathered from these questions were then used in the design thinking process contemporized by the Office of Experience to empathize, define, and ideate to build new processes and practices to improve the ED patient experience.⁶

Two inpatient medicine units were chosen, both with greater than 90% of patients admitted from the ED. The round was structured for ED leaders to share name, title, role, and reason for visiting the patient, emphasizing their desire to hear about their ED experience. Then two questions were asked:

1. *What should we always do when you come to the ED?*
2. *What should we never do when you come to the ED?*

The format was simple and straightforward, demonstrating the desire to learn from the patient. Each interaction ended with thanking the patient for their valuable feedback. The leaders initially planned to round Monday through Friday for a 4-week period with weekly report outs with the Office of Experience to review patient feedback and make changes based on patient responses.

What We Learned

The first week report out was surprisingly emotional and powerful. It consoled us that the patients did not harbor anger or ill will about their ED care. They made supportive statements and thanked us for caring for them. We had been so overwhelmed with the negativity of the pandemic about overcrowding in the ED, feeling a sense of blame and disconnection, so the positive sentiments patients shared were a major turning point for us coming out of the pandemic. We had been so busy, just getting through one shift to the next, and one day to the next.

During the rounding, we were able to slow down and sit with our patients, listen to what they had to say about their ED experience and, most importantly, understand their perspective. We realized that we see only one snapshot of the patient's care in the ED before we transition them along to the next team. The two questions we asked allowed us to get a sense, perhaps for the first time, of the patient experience in their own voice.

During the first four weeks, the patients shared little things that were important to them when they were in the ED, and we began to see ED care through a new lens. It was a realization that patients appreciated and valued their ED care and the team, and their feedback included things that empowered and inspired us to change or fix.

It was exciting that the *'things we should always do'* were not difficult things to implement. We had not been able to do anything about the pandemic, masking guidelines or visitor restrictions, so it was incredibly exciting to hear about things that we could fix, things that were in our locus of control. We knew that patients experienced long ED lobby wait times but were very surprised when lobby wait times did not top the list of patient concerns. They understood why they waited, though it was unpleasant for them. Instead, they shared things we could *'always'* do to make the wait more tolerable. They were simple things. They told us that our lobby chairs were uncomfortable. Immediately, we found 10 recliners from within the hospital and placed them in the ED lobby. It was amazing how quickly this intervention was reflected in the patient feedback. Unprompted, patients would say things like, "I loved that recliner." Patients could recline, sit with their

feet up, and even nap while they waited to be seen. Something as simple as a recliner made a significant difference for how patients experienced their ED care. If we had not taken the time to ask the questions and listen to their voice, we would have missed it, because we were so busy focusing on providing care and getting the next person out of the lobby. This real time improvement and feedback was incredibly motivating. We finally felt like there were things we could do to make a difference in the ED experience!

Providing warm blankets for patients was also identified by patients as something *'we should always do'* while they waited. We shared this with the ED team, and once offering warm blankets to patients was done consistently, we began receiving feedback from patients stating, "I really liked that warm blanket in the waiting room."

A third example of improving the ED experience based on patient feedback was related to our ED food cart. The cart provides healthy snacks and water and circulates through the lobby three times a day; morning, afternoon, and evening. Based on patient feedback, the times of the cart were modified to align with patients experiencing longer wait times, eliminating the morning and adding a second time in the afternoon when wait times were the longest.

The most heartfelt and impactful feedback on *'what we should always do'* was the importance of being kind, demonstrating compassion, providing assistance, and simply being nice. We recognized that our ED team was struggling to devote time to talk and connect with patients and were experiencing different levels of burnout themselves throughout the pandemic. We approached this by sharing all the positive feedback from our rounds with the team and reinforced how much they mattered and how much our patients appreciated them. We received so much positive feedback that the ED manager created a bulletin board in the breakroom to post these comments.

Outcomes

It was magical to feel so much personal joy in the rounds and that we, as ED leaders, were able to share the joy with our team. It was so impactful that we opted to extend the rounds for three additional weeks. By the end of the seven-week period, we had rounded on over 500 patients.

As the weeks progressed and we made changes, feedback became more and more positive. Patients shared comments like,

"Everyone has been so nice and so caring."

"They did extra things."

"They went out of their way."

"They treated me like family."

"Everyone is so friendly."

"They really care about you and your needs."

"Can't think of anything they didn't do well."

"Everything has been perfect."

"The food cart is wonderful."

"I couldn't have waited that long in a regular chair; the recliner and blanket were a blessing."

We continued to share the positive feedback with the team, and it was as if we could see and feel the dark cloud of the pandemic lifting.

We wondered whether the patient experience survey data would also reflect this positivity. Fifteen measures were used to evaluate the patient experience pre-rounding and then during the leadership dyad rounding. Nine measures were from HCAHPS survey domains, one measure focused on meals and was an additional question added to the HCAHPS survey, and six measures were Watson Caritas Human Caring (WCHC) questions, also added to the HCAHPS survey supporting the Watson Caring Model which includes "to practice loving-kindness, compassion, be authentically present and allow for the expression of both positive and negative feelings."⁷ Only inpatient survey responses from patients who had been admitted from the ED were used in the data collection.

Both inpatient units saw statistically significant improvements when compared to the previous seven weeks of non-rounding. One unit had six of nine HCAHPS measures improve, two of five WCHC questions, and the meals question. On the second unit, seven of nine HCAHPS measures improved and four of five responses to the WCHC questions improved. Though patient experience showed noticeable improvement during the dyad rounding, the effects the rounds had on us were even more profound.

Conclusion

As ED leaders, we felt the full weight of the pandemic on our shoulders, and it was crushing. Rounds became our bright light in the pandemic. Heading to the inpatient units, connecting with patients, and hearing about their ED experiences was pure joy. It was a welcome reprieve from the gravity of the ED and a gift that only our patients could give to us. It was a true pivotal moment for us as we emerged from the height of the pandemic. The perceived negativity and disconnection morphed into positivity and possibility. The patients responded with sincerity and resounding praise and appreciation. Our effort to understand and improve the experience of the ED patients through rounds on inpatient units the day after their admission allowed us to re-center, re-energize, and remind us how important our work is to our ED patients and their experiences and to us, personally. By sharing our findings and engaging our ED team, they re-centered, reenergized, and refocused, too.

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