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Enhancing Patient Experience in the Emergency Department of a Secondary Care Hospital in North-East India - A Pilot Study

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ABSTRACT

The emergency department (ED) of the selected secondary care hospital of Northeast India plays a critical role in delivering acute care services to the people of the state and the neighbouring states. However, challenges such as overcrowding, communication gaps and delays in care processes can negatively influence patient experience despite strong clinical delivery. This study aimed to assess patient experience in ED, identify key determinants of satisfaction and explore patient-perceived interventions to enhance overall care experience. A mix method design was adopted. Quantitative data were collected using structured patient satisfaction surveys from 33 participants and qualitative data were obtained through semi structured interviews with 8 patients. Descriptive statistics were used for quantitative analysis while thematic analysis was conducted for qualitative data. The findings of the study revealed high levels of satisfaction with staff behaviour, professionalism and clinical care, with over 90% patients reporting positive experiences in these domains. However, significant gaps were identified in communication, particularly regarding test results (42.4%) and cost transparency (24.2%) one key concern that emerged was waiting time especially for patients with perceived serious conditions. Qualitative analysis highlighted themes of compassionate care, strong teamwork and overall satisfaction, alongside concerns about delays and limited communication during waiting periods. While the ED demonstrates strong interpersonal care and clinical competence, patient experience is hindered by communication gaps and perceived delays. Overall Interventions focussing on structured communication, transparency in costs, proactive updates during waiting periods are likely to yield significant improvements. Strengthening these areas while leveraging existing staff strengths can transform patient experience from satisfactory to exceptional.

Keywords: Patient experience, Emergency department, Patient satisfaction, Triaging, Waiting time, Communication

INTRODUCTION

The Emergency medicine department of the selected secondary care hospital in North-East India, serves as a pivotal unit for providing care and treatment of emergency cases in the region. Currently, the ED operates near or beyond its capacity with 13 beds and limited resources, contributing to overcrowding. This overcrowding leads to prolonged wait times and challenges in performing triaging and promptly managing the acute and life- threatening conditions.

The average wait time at the ED is less than 5 minutes while receiving patients one or two at one time, but when the ED has more patients, the average wait time becomes around 7 minutes and goes to a maximum of more than 10 minutes. According to WHO standards, the triaging time should be within a range of a few seconds to 2 minutes.

Long waits can lead to confusion and heightened anxiety, feelings of neglect, lack of clarity about treatment or, investigative procedures, and lack of emotional support due to overburdened staff during patient overload. It can also create a chaotic environment. These factors collectively may have a negative effect on patient's satisfaction, trust, outcomes, and also staff morale. There is a clear imperative to adopt a holistic, evidence- based approach to improve the patient experience in our ED and for this reason the study was undertaken.

Primary Objective:

1. To assess the patient satisfaction level in the ED.

Secondary objectives:

1. To assess the contributing factors for negative patient experience in ED.
2. To explore the communication gaps between ED staff and patients.

LITERATURE REVIEW

The Emergency Department (ED) is a critical frontline interface between the healthcare system and the community, providing care to patients with a diverse array of medical conditions Improving patient experience in this department has become a pivotal focus due to its impact on clinical outcomes, patient satisfaction and health care quality metrics.

This review of literature synthesizes recent evidence on the key dimensions influencing patient experience in the ED, including patient waiting times, staff patient communication, operational efficiency and environmental factors. It concludes by examining the role of quality improvement project frameworks in implementing change and identifying critical gaps in review of literature, especially relevant to low-resource setting hospitals the selected Secondary care hospital of North-East India.

2. Key Determinants of Patient Experience:

A constellation of factors has been identified by various researchers that have shaped collectively the patient's perception of care in ED. These can be categorised as interpersonal, operational and environmental domains.

2.1 The Interpersonal factors: Empathy and Communication:

The quality of interpersonal interactions is the key determinant to patient experience and the level of satisfaction. A comprehensive systematic review of 107 studies provided by Sonis et al (2023) highlights three key factors that influences patience experience in the ED. They are efficient communication, staff empathy and professionalism. The authors emphasized how poor communication and perceived neglect are most often the root causes of dissatisfaction and anxiety among patients, while positive staff- patient interactions enhance trust and quality of care. This focus on human dimension of care has been reinforced by other studies. Idahor and Kingsley (2022) underscores the critical role of using clear and sensitive communication during patient and health care provider interactions. The article highlighted that adopting clear and sensitive communication improves patient satisfaction significantly. It also highlights important environmental factors like cleanliness and noise. This significantly contributes to patient's comfort and dignity, which are usually overlooked during operational planning. Further refining this understanding, Yilmaz, Kati and Yarden (2023) found out that doctor and perceived quality of medical care are primary drivers of satisfaction along with communication which is being identified as the central component. Further, looking through the demographic lens, Degabrial et al's (2022) study of EDs in two hospitals in Switzerland pointed out that younger patients

and those arriving by ambulance reported lower patient satisfaction levels, thus emphasizing the need for tailored communication strategies to meet the needs of various patient population groups.

2.2 Operational and Systemic factors: Patient Waiting time and Triaging

Operational and systemic inefficiencies, such as prolonged patient waiting time, delayed triaging and overcrowding, are well-identified reasons for frustration among patients. These issues have been linked with negative patient experiences by Sonis et al. (2023).

Compass One Healthcare's practical guide highlights that operational challenges related to patient flow and overcrowding are central themes and encourages streamlining the patient journey by using process mapping and bottleneck identification to reduce waiting time and improve throughput without compromising the quality of care. 3

Through a survey of 565 ED patients at a Turkish hospital, Yilmaz, Kati and Yalden (2023) identified doctor's behaviour and perceived medical care quality as primary determinants of patient satisfaction, with environmental factors as secondary but meaningful contributors. Degabriel, et al., further found that patients wanted the medical team to encouraged them to ask questions. Younger patients and those brought by ambulance were found to have low satisfaction.

The initial point of contact, which is the triaging process, is particularly critical. Janerka's (2024) review of 29 articles focuses on patient experiences related to triage processes, highlighting timely communication and fairness as critical to calming patient anxiety during initial assessment. Reznek et al. (2022), reviewing 2019 patient-satisfaction survey data from 78 EDs, also identified operational factors including triage, staff workload, and resource availability as care points to leverage patient satisfaction and reducing adverse events in the ED. Both studies identify triaging as not just a clinical patient sorting mechanism but as a strategic intervention for improving the entire ED experience.

2.3 Environmental factors:

The physical environment of ED contributes meaningfully to comfort patient and provide dignity. Idahor and Kingley (2022) highlighted factors such as cleanliness, level of noise and an overall good ambience as often-overlooked components that play an important role in shaping a patient's holistic ambience.

3. Quality improvement Frameworks and patient experience in ED:

Recognizing multifaceted determinants as identified above, the health care community has turned to solutions like structured quality improvement frameworks to bring out desired changes. The effectiveness of a quality improvement has been highlighted by Abid et al. (2022), who implemented a quality- improvement project using standardized communication framework called AIDET framework (Acknowledge, Introduce, Duration, Explanation, Thank You). The framework was used as an intervention for trained staff on how to use structured communication behaviours at key touch points. As a result, patient satisfaction scores for nurses and doctors improved dramatically in the study setting, demonstrating that standardizing interpersonal professional communication can be highly effective in improving patient perceptions of care in a complex clinical environment.

Gaps in literature:

The review of literature provides a good understanding of the topic and the need for a multi-dimensional strategy to improve ED patient experience. However, several critical gaps remain in terms of contextual and cultural specificity, holistic implementation and prioritization and long term sustainability. The majority of the evidence originates from Western and well-resourced settings. There is lack of research identifying the causes of low levels of patient

satisfaction or experience from similar secondary hospitals. There is limited guidance on how to effectively implement bundle and sequence multi-dimensional strategies within a single institution in a low-resource setting. Evidence for long term quality improvement initiatives like AIDET is scarce. Only around 12 studies were found on AIDET and all could not be cited. Research is needed to understand the factors leading to decay of these practices over time, in times specially when there is staff turnover and burnout.

MATERIALS & METHODS

Study Design

A convergent parallel mixed-methods design was used, integrating quantitative and qualitative data collected concurrently to provide understanding of patient experience.

QUANTITATIVE PART:

Population: All inpatients admitted through Emergency medicine department

Sample: All inpatients admitted through Emergency medicine department who are willing to participate in the study.

Data Collection

Sample Size Calculation:

With,

Z value at 95% confidence (Z=1.96),

D= 5% margin of error,

p=0.5 (proportion at 50%)

$$n = \frac{Z^2 \times p \times (1-p)}{d^2}$$

$$n = \frac{(1.96)^2 \times 0.5 \times (1-0.5)}{(0.05)^2}$$

$$= 385$$

After finite population correction (N= 500),

$$n_{adj} = \frac{385}{1 + \frac{384}{500}}$$

$$= 214$$

Considering a 2% non-response rate, the final sample size comes to 220

For the pilot study, 33 participants were recruited as per consent to participate in the study.

Sampling Method: Systematic Sampling method was used for the study.

Data Collection Method:

- Patient Satisfaction Survey: Structured questionnaire was administered participants who got admitted through ED, using Non- probability consecutive sampling technique.

QUALITATIVE PART:

Participants

Patient Interviews: Semi-structured with purposively selected from survey respondents till data saturation was achieved.

Inclusion and Exclusion Criteria:

Inclusion	Exclusion
1. All patients admitted through ED to various inpatients wards.	1. Patients who are critically ill or unable to respond due to medical condition at time of data collection 2. Patients under 18 years old without guardian consent 3. Patients who were discharged from the ED without admission including Leave against medical advice (LAMA).

Data Collection:

Interviews were transcribed for thematic analysis.

DATA ANALYSIS

Quantitative: Descriptive statistics (means, frequencies) using spss version 21.

Qualitative: Thematic analysis with manual coding was carried out.

Ethical Considerations

- ✓ Clearance from the Institutional ethics committee was taken (**Ref no:033/2025-26/IEC-CIHSR**)
- ✓ Written informed consent for surveys from participants.
- ✓ Anonymity via coding; data in password-protected laptop (5-year retention, then deletion).

RESULT

Data analysis was done separately for the quantitative and qualitative data as follows:

Table 1. Distribution of participants based on Sociodemographic Variables (N= 33):

Sociodemographic variable		Frequency (*n*)	Percentage (%)
Age (Mean age-47 Standard deviation-18.3 Minimum-20 Maximum-86)	Less than 25 years	4	12.1
	25 to 44 years	11	33.3
	45 to59 years,	10	30.3
	60 to 74 years	5	15.2
	More than 75 years	3	9.1
Gender	Male	17	51.5
	Female	16	48.5
State	Nagaland	23	69.7
	Outside- Nagaland	10	30.3
Highest Level of education	No Formal schooling	7	21.2
	Under Matric,	11	33.3
	Matriculate	3	9.1
	Higher secondary	6	18.2
	Graduate and above	6	18.2

Interpretation:

The sociodemographic profile of 33 participants reveals a diverse representation across all variables. The mean age of the participants was approximately 45 years, and majority (33.3%) falling in the category of young adults (25-44 years). In terms of gender, 51.5% of them were males, 69.7% of them residing in Nagaland and majority (33.3%) had under matric education.

Table 2. Distribution of participants based on clinical variables (N=33):

Clinical Variable		Frequency (*n*)	Percentage (%)
Shift of Arrival	Morning (7 am–2 pm	21	63.6
	Evening (2 pm–8 pm)	9	27.3
	Night (8Pm- 7 am)	3	9.1
First time visit to Emergency Department	Yes	18	54.5
	No	15	45.5

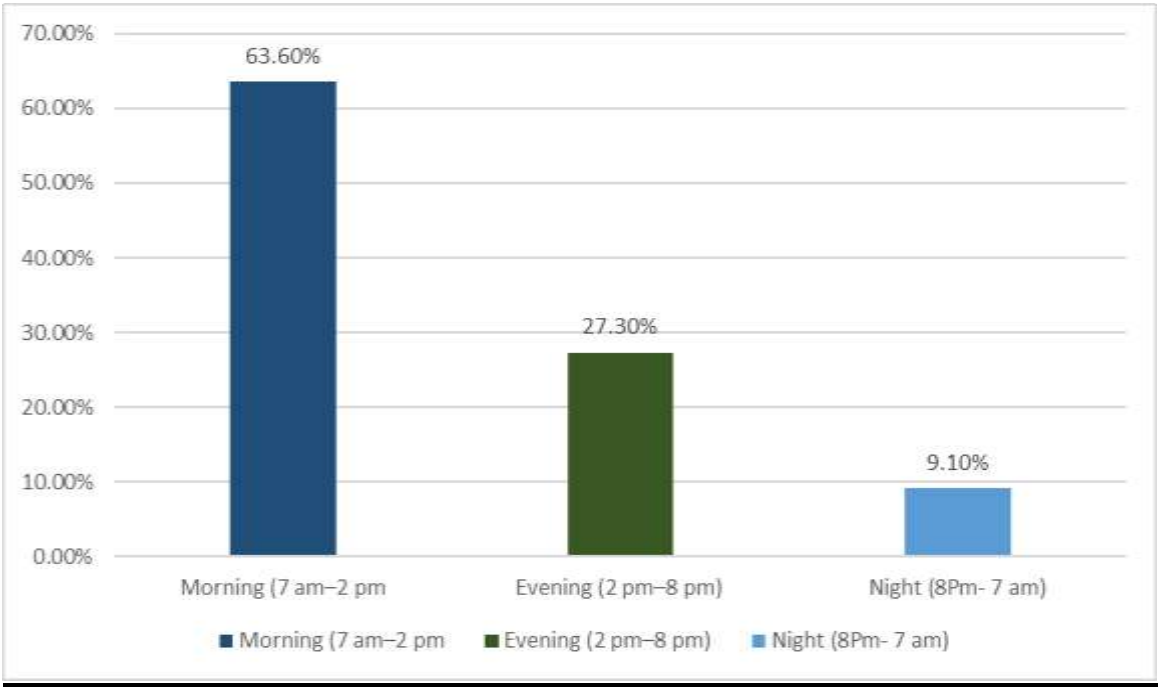

Fig 1. Distribution of participants based on shift of duty.

Interpretation:
The figure shows the progressive decline of patient arrivals from morning through evening to night shifts. Morning shift accounts for nearly (63.6% of all arrivals, establishing it as the busiest period in the emergency department.

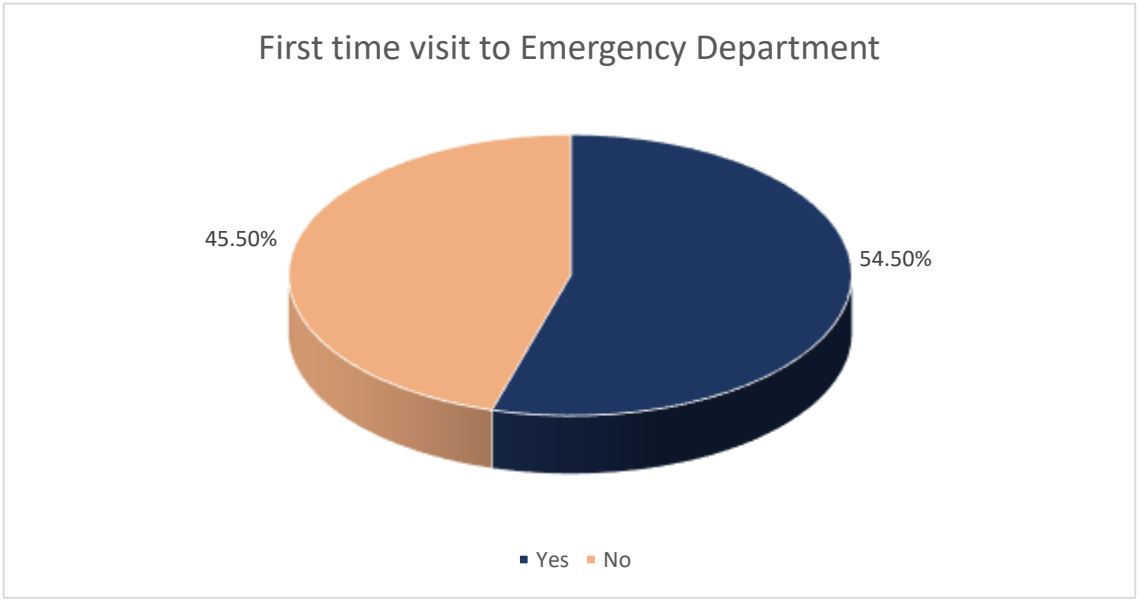

Fig 2. Distribution of participants based on their first time visit to emergency department (N=33)

Interpretation:
Majority (54.5%) of the participants were visiting the emergency department for the first time, while 45.5% of them were returning visitors showing a near balanced distribution of a mix of new and repeat users of emergency services.

Table 3. Distribution of participants based on their response to Survey Questionnaires (N=33):

Statements	Negatives				Positives		
	Strongly Disagree	Disagree	Neutral	Total Percentage	Agree	Strongly Agree	Total Percentage
1. I was received promptly upon arrival at the emergency department.					66.70%	33.30%	100.00%
2. The triage staff were caring and professional during my initial assessment.			6.10%	6.10%	51.50%	42.40%	93.90%
3. I felt my medical urgency was understood correctly during triage.			3%	3%	54.50%	42.40%	96.90%
9. I would choose this emergency department again for future urgent needs.			6.10%	6.10%	57.60%	36.40%	94.00%
10. I would recommend this emergency department to family and friends.			9.10%	9.10%	54.50%	36.40%	90.90%
4. The time I waited to first see a doctor was reasonable for my condition.		6.10%	9.10%	15.20%	66.70%	18.20%	84.90%
5. The doctors and nurses explained my condition and treatment clearly.			18.20%	18.20%	54.50%	27.30%	81.80%
8. My privacy was respected throughout the visit (during examination and conversations).		9.10%	12.10%	21.20%	60.60%	18.20%	78.80%
6. Staff communicated test results and next steps in a way I could understand.		24.20%	33.30%	57.50%	33.30%	9.10%	42.40%
7. Cost-related information was communicated transparently.	3%	63.60%	9.10%	75.70%	21.20%	3%	24.20%

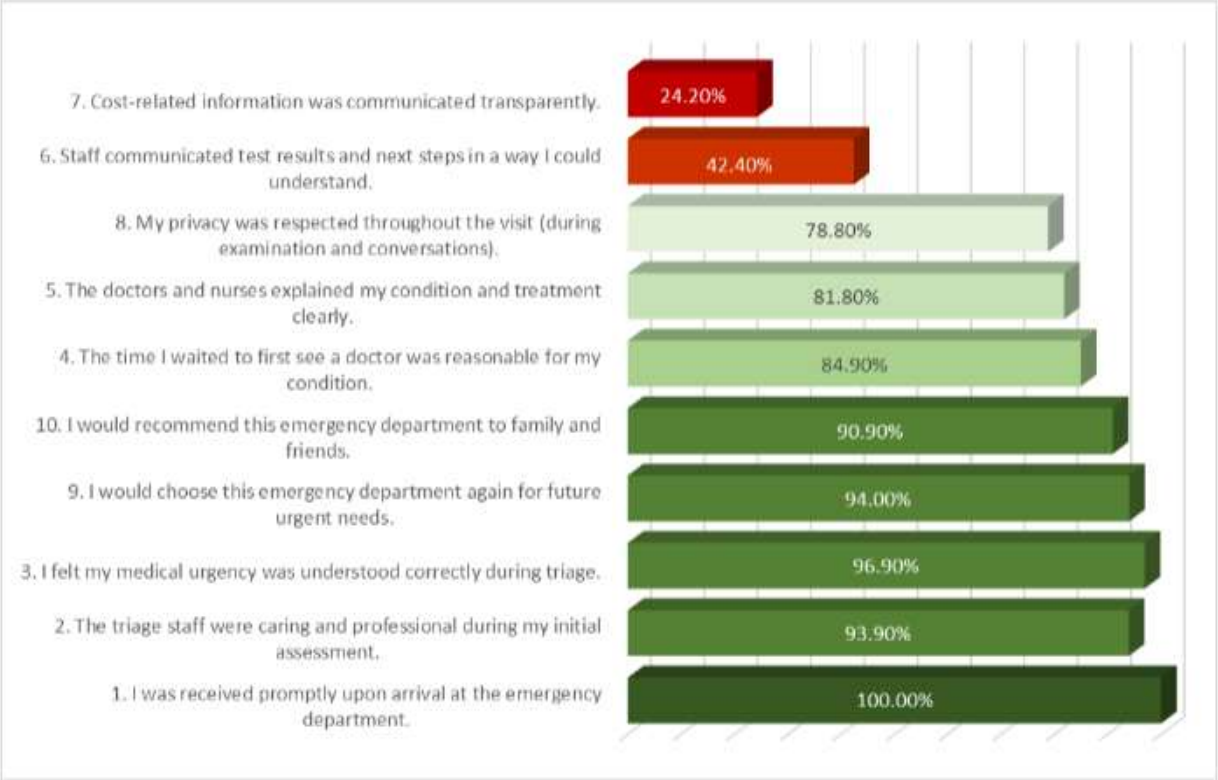

Figure 3: Distribution of participants based on their response to survey questionnaires, ordered by highest to lowest agreement (N=33)

Interpretation:

All the participants were promptly received upon arrival (100% positive), staff were found to be caring and professional during initial assessment (93.9% positive) and had high loyalty and recommendation rates (over 90% positive). However, significant gaps exist in communication (only 42.4% positive) and transparency regarding costs (only 24.2%)

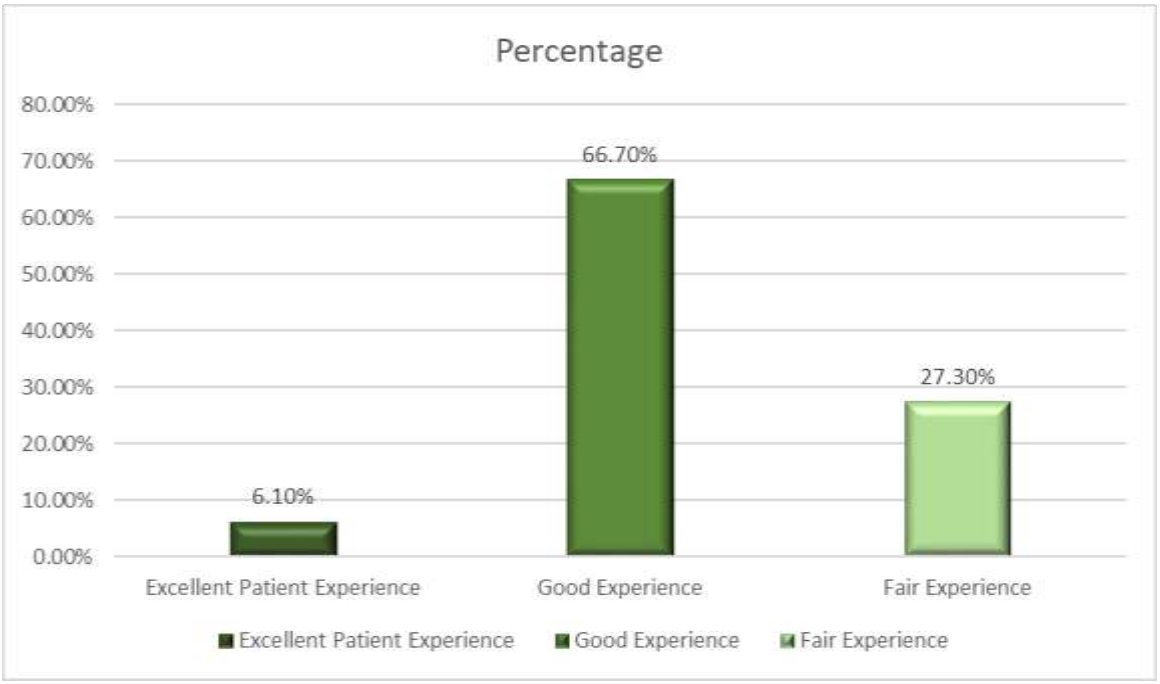

Figure 4: Overall satisfaction of the patients based on their experience in Emergency department (N=33)

Interpretation:
Majority of the participants were found to have had good experience (66.70%) and 27.30% of them had fair experience.

I. QUALITATIVE DATA ANALYSIS:

The following data analysis presents the key themes, sub-themes and patterns emerging from the interview of 8 patients.

Theme 1: Positive perception of staff and care received.

This theme is quite dominant across all the responses received from the participants. Majority of the responses focus on the human element of care received.

Sub theme: 1.1: Kindness and caring attitude of the staff

Participant patients frequently used words like "Caring", "Kind", and "good" to describe the staff. This is one of the most frequently mentioned positive point.
Patient 2: "The staff were caring. It was good"
Patient 5 "It was nice. Good care was given"
Patient 6 "Satisfaction with the staff"
Patient 8: "The staff were kind and good"

Sub-theme 1.2: Good Medical treatment/ Care

The responses highlighted patient's satisfaction with actual medical treatment and care indicating fundamental trust in the clinical and professional competence of the team.
Patient 1. "It was good; the treatment was good."
Patient 4 "I think good care. I wish to continue to have similar treatment even in future"
Patient 5 "It was nice. Good care was given"

Sub-theme 1.3: Overall satisfaction and willingness to Return

Many responses highlighted that their overall experience was "good" or they were "Satisfied". One patient even mentioned that they would choose to return if needed in future which is a strong indicator of overall confidence in the department.
Patient 3 Overall experience was good. It is not my first time and it won't be my last time"

Sub-theme 1.4: Recognition of teamwork

Departmental teamwork has been specifically praised by patient no 3.
Patient 3 "I think what I like about your hospital is that, teamwork is very good. I have observed that everybody works hand in hand and that's something I really like"
This reflects a positive workplace that is visible and appreciated by patients.

Theme 2: Concern regarding wait times

Although majority of the responses are positive, one patient raised a critical point regarding wait times, making it a key finding.

Sub-theme 2.1 Perception of slow response for serious cases

Patient 1 acknowledged that the department was busy when was there but felt the severity of their own case should have led to faster response.
Patient 1 "To be frank , the service given was slow. We understand you have other patients to look after, however in our case , it was serious, things could have been done faster"
This highlights a potential gap in triage communication and process flow, which left the patient feeling that their serious condition wasn't priotized appropriately.

Sub-theme 2.2 Acknowledgment of busy condition of the department

Even though patient 1 was expressing the frustration for slow response, the patient still showed empathy, demonstrating an understanding that ED operates under high pressure.
Patient 1 "…….. We understand you have other patients to look after, however in our case, it was serious, things could have been done faster"

Theme 3: Lack of constructive feedback

A recurring pattern was observed for question 3 and 4, was the inability to share suggestions for improvement which can be interpreted in 2 ways.

Interpretation no 1: Genuine satisfaction

This might suggest that the degree of satisfactions met by patients exceeded their expectations and they felt no changes were necessary. This reinforces the strength of theme 1.

Patient 3 "You all are doing an excellent job. No suggestions for now"

Patient 5 "Everything is ok"

Patient 6 "Satisfied, no suggestion"

Patient 7 "According to my experience, nothing much, everything was fine"

Patient 8 "I didn't stay in emergency for long time, so I can't give any suggestions yet"

Interpretation 2: Reluctance to criticize or limited exposure

Another reason for lack of constructive feedback could be because of reluctance to criticize or an actual limited exposure.

Patient 4 "I didn't stay long enough to observe and give suggestions. But good work to the team"

Patient 8 "I didn't stay in emergency for long time, so I can't give any suggestions yet"

Overall summary of key findings:

1. The cornerstone of patient's experience is the staff's compassionate and caring approach. This consistently praised and forms the basis of overall satisfaction.
2. The primary area for improvement is the perception of wait times, especially for patients who believe their condition is serious. While the clinical treatment and care is appreciated, the process was felt slow.
3. The unsolicited praise for teamwork suggest a healthy and collaborative environment that positively impacts patient perception.

DISCUSSION

This pilot study aimed to assess patient satisfaction levels in the Emergency Department (ED) and to explore the contributing factors for negative experiences, specifically communication gaps. The findings reveal a complex landscape where high interpersonal satisfaction coexists with significant systemic and informational deficits.

1. Assessment of Patient Satisfaction Level in the ED:

The overall satisfaction with the ED experience was notably high, with 66.7% of participants reporting a "good" experience and 27.3% a "fair" experience. This positive sentiment is strongly supported by the quantitative data, where 100% of patients felt they were received promptly, and 93.9% rated triage staff as caring and professional. Qualitatively, the dominant theme was the positive perception of staff kindness, medical treatment, and teamwork. Patients explicitly praised the "caring" and "kind" attitude of staff, and one patient specifically commended the departmental teamwork as "very good."

These findings align with global literature identifying staff empathy and professionalism as the most powerful drivers of patient satisfaction in EDs, often buffering against other operational shortcomings (Sonis et al., 2017; Babu et al., 2024). The high loyalty (94% would return) and recommendation rates (90.9%) further reinforce that, for the majority of patients, the humanistic elements of care successfully met or exceeded expectations.

2. Contributing Factors for Negative Patient Experience

While overall satisfaction was high, specific factors contributing to negative or suboptimal experiences were identified. The most significant factor was poor communication of clinical information, with only 42.4% of patients feeling that test results and next steps were explained clearly. This represents a critical gap, as an "information

void" is a primary contributor to patient anxiety and perceived poor quality of care, often outweighing the impact of actual wait times (Kasmad, 2025).

The second major factor was a lack of financial transparency, which yielded the most negative response of any domain (only 24.2% positive). This finding is a substantial institutional risk. In the Indian context, unclear cost communication is a well-documented driver of public distrust and a frequent trigger for dissatisfaction and even workplace violence from patients and attendants facing unexpected bills (Davey et al., 2020).

Finally, perceived delays in response for serious cases emerged as a qualitative concern. Although the average wait time appeared low, one patient with a serious condition felt service was "slow," highlighting that the perception of time is subjective and heavily influenced by the severity of one's own condition and a lack of process updates.

3. Exploration of Communication Gaps Between ED Staff and Patients

The study successfully identified two distinct and critical communication gaps:

Gap 1: Lack of Clear Clinical Updates (The "Information Void")

More than half (57.6%) of patients did not feel that staff communicated test results and next steps understandably. This is not merely a courtesy issue; it is a therapeutic failure. Research shows that patients who receive regular, clear updates—even if they don't fully understand the medical details—report significantly lower anxiety levels and feel less "forgotten" (Haug et al., 2022; Kim et al., 2023; Manukumar et al., 2025). The qualitative finding that many patients had "no suggestions" may ironically reflect a reluctance to criticize or a limited exposure to better models of care, rather than genuine satisfaction with communication.

Gap 2: Lack of Cost-Related Communication

The 75.7% negative response regarding cost transparency indicates a near-total breakdown in financial communication. This gap prevents patients from making informed decisions and erodes self-efficacy (Caldwell et al., 2013). Unlike clinical care, where empathy can buffer dissatisfaction, financial uncertainty appears to be an independent and potent driver of negative experiences.

Gap 3: Misaligned Triage Communication

The qualitative complaint from Patient 1 ("…..but felt the severity of their own case should have led to faster response") suggests a gap in explanatory communication during triage. The patient understood the department was busy but did not understand why their perceived severity did not translate into faster action. Research suggests that patients who are well-informed about the reasons for a delay are over 2.4 times more likely to report higher satisfaction (Manukumar et al., 2025). The lack of real-time updates or status explanations left this patient feeling deprioritized despite the staff's best clinical judgment.

CONCLUSION

The ED excels in the affective domain of care (kindness, professionalism) but has a critical weakness in the informational domain (clinical and financial updates). Future quality improvement efforts should prioritize structured communication protocols for test results and transparent cost discussions, as these are the primary levers for converting "good" experiences into consistently "excellent" ones.

Declaration by Authors

Ethical Approval: Approved (Ref no:033/2025-26/IEC-CIHSR)

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Conflict of Interest: The authors declare no conflict of interest.

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