

Review of Victorian public hospital outpatient departments

Physical amenities, information materials and communication practices

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Background

The Victorian Government is committed to improving the delivery of outpatient services. In 2006, the Victorian Auditor General completed an audit of outpatient services. The resulting report, *Access to specialist medical outpatient care* (Auditor General Victoria, 2006), highlighted the need for the Department of Human Services to improve strategic planning and performance in relation to outpatient services. The department has developed an Outpatient Improvement and Innovation Strategy to improve the quality and accessibility of outpatient services.

To inform development of the Outpatient Improvement and Innovation Strategy, consumer focus groups and staff interviews were conducted to provide information about experiences and expectations in relation to the provision of outpatient services. Although the results indicated variability in services provided, common concerns were identified regarding the condition of physical amenities, communication practices and consumer information materials provided in outpatient departments. Prior to developing strategies to address the concerns raised in the consumer focus groups and staff interviews, it was agreed there was a need to establish a better understanding of the current state of Victorian public hospital outpatient departments.

Dench McClean Carlson was contracted to complete the outpatient review at 23 metropolitan and five regional hospitals in May 2007 with the following objectives:

- to observe the current state of physical amenities, information materials and communication practices in Victorian public hospital outpatient departments
- to identify good design and practice
- to identify areas where improvement may be desirable.

The Outpatient Experience Sub-Committee acted as a reference group, advising on the development of the review process and providing feedback on how the results could be incorporated into the Outpatient Improvement and Innovation Strategy. The Outpatient Experience Sub-Committee members comprises of outpatient staff (medical, nursing, allied health and clerks), consumers and representatives from the Department of Human Services.

The hospital representatives and outpatient staff participated in the review with enthusiasm, sharing lessons learned, providing examples of good practice and identifying areas that could benefit from improvement. We wish to acknowledge the cooperation of the outpatient staff who assisted with the review process by making their time available to conduct tours and provide information on the outpatient facilities and practices in their hospital. Their valuable contribution is greatly appreciated.

Methodology

A literature review was conducted to gain an understanding of the potential impact physical amenities, information materials and communication practices in outpatient departments can have on consumers and hospital staff. Although limited studies specifically quantified the outcomes associated with these factors in outpatient departments, there was an abundance of literature indicating a link between the general hospital environment (including the physical environment and the social aspects) and important outcomes such as effectiveness of clinical care, perceptions of quality of care, consumer satisfaction, consumer safety, staff stress and workforce retention (Ulrich, Quan, Zimring, Joseph, & Choudhary, 2004).

The Outpatient Review Tool was developed based on the findings from the literature and expert advice from the members of the Outpatient Experience Sub-Committee and the Outpatient Reform Team. Supporting the questions with literature enhanced the overall content validity of the Outpatient Review Tool. The Outpatient Review Tool included questions about parking and transport, signage, outpatient reception, physical amenities (including for consumers with special needs), general services, toilet facilities, positive distracters, consulting rooms, file privacy and tracking, information materials, communication practices, staff communication training and staff facilities.

The Outpatient Review Tool was distributed to a nominated hospital representative prior to each visit to allow them to consider the questions. The contractor from Dench McClean Carlson was trained in the use of the Outpatient Review Tool, which was completed with the assistance of the nominated hospital representative.

To examine the inter-rater reliability of the data collected, a member of the Outpatient Experience Sub-Committee completed the Outpatient Review Tool at the same time as the contractor at eight of the hospitals. Comparisons between the results obtained from the contractor and the representative from the Outpatient Experience Sub-Committee indicated good inter-rater reliability (Burns & Grove, 1993; De Vaus, 2002). The outpatient review process included completion of the Outpatient Review Tool, a tour of the facilities, a discussion about the outpatient areas and services with the nominated hospital representative and photographic documentation of areas demonstrating good practice principles. Each visit took approximately two hours.

Findings and Recommendations

The review found that outpatient services across Victoria vary greatly in their physical amenities, the information materials they provide to consumers and their communication practices. Outpatient services also face different challenges in providing efficient and sustainable services due to the physical layout. Many health services operate their outpatient departments within the constraints of available resources and have developed effective strategies to maximise the operations. The review has identified examples of good practice and a number of areas where substantial benefit can be gained from targeted improvements. There were 21 general recommendations made from this review that health services should consider when developing strategies to improve their outpatient departments. Specific feedback on the findings of the review will be provided to each hospital.

The general recommendations of this review are:

Way finding and access

1. A statewide standard to be developed by the DHS to promote consistent signage for outpatient departments (for example, developing way finding standards that outline type, size, placement and frequency of signage).
2. Clear signage to be displayed by hospitals to notify consumers of the process for arranging a taxi service.
3. Future planning to be undertaken to ensure car parking is relatively affordable, conveniently located to the outpatient department (particularly to allow easy access for consumers with limited mobility) and car spaces are provided to accommodate periods of high patient demand.

The waiting room environment

4. Strategies are developed by hospitals to maximise the efficiency of consumer flow through waiting and treatment areas to prevent appointment delays (for example, improved appointment scheduling).
5. Comfortable seating constructed from non-porous and durable materials should be provided by hospitals for outpatient areas.
6. A working party is established by DHS to develop a plan for the utilisation of volunteers in the outpatient setting.

Meeting the special needs of consumers

Children and families

7. Hospitals should consider providing a designated area for children that is decorated in an appealing manner and has appropriate play items available (e.g. toys that can be easily cleaned to minimise the risk of contamination).
8. Private areas to be made available by hospitals for parents with infants for feeding and changing purposes.

Disabled consumers

9. Hospitals should include appropriate seating facilities and spacing between seating for disabled consumers and bariatric patients in outpatient areas.
10. Hospitals should provide conveniently located designated car parking spaces for disabled consumers, which also have a clear and continuous accessible path of travel to the outpatient area.
11. Facilities catering for visually and hearing impaired consumers should be made available at all outpatient services.

Elderly consumers

12. Hospitals should recognise the special needs of elderly consumers and ensure they have access to suitable physical amenities (including comfortable seating with arm rests and a safe environment to minimise the risk of falls).

The consulting rooms and outpatient file management

13. Hospitals to aim for 100 per cent height adjustable electronic plinths (high/low beds) on occupational health and safety grounds in all outpatient areas.
14. The patient's privacy and confidentiality must be maintained by the hospital at all times. To achieve this recommendation, robust file privacy and tracking systems should be implemented and patients should be taken to private areas when giving personal details that need to be kept confidential.

Consumer information and communication practices

15. Relevant health promotion/self-management information to be sourced by hospitals and made readily available to consumers in multiple languages (including consideration of multi-media provision).
16. A standardised training package will be developed by DHS that incorporates customer service, cultural diversity and aggression management modules. This package will be delivered to frontline staff across outpatient services in Victoria.
17. Patients should preferably not be kept waiting for appointments, however where unavoidable situations occur that result in a delay, hospitals should ensure consumers are kept well informed and develop notification processes to regularly update them of expected waiting times.

18. Hospitals install a call-back system (for example, paging) to allow consumers to leave the outpatient waiting areas and be notified when they need to return for their appointment.
19. A generic outpatient satisfaction survey in multiple languages to be developed by DHS and implemented across all Victorian outpatient services.

Staff facilities

20. Hospitals ensure appropriate physical amenities for staff are made available, including meeting facilities, toilets and areas for break periods.
21. Hospitals provide appropriate facilities for staff education and training.

A summary of the review findings and relevant research to consider when addressing the priority items.

Physical amenities and meeting the special needs of patients

Findings

An inadequate number of seats and spacing between seats was reported at many outpatient services. Most had seats with padding made from durable materials. The literature supports the provision of seating made from durable, non-porous material because it can be more easily disinfected to prevent the spread of infection and is usually hard-wearing to withstand high traffic (Huddy & McKay, 1996). Seating with arm rests was present at most hospitals, however there was a variable range of those with arm rests in the waiting area. Many areas were unable to monitor all seating from the reception area, which is potentially a safety risk for patients.

The seating provided could be moved into small flexible groupings at most hospitals. The literature suggests that this sort of seating markedly increases social interactions between consumers, compared to fixed seating that is arranged side-by-side along the walls of a waiting area (Ulrich, 1997). Seating arrangements that encourage social interactions have been shown to improve patient satisfaction during the hospital visit (Ulrich, 1997).

The outpatient areas reviewed were very different in design and location within the hospitals. Although general hospital amenities were often located close to the main outpatient area, most hospitals had multiple outpatient areas, which made it difficult to establish a minimum standard for the provision of general amenities. Consumers usually had good access to toilet facilities, public telephones, taxi phones, drinking fountains and vending machines in the outpatient department. In terms of the outpatient waiting area environment, most had climate control, natural lighting, lights that could not dim and were well maintained.

Most hospitals used positive distracters in the outpatient areas. Positive distracters refer to environmental features that have been found by research to often increase consumer satisfaction and improve the patient experience. For example, studies have shown that positive distracters, such as nature, television, artwork, music, humour, reading material and music, may reduce patient stress and boredom associated with waiting for an appointment (Bilchik, 2002; Fry, 1992; McCaffery & Freeman, 2003; McCarthy, 2004; Ulrich, 1991; Ulrich, Simons, & Miles, 2003; Verderber, 1986). Other studies have reported that positive distracters can also have beneficial effects on hospital staff and reduce stress, improve job satisfaction and result in fewer health-related complaints (Verderber, 1986).

An insufficient number of consulting rooms was reported at most hospitals. The average size of commonly used consulting rooms varied greatly, from the smallest reported at 2.5 by 3 metres to the largest at 6 by 8 metres. Many services had larger rooms available if required for multidisciplinary review of patients or when patients attended with a few carers/family members. Almost all consulting rooms had a telephone, computer and basic examination equipment available. At least one electric height adjustable plinth (high/low bed) was available in most outpatient departments. The actual availability of these plinths ranged from being present in 5 per cent to 100 per cent of consulting rooms. The nominated hospital representative usually reported that the limited availability of adjustable plinths was identified as an occupational health and safety issue that the hospital was currently addressing.

There is strong evidence in the literature that small design modifications to improve the hospital's physical environment such as including natural light, creating a pleasant temperature, reducing crowding, incorporating aesthetically pleasing elements (e.g. artwork and nature), furniture repositioning to support social interaction and providing comfortable seating can all have a positive impact on the patient experience (Arneil & Devlin, 2002; Leather, Beale, Santos, Watts, & Lee, 2003; Leddy, Kaldenberg, & Becker, 2003; Rosenfeld & Guenther, 1999; Ulrich, Quan, Zimring, Joseph, & Choudhary, 2004; Ulrich et al., 2003). The outcomes reported by some studies after improvements were made to the design of waiting areas include an increase in patient satisfaction, more positive appraisals of the environment and higher ratings for the quality of care being delivered by the service (Arneil & Devlin, 2002; Leather et al., 2003). Staff also benefit from well-designed hospital environments. Investigations have found that supportive physical designs (including sufficient lighting, lower noise levels, good ventilation, positive distracters and work areas designed using ergonomic principles) have been associated with reduced workplace stress, reduced staff turnover, lower rates of absenteeism, greater morale and improved ability to attract other employees (Mroczek, Mikitarian, Viera, & Rotarius, 2005; Ulrich et al., 2004).

It is important to acknowledge that the hospital environment can impact on the safety of consumers and staff. Good design (including appropriate door openings, adequate lighting, sufficient room between seating and correct toilet/furniture heights) has been shown to reduce the incidence of patient falls and workplace injuries reported by staff (Brandis, 1999; Ulrich et al., 2004). Additionally, selecting furniture and floorings made from non-porous materials can improve the extent to which they can be decontaminated during routine cleaning processes and reduce the risk of infections being transmitted (Akhter, Al-Hajjar, Myint, & Qadri, 1995; Suviste, 1996; Ulrich et al., 2004).

Children and families

Children and their families have particular needs that should be considered when trying to create a positive experience for them whilst they attend a hospital appointment. Playing can be an effective distraction to assist children to cope with any stress or boredom that may be experienced in a hospital environment (Doverty, 1992). Play items for children were available in the outpatient waiting areas at most hospitals and included books, toys, televisions, wall-mounted activity centres and chalkboards.

Designated areas for children, that were separated from areas for adult patients, were provided in around half of hospitals. These areas were mostly decorated and furnished in a manner that was bright, comfortable and appealing to children. The Australian College of Paediatrics released a policy statement to support this practice of providing well defined children areas that are separate to adult patients (Australian College of Paediatrics, 1985). The benefits of this approach include protecting children from exposure to potentially stressful situations and ideally keeping them contented to improve the overall comfort of the waiting environment for other consumers (Australian College of Paediatrics, 1985).

Facilities for changing babies were available in most services. These facilities were often only found in the female toilets and were therefore not accessible to male parents. There were few facilities available for nursing mothers to breastfeed their children. It was recognised that some women may not feel comfortable breastfeeding in public areas for various social, emotional, cultural and religious reasons. Consequently, many of the hospitals that did not have facilities specifically for nursing mothers reported that if requested by the consumer, they would find an appropriate location for them to breastfeed in privacy.

Play items for children were raised at most of the hospitals as an infection control issue. The literature shows that to minimise the risk of transmission of infections between children playing with toys, hospitals should implement appropriate disinfection procedures and choose play items that can be easily decontaminated (Fleming & Randle, 2006; Merriman, Corwin, & Ikram, 2002; Randle & Fleming, 2006). Research findings support the provision of hard, plastic toys, in comparison to soft toys which usually have a higher prevalence of micro-organisms and probability of contamination (Merriman et al., 2002). The research also suggests that hospital staff and parents should be educated to minimise the sharing of toys between children, unless they have been properly disinfected, and adhere to stringent hand hygiene procedures to reduce the infection transmission risk (Fleming & Randle, 2006). If appropriate toys are chosen and subjected to routine, efficient cleaning, the literature indicates that it is likely they can safely be made available in outpatient waiting areas (Fleming & Randle, 2006; Merriman et al., 2002; Randle & Fleming, 2006).

Disabled patients

All hospitals that participated in this review had designated parking facilities for patients with disabilities. Although the disabled car parking spaces were often close to the hospital's main entrance, a few were located at inconvenient distances from the outpatient departments. Some nominated hospital representatives reported that where the disabled car parking spots were located a great distance from the outpatient department, they had arranged 'un-official drop-off points' and alternative entries into the outpatient department that could be used if required. Hospitals should note that *"providing access for people who use a wheelchair or a walking frame through a separate entrance to the one used by the general public is not acceptable if the main entrance can be adjusted and therefore made accessible without causing unjustifiable hardship. This is particularly the case if entry to a building by an alternate access route is dependent on making prior arrangements such as alerting staff to the need for doors to be unlocked"* (Australian Human Rights and Equal Opportunity Commission, 2007).

In terms of access to physical amenities, almost all hospitals provided suitable disabled toilet facilities that were accessible from the outpatient area. It was noted that the actual design of the outpatient environment often made it difficult for a person in a wheelchair or with a walking frame to move between seating because the spacing was inadequate at many hospitals. The nominated hospital representatives commonly reported that particular spaces were provided for patients in a wheelchair to wait, however they acknowledged that access throughout the outpatient area was often restricted.

Specific seating for people with disabilities and other special needs was available at a majority of services. It consisted mainly of high seating for orthopaedic outpatient services for consumers with hip replacements. There was very little dedicated bariatric seating available in outpatient areas. While some hospitals reported that they had seating that could accommodate bariatric consumers, the safe capacity of the seating was unknown.

Very few hospitals had appropriate features catering for consumers with moderate to severe visual impairment (e.g. raised tactile and Braille information on signage) and hearing impairment (e.g. Auslan sign language, assistive listening systems and hearing loops).

Elderly patients

Elderly patients often have the presence of a number of factors that cause them to have special needs that should be considered when they attend hospital appointments. These factors include multiple medical conditions, decreased mobility, increased falls risk and sensory deficits (e.g. visual and hearing impairment) (Halfon, Egli, Van Melle, & Vagnair, 2001; Watson, Marshall, & Fosbinder, 1999). Investigations have found that elderly patients are less tolerant of waiting and often complain about the temperature of the hospital environment, comfort of seating, noise levels and lack of information about what to expect during their appointment (Arneil & Devlin, 2002; Hayes & Koziol-McLain, 2000; Watson et al., 1999).

The nominated hospital representatives in this review reported that in terms of catering to the needs of elderly consumers, most had hospital climate control and comfortable seats with padding and arm rests. Some hospitals provided only a few seats with arm rests, whereas others had this as a standard for all seating. The nominated hospital representatives reported that priority was given to consumers with poor mobility, including elderly patients, for the chairs with arm rests as it was understood that this feature facilitated ease of movement in and out of the seat (Christie, 2005).

Although data was not specifically collected whilst completing the Outpatient Review Tool, it was acknowledged that many hospitals had site-wide falls prevention strategies and conducted environmental audits to remove potential hazards that could increase the potential of a fall occurring. This practice was particularly relevant to elderly patients who often have poorer mobility and are at a higher risk of falling (Creditor, 1993; Halfon et al., 2001; Hayes & Koziol-McLain, 2000; Watson et al., 1999). The literature also indicates that poor hospital design (e.g. slippery floors and inappropriate furniture height) can contribute to increasing the incidence of falls (Creditor, 1993; Hayes & Koziol-McLain, 2000; Watson et al., 1999). Most nominated hospital representatives acknowledged that attention should be given to the special needs of elderly consumers to improve their experience in the outpatient area.

Way finding and signage

Findings

Outpatient services were often operating at multiple locations. Despite most health services having signage directing consumers from the main hospital entrance to the main outpatient area, this was adequate and easy to follow at a few hospitals. Within the outpatient area, the reception desk was usually clearly signed, however signage or maps to direct consumers from the outpatient department to other areas of the hospital were not readily available.

Comments

An effective way finding system promotes simple navigation through use of a combination of options including clear external building cues, a logical physical layout, signage, verbal directions and informational handouts/maps (including those sent to the consumer prior to an appointment and those made available inside the health care facility) (Carpman & Grant, 1993). For patients attending an outpatient department a way finding system is required to locate the car park or drop-off point, the entrance to the right hospital building, the specific location of the outpatient area and other areas in the hospital (e.g. physical amenities, x-ray, pharmacy and pathology). People under the stress of attending a medical appointment have been reported to be more susceptible to information overload, have difficulties processing information provided by environmental cues and are more dependent on others to assist them with navigation (Horsburgh, 1995). It is therefore essential to ensure way finding material is as clear, consistent, legible and straight forward as possible.

Whilst completing the Outpatient Review Tool the reviewers used the available signage to navigate their way from the hospital entrance to the main outpatient area. They found this activity difficult at some hospitals because of poor signage placement, an insufficient number of signs and a lack of logical flow. In contrast to the belief that fewer hospital signs means less clutter and less visual distraction, a study found that hospital patients who had access to more signs reached their destination faster, asked for less directions and reported reduced stress levels (Carpman, Grant, & Simmons, 1984). The literature suggests that to optimise effectiveness, directional signs should be placed at all key decision points and regularly along the route (Carpman et al., 1984; Douglas & Douglas, 2005; Martin, 1993).

Whilst navigating to the outpatient department the reviewers commented that some of the existing signs were difficult to read because of small lettering or poor contrast between lettering and the sign's background. According to guidelines published by The Australian Human Rights and Equal Opportunity Commission, good signage includes lettering that is at least 17.5mm high for each metre of viewing distance, a sans serif font, highly contrasted with the surrounding sign's background and is both upper and lower case text (Australian Human Rights and Equal Opportunity Commission, 2007). The reviewers also noted there was inconsistency in the nomenclature used both between hospitals and within the same hospital (for example, the signage referred to the services as clinics, outpatients and ambulatory care). All of these signage issues made it challenging for the reviewers to confidently navigate to the outpatient department. Investigations have found that way finding problems, like those reported by the reviewers, are likely to have adverse effects on the patient experience and increase consumer stress levels (Miller & Lewis, 1999; Ulrich et al., 2004; Zimring, 1990).

The nominated hospital representative reported that staff often provided verbal directions where clear signs or maps were not apparent to assist consumers with navigation. There were general concerns that this was a poor use of staff time and it was agreed that better way finding information could minimise the need for staff to perform this task. This findings was consistent with the literature where the time staff spent directing patients, instead of doing their regular work, was reported to be costly and inefficient compared to a well designed way-finding system (Zimring, 1990).

Staff communication training

Findings

Various training programs were available for outpatient staff, including customer service, aggression management and increasing cultural diversity awareness. It was noted that these programs varied in terms of content, comprehensiveness and frequency.

Comments

Many services offered one-off or ad-hoc training programs, which often occurred during orientation and did not have a review process. More developed programs were available in areas where incidents had occurred and had highlighted the need for more formal training. However, it was agreed that a proactive approach to staff training was likely to be more effective and assist in preventing incidents from occurring.

Some examples of good practice in staff training were identified during the review. One centre had reclassified their clerks as customer service officers after completing a fully funded certificate course in customer service. Another service had implemented an annual module-based training program for all staff to comprehensively address many topics (including customer service, aggression management and cultural diversity awareness).

Good staff communication has been identified as the single most important determinant of patient satisfaction (Frederickson, 1995; Hall, Irish, Roter, Erlich, & Miller, 1994; Ulrich et al., 2004). The research indicates that just giving feedback to staff regarding communication practices is unlikely to impact on their performance in this area (Hostutler, Taft, & Snyder, 1999). Alternatively, communication training programs have been shown to be an effective strategy to improve and maintain these skills over time (Fellowes, Wilkinson, & Moore, 2004). One hospital reported that following staff training there was an increase in patient satisfaction demonstrated by a 70 per cent drop in complaints and a 100 per cent rise in compliments (Mayer & Zimmermann, 1999). Staff have also reported less frustration and better ability to handle difficult patient situations following communication training that targeted specific skills (Brown, Boles, Mullooly, & Levinson, 1999; Stein & Kwan, 1999).

Supporting these positive outcomes other research has found that where staff attended a training courses in aggression management, although the frequency and severity of aggressive patient behavior did not change, the extent to which staff felt competent to effectively manage these situations improved and they reported less stress (Needham et al., 2004). Additionally, staff training in the remediation of challenging behaviors, particularly associated with people who have intellectual disabilities, was found to improve staff performance, increase staff knowledge on effective intervention strategies, reduce staff psychological distress, reduce the frequency of these behaviors and result in better outcomes for those with the intellectual disability (Jahr, 1998; McClean et al., 2005; McGill, Bradshaw, & Hughes, 2007). Although some health care facilities consider it to be difficult and costly for staff to be excused from their clinical duties to attend training courses, the resulting benefits reported in the literature suggest that it is often a worthwhile investment.

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