An-Najah National University

Faculty of Graduate Studies

ASSESSMENT OF PATIENTS' EXPERIENCE IN THE EMERGENCY DEPARTMENTS IN WEST BANK – PALESTINE: A QUANTITATIVE CROSS-SECTIONAL STUDY

By

Sojoud Bashar Fayez Abdullah

Supervisor

Dr. Nizar Said

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This Thesis was Defended Successfully on 23/10/2024 and approved by

Dr. Nizar Said Supervisor	 Signature
Dr. Imad abu kader External Examiner	 Signature
Dr. Mohammed hayek Internal Examiner	 Signature

Dedication

I want to express my deep appreciation to Dr. Nizar Said for his exceptional guidance and invaluable feedback during my thesis work. His expert advice played a crucial role in shaping my research and bringing it to fruition.

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Finally, I also want to express my sincerest appreciation to my parents, whose constant support and care have been a continuous source of strength and motivation. Their belief in me and encouragement throughout my academic pursuits have been instrumental in my achievements.

Declaration

I, the undersigned, declare that I submitted the thesis entitled:

ASSESSMENT OF PATIENTS' EXPERIENCE IN THE EMERGENCY DEPARTMENTS IN WEST BANK – PALESTINE: A QUANTITATIVE CROSS-SECTIONAL STUDY

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

Student's Name: **Sojoud Bashar Fayez Abdullah**

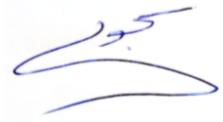
Signature: 

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Table of Content

List of Tables

List of Figures

List of Appendices

ASSESSMENT OF PATIENTS' EXPERIENCE IN THE EMERGENCY DEPARTMENTS IN WEST BANK – PALESTINE: A QUANTITATIVE CROSS-SECTIONAL STUDY

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Dr. Nizar Said

Abstract

Introduction: The experience of patients in healthcare institutions is a complex and multifactorial, and is related to sociodemographic, cultural, and institutional factors, and their perceptions of healthcare services. This is more obvious in critical and overcrowded settings like emergency departments (EDs), in which the following study aimed to assess patients' experience in selected Palestinian hospitals, as well as the main demographic and patient-related factors affecting the general experience level.

Method: The study implemented a cross-sectional, quantitative design on a convenient sample of 405 adult patients who visited EDs in the targeted hospitals, and were asked to fill in a valid questionnaire called the Accident and Emergency Department Questionnaire (A&ED) that was translated and back-translated to Arabic language, and validated by 5 experts. Data were treated in anonymity and confidentiality and were analyzed using SPSS software.

Results: The median age of patients was 28 years old (IQR = 2), with (57.8%) females, (24.2%) visited the ED for respiratory system indication, (27.2%) care for others, and (72.8%) of the questionnaires were filled in by the patient. More than half of the patients reported being treated in dignity and respect all of the time (56.0%), which was reflected by positive opinions related to waiting, communication, environment, and other domains, resulting in a satisfactory median score of overall experience (7 out of 10), which was significantly higher with age ($r = 0.114$, p-value = 0.022), female patients (p-value = 0.010), who did not suffer from health conditions for the last 12 months (p-value = 0.012), who do not care for others (p-value = 0.038) and when the questionnaire was filled in by the patient himself/herself (p-value < 0.001).

Conclusion: The overall experience of Palestinian patients in EDs is moderate, and affected by several factors, which should be considered in continuous and evidence-based programs that enhance environmental and institutional factors and target the improvement of HCPs skills and emergency dynamics. Further longitudinal research is needed that covers more related factors.

Keywords: Patient, Experience, Perception, Emergency Department, Emergency Room

Chapter One
Introduction and Theoretical Background

1.1 Background

The Palestinian Ministry of Health (MoH) recorded a total of 2,653,913 emergency visits throughout Palestine in 2022, with 1,035,032 of these occurring in West Bank's emergency departments (Ministry of Health, 2023). In comparison to the United Sates (US), latest statistics by the National Hospital Ambulatory Medical Care Survey (NHAMCS) recorded an estimate of 140 million visits to the emergency departments (EDs) as of 2021, which translates to about 43 visits per 100 people (National Center for Health Statistics, 2021). Further details in the US revealed that the estimated ED visits have increased between 2016 and 2019 in the rural areas from 16.7 million to 28.4 million, compared to an increase from 98.6 million to 117.2 million in the urban areas (Greenwood-Ericksen & Kocher, 2019).

The previously mentioned statistics, both in the national and international levels, highlights the importance of studying patients' experience in the EDs. In addition, several phenomena are witnessed in EDs that affect the patients' experience, like overcrowding, which is a unique characteristic of EDs. Overcrowding is defined as "the situation in which ED function is impeded primarily because of the excessive number of patients waiting to be seen, undergoing assessment and treatment, or waiting for departure comparing to the physical or staffing capacity of the ED" (Australian College of Emergency Medicine, 2021, p. 2), which directly and indirectly affects the patients' experience by affecting safety and privacy, as well as the timing of the services (Yarmohammadian et al., 2017). The effect on patients' experience is also stated by studies that it turns the "ED overcrowding" to "hospital overcrowding", because it affects bed capacity, length of stay (LOS) and experiences with medical staff (McKenna et al., 2019).

While "patient experience" as a term was defined by the Agency for Healthcare Research and Quality (AHRQ) as the "range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities", the definition was limited by not focusing on the lived experience of the patient's illness, and therefore, Zakkar

(2019) proposed a simple classification of the patient experience dimensions, which included five dimensions: healthcare services quality, healthcare politics, health system responsiveness, patient's illness experience and patient's subjective influence, in addition to two manifestations, which are patient's satisfaction and engagement.

The concept of patient's experience was illustrated by Oben (2020) as a continuum, where the patient moves from being a "person", having normal well-being, no disease and lives in the context of family and community, with four important dimensions that define such part, including physical, psychological, social and spiritual. Then, moving to being a "patient", where it happens before the actual contact with healthcare services, as the disease starts to happen, which often triggers his/her fear and anxiety, ending with being a "user", where the contact with healthcare services begins, and the patient takes the role of a consumer or user, taking into consideration that the patient remains the same individual as he/she has always been throughout this hypothetical three-phase continuum of patient's experience. In the hospital-based and primary healthcare settings, leadership and culture are considered the main drivers of the shifting from patient satisfaction to patient experience, where patients expect more than safe and high-quality medical care, but also politeness and shorter waiting times, in addition to comfortable waiting halls and convenient care areas (Karam, 2017).

Research has identified several recurring themes that influence patients' experiences in emergency departments (EDs). Among the most frequently highlighted factors are staff-patient communication, ED waiting times, staff empathy and compassion, as well as the demographics of the patients themselves. Other notable factors include the medical competence of staff, patients' expectations of care, pain management and control, staff professionalism, and effective staff-staff communication (Sonis, Aaronson, Lee, et al., 2018). These elements collectively shape how patients perceive their care and satisfaction during their time in the ED.

Further studies expand on these factors, emphasizing the importance of emotional and competent care in improving patient experience. For instance, the ability of staff to provide compassionate and empathetic care significantly impacts patients' emotional well-being. Additionally, the physical environment of the ED, including cleanliness, comfort, and accessibility, plays a critical role in shaping patients' overall impressions of the care they receive (Graham et al., 2019). A well-organized, welcoming environment

can alleviate stress and contribute to a more positive experience, even in high-pressure settings like EDs.

Patient experience is inherently a complex and multifaceted concept, often intertwined with patient satisfaction. However, measuring it presents several challenges. One key difficulty lies in the lack of consistent terminology and definitions related to patient experience, which complicates efforts to standardize measurement across different healthcare settings. Moreover, patient experience is heavily influenced by individual patient factors, such as personal expectations, emotional state, and cultural background. Patients tend to evaluate their experience based on their expectations of how care should have been provided rather than the objective quality of the medical and nursing care received. This gap between expectation and perception adds to the complexity of assessing patient experience (Berkowitz, 2016).

To address these challenges and enhance patient experience, various clinical practices can be implemented. For example, the use of technology, such as digital communication tools or automated systems, can streamline care processes and improve efficiency. Additionally, fostering a positive work environment for healthcare providers, including reducing burnout and promoting teamwork, can lead to more compassionate and effective care delivery. Lastly, care coordination, which involves seamless collaboration among healthcare teams, ensures that patients receive consistent, high-quality care tailored to their needs.

Patients' experience in the EDs can be improved using several effective and practical interventions, including hourly and leader rounding, which helps in identifying the most common patient needs and the contributing factors, as well as building a trust relationship between patients and medical and nursing staff, reaffirming the commitment of staff and leaders to the patient's own expectations (McFarlan et al., 2019). The World Health Organization (WHO) states that person-centered care includes measures of health system quality and responsiveness, starting from the level of country and health system context, taking into account the facilities characteristics, service types and patients' characteristics, which focus on the main elements of patients' experience, including effective communication, respect, dignity and emotional support, leading to favorable outcomes, like health outcomes, patient satisfaction and confidence in health system (Larson et al., 2019). Also, a competent team of nurses that seeks increasing patient's

satisfaction is an important factor of enhancing patients' experience in EDs (Al-Neyadi et al., 2018).

The focus in the patient's experience is that the care which is delivered should be patient centered, and the enhancement of such experience results in the improvement of overall wellbeing, with several actions that can be implemented to encourage the patient-centered care (PCC), including effective communication, proper history taking that is thoughtful and sensitive to the cultural differences, and the utilization of guideline-based care in an efficient and appropriate way, in addition to remembering that such experience can be objectively measured and monitored, and therefore scientifically improved (Edwards & Jason, 2017). It is true that hospitals that provide high quality medical care tend to have patients that are more satisfied and with positive experience, but the terms of clinical quality and patient experience should be seen as distinct but inter-related aspects of quality of care that is provided, and because experience is related to several patient related factors, the adjustment of patient experience scoring and measurement is needed as it increases the acceptability of their results to healthcare providers (HCPs) (Ahmed et al., 2014).

In Palestine, the quality standards for EDs involves two main pathways: clinical and administrative, where the clinical pathway domain consists of nine subdomains, including treatment/transfer of emergency patients, followed by triage system, medication safety, guidelines and protocols, ambulance services, patient flow and their length of stay, and medical diagnostic services, while the administrative pathway domain consisted of other subdomains, like access, location and design of the department, documentation and information management system, styles of leadership and management, training and staffing of workforce, equipment, capacity, including resuscitation rooms, resources that are allocated to support a safe working environment, and patient safety-infection prevention and control program, with the performance indicators, which adds up to a total of 103 standards of care in the Palestinian EDs, affecting the patients experience and the quality of care (Bani Odeh et al., 2024). On the other hand, the emergency services in Palestine are highly affected by the Israeli occupation, which arises from their violation of human rights, that have contributed to deficiencies in high-risk cases and presentations management to Palestinian EDs, and is caused by Israeli occupation's specific actions of movement restrictions, as well as restrictions of getting drugs and medical equipment,

and the development of a national healthcare system in Palestine (Rosenbloom & Leff, 2022).

In the Palestinian healthcare context, the patient experience is extremely influenced by the geopolitical challenges and ongoing conflict (Najjar et al., 2021; Sousa & Hagopian, 2011). The construction of barriers in the West Bank has notably disrupted access to healthcare services, directly impacting patients' ability to receive timely and adequate medical care, and this disruption has led to significant economic and social consequences, affecting the well-being of patients. Additionally, the lack of an organized approach among healthcare professionals, compounded by political instability and economic hardships, has resulted in obvious gaps in health outcomes (Mahmoud, 2013). A study found that, because of the movement restrictions that the Israeli occupation put on medical services, patients who reach EDs after being delayed at checkpoints significantly have higher admission rates (32%) compared with non-delayed patients (13%), taking into account that 18% of the ED contacts in Palestine are delayed because of the occupation, resulting in increasing the severity of presented medical conditions (Rytter et al., 2006).

As the experience of patients in EDs is also reflected by their satisfaction level, a study in Palestine showed that the overall satisfaction of patients in the Palestinian EDs had a mean score of 3.77 out of 5, indicating an overall acceptable level (Amro et al., 2018), which calls for the necessity of assessing the experience of patients in the Palestinian EDs as a cardinal aspect of their satisfaction towards healthcare services and HCPs. Therefore, the current study aims to measure the patients' experience in the Palestinian EDs in the West Bank, as well as to investigate the most common corresponding factors to the experience level, including patients' sociodemographic factors.

1.2 Problem Statement

Emergency departments (EDs) are often characterized by their fast-paced and overcrowded environments, creating significant challenges that impact the patient experience. Multiple factors influence the quality of care and the perception of patients in EDs, including those related to staff and management. Staff-related issues, such as skepticism or lack of empathy from medical and nursing teams, can adversely affect patient satisfaction (McFarlan et al., 2019; McKenna et al., 2019). Managerial challenges, such as the unavailability of leaders due to busy schedules, further exacerbate these issues.

Moreover, patient-specific factors, such as their emotional and psychological state, also play a vital role in shaping their overall experience (Al-Neyadi et al., 2018). A fundamental challenge lies in the fact that healthcare providers (HCPs) may occasionally view patients as routine consumers rather than individuals seeking vital healthcare services, thereby diminishing the quality of interaction and care provided.

From my own perspective, the situation in EDs within Palestine reflects many of these challenges while presenting additional unique factors that negatively affect patient experiences. Palestinian EDs often operate in chaotic and stressful environments, which significantly influence the emotional and psychological well-being of patients. These conditions frequently leave patients feeling vulnerable, disrespected, and undervalued. For instance, the overwhelming nature of EDs creates an atmosphere where patients may perceive a lack of attentiveness and personal care. Additionally, there are considerable barriers to accessing accurate and timely information, leading to confusion and mistrust among patients.

Resource limitations further compound these challenges, resulting in delays in delivering care and fostering frustration among both patients and healthcare providers. In Palestinian EDs, the strain on resources is amplified by the broader political and economic burdens associated with the ongoing conflict. Healthcare staff often face extreme levels of fatigue and burnout due to these pressures, which directly impacts the quality of care they can provide. The mental and physical exhaustion of healthcare providers undermines their ability to meet patients' expectations, leaving patients dissatisfied and unfulfilled.

A significant issue in Palestine is the limited research available on patient experience within healthcare systems, particularly in EDs. While some governmental hospitals in Palestine have introduced patient satisfaction surveys, these initiatives remain largely underdeveloped and lack rigorous, peer-reviewed research to validate their findings. Satisfaction surveys, though a step in the right direction, often fail to capture the full scope of patient experience. Comprehensive studies focusing on patient perspectives are essential for identifying gaps in service delivery and improving the quality of care in EDs and other healthcare settings.

The lack of empirical studies addressing patients' experience within the Palestinian healthcare context highlights a critical gap in the literature. Despite the importance of

understanding and improving patient experiences, there are no published studies specifically measuring patient experiences in EDs. This dearth of research underscores the need for systematic investigations to provide evidence-based insights. Such studies would enable healthcare providers, policymakers, and administrators to implement targeted interventions aimed at enhancing patient satisfaction and care quality.

In conclusion, the factors affecting patient experience in EDs are multifaceted, involving staff, managerial, and environmental elements. In the context of Palestinian EDs, these challenges are further intensified by the political and economic realities of the region. Addressing these issues requires not only improving resource allocation and staff support but also conducting detailed studies to capture patient perspectives and identify actionable solutions. The absence of research in this field calls for urgent attention to develop and implement strategies that promote patient-centered care, ensuring a more humane and effective healthcare system in Palestine.

1.3 Significance of the Study

Measuring patient experience in emergency departments (EDs) is a crucial step in evaluating and enhancing the quality of healthcare services. It provides valuable insights into various aspects of patient satisfaction, safety, and the overall effectiveness of care delivery. By understanding patient perspectives, healthcare providers can identify areas that require improvement, such as reducing wait times, enhancing communication, and creating a more comfortable and efficient care environment. From my perspective, obtaining feedback from patients is not only vital for improving their health outcomes but also for fostering a culture of patient-centered care. This approach ensures that healthcare services are designed around the needs and expectations of the patients, ultimately guiding policy and operational decisions in healthcare settings.

For instance, findings from this study could be instrumental for policymakers in improving several critical areas. These include emergency response times, staffing policies, patient safety regulations, and standards of privacy and confidentiality. Furthermore, the results may provide actionable insights for enhancing communication and information-sharing practices, as well as guiding infrastructure development to create better facilities. By leveraging patient feedback, healthcare leaders can address access-to-care challenges and promote initiatives that prioritize patient-centered care. Such

improvements are essential for ensuring that healthcare services are both effective and responsive to patient needs.

Additionally, this study emphasizes the importance of investigating differences in patient experience based on individual factors such as age, gender, socioeconomic status, and other demographic variables. Such an approach allows healthcare administrators to address disparities in care and work towards improving the equity of the services provided. In my opinion, this focus on individual variations in patient experience can lead to more tailored and inclusive healthcare practices. By accounting for these demographic factors, EDs can deliver more personalized care that meets the unique needs of diverse patient populations.

The assessment of patient experience, as conducted in this study, holds the potential to make EDs more responsive and efficient. It highlights areas requiring immediate attention while offering a roadmap for long-term improvement. Ultimately, this benefits not only the patients by ensuring better care outcomes but also the healthcare providers by fostering a system that is more aligned with patient expectations. A patient-focused approach strengthens the relationship between patients and providers, leading to greater trust, satisfaction, and overall improvements in healthcare delivery.

1.4 Aims of the Study

The current study aims to:

1- Assess the patients' experience in the Palestinian EDs using a valid tool that evaluates several domains related to satisfaction, perception, team and communication, in the West Bank – Palestine.
2- Identify most common sociodemographic factors of patients that affect their experience in EDs in the West Bank – Palestine, including age, gender, health-related issue and severity, ... etc.
3- Propose recommendations for enhancing patients' experience in the Palestinian EDs in the West Bank.

1.5 Questions of the Study

The current study will try to answer the following questions:

1- What is the level of patients' experience in the Palestinian EDs in several domains related to satisfaction, perception, team and communication, in the West Bank – Palestine?
2- How do sociodemographic factors of patients affect their experience in EDs in the West Bank – Palestine, including age, gender, health-related issue and severity, ... etc.?
3- What recommendations can be proposed for enhancing patients' experience in the Palestinian EDs in the West Bank?

1.6 Hypotheses of the Study

H_0: The overall experience of patients in emergency departments in Palestine was satisfactory.

H_0: There is no significant difference in patients' experience in emergency departments according to demographic factors of the patients (age, gender, health conditions in the last 12 months, caring for others and who filled the questionnaire) at a significance level of 0.05.

1.7 Definition of Terms

1.7.1 Conceptual Definitions

Experience of patients: Patient experience in the context of emergency departments refers to the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care, and it contains a range of interactions that patients have with the healthcare system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities (Wolf et al., 2014). Specifically, in the emergency department setting, it pertains to the immediacy of response, the quality of communication, the degree of compassion and empathy conveyed, the efficiency and effectiveness of clinical care, the physical and emotional comfort provided, and the overall sense of safety and trust engendered in patients during their visit (Wolf, 2017). This definition acknowledges the critical nature of care delivery in emergency contexts, where patient experiences are significantly shaped by the urgency, stress, and unpredictability of situations.

Emergency Department (ED): A specialized unit within a hospital or medical facility that provides immediate and acute care to patients with a wide range of medical conditions that require urgent attention, with a primary function of patient stabilization and the management of life-threatening conditions, injuries, or illnesses until further care can be provided, either within the hospital or through referral to other healthcare services (Welch et al., 2011)

1.7.2 Operational Definitions

Experience of patients in the context of this study, "patient experience" refers to the assessment of multiple care-related dimensions within emergency departments (EDs) as captured through the standardized Accident and Emergency Department Questionnaire (A&ED). This definition focuses on systematically examining patients' perspectives on their care experiences, offering a structured framework to evaluate various domains critical to healthcare delivery in EDs. These domains include communication with healthcare providers, waiting times, quality and clarity of information, privacy, and the overall care environment.

By utilizing the A&ED, this study employs a quantitative, cross-sectional approach to capture patient experiences in EDs across the West Bank. This approach ensures that the analysis is grounded in measurable and specific aspects of care, providing insights that are essential for understanding and improving patient satisfaction and outcomes. Furthermore, the use of this tool highlights the importance of focusing on patient-centered care, as it systematically gathers feedback on the factors that matter most to patients. Understanding these factors enables healthcare providers and administrators to identify areas for improvement, ultimately enhancing the quality of care delivered in EDs.

The study also acknowledges that patient experiences are shaped by their expectations, prior healthcare encounters, and personal circumstances, such as age, gender, and cultural background. These individual factors further emphasize the need for a tailored approach to care delivery, ensuring that the services provided align with the unique needs and expectations of each patient.

Emergency departments (EDs) are essential healthcare units operating 24/7 to provide immediate care for acute medical conditions. They are characterized by fast-paced and high-pressure environments, which often create unique challenges for maintaining a

positive patient experience. The quality of care in EDs is influenced by several key factors, including waiting times, the efficiency of care delivery, staff-patient communication, and the overall atmosphere of the department (Gordon et al., 2010).

Waiting times, in particular, are a critical aspect of patient experience, as long delays can lead to frustration, anxiety, and dissatisfaction among patients. Effective communication between healthcare providers and patients is equally vital, as it fosters trust, ensures patients are informed about their condition and treatment, and helps reduce confusion and stress. Additionally, the efficiency of care delivery, which involves timely diagnosis, treatment, and discharge processes, plays a significant role in shaping the overall experience.

The atmosphere within the ED, including cleanliness, noise levels, and the availability of private spaces, further impacts patients' perceptions of their care. By addressing these factors, healthcare institutions can work towards creating an ED environment that prioritizes patient-centered care and ensures a better overall experience for those seeking emergency medical attention.

1.8 Literature Review

The following review of literature was based on searching scientific databases of PubMed, Science Direct and Google Scholar of studies that are mostly related to the patients' experience in EDs, which have been published in English language, peer-reviewed journals in the recent years, using the following keywords: patient, experience, emergency department, emergency room. The conclusion of this literature review is that several factors, including demographic and patient-related factors, play a role in their experience when visiting EDs, as well as that results may vary depending on the used tool to measure patients' experience, in addition to that patients' experience in the EDs is unique compared to other hospital departments, mostly related to the overcrowded environment and fast-paced work nature.

A scoping review of studies that aimed to evaluate patients' experience in the ED found that a variety of tools included different domains in their assessment, with the most domains are in the National Health Service (NHS) Trust questionnaire, including 10 domains, while Accident and Emergency Department Questionnaire (A&ED), which contained 6 of these domains, including arrival at ED, waiting, doctors and nurses, pain,

leaving ED and the overall experience (Oyegbile & Brysiewicz, 2020). Despite the challenges that EDs have, as well as drivers that affect the patients' experience, including communication, patient expectation, environment, pain control and other convenience factors, some studies have focused on the potential of improving patients' experience in ED, focusing on creating a model of improvement that includes several measures and metrics (Sonis, & White, 2020).

Aaronson, Lee, et al. (2018). For example, on the context level, managers should focus on categorizing the factors they find to affect the patients' experience to system-, patient, staff- and leadership-related factors, while on the level of service delivery, patient-centered care is the focus, involving their perception of ED and staff, as well as the staff capacity (Lee, 2016), which actions and interventions are built accordingly. Lastly, on the outcomes level, patients' experience includes a variety of variables, like care quality and efficiency, reducing complaints, confidence in team, staff morale and positive feedback loop (Sonis & White, 2020).

For the purpose of experience research, it is suitable to conduct a qualitative study, which was done by Blackburn et al. (2019), using focus staff groups and patient family interviews, targeting the outcomes and effects of communication and information. The results showed that several themes are involved in communication, which focused on patients being continuously informed about their situation, and the timing, mainly how much time the patient will wait. The second theme focused on the explanation of the treatment and care, including the explanation of being triaged, while the third theme focused on the explanation of ED itself, followed by the theme of written communication, although it should take the literacy level of patients in consideration. The study concluded the importance of communication and information on the empowerment of patients and their patient satisfaction and experience improvement. The interventions needed to improve patients' experience in ED are mostly simple and easy to apply, requiring nonsignificant financial investment, focusing on patient engagement, connection, empathy and being closer to them (Aleksandrovskiy et al., 2022).

A rigorous American study utilized a retrospective cohort study on a sample of 7,872 ED patients who were contacted via telephone and asked to answer a questionnaire that was used to investigate the most commonly related factors that affect their experience in a large, academic medical center, with factors predicting their satisfaction and

dissatisfaction, using chi-square and multivariate logistic regression. Results showed that better patient experience and satisfaction were significantly predicted by older patient's age, shorter time to initial evaluation, being updated on waiting time, better cleanliness of waiting area, shorter time to be seen by a doctor, family/friends being updated, presentation of doctors with respect and courtesy, listening carefully, staff talking about pain, comfortable waiting beds, higher perceived teamwork, shorter total time spent in ED and help that is received in healthcare. The researchers concluded the significant impact of teamwork, communication, waiting time, environment and perceived helpful healthcare on the patient's experience in EDs (Aaronson, Mort, et al., 2018).

In a retrospective cohort study of more than 9,000 patient records of ED visits, the researchers aimed to investigate the most common factors that affect discharged patient-reported experience as affected by crowding and used a 10-point scale to categorize the patients to detractors (negative patient experience, who had the scores of 0 to 6), while scores of 7 to 10 categorized the patient's experience as non-detractor. The results showed that several factors significantly predict patient's experience as detractor, including the type of the ED service, with more acuity of care significantly predicting more detracting experience, mostly related to the physical status and consciousness of the patients (OR down from 0.71 to 0.19). Also, patients' gender significantly predicted the detracting experience, with female gender predicting less detracting experience (OR = 0.60, p-value < 0.001), as well as larger number of ED care areas (OR = 1.62, p-value < 0.001) and waiting rooms (OR = 1.16, p-value = 0.031). Also, patients who left ED against medical advice (AMA) have predicted higher detractor (OR = 5.15, p-value < 0.001), as well as having higher length of stay in hours (OR = 1.71, p-value < 0.001). The study emphasizes on the negative impact of ED overcrowding on the patients' experience, and therefore it is a worth focusing on it (Berlyand et al., 2022).

Pain can be considered of the most commonly concerned aspects of care that affects patient's satisfaction and experience in ED, which is simply related to that pain is mostly the sole or priority symptom that leads to ED visit. Therefore, a study utilized a prospective cohort design on a sample of 190 adult patients in Australia in order to assess the impact of several aspects of patient care in EDs on their overall experience. Results of the predictors of better experience related to different aspects were tested using regression models, where better experience of getting timely care was significantly predicted by arriving using an ambulance service, having an insurance, reaching the

targeted area of emergency care (resuscitation or acute care rooms), less daily presentation, shorter time to be seen, administering analgesic medications and shorter time to administering them. Moreover, a better experience of communication with nurses and doctors was significantly predicted by younger age of patient, shorter time to be seen, and having higher rate of overall health, while better experience of pain care was significantly predicted by reaching to the targeted treatment are rather than ramping or waiting room, administering analgesic medications and shorter time to administer them. Lastly, the overall experience of care was significantly predicted by shorter time to be seen, shorter time to administer analgesics and not having 3 or more ED visits in the last 6 months. The authors concluded the importance of assessing such factors because they help in modifying the current practices to enhance pain and overall care of emergency patients (Hughes et al., 2021).

Different ED types have specific considerations, like the pediatric EDs. A study on 170 families of pediatric patients has been conducted using a structures questionnaire of 12 question. Results showed that 38.8% and 30.6% of the patients waited for less or equal to the expected time, while 77.6% rated the environment as very clean, 90.0% stated they have received an explanation of the treatment by doctors and nurses, compared to 81.1% who stated that doctors and nurses have done what is necessary to keep the patient and the family calm and reassured. Also, a high percentage of 81.7% stated they have been treated in privacy, and the overall experience was rated as very well (the highest rating) by 80.0% of the patients and their families (Parra et al., 2020). Some studies also recommended the inclusion of children in the assessment of patients' experience in pediatric ED, rather than depending on parents only. A study included 109 children (older than 7 years old) and 237 parents in a quantitative study to examine the experience, and found that having enough to do (like toys, ... etc.) while waiting (53.5%) and restarting usual activity timing (34.7%) were the highest problem detected by both parents and children, while significant differences in the problems were seen when taking parents or children separately. This difference included that parents significantly detected problems of nurses and doctors explaining what they are doing (19% vs 24.7%) and privacy while treating (17.3% vs 36.7%) less than children, respectively (Bal et al., 2020).

Focusing on the discharge process in EDs, a retrospective, observational study was conducted in the United States on a consecutive sample of 4,103 patients in the pediatric ED to investigate the impact of diagnostic decisions on the patient's satisfaction in EDs,

where they have found significantly better experience with shorter waiting time, and having diagnostic work, like magnetic resonance imaging (MRI), x-ray and/or electrocardiogram (ECG), as the main diagnostic factors, while prescribing antibiotics at discharge was found to be the only significant factor to have an impact of the treatment factors (Gorski et al., 2022).

In a Palestinian study that recruited a sample of 199 emergency nurses, a 27-item questionnaire was used to investigate the most commonly perceived barriers to effective nurse patient communication in EDs. The results showed that environmental factors were considered the highest affecting nurse-patient communication, followed by knowledge-related factors, which were significantly perceived higher among male than female, and older than younger nurses, psychological factors, social factors, economic factors and demographic factors. Based on such findings, the researchers recommended nurses to have a pre-registration training on ED environment and its dynamics, which can include role playing, simulation training and case scenarios, as well as recommending actions to be implemented by stakeholders to improve the ED environment in Palestine, like appropriate and adequate staffing level and maintenance of patient's flow and numbers. It is worth mentioning that this study was published in a challenging period in the healthcare system, which is the COVID-19 pandemic (Al-Kalaldeh et al., 2020).

When appropriately implementing the patient-centered care in EDs, the clinical and quality of care outcomes are the most of what is investigated to ensure that patient experience is efficient and positive. A systematic review included 19 studies that used a valid tool to assess patient's satisfaction in hospital settings, where 10 of them evaluated the clinical outcomes and the other 9 studies evaluated the quality measures. The self-reported mental and physical health of the patients was most significantly related to the HCPs effective communication, which also positively affected the frequency of ED visits, hospital stays, length of stay (LOS) and the rating of the hospital (Navarro et al., 2021). Another qualitative study aimed to evaluate the performance and quality of care in EDs by focusing on the patient experience as a critical measure instead of considering patients solely clinical care measurement. The findings showed that improved quality of care is driven by positive patient experience related to assurance, empathy, information access, reliability, and tangibles such food and surroundings in EDs (Swallmeh et al., 2018).

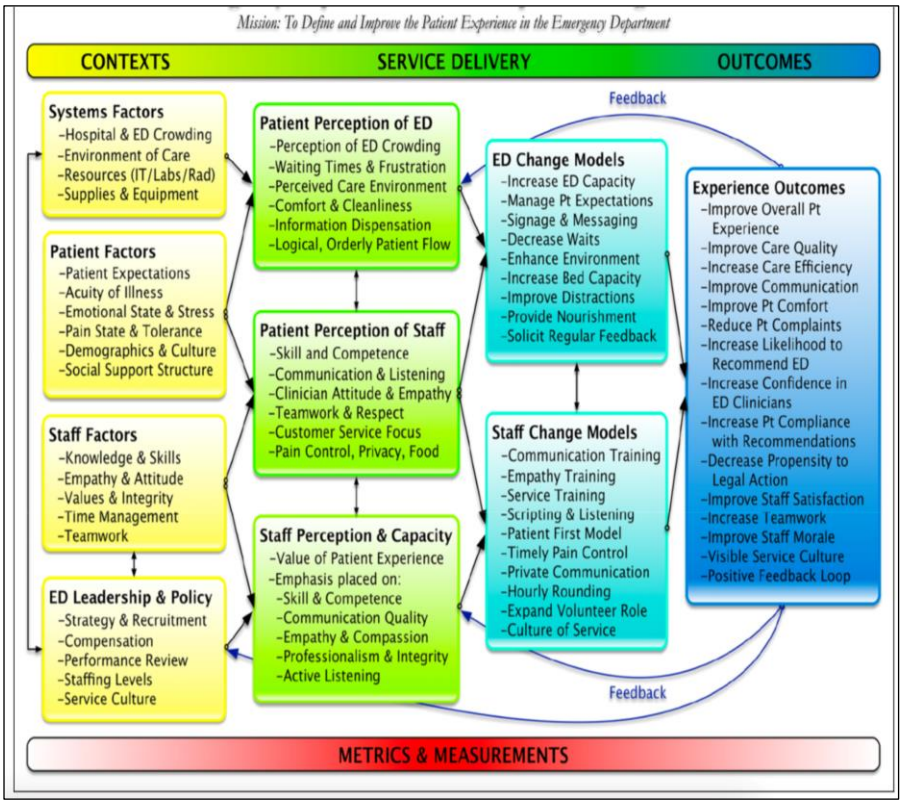
The provision of a patient-centered care is focused on being concerned with the individual variations among patients, including their health condition history, like having mental illnesses. In this context, a qualitative study was conducted on a sample of 10 adults who frequently visited ED for mental health-related issues, and the thematic analysis found that most commonly factors that affect their experience in ED visits are categorized into three themes: experience, providers and protective factors. As the patients perceived their ED visits as necessary to restore their health, they interpreted ignoring such needs by the HCPs as disrespectful and prejudicing. Patients with such conditions are well-known among the team due to their recurrent visits to ED, which was perceived as having positive and negative consequences on the patients, where positive perception resulted in better experience of staff meeting their needs and accommodating their care to account for them. For the protective factors, these included work and having coping skills, where having a job was perceived as having a purpose and responsibility. The researchers emphasized on the necessity of conducting further research to understand the dynamics of EDs towards mentally-ill patients because of their unique and challenging situation with their disorders and the surrounding society (Digel Vandyk et al., 2018).

1.9 Conceptual Framework

The experience of patients in the EDs can be understood using a logic model. For example, a logic model conceptual framework was developed by Sonis, Aaronson, Castagna, et al. (2018) that was provided to understand and improve patient experience in EDs. The model consisted of the context that affect patient's experience, including system, staff and policymakers' factors, in addition to patients factors, like their expectations, acuity of illness, emotional status, pain tolerance, demographic and cultural factors, and the structure of social support. Secondly, the central factors that influence service delivery are the patients' perceptions of ED and staff, as well as the staff perception and capacity. Thirdly, the model included the focus on outcomes, which are defined as the desired and expected changes and improvements after implementing the aspects of service delivery, like increasing capacity, providing nourishment and encouraging feedback loops, with changes to the staff by establishing training and expanding the roles of volunteering.

Figure 1

Emergency Department Pa4ent Experience Logic Model as a conceptual model of the current study

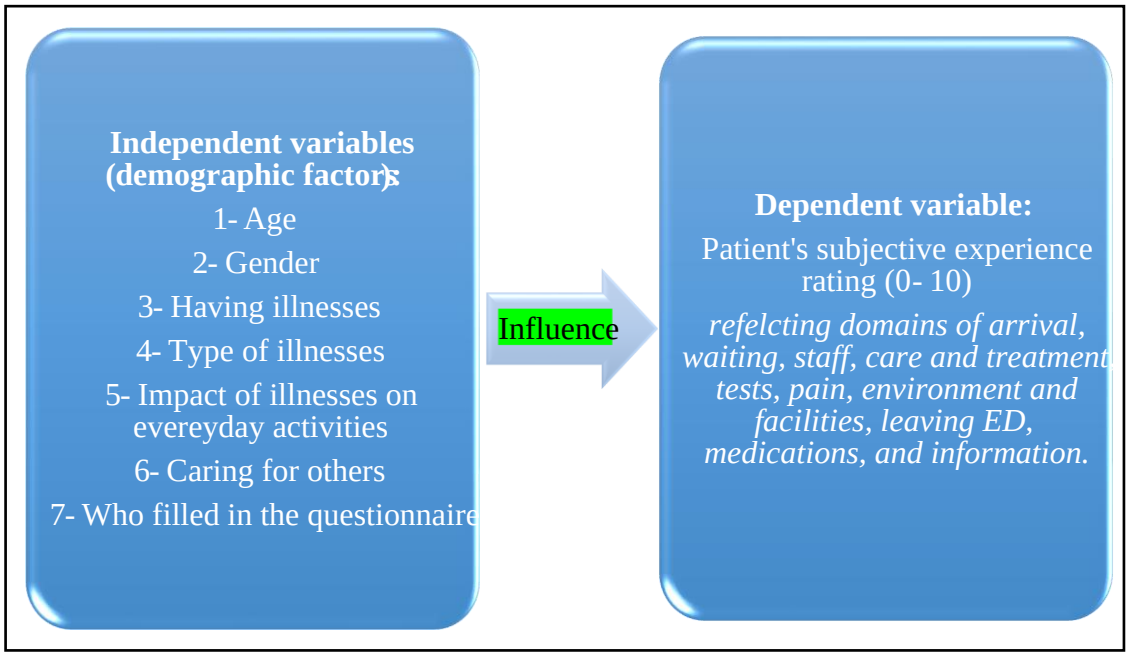


Source: Sonis, Aaronson, Castagna, et al., 2018

In the current study, the conceptual framework that was applied includes a variety of the factors and aspects that were reviewed by the previous logic model, which is illustrated in the following figure, where the independent variables of the demographic factors of the patients include their age, gender, experiencing illnesses and their types, caring for others (social context) and who has filled in the questionnaire, while the main dependent variable was considered to be the overall evaluation of the patient's subjective experience in the targeted EDs, which was rated on a scale from 0 (the worst ever) to 10 (the best ever), taking into account that it was the final question after answering multiple domains of experience in EDs.

Figure 2

Conceptual framework of the current study (Independent variables that were found to mostly appear in the previous literature to influence the pa4ents' experience in emergency departments were selected, with various types of influence, i.e., nega4ve or posi4ve influence, on the main dependent variable, i.e., overall pa4ent's experience)



Chapter Two
Methods

This chapter describes the methodological aspects that were adopted in the current study in terms of design, location, sampling, variables, data collection and analysis and ethical consideration.

2.1 Study Design

The study employed a cross-sectional, quantitative design, in which the researcher recruited a sample of patients who were asked to fill in a structured questionnaire on the experience of patient in EDs, as the data was collected in a single time point without a follow-up. This design is time and cost effective, and allowed the researcher to search for multiple variables and explore the relationship between independent and dependent variables (Kesmodel, 2018; Wang & Cheng, 2020).

2.2 Site and Setting

The setting of the study consisted of the EDs in different private and governmental hospitals in Nablus (Rafidia Surgical Hospital, Al-Watani Hospital, Arab Specialized Hospital, An-Najah National University Hospital) and Ramallah (Palestine Medical Complex, Istishari Arab Hospital, H-Clinic Hospital, Yaffa Specialized Hospital, Arab Care Specialized Hospital). The selected hospitals are suitable for the current study, as they contain EDs with relatively more load of care, resulting in more representation of the overall population of patients who visit EDs in these cities, as they represent the governmental and private sectors of healthcare services in Palestine, and fulfill the need for an appropriate sample size.

The Palestinian Central Bureau of Statistics (PCBS) reported that as of 2022, Palestine has a total of 93 hospitals, comprising 29 governmental and 64 non-governmental facilities, with an overall bed capacity of 6,900. This equates to a ratio of 1.3 beds per 1,000 residents. In the West Bank, the hospital count stands at 58, including 18 governmental and 40 non-governmental, providing 4,286 beds, maintaining the same bed-to-citizen ratio of 1.3 per 1,000 (Palestinian Central Bureau of Statistics, 2023). The targeted settings represented the EDs in Nablus and Ramallah cities with variations in the number of patients received in EDs, reflecting the crowding level, and the complexity of

cases, as well as receiving patients with different insurance types. Such factors strengthen the representation of the recruited sample to be more generalizable to the overall Palestinian patients in EDs in Nablus and Ramallah cities.

2.3 Sample and Sampling

The study population included all patients who visited EDs, regardless of age, gender, chief complaint, type of ED, … etc., and the sample was calculated using Raosoft Sample Size Calculator, based on (5%) margin of error, (95%) confidence level, and a population size of the total ED visits in West Bank as of 2022 (1,035,032), according to the latest available annual health report by MoH. The calculated sample size was 385 patients, in addition to (10%) of the calculated sample size who were added for the attrition, and therefore the total required sample size was 424 patients who were conveniently recruited from the EDs of the study settings. On the other hand, the overall sample size that was analyzed was 405 patients, where 19 questionnaires were disposed due to incomplete answers that affect the overall data analysis process, like several consecutive missing answers and not answering several demographic factors.

2.4 Eligibility Criteria

Inclusion criteria: Adult patients (18 years old and more), and who agreed to participate, regardless of the healthcare service type that referred him/her to the targeted ED, as well as to the demographic characteristics.

Exclusion criteria: Patients who are diagnosed with mental illnesses, who presented to the ED with a serious medical condition (identified by labeling as “red” using the triage system or the need for a resuscitation room care), who have multiple visits in the last three months and who refused to participate.

2.5 Study Variables

Independent variables: The sociodemographic data of the patients (age, gender, educations, presence and type of illnesses in the last 12 months and their impact of everyday life, caring for others and who filled in the questionnaire).

Dependent variable: The experience of the patients in EDs as scored in A&ED tool.

2.6 Data Collection Tool and Process

Data collection was done using a self-administered questionnaire that contains two main sections (Appendix B). The first section is related to the demographic variables of the patients, while the second section contained the Accident and Emergency Department Questionnaire (A&ED) (Bos et al., 2013), which is a tool developed for assessing patient experiences in EDs, and encompasses various domains, including arrival, waiting, staff, care and treatment, tests, pain, environment and facilities, leaving ED, medications, and information.

The 47^{th} question in the A&ED questionnaire consisted of a score from 0 (the worst ever) to 10 (the best ever) overall experience, which was used as the quantitative representation of the dependent variable of the study (overall experience level).

Data collection process involved recruiting the patients from the targeted EDs in a nonprobability way, where the researcher patients that applied to the inclusion criteria to participate in the study, after explaining the aims and process of data collection, with no further follow-up, and the patients helped in disseminating the questionnaire to more patients they know they have visited the targeted EDs, i.e., in a snowball sampling method. The data collection took an average of 10 to 20 minutes from each patient, which was noticed to vary according to the educational level of the patient, as well as the type of person who filled in the questionnaire, whether it was the patient himself/herself, a friend/relative, both of them, or a healthcare provider.

2.7 Piloting

Before the official data collection, (10%) of the calculated sample size (39 patients) were asked to participate in a piloting phase, in which the questionnaire was filled by the patients, and was followed by feedback questions about the clarity and relevance of the questions, what parts found difficult, and calculate the mean time to complete the questionnaire.

The feedback on the questionnaire's items was generally positive, as all of the questions are close ended, in addition to its broad coverage of several dimensions of the care that is delivered in EDs. Also, the questionnaire was found to be suitable for the Palestinian EDs context after its translation and editing some of the demographic factor's questions.

The researcher recruited patients who visited EDs outside of the targeted hospitals to ensure not being included in the final data analysis.

2.8 Validity and Reliability of Study Tool

The tool was developed by Bos et al. (2013), and is designed to measure patients' experiences in the Accident and Emergency Department (Appendix A). The questionnaire's development involved analyzing data from 151 hospital trusts, covering 49,646 patients, and the process ensured the questionnaire's validity and reliability in assessing various aspects of patient experience in the emergency department setting, therefore, it is considered a robust tool for evaluating and comparing healthcare performance across different emergency departments.

The original questionnaire was translated into Arabic language (Appendix B) to suit the Palestinian emergency patient's population, which was done by translation and back-translation method by two native speakers of both languages. The translated version was also reviewed by 5 experts in the study's field, including 2 faculty doctors, 2 experienced emergency nurses and an emergency doctor. Some questions were modified in the Arabic language form that was finally used in the data collection phase to suit the Palestinian context, including modifying the 56th question related to religion to have only 3 options: Islam, Christianity and others. Also, the 57th and 58th questions related to sexual characteristics and ethnic group, respectively, were deleted.

For reliability, internal consistency was measured on the piloting phase sample using Cronbach's alpha test, with a cut point of 0.70 for an acceptable reliability score. The Cronbach's alpha test had a result of 0.788, indicating an overall acceptable reliability level, and therefore the results of the current study can be generalized on the population of Palestinian patients who visit EDs.

2.9 Data Analysis

For the purpose of data analysis, Statistical Package for Social Sciences (SPSS) software version 25.0 was used to produce the descriptive and analytical results of the study's data. The descriptive results included frequencies and percentages of the patients' responses to their demographic factors and items of A&ED, as well as median and interquartile range (IQR) of scale variables and scores of A&ED, taking into account that non-parametric tests were used as the normality test using Kolmogorov-Smirnov and Shapiro-Wilk tests showed the rejection of null hypothesis regarding the normal distribution of the study data (p-value < 0.001).

The analytical results investigated the relationship between study's independent variables (demographic factors) and the dependent variable (patient experience scoring), in order to test the study's hypotheses. Inferential tests included Mann-Whitney U and Kruskal-Wallis to test the differences in mean ranks of A&ED experience across the categories of the demographic factors, while Spearman Correlation test will be used for the test of correlation between scale demographic factors and scores of A&ED experience, with 0.05 as the cut point of p-value to consider significant relationships.

2.10 Ethical Considerations

Every study process followed the guidelines set forth in the Helsinki Declaration for research with human beings. Approval was granted from the Institutional Review Board (IRB) of An-Najah National University before the start of the data collection, which was followed by the approval from the MoH for starting data collection from the governmental settings, and from each of the private settings individually. Also, before any data was collected, an Arabic consent form (Appendix C) was received from each participant, indicating that answering the online form questionnaire was considered an implied consent to participate.

As the targeted population was patients who visited EDs, the researcher intended to implement several aspects of ethical rights of patients in clinical research, including beneficence, where the overall aim of the study was to collect subjective data about their experience in EDs, which can be used as valuable insights into the potentials of developing and improving healthcare services that are provided in the Palestinian EDs. In addition, the principle of non-maleficence was applied, where every effort was made to minimize potential harm or discomfort of patients during data collection, including using non-invasive data collection method (filling in a questionnaire), as well as assuring that the collected data will not affect the type or quality of the healthcare services provided to them. Also, the principle of justice included equitable selection and recruitment from diverse backgrounds to ensure the representativeness of the sample to the overall population.

The names and phone numbers of the participants were kept anonymous, and the data were used by the researcher and the supervisors for research purposes only. Finally, the patients had the ability to withdraw from the participation at any time, without the need to declare any reasons.

Chapter Three
Results

The current chapter is concerned with the descriptive and analytical results of the current study related to the patients' experience inside selected emergency departments (EDs) in Palestine. The descriptive results include the frequencies and percentages of the patients' demographic data, and their responses to the different domains of accident and emergency department questionnaire (A&ED) items. Moreover, the analytical results investigate the relationship between the patients' demographic factors and the scores of specific domains that the researcher was able to give a specific score to them.

3.1 Part 1: Demographic data of the patients

The sample of the study consisted of 405 patients who visited targeted EDs, with the majority of the patients were between 18 and 30 years old (71.3%), and a median age of 28 years old (IQR = 9), ranging from 18 to 66 years old. The sample also consisted of more female patients (57.8%), and mostly did not have specific health conditions that lasted or were expected to last for 12 months (83.7%). Of those who stated having such health conditions, the most common were breathing problems (24.2%), such as asthma, followed by joint problems (18.2%), such as arthritis, then diabetes (15.2%) and equal percentage for both heart problem (such as angina) and mental health condition (12.1% each). Also, among such patients, (39.4%) of them stated that these health problems reduce their ability to carry out day-to-day activities a little, while 30.3% said they do a lot.

When all patients were asked about experiencing specific issues in the last 12 months, around two thirds (65.3%) stated that they did not experience any of them, which included problems with physical mobility (11.5%), falls that needed medical attention (10.0%) and feeling isolated from others (16.2%). Also, more than two thirds of the patients (72.8%) stated they were not caring for another person, a family member, relative or friend in terms of long-term physical or mental disability or age-related problems during the attendance to ED. Most of the questionnaires were filled by the patients themselves (72.8%).

Table 1

Distribution of patients' demographic data

Variables	Values	Frequency	Percentage
Age	18 – 25 years old	135	33.30%
	26 – 30 years old	154	38.00%
	31 – 35 years old	49	12.10%
	36 – 40 years old	22	5.40%
	> 40 years old	45	11.10%
	Median (IQR), min – max	28 (9), 18 – 66	
Gender	Male	171	42.20%
	Female	234	57.80%
Do you have any health issues that have lasted or are expected to last for 12 months or more?	No	339	83.70%
	Yes	66	16.30%
If "Yes", what conditions do you have?	Breathing problem	16	24.20%
(Multiple selection)	Blindness or partial sight	6	9.10%
	Cancer in the last 5 years	2	3.00%
	Dementia or Alzheimer's	4	6.10%
	Deafness or hearing loss	0	0.00%
	Diabetes	10	15.20%
	Heart problem	8	12.10%
	Joint problem	12	18.20%
	Kidney or liver disease	6	9.10%
	Learning disability	2	3.00%
	Mental health condition	8	12.10%
	Neurological condition	4	6.10%
	Autism or ASC	4	6.10%
	Stroke*	2	3.00%
	Another long-term condition	12	18.20%
If "Yes", Do any of these reduce your ability to carry out day-to-day activities?	Yes, a lot	20	30.30%
	Yes, a little	26	39.40%
	No, not at all	20	30.30%
Have you experienced any of the following in the last twelve months?	Physical mobility problem	46	11.50%
	Falls**	40	10.00%
	Feeling isolated from others	65	16.20%
	None of these	262	65.30%
Caring for other(s) for long-term or age-related physical or mental illness?	Yes	110	27.20%
	No	295	72.80%
Who was the main person or people that filled in this questionnaire?	The patient	295 69	72.80%
	A friend or relative		17.00%
	Both	37	9.10%
	The patient with HCP help	4	1.00%

Not: HCP = Healthcare provider, ED = Emergency department, IQR = Interquartile range, ASC = autism spectrum disorder, * = A stroke that affected the day-to-day activities, ** = that have needed medical attention

3.2 Part 2: Accident and Emergency Department (A&ED) Questionnaire

This part is dedicated to distributing the frequencies and percentages of patients' responses to items related to all domains of A&ED questionnaire.

3.2.1 Patient's Arrival and Waiting

Most of the patients (73.8%) reached to ED the first service to help, while among patients who did not reach the current ED first, 51.9% of them stated they went to a private doctor clinic, and (47.2%) stated that they were the reason of coming to ED. Majority of the patients stated they did not reach the ED with an ambulance (84.0%), while among patients who reached the ED with an ambulance, (63.1%) of them stated they did not have to wait with the ambulance crew before handing their care to the ED staff.

Around half of the patients (48.9%) stated they were definitely given enough privacy when discussing the condition with the receptionist, while (64.9%) stated they were not treated in a separate area because of having coronavirus or its symptoms. More than half of the patients (51.6%) stated that they did not visit the same ED for the same or related health condition.

Around two thirds of the patients (62.5%) of the patients waited for up to 15 minutes before first spoken with a doctor or a nurse, with majority of them stating that the doctor or the nurse definitely (43.0%) or to some extent (42.5%) explained what would happen with the patient. Also, most of the patients stated they had to wait for 1 – 30 minutes (35.5%) or did not have to wait at all (37.7%), from the time of arrival to the first examination of a doctor or a nurse. On the other hand, (39.1%) of the patients stated that they were not told about the expected time they would have to wait to be examined.

More than half of the patients (51.4%) stated they were able to get help with their condition or symptom from a member staff while they were waiting. Overall, (42.0%) of the patients stated they lasted for up to one hour in their ED visit, while (29.9%) stated they lasted for 1 – 2 hours.

Table 2

Distribution of patients' arrival to and waiting at ED

Questions	Answers	Frequency	Percentage
Was this A&E department the first service you went to, or contacted, for help with your condition?	Yes	299	73.80%
	No	106	26.20%
If "No", Before going to this A&E department, where did you go to, or contact, for help with your condition?	Local emergency center	22	20.80%
	Doctor's private clinic	55	51.90%
	Different ED	10	9.40%
	A pharmacist	8	7.50%
	Out-of-service doctor	11	10.40%
If "No", What was the MAIN reason for going to A&E following your contact with the service(s) above?	The service(s) (above) referred / took me	50	47.20%
	I couldn't get a GP appointment quickly enough	16	15.10%
	I am not registered with a GP	0	0.00%
	My condition became worse	10	9.40%
	I was not satisfied with the help I received	4	3.80%
	A different reason	26	24.50%
Were you taken to ED in an ambulance?	Yes	65	16.00%
	No	340	84.00%
If "Yes", how long did you wait with the ambulance crew before your care was handed over to the ED staff?	I did not have to wait	41	63.10%
	Up to 15 minutes	8	12.30%
	16 – 30 minutes	4	6.20%
	31 – 60 minutes	4	6.20%
	More than 1 hour but no more than 2 hours	2	3.10%
	More than 2 hours	0	0.00%
	Don't know / can't remember	6	9.20%
Were you given enough privacy when discussing your condition with the receptionist?	Yes, definitely	198	48.90%
	Yes, to some extent	156	38.50%
	No	28	6.90%
	I did not discuss my condition with a receptionist	23	5.70%
Were you treated in a separate area of A&E because you had coronavirus, or symptoms of coronavirus?	Yes	60	14.80%
	No	263	64.90%
	Don't know	43	10.60%
	Can't remember	39	9.60%
Before your most recent visit to A&E, had you previously been to the same A&E department about the same condition, or something related to it?	Yes, within the previous week	20	4.90%
	Yes, between one week and one month earlier	24	5.90%
	Yes, more than a month earlier	88	21.70%
	No	209	51.60%
	Don't know / can't remember	64	15.80%
How long did you wait before you first spoke to a nurse or doctor?	0 -15 minutes	253	62.50%
	16 - 30 minutes	96	23.70%
	31 - 60 minutes	23	5.70%
	More Than 60 minutes	14	3.50%
	Don't know / can't remember	19	4.70%
Did the nurse or doctor explain what would happen next?	Yes, definitely	174	43.00%
	Yes, to some extent	172	42.50%
	No	49	12.10%
	I did not need it	4	1.00%
	Don't know / can't remember	6	1.50%
From the time you arrived, how long did you wait before being examined by a doctor or nurse?	I did not have to wait	152	37.70%
	1-30 minutes	143	35.50%
	31-60 minutes	46	11.40%
	1 – 2 hours	22	5.50%
	2 – 4 hours	10	2.50%
	More than 4 hours	4	1.00%
	Don't know / remember	26	6.50%
Were you informed how long you would have to wait to be examined?	Yes, but was shorter	44	17.40%
	Yes, as I was informed	50	19.80%
	Yes, but was longer	56	22.10%
	No, I was not informed	99	39.10%
	Don't know / remember	4	1.60%
While you were waiting, were you able to get help with your condition or symptoms from a member of staff?	Yes	130	51.40%
	No	65	25.70%
	I did not need any	58	22.90%
Overall, how long did your visit to ED last?	Up to 1 hour	170	42.00%
	1 – 2 hours	121	29.90%
	2 – 4 hours	58	14.30%
	4 – 6 hours	18	4.40%
	6 – 8 hours	4	1.00%
	8 – 12 hours	4	1.00%

ED = Emergency department

3.2.2 Experience with doctors and nurses

Majority of the patients stated they definitely (49.4%) or to some extent (42.2%) had enough time to discuss their health condition with the doctors and nurses, with similar percentages regarding completely (38.0%) or to some extent (48.6%) receiving an explanation of the condition in an understandable way. Mostly, patients stated that nurses and doctors definitely (60.7%) listened to what they had to say, with

(44.9%) stated that nurses and doctors, to some extent, discussed the anxieties and fears that have been had about their health condition. Around half of the patients (50.1%) stated that, to some extent, they built a trust and confidence in the doctors and nurses who examined and treated them, while (70.6%) of them stated that nurses and doctors did not talk to each other about them as if they were not there.

Table 3

Distribution of patients' experience with doctors and nurses

Questions	Answers	Frequency	Percentage
Did you have enough time to discuss your condition with the doctor or nurse?	Yes, definitely	200	49.40%
	Yes, to some extent	171	42.20%
	No	34	8.40%
While you were in ED, did a doctor or nurse explain your condition and treatment in a way you could understand?	Yes, completely	154	38.00%
	Yes, to some extent	197	48.60%
	No	36	8.90%
	I did not need an explanation	18	4.40%
Did the doctors and nurses listen to what you had to say?	Yes, definitely	246	60.70%
	Yes, to some extent	140	34.60%
	No	19	4.70%
If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	Yes, completely	160	39.50%
	Yes, to some extent	182	44.90%
	No	63	15.60%
	I did not have any anxieties or fears	0	0.00%
Did you have confidence and trust in the doctors and nurses examining and treating you?	Yes, definitely	153	37.80%
	Yes, to some extent	203	50.10%
	No	49	12.10%
Did doctors or nurses talk to each other about you as if you weren't there?	Yes, definitely	44	10.90%
	Yes, to some extent	75	18.50%
	No	286	70.60%

ED = Emergency department

3.2.3 Patient's care and treatment

More than two thirds of the patients (68.4%) stated they have received the right amount of information about the treatment or care that they received, with majority of them stated that they have definitely (48.9%), or to some extent (44.2%), have received the enough privacy when being examined.

Also, (44.9%) of the patients said that they sometimes were able to get a member of medical or nursing staff to help if they need attention, compared to (32.8%) who stated they always do. More than half of the patients (53.8%) stated that the nurses and doctors do not say things different from each other related to their health condition, with (30.1%) definitely and (48.1%) to some extent were involved in the decision-making of their health condition.

Table 4

Distribution of patients' care and treatment

Questions	Answers	Frequency	Percentage
While you were in ED, how much information about your condition or treatment was given to you?	Not enough	114	28.10%
	Right amount	277	68.40%
	Too much	4	1.00%
	I was not given any information	10	2.50%
Were you given enough privacy when being examined or treated?	Yes, definitely	198	48.90%
	Yes, to some extent	179	44.20%
	No	28	6.90%
If you needed attention, were you able to get a member of medical or nursing staff to help you?	Yes, always	133	32.80%
	Yes, sometimes	182	44.90%
	No, I could not find a member of staff to help me	46	11.40%
	was with me all the time	4	1.00%
	I did not need attention	40	9.90%
Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Yes, definitely	64	15.80%
	Yes, to some extent	123	30.40%
	No	218	53.80%
Were you involved as much as you wanted to be in decisions about your care and treatment?	Yes, definitely	122	30.10%
	Yes, to some extent	195	48.10%
	No	59	14.60%
	I was not well enough to be involved in that	29	7.20%

ED = Emergency department

3.2.4 Emergency tests and experience with pain

Regarding the tests that the patients have received in the ED, most of the patients (81.2%) stated they had done tests in the ED, including blood tests and radiology scans. Of them, (56.5%) stated that they completely received an explanation of the purpose of doing such tests from a member of staff in an understandable way. Also, (75.7%) of them stated that they have received their test results, with (54.6%) of the patients stating that the member of staff definitely explained the results in an understandable way. When asked about a specific question related to pain, 48.1% of the patients definitely, and (40.0%) to some extent, think that the hospital staff did everything they could to help them control their pain.

Table 5

Distribution of patients' answers to items related to tests and pain

Questions	Answers	Frequency	Percentage
Did you have any tests (such as x-rays, scans or blood tests) when you visited ED?	Yes	329	81.20%
	No	76	18.80%
If "Yes", Did a member of staff explain why you needed these test(s) in a way you could understand?	Yes, completely	186	56.50%
	Yes, to some extent	118	35.90%
	No	25	7.60%
Before you left ED, did you get the results of your tests?	Yes	249	75.70%
	No	34	10.30%
	To be given later	30	9.10%
	Don't know / can't remember	16	4.90%
Did a member of staff explain the results of the tests in a way you could understand?	Yes, definitely	137	54.60%
	Yes, to some extent	96	38.20%
	No	14	5.60%
	Not sure / can't remember	4	1.60%
If you did not get the results of the tests when you were in ED, did a member of staff explain how you would receive them?	Yes	28	42.40%
	No	26	39.40%
	Don't know / can't remember	12	18.20%
Do you think the hospital staff did everything they could to help control your pain?	Yes, definitely	195	48.10%
	Yes, to some extent	162	40.00%
	No	18	4.40%
	I was not in pain while I was in ED	24	5.90%
	Can't say / don't know	6	1.50%

ED = Emergency department

3.2.5 Hospital Environment and Facilities

When asked about the hospital's environment and facilities, more than half of the patients (57.8%) rated the ED as fairly clean, and (23.7%) as very clean. There were more patients who have seen specific things that were asked about than who did not see them, including social distancing measures (42.7% vs 39.5%), handwashing (53.6% vs 26.4%), staff wearing PPE (71.9% vs 21.7%), staff disposing gloves and aprons (71.6% vs 15.6%), cleaning the surfaces (47.7% vs 31.6%), available tissues (71.6% vs 20.5%) and waste bins (90.1% vs 5.9%), respectively.

Majority of the patients (87.7%) stated that they did not feel threatened by other patients or their visitors, while regarding food, 28.6% stated they did not get suitable food or drink, and (29.9%) stated they did not need any of them while being in the ED.

Table 6

Distribution of patients' answers to hospital environment and facilities

Questions	Answers	Frequency	Percentage
In your opinion, how clean was the emergency department? Fairly clean	Very clean	96	23.70%
	Fairly clean	234	57.80%
	Not very clean	58	14.30%
	Not at all clean	9	2.20%
	Can't say	8	2.00%
While you were in ED, did you feel threatened by other patients or visitors?	Yes, definitely	22	5.40%
	Yes, to some extent	28	6.90%
	No	355	87.70%
Were you able to get suitable food or drinks when you were in ED?	Yes	78	19.30%
	No	116	28.60%
	I was told not to eat or drink	33	8.10%
	I did not know if I was allowed to eat or drink	57	14.10%
	I did not want anything to eat or drink	121	29.90%

While you were in ED, did you see any of the following?	YES		NO		Don't Know	
	F	%	F	%	F	%
Social distancing measures	173	42.70%	160	39.50%	72	17.80%
Handwashing with hand sanitizer or soap	217	53.60%	107	26.40%	81	20.00%
Staff wearing PPE	291	71.90%	88	21.70%	26	6.40%
Staff disposing of gloves and plastic aprons	290	71.60%	63	15.60%	52	12.80%
Cleaning of surfaces	193	47.70%	128	31.60%	84	20.70%
Tissues available	290	71.60%	83	20.50%	32	7.90%
Waste bins provided	365	90.10%	24	5.90%	16	4.00%

ED = Emergency department, F = Frequency

3.2.6 Medications and Information

More than one fourth (28.6%) of the patients were transferred to a hospital ward, who were asked to skip answering the next two parts related to medications and information.

Table 8: Distribution of patients' answers to items related to leaving ED domain in A&ED questionnaire

Among patients who were not transferred to a hospital ward, (76.5%) stated they were prescribed new medications, of them are (57.0%) who stated that a staff member completely explained the purpose of such medications to be taken at home in an understandable way, while (44.3%) stated that they did not explain their side effects.

Also, the patients were asked about specific areas of the information that they have received during their visit. As shown in Table 2.10, most of the patients stated that the staff completely (32.2%) or to some extent (38.8%) explained the symptoms to watch for when going back home, while nearly half of them (49.5%) stated that they were not told who to contact if being worried about their condition or treatment after leaving ED. Also, (43.9%) of the patients stated that they received information to some extent to help them taking care of their health condition at home, while (36.3%) stated that staff did not discuss the transportation for leaving ED, as (32.9%) stated this was not necessary.

There were also more patients who stated that discussing the need for further health or social care services after leaving ED as not necessary, while (34.9%) stated that staff discussed such area of care with them. Lastly, more than half of the patients (50.9%) stated that the care they received after leaving ED was as expected and available, while (30.8%) (stated that they did not expect any kind of care or support after leaving ED.

Table 7

Distribution of patients' answers to items related to medications and information domains in A&ED questionnaire

Questions	Answers	Frequency	Percentage
At the end of your visit to ED, were you transferred to a hospital ward?	Yes	116	28.60%
	No	289	71.40%
Before you left ED, were you prescribed any new medications?	Yes	221	76.50%
	No	68	23.50%
If "Yes", Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	Yes, completely	126	57.00%
	Yes, to some extent	73	33.00%
	No	18	8.10%
	I did not need an explanation	4	1.80%
If "Yes", Did a member of staff tell you about medication side effects to watch for?	Yes, completely	66	29.90%
	Yes, to some extent	49	22.20%
	No	98	44.30%
	I did not need this type of information	8	3.60%
Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?	Yes, completely	93	32.20%
	Yes, to some extent	112	38.80%
	No	60	20.80%
	I did not need this type of information	24	8.30%
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left ED?	Yes	94	32.50%
	No	143	49.50%
	Don't know / can't remember	52	18.00%
Did staff give you enough information to help you care for your condition at home?	Yes, definitely	84	29.10%
	Yes, to some extent	127	43.90%
	No	50	17.30%
	I did not need this type of information	28	9.70%
Before you left the hospital, did a member of staff discuss your transport arrangements for leaving ED?	Yes	76	26.30%
	No	105	36.30%
	It was not necessary	95	32.90%
	Don't know / can't remember	13	4.50%
Did hospital staff discuss with you whether you may need further health or social care services after leaving ED?**	Yes	101	34.90%
	No, but I would have liked them to	61	21.10%
	No, it was not necessary to discuss it	127	43.90%
After leaving A&E, was the care and support available when you needed it?	Yes	147	50.90%
	No	53	18.30%
	I did not expect any further care or support after I left ED	89	30.80%

*ED = Emergency department, * = Patients who answered "Yes" were asked to skip "Medications" and "Information" domains of the questionnaire. ** = e.g. services from GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector.*

3.2.7 Overall Experience

Overall, (56.0%) stated that they were all of the time treated in respect and dignity while being in ED, with most of the patients rating the overall experience as 7 (20.7%) and 8 (23.7%) out of 10, with a median score of 7 (IQR = 2).

Table 8

Distribution of patients' answers to items related to overall domain in A&ED questionnaire

Questions	Answers			Frequency			Percentage			
Overall, did you feel you were treated with respect and dignity while you were in ED?	Yes			227			56.00%			
	Yes, some of the time			154			38.00%			
	No			24			5.90%			
Overall experience* Median (IQR) = 7 (2)	1	2	3	4	5	6	7	8	9	10
	1.5	1.5	3	3.5	7.4	14.3	20.7	23.7	9.4	13.6

ED = Emergency department, * = 0 is a very poor experience and 10 is a very good experience and are presented in percentages, IQR = Interquartile range

3.3 Part 3: Analytical results

This part aims to investigate the relationship between patients' demographic factors and the overall experience rating in the targeted EDs. The non-parametric tests were used as the data were not normally distributed, where Mann-Whitney U test was used for the relationship between the dichotomous factors and the experience score, while Kruskal-Wallis was used for the purpose of investigating the relationship between non-dichotomous factors and the experience score, and Spearman Correlation test was used to test the correlation between patients' age (as a continuous factor) and the experience score.

The age category of the patients was significantly associated with a significantly higher overall experience in ED among patients in the 26 – 30 years old category (mean rank = 214.38) and who are older than 40 years old (mean rank = 243.81) compared to patients with age between 36 and 40 years old (mean rank = 163.14) and between 18 and 25 years old (mean rank = 184.06), indicating variations in overall experience in EDs based on the age category (H = 13.435, p-value = 0.009), with a significant, although mild, correlation between higher age and more positive overall experience using Spearman Correlation test (r = 0.114, p-value = 0.022). Also, female patients significantly had higher overall

experience in ED (mean rank = 215.63) than male patients (mean rank = 185.72, U = 17052.0, p-value = 0.010).

In terms of their health conditions, patients who stated having health problems that lasted or expected to last for 12 months significantly showed lower overall experience in ED (mean rank = 170.44) than who did not (mean rank = 209.34, U = 90.38.0, p-value = 0.012). In addition, the level of how much such health conditions affected their day-to-day life showed significant relationship with the overall experience in ED, where lower scores were found among who were a lot affected (mean rank = 24.20) compared to being a little (mean rank = 32.12) or not affected at all (mean rank = 44.60, H = 11.748, p-value = 0.003).

Most of the issues that were asked about significantly related to differences in overall experience in ED, and while having physical problems did not significantly related to experience differences (mean rank = 186.27, U = 7487.5, p-value = 0.353), other conditions were significantly worse overall experience in ED compared to not having them, including falls (mean rank = 85.05 vs 213.85, U = 2582.0, p-value < 0.001) and feeling isolated from others (mean rank = 154.53 vs 209.99, U = 7899.5, p-value < 0.001), with having none of them was significantly related to higher overall experience in ED (mean rank = 217.15 vs 170.55, U = 13976.5, p-value < 0.001).

Moreover, patients who stated they were caring for other family members, relatives or friends significantly showed lower overall experience in ED than who did not (mean rank = 189.87 vs 207.89, U = 14782.0, p-value = 0.038). Lastly, when the patient himself/herself filled in the questionnaire, the overall satisfaction in ED were significantly higher (mean rank = 221.35) than when the relative or friend did (mean rank = 168.86) or even the HCP (mean rank = 99.50, H = 30.928, p-value < 0.001).

Table 9

Relationship between patients' demographic factors and experience scores

Factors	Values		Mean score	Mean rank	Test result	p-value
Age	18 – 25 YO		6.71	184.06	13.435	0.009
	26 – 30 YO		7.32	214.38		
	31 – 35 YO		7.02	199.83		
	36 – 40 YO		6.18	163.14		
	> 40 YO		7.62	243.81		
Spearman Correlation				r = 0.114	0.022	
Gender	Male		6.63	185.72	17052.5	0.010
	Female		7.36	215.63		
Health conditions	Yes		6.21	170.44	9038.0	0.012
of 12 months	No		7.22	209.34		
How much it	A lot		4.90	24.20	11.748	0.003
affected daily	A little		6.00	32.12		
activities	Not at all		7.80	44.60		
Experiencing any	Physical	Yes	6.674	186.27	7487.5	
of the following	problems	No	7.11	202.91		0.353
	Falls	Yes	4.25	85.05	2582	< 0.001
		No	7.37	213.85		
	Feeling	Yes	6.42	154.53	7899.5	< 0.001
	isolated	No	7.18	209.99		
	None	Yes	7.41	217.15	13976.5	< 0.001
		No	6.4	170.55		
Caring for	Yes		6.62	189.87	14781	0.038
other(s)	No		7.21	207.89		
Who filled the	The patient		7.40	221.35	30.928	< 0.001
questionnaire?	A friend or relative		6.36	168.86		
	Both the patient and friend		5.78	131.55		
	The patient with an HCP help		5.00	99.50		

3.4 Conclusion

The patients were mostly 30 years old or younger, with a median age of 28 years old, and more females (58.7%) than males (42.2%). Mostly, they did not suffer from illnesses that lasted or expected to last for 12 months (83.7%), and did not care for another family member or a relative (72.8%).

Around three fourths of the patients (73.8%) reached to ED as the first health service, rather than local emergency center or a private doctor. Also, (84.0%) did not reach the ED using an ambulance, with most of the patients stated they have given enough privacy when discussing their health condition with the receptionist and staff members. Most of the patients waited for up to 30 minutes till first examined by a doctor or nurse (73.2%), with 42.0% stated that their ED visit lasted for up to one hour.

Mostly, patients definitely had enough time to discuss health condition with nurses and doctors (49.4%), explain the health condition (38.0%), listened by them (60.7%) and establishing confidence and trust (37.8%). More than two thirds of the patients (68.4%) rated the amount of information that they received about their care and treatment as the right amount, with 53.8% stated that nurses and doctors did not say opposite things about their care and treatment.

Majority of the patients (81.2%) had specific tests in the ED, where the staff appropriately explained their purposes and interpretation of their results. Regarding the ED environment, it was mostly rated as fairly clean (57.8%), with availability of several measures like social distancing (42.7%), wearing PPE (71.9%), appropriate disposing of PPE (71.6%), clean surfaces (47.7%) and waste bins (90.1%).

More than two thirds of the patients were not transferred to another ward in hospital (71.4%), with (76.4%) stated that they received medication prescriptions. The overall experience had a median of 7 out of 10, which was significantly higher among patients with older age, females, having no health conditions that lasted for 12 months, having no falls or being isolated, not caring for other family member or a friend, and when the questionnaire was filled by the patient (p-value < 0.05).

Chapter Four

Discussion and Conclusions

The following is a discussion of the current study results, which is done by comparing the findings with previous literature, and giving comments from the researcher.

4.1 Discussion of study findings and comparison with previous studies

From the descriptive point, the study results showed interesting results related to different aspects of Palestinian patients' experience in EDs. First, the adult patients were mostly up to 30 years old (71.3%), which means that the ages of recruited patients are not evenly distributed across the age groups, which appears in the median age of 28 years old, while it ranges from 18 to 6 6years old, and this can be related to more cooperation and compliance with research importance among the younger generations.

Moreover, several reasons can be related to the fact that most of the sample are young. For example, it can be related to the more engagement of people between 18 and 30 years old in risky behaviors, like physical activities, leading to more visits to EDs. Also, previous studies have linked the personal traits to ED visits, like Chapman et al. (2009) and Hull et al. (2018) who stated that demographic factors and personal traits like extroversion and assertiveness among the younger generations are linked to more accessibility to emergency care. In addition, Bazargan et al. (2019) stated that the overall lower socioeconomic status of the younger patients lead them to seek emergency care rather than scheduled appointments, caused by economic constraints, like lower income and unstable employment.

The findings of age distribution is also connected with the result related to that 72.8% of the questionnaires were filled in by the patients themselves, and this can be interpreted by several reasons that are found among younger populations as discussed in previous studies, like patients' independence and cognitive ability (Frank et al., 2011) and health literacy leading to more engagement in health-related surveys and questionnaires (Reichmann et al., 2010).

The distribution of patients according to their long-term health issues that led to emergency visits shows that the most common problems are related to respiratory issues (24.2%), followed by joint problems (18.2%), diabetes and its complications (15.2%) and

cardiovascular issues (12.1%), with more than tenth of the patients (12.1%) visit EDs for mental health conditions. A previous study (Hull et al., 2018) found that the most common issues that lead to emergency visits are related to respiratory system, which aligns with the findings of the current study. In addition, Bazargan et al. (2019) found that diabetes and cardiovascular diseases are also among the highest frequently and common reasons for ED visits, while Chapman et al. (2009) focused on the mental health issues as reasons for ED visits, like anxiety, depression and psychosis. Joint problems were not found to be compliant with the current study, while a previous study Aminzadeh & Dalziel, (2002) stated that musculoskeletal problems are more commonly found among older adults to cause ED visits.

Most of the patients (73.8%) stated that EDs were the first place they sought medical treatment for their emergency condition, rather than local doctors, clinics or pharmacists, which can be related to subjective and objective factors that were discussed in previous studies. For example, EDs tend to be more convenient and accessible than outpatient and private clinics, because they are open 24/7, with no need for appointment to provide care (Marco et al., 2010), in addition to severity perception by the patient, even his/her condition might not be life-threatening, but it can be affected by their fear of symptoms worsening, resulting in more need for quick assurance by the ED (Ragin et al., 2005). Other factors may be related to barriers related to lack of access to primary care, related to long wait times for appointments, limited office hours and lack of nearby clinics, which are more related to transportation issues (van den Berg et al., 2016), as well as financial barriers related to lack of insurance coverage for private care (Tsai et al., 2010).

The perception of safety may also affected the choice of patients to reach EDs without mostly using ambulance (84.0%), in which patients may perceive their health condition as nonlife-threatening or manageable without immediate medical intervention (Thuresson et al., 2008). Other factors may include cost concerns, where ambulance services are mostly not covered by health insurance, which lead to choosing private vehicles, public transportations or even walking (Prah Ruger et al., 2006). Patients or their families may also be not aware of the availability and accessibility method to ambulance services, (Ma et al., 2017), while other patients may have preferences for self-transport to EDs as it is influenced by beliefs of more control over the situation (Yarris et al., 2006).

The findings also showed positive opinions related to privacy issues when seeking emergency services, where most of the patients stated they definitely (48.9%) or to some extent (38.5%) received a proper privacy level when discussing their health condition with the receptionist, with higher percentages related to receiving privacy when being examined by nurses or doctors (48.9% and 44.2%, respectively). Such results reflect an overall high positive perception of privacy among the patients, especially in more intimate aspects of care, like being examined by HCPs, as well as the effective training that HCPs receive (Lee, 2016), protocols they follow and environmental circumstances that they work at in the targeted hospitals. The highly positive perception of privacy among Palestinian patients who visit EDs reflects the importance of privacy, and how much respected it is, which appears in open communication with HCPs, resulting in more accurate diagnoses and effective treatment (Lin & Lin, 2010).

On the other hand, the study showed a finding related to that (39.1%) of the patients were not informed about the time they would spend waiting to be examined, which is relatively high, considering that the percentages of patients who reported that they waited shorter (17.4%), longer (22.1%) or as informed (19.8%) are approximate. This finding can be used a suggestion for improvement in the communication process between patients who visit EDs and the health staff and receptionists. Patients being informed about the length of waiting tend to be more satisfied with the health services they received (Thompson et al., 1996), as well as helping in managing patient expectations and reduction of anxiety, enhancing the overall patient experience (Shah et al., 2015; Soremekun et al., 2011).

Regarding the overall waiting time, majority of the patients have spent up to 2 hours in their visit to ED (71.9%), with a significant proportion of them (42.0%) spending less than 1 hour. This finding is considered a positive indicator of the Palestinian emergency departments' efficiency and ability to handle cases, which contributes to higher patient's satisfaction. On the other hand, some patients have spent more than 4 hours (6.4%), with some over 12 hours, and even if it is a small percentage, it may lead to concern, that may lead to negative perceptions towards the received care (Shah et al., 2015; Soremekun et al., 2011), especially if not informed about the reasons of delay. Such percentage may be present due to complexity of cases.

The communication between patients and HCPs was also found to be highly positive, as (60.7%) of the patients stated that nurses and doctors definitely listen to what they say,

with (39.5%) definitely and (44.9%) to some extent listen to their fears and anxieties about their health condition, which highlights a positive patient-staff communication process, and adherence with the importance of addressing patient anxieties in improving the overall patient experience (Villalona et al., 2020; Wright et al., 2013), as well as themes of treatment explanation for emergency patients, especially in triage level (Blackburn et al., 2019). Enhancement of effective communication is important to implemented by hospitals' administrations, including the conduction of quality improvement initiatives (Taher et al., 2020), as well as projects and research that focuses on communication gaps and the necessity of empathy and providing clear information from HCPs (Alghamdi et al., 2023). The provision of clear and enough amount of information was generally positive in the current study, where (68.4%) of the patients reported receiving the right amount of information about their condition or treatment during their ED visit.

Another positive aspect of the care that patients received in EDs was related to the consistency of information they received from nurses and doctors, where 53.8% of them answered

"No" regarding the question of telling different things about their health condition or treatment. This aligns with the overall recommendation to emphasize the importance of information consistency between health staff and patients (Lutwak & Dill, 2017), with the importance of implementing proper training through quality improvement projects on this topic, which would help in increasing patients and family satisfaction (Kuehnel et al., 2019) and patient outcomes (Aaronson, White, et al., 2018).

The patients in the current study also generally perceived a high level of cleanliness of ED environment, where majority of them (81.5%) perceived it as very or fairly clean, which is important to consider focusing on using the appropriate quality improvement and monitoring of cleaning services, as it helps in maintaining hygiene, but rather enhances patient's experience, especially for stressful and highly sensitive surroundings (Elliott et al., 2015).

The previous study of Aaronson, Mort, et al. (2018) stated that patients' experience is significantly related to their age, which was similar to the findings of the current study, where a positive, although mild, correlation was found between patient's age and their

overall experience rating (r = 0.114, p-value = 0.022), with more positive experience among patients aged more than 40 years old. The previous study also emphasized on the importance of teamwork, communication, waiting time and environment on the patient experience, which were positively perceived by the patients who were recruited in the current study. It also worth noting that it is important for policymakers and hospital administrations to invest in improving such aspects of care in EDs, as they were found to be easy to implement with no significant financial burden (Aleksandrovskiy et al., 2022; Sonis & White, 2020).

Female gender was found by a previous study to be significantly predicting less detracting (more satisfying) experience in ED (Berlyand et al., 2022), which is consistent with the findings of the current study, where female patients significantly had higher overall satisfaction mean scores (7.36) than male patients (6.63, p-value = 0.010). The similarity in this finding is found despite the differences in both studies' methodological aspects, including larger sample size in the previous study (9,000), which is much higher than the current study, and can be related to the use of retrospective cohort design rather than cross-sectional design. Previous studies also showed that female patients often perceive more positive experience in EDs, which was interpreted by Chen et al. (2021) as potentially due to differences in how they are treated by healthcare staff, while Chekijian et al. (2020) stated that female patients often perceived better experience in EDs when treated by female physicians and nurses, in addition to Pineault et al. (2017) who stated that femaledominant organizations often providing care that is perceived as more comprehensive and responsive, explaining why female patients report better experiences.

In the previous study of Parra et al. (2020) on a sample of pediatric patients families, the findings highlighted that (30.6%) of them waited for the expected time, compared to (19.8%) in the current study, while (38.8%) have waited for less than expected, compared to (17.4%) in the current study. The difference in such percentages is that a large percentage of patients in the current study

(39.1%) stated that they were not informed about the time they would wait till examination starts. Therefore, it is important to assure patients with such information, as it affects their experience and satisfaction with the provided care. Also, a higher percentage of families reported a very clean ED environment in the previous than in the current study (77.6% vs 23.7%), which is mostly related to differences in settings, where

more focus on environmental surroundings may be found in private hospitals that are found in the Western countries. The overall experience was also higher in the previous stud, which was found to be very high (8 out of 10 or more) by (80.0%) of the sample, compared to a cumulative percentage of (46.7%) of the patients in the current study. Differences in experience can be related to institutional and socioeconomic differences between the settings of both studies, as well as the inclusion of pediatric patient families in the previous study, compared to adult patients in the current study.

The emphasis on environmental factors of EDs is also found in the previous Palestinian study by Al-Kalaldeh et al. (2020), who stated that such factors are at the top priority of what affects the nurse-patient communication process. A pre-registration training is also recommended to be received on proper emergency dynamics by the HCPs, which aligns with the recommendations of the previous study.

4.2 Conclusion

The current study was conducted with the main aim to describe the different aspects of Palestinian patients' experience with visiting emergency departments (EDs), as well as the most common factors that affect the overall experience score. The researcher recruited a convenient sample of 405 adult patients, and were asked to fill a valid questionnaire that was translated to Arabic language, which consisted of domains related to arrival, waiting, staff, care and treatment, tests, pain, environment and facilities, leaving ED, medications, and information, in addition to the overall experience rating, and was analyzed using SPSS software with commitment to ethical considerations of anonymity and confidentiality.

Main results found an overall score of experience that had a median of 7 out of 10 (IQR = 2), which was significantly mildly correlated with age, and was higher among female patients, who reported not having a health condition that lasted for the last 12 months, with less related physical activity limitation, who did not experience falls or being isolated, who doesn't care for another person who needs health care, and when the form was filled in by the patient himself/herself.

The results related to general positive experience of communication, treatment, privacy and environment were satisfactory, and compliant with the findings of many previous studies, with the recommendation to conduct further studies on larger samples and

including more hospitals, with the focus on other demographic and health-related factors that may contribute to patients' experience in EDs, which will help policymakers and hospital administrations to establish effective programs to improve the quality of care in EDs.

4.3 Recommendations

In light of the study findings, the following recommendations are proposed for various stakeholders to improve the patient experience in emergency departments (EDs):

4.3.1 For Patients

1. Raising Awareness About ED Visits: It is essential to educate patients about the appropriate use of ED services, emphasizing the conditions that necessitate emergency care. This includes understanding the dynamics of emergency care, such as triage procedures, waiting times, and prioritization of critical cases. Public awareness campaigns through media, healthcare facilities, and community outreach programs can help increase patient knowledge and ensure the optimal use of ED resources.
2. Encouraging Patient Participation in Care: Patients should be encouraged to actively participate in their care and treatment while in the ED. This can be achieved by empowering patients to ask questions, seek clarifications regarding their health conditions and treatment plans, and inquire about the expected duration of their stay. Such engagement not only reduces patient anxiety but also fosters trust and satisfaction. Providing educational materials or hosting informational sessions could further promote patient involvement and better communication between patients and healthcare providers (HCPs).

4.3.2 For Healthcare Providers (HCPs)

1. Enhancing Communication Skills: Effective communication between HCPs and patients is a cornerstone of positive patient experiences. To improve this, it is recommended that HCPs participate in ongoing education and training programs focusing on communication skills. These programs should include active listening, displaying empathy, and delivering clear and concise explanations about treatment plans and waiting times. Training should also address interpersonal communication between HCPs to ensure cohesive teamwork.

2. Maintaining Consistent Communication: Patients often receive conflicting information from different members of the healthcare team, which can lead to confusion and dissatisfaction. To minimize this, HCPs should ensure consistency in the information delivered to patients. This can be achieved through effective teamwork, regular briefings, and coordinated communication within the team to align messaging about patient care plans and progress.
3. Considering Demographic and Individual Factors: Variations in patients' demographic and health-related factors must be taken into account when providing care. For instance, gender sensitivity is a significant consideration, as some female patients may prefer to be treated by female doctors or nurses. Understanding cultural and social preferences can improve patient comfort and satisfaction while ensuring equitable and personalized care.

4.3.3 For Healthcare Institutions and Administrations

1. Investing in Environmental Improvements: The physical environment of EDs plays a critical role in shaping patient experiences. Healthcare institutions should prioritize maintaining clean, comfortable, and organized EDs. Regular assessments of the physical environment should be conducted, identifying areas requiring improvement. Investments in waiting areas, lighting, noise reduction, and general cleanliness can greatly enhance the overall experience for patients and their families.
2. Addressing Gaps in Communication and Privacy: Administrators should implement quality improvement initiatives targeting communication gaps, privacy concerns, and other environmental factors within EDs. These initiatives should be informed by patient feedback and staff input to ensure relevance and effectiveness. For instance, introducing private consultation spaces can enhance patient privacy, while technology-based solutions can improve communication channels between patients and staff.
3. Providing Regular Training for HCPs: Administrations must prioritize regular and comprehensive training programs for HCPs. These should focus on teamwork, patient-centered care, and effective communication strategies. According to Aaronson et al. (2018), such training is essential for fostering best practices in healthcare delivery. By making these programs mandatory and continuously updated, institutions can ensure that their staff remains competent and responsive to patient needs.
4. Conducting Research and Audits: Healthcare institutions should promote regular audits and clinical research to gain deeper insights into factors influencing patient

experience. Research could focus on various aspects, such as evaluating the effectiveness of staff training programs or understanding the unique experiences of different patient groups, including pediatric patients and their families. Rigorous methodological approaches, such as prospective cohort studies, can provide valuable data on the impact of interventions aimed at improving patient experiences.

4.4 Limitations

The study faced several limitations that should be acknowledged to provide context for the findings and their generalizability:

1. Sample Distribution and Representation: One significant limitation was the uneven distribution of patients across different age groups. The sample lacked broader coverage in terms of geographic and institutional representation, as data was collected from a limited number of hospitals. Expanding the sample to include more diverse institutions and patient demographics would improve the generalizability of the findings.
2. Cross-Sectional Design**:** The study utilized a cross-sectional design, which captures patient experiences at a single point in time. While this approach provides a snapshot of experiences, it does not allow for the establishment of causality or changes over time. Additionally, reliance on patient recall introduces recall bias, as patients may not accurately remember their experiences. The cross-sectional nature of the study was primarily due to time constraints and academic pressures. Future research could address this limitation by incorporating longitudinal designs to track patient experiences over time.
3. Response Bias: Self-reported data inherently carries the risk of response bias. Patients may provide socially desirable answers or misinterpret survey questions, which could influence the accuracy of the data. Efforts should be made in future studies to minimize this bias by designing clear and culturally sensitive questionnaires and conducting interviews to validate responses.
4. Limitations in Questionnaire Design**:** The study's original and translated questionnaires lacked a focus on specific socioeconomic and cultural factors that could influence patient experiences, such as income, educational level, employment status, and insurance coverage. Additionally, complex cultural variations were not adequately

addressed. Future studies should aim to incorporate these variables to provide a more comprehensive understanding of the factors affecting patient experiences in EDs.

By addressing these limitations, future research can provide a more accurate and in-depth analysis of patient experiences, ultimately contributing to the improvement of emergency care quality.

List of Abbreviations

Abbreviation	Meaning
US	United States
MoH	Ministry of Health
NHAMCS	National Hospital Ambulatory Medical Care Survey
ED	Emergency department
LOS	Length of stay
AHRQ	Agency of Healthcare Research and Quality
WHO	World Health Organization
PCC	Patient-centered care
HCP(s)	Healthcare provider(s)
A&ED	Accident & Emergency Department (questionnaire)
NHS	National Health Service
OR	Odds ratio
AMA	Against medical advice
MRI	Magnetic resonance imaging
ECG	Electrocardiogram
COVID-19	Coronavirus 19
PCBS	The Palestinian Central Bureau of Statistics
SPSS	Statistical Package for Social Sciences
IQR	Interquartile range
IRB	Institutional Revie Board
ASC	Autism spectrum disorder
F	Frequency (in tables)
GP	General physician
r	Correlation coefficient (statistical result)

References

Aaronson, E. L., Mort, E. A., Sonis, J. D., Chang, Y., & White, B. A. (2018). Overall Emergency Department Rating: Identifying the Factors That Matter Most to Patient Experience. *Journal for Healthcare Quality*, *40*, 367–376.

Aaronson, E. L., White, B. A., Black, L., Brown, D. F. M., Benzer, T. I., Castagna, A., Raja, A. S., Sonis, J. D., & Mort, E. A. (2018). Training to Improve Communication Quality: An Efficient Interdisciplinary Experience for Emergency Department Clinicians. *American Journal of Medical Quality*, *34*, 260 - 265.

Ahmed, F., Burt, J., & Roland, M. (2014). Measuring Patient Experience: Concepts and Methods. *The Patient - Patient-Centered Outcomes Research*, *7*, 235-241.

Al-Kalaldeh, M., Amro, N., Qtait, M., & Alwawi, A. (2020). Barriers to effective nurse-patient communication in the emergency department. *Emerg Nurse*, *28*(3), 29-35. https://doi.org/10.7748/en.2020.e1969

Al-Neyadi, H. S., Abdallah, S., & Malik, M. (2018). Measuring patient's satisfaction of healthcare services in the UAE hospitals: Using SERVQUAL. *International Journal of Healthcare Management*, *11*(2), 96-105. https://doi.org/10.1080/20479700.2016.1266804

Aleksandrovskiy, I., Ganti, L., & Simmons, S. (2022). The Emergency Department Patient Experience: In Their Own Words. *J Patient Exp*, *9*, 23743735221102455. https://doi.org/10.1177/23743735221102455

Alghamdi, A., Hmed, G., Aloqbawi, A., Almutairi, B., Alsumari, F., Alharbi, M., Nemer, R., & Alshehri, R. (2023). Patient-Healthcare Worker Communication in Emergency Departments: Patient Perspectives. *Saudi Journal of Emergency Medicine*.

Aminzadeh, F., & Dalziel, W. B. (2002). Older adults in the emergency department: a systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. *Annals of emergency medicine*, *39 3*, 238-247.

Amro, N., abu kamel, A., Qtait, M., Yagi, H., Amro, B., Amro, R., & Amro, R. (2018). Factors Affect Patients Satisfaction in Emergency Departments in Palestine.

Australian College of Emergency Medicine. (2021). *Position Statement: ED Overcrowding*https://acem.org.au/getmedia/dd609f9a-9ead-473d-9786-d5518cc58298/S57-Statementon-ED-Overcrowding-Jul-11-v02.aspx

Bal, C., AlNajjar, M., Thull-Freedman, J., Pols, E., McFetridge, A., & Stang, A. S. (2020). Patient Reported Experience in a Pediatric Emergency Department. *J Patient Exp*, *7*(1), 116-123. https://doi.org/10.1177/2374373519826560

Bani Odeh, A. A., Wallis, L. A., Hamdan, M., & Stassen, W. (2024). Consensus-based quality standards for emergency departments in Palestine. *BMJ Open Qual*, *13*(1). https://doi.org/10.1136/bmjoq-2023-002598

Bazargan, M., Smith, J. L., Cobb, S., Barkley, L., Wisseh, C., Ngula, E., Thomas, R. J., & Assari, S. (2019). Emergency Department Utilization among Underserved African American Older Adults in South Los Angeles. *International Journal of Environmental Research and Public Health*, *16*.

Berkowitz, B. (2016). The Patient Experience and Patient Satisfaction: Measurement of a Complex Dynamic. *Online J Issues Nurs*, *21*(1), 1. https://doi.org/10.3912/OJIN.Vol21No01Man01

Berlyand, Y., Copenhaver, M. S., White, B. A., Dutta, S., Baugh, J. J., Wilcox, S. R., Yun, B. J., Raja, A. S., & Sonis, J. D. (2022). Impact of Emergency Department Crowding on Discharged Patient Experience. *West J Emerg Med*, *24*(2), 185-192. https://doi.org/10.5811/westjem.2022.10.58045

Blackburn, J., Ousey, K., & Goodwin, E. (2019). Information and communication in the emergency department. *Int Emerg Nurs*, *42*, 30-35. https://doi.org/10.1016/j.ienj.2018.07.002

Bos, N., Sizmur, S., Graham, C., & van Stel, H. F. (2013). The accident and emergency department questionnaire: a measure for patients' experiences in the accident and emergency department. *BMJ Qual Saf*, *22*(2), 139-146. https://doi.org/10.1136/bmjqs-2012-001072

Chapman, B. P., Shah, M. N., Friedman, B., Drayer, R., Duberstein, P. R., & Lyness, J. M. (2009). Personality traits predict emergency department utilization over 3 years in older patients. *The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry, 17 6*, 526-535.

Chekijian, S. A., Kinsman, J., Taylor, R. A., Ravi, S., Parwani, V., Ulrich, A. S., Venkatesh, A. K., & Agrawal, P. (2020). Association between patient-physician gender concordance and patient experience scores. Is there gender bias? *The American journal of emergency medicine*.

Chen, P. G., Tolpadi, A., Elliott, M. N., Hays, R. D., Lehrman, W. G., Stark, D. S., & Parast, L. (2021). Gender Differences in Patients' Experience of Care in the Emergency Department. *Journal of General Internal Medicine, 37*, 676 - 679.

Digel Vandyk, A., Young, L., Macphee, C., & Gillis, K. A. (2018). Exploring the Experiences of Persons Who Frequently Visit the Emergency Department for Mental Health-Related Reasons. *Qualitative Health Research, 28*, 587 - 599.

Edwards, B. E., & Jason, C. (2017). The Patient Experience.

Elliott, M. N., Cohea, C. W., Lehrman, W. G., Goldstein, E. H., Cleary, P. D., Giordano, L. A., Beckett, M. K., & Zaslavsky, A. M. (2015). Accelerating Improvement and Narrowing Gaps: Trends in Patients' Experiences with Hospital Care Reflected in HCAHPS Public Reporting. *Health Serv Res, 50*(6), 1850-1867. https://doi.org/10.1111/1475-6773.12305

Frank, C., Asp, M., Fridlund, B., & Baigi, A. (2011). Questionnaire for patient participation in emergency departments: development and psychometric testing. *Journal of advanced nursing, 67 3*, 643-651.

Gordon, J., Sheppard, L. A., & Anaf, S. (2010). The patient experience in the emergency department: A systematic synthesis of qualitative research. *International emergency nursing, 18 2*, 80-88.

Gorski, J. K., Mendonça, E. A., & Showalter, C. D. (2022). The Impact of Diagnostic Decisions on Patient Experience in the Pediatric Emergency Department. *Pediatr Emerg Care, 38*(2), e644-e649. https://doi.org/10.1097/pec.0000000000002485

Graham, B., Endacott, R., Smith, J. E., & Latour, J. M. (2019). 'They do not care how much you know until they know how much you care': a qualitative meta-synthesis of patient experience in the emergency department. *Emergency Medicine Journal*, *36*(6), 355-363. https://doi.org/10.1136/emermed-2018-208156

Greenwood-Ericksen, M. B., & Kocher, K. (2019). Trends in Emergency Department Use by Rural and Urban Populations in the United States. *JAMA Network Open*, *2*(4), e191919-e191919. https://doi.org/10.1001/jamanetworkopen.2019.1919

Hughes, J. A., Alexander, K., Spencer, L. M., & Yates, P. (2021). Factors associated with the experience of patients presenting in pain to the emergency department. *Journal of Clinical Nursing*.

Hull, S. A., Homer, K., Boomla, K., Robson, J., & Ashworth, M. (2018). Population and patient factors affecting emergency department attendance in London: retrospective cohort analysis of linked primary and secondary care records. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *68 668*, e157-e167.

Karam, C. (2017). The Evolution of Patient Satisfaction to Patient Experience. *Frontiers of health services management*, *33*, 30–34.

Kesmodel, U. S. (2018). Cross-sectional studies - what are they good for? *Acta Obstet Gynecol Scand*, *97*(4), 388-393. https://doi.org/10.1111/aogs.13331

Kuehnel, N., Morrison, A. K., & Ferguson, C. C. (2019). Rapid cycle testing drives improved communication and satisfaction using in-person survey. *BMJ Open Quality*, *8*.

Larson, E., Sharma, J., Bohren, M. A., & Tunçalp, Ö. (2019). When the patient is the expert: measuring patient experience and satisfaction with care. *Bull World Health Organ*, *97*(8), 563-569. https://doi.org/10.2471/blt.18.225201

Lee, T. H. (2016). Physician burnout and patient experience: flip sides of the same coin. *NEJM Catalyst*, *2*(3).

Lin, Y.-K., & Lin, C.-J. (2010). Factors predicting patients' perception of privacy and satisfaction for emergency care. *Emergency Medicine Journal*, *28*, 604 - 608.

Lutwak, N., & Dill, C. E. (2017). VA Emergency Department Has Improved Communication to Increase Quality of Care and Patient Satisfaction. *American Journal of Medical Quality*, *32*, 339 - 339.

Ma, J., Wang, J., Zheng, W., Zheng, J., Wang, H., Wang, G., Zhang, H., Xu, F., & Chen, Y. (2017). Usage of ambulance transport and influencing factors in acute coronary syndrome: a crosssectional study at a tertiary centre in China. *BMJ Open*, *7*.

Mahmoud, A. (2013). *Health Challenges in Palestine* https://www.sciencediplomacy.org/perspective/2013/health-challenges-in-palestine

Marco, C. A., Weiner, M. G., Ream, S. L., Lumbrezer, D., & Karanovic, D. (2010). Access to care among emergency department patients. *Emergency Medicine Journal*, *29*, 28 - 31.

McFarlan, S., O'Brien, D., & Simmons, E. (2019). Nurse-Leader Collaborative Improvement Project: Improving Patient Experience in the Emergency Department. *Journal of Emergency Nursing*, *45*(2), 137-143. https://doi.org/https://doi.org/10.1016/j.jen.2018.11.007

McKenna, P., Heslin, S. M., Viccellio, P., Mallon, W. K., Hernandez, C., & Morley, E. J. (2019). Emergency department and hospital crowding: causes, consequences, and cures. *Clin Exp Emerg Med*, *6*(3), 189-195. https://doi.org/10.15441/ceem.18.022

Ministry of Health. (2023). *Health Annual Report 2022* https://site.moh.ps/Content/Books/7B3a7X1pBCWOEINRCY7q9EWTDQUqfaw9pPoeWDZ6OsSLnxZqVGBuyY_rDZGco6Zb5437Fqi2OJDNvtmezzUdHQ79UmhKgrDjxmrz xFxoI5Zeu.pdf

Najjar, S., Shaer, T. A., Hamad, K., Kahlout, M. A., Mughari, H., & Jadba, G. A. (2021). Emergency response of the UNRWA health programme to Great March of Return injuries: a descriptive analytic study in Gaza. *The Lancet*, *398*.

National Center for Health Statistics. (2021). *Ambulatory Health Care Data* https://www.cdc.gov/nchs/ahcd/index.htm

Navarro, S., Ochoa, C. Y., Chan, E., Du, S., & Farias, A. J. (2021). Will Improvements in Patient Experience With Care Impact Clinical and Quality of Care Outcomes?: A Systematic Review. *Med Care*, *59*(9), 843-856. https://doi.org/10.1097/mlr.0000000000001598

Oben, P. (2020). Understanding the Patient Experience: A Conceptual Framework. *Journal of Patient Experience*, *7*, 906 - 910.

Oyegbile, Y. O., & Brysiewicz, P. (2020). Measuring patient experience in the emergency department: A scoping review. *Afr J Emerg Med*, *10*(4), 249-255. https://doi.org/10.1016/j.afjem.2020.07.005

Palestinian Central Bureau of Statistics. (2023). 2023 كتاب فلسطين الإحصائي السنوي ، https://www.pcbs.gov.ps/Downloads/book2688.pdf

Parra, C., Carreras, N., Vergés, A., Trenchs, V., & Luaces, C. (2020). Patient Experience in a Spanish Pediatric Emergency Department. *Pediatr Emerg Care*, *36*(8), e456-e459. https://doi.org/10.1097/pec.0000000000001713

Pineault, R., Borgès da Silva, R., Provost, S., Fournier, M., Prud'homme, A., & Levesque, J.-F. (2017). Do Gender-Predominant Primary Health Care Organizations Have an Impact on Patient Experience of Care, Use of Services, and Unmet Needs? *Inquiry: A Journal of Medical Care Organization, Provision and Financing*, *54*.

Prah Ruger, J., Richter, C. J., & Lewis, L. M. (2006). Clinical and Economic Factors Associated With Ambulance Use to the Emergency Department. *Demand & Supply in Health Economics eJournal*.

Ragin, D. F., Hwang, U., Cydulka, R. K., Holson, D. G., Haley, L. L., Richards, C. F., Becker, B. M., & Richardson, L. D. (2005). Reasons for using the emergency department: results of the EMPATH Study. *Academic emergency medicine: official journal of the Society for Academic Emergency Medicine*, *12 12*, 1158-1166.

Reichmann, W. M., Losina, E., Seage, G. R., Arbelaez, C., Safren, S. A., Katz, J. N., Hetland, A., & Walensky, R. P. (2010). Does Modality of Survey Administration Impact Data Quality: Audio Computer Assisted Self Interview (ACASI) Versus Self-Administered Pen and Paper? *PLOS ONE*, *5*.

Rosenbloom, R., & Leff, R. (2022). Emergency Care in the Occupied Palestinian Territory: A Scoping Review. *Health Hum Rights*, *24*(2), 255-263.

Rytter, M. J. H., Kjældgaard, A.-L., Brønnum-Hansen, H., & Helweg-larsen, K. (2006). Effects of armed conflict on access to emergency health care in Palestinian West Bank: systematic collection of data in emergency departments. *BMJ : British Medical Journal*, *332*, 1122 - 1124.

Shah, S., Patel, A. R., Rumoro, D. P., Hohmann, S. F., & Fullam, F. A. (2015). Managing patient expectations at emergency department triage. *Patient experience journal*, *2*, 31-44.

Sonis, J. D., Aaronson, E. L., Castagna, A., & White, B. A. (2018). A Conceptual Model for Emergency Department Patient Experience. *Journal of Patient Experience*, *6*, 173 - 178.

Sonis, J. D., Aaronson, E. L., Lee, R. Y., Philpotts, L. L., & White, B. A. (2018). Emergency Department Patient Experience:A Systematic Review of the Literature. *Journal of Patient Experience*, *5*(2), 101-106. https://doi.org/10.1177/2374373517731359

Sonis, J. D., & White, B. A. (2020). Optimizing Patient Experience in the Emergency Department. *Emerg Med Clin North Am*, *38*(3), 705-713. https://doi.org/10.1016/j.emc.2020.04.008

Soremekun, O. A., Takayesu, J. K., & Bohan, S. J. (2011). Framework for analyzing wait times and other factors that impact patient satisfaction in the emergency department. *The Journal of emergency medicine*, *41 6*, 686-692.

Sousa, C., & Hagopian, A. (2011). Conflict, health care and professional perseverance: A qualitative study in the West Bank. *Global Public Health*, *6*, 520 - 533.

Swallmeh, E., Byers, V., & Arisha, A. (2018). Informing quality in emergency care: understanding patient experiences. *Int J Health Care Qual Assur*, *31*(7), 704-717. https://doi.org/10.1108/ijhcqa-03-2017-0052

Taher, A., Magcalas, F. W., Woolner, V., Casey, S., Davies, D., & Chartier, L. B. (2020). Quality improvement initiative for improved patient communication in an ED rapid assessment zone. *Emergency Medicine Journal*, *37*, 811 - 818.

Thompson, D. A., Yarnold, P. R., Williams, D. R., & Adams, S. L. (1996). Effects of actual waiting time, perceived waiting time, information delivery, and expressive quality on patient satisfaction in the emergency department. *Annals of emergency medicine*, *28 6*, 657-665.

Thuresson, M., Jarlöv, M. B., Lindahl, B., Svensson, L., Zedigh, C., & Herlitz, J. (2008). Factors that influence the use of ambulance in acute coronary syndrome. *American heart journal*, *156 1*, 170-176.

Tsai, J. C.-H., Liang, Y.-W., & Pearson, W. S. (2010). Utilization of emergency department in patients with non-urgent medical problems: patient preference and emergency department convenience. *Journal of the Formosan Medical Association = Taiwan yi zhi*, *109 7*, 533542.

van den Berg, M. J., van Loenen, T., & Westert, G. P. (2016). Accessible and continuous primary care may help reduce rates of emergency department use. An international survey in 34 countries. *Family practice*, *33 1*, 42-50.

Villalona, S., Boxtha, C., Webb, W. A., Cervantes, C., & Wilson, J. (2020). "If at Least the Patient Could Not Be Forgotten About": Communication in the Emergency Department as a Predictor of Patient Satisfaction. *Journal of Patient Experience*, *7*, 1015 - 1021.

Wang, X., & Cheng, Z. (2020). Cross-Sectional Studies: Strengths, Weaknesses, and Recommendations. *Chest*, *158*(1s), S65-s71. https://doi.org/10.1016/j.chest.2020.03.012

Welch, S. J., Asplin, B. R., Stone-Griffith, S., Davidson, S. J., Augustine, J. J., & Schuur, J. D. (2011). Emergency department operational metrics, measures and definitions:

results of the Second Performance Measures and Benchmarking Summit. *Annals of emergency medicine*, *58 1*, 33-40.

Wolf, J. A. (2017). Patient Experience: The New Heart of Healthcare Leadership. *Front Health Serv Manage*, *33*(3), 3-16. https://doi.org/10.1097/hap.0000000000000002

Wolf, J. A., Niederhauser, V., Marshburn, D., & LaVela, S. L. (2014). Defining patient experience. *Patient experience journal*, *1*(1), 7-19.

Wright, G. S., Causey, S., Dienemann, J. A., Guiton, P., Coleman, F. S., & Nussbaum, M. L. (2013). Patient Satisfaction With Nursing Care in an Urban and Suburban Emergency Department. *JONA: The Journal of Nursing Administration*, *43*, 502–508.

Yarmohammadian, M. H., Rezaei, F., Haghshenas, A., & Tavakoli, N. (2017). Overcrowding in emergency departments: A review of strategies to decrease future challenges. *J Res Med Sci*, *22*, 23. https://doi.org/10.4103/1735-1995.200277

Yarris, L. M., Moreno, R. A., Schmidt, T. A., Adams, A. L., & Brooks, H. S. (2006). Reasons why patients choose an ambulance and willingness to consider alternatives. *Academic emergency medicine : official journal of the Society for Academic Emergency Medicine*, *13 4*, 401-405.

Zakkar, M. A. (2019). Patient experience: determinants and manifestations. *International Journal of Health Governance*.

Appendices

Appendix A

Accident and Emergency Department (A&ED) questionnaire (English)

Accident and Emergency (A&E) Department Questionnaire

This survey is about your **most recent** visit to the Accident and Emergency Department at the hospital named in the letter enclosed with this questionnaire. The department may also be referred to as **Casualty, Emergency Department** or **A&E.** It does not include other wards or units that you might have been moved to whilst you were at the hospital, such as an inpatient ward.

What you tell us is confidential and taking part is voluntary.

WHAT TO DO

Put a cross ☒ clearly inside one box using a black or blue pen.

If you make a mistake, just fill in the box ■ and put a cross ☒ in the correct box.

If you cannot answer a question, or do not want to answer it, just leave it blank and go to the next question.

Please remember not to write your name or address anywhere on the questionnaire.

When you have filled in as much as you can, please return it in the Freepost envelope provided.

NEED MORE HELP?

For help completing the questionnaire, please call the survey helpline on <insert helpline number here> or email <insert email helpline here>

If you have concerns about the care you or others have received please contact the Care Quality Commission (CQC) on 03000 61 61 61.

ARRIVAL

Please remember, this questionnaire is about your **most recent visit** to the A&E department at the hospital named in the letter.

1. Was this A&E department the **first** service you went to, or contacted, for help with your condition?

1 ☐ Yes **➔ Go to 4**

2 ☐ No **➔ Go to 2**

2. Before going to this A&E department, where did you go to, or contact, for help with your condition? **(Cross ALL that apply)**

1 ☐ 999 emergency service

2 ☐ NHS 111 telephone service

3 ☐ NHS 111 online service

4 ☐ A different A&E department

5 ☐ Pharmacist

6 ☐ GP practice

7 ☐ GP out-of-hours service

8 ☐ Urgent Treatment Centre/ Urgent Care Centre / Minor Injuries Unit / Walk-in Centre

9 ☐ Somewhere else

3. What was the **MAIN** reason for going to A&E following your contact with the service(s) above? **(Cross ONE only)**

1 ☐ The service(s) (above) referred / took me

2 ☐ I couldn't get a GP appointment quickly enough

3 ☐ I am not registered with a GP

4 ☐ My condition became worse

5 ☐ I was not satisfied with the help I received

6 ☐ A different reason

4. Were you taken to A&E in an ambulance?

1 ☐ Yes **➔ Go to 5**

2 ☐ No **➔ Go to 6**

5. Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the A&E staff?

1 ☐ I did not have to wait

2 ☐ Up to 15 minutes

3 ☐ 16 – 30 minutes

4 ☐ 31 – 60 minutes

5 ☐ More than 1 hour but no more than 2 hours

6 ☐ More than 2 hours

7 ☐ Don't know / can't remember

6. Were you given enough privacy when discussing your condition with the **receptionist**?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not discuss my condition with a receptionist

7. Were you treated in a separate area of A&E because you had coronavirus, or symptoms of coronavirus? *This is regardless of your reason for visiting.*

1 ☐ Yes

2 ☐ No

3 ☐ Don't know

4 ☐ Can't remember

8. Before your most recent visit to A&E, had you previously been to **the same** A&E department about **the same condition** or something related to it?

1 ☐ Yes, within the previous week

2 ☐ Yes, between one week and one month earlier

3 ☐ Yes, more than a month earlier

4 ☐ No

5 ☐ Don't know / can't remember

WAITING

9. How long did you wait before you **first spoke** to a nurse or doctor? *This does not include staff screening for coronavirus at the entrance to A&E.*

1 ☐ 0 -15 minutes
2 ☐ 16 - 30 minutes
3 ☐ 31- 60 minutes
4 ☐ More than 60 minutes
5 ☐ Don't know / can't remember

10. Did the nurse or doctor explain what would happen next?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ I did not need an explanation
5 ☐ Don't know / can't remember

11. Sometimes, people will first talk to a doctor or nurse and be examined later. **From the time you arrived**, how long did you wait **before being examined** by a doctor or nurse?

1 ☐ I did not have to wait → **Go to 14**
2 ☐ 1-30 minutes → **Go to 12**
3 ☐ 31-60 minutes → **Go to 12**
4 ☐ More than 1 hour but no more than 2 hours → **Go to 12**
5 ☐ More than 2 hours but no more than 4 hours → **Go to 12**
6 ☐ More than 4 hours → **Go to 12**
7 ☐ Don't know / can't remember → **Go to 12**

12. Were you informed **how long** you would have to wait to be examined?

1 ☐ Yes, but the wait was **shorter**
2 ☐ Yes, and I had to wait about as long as I was informed
3 ☐ Yes, but the wait was **longer**
4 ☐ No, I was not informed
5 ☐ Don't know / can't remember

13. While you were waiting, were you able to get help with your condition or symptoms from a member of staff?

1 ☐ Yes
2 ☐ No
3 ☐ I did not need any help with my condition or symptoms

14. Overall, how long did your visit to **A&E** last?

1 ☐ Up to 1 hour
2 ☐ More than 1 hour but no more than 2 hours
3 ☐ More than 2 hours but no more than 4 hours
4 ☐ More than 4 hours but no more than 6 hours
5 ☐ More than 6 hours but no more than 8 hours
6 ☐ More than 8 hours but no more than 12 hours
7 ☐ More than 12 hours
8 ☐ Can't remember

DOCTORS AND NURSES

Thinking about your experience in A&E only….

15. Did you have **enough time** to discuss your condition with the doctor or nurse?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No

16. While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?

1 ☐ Yes, completely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ I did not need an explanation

17. Did the doctors and nurses listen to what you had to say?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No

18. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

1 ☐ Yes, completely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ I did not have any anxieties or fears

19. Did you have confidence and trust in the doctors and nurses examining and treating you?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No

20. Did doctors or nurses talk to each other about you as if you weren't there?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No

YOUR CARE AND TREATMENT

21. While you were in A&E, how much information about your condition or treatment was given to **you**?

1 ☐ Not enough
2 ☐ Right amount
3 ☐ Too much
4 ☐ I was not given any information about my condition or treatment

22. Were you given enough privacy when **being examined or treated**?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No

23. If **you** needed attention, were you able to get a member of medical or nursing staff to help you?

1 ☐ Yes, always
2 ☐ Yes, sometimes
3 ☐ No, I could not find a member of staff to help me
4 ☐ A member of staff was with me all the time
5 ☐ I did not need attention

24. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No

25. Were you involved as much as you wanted to be in decisions about your care and treatment?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ I was not well enough to be involved in decisions about my care

TESTS

26. Did you have any tests (such as x-rays, scans or blood tests) when you visited A&E?

1 ☐ Yes → **Go to 27**
2 ☐ No → **Go to 31**

27. Did a member of staff explain **why you needed** these test(s) in a way you could understand?

1 ☐ Yes, completely
2 ☐ Yes, to some extent
3 ☐ No

28. Before you left A&E, did you get the **results** of your tests?

1 ☐ Yes → **Go to 29**
2 ☐ No → **Go to 30**
3 ☐ I was told that the results of the tests would be given to me at a later date → **Go to 30**
4 ☐ Don't know / can't remember → **Go to 31**

29. Did a member of staff explain the **results of the tests** in a way you could understand?

1 ☐ Yes, definitely ➔ **Go to 31**
2 ☐ Yes, to some extent ➔ **Go to 31**
3 ☐ No ➔ **Go to 31**
4 ☐ Not sure / can't remember ➔ **Go to 31**

30. If you did not get the results of the tests when you were in A&E, did a member of staff explain **how** you would receive them?

1 ☐ Yes
2 ☐ No
3 ☐ Don't know / can't remember

PAIN

31. Do you think the hospital staff did everything they could to help control your pain?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ I was not in pain while I was in A&E
5 ☐ Can't say / don't know

HOSPITAL ENVIRONMENT AND FACILITIES

32. In your opinion, how clean was the A&E department?

1 ☐ Very clean
2 ☐ Fairly clean
3 ☐ Not very clean
4 ☐ Not at all clean
5 ☐ Can't say

33. While you were in A&E, did you see any of the following?

	1 Yes	2 No	3 Don't know
1 Social distancing measures (such as markers on the floor or signage at the entrance)	☐	☐	☐
2 Handwashing with hand sanitiser or soap	☐	☐	☐
3 Staff wearing PPE (e.g. gloves, masks, plastic aprons, eyewear)	☐	☐	☐
4 Staff disposing of gloves and plastic aprons	☐	☐	☐
5 Cleaning of surfaces	☐	☐	☐
6 Tissues available	☐	☐	☐
7 Waste bins provided	☐	☐	☐

34. While you were in A&E, did you feel threatened by other patients or visitors?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No

35. Were you able to get suitable food or drinks when you were in A&E?

1 ☐ Yes
2 ☐ No
3 ☐ I was told not to eat or drink
4 ☐ I did not know if I was allowed to eat or drink
5 ☐ I did not want anything to eat or drink

LEAVING A&E

36. At the end of your visit to A&E, were you transferred to a hospital ward?

1 ☐ Yes ➔ **Go to 46**
2 ☐ No ➔ **Go to 37**

MEDICATIONS (e.g. medicines, tablets, ointments)

37. Before you left A&E, were you prescribed any **new** medications?

1 ☐ Yes ➔ **Go to 38**

2 ☐ No ➔ **Go to 40**

38. Did a member of staff explain **the purpose** of the medications you were to take at home in a way you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

39. Did a member of staff tell you about **medication side effects** to watch for?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need this type of information

INFORMATION

40. Did a member of staff tell you about what **symptoms to watch for** regarding your illness or treatment after you went home?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need this type of information

41. Did hospital staff tell you **who to contact** if you were worried about your condition or treatment after you left A&E?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know / can't remember

42. Did staff give you enough information to help you care for your condition at home?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need this type of information

43. Before you left the hospital, did a member of staff discuss your transport arrangements for leaving A&E?

1 ☐ Yes

2 ☐ No

3 ☐ It was not necessary

4 ☐ Don't know / can't remember

44. Did hospital staff discuss with you whether you may need further health or social care services after leaving A&E (e.g. services from GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?

1 ☐ Yes

2 ☐ No, but I would have liked them to

3 ☐ No, it was not necessary to discuss it

45. After leaving A&E, was the care and support you expected available **when** you needed it?

1 ☐ Yes

2 ☐ No

3 ☐ I did not expect any further care or support after I left A&E

OVERALL

46. Overall, did you feel you were treated with respect and dignity while you were in A&E?

1 ☐ Yes, all of the time

2 ☐ Yes, some of the time

3 ☐ No

47. Overall... **(please circle a number)**

I had a very poor experience — I had a very good experience

0 1 2 3 4 5 6 7 8 9 10

ABOUT YOU

48. Who was the main person or people that filled in this questionnaire?

1 ☐ The **patient** (named on the front of the envelope)

2 ☐ A **friend or relative** of the patient

3 ☐ **Both** patient and friend / relative together

4 ☐ The patient with the help of a health professional

Reminder: All questions should be answered from the point of view of the person named on the envelope, including these background questions.

49. Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?

Include problems related to old age.

1 ☐ Yes ➔ **Go to 50**

2 ☐ No ➔ **Go to 52**

50. Do you have any of the following?
Select **ALL** conditions you have that have lasted or are expected to last for 12 months or more.

1 ☐ Breathing problem, such as asthma

2 ☐ Blindness or partial sight

3 ☐ Cancer in the last 5 years

4 ☐ Dementia or Alzheimer's disease

5 ☐ Deafness or hearing loss

6 ☐ Diabetes

7 ☐ Heart problem, such as angina

8 ☐ Joint problem, such as arthritis

9 ☐ Kidney or liver disease

10 ☐ Learning disability

11 ☐ Mental health condition

12 ☐ Neurological condition

13 ☐ Autism or autism spectrum condition

14 ☐ Stroke (which affects your day-to-day life)

15 ☐ Another long-term condition

51. Do any of these reduce your ability to carry out day-to-day activities?

1 ☐ Yes, a lot

2 ☐ Yes, a little

3 ☐ No, not at all

52. Have you experienced any of the following in the last twelve months? **(Cross ALL that apply)**

1 ☐ Problems with your physical mobility, such as difficulty getting about your home

2 ☐ Two or more falls that have needed medical attention

3 ☐ Feeling isolated from others

4 ☐ None of these

53. Around the time of your A&E visit, were you responsible for looking after, giving support to, or helping family members, friends, neighbours or others because of their:

- Long-term physical or mental ill health / disability, or
- Problems related to old age?

1 ☐ Yes

2 ☐ No

54. Are you male or female?

1 ☐ Male

2 ☐ Female

55. What was your **year** of birth?

(Please write in) e.g. | 1 | 9 | 6 | 4 |

56. What is your religion?

1 ☐ No religion

2 ☐ Buddhist

3 ☐ Christian (including Church of England, Catholic, Protestant, and other Christian denominations)

4 ☐ Hindu

5 ☐ Jewish

6 ☐ Muslim

7 ☐ Sikh

8 ☐ Other

9 ☐ I would prefer not to say

57. Which of the following best describes how you think of yourself?

1 ☐ Heterosexual / straight
2 ☐ Gay / lesbian
3 ☐ Bisexual
4 ☐ Other
5 ☐ I would prefer not to say

58. What is your ethnic group?
(Cross ONE box only)

a. WHITE

1 ☐ English / Welsh / Scottish / Northern Irish / British
2 ☐ Irish
3 ☐ Gypsy or Irish Traveller
4 ☐ Any other White background, **write in...**

b. MIXED / MULTIPLE ETHNIC GROUPS

5 ☐ White and Black Caribbean
6 ☐ White and Black African
7 ☐ White and Asian
8 ☐ Any other Mixed / multiple ethnic background, **write in...**

c. ASIAN / ASIAN BRITISH

9 ☐ Indian
10 ☐ Pakistani
11 ☐ Bangladeshi
12 ☐ Chinese
13 ☐ Any other Asian background, **write in...**

d. BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH

14 ☐ African
15 ☐ Caribbean
16 ☐ Any other Black / African / Caribbean background, **write in...**

e. OTHER ETHNIC GROUP

17 ☐ Arab
18 ☐ Any other ethnic group, **write in...**

ANY OTHER COMMENTS

If there is anything else you would like to tell us about your experiences in the A&E department, please do so here.

*Please note that the comments you provide will be looked at in full by the NHS Trust, CQC and researchers analysing the data. We will remove any information that could identify you before publishing any of your feedback. Your details will **only** be passed back to the NHS Trust if **your comments in this section** raise concerns for your own or others' safety and wellbeing.*

THANK YOU VERY MUCH FOR YOUR HELP

Please check that you answered all the questions that apply to you.

Please post this questionnaire back in the **FREEPOST** envelope provided.

No stamp is needed

Appendix B

Accident and Emergency Department (A&ED) questionnaire (Arabic)

يرجى اختيار الإجابة الأكثر مناسبة من الخيارات التي تقابل كل سؤال

يرجى اختيار الإجابة الأكثر مناسبة من الخيارات التي تقابل كل سؤال

السؤال	الخيارات
القسم الأول: الوصول	
1. هل كان قسم الطوارئ الوجهة الأولى التي ذهبت أو تواصلت معها لطلب المساعدة لوضعك الصحي؟	1. نعم (اذهب للسؤال 4) 2. لا (اذهب للسؤال 2)
2. قبل الذهاب للطوارئ، ما هي الوجهة التي طلبت منها المساعدة أو تواصلت معها بشأنك الصحي؟ **(يمكنك اختيار أكثر من إجابة)**	1. مركز طوارئ محلي 2. عيادة خاصة لطبيب (عام أو متخصص) 3. قسم طوارئ مختلف 4. صيدلاني 5. طبيب خارج الخدمة 6. مكان آخر
3. ما هو السبب الرئيسي لتوجهك لقسم الطوارئ بعد التواصل مع أو الذهاب لأحد المرافق السابق ذكرها؟ **(اختر إجابة واحدة فقط)**	1. الخدمة أعلاه هي من قامت بتحويلي للطوارئ 2. لم أستطع أخذ موعد مع الطبيب بسرعة كافية 3. لست مسجلاً في سجلات الطبيب 4. حالتي أصبحت أكثر سوءاً 5. لم أكن راضياً عن الخدمة التي تلقيتها 6. سبب آخر
4. هل تم أخذك لقسم الطوارئ في سيارة الإسعاف؟	1. نعم (اذهب للسؤال 5) 2. لا (اذهب للسؤال 6)

5. عندما وصلت سيارة الإسعاف لقسم الطوارئ، كم انتظرت حتى تم تسليم حالتك لطاقم قسم الطوارئ؟	1. لم أحتج للانتظار 2. حتى 15 دقيقة 3. 16 – 30 دقيقة 4. 31 – 60 دقيقة 5. أكثر من ساعة، ولكن أقل من ساعتين 6. أكثر من ساعتين 7. لا أعلم / لا أتذكر
6. هل تم إعطاؤك الخصوصية الكافية عندما تناقشت حالتك مع من استقبلك؟	1. نعم، بالتأكيد 2. نعم، إلى حد ما 3. لا 4. لم أناقش حالتي من موظف الاستقبال
7. هل تم علاجك في منطقة أخرى من الطوارئ بسبب إصابتك بفايروس كورونا؟ بغض النظر عن حالتك الأساسية	1. نعم 2. لا 3. لا أعلم 4. لا أتذكر
8. قبل ذهابك لزيارة قسم الطوارئ هذا، هل ذهبت لنفس الطوارئ لنفس السبب أو لسبب قريب منه؟	1. نعم، خلال الأسبوع الماضي 2. نعم، خلال أسبوع لشهر مضى 3. نعم، منذ أكثر من شهر مضى 4. لا 5. لا أعلم / لا أتذكر
القسم الثاني: الانتظار	

9. كم انتظرت من الوقت قبل أن يقوم ممرض أو طبيب بالتحدث معك للمرة الأولى؟	1. 0 – 15 دقيقة 2. 16 – 30 دقيقة 3. 31 – 60 دقيقة 4. أكثر من 60 دقيقة 5. لا أعلم / لا أتذكر
10. هل قام الطبيب/الممرض بتفسير ما سيتم عمله تالياً؟	1. نعم، بالتأكيد 2. نعم، إلى حد ما 3. لا 4. لم أناقش حالتي من موظف الاستقبال 5. لا أعلم / لا أتذكر
11. في بعض الأحيان، يتكلم المريض مع الطبيب/الممرض أولا ثم ينتظر العلاج. من وقت وصولك، من انتظرت حتى يتم معاينتك للمرة الأولى من قبل طبيب أو ممرض؟	1. لم أحتج للانتظار (اذهب للسؤال 14) 2. حتى 15 دقيقة (اذهب للسؤال 12) 3. 16 – 30 دقيقة (اذهب للسؤال 12) 4. 31 – 60 دقيقة (اذهب للسؤال 12) 5. أكثر من ساعة، وأقل من ساعتين (اذهب للسؤال 12) 6. أكثر من ساعتين (اذهب للسؤال 12) 7. لا أعلم / لا أتذكر (اذهب للسؤال 12)
12. هل تم إعلامك بالمدة التي تتطلب الانتظار لبدء الفحص أول مرة؟	1. نعم، ولكن انتظرت وقتاً أقصر 2. نعم، لقد انتظرت تقريبا كما تم إخباري 3. نعم، ولكن انتظرت وقتاً أطول 4. لا، لم يتم إعلامي

	.5	لا أعلم / لا أتذكر
13. خلال انتظارك، هل استطعت الحصول على المساعدة بشأن وضعك أو أعراضك من قبل الطاقم؟	.1	نعم
	.2	لا
	.3	لم أحتج لمساعدة بشأن وضعي أو أعراضي
14. بشكل عام، كم أخذت زيارتك للطوارئ من وقت؟	.1	حتى ساعة واحدة
	.2	أكثر من ساعة وأقل من ساعتين
	.3	أكثر من ساعتين وأقل من أربع ساعات
	.4	أكثر من أربع ساعات وأقل من ست ساعات
	.5	أكثر من ست ساعات وأقل من ثمان ساعات
	.6	أكثر من ثمان ساعات وأقل من اثني عشرة ساعة
	.7	أكثر من اثني عشرة ساعة
	.8	لا أتذكر
القسم الثالث: الأطباء والممرضين (فكر بتجربتك في الطوارئ فقط)		
15. هل أخذت وقتاً كافياً في مناقشة حالتك مع الطبيب أو الممرض؟	.1	نعم بالتأكيد
	.2	نعم، إلى حد ما
	.3	لا
16. خلال وجودك في الطوارئ، هل شرح لك الطبيب أو الممرض حالتك وعلاجك بشكل يسهل فهمه؟	.1	نعم، بشكل كامل
	.2	نعم، إلى حد ما
	.3	لا
	.4	لم أحتج إلى توضيح عن حالتي
17. هل استمع الأطباء أو الممرضين لما تكلمت به؟	.1	نعم، بالتأكيد
	.2	نعم، إلى حد ما

	3. لا
18. إذا كان هنالك مخاوف أو توتر من وضعك أو علاجك، هل ناقشها طبيب أو ممرض معك؟	1. نعم، بشكل كامل
	2. نعم، إلى حد ما
	3. لا
	4. لم يكن هنالك مخاوف أو توتر
19. هل كان لديك ثقة ووثوق بالفحص والعلاج الذي قدمه لك الأطباء أو الممرضون؟	1. نعم، بالتأكيد
	2. نعم، إلى حد ما
	3. لا
20. هل تكلم عنك الأطباء أو الممرضون كأنك لم تكن موجوداً؟	1. نعم، بالتأكيد
	2. نعم، إلى حد ما
	3. لا
القسم الرابع: رعايتك وعلاجك	
21. خلال وجودك في الطوارئ، كم من المعلومات تلقيتها عن حالتك أو علاجك؟	1. ليس كافياً
	2. كمية صحيحة
	3. أكثر من اللازم
	4. لم أتلق معلومات عن حالتي أو علاجي
22. هل تلقيت خصوصية كافية خلال فحصك أو علاجك؟	1. نعم، بالتأكيد
	2. نعم، إلى حد ما
	3. لا
23. إذا كنت بحاجة للاهتمام، هل كنت قادراً على طلب أحد الطواقم الطبية أو التمريضية لمساعدتك؟	1. نعم، دائما
	2. نعم، في بعض الأحيان
	3. لا، لم أستطع إيجاد أحد الطواقم الطبية أو التمريضية

	4. أحد الطواقم كان معي دائماً
	5. لم أحتج إلى هذا الاهتمام
24. في بعض الأحيان، قد يتكلم أحد الطواقم بشيء ويتكلم آخر بشيء مختلف. هل حدث ذلك معك؟	1. نعم، بالتأكيد
	2. نعم، إلى حد ما
	3. لا
25. هل كنت ضمن القرارات التي تخص علاجك ورعايتك كما شئت؟	1. نعم، بالتأكيد
	2. نعم، إلى حد ما
	3. لا
	4. لم أكن بالوضع الكافي لأكون ضمن اختيار العلاج
القسم الخامس: الفحوصات	
26. هل تم عمل فحوصات لك (أشعة، تصوير، فحوصات دم، ... إلخ) عندما زرت الطوارئ؟	1. نعم (اذهب للسؤال 27)
	2. لا (اذهب للسؤال 31)
27. هل قام أحد الطواقم بشرح السبب الذي من أجله تحتاج عمل الفحوصات بشكل يسهل فهمه؟	1. نعم، بالتأكيد
	2. نعم، إلى حد ما
	3. لا
28. قبل مغادرتك الطوارئ، هل تلقيت نتائج الفحوصات التي تم عملها لك؟	1. نعم (اذهب للسؤال 29)
	2. لا (اذهب للسؤال 30)
	3. لقد أخبرت أني سأستلمها لاحقاً (اذهب للسؤال 30)
	4. لا أعلم / لا أتذكر (اذهب للسؤال 31)
29. هل قام أحد الطواقم الطبية بشرح نتائج الفحوصات لك بشكل يسهل فهمه؟	1. نعم، بالتأكيد (اذهب للسؤال 31)
	2. نعم، إلى حد ما (اذهب للسؤال 31)

	3. لا (اذهب للسؤال 31)			
	4. لست متأكداً / لا أتذكر (اذهب للسؤال 31)			
30. إذا لم تتلق النتائج خلال وجودك في الطوارئ، هل وضح لك أحد الطواقم كيف يمكن استلامها؟	1. نعم			
	2. لا			
	3. لا أعلم / لا أتذكر			
القسم السادس: الألم				
31. هل تعتقد أن الطاقم الطبي فعل ما بوسعه لمساعدتك في السيطرة على الألم؟	1. نعم، بالتأكيد			
	2. نعم، إلى حد ما			
	3. لا			
	4. لم أكن أتألم عندما زرت الطوارئ			
	5. لا أعلم / لا أتذكر			
القسم السابع: مرافق وبيئة المستشفى				
32. في رأيك، كم كانت نظافة قسم الطوارئ؟	1. نظيفة جدا			
	2. معتدلة النظافة			
	3. ليست نظيفة جدا			
	4. ليست نظيفة أبدا			
	5. لا أستطيع القول			
33. خلال وجودك في الطوارئ، هل رأيت ما يلي؟		**نعم**	**لا**	**لا أعلم**
أ. مقاييس التباعد الاجتماعي (علامات)				
ب. غسل الأيدي بالمعقم أو الصابون				
ت. ارتداء الطاقم لمعدات الوقاية الشخصية				

ث. تخلص الطاقم من القفازات والمراييل				
ج. تنظيف الأسطح				
ح. توفر المحارم				
خ. توفير سلال المهملات				
34. خلال وجودك في الطوارئ، هل شعرت بالتهديد من مريض آخر أو أحد الزوار؟	1. نعم، بالتأكيد			
	2. نعم، إلى حد ما			
	3. لا			
35. هل كنت تستطيع الحصول على الأطعمة والأشربة خلال وجودك بالطوارئ؟	1. نعم			
	2. لا			
	3. تم إخباري بعدم تناول الأطعمة أو الأشربة			
	4. لم أكن أعلم إن كان مسموحا لي أن أشرب أو آكل			
	5. لم أرد شيئاً للأكل أو الشرب			
القسم الثامن: مغادرة الطوارئ				
36. عند نهاية زيارة الطوارئ، هل تم نقلك إلى قسم آخر في المستشفى؟	1. نعم (اذهب للسؤال 46)			
	2. لا (اذهب للسؤال 37)			
القسم التاسع: الأدوية				
37. قبل مغادرتك الطوارئ، هل تم وصف أدوية جديدة لك؟	1. نعم (اذهب للسؤال 38)			
	2. لا (اذهب للسؤال 40)			
38. هل قام أحد الطواقم بشرح الهدف من هذه الأدوية التي ستأخذها للمنزل بطريقة يسهل فهمها؟	1. نعم، بالتأكيد			
	2. نعم، إلى حد ما			
	3. لا			
	4. لم أحتج إلى شرح			

39. هل قام أحد الطواقم بشرح الأعراض الجانبية للأدوية التي يجب مراقبتها؟	1. نعم، بالتأكيد 2. نعم، إلى حد ما 3. لا 4. لم أحتج هذا النوع من المعلومات
القسم العاشر: المعلومات	
40. هل قام أحد من الطواقم بشرح الأعراض التي يجب مراقبتها بالنسبة لوضعك الصحي بعد المغادرة للمنزل؟	1. نعم، بالتأكيد 2. نعم، إلى حد ما 3. لا 4. لم أحتج هذا النوع من المعلومات
41. هل قام طاقم المستشفى بإخبار بمن تتصل إذا قلقت بشأن وضعك أو علاجك بعد مغادرة الطوارئ؟	1. نعم 2. لا 3. لا أعلم، لا أتذكر
42. هل أعطاك الطاقم الطبي معلومات كافية عن علاج حالتك في البيت؟	1. نعم، بالتأكيد 2. نعم، إلى حد ما 3. لا 4. لم أحتج هذا النوع من المعلومات
43. قبل مغادرتك المستشفى، هل ناقش أحد الطاقم الطبي ترتيبات النقل لمغادرة الطوارئ؟	1. نعم 2. لا 3. لم يكن ذلك ضرورياً 4. لا أعلم / لا أتذكر
	1. نعم 2. لا، ولكن وددت لو حصلت عليها

44. هل ناقش أحد الطاقم الطبي معك إمكانية احتياجك لنوع آخر من الرعاية الطبية بعد مغادرتك الطوارئ؟ (طبيب أو عيادة، ... إلخ)	3. لا، لم يكن ذلك ضرورياً
45. بعد مغادرتك للطوارئ، هل كان الدعم والرعاية متوفرين وقت حاجتك لهما؟	1. نعم 2. لا 3. لم أتوقع رعاية أو دعماً بعد مغادرة الطوارئ
القسم الحادي عشر: بشكل عام	
46. بشكل عام، هل تشعر أن تلقيت العلاج باحترام وكرامة عند وجودك في قسم الطوارئ؟	1. نعم، طيلة الوقت 2. نعم، بعض الوقت 3. لا
47. بشكل عام، قيم تجربتك للخدمة المقدمة (0 = الأسوأ، 10 = الأفضل)	0 1 2 3 4 5 6 7 8 9 10
القسم الثاني عشر: عنك أنت	
48. من كان الشخص الرئيسي الذي قام بتعبئة هذه الاستبانة؟	1. المريض نفسه 2. أحد الأصدقاء أو المعارف 3. كلا المريض وأحد الأصدقاء أو المعارف 4. المريض بمساعدة أحد الطواقم الطبية
49. هل لديك أحد المشاكل الطبية أو الصحية أو الإعاقات أو المشاكل النفسية التي دامت أو من الممكن أن تدوم لأكثر من 12 شهراً؟ يتضمن ما يسببه العمر	1. نعم (اذهب للسؤال 50) 2. لا (اذهب للسؤال 52)
50. هل تمتلك أي من هذه الخيارات؟ (اختر كل ما ينطبق عليك والذي دام أو من المتوقع أن يجوم أكثر من 12 شهراً)	1. مشاكل في التنفس، مثل الأزمة 2. فقدان البصر كلياً أو جزئياً 3. السرطان خلال آخر خمس سنوات

	4. الخرف أو مرض الزهايمر
	5. الطرش أو فقدان للسمع
	6. السكري
	7. مشاكل في القلب، مثل الذبحة الصدرية
	8. مشاكل في المفاصل، مثل التهاب المفاصل
	9. مشاكل في الكلى أو الكبد
	10. صعوبات أو إعاقات في التعلم
	11. مشكلة في الصحة النفسية
	12. مشكلة عصبية (الجهاز العصبي)
	13. التوحد أو مشكل طيف التوحد
	14. الجلطة الدماغية (التي تؤثر على حياتك اليومية)
	15. مشكلة أخرى طويلة الأمد
51. هل أي من المشاكل السابقة تؤثر على قيامك بنشاطاتك اليومية؟	1. نعم، كثيرا
	2. نعم، قليلا
	3. لا، أبدا
52. هل واجهت أي من المشاكل التالية خلال ال 12 شهرا الماضية؟ (يمكنك اختيار كل ما ينطبق عليك)	1. مشاكل جسدية، كالقدرة على الوصول للبيت
	2. سقوط أو اثنين احتاج لاهتمام طبي
	3. الشعور بالعزلة عن الآخرين
	4. لا مشكلة من المذكورة
53. حوالي الوقت الذي زرت فيه قسم الطوارئ، هل كنت ترعى أحدا بسبب وضع جسدي أو نفسي أو إعاقة أو مشاكل تتعلق بالعمر، من الأقارب أو المعارف أو الأصدقاء؟	1. نعم
	2. لا

54. الجنس	1. ذكر
	2. أنثى
55. ما هي سنة ميلادك؟ (مثلا: 1995)	
56. ما هي ديانتك؟	1. الإسلام
	2. المسيحية
	3. أخرى
57. محذوف (الميول الجنسي)	
58. محذوف (العرق)	
هل لديك أي تعليقات أخرى؟	

Appendix C

Informed Consent Form (Arabic)

عزيزي المريض / عزيزتي المريضة

أنا الطالبة سجود بشار عبد الله، وأطلب من حضرتك الإجابة عن الاستبيان التالي الذي يعتبر جزءاً من رسالتي في ماجستير تمريض الطوارئ في جامعة النجاح الوطنية، وهو يهدف إلى استكشاف تجربة المرضى في أقسام الطوارئ في الضفة الغربية، تحديداً مدينتي نابلس ورام الله، وكذلك أهم العوامل الشخصية والطبية الخاصة بالمريض/ـة التي تؤثر على هذه التجربة. أرجو من حضرتك الإجابة على جميع أسئلة الاستبيان، والأخذ بعين الاعتبار أن الأسئلة هي عن زيارتك الأخيرة لقسم الطوارئ .

يتكون هذا الاستبيان من 58 سؤالاً (قد لا تضطر للإجابة عنها جميعاً)، وهو استبيان موثوق مترجم من اللغة الإنجليزية، ويضم أسئلة تتطلب اختيار الإجابة المناسبة من عدة خيارات مرفقة، ويتناول عدة محاور، هي: الوصول، الانتظار، الأطباء والممرضين، عنايتك ورعايتك، الفحوصات، الألم، بيئة ومرافق المستشفى، مغادرة الطوارئ، الأدوية، المعلومات، التقييم بشكل عام، وأسئلة عنك .

أود التأكيد هنا أن جميع المعلومات التي سيتم جمعها سيتم التعامل معها بسرية وخصوصية تامة، حيث إنه لن يتم جمع معلومات حساسة عنك، بما في ذلك الاسم أو رقم التواصل، وأن هذه المعلومات ستظل في مغلف مغلق بإحكام حتى بدء تحليلها، وأن سيتم التعامل معها من قبل الباحث والمشرف ولأغراض البحث العلمي فقط، كما ويمكنك الانسحاب من الدراسة في أي وقت تشاء .

لأي استفسارات يرجى التواصل مع الباحثة الرئيسية :

سجود بشار عبد الله. جوال: 0597242574

أو المشرف: الدكتور نزار سعيد :0599594960

أشكر لك استثمار وقتك الثمين

Appendix D

Institutional Review Board (IRB) form

An-Najah National
University
Faculty of Medicine &
Health Sciences
Institutional Review Board

جامعة النجاح الوطنية
كلية الطب وعلوم الصحة
لجنة اخلاقي البحث العلمي

Ref: Mas. March 2024/28

IRB Approval Letter

Title of Research:

Measurement of Patients' Experience in the Emergency Departments in West Bank – Palestine: A Quantitative Cross-sectional Study

Submitted by:
Sojoud Bashar Fayez Abdullah

Supervisor:
Nizar Said

Approved:
26th March. 2024

Your Study Title **"Measurement of Patients' Experience in the Emergency Departments in West Bank – Palestine: A Quantitative Cross-sectional Study"** reviewed by An-Najah National University IRB committee and was approved on 26th March 2024.

Hasan Fitian, MD

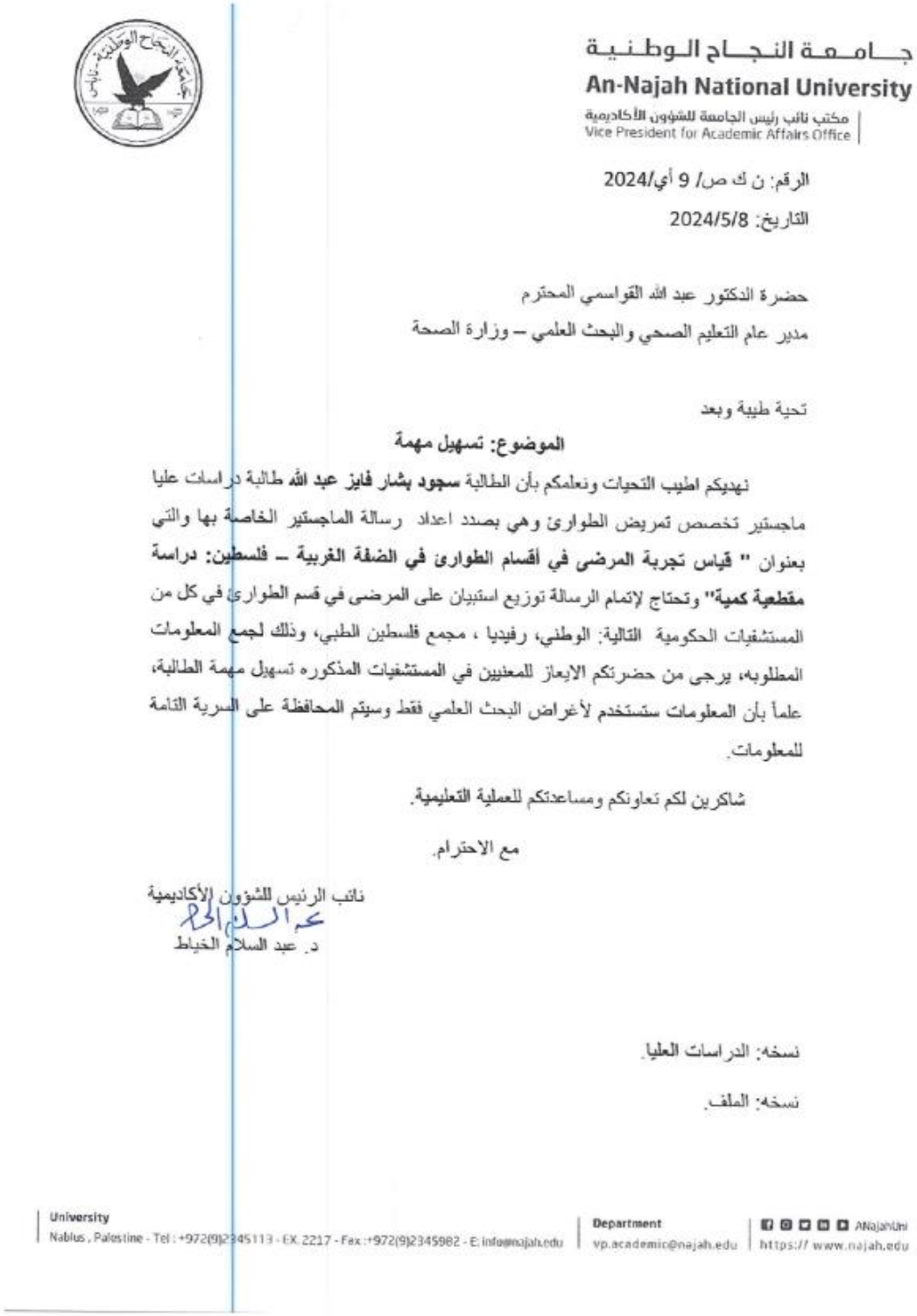
IRB Committee Chairman

IRB
Institutional Review Board

Nablus - P.O Box :7 or 707 | Tel (970) (09) 2342902/4/7/8/14 | Faximile (970) (09) 2342910 | E-mail : IRB@najah.edu

Appendix E

Approval from An-Najah National University Hospital



جـــامـعـة النـجـــاح الـوطـنـيـة
An-Najah National University
مكتب نائب رئيس الجامعة للشؤون الأكاديمية
Vice President for Academic Affairs Office

الرقم: ن ك ص/ 9 أي/2024
التاريخ: 2024/5/8

حضرة الدكتور عبد الله القواسمي المحترم
مدير عام التعليم الصحي والبحث العلمي – وزارة الصحة

تحية طيبة وبعد

الموضوع: تسهيل مهمة

نهديكم اطيب التحيات ونعلمكم بأن الطالبة **سجود بشار فايز عبد الله** طالبة دراسات عليا ماجستير تخصص تمريض الطوارئ وهي بصدد اعداد رسالة الماجستير الخاصة بها والتي بعنوان **" قياس تجربة المرضى في أقسام الطوارئ في الضفة الغربية – فلسطين: دراسة مقطعية كمية"** وتحتاج لإتمام الرسالة توزيع استبيان على المرضى في قسم الطوارئ في كل من المستشفيات الحكومية التالية: الوطني، رفيديا ، مجمع فلسطين الطبي، وذلك لجمع المعلومات المطلوبه، يرجى من حضرتكم الايعاز للمعنيين في المستشفيات المذكوره تسهيل مهمة الطالبة، علماً بأن المعلومات ستستخدم لأغراض البحث العلمي فقط وسيتم المحافظة على السرية التامة للمعلومات.

شاكرين لكم تعاونكم ومساعدتكم للعملية التعليمية.

مع الاحترام.

نائب الرئيس للشؤون الأكاديمية
د. عبد السلام الخياط

نسخه: الدراسات العليا.

نسخه: الملف.

University
Nablus , Palestine - Tel : +972(9)2345113 - EX. 2217 - Fax :+972(9)2345982 - E: info@najah.edu
Department
vp.academic@najah.edu
ANajahUni
https:// www.najah.edu

Appendix F

Approval to Use and Translate A&E Department Questionnaire

Request for Permission to Use and Translate A&E Department Questionnaire

٦ رسائل

Sojoud Abdallah <sojoudabdallah5@gmail.com> الاثنين، ٢٦ فبراير ٢٠٢٤ في ١١:٤٧ م

إلى: n.bos@nivel.nl

Dear NHS Surveys,

I am a master's student planning to conduct a study on patient experiences in the Emergency department. During my research, I came across the A&E department questionnaire and believe it would be instrumental to my study.

I kindly request your permission to use the respect questionnaire from the A&E department questionnaire and translate it into Arabic for inclusivity. Additionally, I would appreciate access to the scoring system associated with the questionnaire for accurate data analysis.

Please rest assured that the questionnaire will only be used for research purposes, and not for commercial gain.

Your consideration of this request is greatly appreciated.

Kind regards,
Sojoud

Sojoud Abdallah <sojoudabdallah5@gmail.com> الثلاثاء، ٢٧ فبراير ٢٠٢٤ في ٦:٠٠ م

إلى: n.bos@nivel.nl

reminder
[النص المقتبس مخفي]

Sojoud Abdallah <sojoudabdallah5@gmail.com> الأربعاء، ٢٨ فبراير ٢٠٢٤ في ٣:٢٨ م

إلى: n.bos@nivel.nl

reminder
[النص المقتبس مخفي]

Sojoud Abdallah <sojoudabdallah5@gmail.com> الخميس، ٢٩ فبراير ٢٠٢٤ في ١١:٥٠ م

إلى: n.bos@nivel.nl

reminder
I am sorry. Can you respond to me as it is necessary and to continue working on my master's thesis
[النص المقتبس مخفي]

Nanne Bos <N.Bos@nivel.nl> الجمعة، ١ مارس ٢٠٢٤ في ٢:١٢ م

إلى: Sojoud Abdallah <sojoudabdallah5@gmail.com>

Dear Sojoud,

There are no licence costs or limitations for using the A&E department questionnaire. Scorings and analysis are accessible via my PhD thesis.

Bos.pdf

Good luck.

جـامعـــة النجاح الوطنية

كليـــة الدراســـات العليـــا

تقييم تجربة المرضى في أقسام الطوارئ في الضفة الغربية – فلسطين: دراسة مقطعية كمية

إعداد

سجود بشار فايز عبدالله

إشراف

د. نزار سعيد

قدمت هذه الرسالة استكمالا لمتطلبات الحصول على درجة الماجستير في تمريض الطوارئ، من كلية الدراسات العليا، في جامعة النجاح الوطنية، نابلس– فلسطين.

2024

تقييم تجربة المرضى في أقسام الطوارئ في الضفة الغربية – فلسطين: دراسة مقطعية كمية

إعداد

سجود بشار فايز عبدالله

إشراف

د. نزار سعيد

الملخص

المقدمة: تعتبر تجربة المرضى في المؤسسات الصحية تجربة معقدة ومتعددة العوامل، وترتبط بالعوامل الاجتماعية والديموغرافية والثقافية والمؤسسية، بالإضافة إلى تصوراتهم حول الخدمات الصحية. وتظهر هذه العلاقة بشكل أوضح في البيئات الحرجة والمزدحمة مثل أقسام الطوارئ .(EDs) تهدف هذه الدراسة إلى تقييم تجربة المرضى في عدد من المستشفيات الفلسطينية، بالإضافة إلى تحديد العوامل الديموغرافية وعوامل المرضى التي تؤثر على مستوى التجربة بشكل عام .

المنهجية: اعتمدت الدراسة على تصميم مقطعي كمي تم تطبيقه على عينة ملائمة شملت 405 مرضى بالغين زاروا أقسام الطوارئ في المستشفيات المستهدفة. تم استخدام استبيان معتمد يسمى "استبيان الحوادث والطوارئ(A&ED) "، والذي تم ترجمته إلى اللغة العربية وإعادة ترجمته لضمان الدقة، وتمت مراجعته من قبل خمسة خبراء. تم التعامل مع البيانات بسرية تامة وتحليلها باستخدام برنامج .SPSS

النتائج: بلغ العمر الوسيط للمرضى 28 عامًا(IQR = 2) ، حيث كانت نسبة الإناث (57.8%)، وزار (24.2%) من المرضى قسم الطوارئ لأسباب تتعلق بالجهاز التنفسي، و(27.2%) كانوا يقدمون رعاية لآخرين. وقد قام (72.8%) من المرضى بتعبئة الاستبيان بأنفسهم. أشار أكثر من نصف المرضى إلى معاملتهم بكرامة واحترام بشكل دائم (56.0%)، وهو ما انعكس في آراء إيجابية حول جوانب الانتظار، التواصل، البيئة، وغيرها، مما أدى إلى درجة متوسطة مرضية للتجربة العامة (7 من 10). وكانت الدرجة

أعلى بشكل ملحوظ مع تقدم العمر ($r = 0.114$) ، قيمة ($p = 0.022$ ، لدى الإناث) قيمة ($p = 0.010$ ، ولدى المرضى الذين لم يعانوا من مشاكل صحية خلال الـ 12 شهرًا الماضية) قيم($p = 0.012$ ، الذين لا يقدمون رعاية لآخرين) قيمة ($p = 0.038$ ، وعندما قام المريض نفسه بتعبئة الاستبيان) قيمة $p < 0.001$).

الاستنتاج: تعد تجربة المرضى الفلسطينيين في أقسام الطوارئ متوسطة المستوى، وتتأثر بعدة عوامل يجب أخذها في الاعتبار عند تصميم برامج مستمرة ومستندة إلى الأدلة لتحسين العوامل البيئية والمؤسسية وتعزيز مهارات مقدمي الرعاية الصحية وديناميكيات الطوارئ. كما توصي الدراسة بإجراء أبحاث طولية تغطي المزيد من العوامل ذات الصلة .

الكلمات المفتاحية: مريض، تجربة، إدراك، قسم الطوارئ، غرفة الطوارئ.