Original Article

Improving care for patients in the outlying wards: Lessons from patients' care experience

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Abstract

Importance: Overcrowding in hospitals and lack of capacity in general medical wards can result in a medical patient being transferred to other specialty wards often referred as 'outlying' or 'boarding' wards.

Objectives: We explored the experiences of our outlying patients to identify local factors that affect their care experience and inform interventions that could improve their care deliveries and outcomes.

Design, setting, and participants: Qualitative interviews using semi-structured questions were conducted in 21 medical patients from a mixture of specialty wards in a large tertiary NHS hospital.

Main Outcomes and Measures: Perceptions of the factors contributing to the experience of being a patient on a boarding ward, and potential solutions.

Results: Almost all participants reported experiences of good care in an outlying ward. Positive comments highlighted good nursing care, restful environment and a strong focus on patient-centred care. However, none of the participants could identify the team or consultant responsible for their care and this was linked to multiple doctors being involved in the patient's care. Participants also perceived that the frequency of review was reduced and occurred much later in the day than that experienced in the medical ward. Most felt indifferent about the care ownership, timing and frequency of review but in some cases, this led to confusion and the perception of poor progress. Further, participants felt that they had to actively seek information relating to clinical progress. Negative experience of discharge planning was also reported. The associated themes included conflicting information and delays in social care provision. This led to anxiety, frustration and the perception of being a barrier to patient flow.

Conclusions and Relevance: Patient experience of the outlying ward is positive, and this can provide a foundation for improvement. Our findings suggest that better care processes and improved communication are needed to promote equity and quality of care. However, this should be complemented with efforts to overcome wider challenges that affect the entire continuum of flow within the healthcare system.

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Background

Increased life expectancy and the continual population growth have placed a significant demand on hospital and community care.[1] Hospitals are experiencing overcrowding with considerable pressure on flow. There are inherent safety risks to overcrowding, and to mitigate these risks, flow is often created by moving patients to the next available bed in a ward designed for a different specialty.[2] For example, lack of capacity in general medical wards can result in a medical patient being moved to a surgical ward where they will be looked after by the surgical nursing team but will remain under the care of a medical team. This phenomenon is often referred to as 'boarding', and the term 'outliers' or 'boarders' denotes the cohort of patients who are being cared for in an area designated for other specialties.

Previous studies in this area were largely focused on medical patients, as they are most likely to be affected.[3-5] A high prevalence of frailty, often necessitating social care to support discharges, can hinder flow in general medical wards. In a recent study, 60% of all 11 034 outliers were medical patients and almost 20% of the 34 863 medical admissions had spent time in an outlying ward.[6] Outlying patients have been reported to be more likely to have emergency calls than those in the correct ward.[6] More importantly, studies have shown higher mortality, longer length of stay and higher readmission rates in outliers when compared with those being cared in the home wards.[3-5 7]

Patient experience in relation to boarding has not been extensively studied. To our knowledge, there is one study in the literature that has focused on the outliers' experience. Goulding et al interviewed 19 patients under different specialties and reported that patients preferred to be cared for in the correct specialty ward.8 Poor communication, lack of medical staff and lack of appropriate resources were among the issues highlighted. Understanding factors that shape these perceptions is important; their opinion of care received can influence the outcome.[9-11]

Despite the concerns, many institutions, including ours, have not been able to completely avoid transferring many patients to the outlying

wards. Therefore, as part of a quality improvement programme, we explored the experiences of our outlying patients in order to identify local factors that affect their perceptions and inform interventions that could improve their care experiences and outcomes.

Methods

Setting

Qualitative interviews were conducted in patients under the care of general medical physicians in a large NHS teaching hospital. Patients who required ongoing care from general physicians were transferred from the acute medical unit to the general medical wards or one of the fourteen specialty wards as an outlier. Additionally, patients were transferred from the general medical wards to an outlying ward to create capacity.

Participants

An outlier is defined as a patient who has been moved to a ward designed for other specialty care but remained under the care of a general medical physician. Suitable participants were identified by the attending clinicians and approached by the interviewers after spending at least 24 hours on the wards. A purposive sampling method was applied to include age above and below 70 years inclusive, all of the outlying wards, and direct transfer from the acute medical unit as well as transfer from the general medical wards. Exclusion criteria were: inability to provide consent, unable to communicate in English, deemed to be clinically too unwell to participate, significant cognitive impairment and patients under a detaining order. A total of 21 interviews were completed. Of these, 15 were conducted in participants from the outlying wards and six were participants being cared for in general medical wards for comparison. One participant in the general medical ward had initially been transferred from the acute medical unit to an outlying ward but was subsequently repatriated to a general medical ward. Table 1 shows the demographic of the participants.

Qualitative interviews

Interviews were conducted according to an interview guide between 1st of March 2017 to 31st of October 2017. The semi-structured, open-ended questions were based on the following dimensions: care experience, the implication of being an outlier on care ownership, care process, communication and discharge. There was a significant degree of freedom in the formulation and the sequence of questions to encourage natural flow in participants' thoughts and feelings towards their experience and attitudes towards being on the outlying wards. The interviews were conducted by three different interviewers (FC, HD, IM) none of whom had any clinical responsibility for the participants. A participant information sheet was provided, and consent was obtained. No participants declined to be interviewed. Interviews were conducted on the wards prior to discharge. Each interview was transcribed verbatim and expanded as soon as it was completed. Critical reflective discussions among the interviewers were initiated at this stage. The interviews provided rich and in-depth data and the final number of participants was determined when data saturation was reached. The median time taken for the interview was nine minutes [Interquartile range (IQR) 7-13.7].

Data analysis

Thematic analysis was conducted. Two researchers (KAL and FC) independently analysed the interview data. Briefly, the researchers carefully read the transcripts to listen, feel and think with the narratives. Data were coded and themes were developed inductively. The themes were exhaustive and mutually exclusive. Interview narratives were also carefully analysed to capture sentiments as well as temporal relationships between themes. The

Table 1. Summary of participants' characteristics. Fifteen participants were from seven different outlying wards and six participants were from general medical wards.

Participant number	Age (years)	Gender	Duration of Admission (days)	Specialty
1	20-29	Man	<7	Hepatology
2	70-79	Man	>14	Cardiology
3	70-79	Woman	>14	Cardiology
4	70-79	Woman	<7	General medicine
5	20-29	Woman	7-14	Gynaecology
6	20-29	Woman	<7	Gynaecology
7	80-89	Woman	>14	Surgical
8	60-69	Man	>14	Surgical
9	80-89	Woman	<7	Gynaecology
10	80-89	Woman	>14	Gynaecology
11	50-59	Man	>14	Orthopaedics
12	80-89	Woman	7-14	Orthopaedics
13	40-49	Man	<7	General medicine
14	80-89	Woman	7-14	General medicine
15	40-49	Man	7-14	General medicine
16	70-79	Woman	<7	Orthopaedics
17	40-49	Woman	<7	Orthopaedics
18	30-39	Woman	<7	Gynaecology
19	70-79	Woman	>14	Gynaecology
20	90-99	Woman	<7	General medicine
21	60-69	Man	>14	General medicine

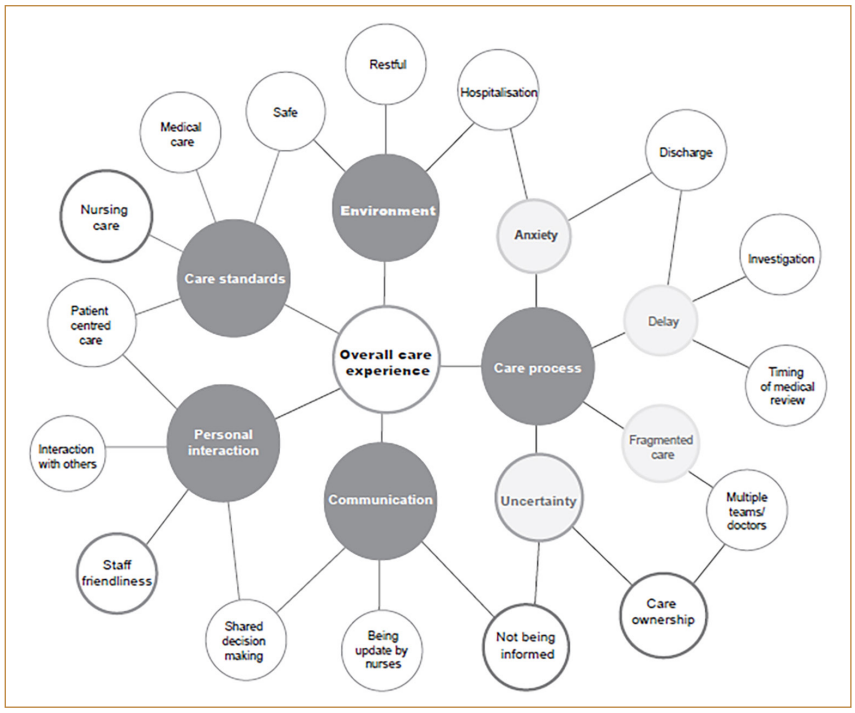

Figure 1. A conceptual model to illustrate patterns and associations between themes that emerged from thematic analysis. There were five overarching themes relating to the overall experience in the outlying wards: care process, communication, care standards, personal interaction and environment.

researchers discussed and compared the themes. Once the themes were agreed, a framework was devised using Microsoft Excel (Excel for Mac Version 15.28, Microsoft Corp, WA, USA). The next phase of the analytical process was focused on establishing patterns and associations between themes and a conceptual model for this was constructed (Figure 1).

Ethical and governance

This study was conducted as part of a larger quality improvement and service evaluation. Advice from the institutional research ethics committee was sought and their opinion was that no formal ethical approval was required.

Results

Five overriding themes emerge in the experiential account of the participants: care standards, care process, environment, personal interaction and communication (Figure 1). These themes are interwoven through the narratives and interact with each other to shape the underlying perception, attitude and the overall experience (Figure 1).

The overall experience is associated with personal interaction, care standards and environment

Almost all participants reported experiences of good care during the stay in an outlying ward and many expressed preferences for the outlying wards over the acute or general medical wards. The positive comments immediately reflected the sense of gratitude for the good standard of nursing care received and these highlighted friendly staff attitude and a strong focus on patient-centred care:

"If I have a choice, compared to the other ward, I will stay here. Staff here…oh… is fantastic. I prefer this ward." [Participant 8]

"This is wonderful. Just the treatment. Everything was explained before procedure being done. The group is lovely." [Participant 3]

Furthermore, the outlying wards were often associated with a restful environment. The pace created better interaction with others on the ward, which generated a strong sense of community. This helped to alleviate anxiety associated with the transfer and hospitalisation:

"Being in [parent medical ward] was alright but I like it in here because I get to talk to a lot of people and make a lot of friends. I find it better here than [parent medical ward] because I get time to talk to people." [Participant 11]

Of the participants who reflected on their previous stay in the parent medical ward, there were mixed experiences. Some related negative experiences involving instances of delay in care, busy and impersonal environment. However, many acknowledged that staff were doing their best to provide care in challenging circumstances:

"Acute medical ward… sometimes it's too busy but the nurses do their best. Anything you want, you always get, but it can take a wee while to get it." [Participant 16]

Attitude towards transfers

Many participants, particularly those who have been transferred directly from the acute medical unit, were aware that the move to the outlying ward was to enable flow or ease the bed pressure. The narratives often reflected acceptance and understanding of this, although there was a sense of lack of autonomy and impersonal nature to the process:

"The receiving place, it is kind of…get you in, get you into a bed and move you out or put you somewhere else. Here it is much more personal."

[Interviewer: How do you feel when you were in the medical unit with that being get you in get you out…?]

"It is kind of normal for me now, I am used to it, in and out. It put me in the next best place to go." [Participant 6]

There was also anxiety and fear of change, and the adjustment to a new environment provoked a sense of isolation and vulnerability:

"They were really lovely down there, and I got to know the women, and so when I first came here, I was worried I wasn't going to get the same standard of care. I found it strange here at first, but they're all really lovely."

[Interviewer: So how did you feel when you got transferred?]

"At first, I felt I wanted to go back downstairs. I felt looked after and secure there. There was lots going on. I felt a bit lonely up here. I think it was just the time I came in. I don't know the word for it…" [Participant 18]

Influence of inadequate communication about changes in care processes on experience

An important theme in the data was uncertainties surrounding the medical care processes. All participants, including those interviewed on the medical wards, could not identify the medical consultant responsible for their care. Many participants felt that the uncertainties in the care ownership occurred as a result of multiple doctors involved in their care. All of the participants reported that they had been reviewed by several different doctors since admission and that the numbers were too many to recall. However, none were concerned with the number of different care providers. For most participants, knowing the consultant in charge was not necessary; the emphasis in the encounter was placed on how they were treated as an individual:

[Interviewer: Do you think it's important to know (the name of the consultant)]?

"Not really, I've never came across one that wasn't nice, none of them are abrupt or anything" [Participant 16].

Some participants in the outlying wards were unsure what medical team was responsible for their care or were not aware that their parent team was not based on their current ward.

"I heard from snippets of conversation from nurses, and they said we heard this and that. Some things that I heard I am not happy with, so I am a bit frustrated. So, I want to speak to a doctor, like what actually is happening. I don't really understand… They try to pass me to [specialty redacted] but it's never [specialty redacted]. It's all a bit muddled up this time." [Participant 6]

Some presumed that their medical care would be taken over by the doctors on the outlying ward. Moreover, there was an expectation of continuing care from the specialty team who had been managing the same illness previously:

"No, they are not [based on this ward]. Who I thought, who would be my consultant was [specialty redacted], and the [specialty redacted] team but I don't think they are based here, but they said I was under general medicine? So, I don't have a clue…." [Participant 5]

The concept of being an outlier was only apparent to some participants when they were reviewed at a different time and by different doctors from other patients on the ward. In some cases, the disparity was perceived as an inequity in treatment:

"The staff said that I may be seen last because it's the [specialty] ward. When I asked, they said the doctors have been in, but your doctor come from somewhere else." [Participant 5]

The fact that they were seen at a different time from the rest of the ward also compounded the lack of sense of belonging:

"Some doctors come around and see other patients and bypass me. I am a "bed blocker" (whispering). That's how I feel."

[Interviewer: What has made you feel that you are a bed blocker?]

"I don't know, they are so busy, people coming in and out and I am still here."

[Interviewer: How does that make you feel?

"Not sure. Just different". [Participant 10]

The sense of being "different" often coincided with guilt, apprehension and a perception that they were taking up a bed from someone else:

"I was in the [specialty redacted] ward because there was no bed. I felt very uncomfortable in the [specialty redacted] ward…because you see the bigger picture. They were sick." [Participant 15]

Participants also perceived a change in the frequency of review once they became a medical outlier; the frequency was reduced, and the review occurred much later in the day compared to the parent medical ward. The majority were not overly concerned with the change; they felt that their conditions had improved, and hence a daily review was no longer necessary:

"Every two or three days. When I first came, they came in every day. Now, I have recovered from my illness, medically I am fit you know…" [Participant 2]

However, for some participants the delay and the unpredictability of the review added to the uncertainties, especially if they had not been informed or had to actively ask for information relating to their clinical progress:

"The blood tests I need to ask, it's sort of a secret. I have to ask about them. But everything like blood pressure they just say." [Participant 1]

Many participants, including those on the medical ward, relied on the nursing staff rather than doctors to provide information on their progress. The narratives often reflected acceptance: doctors were often too busy, the nurses have already provided them with adequate information, and that the routine updates ceased once decisions have been

made. This is compounded by the perception that the ward staff encountered difficulties in contacting the responsible team:

"This ward… a lot later."

[Interviewer: How does that make you feel?]

"I'd rather get told… be updated as supposed to waiting, when will I get seen."

[Interviewer: So, you'd rather know if it's going to be later in the day?]

"I often asked the nurses, they said we are trying to track them down." [Participant 1]

Concerns and dissatisfaction about discharge were common and are not restricted to those being cared for in the outlying wards. Participants were anxious about the impact of illness on their ability to be independent in the community and some feared that they would be discharged to a different destination other than their own home. Their anxiety was often exacerbated by the lack of clarity in the discharge arrangement. Many participants on the outlying wards described a long delay in the provision of care in the community. The long waiting time was often described as a waste of resources, and the sense of lacking in control led to exasperation:

"I've lay here for a week and nothing's been done. I think it's not fair that people are lying here for a whole week with nothing getting done, waiting to be assessed, waiting to see what they're going to do. I think that's very unfair – especially for the old people…" [Participant 12]

Two participants stated that their discharge had been delayed because they were a medical outlier. Delay in medical review and lack of communication between services were among the perceived factors:

"Apparently there was a CT…sorry, MRI organised, it was over the weekend and it didn't happen anyway. It was supposed to happen Monday but that didn't happen. Apparently, they went to [the base ward] to look for me and I don't know whether the staff there know I have been moved here. So, I lost my slot." [Participant 3]

Discussion

In this study, we examined the experiential account of general medical patients being cared for in a ward dedicated to a different specialty. We have shown that for many participants their status as an outlier did not concern them or affect their overall care experience received whilst on the ward. In contrast to a previous study, all of the participants in our study described positive overall experience in the outlying wards.[8] The favourable experience was largely shaped by the standard of the nursing care received, which addressed many issues that matter to them as individuals and alleviated anxiety and vulnerability associated with hospitalisation. On the contrary, their experience of medical care was predominantly characterised by uncertainties.

In our data, patient centredness resonates in the narratives that described good experience. How they are treated as a person is fundamental. When this is strongly embedded in the daily care, it outweighs the less positive experiences brought about by the complexities of the care processes. Thus, factors such as the care environment can influence their experience; the high level of clinical activity in AMU care is often perceived as impersonal. More importantly, boarding leads to a geographical separation from the parent team, and it occurs when demand on the medical team is exceptionally high. Consequently, the interactions with the team often become succinct, intermittent, and lacking in fluidity. In contrast, nursing care is a far more continuous and consistent process. When faced with such care complexities, patients value the familiarity, solidarity and empathy shown by the staff in the immediate care environment.[12]

Being moved to a different area will lead to a change in the care team. The multiple transitions can leave patients with a perception of an unconnected medical team, which inevitably can be a challenging experience. The lack of continuity can be compounded by the perceived lack of clearly defined responsibility; none of the participants in our study knew who their consultant was. In part, this is probably related to the shift from a consultant-led firm where a patient remains under the care of a well-defined team of doctors throughout their journey to a more collaborative working pattern with multiple changes in the care providers. Another problem is that the changes in the care processes are not often explained. The concept of being an outlier was ambiguous to many participants, leading to uncertainties and sense of fragmented care, particularly when different care processes exist within the same environment.

So how do we fix the problem of medical outliers? In the current fiscal constraints medical outliers will continue to exist. We, therefore, need to do more to remove the complexities and the boundaries for patients on the outlying wards. Several approaches that have been reported in the literature are resource intensive. Rae et al have implemented a number of different changes including active discharge planning and implementing consultant-led ward rounds seven days a week.[14] Gilligan et al have introduced the idea of "physician of the week" to review their outlying patients to improve communication and continuity of care.[15] Another approach is to create a dedicated multidisciplinary team for the medical outliers, similar to that of the orthogeriatric team, which has been associated with improved survival and functional rates.[16]

Irrespective of the approach adopted, it has to be complemented with efforts to design better processes to improve the entire patient journey. Partnership and collaboration have to be forged beyond the context of hospital care. A critical underpinning to any approach is a strong commitment for patient centred care; patients should be at the centre of the improvement effort. The characterisation as an 'outlier' or a 'boarder' can inadvertently shift the focus from the patient's individual need to simply highlighting differences, which in turn, can subconsciously introduce inequity in the care provision. Patients can be perceptive to this and manifest it as the loss of sense of belonging which can affect their well-being and self-perceived health.[11 13]

Some limitations have to be acknowledged. All participants were drawn from a single centre and, therefore, findings cannot be generalised. Although steps were taken to minimise interviewers' positional bias, their clinical backgrounds may have influenced participants' responses. We also have to recognise an element of selection bias. These outlying patients are deemed to be at low risk of deterioration. We did not explore the impact of boarding on length of stay or mortality. In our institution, adaptations have been made to improve safety and outcomes for these patients, including better assessment of suitability for boarding, safety brief discussions and electronic tracking systems. We have no data on the reliability of these processes or their influence on the experience for our patients.

Conclusion

While flow remains an issue and hospitals are crowded, medical outliers will continue to exist. Being on an outlying ward can add complexities to the care of patients. However, the experience of care as an outlier can be positive. For many patients, the care location may not matter, what is important to them is patient-centred, seamless and safe care. This requires partnerships grounded in collaboration, communication and efforts to overcome wider challenges that affect the entire continuum of flow within the healthcare system.

Declaration of competing interests

Nothing to declare.

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