



Enhancing quality and efficiency: The impact of patient experience officers on teamwork and staff experience in Australian emergency departments

Jodie Brabin^{a,*}, Sharon Laver^a, Rosemary Phillips^a, Rachel Rossiter^b, Samantha Jakimowicz^a

^a School of Nursing, Paramedicine and Health Sciences, Charles Sturt University, Panorama Ave. Bathurst 2795 NSW, Australia

^b School of Rural Medicine, Charles Sturt University, Leeds Parade. Orange, 2800 NSW, Australia

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ABSTRACT

Background: The Patient Experience Officer (PEO) position was implemented into Emergency Department (ED) waiting rooms to address increased rates of occupational aggression and improve patient experience.

Rising ED presentations have lengthened patient wait times, increased risk of clinical deterioration and aggression and violence towards ED staff.

Methods: This study used a mixed-methods approach including staff surveys, focus groups and semi-structured interviews with a range of ED staff. Data was analysed using content analysis and descriptive statistics.

Results: Staff benefit from the PEO's presence in the waiting room through improved communication with patients, fewer disruptions and humanising the atmosphere within the traditionally chaotic ED environment.

Workflow and teamwork is improved through preparing patients for treatment, supporting ED clinicians in managing the waiting room and streamlining processes.

The PEO position improves patient safety for those in the waiting room through proactive escalation of possible deterioration and early communication with patients, which decreases aggression and anxiety.

Conclusion: Based on this evaluation, the PEO position contributes to improving the safety of staff and patients by providing an important point of contact, a calming presence for patients and, supporting ED staff through improved communication, and escalation of care needs.

1. Introduction

The consequences of Emergency Department (ED) overcrowding are felt by patients, staff, and the health system. A 2018 systematic review found errors, delays to care, poor patient experience and outcomes were all associated with ED overcrowding. For staff, weak adherence to clinical guidelines and, stress and violence were amplified in overcrowded EDs. From a systems perspective, ED length of stay is also associated with overcrowding [1]. The pressures and challenges facing Australian EDs means that to maintain patient safety and efficient functioning alternate approaches to ED service provision are needed.

Increasing presentation rates and ED wait times have been reported since 2021 in Australian hospitals [2]. Exacerbating these changes is the growing complexity of patient presentations, combined with substantial workforce challenges, redevelopment initiatives and, significant demographic changes in some regions. Collectively, these factors impact on wait times and clinical care, and patients' experiences of presenting to EDs.

The aim of this paper is to report on the broad impacts of a statewide initiative that introduced Patient Experience Officers to EDs on patients, carers and staff within emergency department waiting rooms.

2. Background

Aggression and occupational violence in ED's has been increasing in Australia, with staff most commonly the victim of this aggression [3]. Studies have examined the contributing factors which increase the risk of aggression occurring within EDs. Lack of privacy, long wait times, lack of information and updates and patient stress all contribute to an increased risk of aggression [4–7]. The ED is a challenging environment for both patients and staff. Increased attendance leading to overcrowding, communication barriers, burnout and compassion fatigue, and longer delays to care creates an environment of increased risk of aggression and violence [4]. Given the escalating pressures and challenges encountered in Australian EDs, innovative approaches are required to maintain patient safety and improve the efficiency of

* Corresponding author at: Charles Sturt University, Panorama Ave. Bathurst 2795, NSW, Australia.

E-mail address: jbrabin@csu.edu.au (J. Brabin).

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healthcare delivery.

Various patient experience initiatives have been implemented in EDs including patient-centric waiting room designs, availability of refreshments and wayfinding strategies [8]. The introduction of specialised nursing roles such as the Waiting Room Nurse (WRN) and the Clinical Initiatives Nurse (CIN) in the mid-2000's aimed to improve patient communication and respond to any signs of patient deterioration. [9–12].

To date however, there is little evidence about the impact of non-clinical positions within EDs. A 2015 integrative review identified six studies evaluating the effectiveness of ED waiting room positions focusing on the CIN or clinical assistant positions [13]. Likewise, Gijs and colleagues' (2019) systematic review examining interventions to reduce over-crowding of older adults failed to identify non-clinical roles situated in EDs [14]. A 2020 scoping review on strategies to improve ED performance, captured 77 studies. Of these, four included the addition of a non-clinical 'scribe' to document patients' notes for doctors, with no patient-focused responsibilities. Re-designing work processes, communication channels and patient documentation were all highlighted as other approaches to improving ED performance, however, dedicated waiting room roles were not presented [15]. This study aims to address the gap in evidence on the impact on non-clinical staff in the management of patients in the ED through the evaluation of the Patient Experience Officer (PEO) role. The PEO role, or intervention in this case, is based on customer service techniques, and non-clinical responsibilities and is focused on supporting patients by providing general information and comfort to improve their experience of waiting in the ED. Their role aims to mitigate contributing factors to aggression and improving the overall patient experience in the waiting room.

The Ministry of Health (MoH) funded the PEO roles since project inception in 2021. The position is graded at an administration officer, level 5 (AO5) with a generic position description for local adaptation (see supplementary file). Local Health Districts (LHDs) determined the allocation of the roles and shift coverage based on locally defined service demand. Thirty-six of the 51 ED's have 7-day coverage; 7 have only weekday coverage, and; 8 have a rotating roster pattern. Monday and Friday are the only two days in which all ED's have a PEO rostered. No service has 24-hour coverage, with 1am to 6am devoid of PEO coverage across all sites and all days. The hours between 10am and 8pm experience the greatest coverage across all EDs, this may reflect ED activity, staff availability, or both.

Initial PEOs in the pilot program were supported by Service NSW training in customer service. Training is now provided at a local level based on identified need and supplemented by the MoH through statewide PEO workshops, human experience week events and regular communications. Supervision arrangements vary, with some under the ED Nurse Manager, the clinical governance team or the ED administration team. Their team engagement reflects broader ED team dynamics. They are most often included, but due to differing shift patterns, are frequently unable to attend handover meetings.

As a new and innovative approach to waiting room management, this study can provide insights for other health services in improving the experience of both staff and patients in the ED.

3. Materials and methods

3.1. Study design

A mixed methods approach was employed to collect data and content analysis was adopted to bring together the quantitative and qualitative data to explore the broad impacts across diverse ED settings and contexts. Considering the context was important in the analysis as the external complexities of the program under evaluation in varying settings was important to the overall evaluation.

Data collection included statewide health facility and survey data and focus groups and semi structured interviews. The PEO program was

rolled out across the state therefore a statewide survey of ED staff offered an efficient way of gathering general data. Four case study sites, including rural and metropolitan hospitals, were randomly selected to enable focussed and context specific focus groups and interviews exploring staff experiences of implementation and outcomes in more detail [16]. This enabled analysis of local factors, and identification of state-wide trends [17]. This paper focuses on the commonalities identified across the four case study sites answering two of the evaluation questions outlined in Table 1. While patient perspectives are an important aspect of evaluating care, time constraints limited their involvement in the study design. Patient survey data were considered as part of the evaluation; however, inconsistencies in data availability and quality meant it could not be incorporated into this paper.

3.2. Participant recruitment

A survey link was distributed through various state level electronic communication channels to gather anonymised staff feedback on the impact of the PEO role within EDs. At the case study sites, surveys were also distributed through localised approaches within their organisations. Invitations to participate in interviews and focus groups were extended through case study site contacts established for the evaluation. Case study site contacts for the evaluation promoted participation through existing local communication channels and direct requests to senior executive staff. PEOs, ED clinicians and managers, administrators and ward clerks self-nominated to participate in focus groups and interviews.

3.3. Data collection

Some program monitoring and patient feedback data was provided by the state health agency. Statewide staff surveys were distributed to gather anonymised feedback on the impact of the PEO role within their ED. Semi structured interviews and focus groups were conducted via Microsoft Teams to explore the impacts of the PEO role on patients, staff and ED efficiency. Interviews and focus groups were recorded and transcribed for later analysis. Table 1 summarises specific evaluation questions and associated data sources.

To ensure consistency in interview and focus group data collection, scripts were prepared with questions relevant to the category of staff participants. This approach recognised the different perspectives participants could offer the overall program evaluation and enabled analysis of responses from staff groups as well as sites.

4. Data analysis

RedCap was used to collect survey data which was then analysed in excel using descriptive statistics, and responses to open-ended questions were analysed alongside data provided by the state health agency. Interview and focus group recordings were transcribed and cleaned for analysis. Content analysis, guided by the work of Krippendorff (2004),

Table 1
Evaluation questions and data sources.

Evaluation question	Data sources
How has the ED PEO role affected the experience of clinicians and staff working in EDs?	<ul style="list-style-type: none"> • Interviews • Focus groups • Staff surveys
What has been the effect of the ED PEO role on the system-wide utilisation of ED resources?	<ul style="list-style-type: none"> • Interviews • Focus groups • Staff surveys

Bengtsson (2016), and Erlingsson & Brysiewicz (2017), led to the identification of broad themes [18–20]. One researcher initially coded the data using NVivo, and identified preliminary themes, which were then reviewed and refined by other members of the research team using the same content analysis framework. This collaborative process ensured consistency and rigour, with final themes agreed upon through team discussion. These themes were further interpreted with reference to contextual and mechanistic factors impacting program outcomes and triangulated with quantitative data. The study integrated both quantitative and qualitative data to explore the impacts of the PEO role. The statewide survey included closed and open-ended questions, allowing for the integration of descriptive statistics with thematic analysis. Quantitative findings were used to confirm and contextualise qualitative insights, supporting a mixed-methods design that reflects the complexity of the intervention and its varied implementation across ED settings.

4.1. Ethical considerations

The evaluation project has been guided by the National Statement on Ethical Conduct in Human Research and the NHMRC Ethical Consideration in Quality Assurance and Evaluation Activities. Ethics approval for the research was received from health service HRECs, including site specific approvals from each of the case study sites. These approvals were ratified by Charles Sturt University Human Research Ethics Committee (approval ref: H23873).

5. Results

Across the state 1047 survey submissions were received from Local Health Districts and Specialty Health Networks with an ED. More than half of respondents were nurses, which reflects the proportion of health professionals registered in Australia [21]. Table 2 summarises the occupational groups and number of staff who completed the survey.

Eighty-six staff participated in semi-structured interviews and focus groups. Staff groups represented in interviews and focus groups were PEOs (interviews n = 14; one focus group n = 35 participants), ED clinicians (n = 17), Clinical governance staff (n = 3), ED administrative staff (n = 5) health service executives/general managers (n = 9), security staff (n = 3). Interviewees were from all professional groups, including Ministry of Health Executives, Local Health District Chief Executives, ED Nurse Unit Managers, clinicians and administrators.

The study results can be grouped into three distinct but interrelated themes: the experience of staff; the impact on workflow, processes and teamwork, and; patient safety and facilitation of care. Quantitative and qualitative data are presented concurrently based on descriptive themes identified in the data. Patients’ safety and facilitation of care emerged as an important indicator of the impact of the PEO role on staff experience and on the ED workflow and teamwork.

5.1. Impacts on staff experience

Staff found the PEO role contributed positively to their experience in delivering care in the ED waiting room. PEOs act as a conduit between patients and other staff with 75 % of survey respondents indicating a

Table 2
All staff survey- participant’s occupations.

Professional grouping	N	%
Administration	172	16.4
Allied health	28	2.7
Management	28	2.7
Medical	135	12.9
Nursing	617	58.9
Other	22	2.1
PEO	45	4.3
TOTAL	1047	100.00

decrease in interruptions allowing them to concentrate and fulfill their role more effectively.

“You walk out there and there’s just people everywhere and coming up all the time and it is just being that buffer and it just allows them to do what they can do, which we can’t, which is nursing, being a doctor, doing admissions.” (PEO)

“They have been a huge asset to the department, ensuring ongoing communication with those patients waiting to be seen and waiting for results, etc. They are an excellent conduit between the patients and staff (medical and nursing) and enhance the wellbeing of both. I would love to see them included in handovers and huddles.” (Medical Officer)

Respondents reported that the position supports staff wellbeing and decreases occupational stress associated with their roles through the management of the waiting room and de-escalating crises.

“I find my shift to be much less stressful when we have our PEOs working. They keep the patients aware of what’s happening and keep the mental health patients calm. I can ask them for help with anything and they usually know the answers, or if they don’t they know who to ask. I can also direct patients to them when they have questions and the PEOs liaise with the nursing staff to answer the patient’s questions. They are such a wonderful asset to the ED team.” (Administration)

Seventy percent of staff report the PEO is most effective on afternoon shifts when the waiting room is busier compared to morning (7 %) or evening (2.6 %) shifts. PEO rosters are determined locally based on the presentation rates unique to that ED and in negotiation with the management team. This is reflective in current rostering patterns statewide, with the hours between 10:00am and 8:00 pm receiving the most staff coverage across all hospitals.

The PEO role assist ED staff by supporting patients, proactively managing issues and acting as a conduit between patients and staff. This is reported to alleviate staff stress and support staff wellbeing.

5.2. Enabling effective workflow and teamwork

The PEO role was designed to support the overall functioning of the ED, assisting clinical staff by undertaking non-clinical activities that could be done while patients were in the waiting room. As illustrated by Fig. 1, participants reported the PEO made a difference across numerous areas of service delivery, particularly improving patient communication (207 responses) and facilitating efficient workflow processes (188 responses).

Key impacts reported by participants are highlighted in Fig. 2, with the strongest responses on workflow processes related to reducing aggression (71 %) and decreasing clinician interruptions (74.6 %).

This was reinforced by interviewee feedback. All interviewees acknowledged that the PEO contributes to improved functioning of the ED, as summarised below:

“They have been a huge asset to the department, ensuring ongoing communication with those patients waiting to be seen and waiting for results, etc. They are an excellent conduit between the patients and staff and enhance the wellbeing of both.” (Medical officer)

Another medical officer highlighted that the PEO’s presence meant patients can be located more quickly, reducing delays to consultation and treatment:

“The biggest thing I’ve noted is finding patients in the waiting room. They (PEO) often know who a person is and in a busy waiting room with people sometimes outside, they help find them. They can also know when people leave without being seen. All saves time.” (Medical Officer)

Nursing staff reported that PEOs contribute to workload efficiency through reduced interruptions particularly for the CIN and Triage Nurses, as illustrated by the following observations:

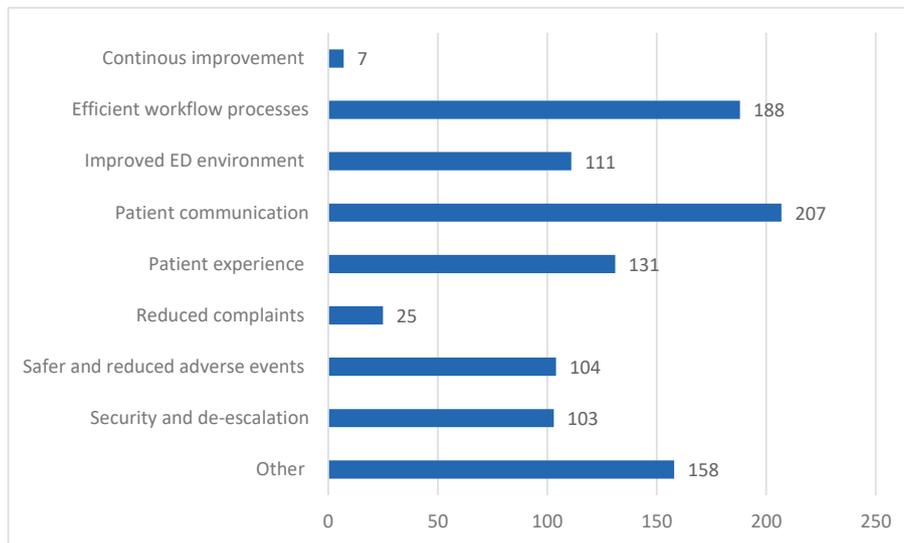


Fig. 1. Difference the PEO has made to the ED.

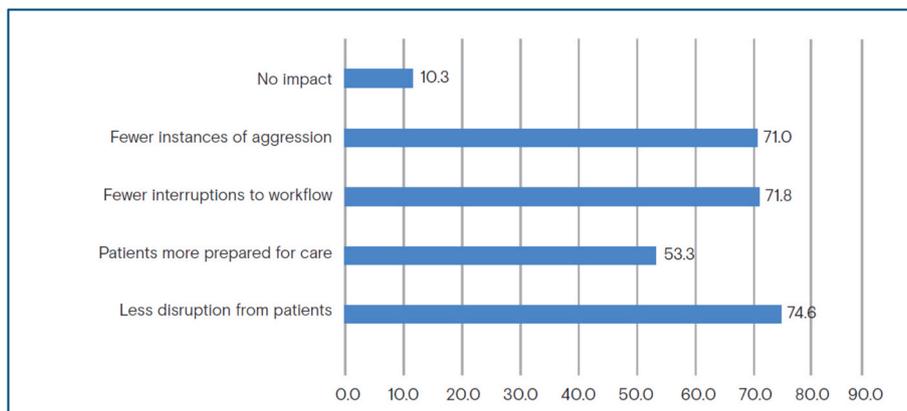


Fig. 2. Impact the PEO has had on work and/or work processes in the ED.

“When they’re not on shift it definitely increases the workload for triage nurses. They stop the interruptions.” (Nurse Manager)
“we’ve done a recent survey with the CIN nurses at the front of house and there’s been noticed improvement in staff satisfaction and morale because

they feel like they don’t always have a (patient) tap on the door while they’re doing something.” (ED Nurse Unit Manager)

The PEO enhanced workflows within the ED through proactively addressing patient concerns and issues while they waited, reducing interruptions to nursing staff.

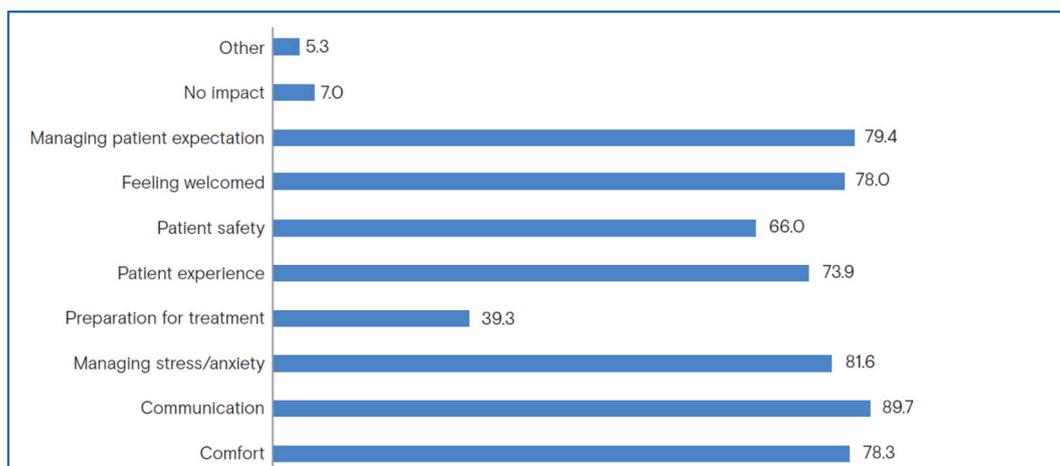


Fig. 3. Impact the PEO has had on patient care in the ED.

5.3. Patient safety and facilitation of care

One unexpected finding from the study was the role of the PEO in creating a safe environment through observation of patient behaviour and facilitating their preparation for care while in the waiting room.

The survey asked staff to identify impacts the PEO has on patient care within the waiting room as illustrated in Fig. 3. While communication was identified most frequently (89.7 %), one third of respondents believed the PEO played a role in patient safety (66 %).

This was explained by one nurse manager, who highlighted:

“We made sure that they could pick up on behavioural signs and what happens when somebody is deteriorating or when someone’s family member is deteriorating: their behaviours changes as well.” (Nurse Manager)

While not seen as the primary role of the PEO, observing the condition of the patient was noted by some participants as an emerging element of the position particularly in periods of high attendance when clinical observation by nursing staff is limited.

As illustrated in Fig. 2, 71 % of survey respondents believed the PEO has impacted the level and frequency of patient aggression occurring in the waiting room. Both nurses and medical officers noted that there was a discernible difference when the PEO was on shift, *“I don’t personally experience aggression like verbal aggression as much when there is a PEO on shift”* (Registered Nurse). Staff credited the PEOs’ proactive communication and regular patient interactions with their experience, as illustrated by the following:

“Staff, I think feel really secure that there’s someone out there de-escalating things before they have a chance to escalate.” (Medical officer)

Security call-out data was not made available for analysis in this evaluation. There was, however, a consensus that incidents of aggression had decreased across the case study sites. Security officers were interviewed and concurred that call outs had reduced. *“There are a few regulars that come to ED and can be disruptive but they have come to know the PEOs and their behaviour has changed... they (PEOs) are a calming influence”*. (Security Officer)

Staff indicated that a reduction in the rates of aggression in the waiting room improved the overall patient experience and preparation for care through decreased anxiety and a clearer understanding of ED processes, as illustrated below:

“they’re (patients) much more likely to hear what’s been said to them. They’re much more likely to follow instructions, which means they’re much less likely to bounce back.” (Clinical Nurse Consultant)

In some case study sites, the PEO was involved in explaining discharge instructions, locating patients for their next stage of care, or assisting with transfers for diagnostic procedures. While not a clinical position, PEOs facilitated the delivery of clinical care through patient support and preparation.

6. Discussion

6.1. Staff experience and wellbeing

The patient-clinician relationship and its impact on clinical outcomes is well established. A systematic review found that the patient-clinician relationship influences healthcare outcomes through both cognitive and emotional care [22]. Another study looking at empathic touchpoints suggest that these interactions contribute to positive experiences and health outcomes [23]. Delayed communication in EDs contributes to patient anxiety and shapes their interactions with staff [24]. PEOs play a vital role in mitigating this by providing early and ongoing updates to people in waiting areas about ED processes, wait times, and treatment expectations. This proactive communication reduces interruptions for

clinical staff, allowing them to focus on core responsibilities. The inclusion of the PEO enables the establishment of the patient relationship, gathering personal information and providing emotional care to patients.

Interruptions have been defined as secondary tasks that, to perform, require a person to stop working on their primary, or original, task [25]. Interruptions increase staff workload, reduce cognitive capacity and increase the risk of errors [26]. Kwon, et al (2021) found ED nurses were interrupted 6.4 times per hour and patient, or family communication was the most common reason. Primary task completion time increased when an interruption occurred, leading to delays in treatment [27]. When PEOs were in ED waiting rooms, administrative and nursing staff participants in this research reported fewer interruptions from patients, allowing them to focus on the needs they were addressing at that time.

Our research shows the PEOs fill a gap left by clinical staff who often lack time to build a rapport with patients, beyond addressing specific clinical needs. For example, ED physicians prioritised efficiency over interpersonal rapport due to time pressures, especially during high ED attendance, even though they recognised the importance of effective communication [28] and the importance of empathic interactions [23]. Participants in this research reported the value of PEOs in reducing interruptions to their work by addressing non-clinical patient concerns and issues while they waited, thereby improving efficiency and workflow. The PEO’s presence helps mitigate interruptions, contributing to a more efficient and focused clinical environment.

Persistent high workloads impact quality of patient care through reduced job satisfaction that lead to stress and burnout [29]. Stress and burnout remain a significant global challenge in healthcare, affecting workforce retention and staff wellbeing [30]. A recent Irish study using the Oldenburg Burnout Inventory found that 74 % of ED healthcare workers – including nurses, physicians, and auxiliary staff experienced burnout, largely attributed to the pressures of the COVID-19 pandemic [31]. This trend was reflected in our study, where the PEO role became essential during periods of social distancing and heightened demand.

Exploration of clinician experiences of aggression and violence in Australian hospital highlight burnout, anxiety, compassion fatigue and concerns for personal safety [28]. Wait times and delays to care are a well-recognised contributors to aggression and occupational violence risk towards ED staff [3]. Alomari et al. (2021) found that interactions with patients and families were among the most stressful aspects of nursing, particularly when patients were abusive or violent—often due to perceived delays or lack of privacy [4]. Timely communication from PEOs reduces these triggers. Consistent with literature that highlights the importance of effective staff-patient communication in fostering safety and reducing conflict [23,32,33], the PEO role was described as an important conduit of information, providing timely, empathic and compassionate communication and updates to patients. Staff reported that this created a calmer waiting room, deescalating patient aggression early.

6.2. Enabling effective workflow and teamwork

One of the aims of the PEO position was to reduce the incidence of aggression and violence in the ED. The presence of the PEO positively affected overall efficiency and staff experience because the waiting room felt calm and safe. The more patients can receive timely information within the waiting room, the risk of aggression towards staff decreases. This is reinforced by a 2018 study that identified a positive association between staff visibility and decreased security issues with patients. Additionally, visibility between staff improved the communication, efficiency and productivity of teams leading to better workflow and practices [5,6].

6.3. Patient safety and facilitation of care

This study found that while not a clinical role, the PEO was

important in facilitating clinical care in three ways: improved patient preparedness for care; decreased patient anxiety and aggression, and observation of behavioural changes indicative of clinical deterioration.

Communication has a measurable impact on patient stress and anxiety in the ED. Studies indicate that almost all patients and their caregivers attending an ED experience some level of stress while in the department [34]. In our study, managing patient anxiety and stress was one of the most impactful aspects of the PEO role.

There has been an increase in occupational violence experienced in Australian EDs [3]. From a 2024 systematic review, discontent with the quality of service, long waits, lack of staffing and a dissatisfaction with the clinical treatment were the most reported triggers of aggression [7]. We found the PEO role enhances the sense of safety in the waiting area, by helping patients understand reasons for delays in care and reducing triggers to aggression.

From this study, PEOs observed and reported behavioural changes indicative of patient deterioration. Recent studies have linked increased patient deterioration and overcrowding in ED waiting rooms [35,36]. A 2015 study found one in seven patients had unreported deterioration, with patients aged over 65 years having a fourfold increase in unreported deterioration during their ED stay [37]. Inadequate escalation of deterioration is more likely in overcrowded waiting rooms with limited coverage and visibility [36,38]. High demand reduces time for thorough patient observation and discourages patients and families from notifying of changes due to perceived busyness of staff [38]. Supporting PEOs with training in the identification of behavioural changes associated with deterioration, could enhance patient safety through timely escalation of care.

7. Conclusions

ED waiting rooms can be chaotic places. Improving the experience of patients in ED waiting rooms through initiatives like the PEO role impacts efficiency and safety, and ED staff sense of wellbeing. Timely communication with patients, decreased interruptions, reduced incidents of patient aggression, improved workflow and a more collaborative team environment were attributed to the PEO role in ED waiting rooms. As emergency care delivery becomes more complex, traditional waiting room management models are insufficient. The PEO provides the first point of contact for patients on arrival at the ED. They facilitate a safe, accessible and, calm environment for patients through their presence and communication. The inclusion of the PEO enables the establishment of compassionate patient relationships.

8. Future research

Given this role is unique to only a few Australian hospitals, there is limited comparative evidence on the impact of the role on improving patient outcomes indicating future research in this area is required. Additional cost benefit analysis of the role and analysis of patient experience could further strengthen the business case for adoption of the PEO model in health services.

9. Strengths and limitations

ED staff actively participated in this research, resulting in high survey completion rates and interviews across all professional groups. Cost benefit analysis was unable to be undertaken to provide greater evidence on the potential efficiency impacts of the role, in part due to the limited timeframe and the impact of COVID-19 on staffing, when the PEOs were often redeployed to other roles to cover staff absences. Exploring patient experience was beyond the scope of this report.

Self-nomination to complete the surveys and participate in interviews and focus groups may have influenced the feedback provided. Other perspectives and experiences from some staff and professional groups may be absent from this study.

During the evaluation, the health service announced the PEO role funding may not continue. It is possible that this announcement influenced staff participation in the evaluation and shaped the feedback. On receipt of the report, the health ministry decided to continue funding the PEO role.

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CRedit authorship contribution statement

Jodie Brabin: Writing – review & editing, Writing – original draft, Investigation. **Sharon Laver:** Writing – review & editing, Writing – original draft, Investigation, Formal analysis. **Rosemary Phillips:** Project administration, Investigation, Data curation. **Rachel Rossiter:** Methodology, Conceptualization. **Samantha Jakimowicz:** Writing – review & editing, Methodology, Investigation, Funding acquisition, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ienj.2025.101718>.

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