


Care Experiences of Older People in the Emergency Department: A Concurrent Mixed-Methods Study

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Magreth Thadei Mwakilasa, MSc^{1,2} , Conor Foley, PhD³,
Tracy O'Carroll, MSc³, Rachel Flynn, MSc^{3,*},
and Daniela Rohde, PhD^{1,3,*} 

Abstract

The growing population of older people has increased demand to meet their complex healthcare needs, including in emergency departments (EDs). This study explored the experiences of people aged 65+ in Irish EDs, involving secondary analysis of quantitative and qualitative data from the 2019 National Inpatient Experience Survey (NIES). Experiences in the ED and overall hospital experiences were dichotomized as poor to fair or good to very good. Logistic regression was used to model quantitative data. Free text comments relating to EDs were thematically analyzed. Of 12,343 survey participants, 4,442 (39.9%) were aged 65+ years and used the ED. Longer waiting times, completion of the questionnaire by another person either with or on behalf of the patient, and having both a medical card and private health insurance were predictors of poor to fair ED experiences. Patients aged 85+ years were more likely to report good to very good ED experiences. Poor experiences in the ED were associated with poorer overall hospital experiences (odds ratio [OR]: 2.19, 95% confidence interval [CI]: 1.76 to 2.73, $p < .001$). Thematic analysis revealed that long waiting times and unpleasant waiting conditions, including lack of communication, privacy, and personal care were important challenges encountered in the ED, with some older patients noting their preference for separate ED services. There is a need to reduce waiting times and integrate user perspectives in the planning, organization, and delivery of ED care to improve experiences and quality of care for a growing older population.

Keywords

older people, emergency department, emergency care, patient experience, care experience, mixed methods

Introduction

Internationally, it is predicted that 16.7% of the population will be aged 65 years or above by 2050 (1). The increase in the number of older people is accompanied by an increasing demand to meet their healthcare needs, as old age is associated with many health challenges that often require immediate attention through the emergency department (ED) (2,3). Studies in the UK, Ireland, and Australia have reported that older patients tend to utilize ED services frequently and are more likely to have a return visit than younger patients (4–6). While older patients tend to report more positive experiences with ED and hospital care than younger patients (7–9), their pathways in hospitals are not always straightforward (8,10). The increasing number of older people utilizing EDs has resulted in capacity problems in the acute hospital system and manifested as overcrowded EDs due to postponed admissions, inadequate numbers of acute hospital beds, and long ED waiting times (11).

In 2018, the Irish Health Service Executive reported that over 1.15 million patients were being treated and cared for in public EDs (3). Previous studies have focused on identifying characteristics of ED attendees and outcomes, physician perspectives of care and conditions, ED waiting time differences between older and younger patients, and the factors influencing the 6-hour waiting target in Irish EDs (12–17).

¹ School of Social Work and Social Policy, Trinity College Dublin, Dublin, Ireland

² Muhimbili University of Health and Allied Sciences, Ilala, Tanzania

³ Health Information and Quality Authority, Dublin, Ireland

*Joint senior authors.

Corresponding Author:

Magreth Thadei Mwakilasa, School of Social Work and Social Policy, Trinity College Dublin, College Green, Dublin, D02 PN40, Ireland.
Email: margareth.thadei@gmail.com



Little is known about older patients' experiences of ED care. This is the first study to employ a mixed-methods approach to provide an in-depth description of older people's experiences in the ED, as well as exploring potential factors associated with good or poor experiences of ED care. Patient experiences are a key component of healthcare quality, and a deeper understanding of older patients' experiences of ED care could aid in planning and advancing the quality and standards of care offered in acute public hospitals for older patients.

Methods

Study Design

This concurrent mixed-methods study involved secondary analysis of qualitative and quantitative data from the 2019 National Inpatient Experience Survey (NIES) (7,18), a national cross-sectional survey of the experiences of acute hospital inpatients in Ireland.

Sample

Patients aged 16 years and above, who spent at least 24 h in an Irish acute public hospital and were discharged in May 2019 were eligible to participate. Psychiatric and maternity hospitals were excluded (18). Of 26,897 invited individuals, 6,852 patients aged 65 years and over responded to the survey. The present study included the 4,442 patients aged 65 years and over who entered the hospital through the ED. (Figure 1).

Qualitative Methods and Analysis

Free Text Questions. The NIES questionnaire included three open-ended questions, which asked, "Was there anything particularly good about your hospital care?", "Was there anything that could be improved?", and "Any other comments or suggestions?" and allowed respondents to answer in their own words. Only comments that referred to experiences in the ED were included in this study.

Qualitative Analysis. All qualitative comments received in response to the three open-ended questions from patients aged 65 years and older, relating to their experiences in the ED, were thematically analyzed. Initially, the comments were grouped into two categories: ED waiting time ($n = 1,421$ comments) and ED management ($n = 589$ comments). The comments were coded in Microsoft Excel using the six principles of thematic analysis outlined by Braun and Clarke (19) by the first author, in discussion with a senior author (DR). Initially, 11 codes were identified. Once all comments were coded, similar codes were combined and grouped into 6 broader categories. Similar categories were then combined to form the final 4 themes, which reflected the issues identified by respondents as vital to their ED care experiences (20).

Quantitative Methods and Analysis

ED Experiences. Scores for overall ED experiences were calculated from five questions that asked patients about communication, privacy, and whether they were treated with dignity and respect in the ED. Responses for each question were scored according to methods utilized by the Care Quality Commission in the UK (21) as follows: "yes, always" (10), "yes sometimes" (5), "No" (0). A detailed description of the scoring procedure has been published elsewhere (18).

Overall Hospital Experiences. Overall experiences of care in the hospital were rated on a scale from 0 (poor overall experience) to 10 (positive experience). Both the composite ED experience and overall hospital experience variables were dichotomized into poor to fair (0–6) or good to very good (7–10) experiences.

Predictors. Variables of interest included sex, age (65–74, 75–84, and 85+), health insurance status (medical card,¹ private health insurance, neither, or both), time spent in the ED (<6 h, 6–24 h, >24 h), and the main person completing the questionnaire (the patient, patient with assistance or someone else on the patient's behalf). Experiences in other parts of the hospital, such as care on the ward, experiences during examination, diagnosis or treatment, and discharge or transfer (scored on a scale from 0 to 10) were included as covariates.

Quantitative Analysis. Quantitative data were categorized and summarized using frequencies and percentages. Binary logistic regression was employed to investigate predictors of the composite ED experience score, adjusting for age, sex, time spent in the ED, health insurance status, and the person who completed the questionnaire. Hierarchical binary logistic regression was used to investigate if ED experiences predicted overall care experiences in the hospital, adjusting for experiences in other parts of the hospital, and demographic variables. Odds ratios (OR) and 95% confidence intervals (CI) are presented. An alpha level of <.05 was used to denote statistical significance. Quantitative data were analyzed using IBM SPSS software version 26.

For this mixed-methods study, the findings from the qualitative and quantitative analyses were integrated in the discussion.

Results

Experiences of Older Patients in the ED

We identified four main themes that older patients encountered in the ED: (1) prompt triage, seamless, fast and efficient services, (2) unpleasant long waiting time, (3) the reality of waiting, and (4) preferences for a segregated ED with separate services for older patients.

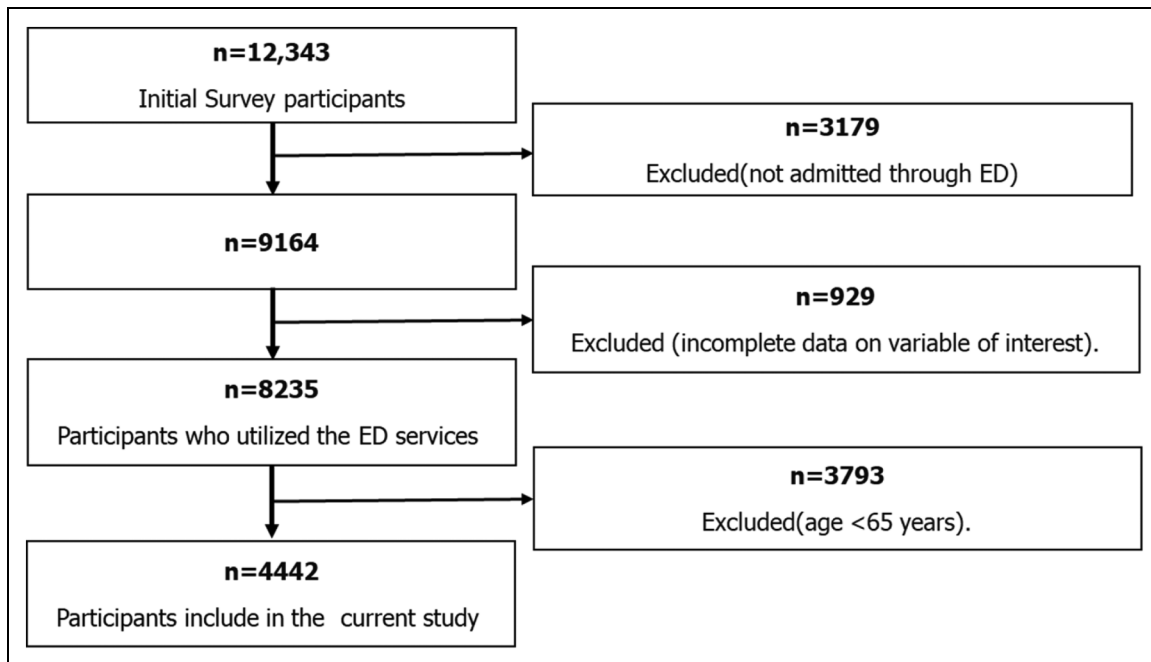


Figure 1. Study respondents flow chart.

Prompt Triage, Seamless, Fast, and Efficient ED Services

Some older patients explained that the triage services were efficient and prompt, and usually offered within 10–30 min of arrival. Some respondents appeared to be impressed with the knowledge of the nurses, who identified their condition as urgent:

“I was triaged and admitted to A&E² within 10 min, waiting 10–20 min on doctor, who administered care straight away. The knowledge of staff to know this was an urgent illness was extremely good and on a Sunday evening.” (Female, age 73).

Some older patients who were fairly ill or had severe health conditions described that everything was excellent from their initial arrival to exiting the ED through admission onto a ward or discharge from the hospital. Where older patients reported exceptional care in the ED, they explained how quickly their journey progressed:

“The speed of my admission. Arrived A&E at 11.00 saw triage nurse at 11.30. Transferred Medical Assessment Unit at 12 noon. After 6 h of investigations and treatment transferred to medical ward.” (Female, age 88).

Unpleasant Long Waiting Time

Prolonged waiting times in the ED were a significant issue of concern for many older people, with visits to the ED characterized by the uncertainty of not knowing how long they were

expected to wait for services. Three separate waiting periods were identified: the first delays were on waiting to see a doctor after triage, the second on waiting for tests, treatments, and results, while the third delay was waiting to be admitted to a ward:

“Waiting a day to go for a scan and then waiting another day for doctors to come about results. This time wait would/could be improved.” (Male, age 66).

One relative of an older patient explained how their father waited in the ED to get a bed on a ward:

“The A&E dept. could be improved for elderly people. My dad is 92 and came from a nursing home and he was waiting 27 h before he got a bed. That’s unacceptable.” (Male, age 92).

The Reality of Waiting in the ED

Some older patients described the waiting environment in the ED unfavorably, including descriptions of dirty floors, unhygienic bathrooms, lack of personal care, lack of appropriate food, and lack of physical and auditory privacy. The seating arrangement often comprised older patients sitting on hard chairs in waiting rooms or lying on trolleys in overcrowded hospital corridors. These circumstances appeared to be influenced by lack of beds, small spaces, and lack of enough staff to provide immediate care:

Table 1. Demographic Characteristics, Experiences in the Emergency Department (ED), and Overall Experiences by age.

Demographic and experience variables		65–74 years N (%)	75–84 years N (%)	85+ years N (%)	P
Sex	Male	1,031 (56.4)	850 (48.4)	366 (42.8)	<.001
	Female	798 (43.6)	908 (51.6)	489 (57.2)	
Medical cover	No medical cover	111 (6.1)	29 (1.6)	4 (0.5)	<.001
	Private health insurance only	358 (19.6)	189 (10.8)	58 (6.8)	
	Medical card only	1,151 (62.9)	1,128 (64.2)	578 (67.6)	
	Both private and medical card	209 (11.4)	412 (23.4)	215 (25.1)	
Person completing the questionnaire	Patient	1,417 (77.5)	1,041 (59.2)	283 (33.1)	<.001
	Patient with assistance	248 (13.6)	390 (22.2)	293 (34.3)	
	Someone else on patient's behalf	164 (9.0)	327 (18.6)	279 (32.6)	
Waiting time in the ED	Less than 6 h	581 (31.8)	536 (30.5)	243 (28.4)	.169
	Between 6 and 24 h	992 (54.2)	982 (55.9)	508 (59.4)	
	More than 24 h	256 (14.0)	240 (13.7)	104 (12.2)	
Overall ED experience	Good to very good	1,502 (82.1)	1,437 (81.7)	698 (81.6)	.938
	Poor to fair	327 (17.9)	321 (18.3)	157 (18.4)	
Overall hospital experience	Good to very good	1,480 (84.3)	1,392 (82.9)	644 (79.1)	.005
	Poor to fair	275 (15.7)	287 (17.1)	170 (20.9)	
When you had important questions to ask doctors and nurses in the ED, did you get answers you could understand?	Yes, always	1,142 (71.8)	1,061 (70.5)	481 (66.2)	.027
	Yes, sometimes	378 (23.8)	381 (25.3)	219 (30.1)	
	No	71 (4.5)	62 (4.1)	27 (3.7)	
While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	Yes, completely	1,081 (64.2)	936 (58.2)	430 (54.0)	<.001
	Yes, to some extent	465 (27.6)	545 (33.9)	304 (38.2)	
	No	139 (8.2)	128 (8.0)	62 (7.8)	
Were you given enough privacy when being examined or treated in the emergency department?	Yes, definitely	1,280 (71.5)	1,257 (73.1)	592 (71.6)	.585
	Yes, to some extent	365 (20.4)	316 (18.4)	169 (20.4)	
	No	145 (8.1)	147 (8.5)	66 (8.0)	
Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	Yes, always	1,543 (85.0)	1,485 (85.6)	699 (83.0)	.491
	Yes, sometimes	208 (11.5)	186 (10.7)	105 (12.5)	
	No	65 (3.6)	64 (3.7)	38 (4.5)	

“There were eight or ten trolleys lined up in the corridor waiting for a doctor to see to them. There was no privacy, the lights were full on you could not rest or sleep. Nurses were trying to see to everyone it was noisy. The trolley was most uncomfortable. I could not have stayed on it much longer as my back was really painful.” (Female, age 78).

Some older patients expressed how the ED lacked auditory privacy: *“Just because one is surrounded by a blue curtain does not mean privacy. Personal details are generally overheard by other patients.”* (Male, age 69).

Nursing Care in the ED

The majority of older respondents recognized and applauded the exceptional care offered by ED staff while attending to them. Many patients acknowledged the difficult conditions under which doctors and nurses in the ED provided care, noting that they were overworked, under pressure, and overstretched. Older patients and the people who assisted them generally agreed that ED staff were exceptionally attentive, professional, caring, friendly, and accessible, and provided genuine care despite the department being extremely busy:

“The level of service given by the doctors in the A&E was excellent. I was updated on my condition at all times. They were thoroughly efficient, extremely caring, they were working under very busy conditions yet the level of service I received was not compromised at any stage of my visit.” (Male, age 69).

Some patients further proposed that there was an urgent need to employ more staff and to improve working conditions:

“Increase in staff numbers is required urgently. Patients cannot receive appropriate care when staff are so busy dealing with the large number of patients presenting in ED.” (Male, age 70).

Preferences for a Segregated ED with Separate Services for Older Patients

Many older patients urged for particular units or rooms within or outside of the general ED that could provide services for people with addictions such as drug and alcohol users, patients with a minor illness or injury, and a separate, special ED unit for older people. Drug and alcohol users were

seen by some older patients as disruptive, which caused distress. Many older respondents emphasized that services should be provided to older patients first, because they required more immediate medical care than drug users or patients with minor health issues:

“A&E definitely could be improved. [Drug and alcohol users] should be kept in separate areas due to the fact the elderly and really sick people feel so threatened by them.” (Male, age 73).

“It would be an improvement to separate real emergency from minor, minor cuts and bruises and take admissions that a doctor deemed necessary through the hospital not A&E.” (Male, age 73).

Some older patients believed that to reduce the challenges encountered during their visits to the ED, such as long waiting times under challenging conditions and overcrowding, a separate, specific unit within or outside of the general ED, devoted to older patients, was needed:

“Emergency Dept – for 70’s and over, should be a separate area – should not be in A&E on a trolley for 28 h ... should be in a separate area of hospital.” (Female, age 89).

Patient Characteristics and Correlates of ED Experiences

In total, 6,852 patients aged 65 years and above responded to the survey, of whom 4,442 utilized the ED. Of these, 50.6% were male ($n=2,247$) and 49.4% female ($n=2,195$). The majority of patients aged 65 years and over had a medical card only ($n=2,857$, 64.4%), waited between 6 and 24 h for admission ($n=2,482$, 55.9%), and completed the questionnaire themselves ($n=2,741$, 61.7%). Patients aged 65–74 years were significantly more likely to report a good or very good experience with their overall hospital care compared to patients aged 85 years and above (Table 1). Patients aged 65–74 were also more likely to report that they got answers they could understand when they had questions to ask while they were in the ED, and to report that their condition and treatment were explained in a way that they could understand compared to patients aged 85+ years.

Longer waiting times of between 6 and 24 h (OR 6.02, 95% CI 4.44 to 8.15, $p<.001$) or more than 24 h (OR 23.37, 95% CI 16.82 to 32.48, $p<.001$), completion of the questionnaire with someone else’s assistance (OR 1.48, 95% CI 1.20 to 1.82, $p<.001$) or by someone else on behalf of patients (OR 1.82, 95% CI 1.46 to 2.27, $p<.001$), and having both a medical card and private insurance (OR 1.94, 95% CI 1.13 to 3.35, $p<.001$) significantly increased the likelihood of patients aged 65 years and over reporting poor to fair overall ED experiences. Patients aged 85+ years were significantly less likely to report poor to fair experiences in the ED (OR 0.77, 95% CI 0.59 to 0.98, $p=.035$) compared to those aged 65–74 (Table 2).

Table 2. Logistic Regression Model of Poor to Fair Emergency Department (ED) Experiences.

Predictor variables	OR (95% CI)	P-value	
The main person completed the questionnaire	Patients (Ref.)		
	Patients with assistance	1.48 (1.20, 1.82)	<.001
	Other on behalf of patients	1.82 (1.46, 2.27)	<.001
Waiting time	Less than 6 h (Ref.)		
	Between 6 and 24 h	6.02 (4.44, 8.15)	<.001
	More than 24 h	23.37 (16.82, 32.48)	<.001
Health insurance status:	No Cover (reference)		
	Medical insurance only	1.55 (0.92, 2.62)	.099
	Private insurance only	1.65 (0.95, 2.89)	.076
	Both Medical card and private insurance	1.94 (1.13, 3.35)	.019
Sex	Male (Ref.)		
	Female	1.02 (0.86, 1.20)	.862
Age	65–74 (Ref.)		
	75–84	0.88 (0.73, 1.06)	.178
	85+ years	0.77 (0.59, 0.98)	.035

Note: Model: $\chi^2(8) = 599.891$, $p<.001$, Pseudo $R^2 = 0.126$ (Cox and Snell), 0.205 (Nagelkerke).

While age was not associated with overall hospital experience ratings in adjusted analyses, older patients who reported poor to fair experiences with their ED care were twice as likely to report poor to fair experiences with overall hospital care (OR 2.19, 95% CI 1.76 to 2.73, $p<.001$) (Supplementary Table 1).

Discussion

This study explored older people’s experiences of ED care, employing a concurrent mixed-methods approach. While the quantitative results suggested that older patients tended to report positive experiences with various aspects of ED care, the qualitative comments revealed several areas of poor experience and areas requiring improvement. Significant issues highlighted by older people included prolonged waiting time, unpleasant waiting conditions such as laying on trolleys, overcrowded waiting rooms, lack of communication, privacy, and lack of appropriate food and personal care.

Predictors of Poor Experiences

Similar to previous studies, we found that patients in the oldest age groups were more likely to report good

experiences in the ED and with overall hospital care (7–9,22). Poorer experiences in the ED were more likely to be reported by those who waited for longer periods, older patients with private health insurance, and those who had assistance with completing the questionnaire. Older patients who had poor to fair experiences in the ED were twice as likely to report poor to fair overall hospital experiences, suggesting that ED care has a significant impact on patients' overall hospital experiences, even when adjusting for subsequent experiences in other parts of the hospital. These findings were reflected in the qualitative comments of family members of older patients, who expressed concerns over ED services that are of poor quality and highlighted the need for immediate improvements to waiting times, personal care, and privacy. Morphet et al. (23) similarly reported that family members of patients tended to be less satisfied with ED care than patients themselves. The reasons for these findings are not apparent. Family members may have higher expectations regarding the care that they would like their relatives to receive, although further research is required to explore the experiences of family members who escort older patients in the ED.

Older patients in our study placed a high value on the amount of time they spent waiting in the ED, which is similar to previous studies (10,13,24–26). Patients who waited more than 24 h were significantly more likely to report poor ED experiences compared to those who waited less than 6 h. These findings were reflected in the comments, where many older patients expressed concerns over the length of time they spent waiting in the ED and for admission to a ward. Studies conducted in the UK, Australia, Sweden, Canada, and Taiwan (10,27,28) have similarly identified an urgent need to reduce ED waiting times. Older patients suggested a cleaner, more comfortable environment, hiring more medical staff, increasing the number of beds, and diverting patients with minor injuries or nonemergency cases out of the general ED as possible solutions (23,25). Older patients in our study believed that the availability of units based on patient need could reduce congestion, overcrowding, and long waiting times.

ED Waiting Conditions

In many cases, older patients in our study were expected to wait on uncomfortable chairs or trolleys without personal care, appropriate food, lack of privacy, little communication, and difficulties sourcing nursing care. Similar findings have been reported previously (10,25,29–32), with an Australian study by Considine et al. (33) reporting that waiting conditions in the ED are unsuitable for older people. Studies conducted by Olofsson et al. (34) and Nikki et al. (35) reported the difficulties that patients encountered sourcing nursing care while waiting for treatment in the ED. Despite the challenges in securing the attention of nurses, we found that both older patients and relatives praised the efficiency and caring attitudes of nurses. Patients were generally contented with the care they received

and acknowledged that despite the busy and challenging working conditions, the care offered was not compromised at any stage. The findings of our study contrast with previous studies (30), which reported that poor attitudes of ED staff had a significant impact on patients' experiences.

In the ED, personal care tasks such as going to the toilet, feeding, and bathing of older patients who required assistance were usually left to relatives and carers. In a situation where family members are not around, older patients were left to take care of themselves. In Middlesex, UK, hospitals have partnered with local NGOs to have volunteers in the ED to assist in taking care of patients (36), an approach that could be considered in other countries. Moreover, patients and relatives in our study, similar to a study conducted in Sweden (37), showed concern about the safety of nurses and other patients in the ED from patients with addictions and alcohol users. As a result, participants in our study suggested that to better meet their needs, older patients should receive care in a separate area outside of the general ED. Previous studies have highlighted the need for a paradigm shift from the traditional general ED model since it no longer meets the growing needs of older patients seeking care in the ED (38). EDs are designed for a general population, which can have the unintended consequence of making them less suitable for the entire population, as each patient group has its own specific health needs. Therefore, studies in the United States and Australia have recommended adopting a Geriatric Emergency Department model, which involves structural and operational enhancements specific to meeting the needs of older people (38,39). Older patients in our study believed that the availability of units based on patients' needs could reduce congestion, overcrowding, and long waiting times for care in the ED. Additionally, patients in the present study highlighted the need for units that can provide care for patients with minor health conditions who do not require urgent care in the ED (23,25).

Strengths and Limitations

Our study utilized data from the 2019 NIES, which employed a robust design, methods, and internationally validated questions to capture inpatient experiences in all public acute hospitals in Ireland (40). The present study employed a concurrent mixed-methods approach, which allowed for a comprehensive analysis of older patients' experiences in the ED, while offsetting the weaknesses inherited by conducting two separate studies. However, our study was reliant on secondary data and comments in response to three broad, open-ended questions from the survey; therefore, it was difficult to provide an exhaustive analysis of patients' experiences, since questions were not specific about care in the ED. Demographic data on the characteristics of patients who did not respond to the survey were not collected, and it is not known how many patients aged 65+ years were invited to participate in the survey. Results may not be generalizable to older patients who did not participate in the survey.

Conclusion

This study found long waiting times, unpleasant waiting conditions, and lack of communication to be among the challenges faced by older people when seeking care in the ED. To address these challenges, there is a need to integrate user perspectives in the planning, organization, and delivery of ED care to accommodate the needs of a growing older population.

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Ethical Approval

Ethical approval for the National Inpatients Experiences Survey (NIES) was granted in March 2018 by the Royal College of Physicians in Ireland (RCPI) Research Ethics Committee. Ethical approval for the present study was granted by the School of Social Work and Social Policy Research Ethics Committee (REC), Trinity College Dublin in May 2020.

Statement of Informed Consent


Informed consent was obtained from the patients to take part in the survey. The decision to participate was voluntary as patients were provided with five options to opt out of the survey: one while they were in the hospital and four after discharge by either calling a Free Phone number, emailing, opting out online, or by returning a blank questionnaire. Informed consent for patient information to be published in this article was not obtained because this was a secondary analysis of survey data aimed to understand older respondents' experiences of emergency services.

Statement of Human Rights

This article does not contain any studies with human or animal subjects.

ORCID iD

Magreth Thadei Mwakilasa  <https://orcid.org/0000-0002-2649-6556>

Daniela Rohde  <https://orcid.org/0000-0001-8834-2539>

Supplemental Material

Supplemental material for this article is available online.

Notes

1. A medical card entitles the holder to a range of free services, including general practitioner and hospital visits. Access to medical cards is means tested.
2. Emergency departments were previously known as Accidents and Emergencies (A&E) in Ireland, with some patients still referring to emergency departments as A&E.

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Author Biographies

Ms. Magreth Thadei Mwakilasa, MSc is an Assistant Research Fellow at Muhimbili University of Health and Allied Sciences.

Dr. Conor Foley, PhD is the Senior Analyst at the National Care Experience Programme, Health Information and Quality Authority.

Ms. Tracy O'Carroll, PhD is the Senior Programme Manager of the National Care Experience Programme, Health Information and Quality Authority.

Ms. Rachel Flynn, MSc is the Director of the National Care Experience Programme and Director of Health Information and Standards, Health Information and Quality Authority.

Dr. Daniela Rohde, PhD is an Analyst at the National Care Experience Programme, Health Information and Quality Authority, and Adjunct Assistant Professor at the School of Social Work and Social Policy, Trinity College Dublin.