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Original Article

Developing the Person-Centered Emergency Care Assessment: A Holistic Performance Framework for Indonesian Hospital

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Abstract

The emergency department at one of the Indonesian Public Hospital faces challenges of overcrowding, inadequate performance assessments, and the lack of a holistic team evaluation system, adversely affecting service quality and patient outcomes. This study proposes the Person-Centered Emergency Care Assessment (PECAS), a performance assessment system aligned with the person-centered care paradigm. Employing a qualitative approach and hermeneutic method, data were collected through interviews, observations, and document studies involving directors, medical and nursing committees, team members, and patients. The PECAS instrument was developed in three stages: exploring indicators, constructing the instrument, and determining methodologies, with a 360-degree evaluation approach to capture diverse perspectives. The trial results indicated team performance ranged from "Lacking" to "Adequate," reflecting the need for further improvement, yet the system was endorsed for its potential to enhance service quality and establish benchmarks. This study highlights the need for better teamwork, empathy, and clear communication to improve patient satisfaction and safety in emergency care. PECAS offers a comprehensive framework for assessing and improving emergency department team performance, addressing procedural clarity, and balancing operational demands and person-centered approaches to optimize healthcare outcomes.

Keywords: Person-centered Care, Performance Assessment, Emergency Department, Healthcare Quality.

1. Introduction

The increasing awareness of the importance of health maintenance has led to a rise in demand for health services. In the European Union and Australia, the cost of accessing healthcare reached 10% of gross domestic product in 2018. Concurrently, in the United States, the figure has attained 18% for the same year (Jayaraman et al., 2020). In India, health transactions are projected to reach 280 billion USD by the end of 2020, with hospital growth of 16–17% per annum. This rapid expansion is anticipated to facilitate the absorption of 40 million individuals (Ajmera and Jain, 2019). Nevertheless, this increase in demand is not solely observed by entrepreneurs in the health sector. Consequently, the health industry has become one of the red oceans characterized by intense competition (Pritchett, 2014).

Global competition in the healthcare industry, notably in Indonesia, intensified with the 2014 National Health Insurance (JKN) implementation. Initially, this policy threatened private healthcare facilities as patients preferred government institutions. However, private facilities quickly regained prominence by improving service quality and participating in the

JKN program (Ross et al., 2018). In contrast, government healthcare facilities struggled to benefit from the JKN system, showing no significant service quality improvement despite better facilities and technology (Wardhani et al., 2019). Meisari (2017) noted that government hospitals lag in communication quality and employee job satisfaction, which is critical for enhancing team performance and public image (Kennedy, 2017; Sari et al., 2020).

Government-owned health facilities must enhance their performance by adopting a new healthcare paradigm. This shift moves from "patient-centered care," which allows patients to make their own clinical decisions, to "person-centered care." The latter emphasizes clinical care, patient satisfaction, and sustainable, integrated care by involving patients' support networks. This transition also tackles the uncertainty in health structures and regulations, adapting to changing patient expectations regarding services (Bedgood, 2019).

The person-centered care paradigm is based on values of patient respect, individual autonomy, family involvement, and mutual understanding between patients and providers (Slater et al., 2017). McCormack and McCance (2006) identify four main concepts: (1) staff prerequisites, (2) the care environment, (3) patient-centered processes, and (4) patient-centric outcomes. This paradigm is being adopted globally, evidenced by its inclusion in The International Society for Quality in Health Care (ISQua) strategic goals for 2018–2020, which focus on patient-centered services and global health system development (International Society for Quality in Health Care, 2019). The efforts of the Hospital Accreditation Committee (KARS) to gain ISQua accreditation suggest that person-centered care will soon be integral to Indonesian health services (Fossati, 2017; Meilanova, 2019; Nicklin et al., 2017). The development or shift of this paradigm is one of the measures to address the unresolved issues, particularly in health services (Anand et al., 2020; Kelley and Gravina, 2018; Khorasani and Almasifard, 2017).

Unlike other units (outpatient and inpatient), the emergency department of one of the Public Hospital, situated in Tanah Bumbu Regency of Kalimantan Indonesia, is a facility that patients must visit urgently. This reality occasionally results in the unit experiencing overcrowding as the number of patients exceeds its capacity. While no quantitative data indicates the frequency of such occurrences in this hospital's emergency department, they are not uncommon. Under such circumstances, the emergency department team, comprising medical personnel, paramedics, and non-medical staff, must maintain optimal performance while ensuring service quality and patient safety (Care Quality Commission, 2017).

The hospital implements individual performance management with formal assessments conducted bi-annually, utilizing the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) 2007 instrument for physicians. However, this tool inadequately represents emergency room physicians' patient care, particularly during pandemics (J. Allen et al., 2002; Ardekani et al., 2021; Lucey and Johnston, 2020). The JCAHO 2007 instrument involves self-assessment, wherein physicians evaluate themselves based on six indicators and nine sub-indicators established by the medical committee. This method's advantage is accurately reflects actual field conditions (Andrade, 2019). Continuous performance assessment of ER physicians is challenging without an appointed assessment team, rendering self-assessment more practical. However, this approach has limitations, including high subjectivity and potential bias (Armstrong, 2006; Tyskbo, 2020; Yan and Brown, 2017).

The absence of a team performance assessment system negatively impacts finances (Beauvais et al., 2019) and healthcare services, resulting in higher employee turnover, low productivity, patient dissatisfaction, reduced care quality, increased medical errors, and legal issues (Frisina, 2018; Haugland et al., 2019). Patients and their families may experience adverse outcomes from delayed or erroneous medical procedures (Epner and Siegal, 2019),

resulting in higher morbidity and mortality rates for preventable cases. Adopting a person-centered care approach, as promoted by WHO and ISQua since 2015 (International Society for Quality in Health Care, 2019; Morton and Sellars, 2019; World Health Organization, 2015), alongside an integrated assessment involving all emergency room elements, could standardize performance evaluation, providing a holistic, systematic method applicable nationally and internationally.

2. Literature Review

2.1. Performance Management in Health Services

Performance management is a systematic process to enhance organizational performance by improving individual and team performance (Armstrong, 2006). In healthcare, this entails informal, continuous reviews and multiple formal reviews, a flexible process, a focus on values and behaviors, and management by first-line managers (Armstrong, 2006). This approach requires collaboration and cannot be implemented in isolation, especially when integrating person-centered care. Healthcare must evolve from traditional paradigms to a more comprehensive approach (Allen and Pak, 2023).

Personalization, standardization, and equality are crucial. Categorizing patients meaningfully helps allocate care effectively. System frameworks assist stakeholders in maintaining standard assessments by selecting appropriate measures for specific contexts. Four recommendations for implementing performance management in health services using the person-centered care paradigm are 1) collaboration between specialists and psychometric experts to develop and modify measurements with a theoretical basis; 2) ensuring scientifically rigorous measurements are accessible and convenient; 3) collaboration between data managers and vendors to create flexible, durable, and secure systems accessible to patients and clinicians; and 4) collecting satisfaction and effectiveness data to demonstrate clinical practice quality and improvement over time. Collaboration at all levels is necessary to realize the impact of measuring outcomes according to the person-centered care paradigm.

In the emergency department, performance management is influenced by unit resources, service time, diagnosis, workload, treatment standards, and service quality. Resource management is the most critical challenge, involving budget limitations, allocation, equipment maintenance, and adequate staffing, especially during critical periods. Optimal performance management is essential to reduce wait times, prevent overcrowding, increase output, and enhance patient experiences (Mostafa and El-Atawi, 2024).

2.2. Conceptual Framework

Conceptual reframing is infrequently addressed in qualitative research. However, this aspect constitutes a crucial step in the research process that warrants attention. Conceptual framing integrates the research ecosystem, encouraging researchers to incorporate all aspects of research into a cohesive process that interconnects these elements, minimizes redundancy, and refines the research context (Ravitch and Carl, 2019).

The research commences with a preliminary study based on empirical investigations. In this initial phase, an exploratory examination of the research site was conducted, with the primary objectives being to conduct preliminary interviews regarding the work system at the research site and to identify relevant regulations pertinent to the study. This preliminary study also aims to identify strengths, weaknesses, opportunities, and challenges at the research site, focusing on improving the performance assessment system of the emergency room team as

the primary entry point for inpatients at this hospital, particularly during the COVID-19 pandemic.

The next stage involves preparing a research proposal that outlines the plan for conducting the research to address the established questions effectively. The research then moves to data collection through structured interviews and observations, culminating in the Nominal Group Technique (NGT). NGT, a structured form of small group discussions, aims to achieve consensus by having participants respond to moderator questions and then prioritize ideas from the group. This method prevents individuals from dominating discussions, encourages equal participation, and results in prioritized solutions representing the group's collective preferences. NGT has several key functions (Mukherjee et al., 2018), such as generating more ideas than traditional discussions, balancing individual influence, and reducing competition and conformity pressures.

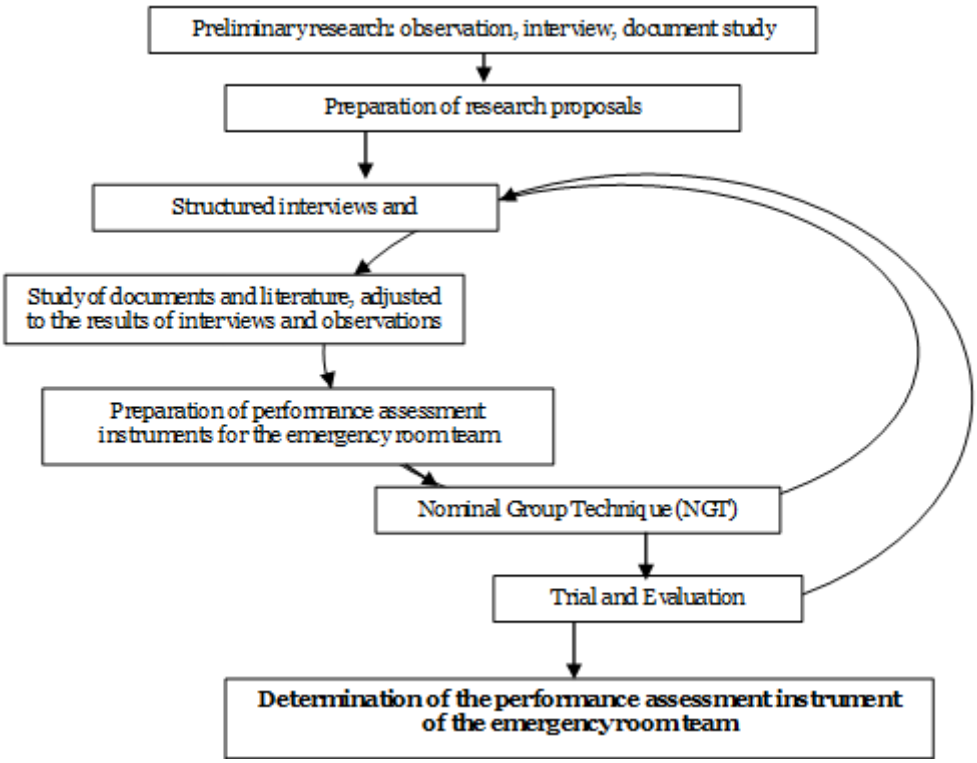

Figure 1. Conceptual Framework
Source: Author's Work (2024)

The NGT discussion aims to determine whether the prepared instrument can be agreed upon for testing. However, if refinements are deemed necessary, the data collection process at the research site will be repeated and continued with the subsequent stage until consensus on the instrument is achieved.

Table 1. Question Asked on NGT

Research question	Prompting	Question	Expectation
Setting indicators for the performance assessment of the emergency room team	Are there any indicator items that need to be added to the list of performance assessment indicators of the emergency room team?	From the list of indicators that have been compiled by the author, which is the most appropriate to assess the performance of the emergency room team?	An agreement was reached on the indicators that are the basis for the performance assessment instrument of the emergency room team

Establish sub-indicators for the performance assessment of the emergency room team Determining the performance appraisal system of the emergency room team	Are there any sub-indicator items that need to be added to the draft of the emergency room team's performance assessment instrument? Do you have any suggestions on the right assessment system to measure the performance of the emergency room team?	From the list of sub-indicators that have been compiled, which one can represent the related indicators? (Discussion is carried out per indicator) What kind of assessment system should be used that makes it easier for all parties, both the board of directors and the emergency room team, to be assessed, to maintain the quality of service to patients?	An agreement was reached on sub-indicators that can represent related indicators An agreement was reached on a performance assessment system for the emergency room team that makes it easier for all parties but still maintains the quality of service

Source: Author's Work (2024)

3. Methods

To develop a performance assessment instrument for the emergency room team, this study employed a qualitative approach to identify necessary performance indicators deeply. The hermeneutic method was used to interpret informants' experiences and phenomena in the emergency room, translating them into useful indicators and sub-indicators for performance assessment, aligning with the person-centered care paradigm (Mehta, 2020). Utilizing a 360-degree method, this approach formulates an assessment system accurately addressing the research questions.

The study develops performance assessment instruments for the emergency room team within the person-centered care paradigm, widely adopted globally. The instrument preparation involves three stages: 1) exploring potential indicators, 2) constructing assessment instruments, and 3) determining appropriate methodologies.

The analysis unit includes informants from four groups: the board of directors, medical and nursing committees, team members, and patients. The director, representing the Board of Directors, used the snowball technique to gather additional information from other healthcare facilities. Referrals included the head of the medical field, environmental health section, and emergency room. The medical committee chairman provided insights and directed researchers to consult emergency room doctors. Emergency room doctors and nurses shared their experiences and aspirations for improved team performance.

Utilizing the person-centered care paradigm, the emergency room team's performance assessment instrument was designated the Person-centered Emergency Care Assessment (PECAS). The PECAS instrument represents the ultimate objective of this research. Although numerous instruments have been developed, none have applied the person-centered care paradigm as intended with PECAS.

This research necessitates comprehensive information to support the development of performance assessment instruments for the emergency room team. To obtain this information, data were extracted from three research sources: interviews, observations, and document studies.

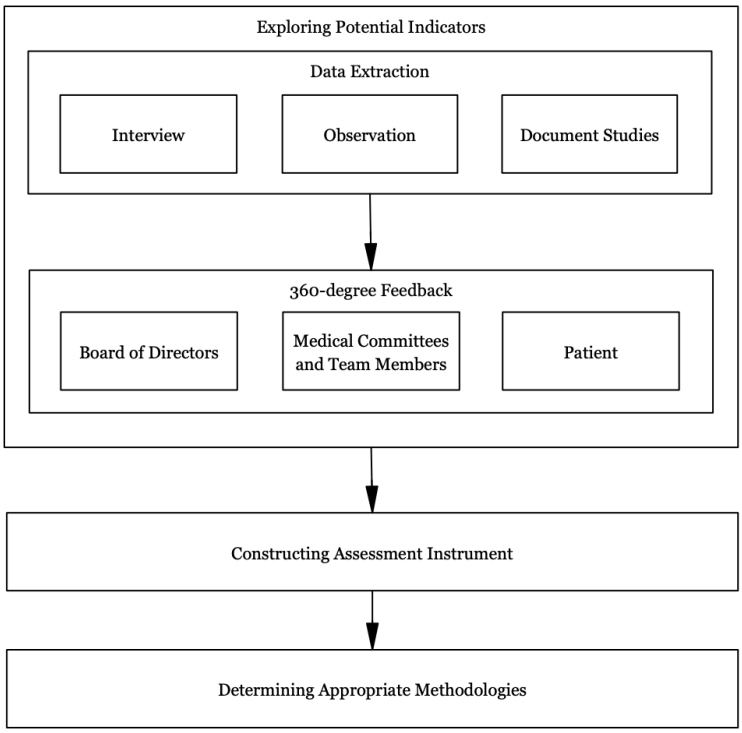

Figure 2. PECAS Instrument Development Stage
Source: Author's Work (2024)

4. Results and Discussion

4.1. Results

This research investigates the importance of measuring team performance in healthcare, particularly in hospitals. In the hospital studied, and likely in most hospitals in Indonesia, team performance is measured through individual assessments, which differ in focus from team evaluations. Individual performance of doctors, nurses, midwives, and non-healthcare workers is generally rated satisfactory by their superiors. However, patients perceive the emergency department's service as slow, affecting patient satisfaction and safety.

According to WHO standards, the maximum emergency response time is 8 minutes, considering secondary outcomes like the ambulance response interval and out-of-service interval (Cabral et al., 2018). In the hospital's emergency department studied, the average response time is 11 minutes, which contradicts the generally positive individual performance assessments. This discrepancy arises because regulatory standards do not explicitly define response times, using vague terms like "immediately assess" and "respond quickly," which are not measurable benchmarks. Additionally, staff members lack the initiative to address this issue, as evidenced by repeated neglect of response time in the admission and triage areas.

Patients generally feel they receive adequate service only after direct consultation with the treating physician, often ignoring indirect services like queuing, administrative processes, and ancillary services. This perception is particularly challenging in emergency departments with high patient volumes, averaging 24 patients daily (Saputera and Prasetya, 2020). Effective time management by physicians and emergency department staff is crucial to balance new admissions with urgent cases among existing patients. This issue can be mitigated using three team performance indicators for performance evaluation.

In the emergency department, the patient registration process is critical. Ideally, patients should be promptly assessed by healthcare professionals upon arrival, but they often first encounter administrative staff who check their health insurance status due to the department's layout. Patients report higher satisfaction when their initial contact is with the attending physician rather than administrative personnel, especially in private hospitals. According to the customer-perceived service wellbeing (CPSW) theory, a patient's experience with received services significantly impacts hospital marketing strategies. CPSW is a positive response from a service's experiential, relational, process, and interactive characteristics that enhance individual and community well-being (Islam et al., 2022).

This perspective aligns with the opinions expressed by patients' families regarding the registration service in the emergency department during interviews.

"... If we were in the emergency room of Marina Hospital (a private hospital), we were served first and then asked about insurance problems. Here (public hospital), we are always asked if the insurance is available first..."

This constitutes one of the reasons why patients prefer to seek treatment at private hospitals rather than public hospitals.

"... Actually, we prefer to take him to Marina Hospital because we no longer have time, so we are forced to bring him here."

Medical staff workstations are often near the emergency room entrance in private hospitals, especially in metropolitan areas. This setup facilitates quick patient service, enhancing patient trust and comfort and improving therapy adherence (Agyei et al., 2020; Pope and Mays, 2020). However, the strategic placement of these workstations is not a priority for management and emergency room teams.

The triage process is crucial in this study, with delays observed in its implementation compared to Standard Operating Procedures (SOPs). Supervision significantly impacts the availability of this service. Patient management and transfer depend on several factors: the speed of obtaining examination results (laboratory, radiology, etc.), prompt specialist consultations, availability of treatment rooms, completion of medical records, efficiency of medication provision by the pharmacy, and the complexity of the emergency. These factors are internal (modifiable by emergency room staff) and external.

Internal factors include the completion of medical records, the efficiency of medication provision by the pharmacy, and the complexity of the emergency. Effective teamwork should mitigate documentation delays. The complexity of emergencies involves preventing nosocomial infections, particularly during the COVID-19 pandemic. Although medication provision by the pharmacy could be seen as an external factor, it is classified as internal in this study because it is integrated with the emergency room, located only seven meters away. Thus, any delays should be addressed by emergency room staff, either by assisting with supply or expediting the process. The classification of internal and external factors may vary in different hospitals and should consider the specific circumstances of the hospital under assessment.

External factors affecting patient management and transfer efficiency include the speed of examination results, specialist physician responsiveness, and treatment facility availability. Examination speed depends on patient volume in the support department. This study shows emergency room efficiency drops significantly during polyclinic hours due to a single support unit serving all patients. SOPs regulate examination speed and are beyond the emergency room team's control. Larger hospitals typically have separate support sections for emergency, polyclinic, and inpatient services, requiring additional management skills from the emergency

team. Specialist consultation speed is also impacted, with informal text message practices causing delays. SOP laxity by emergency room management needs addressing to improve this aspect. The emergency room team can only encourage faster consultation responses. Persistent space availability issues necessitate thorough supervision reporting and effective patient education.

The initial PECAS instrument structure includes eight indicators: primary assessment, secondary assessment, procedures, care skills, infection prevention, interpersonal and communication skills, service management, and person-centered care implementation. This structure is based on literature reviews of previous assessment instruments (Cooper et al., 2010; Fariduddin et al., 2018; Häske et al., 2018; Oriot and Bridier, 2016) and individual assessments used at this hospital, such as the JCAHO in 2007. It also incorporates the four main principles of person-centered care in line with the latest ISQua regulations (The Health Foundation, 2016).

Having undergone the triangulation process, the research findings are subsequently aligned with the literature review and conclusions from the NGT meeting to compile indicators and sub-indicators into a comprehensive PECAS instrument. With the initial format referencing the PERFECT checklist (Häske et al., 2018), indicators and sub-indicators for the performance assessment of the emergency room team are formulated.

The assessment was conducted objectively using the 360-degree method, accurately representing the field situation. This instrument has been endorsed by the board of directors, medical and non-medical personnel, and patients as a performance benchmark at this research site and other hospitals. To establish an efficient and accessible assessment system, a team performance test was conducted in the emergency room. Four assessors evaluated the performance of three emergency room teams at different times. The results are shown in Table 2.

Table 2. Recapitulation of performance predicates in the PECAS instrument trial

Team	Assessment	Medical performance		Managerial performance		Cumulative grades	Performance predicate
		Personal	Total value (conversion)	Personal	Total value (conversion)		
1	Superior	44,5	89 (D)	38,5	72,9 (C)	1,4	Lacking
	Co-workers	18,1		14,2			
	Team members	13,3		9,8			
	Patient side	13,1		10,4			
2	Superior	46,6	93,8 (C)	37,2	73,2 (C)	2	Adequate
	Co-workers	19,4		14,6			
	Team members	14,0		11,0			
	Patient side	13,8		10,4			
3	Superior	43,0	86.2 (D)	40,4	76,7 (C)	1,4	Lacking
	Co-workers	16,7		14,6			
	Team members	13,9		11,5			
	Patient side	12,6		10,4			

Source: Author's Work (2024)

The table indicates that this instrument can more efficiently determine the emergency room team's performance, facilitating field application. Despite the trial's performance predicate not meeting expectations, the NGT meeting decided to continue using the assessment system for two reasons: 1)being the initial trial, the team may need several adjustments to achieve the desired performance, and 2)higher expectations could improve

emergency room service quality, potentially setting a regional and national performance benchmark.

4.2. Discussion

The WHO defines person-centered care as empowering patients to take responsibility for their health rather than being passive recipients. This approach is based on the belief that patient insights and experiences improve health outcomes. Enhancing patient-provider interaction is key, making services more empathetic rather than transactional. Healthcare professionals need training to listen, inform, and consult patients, considering their preferences, needs, and values in clinical decisions.

From the patient's perspective, person-centered care addresses many challenges they face. The first step in a successful treatment plan is identifying the patient's most significant problems (Eberts, 2020). This care model shifts the focus from 'What matters with you?' to 'What matters to you?', promoting better patient-provider relationships, meaningful conversations, informed treatment decisions, and improved outcomes (Healthcare Improvement Scotland, 2020).

Person-centered care also requires health workers to act as partners rather than just experts providing instructions (The Health Foundation, 2016). This partnership helps understand what is important to the patient, allowing them to make decisions about their care. Health providers must also identify and achieve patients' and their families' goals.

Implementing this approach globally, person-centered care is deemed the most suitable paradigm for assessing emergency room team performance. This paradigm encourages health workers to innovate in resolving issues that may hinder patient services in emergency settings.

"When assessing the situation in the emergency department, several issues arise after patient treatment. The blood has not been properly cleaned and has contaminated another patient's area. This task falls under the responsibility of either the nursing staff or the cleaning service. Upon inspection of the job description, it becomes apparent that this duty is not included in the cleaning service's remit. The nursing staff have not acknowledged this as part of their care duties, stating they would only intervene if changing bed linens. However, if memory serves correctly, nurses were previously responsible for cleaning both the mattress and its cover."

"... A distinction must be made between managing existing patients and accepting new ones. The latter typically requires more effort. When the facility is at capacity, it becomes challenging to undertake any additional tasks. Furthermore, the administration has not proposed meaningful changes to address this situation."

The primary issue in the emergency department is the unclear allocation of responsibilities among team members, leading to fatigue and stress. The shift leader must have strong interpersonal and communication skills to distribute tasks effectively, which should be included in team performance evaluations. Improving communication skills in teamwork requires targeted training tailored to emergency department competencies. Effective communication ensures optimal team performance by facilitating learning and providing feedback opportunities for all members, enhancing service quality (Kucharčíková et al., 2023; Zainuri and Huda, 2023).

The leadership and members of the emergency department team must also possess proficient communication skills when interacting with patients and their families to mitigate negative experiences or additional complaints while receiving care in the emergency department. One of the negative experiences a patient's family reported during the research on developing the PECAS instrument is as follows.

"The issue lies in the lack of clear communication from the physician. We were instructed to submit samples to the laboratory without being informed about the purpose of the tests. The nature of my father's condition remains unknown. We were simply told to wait and respond to inquiries from medical staff. No additional information was provided to the family members. Eventually, I, too, was apprised of the situation, but only after an extended period. There is still uncertainty about what to expect. Following a five-hour wait, we were finally informed of the diagnosis."

Communicating the patient's condition to the family is crucial for involving the patient in decisions to improve outcomes. Information delivery continues until the patient understands the disease, including symptoms, test results, diagnosis, therapies, medication, risks, potential complications, diet, and treatment plans. Some hospitals provide cost estimates, though the hospital in this study does not. Comprehensive information delivery requires considerable time, which is challenging in emergency departments due to high case volumes and limited time. However, effective communication practices can gradually address this issue, potentially becoming standard practice (Kim et al., 2022; Tiso et al., 2021).

There is ongoing debate regarding the feasibility of person-centered care in emergency departments. Some argue it is incompatible with the urgent nature of these services, while others believe it is achievable. Evidence indicates that this paradigm enhances patient experiences and satisfaction in emergency services (Kim et al., 2022; Walsh et al., 2022). The PECAS instrument identifies five dimensions essential for implementing person-centered care in emergency departments.

Firstly, the demonstration of empathy. Based on observations at the research site, empathy is often absent from the emergency department team. The more senior a health worker is, the less empathy they tend to exhibit. This is illustrated by the patient's explanation below.

"Yes, there is no smile either. He said his motto was 'smile, politeness, greeting', but there was no smile either."

Friendliness and courtesy are often lacking in emergency patient care, requiring a performance review of the emergency department team. The team needs to show greater respect towards patients and their families. Adapting to various situations to avoid inappropriate behavior or attitudes, especially in the emergency department, is essential, as patient feedback suggests.

"I respectfully request that you moderate your joking and laughter, as it is disturbing my wife's rest. The noise is audible in her room despite a wall and glass barrier between us. The sound still carries through."

Demonstrating empathy is crucial for enhancing the positive patient experience and increasing patient trust and compliance with the treatment or intervention administered by healthcare professionals (Kazimi et al., 2020). Consequently, the cultivation of empathy must be delineated in the performance assessment of the emergency team.

Secondly, offering alternative therapies is essential. The practice of providing treatment options or interventions should be established in the emergency department. Many medical personnel still consider offering alternative therapies an inefficient use of time and resources, resulting in its infrequent implementation in the emergency department. This is exemplified in the following description.

"Infrequently, Doctor. Perhaps only 10% of the time, is an option provided. Typically, one is immediately presented with the decision to proceed with the installation or decline. Should you opt against it, you must sign a form indicating your refusal of medical treatment."

"The approach varies depending on the specialist, Doctor. We refer patients to the on-call specialist physician for severe cases requiring hospitalization. Specialist doctors seldom offer alternative treatment options; only about 5-10 percent of patients receive choices, while the remainder must follow the specialist's prescribed therapy. If patients disagree with the specialist's recommended treatment, they must sign a form declining the proposed course of action."

Despite the lack of detailed knowledge regarding the patient's capabilities, their desire for a second opinion (which is their right), their preference for home treatment based on their abilities, and the specific methods thereof, certain challenges arise. In one instance, a patient's family member requested home treatment due to the need to supervise other family members, resulting in the patient's discharge at their request without medication and a comprehensive explanation of the necessary home care procedures.

"Given the circumstances, if the doctor can assure us that home treatment is feasible and provide clear instructions, we would favor outpatient care. This is particularly because my mother requires companionship as well."

The distinction between disease-centered and patient-centered paradigms, emphasizing person-centered care, is characterized by providing treatment options. This approach necessitates healthcare professionals to humanize patients, viewing them holistically. This principle underpins the importance of implementing alternative therapies in emergency departments.

The third aspect involves acknowledging patients' actions, therapies, and hospitalization decisions. The fourth entails elucidating the family's potential contributions to expedite the patient's recovery. This aims to ensure the family's active participation in facilitating the patient's recuperation. Lastly, it is crucial to consider the psychological well-being of both patients and their families. The following description illustrates how healthcare institutions may inadvertently disregard the patient's psychological state.

"The ventilation system is inoperable. There is no cooling unit available. One must endure a prolonged wait. The situation is dire, indeed. Given the choice, Marina Hospital would be preferable. However, the medical staff here indicated admission was impossible due to the pulmonary tuberculosis diagnosis. They lack the necessary facilities for TB treatment."

Applying the person-centered care paradigm in the emergency department aims to alleviate patient suffering and enhance their positive experience. Patients typically enter the emergency department under duress, as it is not a voluntary choice. However, the specific emergency department becomes their selection when emergency care is required. Therefore, improving performance in the emergency department is significant.

To address the challenges and obstacles, the development of a team performance assessment instrument is proposed. This instrument is termed the Person-Centered Emergency Care Assessment (PECAS). The PECAS instrument is constructed based on phenomenology observed directly at the research site and from structured interviews with sources, which researchers interpret through a literature review.

This study emphasizes team performance as the smallest organizational unit in the emergency department. Unlike other settings prioritizing individual performance, the emergency department's diverse staff backgrounds mean individual performance does not reflect team and organizational performance. For example, midwives or nurses, not just physicians, can conduct initial patient examinations or triage. Thus, a physician's poor performance does not necessarily affect team effectiveness. However, the hospital in this study, like many in Indonesia, lacks team performance assessment indicators, focusing instead on individual and organizational performance.

Organizational performance management underscores the importance of team performance for organizational effectiveness and efficiency, reflected in service quality in healthcare. Effective team performance enhances emergency department service quality (Burgess et al., 2020; Burnes, 2020). High-performance PECAS instruments can cultivate a superior work culture, foster team responsibility, and promote continuous management improvement. Trial results (Table 2) show that while team members believe they perform optimally, their work is only "adequate," highlighting the need for ongoing improvement. Continuous improvement should establish a positive work culture, emphasizing person-centered care in emergency services, thereby enhancing unit and organizational performance.

Utilizing goal-setting theory, observations, and structured interviews, this study concludes that an assessment indicator is needed to enhance team performance. This indicator should determine the current performance level of the emergency room team and the final performance goal expected by the board of directors and patients (Deschamps and Mattijs, 2017; Devarajan et al., 2018; Ogbeiwi, 2021). The PECAS instrument measures team performance and sets an optimal performance goal. Incorporating the person-centered care paradigm, PECAS includes expectations from the board and patients in indicator preparation. It integrates top-down and bottom-up decision-making principles in healthcare, potentially catalyzing application across all hospital departments.

This instrument is divided into three main components: medical performance, managerial performance, and assessment. The medical performance section comprises five sub-sections: 1) primary assessment, 2) secondary assessment, 3) procedures, 4) maintenance skills, and 5) infection prevention. The managerial performance section is divided into three sub-sections: 1) interpersonal and communication skills, 2) service management, and 3) the implementation of person-centered care. This division is based on the need for performance assessment derived from the results of structured interviews, observations, and literature reviews, which will be described as follows.

The separation of primary and secondary assessments is predicated on the observation that at this study site, secondary assessments are frequently omitted, while primary assessments are conducted comprehensively by all teams in the emergency room. With the distinction between primary and secondary assessments, it is anticipated that secondary examinations of emergency room patients will be performed more consistently.

Subsequently, the examination procedure and actions are continuous and simultaneous to ensure that no aspect is overlooked in patient care within the emergency room. Executing a collapsed procedure necessitates practice and habituation. The indicators in this sub-section of the procedure are adopted from the PERFECT checklist instrument, with the addition of patient handover points and completion of medical record status, which constitute part of indirect services (Häske et al., 2018; Souza et al., 2019). These additions align with hospital accreditation requirements and aim to enhance patient safety in continuing therapy or procedures in the treatment room.

In the fourth sub-part, 15 procedures commonly performed in the emergency department are detailed, including cervical collar application, immobilization, airway management, cricothyrotomy, needle decompression, cardiopulmonary resuscitation, post-cardiac arrest management, myocardial infarction management, acute hemorrhage management, pelvic stabilization pericardiocentesis, FAST examination, helmet removal, seizure management, and pre-eclampsia management. These were selected through discussions between the researcher and informants (directors, committees, team members, and patients) to address potentially overlooked or improperly executed actions. This selection aims to prompt the emergency department team to act carefully yet swiftly, reducing malpractice in patient care. A 5-point rating scale from "low" to "very good" is used for assessment (Tanujaya et al., 2022), with the maximum points varying by emergency type. Therefore, assessments should occur at least biannually, as more frequent evaluations, while more accurate, would challenge the time constraints of the assessment team.

The subsequent subsection of the medical performance section addresses infection prevention. This indicator is crucial to include in the performance assessment, considering that this research was conducted during the ongoing COVID-19 pandemic. Based on observational findings, prevention of transmission, particularly via airborne and droplet routes, is often neglected by healthcare workers, patients, and their families. The assessment indicators for infection prevention aim to reduce the incidence of nosocomial infections in the emergency department.

There are five indicators in the infection prevention sub-section: hand hygiene (following the World Health Organization's five moments of hand hygiene) (Paudi, 2022), appropriate use of personal protective equipment (PPE), patient cohorts, provision and use of masks for patients at risk of airborne disease transmission, and sterilization of equipment after use.

The managerial performance section encompasses three sub-sections: 1) interpersonal and communication skills, 2) service management, and 3) the implementation of person-centered care. Effective communication is vital for efficient emergency services and can be direct or through documented instructions in medical records. Observations during the study indicate that emergency room teams communicate effectively, resulting in minimal follow-up records. However, this indicator should still be assessed to ensure service quality.

Two indicators within the interpersonal and communication skills sub-section require improvement: task division in patient management and discussions regarding the patient's holistic condition (medical, psychological, and socio-economic). Task division should occur at the patient's admission, specifying who conducts examinations, inserts infusions, prepares emergency medicines and delivers blood test samples. Individuals can manage these tasks for yellow and green triage without significantly affecting service quality. However, the impact is substantial for red triage patients (life-threatening conditions). Although initially challenging, regular training is expected to establish effective task division habits among emergency room team members.

Effective discussions with patients in emergency departments require specialized training tailored to their fast-paced environment, which differs from communication training for other units. All levels of hospital management must recognize this distinction. With this understanding, targeted training and habituation can enhance communication between healthcare professionals and patients (Alghamdi et al., 2023).

The next section covers service management, focusing on the managerial skills of emergency department physicians. These physicians must continually refine their clinical and managerial skills to meet healthcare's evolving demands, where patient satisfaction and

overall experience measure performance. Although a medical emergency might be resolved properly, patient satisfaction may be affected by long waits for test results, delayed specialist consultations, and unprofessional staff interactions—all factors not always captured by standard satisfaction assessments (Irawan et al., 2023; Rane et al., 2023).

This research highlights the need for improved workload management and service efficiency in emergency departments. Unlike the JCAHO 2007 assessment, the PECAS instrument includes these indicators to evaluate managerial performances to ensure equitable distribution based on patient priorities, while service efficiency involves coordinating with various departments to enhance overall service delivery. According to goal-setting theory, incorporating these indicators can motivate improvements in emergency department performance.

The final sub-component of the performance assessment indicator involves implementing person-centered care in emergency department patient care. It includes five indicators: 1) showing empathy towards the patient; 2) explaining alternative therapies; 3) respecting the patient's decisions; 4) involving the patient in their care; and 5) considering the patient's psychological state. However, it is necessary to determine whether this paradigm positively impacts emergency department patient services. Pavedahl (2023) presents "two sides of the story," a narrative illustrating contrasting perspectives of the same incident in the emergency department from patients and nurses.

"I was rushing to work after dropping my daughter at nursery school, with my spouse already at their workplace. Time was tight, as I had a meeting in just ten minutes. Abruptly, there was a thunderous sound, followed by what I believe was my voice. I caught snippets of conversation mentioning ambulances and casualty departments, and I was placed on a stretcher. The atmosphere was chilly, and I experienced agonizing pain. No one would communicate with me, and my garments were sliced off without explanation. I attempted to gain attention and repeatedly enquired about the situation but received no response. The scene was so tumultuous that I began to weep."

"The emergency signal blared – a vehicular collision. Naturally, I was at the forefront, as such incidents always piqued my interest. In moments, the casualty was brought into the AandE, where I served as a critical care nurse. Vital sign monitors were attached to the patient, medical orders were issued, garments were removed, tubes were inserted, and medicines were dispensed. I observed the patient weeping and repeatedly asking, 'What is happening? What has happened to me?' However, no one responded. We were engrossed in our efforts to preserve the individual's life."

Person-centered care implementation in emergency departments consistently challenges healthcare professionals (Jensen et al., 2021; Kim et al., 2022; Pavedahl, 2023). According to the final consensus of the PECAS instrument trial, empathy, communication of alternative therapies, respect for patient decisions, family involvement, and attention to psychological state signify person-centered care in emergency settings. This is illustrated in cases where patients need explanations of their condition, proposed interventions, and psychological support. However, healthcare professionals often struggle to balance multiple tasks, prioritizing life-saving procedures over immediate psychological support. These aspects should be addressed simultaneously, depending on a mutual understanding between patients and healthcare professionals. Board support can help reduce indirect service time (e.g., administrative tasks), potentially increasing direct patient care and communication time.

The primary challenge in implementing person-centered care in emergency departments is the time needed for effective communication. Therefore, achieving improved

service quality via this care paradigm requires operational changes among team members and regulatory adjustments to streamline indirect services.

The PECAS instrument's final component is a 360-degree assessment, consisting of 1) personal evaluations by superiors, colleagues from different units, team members, and patients and 2)a synthesis of these evaluations to determine emergency department team performance. This evaluation informs strategies for performance improvement and enhancing healthcare service quality.

The 360-degree assessment was chosen for its multi-level approach, offering a more objective, representative performance measure. It provides structured data collection and processing, enabling reflection on valuable feedback, which informal assessments lack. This method mitigates the interpersonal threat of face-to-face feedback (Fleenor et al., 2020). The next chapter of this dissertation provides a detailed explanation of this assessment method.

The 360-degree or multi-grader feedback appraisal method offers employees a comprehensive performance evaluation through self-assessment and colleague feedback. This method aims to objectively enhance employee performance to meet organizational goals (Ekune and Anthony, 2024; Wright, 2022).

Assessments are performed by a team of superiors, colleagues, team members, and patient representatives (family or patients themselves), embodying the person-centered care model. Patient participation is integral, both in assessments and in developing research indicators. While this approach is new in Indonesia, international health organizations have long practiced patient involvement in decision-making. For example, the WHO launched the WHO Patient for Patient Safety program in 2005, implementing it in 2021 to expand patient roles in global health services (World Health Organization, 2022). Similar organizations exist in the United States and Ireland. This movement should be adopted in Indonesia to improve health service quality.

The PECAS instrument adopts the university GPA system to gauge student performance, known in Indonesia as the Cumulative Achievement Index (GPA). The five-level GPA system effectively categorizes performance levels (Soh, 2010). This ratio is converted into a cumulative value, resulting in a performance predicate. This predicate was tested on three emergency room teams and evaluated for convenience, accuracy, and alignment with expectations from directors, committees, team members, and patients.

The performance assessment of the emergency room team using the PECAS instrument aims to enhance team and unit performance. Service quality has not improved despite implementing various indicators (hand hygiene compliance, PPE usage, patient identification, satisfaction, emergency handover, triage response time, and nursing assessment completeness). Complaints from patients and healthcare professionals about service quality remain unaddressed by emergency room management, necessitating alternative assessment mechanisms to improve services.

The emergency department management should determine team members' performance levels, a previously overlooked step, along with service quality evaluation. Regulatory changes focus on administrative requirements for hospital classification, accreditation, or other needs rather than improving service quality. Administrative changes do not equate to quality improvements.

The PECAS instrument assesses team performance and promotes person-centered care, aiming to implement this paradigm across Indonesian healthcare facilities. Involving patient perspectives in preparation and assessment is a step towards integrating patient involvement in health service regulations, potentially positioning this instrument as a pioneer for Indonesia's Patient Safety Commission.

The assessment uses the 360-degree method for objectivity, aiming to reflect the field situation accurately. This instrument could gain acceptance from directors, medical and non-medical personnel, and patients as a performance assessment benchmark, particularly at this research site and other hospitals interested in its implementation.

The implementation of person-centered care (PCC) faces several significant challenges. Based on the extant corpus, traditional practices and structures rooted in the biomedical paradigm create resistance to change, as care pathways often lack flexibility, and power dynamics remain predominantly hierarchical, favoring physicians. Physical environments, such as open-plan areas or insufficient private spaces, further complicate the delivery of PCC. Additionally, healthcare professionals' attitudes can impede progress, with skepticism, resistance to change, and misunderstandings about PCC being common. Some professionals erroneously believe they are practicing PCC when they are not, while stereotyping and mistrust exacerbate these challenges in interactions with certain patient groups (Moore et al., 2017).

Time constraints also pose a major barrier, as the fast-paced nature of healthcare often limits opportunities for training, building partnerships, or developing new communication strategies essential for PCC. Population-specific vulnerabilities add further complexity, as frail or cognitively impaired patients, as well as those from diverse cultural or linguistic backgrounds, may require tailored approaches to establish trust and ensure effective care. Finally, inadequate documentation systems and intervention designs hinder the consistent application of PCC principles, particularly in balancing individual and group needs or ensuring comprehensive documentation (Moore et al., 2017).

To overcome barriers to PCC implementation, several strategies can be utilized. Targeted training programs can equip healthcare professionals with essential communication and interpersonal skills to foster patient partnerships and adapt to diverse needs. Addressing traditional hierarchies and rigid biomedical structures requires strong leadership and organizational commitment to enhance collaboration and flexibility. Streamlining documentation through integrated systems can reduce administrative burdens, allowing greater focus on patient care. Additionally, operational adjustments, such as improved time management and resource allocation, can alleviate constraints in fast-paced environments. Emphasizing empathy, cultural competence, and patient engagement in care decisions aligns care practices with PCC principles, improving patient outcomes and professional satisfaction.

The PECAS framework tackles key challenges in Indonesian public hospitals through a structured, team-focused performance assessment. By incorporating person-centered care principles, PECAS emphasizes empathy, effective communication, and coordinated teamwork to mitigate issues like prolonged response times, overcrowding, and unclear role allocations. This ensures comprehensive care and aligns team performance with international standards, such as the WHO's emergency response criteria.

PECAS also promotes a systematic process, involving regular evaluations with its 360-degree assessment method, helping teams identify performance gaps and implement improvements. This process can set national standards for emergency care quality and serve as a model for other public hospitals to enhance patient outcomes and operational efficiency. PECAS addresses procedural inefficiencies and fosters a culture of accountability and patient-centered excellence, contributing to resilient healthcare systems.

5. Conclusion

The Person-Centered Emergency Care Assessment (PECAS) marks a notable step forward in tackling emergency care challenges within Indonesian public hospitals. This comprehensive evaluation method, which incorporates a 360-degree approach and prioritizes person-centered care, helps identify areas for improvement, promotes interdisciplinary teamwork, and ensures emergency departments meet international standards. The key outcomes highlight the urgent need for structured evaluations to enhance service quality, decrease response times, and deliver holistic patient care. PECAS addresses these needs by integrating both medical and managerial performance indicators, while encouraging empathy, clear communication, and synchronized team efforts.

Additional studies should be conducted to validate PECAS in various healthcare environments and geographical areas, establishing its broad applicability and adaptability to different operational settings. This approach will enhance its credibility and expand its potential as a benchmark for assessing emergency care performance. Hospital administrators and policymakers are encouraged to implement PECAS in practical settings. Embracing this framework could initiate a significant shift towards a person-centered model, ultimately improving patient outcomes and operational efficiency throughout healthcare systems.

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