A prospective evaluation of Emergency Department redirection to Primary Care

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Background and Introduction:

- Non-urgent presentations contribute to increased ED workload and overcrowding. Both can adversely affect patient care.[1-3]
- Redirection of non-urgent presentations to more appropriate services is an option to help reduce this burden.
- RCEM and the Scottish Government Health Department support ED and Primary Care co-location, which facilitates redirection.
- Ninewells Hospital ED sees 50,000 patients/annum and has been practising 'redirection' since 1998.
- This study was the first major evaluation of the Ninewells redirection policy since the introduction of the new GP contract in 2004 when significant changes to UK out-of-hours care occurred.

How does redirection work in Ninewells?

Patient arrives and is registered

Triggers used at initial nurse assessment

- **Condition present for 3 days or more**
- **Already seen their GP with the same issue**
- **Problem that is normally dealt with in Primary Care**

Face-to-face conversation with senior doctor

Either seen in the department, given advice or redirected e.g. to GP, pharmacy, dentist etc.
This allows sufficient flexibility to provide a patient-specific approach

Reason for attendance (reported by patients)

Patient factors	74.4%
Primary care factors	8.5%
NHS 24 factors	4.0%
Not known	13.1%

Headline figures during study

Total ED attendances	6643
Number triggered	620 (9.3%)
Number redirected	444 (71.6%)
% of total attendances	6.87%
GP Replies received	381 (85.8%)
Patients subsequently attended GP	250 (56.3%)
% consultation only	14.0%
% requiring treatment	36.0%
% requiring investigation	6.8%
% requiring referral	43.2%
Number admitted after redirection:	
within 24 hours	14 (3.1%)
2-7 days	8 (1.8%)
Suboptimal care	1 (0.23%)
Harm	0

Method

Recruited all patients who triggered the redirection policy over a 2-month period:

- **Basic data were collected on the reason for attendance, presenting condition and whether they were fully assessed or redirected to a more appropriate form of care.**
- **GPs of redirected patients were contacted at least 4 weeks post presentation and asked to supply follow-up information.**
- **Patients who required hospital admission within 1 week of ED redirection had their ED notes, GP feedback and hospital case notes independently reviewed by an ED consultant and a GP, neither of whom was part of the research team.**

Safety Review

Reviewers used an internationally recognised definition of harm developed by the Institute for Healthcare Improvement:

"Was there any unintended physical injury or clinical deterioration resulting from or contributed to by decisions made in the ED that required additional monitoring, treatment or hospitalisation, or that resulted in death?"[4]

Also: "*Would you be happy for your relative to be managed in this way?*"

Top 5 presentation types triggering redirection policy

Injury	183 (29.5%)	128 (70.0%) redirected
Musculoskeletal disease	96 (15.5%)	82 (85.4%) redirected
Skin disease	55 (8.9%)	28 (50.9%) redirected
Respiratory disease	39 (6.3%)	29 (74.4%) redirected
Gastrointestinal disease	37 (6.0%)	27 (73.0%) redirected

Case of sub-optimal care:

Child under treatment of their GP with antibiotics for balanitis and awaiting circumcision.
When redirected from ED, the child was able to pass urine. When seen by the GP later the same day, the child was admitted and had a dorsal slit performed.

Hospital specialties admitting GP referrals after redirection:

Paediatrics	6	General Surgery	4
General Medicine	5	Urology	1
Clinical Oncology	1	ENT	1
Psychiatry	1	Gynaecology	1
		Orthopaedics	1

9 cases had already consulted their GP prior to ED presentation
5 cases were admitted for a different clinical complaint

Conclusions

0.23% incidence of suboptimal care and no episode of harm suggesting a safe system.

We believe this redirection policy to be in the patient's best interest as ED clinicians are not specifically trained to manage Primary Care issues but can discriminate as to who needs ED-level care.

The majority of patients attend due to "patient factors" rather than accessibility of GP practices.

The numbers redirected are small but the authors believe the message to the public is important.

Separate work has shown that the local public is aware of redirection. This has contributed to consistent success in the 98% 4-hour waiting time target over 10 years as well as an annual attendance increase significantly lower than the national average.[5]

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