The impact of Consultant-delivered decision making at the front door of the Emergency Department.

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Background

Hereford County Hospital is a small sized DGH. There are approximately 150 attendances to the Emergency Department per day, with 50 admissions into in-patient beds. Admissions present through multiple entry points and undergo varied processes depending upon referral method. There are significant issues with patient flow through the hospital with challenges to achieve the 4-hour target.

Evidence and assumed practice considers that senior clinical decisions provided as early as possible during ED attendance and subsequent journey has significant benefits on flow and quality of care.

With these points in mind we designed and piloted a model of Consultant-delivered streaming and initial assessment at the “front door” of our ED. The findings will be used to further define our future models of unscheduled care delivery.

Methods

The process to be undertaken during the pilot involved initial signposting of appropriate patients (excluding, for example, minors, resus, those with an established pathway in place already, e.g. stroke) into a rapid assessment area (RAA) staffed by nurses, and an ED or Acute Consultant. All patients were assessed by the Consultant, with basic observations and investigations completed within the RAA. An initial treatment plan was made, with subsequent disposition to home, into the ED for further management, or direct transfer to the ward or ambulatory unit following a referral and decision to admit (DTA) time stamp. An acute medical “comprehensive assessment team” was placed downstream to provide further iterative and Consultant reviews.

This model was undertaken for 5 days between 08:00 and 20:00, with each Consultant undertaking a six-hour streaming shift.

Results

There was no difference in the number of attendances into the ED (mean 155 range 137 to 181), nor overall admissions. Approximately 100 patients were streamed by Consultants within RAA. During each shift the mean number of patients seen by a Consultant Acute Physician was 13 (range 7-18).

A number of the key findings are given below.

**Statistically significant improvements in:**
- Arrival to DTA
- Total time in department

ED 4-hr wait 94-100% (vs YTD mean 81%)

Discussion

Our results suggest that the flow of patients through an ED benefits from having a Consultant review immediately after triage. This appears to be related to earlier referrals for admission and a decision to admit. This supports the concept of Acute Physicians near to the front door minimising non-value adding time.

The 4-hour ED performance was sustained during the pilot even with the limited front door Consultant sessions. Our ED occupancy is often at its highest at 8pm when medical staffing levels fall. This leads to significant issues in processing patients from this time. During this study, 8pm occupancy was lower than usual leading us to a conclusion that improved daytime efficiency allowed a better match of ED demand to resource overnight.

Whilst results support delivering this model on a permanent basis, we are unable to currently provide the required number of Consultant Acute Physicians. For a sustainable model of delivery whilst we continue to recruit, we will employ Acute Physicians to support the development of a nurse led referral process to progress patients to the right place to see the right person more rapidly. This will balance the clear benefits with unavoidable resource limitation.