Implementing an appointment-based system in A&E to ensure appropriate use of services

How an eye unit implemented an appointment-based system for patients with urgent or acute problems, and why it was necessary

INTRODUCTION
In April 2003, all patients who came to the ophthalmic A&E department at Bournemouth Eye Unit were booked in by a clerk before waiting to be triaged by an ophthalmic nurse.

Patients with emergency problems would be seen without delay, but those categorised as urgent or routine would often face long delays to see the doctor.

Facts and figures
An audit at the unit in April 2003 showed that:
- An average of 400 patients were seen and treated over a week;
- Thirty per cent of these waited over 15 minutes for initial triage by the nurse;
- Forty per cent of patients seen were assessed as non-urgent and could have been seen by GPs or optometrists or as an outpatient;
- Over one-third (34%) were assessed as urgent and needed treatment within 24–48 hours;
- Over one-quarter (26%) were assessed as emergency/very urgent and needed immediate or same-day treatment.

This system was clearly not meeting patients’ needs, so a fact-finding visit to Oxford Eye Hospital – where an efficient, appointment-based A&E system has been running for many years – was arranged.

THE PLAN
Following the visit, an appointment system was devised for Bournemouth Eye Unit. The key features were that all patients, whether presenting by telephone or walk-in, would be triaged by an ophthalmic nurse using documentation, and a dedicated emergency helpline would be set up from 8am–9pm seven days a week. Patients would be given an appointment if appropriate or seen immediately in an emergency.

The plan included the following options:
- 120 doctor appointments, Monday–Friday, 9am–4pm;
- 203 nurse appointments, Monday–Sunday, 8.30am–7pm;
- Two slots kept free during each session to allow for ophthalmic emergencies;
- An on-call doctor available in the evenings and weekends for emergencies that cannot be managed by an ophthalmic nurse.

The plan also included renaming the eye casualty/ophthalmic A&E department as the acute referral clinic (ARC).

Nurses’ key functions would be to give reassurance and offer immediate help.

Marsden (2000) defined telephone triage as ‘gathering information by questioning the patient or healthcare professional about the perceived problem and making decisions as to the most appropriate form of management’. Experience, education and expertise are therefore essential to perform this role.

A flow chart was drawn up to help nursing staff decide how urgently patients needed to be seen. Educational seminars were held for all nursing staff in preparation for the telephone triage role.

IMPLEMENTATION
As implementing the new system would affect key stakeholders – including patients, GPs, opticians, nursing staff, doctors and clerical staff – it was important they shared a common vision of how the change would improve patient care. This was especially true of nursing staff as they were likely to be the driving force behind the new plan.

To ensure stakeholders understood the plans:
- Regular meetings were held to inform and support staff through the change;
- Letters were sent to all GPs, optometrists, A&E departments and minor injury units in the area;
- Yellow ‘credit cards’ were printed to hand to patients who turned up without an appointment to remind them to telephone on future occasions;
- A global email was sent to the rest of the hospital about the change;
- An article was published in the local newspaper to inform the public and encourage them to book appointments rather than just turn up.

Negative responses
GPs were often unhappy about having to speak to a nurse before they could get an appointment for their patients – some were insulting. Marsden (2000) showed that some GPs were unwilling to discuss patients or give accurate information to a nurse.

There was evidence that GPs manipulated patients’ symptoms to obtain an urgent appointment. Foat (1999) recognised similar
problems with ophthalmic telephone triage where ‘GPs do not value the expertise of ophthalmic nurses’.

However, literature reviews have concluded that nurses and other healthcare staff compare favourably with doctors in decision-making over the telephone (Nauright et al, 1999).

Patients who had previously been able to walk in complained they now had to make an appointment – some were abusive.

The department received a number of complaints in the first few months, and further educational sessions had to be carried out with staff as some had come to think of the system as a gatekeeping exercise. The importance of information-gathering, advice and reassurance to patients was reiterated.

Local A&E departments were a little slow to recognise the changes and kept telling patients just to turn up rather than telephone first. This was also the case with many GP practices in the area, despite the publicity and information sent out. The eye unit had offered an open-access ophthalmic A&E service for many years, and it took time for A&E departments and GPs to break the habit of advising patients to turn up without an appointment.

Positive outcomes
The following outcomes were positive:

- All patients are assessed immediately on telephone, receive an appointment usually for the same day, and are seen promptly.
- The vast majority (92%) were seen and treated within two hours, with 7% having to wait for up to three hours.
- Some 85% managed to get through on the telephone without delay.
- Additional nursing hours are planned to improve this final percentage. The aim is that a more junior nurse will take calls, supervised by the experienced nurse as part of their training for a full triaging role.

On reviewing the booking of appointments, approximately 75% of patients who contacted us were given an appointment, and the rest were given advice or referred to a GP, optometrist or the community pharmacist.

Of those given an appointment, 31.5% were seen the same day, 42% within 24 hours, 16% within 72 hours and 10% within a week; only 0.5% had to wait longer than one week.

The 72-hour period included patients who telephoned on a Friday but were assessed as being able to wait until Monday, with the provision that if anything changed over the weekend they could call again. The final two time categories (10% within a week and 0.5% more than one week) were due to patient choice: although the nurse considered they needed to be seen, patients were unable to come any sooner.

**IMPLICATIONS FOR NURSES**

Since implementing the new appointment system at Bournemouth ARC, nursing staff are less stressed. The system is generally popular as the work is more controlled and organised. The importance of staff support for decision-making cannot be underestimated and is vital to the scheme’s success.

The department is examining the algorithm used in triaging to see if it can be improved. Documentation is not always completed to a high standard or legibly. We are also looking at implementing an electronic system for the initial assessment to tie in with the electronic patient pathway used.

**CONCLUSION**

The appointment-based system works efficiently. We have had many complimentary letters and positive comments from patients. The group of patients who particularly like the new system are those with recurrent eye conditions. Previously, they would regularly have to sit and wait for hours, whereas now they telephone, receive an appointment usually for the same day, and are seen promptly.

Despite the publicity, an average of 300 patients a month still present without having telephoned first. We accept this is unlikely to change, especially in the summer when tourists arrive. Therefore, as a reminder to the general public, GPs and optometrists, a regular press release appears in the local newspaper.

We stress that this appointment system is not a gatekeeping exercise to reduce the number of patients seen. The intention is to reassure, allay fears and give advice, preventing needless visits to the department.

Since the system’s introduction, the number of patients seen has reduced by about 25%. This is partly due to more appropriate referral, but is also the result of a review of follow-up protocols for patients and a subsequent increase in the number referred to outpatients.

The appointment-based system ensures that patients who need to see an ophthalmologist do so within an appropriate timescale.

**REFERENCES**


