



Why are we waiting? Patients' perspectives for accessing emergency department services with non-urgent complaints



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ABSTRACT

[Background]

Emergency departments world-wide report service demands which exceed resource availability. Themes such as crowding, non-urgent presentations, ambulance diversion and access block have been linked to complications in care, poorer patient outcomes, increased morbidity and staff burnout. People attending the emergency department with problems perceived as non-urgent are frequently attributed blame for increased service demand, yet little is known from the patients' perspective.

[Method]

This project utilised a descriptive cross-sectional waiting room survey of non-urgent patients to identify factors contributing to their decision making process to access ED services at a regional hospital in Tasmania, Australia. Data were analysed using a statistical software package and comparison made between the sample and population groups to determine broad representation.

[Results]

Patients' decision making processes were found to be influenced by convenience, perceived need and referral by a health care provider. Cost did not present as a significant factor. A high incidence of patients under 25 years of age were identified and musculoskeletal complaints were the most common complaint across all age groups.

[Conclusion]

Further consideration is required to determine how to best meet service demand to facilitate the provision of the right service at the right time to the right patient.

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1. Introduction

Crowding in emergency departments (EDs) has become an international dilemma and the subject of much research and discussion. Increasing numbers of presentations continue to be reported with a variety of contributing factors and adverse outcomes. A growing body of literature links issues such as access block, aging population, increased demand for complex chronic disease management and decreased service availability as contributing factors to the crowding dilemma [1–8]. Complications of crowding have been identified as: increases in morbidity and mortality rates; inappropriate time to investigations, treatments

and pain management; difficulties maintaining patient privacy; ambulance diversion and ramping; increased length of stay; decreased staff productivity with increased staff burn-out; increased violence; miscommunication and negative impact on teaching [1,2,8–17].

Complicating these factors further is the growing number of non-urgent patients attending EDs with health concerns which could be more suitably managed by primary health care providers. According to the Australian Institute of Health and Wellbeing (AIHW), Australia continues to observe increases in annual ED presentations with an annual national growth of 2.3% since 2009/10 [18] while population growth sits at 1.5% [19], therefore, ED attendance is increasing more quickly than population growth. Tasmania, Australia's smallest and only island state provides a similar pattern with a 1.0% increase in ED attendance for the same period [18] and a population growth of 0.3% [19]. In addition to this, Tasmania records the second highest percentage of all states and

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territories with the least urgent triage categories comprising 57.2% of total presentations, compared to the national average of 52.8% [20]. Unlike the larger mainland Australian states there is currently limited Tasmanian research considering the factors that may influence the increasing number of non-urgent ED presentations.

Non-urgent or inappropriate presentations are not clearly defined in the literature, owing, according to Lowthian et al. [7] to differences in the perceptions of clinicians and patients. For the purposes of this paper “non-urgent” presentations have been defined as those allocated a triage category 4 and 5 (according to the Australian Triage Score, Department of Health and Aging, [21]). The Australian Triage Score (ATS) is a five point scoring system of which category 4 and 5 patients are the least urgent. Similar classification of non-urgent presentations have been used in previous studies [22–24].

2. Aim

The aim of this research project was to identify profiles in non-urgent presentations and gain insight into: services accessed before presentation to ED; why ED was chosen by attendees with non-urgent complaints and the presenting health complaint of attendees. Through the patient survey the research team sought to build an understanding of the type of health service required by non-urgent patients in the region.

3. Background

This research was undertaken at a regional Tasmanian hospital with a bed capacity of 300 [25] providing acute health care for a catchment population of 135,000 [26]. Tasmania has a population of 514,800 [19] with the highest national mean age of 41.5 [27] and a rate of unemployment (6.5%) higher than the national average (5.6%) [28].

Services currently available in this region consist of general practitioners (GPs) who largely operate Monday to Friday, with some limited after-hours services. Two GP surgeries are located within walking distance of the hospital ED and provide some after-hours services, including access to onsite pathology until 2100 h. Community access to a privately run national home doctor service is available from 1800 weeknights, after 1200 on Saturdays, all day Sundays and public holidays. In addition, various phone services provide medical advice.

The Australian health system provides free ED care to residents, with on-site radiological investigations and pathology services. GPs have the option to bulk bill or charge above the Medicare rebate, resulting in a ‘gap’ paid by patients. The Australian Medicare system also provides low income earners and those on social welfare payments with access to free GP services along with other reduced cost benefits such as pharmaceutical scripts.

4. Method

A descriptive cross sectional survey was available to non-urgent (ATS 4 or 5) patients to complete in the ED waiting room. The survey was previously validated in the Netherlands by Moll van Charante et al. [29] and subsequently translated into English and used in a study in regional Victoria, Australia [30]. The survey consisted of a series of brief, standardised response questions using tick-boxes with some open ended questions where respondents could provide comment. The survey took five to ten minutes to complete and was distributed by a researcher or ED staff.

Prior to commencement of data collection permission was obtained from the Director of Clinical Services within the hospital

and from the Health Research Ethics Committee (Tasmania) Network (reference no. H0015049).

4.1. Sample and data collection

Data were collected from non-urgent patients in the ED of a regional Tasmanian hospital 24 h a day for six weeks to provide varied distribution across time of day and day of week. All non-urgent patients (including those who arrived by ambulance) who attended the ED during the six-week survey period (23rd July to 3rd September 2015) were deemed eligible; where the patient was unable to complete the survey a family member or carer was able to do so on their behalf. Participants were deemed ineligible if they arrived with police or displayed signs of mental illness such as paranoia. Collected data were limited to those able to complete the written survey as providing assistance to complete the survey was outside the resources of this project. An information sheet was attached to the survey providing participants with background information, aims of the project, and contact details of researchers. Completion of surveys was voluntary and anonymous with consent implied on completion. Patients were deemed eligible based on initial triage category, it was beyond the scope of this project to then exclude patients who may have deteriorated and been re-allocated a more urgent triage category.

4.2. Statistical analysis

Surveys were entered into the Statistical Package for the Social Sciences (SPSS) data analysis program [31]. As an exploratory study, descriptive data were interpreted to identify patterns in why non-urgent patients chose to attend the ED, what proportion would attend another service if available, what proportion considered cost in choosing to attend ED, and the profile of services required by participants during the study period. A statistician was consulted at this time. Where possible, comparison was made between the sample group (SPSS) and population data from Emergency Department Information System (EDIS) to assess the representative nature of the sample. The population data were not available within SPSS consequently limiting statistical comparison between the groups. This included gender, age, time of day and day of week. Chi square analysis was used to measure differences between younger (under 25 years) and older (over 25 years) participants for presenting complaint and reason for attendance.

5. Results

Over the period data was collected a total of 5283 patients presented to the ED; 2987 (56.5%) were triaged as category 4 and 5 patients, averaging 71 non-urgent presentations per day and are referred to as the population group in this paper. Collected data from 477 completed surveys (16% response rate) were entered into SPSS with EDIS data being converted to an Excel spreadsheet. Once completed, ten per cent of the entries were subject to a quality check by a second researcher and there was 100% agreement.

5.1. Demographic findings

A summary of age and gender for population and sample groups can be seen in Table 1. A total 1664 (42.1%) patients were aged 0–24 within the population group with the sample group yielding 268 (45.5%) survey responses, the incidence of non-urgent ED presentations in both the population and sample groups decreased with age. In 273 (57.2%, n = 477) instances patients completed their own surveys; 191 (40.0%) were completed by family members or carer; and, 11 (2.3%) by friends.

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