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Literature search results

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**Search details**

Front door redesign of accident and emergency services

**Resources searched**

NHS Evidence; TRIP Database; Cochrane Library; CINAHL; EMBASE; HMIC; Health Business Elite; MEDLINE; Google Scholar; Google Advanced Search

**Database search terms**: “acute care”; “urgent care”; “emergency care”; “A & E”; “accident and emergency”; exp EMERGENCY MEDICAL SERVICES; casualty; exp EMERGENCY SERVICE; HOSPITAL; EMERGENCIES; “emergency department”; ED; “unscheduled care”; “unplanned care”; “front door”; polyclinic; “urgent care center”; “urgent care centre”; UCC; AMBULATORY CARE FACILITIES; “primary care assessment unit”; PCAU; “primary care unit”; PCU; “GP out-of-hours”; GP OOH; “triage service”; TRIAGE; referral; streaming; REFERRAL AND CONSULTATION “primary care”; PRIMARY HEALTH CARE; GENERAL PRACTITIONERS; “general practitioner”*; GP; “family physician”*; FAMILY PRACTICE; PHYSICIANS, FAMILY

**Google search string**: “front door” (“emergency department” OR A&E OR “accident & emergency”) (improvement OR redesign OR pathway)

("front door" OR UCC OR “urgent care center” OR “urgent care centre” OR “primary care unit” OR “primary care assessment unit” OR polyclinic OR “GP OOH” OR “GP out-of-hours”) (“emergency department” OR A&E OR “accident & emergency”)

**Summary**

There is a considerable amount of information on front-door redesign in A&E. As you mention partnerships with primary care, I have also included urgent care centres, which may be integrated with accident and emergency, polyclinics, GP out-of-hours services, primary care units and walk-in centres. In addition a considerable number of Trusts have implemented a redesign of their A&E departments, and you may wish to contact them for details.
**Guidelines**

**Dr Foster Intelligence**

*Intelligent commissioning: the free thinkers leading the information revolution in the NHS*

2007

“At the moment it’s impossible to regulate the demand and therefore you can’t control costs. The only way you can do it is by saying that when Joe Bloggs walks in the front door (of A&E), he’s seen in the first instance by the primary care unit.” Guy says the data suggests that 10-15 per cent of patients could be using A&E inappropriately, and at least £500,000 could be saved by making sure they see primary care staff first.

**King’s Fund**

*Practice based commissioning: reinvigorate, replace or abandon?* 2008

In site A, an accident and emergency department (A&E) triage service was set up to assess patients at the front door of A&E before they entered (and incurred any cost), so that, here appropriate, patients could be redirected to the local GP practices that were operating out-of-hours services.

**NHS Confederation**


The ‘front door’ to acute care in the NHS could see its physical facilities integrated much more closely with online and telephone triage, so that conversations could be started in one channel and finished in another.

**Scottish Government**

*Delivering better health, better care through continuous improvement: lessons from the national programmes* 2008

*Royal Alexandra Hospital, Paisley*

Medicine and A&E teams had previously introduced a process of working jointly within the Emergency Department in a ‘single pile’ approach to demand, making significant improvements to the flow of medical assessment and admissions. The aim was to make further advances to this flow.

**Evidence-based reviews**

None found.

**Published research**

1. **Developing an innovative model of care for nurse-led walk-in centres in the ACT.**

   **Author(s):** Ainsworth B, Hayward S

   **Citation:** Australian Nursing Journal, October 2010, vol./is. 18/4(28-31), 1320-3185;1320-3185 (2010 Oct)

   **Publication Date:** October 2010

   **Source:** MEDLINE

   **Full Text:**

   Available in *fulltext* at [EBSCO Host](#)
2. **Contrasts in acute medicine: a comparison of the British and Australian systems for managing emergency medical patients.**

**Author(s):** Jenkins PF, Barton LL, McNeill GB

**Citation:** Medical Journal of Australia, August 2010, vol./is. 193/4(227-8), 0025-729X;0025-729X (2010 Aug 16)

**Publication Date:** August 2010

**Abstract:** Increasing numbers of patients are presenting for unscheduled medical admission to hospitals worldwide, prompting clinical redesign of "front-door" emergency medical services. In the United Kingdom, there has been considerable investment in the establishment of acute medical units (AMUs) and the training of acute medicine physicians. Some centres in Australia have established similar medical assessment units. While these initiatives have undoubtedly met with some success, the evidence base for their overall benefit remains elusive. We describe key aspects of the recent establishment of acute medical services in Britain and discuss the relevance of these experiences to Australia. Successful models of care in acute medicine have often been shared with other centres. The adaptation of existing models of care to meet local demands is superior to simply adopting an existing model. Once the desired clinical functionality of a service is determined, informed decisions can be made on staffing requirements, skill mix, and the structure of any new clinical unit. The functionality of the acute medical service, rather than simply the physicality of an AMU, should drive service design.

**Source:** MEDLINE

3. **On the same page: making transitions between EMS & urgent care centers smooth.**

**Author(s):** Keseg DP

**Citation:** Journal of Emergency Medical Services, August 2010, vol./is. 35/8(60-2), 0197-2510;0197-2510 (2010 Aug)

**Publication Date:** August 2010

**Abstract:** Medic 25 is called to a local urgent care center to a chief complaint of a possible heart attack at 8:45 p.m. On their way there, one of the medics tells his partner they've been getting multiple calls to this facility at about the same time each evening, so they can "unload" their patients before it closes at 9 p.m. He says it's usually for minor complaints and seems to be more for the convenience of the urgent care center staff than for any true emergencies. Copyright 2010 Elsevier Inc. All rights reserved.

**Source:** MEDLINE

4. **Noncompletion of referrals to outpatient specialty clinics among patients discharged from the emergency department: a prospective cohort study.**

**Author(s):** Friedman SM, Vergel de Dios J, Hanneman K

**Citation:** CJEM Canadian Journal of Emergency Medical Care, July 2010, vol./is. 12/4(325-30), 1481-8035;1481-8035 (2010 Jul)

**Publication Date:** July 2010

**Abstract:** OBJECTIVE: We sought to characterize patients who are referred from the emergency department (ED) to specialty clinics but do not complete the referral, and to identify reasons for their failure to follow up. METHODS: A prospective cohort study was carried out over 3 months of patients who were discharged from the ED of a teaching hospital with referral to internal medicine, cardiology or neurology clinics, but who did not complete the referral. Information on demographics, barriers to care and reasons for not completing the referral was obtained through a standardized telephone interview. RESULTS: Of 171 ED referrals, 42 (24.6%) were not completed. Interviews were completed for 71.4% (30 patients). Of the nonattenders, 80% were functional in English and most had high school (73.1%) or university (60.7%) education. Virtually all (93.0%) interviewees could get to hospital by themselves or have someone take them. Only 42.9% (12 patients) understood why the emergency physician (EP) requested consultation, and
42.9% (12 patients) described EP instructions as poor or fair. Primary reasons for noncompletion of consult were patient choice (46.7%, 95% confidence interval [CI] 27.1%-66.2%), physical or social barriers (13.3%, 95% CI 0.0%-27.2%), communication failure (20%, 95% CI 4.0%-36.0%) and consultant's refusal of the consultation (20% [95% CI 4.0%-36.0%]). All consultant refusals were from one internal medicine clinic, representing 42% (8/19) of ED referrals to that clinic. None of the 6 patients interviewed who were declined consultation was aware that their consultation had been refused.

CONCLUSION: Patients discharged by the EP with referral to specialty clinics frequently do not complete the consultation. Causes for failure to follow up relate to patient decision, inadequate or poorly understood discharge information, and system factors. Institutional audits of patients who fail to complete follow-up may reveal unanticipated barriers to care.

Source: MEDLINE

5. Physiological scoring: an aid to emergency medical services transport decisions?

Author(s): Challen K, Walter D

Citation: Prehospital & Disaster Medicine, July 2010, vol./is. 25/4(320-3), 1049-023X;1049-023X (2010 Jul-Aug)

Publication Date: July 2010

Abstract: INTRODUCTION: Attendance at UK emergency departments is rising steadily despite the proliferation of alternative unscheduled care providers. Evidence is mixed on the willingness of emergency medical services (EMS) providers to decline to transport patients and the safety of incorporating such an option into EMS provision. Physiologically based Early Warning Scores are in use in many hospitals and emergency departments, but not yet have been proven to be of benefit in the prehospital arena. HYPOTHESIS: The use of a physiological-social scoring system could safely identify patients calling EMS who might be diverted from the emergency department to an alternative, unscheduled, care provider. METHODS: This was a retrospective, cohort study of patients with a presenting complaint of "shortness of breath" or "difficulty breathing" transported to the emergency department by EMS. Retrospective calculation of a physiological social score (PMEWS) based on first recorded data from EMS records was performed. Outcome measures of hospital admission and need for physiologically stabilizing treatment in the emergency department also were performed. RESULTS: A total of 215 records were analyzed. One hundred thirty-nine (65%) patients were admitted from the emergency department or received physiologically stabilizing treatment in the emergency department. Area Under the Receiver Operating Characteristic Curve (AUROC) for hospital admission was 0.697 and for admission or physiologically stabilizing treatment was 0.710. No patient scoring<2 was admitted or received stabilizing treatment. CONCLUSIONS: Despite significant over-triage, this system could have diverted 79 patients safely from the emergency department to alternative, unscheduled, care providers.

Source: MEDLINE

6. A&E alternatives 'confuse' the public.

Author(s): West D

Citation: Health Service Journal, March 2010, vol./is. 120/6199(4-5), 0952-2271;0952-2271 (2010 Mar 25)

Publication Date: March 2010

Source: MEDLINE

Full Text:
Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
Available in print at Louth County Hospital Medical Library
Available in print at Louth County Hospital Medical Library
Available in print at Pilgrim Hospital Staff Library
7. Alternative services to deliver urgent care in the community.
Author(s): Mason S, Snooks H
Citation: Emergency Medicine Journal, 01 March 2010, vol./is. 27/3(183-185), 14720205
Publication Date: 01 March 2010
Source: CINAHL
Full Text: Available in fulltext at Highwire Press

8. Rising hospital admissions. Support the new gatekeepers
Author(s): Ali F.R.
Citation: BMJ (Clinical research ed.), 2010, vol./is. 340/(c1046), 1468-5833 (2010)
Publication Date: 2010
Source: EMBASE
Full Text: Available in fulltext at Highwire Press

Author(s): Gentile S, Vignally P, Durand AC, Gainotti S, Sambuc R, Gerbeaux P
Citation: BMC Health Services Research, 2010, vol./is. 10/(66), 1472-6963;1472-6963 (2010)
Publication Date: 2010
Abstract: BACKGROUND: Overcrowding in emergency department (EDs) is partly due to the use of EDs by nonurgent patients. In France, the authorities responded to the problem by creating primary care units (PCUs): alternative structures located near hospitals. The aims of the study were to assess the willingness of nonurgent patients to be reoriented to a PCU and to collect the reasons that prompted them to accept or refuse.METHODS: We carried out a cross sectional survey on patients’ use of EDs. The study was conducted in a French hospital ED. Patients were interviewed about their use of health services, ED visits, referrals, activities of daily living, and insurance coverage status. Patients' medical data were also collected.RESULTS: 85 patients considered nonurgent by a triage nurse were asked to respond to a questionnaire. Sex ratio was 1.4; mean age was 36.3 +/- 11.7 years.Most patients went to the ED autonomously (76%); one third (31.8%) had consulted a physician. The main reasons for using the ED were difficulty to get an appointment with a general practitioner (22.3%), feelings of pain (68.5%), and the availability of medical services in the ED, like imaging, laboratory tests, and drug prescriptions (37.6%).Traumatisms and wounds were the main medical reasons for going to the ED (43.5%).More than two-thirds of responders (68%) were willing to be reoriented towards PCUs. In the multivariate analysis, only employment and the level of urgency perceived by the patient were associated with the willingness to accept reorientation. Employed persons were 4.5 times more likely to accept reorientation (OR = 4.5 CI (1.6-12.9)). Inversely, persons who perceived a high level of urgency were the least likely to accept reorientation (OR = 0.9 CI (0.8-0.9)).CONCLUSIONS: Our study provides information on the willingness
of ED patients to accept reorientation and shows the limits of its feasibility. Alternative structures such as PCUs near the ED seem to respond appropriately to the growing demands of nonurgent patients. Reorientation, however, will be successful only if the new structures adapt their opening hours to the needs of nonurgent patients and if their physicians can perform specific technical skills.

**Source:** MEDLINE

**Full Text:**
Available in fulltext at BioMedCentral
Available in fulltext at National Library of Medicine

10. Avoiding hospital admissions: what does the research evidence say?

**Author(s):** Purdy, Sarah

**Citation:** , 2010

**Publication Date:** 2010

**Abstract:** Emergency admissions to hospital are costly to the NHS and also cause disruption to planned health care. Considerable efforts have been made within the health service to reduce emergency admissions, but few primary care trusts have been successful, with some primary care trusts recording an increase. In order to successfully reduce avoidable emergency admissions, we need to fully understand which interventions are the most effective. The King’s Fund commissioned this review of research evidence to establish which interventions work in avoiding emergency or unplanned hospital admissions. This paper aims to address the following questions: what interventions work in reducing avoidable admissions?; who is at risk, and how do we identify them?; which admissions are potentially avoidable?; and which interventions work in primary care, social care, emergency care, discharge from hospital. The review of available research evidence identified interventions where there is evidence of positive effect on both admissions and re-admissions, those where there is evidence that the intervention has no beneficial effect, and a range of interventions where more evidence is needed to determine whether they have the potential to reduce admissions. The author emphasises that interventions to reduce emergency admissions take place within a complex environment, in which the nature and structure of existing care services, individual professional attitudes, patient and family preferences, and general attitudes to risk management can affect their implementation. It is also acknowledged that some interventions, although they fail to reduce admissions, may have other beneficial effects, such as reducing length of stay or improving patients’ experience of care. The paper concludes that policy-makers, providers and commissioners can introduce a number of changes that have proved to be effective in reducing admissions and includes recommendations for all of these groups, emphasising the importance of using evidence-based interventions. This paper is part of our productivity and efficiency project work

**Source:** HMIC

11. Primary care and emergency departments

**Author(s):** Carson, David, Clay, Henry, Stern, Rick

**Citation:** , 2010

**Publication Date:** 2010

**Abstract:** In May 2009 the Department of Health commissioned the Primary Care Foundation to study the impact of using primary care within or alongside Accident and Emergency. The report highlights that use of primary care clinicians in Accident and Emergency departments can benefit patients where services are integrated and clinicians work together. The findings of this report are being developed into a guide for commissioners on use of primary care clinicians with Accident and Emergency departments and this guide will be available soon. This report will be of interest to NHS chief executives and their commissioning colleagues. [DH website abstract]

**Source:** HMIC
12. Nonurgent patients in the emergency department? A French formula to prevent misuse

Author(s): Gentile, Stephanie, Vignally, Pascal, Durand, Anne Claire, Gainotti, Sabina, Sambuc, Roland

Citation: BMC Health Services Research, 2010, vol./is. 10/66, 1472-6963

Publication Date: 2010

Abstract: Record in progress

Overcrowding in emergency department (EDs) is partly due to the use of EDs by non-urgent patients. In France, the authorities responded to the problem by creating primary care units (PCUs): alternative structures located near hospitals. The aims of the study were to assess the willingness of non-urgent patients to be reoriented to a PCU and to collect the reasons that prompted them to accept or refuse. The authors carried out a cross sectional survey on patients' use of EDs. The study was conducted in a French hospital ED. Patients were interviewed about their use of health services, ED visits, referrals, activities of daily living, and insurance coverage status. Patients' medical data were also collected. The results were, 85 patients considered non-urgent by a triage nurse were asked to respond to a questionnaire. Sex ratio was one in four; mean age was 36.3 +/- 11.7 years. Most patients went to the ED autonomously (76%); one third (31.8%) had consulted a physician. The main reasons for using the ED were difficulty to get an appointment with a general practitioner (22.3%), feelings of pain (68.5%), and the availability of medical services in the ED, like imaging, laboratory tests, and drug prescriptions (37.6%). Traumatisms and wounds were the main medical reasons for going to the ED (43.5%). More than two-thirds of responders (68%) were willing to be reoriented towards PCUs. In the multivariate analysis, only employment and the level of urgency perceived by the patient were associated with the willingness to accept reorientation. Employed persons were 4.5 times more likely to accept reorientation (OR = 4.5 CI (1.6 to 12.9)). Inversely, persons who perceived a high level of urgency were the least likely to accept reorientation (OR = 0.9 CI (0.8 to 0.9). The authors study provides information on the willingness of ED patients to accept reorientation and shows the limits of its feasibility. Alternative structures such as PCUs near the ED seem to respond appropriately to the growing demands of non-urgent patients. Reorientation, however, will be successful only if the new structures adapt their opening hours to the needs of non-urgent patients and if their physicians can perform specific technical skills. Cites 38 references. [Journal abstract]

Source: HMIC

Full Text:
Available in fulltext at BioMedCentral
Available in fulltext at National Library of Medicine

13. Primary paediatric care models and non-urgent Emergency Department utilization: an area-based cohort study

Author(s): Farchi, Sara, Polo, Arianna, Franco, Francesco, Lallo, Domenico Di, Guasticchi, Gabriella

Citation: BMC Family Practice, 2010, vol./is. 11/32, 1471-2296

Publication Date: 2010

Abstract: Record in progress

The aim of this study was to evaluate the association between different primary paediatric practice models (individual, network-affiliated but in separate office-, and group practice) and non urgent utilisation of the Emergency Department (ED). The data sources were: the 2006 Regional Paediatric Patient files (nought to six years old), the Regional Community-based paediatrician (CBP) file and the 2006 Emergency Information System. The authors recorded and studied the ED visits of children, excluding planned ED visits, visits for trauma/poisoning and those that were assigned non deferrable/critical triage codes. A multivariate logistic regression was applied to estimate the adjusted odds ratio of an ED visit. The exposure was the type of paediatric practice that served the child: individual, network or group practice. Various characteristics of the child were considered. The results were, the cohort was composed of 293,662 children. In the 2006, 43,457 ED visits occurred (147.6 per 1,000). Multivariate logistic
models showed lower ED use for group paediatrician patients (OR 0.84; 95% CI 0.73 to 0.96) and for network paediatrician patients (OR 0.92; 95% CI 0.85 to 1.00) compared to patients served by an individual practice. The conclusions were, this study shows that there is a weak association between the type of paediatrician primary practice and emergency department use. The authors results highlight the necessity to continue to improve the organisation of paediatrician primary practice, in order to increase patient access to primary paediatric care. Cites 29 references. [Journal abstract]

Source: HMIC

Full Text:
Available in fulltext at BioMedCentral
Available in fulltext at National Library of Medicine

14. Barriers and facilitators for successful after hours care model implementation: reducing ED utilisation.

Author(s): Fry MM

Citation: Australasian Emergency Nursing Journal, 01 December 2009, vol./is. 12/4(137-144), 15746267

Publication Date: 01 December 2009

Abstract: Background: A systematic review examined the barriers and facilitators influencing the success and sustainability of after hours care models on acute care utilisation. Extensive research had been undertaken in many countries, particularly in the United Kingdom, The United States of America, Ireland, Canada, Denmark, Sweden, and to a lesser degree Australia. The literature covered the period from 1970-2008. The evidence demonstrated a positive impact on acute service utilisation patterns. There were few relevant randomised control trials. The evidence was largely based on quasi experimental (time series), before and after or comparative studies. Study results often noted barriers and facilitators for model success and sustainability. The relevant literature was largely international, so results may need to be interpreted in a considered way given geographical, cultural and social differences. This said the findings are relevant to the Australian context.

Source: CINAHL

15. Can after-hours family medicine clinics represent an alternative to emergency departments? Survey of ambulatory patients seeking after-hours care

Author(s): Wong W.-B., Edgar G., Liddy C., Vaillancourt C.

Citation: Canadian Family Physician, November 2009, vol./is. 55/11(1106-1107+1107.e1-1107.e4), 0008-350X (November 2009)

Publication Date: November 2009

Abstract: OBJECTIVE: To explore patients' motivations for seeking care in the emergency department (ED) after hours and their willingness to consult their family physicians instead, if their family physicians had been available. DESIGN: Survey using an 8-item questionnaire. SETTING: Two tertiary care hospital EDs in Ottawa, Ont, from June 4 to 22, 2007, between 5 PM and 9 PM. PARTICIPANTS: A total of 151 ambulatory patients. Patients who arrived by ambulance or who bypassed those waiting were excluded. MAIN OUTCOME MEASURES: Patients' self-reported motivation for seeking after-hours care in the ED, the perceived urgency of their medical complaints, and their willingness to have sought care from their family physicians instead, if they had been available. RESULTS: There were 218 eligible patients during the study period. Among the 151 respondents (69.3% response rate), 141 qualified for the study. Of the qualified respondents, 57.4% would have chosen to consult their family physicians instead if they had been available. The most common reason for choosing the ED was the perceived need for services unavailable at family medicine clinics, such as specialist consultation or diagnostic imaging. There were no differences in the perceived urgency of patients' medical conditions or the amount of time they were willing to wait before physician assessment between those who would have been willing to seek care from their family physicians and those who would not have been willing. CONCLUSION: After-hour family medicine clinics provide a desirable
primary care service that most patients would choose over the ED if more were available.

Source: EMBASE

Full Text:
Available in fulltext at Highwire Press
Available in fulltext at EBSCO Host
Available in fulltext at National Library of Medicine

16. Shortening the wait: a strategy to reduce waiting times in the emergency department.

Author(s): Finamore SR, Turris SA

Citation: Journal of Emergency Nursing, November 2009, vol./is. 35/6(509-14), 0099-1767;1527-2966 (2009 Nov)

Publication Date: November 2009

Abstract: Emergency Department crowding (EDC), extended wait times, and the issues arising as a result are well described in the health-care literature. Accordingly, reducing waiting times has become a focus across Canada. Less-urgent patient presentations represent a large proportion of the individuals presenting for care in Canadian emergency departments (ED). This patient population contributes to congestion in the ED. In light of these issues, an innovative program is being trialed at Burnaby Hospital, in the lower mainland of British Columbia. The goals of the program include: a reduction of EDC, a shortening of the duration of time between patient presentation and treatment, and an increase reported levels of patient satisfaction.

Source: MEDLINE

Full Text:
Available in fulltext at Ovid

17. How urgent care centers can enhance volume and revenue.

Author(s): Wodinsky H, Sharobeem E, Pancratz B

Citation: Healthcare Financial Management, November 2009, vol./is. 63/11(82-8, 90), 0735-0732;0735-0732 (2009 Nov)

Publication Date: November 2009

Abstract: Providers that operate urgent care centers should: Allow time and resources to build a successful UCC. Include dedicated midlevel providers. Offer key diagnostic tests after hours. Foster referral relationships from other physicians. Manage patient flow from the practice. Seek special designation from payers to add revenue. Integrate workflow with the rest of the clinic.

Source: MEDLINE

Full Text:
Available in fulltext at EBSCO Host

18. Management of minor medical problems and trauma: the role of general practice


Citation: Rural and remote health, October 2009, vol./is. 9/4(1019), 1445-6354 (2009 Oct-Dec)

Publication Date: October 2009

Abstract: INTRODUCTION: It has been established that patients prefer receiving health information from primary care physicians. In Greece, recent reforms supporting urban
primary healthcare have not been enacted, and long waiting times in Athens' emergency departments are common. Aim: To evaluate cases treated in the emergency department of a Greek general hospital and explore the potential role of primary care in managing these cases. METHODS: A total of 53,926 patients visited the emergency department studied during on-call days from February 2005 to February 2006. The cases were classified into 6 groups according to their main complaint: (1) internal medicine; (2) surgical; (3) orthopedic; (4) otolaryngology (ENT); (5) eye disorders (ophthalmology); and (6) gynecology-obstetric. RESULTS: Of the 53,926 patients studied, 9167 (17%) came from a rural area. The internal medicine department was most commonly attended (15,373; 28.5%), followed by orthopedics (16.9%). In the surgical, ENT, ophthalmology and gynecology groups, almost one in three patients could have been managed by a GP, as could 40% of orthopedic cases. Orthopedic and ENT patients had the highest rate of X-rays performed. CONCLUSION: Many emergency patients visiting hospitals can be managed at the primary care level. The development of a 'practice-based curriculum' for GPs would be an excellent method to obtain higher professional standards.

Source: EMBASE

Full Text: Available in fulltext at EBSCO Host

19. Improving patient access to medical services: preventing the patient from being lost in translation

Author(s): Bichel A., Erfle S., Wiebe V., Axelrod D., Conly J.

Citation: Healthcare quarterly (Toronto, Ont.), October 2009, vol./is. 13 Spec No/(61-68), 1710-2774 (Oct 2009)

Publication Date: October 2009

Abstract: The Medical Access to Service project was initiated to broadly engage participants in the health system to collectively improve service integration and patient access to primary care and specialist medical services. The Conference Model (the Axelrod Group, Willmette, IL) was used as a change vehicle. The ideal design was translated into the creation of central access and triage (CAT) processes across medical specialties, development of prioritization tools and implementation of access and efficiency through Alberta AIM (access improvement measures) collaboratives for process re-engineering. The ultimate goal for all Albertans who need care is one point-of-access--one standardized process to ensure equal access for all regardless of where they live.

Source: EMBASE

20. Primary care in the ED - Why?

Author(s): Pierce D.N.

Citation: Nursing management, September 2009, vol./is. 40/9(23-27, 51), 1538-8670 (Sep 2009)

Publication Date: September 2009

Abstract: Certain patient populations regularly access the ED for primary healthcare. How can you help decrease these nonemergent visits in a way that benefits patients and your hospital?

Source: EMBASE

Full Text: Available in fulltext at Ovid


Author(s): Asplin BR

Citation: Academic Emergency Medicine, July 2009, vol./is. 16/7(665-7), 1069-6563;1553-2712 (2009 Jul)

Publication Date: July 2009
22. **Access to care and ED crowding: the impact of our constricting economy.**

**Author(s):** Ogar JM

**Citation:** Journal of Emergency Nursing, July 2009, vol./is. 35/4(358-9), 0099-1767;1527-2966 (2009 Jul)

**Publication Date:** July 2009

**Source:** MEDLINE

**Full Text:**
Available in fulltext at [EBSCO Host](#)

23. **Launching a social enterprise see-and-treat service**

**Author(s):** Clancy E., Mayo A.

**Citation:** Emergency nurse : the journal of the RCN Accident and Emergency Nursing Association, June 2009, vol./is. 17/3(22-24), 1354-5752 (Jun 2009)

**Publication Date:** June 2009

**Abstract:** Many children who attend emergency departments with minor injuries or illnesses can be cared for by primary care services. This article describes an innovative partnership between a primary care trust and a social enterprise company to develop a see-and-treat primary care service that has reduced the number of children attending the traditional emergency department at a London hospital.

**Source:** EMBASE

**Full Text:**
Available in fulltext at [EBSCO Host](#)
Available in print at [Pilgrim Hospital Staff Library](#)

24. **Easing the pressure on A&E**

**Author(s):** Lipley N.

**Citation:** Emergency nurse : the journal of the RCN Accident and Emergency Nursing Association, June 2009, vol./is. 17/3(7), 1354-5752 (Jun 2009)

**Publication Date:** June 2009

**Source:** EMBASE

**Full Text:**
Available in fulltext at [EBSCO Host](#)
Available in print at [Pilgrim Hospital Staff Library](#)

25. **When is urgent care the right option?.**

**Author(s):** anonymous

**Citation:** Johns Hopkins Medical Letter, Health After 50, May 2009, vol./is. 21/3(3, 7), 1042-1882;1042-1882 (2009 May)

**Publication Date:** May 2009

**Source:** MEDLINE

26. **Using Medical Screening Examinations to Reduce Emergency Department Overcrowding**
Author(s): Nash K., Nguyen H., Tillman M.  
Citation: Journal of Emergency Nursing, March 2009, vol./is. 35/2(109-113), 0099-1767;1527-2966 (March 2009)  
Publication Date: March 2009  
Source: EMBASE  
Full Text: Available in fulltext at Ovid  

27. Tricky, but worthwhile. Free-standing EDs spread access, providers' brand.  
Author(s): Atkinson W  
Citation: Modern Healthcare, March 2009, vol./is. 39/13(22), 0160-7480;0160-7480 (2009 Mar 30)  
Publication Date: March 2009  
Source: MEDLINE  
Full Text: Available in fulltext at EBSCO Host  

28. Do non-urgent patients presenting to an emergency department agree with a reorientation towards an alternative care department? [French] Les patients "non urgents" se presentant dans les services d'urgence sont-ils favorables a une reorientation vers une structure de soins alternative?  
Author(s): Gentile S., Durand A.C., Vignally P., Sambuc R., Gerbeaux P.  
Citation: Revue d'epidemiologie et de sante publique, February 2009, vol./is. 57/1(3-9), 0398-7620 (Feb 2009)  
Publication Date: February 2009  
Abstract: BACKGROUND: Emergency department (ED) utilization has increased for several decades. EDs are becoming more and more busy because of patients with non-urgent problems, and their demand for service has resulted in overcrowding in ED. To resolve this problem, primary care units involving general practitioners have been established. The objective of this study is to assess provision of the shift to other health care facilities for no urgent ED patients, starting from entry to ED at the request of the triage nurse. METHODS: A cross-sectional study was conducted during a one-week period in the adult ED of La Conception Hospital in Marseilles, France. Only no urgent patients identified prospectively by the triage nurse were included. Information was gathered regarding the usual source of care, reason for the visit, care itinerary before presenting to the ED, patient's perception of emergency level, their willingness regarding a reorientation to another health care facility, accomplished actions, and type of discharge. RESULTS: Among 245 ED patients, 110 were identified as no urgent by the triage nurse, and 85 effectively answered questions for the purpose of this study. In 76.4% of the cases, the patients were self-referred to ED, however one-third had contacted a physician. The most common reasons provided for attending the ED were pain (55.3%), laboratory and radiographic investigations (37.6%), and difficulty in accessing the usual source of care (22.3%). The mean level of emergency perception was 10.6+/-5.6 on a zero-twenty scale. Half of the patients presented for traumatology concerns. One-third had an additional examination, six received treatments, and none were hospitalized. Upon entry to ED, more than two-thirds of patients accepted the principle of reorientation to another health care facility. Two main factors linked with this decision were employment status (odds-ratio [OR]=4.5; 95% confidence interval [CI]=1.6-12.9) and the perceived emergency level (OR=0.88; 95% CI=0.8-0.9). Among patients who refused reorientation, 41 of them were able to pay an additional cost to receive care in the ED. CONCLUSION: Alternative structures such as primary care units near the ED seem to be an appropriate response to meet the growing demand of no urgent patients. The success of providing this
29. A summative evaluation of an EMS partnership aimed at reducing ED length of stay.

**Author(s):** Gillespie GL, Yap TL, Singleton M, Elam M

**Citation:** Journal of Emergency Nursing, January 2009, vol./is. 35/1(5-10), 0099-1767;1527-2966 (2009 Jan)

**Publication Date:** January 2009

**Abstract:** INTRODUCTION: Freestanding emergency departments are full-service emergency departments with no attached inpatient facility. ED congestion and patient dissatisfaction may occur as patients requiring admission are waiting for ambulance arrival and transfer. A partnership between a freestanding emergency department and a private ambulance company was developed in order to reduce ambulance response times and ultimately ED length of stay. The aim of this manuscript was to describe the Partnership in Care program and evaluate the program's effectiveness.

**METHODS:** The study used a pre-post/post-test summative evaluation design. A retrospective chart review was done for all patients discharged from the freestanding emergency department by the partnered ambulance company during the pre-test period, April 2004 to June 2004, and the post-test period, April 2005 to June 2005. Data variables included time of triage, time ambulance requested, time ambulance arrived, and discharge time. Institutional Review Board approval was obtained.

**RESULTS:** There were 507 patients transported at discharge by the ambulance company. There was a 5-minute increase for mean ED length of stay although not significant. Mean ambulance response time was significantly reduced by 8 minutes.

**DISCUSSION:** The program did not achieve the primary goal of reducing ED length of stay, however the private EMS workers provided countless hours of patient care to the freestanding ED patients without charge to the freestanding emergency department for the EMS providers' time.

**Source:** MEDLINE

Full Text: Available in fulltext at Ovid

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**Author(s):** Ingram JC, Calnan MW, Greenwood RJ, Kemple T, Payne S, Rossdale M

**Citation:** British Journal of General Practice, January 2009, vol./is. 59/558(e16-24), 0960-1643;1478-5242 (2009 Jan)

**Publication Date:** January 2009

**Abstract:** BACKGROUND: Emergency admissions to hospital at night and weekends are distressing for patients and disruptive for hospitals. Many of these admissions result from referrals from GP out-of-hours (OOH) providers.

**AIM:** To compare rates of referral to hospital for doctors working OOH before and after the new general medical services contract was introduced in Bristol in 2005; to explore the attitudes of GPs to referral to hospital OOH; and to develop an understanding of the factors that influence GPs when they refer patients to hospital.

**Design of study:** Cross-sectional comparison of admission rates; postal survey.

**SETTING:** Three OOH providers in south-west England.

**METHOD:** Referral rates were compared for 234 GPs working OOH, and questionnaires explored their attitudes to risk.

**RESULTS:** There was no change in referral rates after the change in contract or in the greater than fourfold variation between those with the lowest and highest referral rates found previously. Female GPs made fewer home visits and had a higher referral rate for patients seen at home. One-hundred and fifty GPs responded to the survey. Logistic regression of three combined survey risk items, sex, and place of visit showed that GPs with low 'tolerance of risk' scores were more likely to be high referrers to hospital (P<0.001).

**CONCLUSION:** GPs' threshold of risk is important for explaining variations in referral to hospital.

**Source:** MEDLINE

Author(s): Weinick RM, Bristol SJ, DesRoches CM

Citation: BMC Health Services Research, 2009, vol./is. 9/(79), 1472-6963;1472-6963 (2009)

Publication Date: 2009

Abstract: BACKGROUND: Due to long waits for primary care appointments and extended emergency department wait times, newer sites for episodic primary care services, such as urgent care centers, have developed. However, little is known about these centers. The purpose of this study is to provide information about the organization and functioning of urgent care centers based on a nationally representative U.S. sample.METHODS: We conducted a mail survey with telephone follow-up of urgent care centers identified via health insurers' websites, internet searches, and a trade association mailing list. Descriptive statistics are presented.RESULTS: Urgent care centers are open beyond typical office hours, and their scope of services is broader than that of many primary care offices. While these characteristics are similar to hospital emergency departments, such centers employ significant numbers of family physicians. The payer distribution is similar to that of primary care, and physicians' average salaries are comparable to those for family physicians overall. Urgent care centers report early adoption of electronic health records, though our findings are qualified by a lack of strictly comparable data.CONCLUSION: While their hours and scope of services reflect some characteristics of emergency departments, urgent care centers are in many ways similar to family medicine practices. As the health care system evolves to cope with expanding demands in the face of limited resources, it is unclear how patients with episodic care needs will be treated, and what role urgent care centers will play in their care.

Source: MEDLINE

Full Text:
Available in fulltext at National Library of Medicine
Available in print at Pilgrim Hospital Staff Library

32. Access and care issues in urban urgent care clinic patients.

Author(s): Scott DR, Batal HA, Majeres S, Adams JC, Dale R, Mehler PS

Citation: BMC Health Services Research, 2009, vol./is. 9/(222), 1472-6963;1472-6963 (2009)

Publication Date: 2009

Abstract: BACKGROUND: Although primary care should be the cornerstone of medical practice, inappropriate use of urgent care for non-urgent patients is a growing problem that has significant economic and healthcare consequences. The characteristics of patients who choose the urgent care setting, as well as the reasoning behind their decisions, is not well established. The purpose of this study was to determine the motivation behind, and characteristics of, adult patients who choose to access health care in our urgent care clinic. The relevance of understanding the motivation driving this patient population is especially pertinent given recent trends towards universal healthcare and the unclear impact it may have on the demands of urgent care.METHODS: We conducted a cross-sectional survey of patients seeking care at an urgent care clinic (UCC) within a large acute care safety-net urban hospital over a six-week period. Survey data included demographics, social and economic information, reasons that patients chose a UCC, previous primary care exposure, reasons for delaying care, and preventive care needs.RESULTS: A total of 1,006 patients were randomly surveyed. Twenty-five percent of patients identified Spanish as their preferred language. Fifty-four percent of patients reported choosing the UCC due to not having to make an appointment, 51.2% because it was convenient, 43.9% because of same day test results, 42.7% because of ability to get same-day medications and 15.1%
because co-payment was not mandatory. Lack of a regular physician was reported by 67.9% of patients and 57.2% lacked a regular source of care. Patients reported delaying access to care for a variety of reasons.

**CONCLUSION:** Despite a common belief that patients seek care in the urgent care setting primarily for economic reasons, this study suggests that patients choose the urgent care setting based largely on convenience and more timely care. This information is especially applicable to the potential increase in urgent care volume in a universal healthcare system. Additionally, this study adds to the body of literature supporting the important role of timely primary care in healthcare maintenance.

**Source:** MEDLINE

**Full Text:**
Available in fulltext at BioMedCentral [↩]
Available in fulltext at National Library of Medicine [↩]


**Author(s):** Jones, Tom

**Citation:** Journal of Telemedicine and Telecare, 2009, vol./is. 15/3(129-1131), 1357-633X

**Publication Date:** 2009

**Abstract:** The Emergency Care Summary (ECS) in Scotland provides essential clinical and demographic information about patients needing unscheduled or emergency care. Information about patients' medications, adverse drug reactions and allergies is transferred twice every day from GP systems to the ECS. Access is then available to authorised health-care professionals at the national help line, at out-of-hours services and in accident and emergency departments. An economic analysis of the ECS implementation showed that annual benefits exceeded annual costs after about seven years. Approximately 77 per cent of the benefits were non-financial and 23 per cent from redeployed finance. No cash savings were planned and none were realised. As ECS utilisation increased from 2006, the net benefits became positive. This relationship between utilisation and net benefits is a common feature of successful e-health investment. 3 figs. 4 refs. [Summary]

**Source:** HMIC

**Full Text:**
Available in fulltext at EBSCO Host [↩]

34. Myths versus facts in emergency department overcrowding and hospital access block

**Author(s):** Richardson, Drew B, Mountain, David

**Citation:** Medical Journal of Australia, 2009, vol./is. 190/7, 0025-729X

**Publication Date:** 2009

**Abstract:** Overcrowding occurs when emergency department (ED) function is impeded, primarily by overwhelming of ED staff resources and physical capacity by excessive numbers of patients needing or receiving care. Access block occurs when there is excessive delay in access to appropriate inpatient beds (> eight hours total time in the ED). Access block for admitted patients is the principal cause of overcrowding, and is mainly the result of a systematic lack of capacity throughout health systems, and not of inappropriate presentations by patients who should have attended a general practitioner. Overcrowding is most strongly associated with excessive numbers of admitted patients being kept in the ED. Excessive numbers of admitted patients in the ED are associated with diminished quality of care and poor patient outcomes. These include (but are not limited to) adverse events, errors, delayed time-critical care, increased morbidity and excess deaths (estimated as at least 1,500 per annum in Australia). There is no evidence that telephone advice lines or collocated after-hours GP services assist in reducing ED workloads. Changes to ED structure and function do not address the underlying causes or major adverse effects of overcrowding. They are also rapidly overwhelmed by increasing access block. The cause of overcrowding, and hence the solutions, lie outside the ED. Solutions will mainly be found
in managing hospital bedstock and systemic capacity (including the use of step-down and community resources) so that appropriate inpatient beds remain available for acutely sick patients. Cites 49 references. [Journal abstract]

Source: HMIC

35. Out-of-hours care in western countries: assessment of different organizational models

Author(s): Huibers, Linda, Giesen, Paul, Wensing, Michel, Grol, Richard

Citation: BMC Health Services Research, 2009, vol./is. 9/105, 1472-6963

Publication Date: 2009

Abstract: Internationally, different organisational models are used for providing out-of-hours care. The aim of this study was to assess prevailing models in order to identify their potential strengths and weaknesses. An international web-based survey was done in 2007 in a sample of purposefully selected key informants from 25 western countries. The questions concerned prevailing organisational models for out-of-hours care, the most dominant model in each country, perceived weaknesses, and national plans for changes in out-of-hours care. The results were a total of 71 key informants from 25 countries provided answers. In most countries several different models existed alongside each other. The Accident and Emergency department was the organisational model most frequently used. Perceived weaknesses of this model concerned the coordination and continuity of care, its efficiency and accessibility. In about a third of the countries, the rota group was the most dominant organisational model for out-of-hours care. A perceived weakness of this model was lowered job satisfaction of physicians. The GP cooperative existed in a majority of the participating countries; no weaknesses were mentioned with respect to this model. Most of the countries had plans to change the out-of-hours care, mainly toward large scale organisations. The conclusions were GP cooperatives combine size of scale advantages with organisational features of strong primary care, such as high accessibility, continuity and coordination of care. While specific patients require other organisational models, the co-existence of different organisational models for out-of-hours care in a country may be less efficient for health systems. Cites 33 references. [Journal abstract]

Source: HMIC

Full Text:
Available in fulltext at BioMedCentral
Available in fulltext at National Library of Medicine

36. Cost reduction strategies for emergency services: insurance role, practice changes and patients accountability

Author(s): Simonet, Daniel

Citation: Health Care Analysis, 2009, vol./is. 17/1, 1065-3058

Publication Date: 2009

Abstract: Progress in medicine and the subsequent extension of health coverage has meant that health expenditure has increased sharply in Western countries. In the United States, this rise was precipitated in the 1980s, compounded by an increase in drug consumption which prompted the government to re-examine its financial support to care delivery, most notably in hospital care and emergencies services. In California for example, 50 emergency service providers were closed between 1990 and 2000, and nine in 1999-2000 alone. In that Stage, only 355 hospitals (out of 568) have maintained emergency services departments (Darves, WebMB, 2001). Reforming hospital Emergency Department (ED) operations requires caution not only because the media pay a lot of attention to ED operations, but also because it raises ethical issues: this became more apparent with the enactment of the EMT-ALA which stipulates that federally funded hospitals are required to give emergency aid in order to 'stabilise' a patient suffering from an 'emergency medical condition' before discharging or transferring that patient to another facility. While in essence the law aims to preserve patient access to care, physicians assert that the EMITALA leads to more patients seeking care for non-urgent conditions in EDs (GAO, Report to Congressional Committees, 2001), leading to overcrowding, delayed care for patients with
true emergency needs, and forcing hospitals to divert ambulances to other facilities resulting in further delays in urgent care. Also, fewer physicians are willing to be on-call in emergency departments because the EMT-ALA law requires on-call physicians to provide uncompensated care. Thus there is a need to find a balance between appropriate care to be provided to ED patients, and low costs since uncompensated care is not covered by state or federal funds. This concerns, first and foremost, hospitals that provide a greater amount of uncompensated care (e.g. hospitals serving communities with a higher population of illegal immigrants). Looking at the intrinsic causes of high ED costs, the paper first explains why costs of care provided in EDs are high, and look at a major cause of high ED costs: overcrowding and ED users' characteristics. This is followed by a discussion on a much-debated factor: the use of EDs for non-emergency conditions, a practice which has often been accused of disproportionately raising costs. The authors look at various mechanisms used either to divert or prevent the patient from using ED: these include triage services; and the role of HMOs in the ED chain of care: though the US government has increasingly relied on Managed Care organisations to contain costs (e.g. Medicaid and Medicare Managed Care), do HMOs make a difference when it comes to ED costs? Of particular interest is the family physician acting as a gatekeeper, and the legislation that was enacted to protect those who bypass the referral system. The authors then look at the other end of the ED chain (i.e. the recipient): the financial responsibility of ED users has increased. Alternative providers such as walk-in clinics are increasingly common. EDs also attempt to reengineer their operations to curb costs. While the data are mostly applicable to a private health care system (e.g. the US) the article, using a critical assessment of the existing literature, has implications for other EDs generally, wherever they operate, since every ED faces similar funding problems. Cites 95 references. [Journal abstract]

Source: HMIC

37. Ambulatory care: what is it and do we need it?

Author(s): Sturgess, Ian, Proudfoot, Alastair

Citation: British Journal of Hospital Medicine, 2009, vol./is. 70/1, 1462-3935

Publication Date: 2009

Source: HMIC

Full Text:
Available in fulltext at EBSCO Host
Available in print at Lincoln County Hospital Professional Library

38. How well are England's urgent care services performing?

Author(s): Hurst K

Citation: Nursing Standard, 26 November 2008, vol./is. 23/12(14-15), 00296570

Publication Date: 26 November 2008

Abstract: A&E and NHS Direct are performing well but communication between services remains a problem, writes Keith Hurst.

Source: CINAHL

Full Text:
Available in fulltext at Ovid
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39. Patient adherence with emergency department referral to a cardiovascular evaluation and risk assessment clinic.
OBJECTIVE: Patient adherence with emergency department (ED) referral has not been well studied in Canada, and there are no Canadian studies assessing patient follow-up for evaluation of cardiovascular disease. Our primary objective was to determine the proportion of patients who adhered with an ED referral to a cardiac evaluation and risk assessment (CERA) clinic in Calgary, Alta. Secondary objectives included determining the final diagnoses and outcomes for patients attending CERA appointments. We also assessed the association between adherence and various system and patient factors.

METHODS: A retrospective review of 385 patients who were referred to CERA from EDs in the study region between June 1, 2004, and Apr. 7, 2005, was performed. Hospital charts and the database at the medical examiner’s office were reviewed for patients who did not attend their CERA appointment.

RESULTS: The majority of patients (345/385, 89.6%) followed through with their referral to CERA. No deaths were identified from hospital records or from the medical examiner’s office for nonadherent patients. Of the 315 patients who completed their follow-up, 225 (71.4%) were diagnosed with noncardiac or low-risk cardiac disease, whereas 90 (28.6%) were diagnosed with cardiovascular disease. The referring hospital was the only variable significantly associated with adherence with the referral (p=0.004).

CONCLUSION: The great majority of patients referred to CERA from Calgary EDs were adherent with the referral. Future studies may identify factors impairing adherence that are amenable to intervention. Implementation of a referral model similar to the one used by CERA may improve adherence with attendance at other outpatient clinics.
Lachman P

Citation: Archives of Disease in Childhood, August 2008, vol./is. 93/8(681-5), 0003-9888;1468-2044 (2008 Aug)

Publication Date: August 2008

Abstract: AIM: To assess the impact of a purpose-built, short stay paediatric ambulatory care unit (PACU) on the patient journey and perceptions of parents, staff and referrers.METHODS: Multi-method evaluation, including a parent survey (n = 104), patient journey mapping (n = 10), staff interviews (n = 10), a referrer survey (n = 16), routine activity analysis, and a comparison with the A&E service (A&E parent survey; n = 41).RESULTS: Almost all parents attending PACU (94%) were satisfied with the service and significantly more likely to feel "very" satisfied than parents attending A&E (PACU: 51%, A&E: 31%; p = 0.03). Further, over three quarters (77%) of PACU parents preferred the new model to traditional A&E services. They reported receiving sufficient information (93%), reduced anxiety (55% anxious before service, 13% anxious after; p<0.001), "quick" waiting times (median: 35 min), and enhanced confidence (87%) and understanding (89%) in dealing with their ill child. The number of stages in the patient journey was reduced from six ("traditional" A&E pathway) to four (PACU pathway). Staff and referrers reported this was a "superior" model to A&E, but that improvements were required around appropriate referrals and the need for more multi-disciplinary protocols and liaison.CONCLUSION: Our study suggests that the PACU model is perceived to be an effective alternative to standard A&E services for the assessment and early management of acutely ill children and their families attending a hospital. It is highly valued by users, staff and referrers and enhances the patient journey. Lessons learnt include the need to enhance multi-disciplinary processes and clarify the role of this form of acute care provision in the wider healthcare system.

Source: MEDLINE

Full Text:
Available in fulltext at Highwire Press
Available in print at Lincoln County Hospital Professional Library

43. Change management at the hospital front door: integrating automatic patient tracking in a high volume emergency department and level 1 trauma center.

Author(s): Laskowski-Jones J

Citation: Nurse Leader, 01 April 2008, vol./is. 6/2(52-57), 15414612

Publication Date: 01 April 2008

Source: CINAHL

44. Uses of first line emergency services in Cuba.

Author(s): De Vos P, Vanlerberghe V, Rodriguez A, Garcia R, Bonet M, Van der Stuyft P

Citation: Health Policy, January 2008, vol./is. 85/1(94-104), 0168-8510;0168-8510 (2008 Jan)

Publication Date: January 2008

Abstract: OBJECTIVES: To rationalise the use of hospital emergency units, the Cuban health system developed from 1996 onwards an extra muros first line emergency system (FLES). We analyse the use of the FLES and its determinants, in order to develop proposals to channel inappropriate users to their family doctor.METHODS: In the FLES of an urban (Cerro) and a rural (Baracoa) municipality we collected, from July 1999 to June 2001, data on the moment of consultation, age and sex of the patient, referral status, motive of consultation, emergency classification, diagnosis and medical conduct. A variable "inappropriate use" was constructed. We used multivariate logistic regression to quantify the strength of the associations between patient characteristics, the night-time use, medical procedures, referral, and inappropriate use of the FLES.RESULTS: Over the 2 years observation period, 24879 and 59795 patient contacts were registered with the principal emergency policlinic in Baracoa and Cerro, respectively. In both municipalities the overall "inappropriate" use was almost 60%. There was no correlation with age and gender but
inappropriate use was 50% more frequent during the day. Referred patients in both localities were up to 12 times more frequently hospitalized.

CONCLUSION: Cuba's FLES attract patients that would be better attended by their family doctor. To strengthen his central position in the health system, one should strengthen the family doctor's technical platform, increase his permanence at the cabinet, and improve communication with the community on the rationale of the family doctor--FLES set up.

Source: MEDLINE

45. Creating sustained improvements in patient access and flow: experiences from three Ontario healthcare institutions.

Author(s): Macleod H, Bell RS, Deane K, Baker C
Citation: Healthcare Quarterly, 2008, vol./is. 11/3(38-49), 1710-2774;1710-2774 (2008)
Publication Date: 2008

Abstract: Ensuring that patients receive timely, high-quality healthcare is the highest priority of Ontario's hospitals, physicians and nurses. Given that the emergency department (ED) is often the "front door" to our healthcare system, developing approaches to improve access and flow in the ED is important - made more challenging by rising patient demand and acuity. Long-standing efforts to improve the ED system have outlined promising approaches and pushed access and flow up the priority list. Recently, in partnership with the Ministry of Health and Long-Term Care (MOHLTC), several Ontario hospitals participated in an intensive and sustained effort to improve access and flow, with promising results. Participants in these efforts described the initiatives as transformational, and the results have been promising and sustained. This article chronicles the efforts of three hospitals to enable other hospitals, physicians and nurses to learn from these experiences and gain confidence that a similar impact can be achieved in their facilities. Specifically, it discusses the following: The three pillars of sustainable transformation. Hospital case studies. St. Joseph's Health Centre (SJHC), Toronto. London Health Sciences Centre (LHSC) - University Hospital. University Health Network (UHN) - Toronto General and Toronto Western. Advice for other hospitals

Source: MEDLINE

46. The concept, delivery and future of medical ambulatory care.

Author(s): Strang, George
Citation: Clinical Medicine, 2008, vol./is. 8/3(276-279), 1470-2118
Publication Date: 2008

Abstract: Bed shortages, efficient modern diagnostic services and increasing risks associated with hospital admission, require review of conventional medical practice. Patients referred as emergencies who are walking, talking sense, eating and drinking and have normal sphincter function can usually be managed as outpatients. Widespread adoption of this practice would require more general physicians and nurse practitioners near the front door, rapid access and early review clinics and prompt diagnostic support. Education of the public, changes in medical training and reallocation of resources would reduce the need for inpatient management, providing beds for those in real need. 3 figs. 1 table 6 refs. [Abstract]

Source: HMIC

Full Text:
Available in fulltext at Ovid

47. More patients with minor injuries could be seen by telemedicine.

Author(s): Mair, Fiona, Ferguson, James
Citation: Journal of Telemedicine and Telecare, 2008, vol./is. 14/3(132-134), 1357-633X
Publication Date: 2008

Abstract: The Grampian minor injuries telemedicine service has been operating since 2001 supporting 15 minor injury units [MIUs] in community hospitals. Currently over 120
new patients are seen each month. We conducted a retrospective review to estimate the number of patients who were sent to the main hospital emergency department [ED] who would have been suitable for telemedicine treatment instead. All attendances at three MIUs and onward referrals to the ED during the months January and July 2006 were identified from a database. A total of 112 patients were referred from the three MIUs during the study period. MIU C, which utilized teleconsultations the most, referred the lowest proportion of its patients (two per cent). MIU B, which had all X-rays reviewed by a general practitioner, referred the most (85 per cent). At MIU B, 80 to 85 per cent of patients referred to the ED without having a teleconsultation could have been managed by telemedicine. Telemedicine for MIUs has been repeatedly reported in the medical literature as being successful, but widespread usage of this technique remains to be achieved. 3 figs. 1 table 10 refs.

Source: HMIC

Full Text:
Available in fulltext at EBSCO Host

48. Refining the model for an emergency department-based mental health nurse practitioner outpatient service

Author(s): Wand, Timothy, White, Kathryn, Patching, Joanna

Citation: Nursing Inquiry, 2008, vol./is. 15/3, 1320-7881

Publication Date: 2008

Abstract: The mental health nurse practitioner (MHNP) role based in the emergency department (ED) has emerged in response to an increase in mental health-related presentations and subsequent concerns over waiting times, coordination of care and therapeutic intervention. The MHNP role also provides scope for the delivery of specialised primary care. Nursing authors are reporting on nurse-led outpatient clinics as a method of healthcare delivery that allows for enhanced access to healthcare, particularly following hospital discharge. However, due to a lack of in-depth substantiation, this mode of service delivery requires more thorough investigation. This study describes the refinement phase undertaken before the implementation and pilot evaluation of a formalised and structured MHNP outpatient service in the ED of a large inner-city hospital in Sydney, Australia. An expert advisory panel (EAP) consisting of key local informants was convened to provide feedback on and refinement to the proposed model. This related to issues such as target population, structure and process considerations, outcome measures and interface within the overall health service. Findings from the EAP meeting are presented and discussed. The importance of linking methods with the appropriate methodology in evaluating a healthcare program is highlighted. Cites numerous references. [Journal abstract]

Source: HMIC

Full Text:
Available in fulltext at EBSCO Host

49. Reducing hospital admissions: guidance should be evidence based and take a holistic view of patient care

Author(s): Purdy, Sarah, Griffin, Tom

Citation: British Medical Journal, 2008, vol./is. 336/7634, 0959-8138

Publication Date: 2008

Abstract: Hospital admissions, especially emergency admissions, put pressure on health service resources. Studies in the US have provided evidence supporting the cost effectiveness of reducing hospital admissions through improved case management, observation units and home care. A directory has been produced advising which illnesses require hospital admission and which do not. The success of the directory depends on effective diagnostic facilities, amongst other factors.

Source: HMIC

Full Text:
50. Why nurses are central to polyclinics.

Author(s): Hunt L

Citation: Nursing Times, 28 August 2007, vol./is. 103/35(16-17), 09547762

Publication Date: 28 August 2007

Abstract: As nurse leaders express high hopes for the 'polyclinic pain', Louise Hunt examines the opportunities for staff.

Source: CINAHL

Full Text:
Available in fulltext at Ovid
Available in print at Lincoln County Hospital Professional Library
Available in print at Pilgrim Hospital Staff Library

51. The impact of co-located NHS walk-in centres on emergency departments.

Author(s): Salisbury C, Hollinghurst S, Montgomery A, Cooke M, Munro J, Sharp D, Chalder M

Citation: Emergency Medicine Journal, April 2007, vol./is. 24/4(265-9), 1472-0205;1472-0213 (2007 Apr)

Publication Date: April 2007

Abstract: OBJECTIVES: To determine the impact of establishing walk-in centres alongside emergency departments (EDs) on attendance rates, visit duration, process, costs and outcome of care.METHODS: Eight hospitals with co-located EDs and walk-in centres were compared with eight matched EDs without walk-in centres. Site visits were conducted. Routine data about attendance numbers and use of resources were analysed. A random sample of records of patients attending before and after the opening of walk-in centres was also assessed. Patients who had not been admitted to hospital were sent a postal questionnaire.RESULTS: At most sites, the walk-in centres did not have a distinct identity and there were few differences in the way services were provided compared with control sites. Overall, there was no evidence of an increase in attendance at sites with walk-in centres, but considerable variability across sites was found. The proportion of patients managed within the 4 h National Health Service target improved at sites both with and without walk-in centres. There was no evidence of any difference in reconsultation rates, costs of care or patient outcomes at sites with or without walk-in centres.CONCLUSIONS: Most hospitals in this study implemented the walk-in centre concept to a very limited extent. Consequently, there was no evidence of any effect on attendance rates, process, costs or outcome of care.

Source: MEDLINE

Full Text:
Available in fulltext at Highwire Press
Available in fulltext at National Library of Medicine
Available in print at Grantham Hospital Staff Library

52. Comparing care at walk-in centres and at accident and emergency
departments: an exploration of patient choice, preference and satisfaction.

Author(s): Chalder M, Montgomery A, Hollinghurst S, Cooke M, Munro J, Lattimer V, Sharp D, Salisbury C

Citation: Emergency Medicine Journal, April 2007, vol./is. 24/4(260-4), 1472-0205;1472-0213 (2007 Apr)

Publication Date: April 2007

Abstract: OBJECTIVES: To explore the impact of establishing walk-in centres alongside emergency departments on patient choice, preference and satisfaction. METHODS: A controlled, mixed-method study comparing 8 emergency departments with co-located walk-in centres with the same number of "traditional" emergency departments. This paper focuses on the results of a cross-sectional questionnaire survey of users. RESULTS: Survey data demonstrated that patients were frequently unable to distinguish between being treated at a walk-in centre or at an accident and emergency (A&E) department and, even where this was the case, opportunities to exercise choice about their preferred care provider were often limited. Few made an active choice to attend a co-located walk-in centre. Patients attending walk-in centres were just as likely to be satisfied overall with the care they received as their counterparts who were treated in the co-located A&E facility, although walk-in centre users reported greater satisfaction with some specific aspects of their care and consultation. CONCLUSIONS: Whereas one of the key policy goals underpinning the co-location of walk-in centres next to an A&E department was to provide patients with more options for accessing healthcare and greater choice, leading in turn to increased satisfaction, this evaluation was able to provide little evidence to support this. The high percentage of patients expressing a preference for care in an established emergency department compared with that in a new walk-in centre facility raises questions for future policy development. Further consideration should therefore be given to the role that A&E-focused walk-in centres play in the Department of Health's current policy agenda, as far as patient choice is concerned.

Source: MEDLINE

Full Text:
Available in fulltext at Highwire Press
Available in fulltext at National Library of Medicine
Available in print at Grantham Hospital Staff Library

53. ED, primary care clinic pilot program for uninsured.

Author(s): anonymous

Citation: Hospital Case Management, February 2007, vol./is. 15/2(30-1), 1087-0652;1087-0652 (2007 Feb)

Publication Date: February 2007

Source: MEDLINE

Full Text:
Available in fulltext at EBSCO Host

54. Hospital-physicians relations: cooperation, competition, or separation?.

Author(s): Berenson RA, Ginsburg PB, May JH

Citation: Health Affairs, January 2007, vol./is. 26/1(w31-43), 0278-2715;1544-5208 (2007 Jan-Feb)

Publication Date: January 2007

Abstract: Because many services performed in hospitals can safely and conveniently be performed in ambulatory settings, physicians have become owners of entities directly competing with hospitals for patients in a new medical arms race. Hospitals and medical staff physicians face growing tensions as a result of physicians' growing reluctance to take emergency department call and the consequences of hospitalists replacing physicians in the care of inpatients. Although there are increasing expectations that health system
challenges will lead hospitals and physicians to collaborate, in many markets the willingness and ability for hospitals and physicians to work together is actually eroding.

Source: MEDLINE

Full Text:
Available in fulltext at Highwire Press
Available in fulltext at EBSCO Host
Available in fulltext at EBSCO Host

55. Plans afoot for national network of for-profit urgent care centres.

Author(s): Jones D

Citation: CMAJ Canadian Medical Association Journal, January 2007, vol./is. 176/1(22), 0820-3946;1488-2329 (2007 Jan 2)

Publication Date: January 2007

Source: MEDLINE

Full Text:
Available in fulltext at Ovid
Available in fulltext at EBSCO Host
Available in fulltext at EBSCO Host
Available in fulltext at National Library of Medicine

56. Shifting care from hospitals to the community: a review of the evidence on quality and efficiency.

Author(s): Sibbald, Bonnie, McDonald, Ruth, Roland, Martin

Citation: Journal of Health Services Research and Policy, 2007, vol./is. 12/2(110-117), 1355-8196

Publication Date: 2007

Abstract: OBJECTIVES: A key objective in many health-care systems is to shift specialist services from acute hospitals to the community and so bring care closer to home for patients. Our aim was to review published research into the effectiveness of strategies for achieving this objective. METHODS: We conducted a 'scoping' review and qualitative data synthesis of four strategies: transfer of services from hospital to primary care; relocation of hospital services to primary care; joint working between primary and acute care; and interventions to alter the referral behaviour of primary care practitioners. RESULTS: One hundred and nineteen studies were identified and data systematically extracted. The findings suggest that transferring hospital services to primary care, and interventions that change the referral behaviour of primary care practitioners generally reduced outpatient activity but also risked reducing quality. Savings in cost were offset by increases in overall service volume and loss of economies of scale. Relocating specialists to primary care, and joint working between primary and acute care, improved access without jeopardizing quality. However, outpatient activity was rarely reduced and costs were generally increased due to loss of economies of scale. CONCLUSIONS: Our findings suggest that the policy may be effective in improving access to specialist care for patients and reducing demand on acute hospitals. There is a risk, however, that the quality of care may decline and costs may increase. 3 tables 23 refs. [Abstract]

Source: HMIC

Full Text:
Available in fulltext at EBSCO Host

57. Urgent care: a position statement from the Royal College of General Practitioners.

Author(s): Lakhani, Mayur, Archard, Graham, Fernandes, Angelo
58. 'We have better networks and continuity of care'

Author(s): Hoban, Victoria

Citation: Health Service Journal, 2007, 0952-2271

Publication Date: 2007

Abstract: Nurse-led walk-in centres across the UK have played a crucial role in appropriately streaming patients to primary care, alleviating the pressure on the A & E four-hour wait target and developing the skills of nurses, writes the author. But, as new services, they can also highlight gaps in patient care that may have been previously overlooked.

Source: HMIC

Full Text: Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
Available in print at Louth County Hospital Medical Library
Available in print at Louth County Hospital Medical Library
Available in print at Pilgrim Hospital Staff Library

59. One stop health care shopping? The rise of "McClinics" and their impact on emergency care.

Author(s): Flynn G

Citation: Annals of Emergency Medicine, November 2006, vol./is. 48/5(566-9), 0196-0644;1097-6760 (2006 Nov)

Publication Date: November 2006

Source: MEDLINE

Full Text: Available in fulltext at Ovid
Available in print at Louth County Hospital Medical Library
Available in print at Pilgrim Hospital Staff Library

60. Keeping people out of hospital: the challenge of reducing emergency admissions

Author(s): Rowell, Hilary

Citation: , 2006

Publication Date: 2006

Abstract: Over a million emergency admissions to hospitals each year are accounted for by people being repeatedly admitted via accident and emergency departments. Many of these conditions could be better managed outside hospital - at home or in the community. The findings are based on the first ever analysis of national hospital data to identify the impact of repeat emergency hospital admissions on the NHS, by patients referred to as high-impact users - those who are admitted to accident and emergency at least three times in a year. The report also reveals that there is wide geographical variation in the number of emergency admissions by high-impact users, from fewer than 1,000 in one south east primary care trust to nearly 10,000 in a primary care trust in the Midlands.

Source: HMIC
The ED as the Hospital's Front Door
R SoRelle - Emergency Medicine News, 2002 - journals.lww.com
... John M. Shiver, MHA, of APACHE/National Health Advisors, in an article in the May 8, 2000, issue of Modern Healthcare, said, Essentially the hospital's front door, the ED can be the ... One of the things the emergency department alone can do is redesign the way it offers care. ...

John M. Shiver, MHA, of APACHE/National Health Advisors, in an article in the May 8, 2000, issue of Modern Healthcare, said, Essentially the hospital's front door, the ED can be the ... One of the things the emergency department alone can do is redesign the way it offers care. ...

3.1 Urgent Care Centre (UCC) ... Some of the emerging principles underpinning these units are: o Close working with other services, eg o GP OOH service o ... Current situation by trust with estimates of the number of people that require A&E, UCC or would self-treat/visit GP if ...

Ignoring the Front Door: US Hospital Operations circa 2009
BR Asplin - Academic Emergency Medicine, 2009 - Wiley Online Library
... The front door is waiting for an answer. References. ... Impact of delayed transfer of critically ill patients from the emergency department to the intensive care unit. Crit Care Med. 2007; 35:1477–83. ... 12 Kelman S, Friedman J. Performance improvement and performance dysfunction ...

Point of Care Testing in the Emergency Department
CW Workman, M Wynn... - Critical Pathways in ..., 2005 - journals.lww.com
... worked with the Society of Chest Pain Centers to develop, test, and implement the current initiative using known process-improvement methods. ... Results: Administrators are actively seeking ways of integrating their front door (the emergency department) with cardiovascular ...

Streamline triage and manage user expectations: lessons from a qualitative study of GP out-of-hours services
JN Egbunike, C Shaw, A Porter... - British Journal of ..., 2010 - ingentaconnect.com
... Thompson K, Parahoo K, Farrell B. An evaluation of a GP out-of-hours service: meeting ... services by international migrants: questionnaire survey of inner city London A&E attenders. ... either contacting a general practice cooperative or accident and emergency department out of ...

Links between systems in Accident & Emergency and primary care
N Harrop - Informatics in Primary Care, 2005 - ingentaconnect.com
... ABSTRACT The hospital emergency department and other ele- ments of rapid access primary care constitute an emergency care network. ... Page 3. Links between systems in Accident & Emergency and primary care 225 GP out-of-hours service within the A&E department. ...

Improvement in time to treatment following establishment of a dedicated medical admissions unit
Improvement in time to treatment following establishment of a dedicated medical admissions unit. Before this, the hospital operated a common front door policy in which all patients, including general practitioner (GP) referrals, were assessed in the emergency department (ED).

From redesign to transformation: Lean thinking & redesign
C Siddall... - 2010 - healthcare-events.co.uk
... Assessment of current service delivery • Service redesign • Structural/organisational change Page 4. ... Hospital discharge Access & Assess Urgent Care Centre Ongoing planned/self care Service Improvement Strategy (4) Clearly understand what we are trying to affect! ...

Life and Death: The blind leading the blind
... accident and emergency (A&E). Perhaps only a tertiary care consultant is able to see a polyclinic located at the front door of A&E as more accessible and less medicalised than the hospital itself. The scarcity and expense ...

The complex causes of delays in A&E
D Pickard, K Bulbeck... - Accident and Emergency Nursing, 2004 - Elsevier
... A number of specific suggestions are made for the improvement of both the local A&E system and more broad suggestions are made for clinicians in other A&E departments to ... At 23:00 Day 1 a 63-year-old man was admitted to A&E via the GP Out-of-Hours co-operative. ...

An evaluation of the care of patients with minor injuries in emergency settings
G Byrne, M Richardson, J Brunsdon... - Accident and Emergency ..., 2000 - Elsevier
... 2. J. Beales, Innovation in Accident and Emergency management: establishing a nurse-practitioner-run minor injuries/primary care unit. ... 3M A&E Focus, 6 (1997), pp. ... and P. Freeland, Should nurses be allowed to request X-rays in an accident and emergency department? ...

EMERGENCY MEDICAL ADMISSIONS SCOPING GROUP
NHSQI Scotland - 2004 - qualityimprovementscotland.net
... and patients having inappropriate delays in an Accident and Emergency Department or being to the Scottish Ambulance Service, A&E/Acute services and GP out-of-hours services. ... These include GP practices, A&E departments, community pharmacies, LHCCs, acute trusts, Out ...

Google Advanced Search (delete if not appropriate)

From 1st 50 results...

Redesign of Front Door – Transforming Acute and Urgent Care
Redesign of Front Door – Transforming Acute and Urgent Care. Ian Aitken, General Manager .... GP surgical referrals managed within Emergency Department ... www.shiftingthebalance.scot.nhs.uk/.../1278431739-Re-design%20the%20Front%20Door

Fastrack Front Door Department: Emergency Care Provider - NHS... The Fastrack Front Door service provides an immediate assessment service for all patients
attending A&E of any age presenting with functional problems. ...
www.sid.scot.nhs.uk/SelectedService.asp?service=417...from= - Cached

1. The Fastrack Front Door service provides an immediate assessment service for all patients attending A&E of any age presenting with functional problems.

2. We are able to provide equipment and care services immediately if required to support a discharge home.

3. Any patient with soft tissue injuries coming into A&E or attending A&E clinic also have the opportunity to be assessed by the Fastrack Physiotherapist and given the appropriate advice, exercises and walking aid if appropriate.

Initiative 5: Unscheduled care

File Format: Microsoft Word - Quick View
This is a Healthcare for London pathway. It covers unplanned acute care ... 12/7 Urgent care services at the front door to A&E on every hospital site (KCH, ...
www.southwarkpct.nhs.uk/documents/5795.doc - Similar

4. Over the last six months we have been working with Kings to implement the redesign of it’s A&E Department, to incorporate an Urgent Care Centre (UCC) which will take patients with primary care type needs, who will be streamed into Urgent Care by experienced meet and greet nurses at the front door. GSTT are in discussion with the LSL Alliance on how to include an UCC as part of the redesigned at St Thomas’ A&E department.

5. 12/7 Urgent care services at the front door to A&E on every hospital site (KCH, St Thomas’ and Guys). These services will actively register unregistered patients who use A&E as their first point of access and deliver a primary care led service to patients attending with minor illness and ailments.

stafford surrounds locality plan 08-09

File Format: PDF/Adobe Acrobat - Quick View
Agreed pathway for unplanned health and social care presenting at MSFT. A&E. • Specification for primary care front door to A&E ...
www.southstaffordshirepct.nhs.uk/.../PBC/SaSLocalityPlan08-09.pdf - Similar

6. Published evidence indicates that 25-50% of patients attending A&E have non-life threatening injury or illness that could be dealt with in a different health or social care setting. This puts significant burdens on the 4hour A&E target and leads to some patients being unnecessarily admitted. Rather than continue to try to direct patients to alternative settings the development of a range of services at the front door of A&E will provide patients with more appropriate care at the place that they intuitively present.

Optimizing Emergency Department Throughput

... to enhance the function of the Emergency Department, the ‘front door’ of every ... The Definitive Guide to Emergency Department Operational Improvement ...
www.psyress.com/optimizing-emergency-department-throughput-9781420083774 - Cached

Elderly Assessment Team at the Front Door - NHS Institute for ...

29 Sep 2009 ... NHS - Institute for Innovation and Improvement ... Care plans and discharge plans are actioned from the A&E department ensuring appropriate ...
www.institute.nhs.uk/.../elderly-assessment-team-at-the-front-door.html - Cached

7. The Elderly Assessment Team is a specialist, integrated, multi-disciplinary team comprising of nurses, therapists, social workers and doctors. It is dedicated to strengthening emergency care systems for frail older people with complex needs (including dementia) through comprehensive assessment. The aim of the team is to improve the experience of older people attending the Accident & Emergency
Redesign the front-door services at both sites to provide a single point of access to A&E, minor injury and illness, NHS Ayrshire Doctors on Call ...
www.nhsayrshireandarran.com/uploads/4543/roshq.pdf - Similar

8. Redesign the front-door services at both sites to provide a single point of access to A&E, minor injury and illness, NHS Ayrshire Doctors on Call (ADOC), mental health crisis response and emergency dental services.

Unscheduled Care Collaborative Programme: Local Changes for ...
6 Mar 2011 ... The role of flow coordinator in A&E was developed on the basis that all ... Direct link to the improvement in performance of Flow 1 patients with 95% now ... concentrating on improving the push at the front door without ...
www.scotland.gov.uk/Publications/2007/10/23093529/10 - Cached - Similar

1. The Flow Coordinator was introduced in April 2006 at the Queen Margaret Hospital in Dunfermline. This post was designed to primarily improve the coordination of the patient flow within the Accident and Emergency department. Not only was it anticipated that this post would improve patient care but it would also help more patients be seen within the 4 hours once they reach Accident and Emergency.

‘Front door’ physiotherapy improves emergency department ...
29 Jun 2010 ... Health Improvement and Innovation Resource Centre. Key Areas ... ‘Front door’ physiotherapy improves emergency department experience ...
www.hiirc.org.nz/.../front-door-physiotherapy-improves-emergency/?... - Cached

1. Over six months in 2005, the pilot of the Front Door Physio project reduced waiting times between referral to intervention from several hours to 30 minutes for 95 percent of patients. The number of patients who left the emergency department without physiotherapy was halved from 32 percent to 16 percent. Staff surveys showed a 90 percent satisfaction rate with the new service.

Formal Paper
5.4 Review the A&E Pathway (including front door and clinical navigator) Clinical navigator concept is still being understood and explored for Front door ...

1. (including front door and clinical navigator) Clinical navigator concept is still being understood and explored for Front door resource within Frimley, although we are very keen to pilot service to ‘treat & triage’ patient and only register patient if further ED support intervention required.

2. Potential to utilise HCHC resource at front door to help patients and provide information about primary care services available to advise and assess dependant on clinical need.

THE METABOLIC SYNDROME INTRODUCTION
MASSIVE IMPROVEMENT! April 04 – Jan 08 97-99%. HOW WAS THIS ACHIEVED? ...
Front door UCC; Single access; A&E led by experienced clinicians ...
www.improvement.nhs.uk/cancer/LinkClick.aspx?fileticket...tabid=187

NHS Buckinghamshire » ImPACT
Primary Care in A&E

File Format: PDF/Adobe Acrobat - Quick View
5 Mar 2010 ... general practice, this is the front door of the NHS. Patients know who their GP is and where the nearest Emergency Department is. ...
secure.collemergencymed.ac.uk/asp/document.asp?ID=5261

10.11.25 OPCT Brd Mtg - QIPP App 2

File Format: PDF/Adobe Acrobat - Quick View
Primary Care Service co-located by A&E. Integrated Front Door - Roving GP Service. ...
www.oxfordshirepct.nhs.uk/…/10.11.25OPCTBrdMtg-QIPPApp2.pdf

1. Integrated Front Door - Single point of Contact 24/7 single phone number to access all urgent care - linked to ‘phone first’ message and scheduling of urgent care.

2. Integrated Front Door - GP Co-location Primary Care Service co-located by A&E

3. Integrated Front Door - Roving GP Service. ASSERT GP 8/24 roving between A&E major and admissions units

Lord Darzi's Healthcare for London Review - The British Medical ...

26 Nov 2007... a ‘front door’ to the A&E department and operate in a network of ... Many people attending A&E could be better cared for by GPs and ... London-wide best practice care pathways should be developed for different LTCs. ...
www.bma.org.uk/…/HealthcareforLondonBriefing210807.jsp - Cached - Similar

1. Acute health

Many people attending A&E could be better cared for by GPs and nurses in new community clinics with extended opening hours. Access would be improved through urgent care centres with multidisciplinary care teams, which would be available 24/7 and be part of all hospital A&E departments. Some existing services, such as GP OOH would become part of services provided by the urgent care centres, as could walk-in centres and minor injury units.

2. There should be a single point of contact (by phone) for urgent care. Call-handlers would assess and determine the most appropriate course of action, from self-care advice to transfer to emergency services. Where clinical advice is given it would be provided by experienced staff (no mention of medical qualification) and quality auditable.

Programme Plan - Improving Emergency Care Pathways Programme Plan ...

File Format: PDF/Adobe Acrobat - Quick View
Interim Improvement to MAU. 15 months. Apl-08. Jun-09. A&E Pilot Front Door Approach. 12 months. Apl-08. Mar-09. Speciality Support to A&E. 9 months ...
www.gatesheadhealth.nhs.uk/…/item9-ImprovingEmergencyCarePathwaysProgrammePlan.pdf

Acute Care Summary.qxd

File Format: PDF/Adobe Acrobat - Quick View
‘front door’ and in the Acute Assessment Unit to follow patients through the pathway ... give advice and, if required, refer patients on to A&E, ...
www.sath.nhs.uk/Library/Documents/…/summary-acutecare.pdf - Similar

1. Our aim is to enable patients to be seen in a primary care or community setting
wherever possible, so that only those who require high level specialist care come to hospital. The new model will operate 24 hours a day, 365 days a year. It will be both simple and seamless for patients, with urgent and emergency care based on clinical need.

Comment from Demas Esberger, head of service at Queen's Medical ... 
9 Mar 2010 ... Comment: A&E staff are making changes at the hospital front door ... staff have devoted a great deal of time to the improvement programme, ...
www.thisisnottingham.co.uk/news/Comment-E-staff.../article.html

1. The first phase of this ambitious programme started in the emergency department last year. We feel that if we can get it right at the “front door” of the hospital, we can get it right everywhere.

2. One example of a simple change involves reducing the wait for blood-test results. We now have one member of staff whose main job is to ensure that all blood tests are taken as soon as possible and immediately sent to the laboratory. This has shortened the time some patients spend in the department.

3. The initial focus is on patients that are able to walk into the department, which equates to about 40% of our workload. We have devised new ways of caring for this group of patients, both in the adult and children's emergency departments.

Swindon Falls & Bone Health Strategy
File Format: PDF/Adobe Acrobat - Quick View
hospital accident and emergency departments (A&E) following a fall and .... common primary and secondary front door, and the virtual hub ... Update the current falls and bone health pathway, to provide the ...
www.swindon.nhs.uk/Library/.../Falls_and_Bone_Health_Strategy.pdf

1. Emergency Department Assessment Team (EDAT) is to become part of the common primary and secondary front door, and the virtual hub

Operational Plan 2009-10 – End Year Review
File Format: PDF/Adobe Acrobat - Quick View
13 Apr 2010 ... Single Front Door/APH Urgent Care Centre: The single front door project has now been piloted on 2 days in A&E with senior primary care nursing staff .... pathway for Wirral under 17 clients of Merseyside Sexual Assault ...

1. Single Front Door/APH Urgent Care Centre: The single front door project has now been piloted on 2 days in A&E with senior primary care nursing staff “streaming” patients who are walking into A&E and directing them straight to the most appropriate service, which could be the All Day Health Centre, the Primary Care Assessment Unit, A&E minor injuries or A&E majors. Initial results over the 2 days have shown that 33% of walk-in patients were redirected to the All Day Health Centre.

GP Update Summer 2010.qxp
File Format: PDF/Adobe Acrobat - Quick View
referrals, to ensure a direct pathway of care to the stroke unit. ... replacement at NNUH. A WORD IN YOUR EAR. A&E will be ‘front door' for suspected stroke.
www.nnuh.nhs.uk/viewdoc.asp?ID=255&t=Publication

1. From mid July the ‘front door’ for stroke will be A&E All suspected stroke patients will be diverted to A&E, including GP referrals, to ensure a direct pathway of care to the stroke unit.

Integrating A&E and Primary Care 'Out of Hours - Healthcare ...
The A&E department silts up with large numbers of ‘minor’ cases and the department through robust signposting and referral pathways from senior clinical assessment to Doc Title proposal to fund A&E front door clinical assessment. Doc Title www.healthcareworkforce.nhs.uk/option.com.../gid,1164.html - Similar

1. Integrating A&E and Primary Care ‘Out of Hours’ Services - pilot evaluation as to the potential impact of having an ‘out of hours’ General Practitioner in the Accident and Emergency Department

Tribal - Reconfiguration of front door services

A&E cubicles; ambulatory care assessment area; combined assessment unit ... This included Institute for Innovation and Improvement Directory of Ambulatory ... Doc Title www.tribalgroup.com/.../Reconfigurationoffrontdoorservices.aspx - Cached

1. NHS Ayrshire and Arran have been undertaking a substantial change programme in particular reviewing how they can best provide acute services to provide a more sustainable and appropriate range of services for patients. The changes are aimed at improving patient flow through: improved management of unscheduled care; enhanced ambulatory care capacity; enhancing front door care to rapidly diagnose patients.

Putting Patients First > Urgent Care Centre

Building works to create the Urgent Care Centre within the current A&E ... to the appropriate care pathway—either in A&E or in the new Urgent Care Centre ... Doc Title www.chelwest.nhs.uk › Putting Patients First - Cached

Changes to emergency care for our patients

The Urgent Care Centre is the new name for the 'minors' area of A&E. ... In a further improvement, patients arriving with a minor injury to the lower arm or ... Doc Title www.uhns.nhs.uk/.../Changestoemergencycareforourpatients.aspx - Cached

1. Patients with severe illness or injury will be transferred into the Emergency Department, while patients with more minor conditions (usually those not needing to lie on a trolley) will be taken through to the Urgent Care Centre.

Plan

As part of the care pathway, patients may move between the UCC and A&E and vice-versa, and any contract awarded to a successful bidder will provide a fair ... Doc Title www.brentpct.org/.../Summary%20of%20UCC%20Service%20Spec%202nd%20April.do... - Similar

1. Patients upon arrival will be streamed through a single booking system and from that point triaged to the most appropriate healthcare professional. Patients will be seen in the UCC where clinically appropriate, or offered alternative primary/community care as appropriate.

Through one integrated reception, the Urgent Care Centre will provide a means of front-ending emergency and urgent care services with a non-appointment primary care service. The UCC will serve as the patient’s point of access to the Emergency Department at Central Middlesex Hospital. Whilst operating in this integrated way, the UCC must also retain the distinctive culture and approach of a primary care service.

Manage Patient Flow Better at the Front Door... Your ED ...

File Format: PDF/Adobe Acrobat - View as HTML caregivers and better manage patient flow. ➤ Understand how the emergency department
can support enterprise-wide patient flow improvements through the...

Whittington NHS Trust Website: Larkman's Line

In March a new urgent care centre is planned to open. organisation in providing a complete pathway through diagnosis and treatment. All people who currently walk into the emergency department will be seen in the urgent care centre;...

1. In March a new urgent care centre is planned to open. This service is an example of what we want to achieve in the new organisation in providing a complete pathway through diagnosis and treatment. All people who currently walk into the emergency department will be seen in the urgent care centre; those who arrive needing emergency care will go into the emergency department as necessary. Those who present with symptoms that need investigating but are not emergencies will be seen and diagnosed by a GP within the urgent care centre.

Regional Centre for Teaching, Trauma & Tertiary Care Minutes of ...

Emergency Medicine at Royal Sussex County Hospital & Princess...

25 Oct 2010 ... Flows and pathways within the UCC have been developed but are still being modified. The floor which houses the Emergency Department is ...

1. An Urgent Care Centre has been built which is co-located and functionally integrated next to the ED. This has been developed with the PCT in several phases, and GPs currently work within it from 08:00 to 24:00 seven days a week. Flows and pathways within the UCC have been developed but are still being modified.

Service provided

This paper sets out the actions and improvements and has duplicated the format .... in Centre with an Emergency Department/Urgent Care Centre is the optimum ...

1. Patients attending the department are initially steamed into those requiring Walk in Centre treatment and those requiring A&E management. Patients directly requesting the Walk in Centre service or who present with certain medical conditions or asking for specific agreed treatments are directed straight to the ENP service. Other patients who do not fall into this category or who are identified as needing A&E management are triaged or rapid assessed. Following triage, patients are directed to the most suitable areas for treatment.

Joint Health Improvement Programme

1. Following the agreement of a considerable milestone by KHT and NHSK jointly agreeing to implement an integrated Urgent Care Centre (UCC) located within the A&E
Department at Kingston Hospital work has been underway to determine how the service can best be delivered.

The UCC will be managed through KHT so that there are common systems, pathways and governance mechanisms to ensure the safety and efficiency of this service. The UCC will provide a GP led front of house solution, co-located with emergency services in the existing A&E. Non blue light patients will be triaged by the UCC and then be treated within the UCC, the A&E or where appropriate referred back to their own GPs, depending upon clinical protocols that will be developed over the next few months.

Reform Of Urgent Care

File Format: PDF/Adobe Acrobat - Quick View

Urgent Care Pathway. ▪ Patient flows adjusted to maintain maximum capacity and flow ... e.g. GPs/0OH's/Nurses/NP's/AHP's/A&E Drs. Presenting patient pool ...

www.burypt.nhs.uk/.../AI%202.3%20Urgent%20Care%2004022009.pdf