The College of Emergency Medicine

Best Practice Guideline

Frequent attenders in the Emergency Department

August 2014

Summary of recommendations

1. Patients identified as 'frequent attenders' should be subject to senior decision maker review on each attendance to the Emergency Department

2. Patients who attend frequently should have a bespoke management plan to inform clinical management and enhance or standardise safe clinical care. This should be considered in all patients where such a plan will enhance clinical care (for example reducing unnecessary tests or provide clear analgesia strategy)

3. Patients identified as 'very high frequency attenders' (e.g. 30 or more attendances per year) should have a multidisciplinary meeting and case management; including social care and primary care, with a review of the bespoke management plan

4. Patients who are both 'frequent attenders' and exhibit challenging behaviours should be managed according to current guidance [15]. This involves establishing and addressing underlying causes, whilst ensuring safety of patients and staff

5. Patients should be involved all case management and in the production of care plans where possible

6. Persistent and recalcitrant challenging behaviours should only be subject to civil orders in exceptional circumstances

7. There should be a process of identifying 'frequent attenders' in all Emergency Departments, in order to enable implementation of the above. One commonly used method is to identify the current highest frequency attenders to a department

Scope

This guideline has been developed to provide advice to Emergency Departments in the United Kingdom, regarding the management of 'frequent attenders' to the Emergency Department.

Reason for development

There is currently little guidance on the management of Emergency Department 'frequent attenders'. Although there is evidence on the demographic features of these patients, there is little published evidence on the management of the pattern of recurrent attendance. This is a contentious issue, as revealed by the recent interest of the U.K. national press. [1]

Background

'Frequent attenders' have been defined as patients who attend a health care facility repeatedly. The frequency of attendance has been variously defined between 3 and 12 attendances per annum. [2]

The burden of work for 'frequent attenders' is difficult to define, however most estimates are that between 1 and 2% of attendances to U.K. Emergency Departments are made by 'frequent attenders'. [2,3,4] Consistent findings from cohort studies reveal that 'frequent attenders' to Emergency Departments tend also to be frequent users of other health and social care facilities (for example, primary care). [5,6] Additionally, they tend to have a higher triage category, greater rates of admission, and a greater burden of chronic disease, when compared to matched groups. [5,6,7,8]

Frequent users of Emergency Departments are also vulnerable patients, with a higher mortality (including death by violent means and suicide) [9], and greater prevalence of alcohol and psychiatric disorders. [4-6]

There is also consistent evidence that 'frequent attenders' for a department do not constitute a stable cohort [2]; that is, most patients do not persist in this pattern of attendance.

A small number of 'very high frequency attenders' have been identified in a number of studies [2], and it is possible that these patients may have different characteristics to 'frequent attenders', being a more stable population with a lower admission rate. It is possible that this cohort has a higher burden of alcohol and substance misuse and/or psychiatric illness. Anecdotally, presentations appear to increase with crises (either in physical or mental health, or social crisis) and wane again following this crisis resolution.

Reducing attendances

There is a paucity of published interventional studies that provide evidence to support effectiveness of strategies to reduce attendance. This is compounded by the demographic data, definition of frequent attendance and the changing pattern of presentation as described above.

There is unpublished evidence to support the recommendations in this guideline, and the effectiveness of multi-disciplinary approach as described; this is mainly in the form of service reviews. Consequently this guideline should be considered as derived from expert opinion, and based on consensus of the development group or on service evaluations.

A number of measures aimed at reducing attendances have been studied, most with limited success.[2] This may be due to the demographics of the cohort as described above (a non-stable cohort who are more 'unwell'), or due to the differences within the cohort (few studies separate 'frequent' from 'very high frequency' attenders).

Given the complex nature, and acute medical needs of these patients, it is suggested that diversion to primary care services is unsuitable, although care plans and clinical presentation may suggest primary care diversion as an option.

Bespoke management care plans for the Emergency Department attendance, while useful in guiding management of these patients, do not appear to change frequency of attendance, although the evidence is conflicting. [10,11]

Patient education strategies have not been shown to reduce attendance rates [12], and neither have psychological therapies or extended primary care 'status interviews'. [13]

A review of the available literature suggests that the most effective method of reducing attendances is through multi-disciplinary approaches (including social services)[14] however, some authorities suggest patient engagement may prove challenging. [14]

The multi-disciplinary approach should include primary care provider, as well as any psychiatric services (including liaison psychiatry if this service is available); social care input is also important. Other services that are frequently needed and useful are chronic pain services, drug and alcohol teams, and patients' carers. Local ambulance services, and specialist teams (e.g. if the patient has a significant chronic disease) may also be included. These case conferences can be useful in sharing of information or discussion of trigger points that the community teams can help with.

While 'very high frequency attenders' may be identified by departmental staff, not all 'frequent attenders' (as described above) will be; so a system of screening is required. The aim of screening is to identify 'very high frequent attenders' to enable multidisciplinary approaches to commence. It might also be useful to identify 'more frequent attenders' to enable bespoke clinical plans and alerts to be established and ensure safer care for these patients.

Management of attendances

Given the nature of the 'frequent attenders' as described above, each attendance of a 'frequent attender' should be reviewed by a senior clinical decision maker; as these patients are both vulnerable and 'high risk' clinically.

While it is appreciated that 'frequent attenders' may be also defined as 'vulnerable patients', and that standard governance principles exist for patients deemed to be 'vulnerable', it should also be appreciated that there may be associated safeguarding issues both for the patient and their contacts. Consider safeguarding issues in every case, and also consider domestic abuse as a trigger for attendances.

Emergency Department management plans should give consideration to who should see the patient when they attend the Emergency Department, how to reduce unnecessary investigations and how to give consistent care for their usual presentations. It can also be useful to outline previous risks that the patient has evidenced e.g. self-harm and the risk of absconding. Consideration should also be given to what can help reduce a patient's distress when they attend the Emergency Department and whether special measures (e.g. particular observations, chaperone use, particular contacts).

Given the increased prevalence of psychiatric and alcohol disorders in this group of patients, there is anecdotal evidence that exhibition of challenging behaviours can be more common in the 'frequent attender' population. While individual or repeated episodes should be managed according to the current NHS Protect advice (15), persistent episodes have, previously, been managed by civil orders such as 'Anti-social Behaviour Orders'. This is controversial and raises some complex medico-legal and ethical issues (such as patient confidentiality). Any risks to the patient or to staff should be included in the management plan.

Authors

Simon M Smith, Consultant in Emergency Medicine

Duncan Chambers, Consultant in Emergency Medicine

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Acknowledgements

The Best Practice sub-committee has been involved in reviewing this guideline.

Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None.

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

The difference in characteristics, if any, between 'frequent attenders' and 'very high frequent attenders'.

Large interventional studies examining strategies to reduce attendances of 'very high frequency attenders'.

Key words for search

Frequent attenders

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

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The College of Emergency Medicine
7-9 Breams Buildings
London
EC4A 1DT
Tel: +44 (0)20 7400 1999
Fax: +44 (0)20 7067 1267
www.collemergencymed.ac.uk
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