**Service Priorities and Programmes**

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# An audit on outcome and appropriateness of referrals to accident and emergency department in Cheung Sha Wan Jockey Club general outpatient clinic

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## Introduction

Primary health care physicians are important gatekeepers to our heavy-loaded emergency department (AED). Appropriate referrals lead to effective patient management and proper use of public resources.

## Objectives

This audit evaluates the outcome and appropriateness of referrals to AED in Cheung Sha Wan Jockey Club general outpatient clinic which aims at improving quality of patient management and utilization of public resources.

## Methodology

Patients referred to AED had records kept by clinic nurses and those referred in June to December 2013 were reviewed. Attendances of these patients and referral outcome were retrieved from the clinical management system. Criterias for "appropriate" referrals include: (1) hospital admission (2) urgent investigation not available at GOPC (e.g. troponin I, blood gases, CT Brain) (3) urgent treatment not available at GOPC (e.g. IV maxolon, IM analgesic, fast acting insulin for very high glucose status, urgent minor procedures, urgent specialist consultation / treatment e.g. by on-call ophalmologist in AED)

## Result

There were 226 referrals (98 male and 128 female, age ranged 4 months – 96 years) to AED during the period. 77% (174/226) referrals were classified as "appropriate". 21 patients (9.3%) defaulted or refused admission in AED. Medical cases was most commonly referred (64.6%), followed by surgical cases (11.9%). Learning points obtained from this audit: (1) Management of poorly controlled hypertension There were 14 cases referred to AED as "poorly controlled hypertension" (with BP >180/110), which was the second commonest referral reason, following chest pain (24/226). Current guideline from Department of Health suggested referral to AED if there is persistent BP >220/120 despite rest or drug treatment, malignant hypertension with

target organ damage including papilloedema, retinal hemorrhage, heavy proteinuria or encephalopathy. There were 7 cases which didn't fit into appropriate criteria but referring these patients presenting with severe uncontrolled hypertension to AED can still be justified as close monitoring of blood pressure is not feasible due to manpower issue, time constrain and lack of observation room in GOPCs. (2) Management of defaulted / DAMA cases There were 21 out of 226 cases who did not attend AED or discharged against medical advice (DAMA) from AED. Better communications with patients by telling them what would be expected in AED or admissions, potential long waiting time, seriousness and potential complications from their condition would be effective in reducing the defaulted / DAMA cases. (3) Improvement in reducing inappropriate referrals Training on referrals especially to new staff and obtaining feedback from AED officers would be important in facilitating more appropriate referrals. Instead of referring some cases to AED, such as subconjunctival hemorrhage, degenerative joint problems, internal hemorrhoids with mild bleeding, mild anaemia with positive fecal occult blood, atrial ectopics and diabetes with trace ketouria as reviewed in our audit, they could be better managed by closer follow up at GOPC or early SOPC referral.