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The rise of the frequent attender

Emergency centres (ECs) are great places to work, and would be even better if we could simply take away the patients. This would indeed truly revolutionise the way ECs are run. Within an instant we would wipe away those ten-minutes-before-shift-end trauma calls, queues in triage and the load from the 17:00 bus; allowing us to check equipment, clean surfaces, make the beds and restock drug and disposables in peace and quiet, without any undue duress or pressure. Sadly we would not be able to call it an EC any longer as it would only be a place where health care staff gather to, well, check equipment, clean surfaces, make the beds and restock drug and disposables – and that suddenly seems pretty dull. Still, we could do with seeing less of some patients, specifically the repeat attenders (also known as friends, regulars, frequent flyers and other colourful descriptions that we are not allowed to put in print). These patients are believed to be well-known in the EC, know several staff members by first name, know what medications they require by dose, generic and trade name and often have a specific bed or space in the EC which they find comfortable (usually affording a good view of the action).

Frequent attenders are defined rather variably in the literature, although the commonest definition tends to be four or more attendances per year which in the United States encompasses anything from 4.5% to 7% of all EC patients and accounts for about a quarter of all EC visits.[1–5] These patients appear to be either between the ages of 25 and 44 or older than 65 years.[4,6] Contrary to the popular belief that these patients attend with issues which are best dealt with through primary care, the majority tend to be sicker with a higher than average EC mortality rate, usually with a substantial attendance track record with other services as well.[1,3–5,7] Interestingly the highest frequency attenders (more than 20 visits per year) tend not to be included in this sicker, higher majority cohort and when compared to the less than 20-group have fewer admissions to hospital. It is likely that it is these patients that we tend to recognise as the friends, regulars, frequent flyers (and other colourful descriptions that we are not allowed to put in print). The vast majority of frequent attenders believe that they have a true need to be admitted, often in contrast to EC clinicians who firmly believe that they should not.[7] As many of these patients present with problems of a chronic nature (such as renal failure, chronic obstructive pulmonary disease or asthma, etc.), discharge is however, not always guaranteed despite objections from inpatient teams.[7]

As only about a quarter to a third of low frequency repeat attenders tend come back year on year,[3,4,7] the solution seems to lie in EC-patient agreed care plans for the worst offenders.[7–9] A care plan takes into account a patient's particular diagnoses, involves other specialist teams and sets the boundaries within which the patient's EC care and treatment should stay under normal circumstances.[8,9] It is important that the writing of care plans also involve the patient in question where possible. A typical care plan would describe the patient's typical presentation, give details as to how this is to be managed and list the names of the clinicians that were involved with setting up this care plan.[8,9] Our view is that it should not be longer than one side of an A4. This succinct structure allows a frequent attender to receive consistent care, which is less confusing to both staff and patient. It should be remembered that a care plan is part of the patient record and although often kept separate from the patient record, should be treated with the same level of confidentiality.

If that fails, clinicians can always consider the novel approach published by Grant Innes in the Canadian Journal of Emergency Medicine.[10] In his paper, Innes suggests an approach that can be successful for any patient who presents with a diagnosis not immediately discernible as an emergency, where the patient believes admission to be vital but the clinician believes discharge to be vital. His approach describes fail-safe advice to guarantee an admission for those patients you just simply cannot get out of the EC (Table 1). Readers should know that this clinical decision rule has neither been validated, nor the results been replicated outside of St. Paul's Hospital, Vancouver, Canada.

In our December issue, Emilie Calvello explores an emergency care model for Liberia; a fitting description of the progress made in a country, given former Liberian president Charles Taylor's sentencing by the International Criminal Court in April earlier this year. Usha Periyanayagam and Benjamin Terry each give their perspectives on the need for resources to deal with African acute care in their respective papers, highlighting not just the problem but also offering a few innovative solutions. Mark Bisanzo kindly shares the

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Table 1 Successful hospitalisation of patients with no discernible pathology algorithm.

1. Recognise high risk patients and then conceal high risk traits (alcoholism, drug abuse, hypochondriacs, the demented and mentally ill)
2. Avoid the term 'chronic' when making a referral (rather use explosive, paroxysmal or unstable)
3. Select a diagnosis that is exotic, difficult to disprove and mandates hospitalisation (Innes likes to use Tumarken's otolithic crisis, familial periodic paralysis without hypokalaemia, and Oppenheimer's progressive haemorrhagic leukodystrophy)
4. Order a large number of tests. The rule of odds would suggest that some false positives are likely to present, thus strengthening your case
5. Turn on the salesperson in you, i.e. yes hi, I'm so glad to hear it's you that's on as I have this really interesting patient we have been scratching our heads about vs. I'm so terribly sorry to have to refer this frequent attender to you, but ...

Ketamine sedation protocol used for his pioneering study on nurse-led Ketamine sedation with us in Practical Pearls. As one of our favourite drugs for procedural sedation, we would encourage you to print a hard copy, or take out the page and keep it in your pocket for the next time you sedate a patient in order to perform a short procedure. Finally, this issue also sees the first publication of the landmark position statement of the African Federation on Emergency Medicine's (AFEM's) Emergency Nursing Workgroup on emergency nursing practice in Africa. This document – which has been signed off by all nursing groups currently affiliated with AFEM – is likely to become the framework by which nursing care in Africa will be defined, and will be an essential resource for countries, such as Liberia, who are hoping to set up a lasting acute care model. On that note we will end our last editorial for 2012 and wish all our readers a peaceful festive season and a happy New Year.

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