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Optimisation of the Casualty Ophthalmic Services at a District General Hospital

The eye casualty clinic is an important part of ophthalmic services in every hospital. Predicting the number of patients attending such a clinic is difficult. Previous studies have shown that a substantial proportion of those attending ophthalmic accident and emergency (A&E) departments have 'non acute problems' that would be more appropriately referred to the ophthalmic outpatient department, and the majority of conditions seen could be satisfactorily treated by the general practitioner.^{1,2,3} The expanding role of nurses in the setting of the modern outpatient clinic and A&E department allows for more effective time management of the medical staff, thus improving waiting times and patient satisfaction.⁴ Also in addition to performing initial assessment for all patients, a triage nurse may effect the complete management of a select group of patients.⁵

At our unit (Clayton Eye Unit,

Wakefield) we felt a need to reconfigure our casualty clinics to be more efficient. The purpose of this retrospective study was to determine the various problems in efficiently organising the casualty eye clinic, applying departmental recommendation and re-audit to observe any improvement of services.

Material and methods

This retrospective study included data from the casualty eye clinic, at Clayton Eye Unit, Wakefield, from April'05–June'05 (three months). Two casualty clinic sessions operate each working day (10 sessions per week). Total number of new and review patients attending the clinic, along with range of patients and average number of patients per clinic were determined. Appointments were made by nursing staff on casualty paper sheets. Depending on the above data the following problems were observed:

- Unequal / overbooked clinics
- Double appointment time booking (because of paper appointment booking system)
- Too many review patients in casualty clinic (blocking the new patient slots)
- Inappropriate referrals (lack of proper triage protocol)
- Attendance without appropriate appointments.

All of the above observations resulted in casualty clinics that were not properly organised. Based on the above results clear departmental recommendations were introduced to reconfigure the casualty clinics. These included:

- The creation of fixed 13 clinic slots (six new / seven review) at 15 minute intervals each on PAS (Patient Administrative System).
- The abolition of paper appointments and introduction of appointments through PAS only.
- The introduction of departmental triage protocols for the nursing staff attending the casualty helpline calls. This helped staff to prioritise the urgency of the appointment to decide and book new appointments (if the decision is difficult because of complexity of the case than the on-call doctor is contacted).
- A ceiling on appointments such that casualty clinic should not be overbooked for more than 13 patients. Any extra casualty patient needs to be seen after hours by the on-call doctor at the most appropriate time (or before depending on the emergency).
- Appropriate referral pathway. All patients seen in casualty clinic should have an appropriate referral

Table 1.

		April'05-June'05		Sept'05–Nov'05	
No. of casualty clinic sessions (range)		98 (7–23)		104 (10–14)	
Total no. of patients	Average no. of patients / session	1545	15.79	1328	12.76
Total no. of new patients	Average no. of new patients per session	663	6.79	583	5.61
Total no. of review patients	Average no. of review patients per session	882	9.0	745	7.15

There were large numbers of patients attending for review in casualty clinics, which in turn reduced the number of appointment slots available for new patients; this contributed significantly for overbooking of casualty clinics

(for example from GP, optician, A&E department etc.).

- Review slots made available for patients needing review within one week. Patients who need review after one week are booked into general / speciality out-patients clinics. This reduces the number of review visits in the acute clinic.

The above recommendations were implemented and data was collected from Sept 2005–Nov 2005 to observe any improvements in the service.

Results

At Clayton Eye Unit, Wakefield, prior to instituting changes, two casualty clinic sessions operated each working day, accounting for 10 sessions per week. Data from April'05–June'05 (three months) included total 1545 patients (663 new and 882

review) from 98 sessions with an average of 15.76 patients (average of 6.76 new and 9.0 review) per session. The range was 7–23, which meant that some clinics had only seven patients and on the other hand some clinics had as much as 23 patients. Thus the clinics had unequal distribution of workload.

After the recommendations were implemented for the casualty clinics and data was re-collected over a similar three month period (Sept'05–Nov'05). It included total 1328 patients (583 new and 745 review patients) from 104 sessions with an average of 12.76 patients (average of 5.61 new and 7.15 review) per session. The range was 10–14 thus leading to much more even distribution. The number of extra patients seen by the on-call doctor after hours on an average was about one per day.



Clayton Hospital, Wakefield.



Dedicated ophthalmic staff at Clayton Eye Centre.

Discussion

Casualty clinics are an integral part of all ophthalmic units. The number of patients referred to the casualty clinic is usually unpredictable. In our study, the casualty clinics initially had quiet a variation in the distribution of patient numbers (7–23 patients per clinic). This resulted in some clinics being short and others too heavily overbooked. There were large number of patients attending for review in casualty clinics, which in turn reduced the number of appointment slots available for new patients; this contributed significantly for overbooking of casualty clinics.

After implementing the recommendations the subsequent clinics were more uniform, regular (10–14 patients per clinic) and identical in patients distribution and workload. There was significant reduction in total number of review patients in casualty clinics and hence more slots were available for new referrals. The clinic format developed on PAS comprised of alternate appointment slot of a new and review patient helped in running the casualty clinic on time (as we found that new patient needed longer consultation time whilst review patient needed shorter consultation time). The departmental triage protocol also helped the nursing staff to make appropriate decisions regarding when to accept new referrals to the casualty clinics for most of the time.

Hence we concluded that a proper and organised ophthalmic casualty clinic can help the medical and nursing staff to provide the high standards of clinical care in the best possible and efficient way. **EN**

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Take Home Message

- Proper and organised ophthalmic casualty clinic is essential for the medical and nursing staff to provide the highest standards of clinical care in the best possible and efficient way.
- Departmental triage protocols are valuable tool for the nursing staff for triaging and allocating the appropriate appointment for new referrals to the casualty clinic.