

Emergency (108) calls to the ambulance service in the state of Gujarat (India) that do not result in the patient being transported to hospital: an epidemiological study

A Pandey, R Ranjan

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Abstract

Objective: To describe the demographic and clinical characteristics of patients who are not transported to hospital after an emergency (108) call to Gujarat EMRI emergency response center, the reason for non-transportation, and the priority assigned when the ambulance is dispatched.

Methods: All non-transported patients from 1 December 2008 to 28 February 2009 were identified from the ambulance service command and control data. Epidemiological and clinical data were then obtained from the patient care record completed by the attending emergency medical technician (EMT) and compared with the initial critical code that determined the urgency of the ambulance response.

Results: Data were obtained for 22186 patients who were not shifted during the study period. Less than one per cent of these calls were labeled critical (the most urgent category) at the time the call was received. Trauma (vehicular) accounted for 30.3% and pregnancy related emergency cases 16.1% of all non-transported calls. This group of patients were predominantly young adults (between 20 to 30 yrs old) and the majority (more than 99%) were identified as less urgent (non critical) at telephone triage. The mean time that an ambulance was committed to each non-transported call was 2hrs 67 minutes per day.

Conclusions: This study shows that trauma (vehicular) account for a significant proportion of non-transported 108 calls inspite of assigning high priority when the call is first received. There could be major gains if some of these patients could be triaged to an alternative response, both in terms of increasing the ability of the ambulance service to respond faster to clinically more urgent calls and improving the cost effectiveness of the health service. Classifying calls into critical and non critical for dispatch system has been shown to be sensitive but this study suggests that its specificity may be poor, resulting in rapid responses to relatively minor problems. More research is required to determine such prioritisation can reliably and safely identify 108 calls where an alternative to an emergency ambulance would be a more appropriate response.

INTRODUCTION

Each year, in the state of Gujarat (India), a large number of emergency (108) calls received by ambulance services do not result in a patient being transported to hospital. These calls have implications both in terms of how rapidly an ambulance can respond to other emergencies and the efficiency of service delivery.¹ To date, little has been published on this group of 108 calls.

Chen et al² in Taiwan reported that 32% of all ambulances dispatched led to no patient being transported. In the United States, Hipskind et al³ found 30% of ambulance responses resulted in the patient refusing transportation. These patients

were commonly asymptomatic, 11–40 years old and involved in motor vehicle accidents. However, this study did not investigate calls where the ambulance crew decided not to transport the patient and differences in the organisation and delivery of emergency health care may limit the relevance of such findings in the UK.

Currently, in England and Wales, 17% of patients are not conveyed to hospital after an emergency ambulance has attended a 999 call.⁴ Ambulance services are not required to transport all patients to an accident and emergency department⁵ and the Department of Health has now permitted careful piloting and evaluation of alternative ways of responding to the least serious (category C) emergency

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calls.⁶ While this has resulted in considerable interest in implementing service developments, till date no ambulance operator in India has carried out an audit of non-transported calls.

Several studies have investigated the inappropriate use of the emergency ambulance service in the UK and provided estimates ranging from 16% to 52%.⁸⁻¹¹ Victor et al⁸ recently studied one week's calls to the London Ambulance Service and reported that while the majority of calls required a 999 response, 40% could have been dealt with by primary care, psychiatric services, or social services. Non-transported calls (20%) were not identified as a separate category in this research, but it might be anticipated that a significant proportion did not need an emergency ambulance response.

Priority based dispatch systems have been introduced by nearly all ambulance services in the UK and are designed to match the urgency of the ambulance response to the clinical needs of the patient. The Advanced Medical Priority Despatch System (AMPDS)¹² uses structured protocols and systematic questioning of the 999 caller to assign a series of alpha-numeric codes and is currently used by over 75% of ambulance services.

In this study we describe, for the first time in India, the epidemiology of the group of patients who were not transported to hospital after an emergency (108) call, the priority assigned at that time, and the reasons for non-transportation.

METHODS

Non-transported cases were defined as those cases where a 108 call was made, an ambulance from any one of the 400 ambulance stations of Gujarat EMRI attended the scene, but the patient was not conveyed to hospital. Cases where the patient was dead before the arrival of the ambulance and those where the call was malicious were excluded. The computer databases that hold both the Command and Control data and information scanned routinely from patient care records completed by the ambulance EMTs¹⁴ were searched to find the first 500 non-transported cases starting from 1 December 2008. The sample size was determined to provide 95% confidence limits of $\pm 5\%$ for each variable with an allowance made for missing data. The patient report forms for these cases were further examined by manual inspection. Clinical categories were attributed to each case after examination of the free text description of the incident recorded on the patient care record. Each case was

categorised by two researchers (AP and RR) using a system devised by the authors. Where there was disagreement about categorisation the case was discussed and a consensus reached.

Data collected comprised age, sex, type of residence, critical / non critical case assigned by emergency response center, clinical category, whether patient had been drinking alcohol, and the reason the patient was not transported to hospital. The time each ambulance was committed was also calculated. This was taken as the interval between the call being passed to the ambulance crew and the time when they became available to respond to another call.

Proportions, means, medians, and 95% confidence intervals were calculated using SPSS for Windows version 9.0.

RESULTS

22186 cases where data were extracted from the patient report forms, the age distribution (fig 1) shows a distinct peak in young adults in age group 21 to 30 yrs. Men accounted for 63.8% of the cases studied.

Figure 1

Figure 1 Age distribution of all non-transported patients.

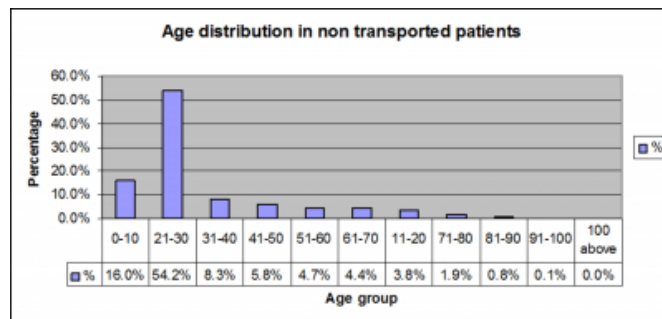


Figure 2

Figure 2 Clinical categories of non-transported patients

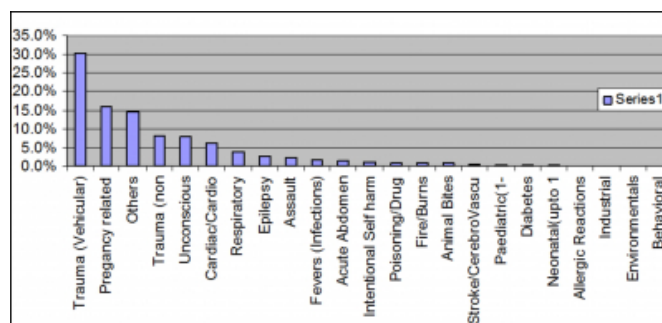


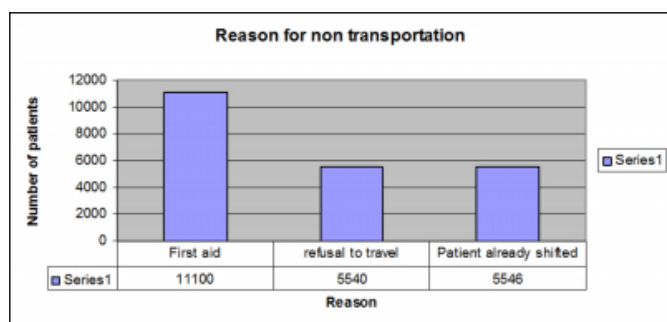
Table 2 shows the reasons for non-transportation. In almost half the cases the reason is recorded as no emergency / first

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aid, in a quarter refusal to travel, and in the rest- patient was already shifted before arrival of 108 ambulance. Trauma (vehicular) was the commonest clinical category for both the refusal to travel (56%) and no injuries (51%) groups, whilst general assistance (13%) was the largest category where the reason for non-conveyance was that a GP visit had been arranged.

Figure 3

Table 2 Reason for non-transportation given by ambulance crew



Criticality codes were available for 16196 (73%) cases. Of those with codes available 213 (0.8%) were critical cases (the most urgent code) and rest 15983 were non critical cases. The mean time the ambulance was committed was 2hrs 67 minutes per day and median 2hrs and 33 minutes (standard deviation 17 minutes, interquartile range 24–43 minutes).

TRAUMA (VEHICULAR)

Trauma (vehicular) accounted for 6733 (30%) of the non-transported calls. The mean age of non-transported cases presenting with falls was 19 years (median 18 years, SD 20, interquartile range 68–86 years).10592 (31.78%) were Male and 6% were linked to alcohol.

DISCUSSION

This is the first Indian study to describe the epidemiology of non-transported 108 calls and link these data to the criticality code used to determine the priority of the ambulance service response. However, there are a number of limitations in the study design.

There was no independent validation of the clinical assessment made by the ambulance crew nor did this study follow up non-transported patients to establish the clinical outcome after the ambulance left the scene. In addition, few criticality criteria were recorded by the crews after they had attended the patient so no comparison could be made with

the initial code assigned by the call taker. Therefore, it was not possible to confirm from our data whether the decision not to transfer the patient to hospital was appropriate or to analyse whether the urgency assigned to the call by emergency response center was justified by the clinical need.

Clinical data on the nature of the incident could not be easily extracted from the routine computer database. Therefore the authors had to develop their own coding system to categorise the free text description of the incident on the patient report form and this limited comparisons between our survey and other published research. Manual inspection also introduced possible observer error into the study findings but this was minimised by two of the authors independently categorising each call.

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Author Information

A. Pandey

Senior Partner, Emergency Medicine Learning & Care, EMRI, Ahemadabad, Gujarat, India

R. Ranjan

Associate Partner, Emergency Medicine Learning & Care, EMRI, Ahemadabad, Gujarat, India