CONSULTATION PAPER:
CLINICAL EXCEPTIONS TO THE 4 HOUR EMERGENCY CARE TARGET

Introduction

1. This discussion paper has been developed by the Department of Health's clinical advisers in conjunction with senior representatives of the British Association for Accident and Emergency Medicine, the Faculty of Accident and Emergency Medicine and the Royal College of Nursing Accident and Emergency Nursing Association.

2. Improving the experience in emergency healthcare is a priority for patients and is a top government priority. High quality clinical care is paramount.

3. As part of this improvement, the NHS Plan has a target that no patient will spend more than 4 hours in an A&E department by 2004.

4. It is vital that this target must not in any way jeopardise the quality of clinical care offered to patients. Clinicians are agreed that there are some circumstances where more than 4 hours care in the emergency department or under the care of emergency care specialists may be the most appropriate clinical care. However, if patients have to spend a prolonged period being assessed then they should, whenever clinically appropriate, be in more comfortable surroundings than the hustle and bustle of the main A&E department and they should have a planned and productive period of clinical care

5. This paper aims to delineate the clinical exceptions to the four hour target and associated issues. The information applies, as does the NHS Plan target, to all types of A&E departments, including minor injury units.

Patients who spend more than four hours in A&E

6. There are two main groups of patients who may clinically benefit from more than 4 hours of care by the A&E team:

   (a) those who need the facilities of the main A&E department, often the resuscitation room (true clinical exceptions - see paragraph 9);

   (b) those who are cared for by Emergency Medicine specialists but do not need the specific facilities of the main A&E department (i.e. best cared for in a ward environment e.g. observation ward, clinical decision unit, assessment ward, that is adjacent to the main A&E department. – see paragraph 13);

7. Clinicians agree that almost all patients attending A&E could be assessed and either discharged or admitted within 4 hours if appropriate systems and processes were in place and resources were available.

8. If the delay in patients leaving the A&E department is due to resource constraints rather than clinical reasons then it cannot be considered an exception. Lack of an appropriate bed for a patient is not considered a clinical exception. For example if a patient needs a critical care bed and resuscitation is complete but no bed is available and they remain in A&E for over four hours, this will be counted as a breach of the target. However, clinical practice must not be distorted in order to achieve time targets e.g. sending this patient to an inappropriate ward or bed. Similarly, patients awaiting transfer to another unit are not exempted unless the delay is to optimise the person's clinical state. The overriding principle must be whether the extra time adds value from the patient's perspective. Other network partners, including PCTs and other community providers should be engaged to ensure patients, if fit to return home, do not remain in A&E after assessment due to lack of community support services including, for example, 24 hour nursing and home care support.

Clinical Exceptions

9. The number of patients who need to remain in the main A&E department for more than 4 hours for clinical reasons (true clinical exceptions) is very small – certainly less than 1% of A&E attenders. These will usually be:

   (a) patients in the resuscitation room undergoing active resuscitation whose clinical condition would be jeopardised by the transfer to another area, e.g. ITU, specialist hospital;

   (b) patients who unexpectedly deteriorate and need the continued care of A&E specialists.

   These groups above are the only exceptions to the 100% target, where it is believed that their clinical care is best undertaken in the main A&E department.

10. The diversity of clinical situations where this occurs is too large to allow strict definitions. We therefore propose that a system of local monitoring would be most effective, with reporting for all such patients that is subject to an audit process.

11. A local system of auditing and peer review of such exceptions as outlined in paragraph 9 should be developed by trusts to allow continuous improvement to occur. Systems to audit all 4 hour breaches will complement this audit of clinical exceptions. Good practice will include involvement of users in the auditing process

12. Strategic Health Authorities would be expected to agree the local monitoring systems.

Other patients spending over four hours in A&E

13. Patients in the second group (needing clinical care beyond 4 hours but not within the main A&E department see paragraph 6(b)) may make up 5-10% of A&E attenders. **All these patients could be effectively cared for in an appropriate ward environment (e.g. observation ward or clinical decision unit or emergency assessment ward) and therefore they should not remain in the main A&E department.** Such patients will rarely need more than 24 hours of care in this type of ward environment before discharge or admission to a specialty ward. The number of these patients is liable to increase as the specialty of emergency medicine develops and undertakes more prolonged assessments in order to reduce admissions and avoid unsafe discharge. This model of care is likely to be preferred by the patient and to be cost effective. The following types of patients fall into this group:

    (a) patients needing a short period of intensive investigation to rule out serious illness who are liable to go home (e.g. patients with chest pain who need tests several hours after onset of the pain);

    (b) patients needing a period of a few hours recovery (e.g. following sedation to enable a dislocation to be treated or after alcohol/drug ingestion);

    (c) patients requiring a period of brief treatment with the expectation of going home (e.g. a person with mild dehydration who is given some fluids over a few hours);

    (d) patients requiring observation, (e.g. after a seizure to ensure full recovery and no further fits or after possible ingestion of excessive amounts of drugs);

    (e) safety considerations (e.g. an elderly tourist who lives a long way from the A&E department may be safer kept in A&E overnight than traveling home in the middle of the night).

14. Prolonged processes such as complex mental health assessments or child protection assessments should be undertaken in an appropriate setting. Such assessments should only take longer than four hours if the process is delayed for clinical reasons. Delay in the initial assessment and/ or treatment or in the response from other agencies is not acceptable wherever the patient is situated. In most cases it is possible to undertake these assessments in less than four hours.

15. The ward environment in which these patients (ie, those described in paragraphs 13 and 14) are cared for must be an appropriate environment with appropriate facilities. This means it must meet the present Sitrep definitions for admission, such as being in a bed with appropriate privacy and toilet facilities in an observation ward or clinical decision unit or emergency assessment ward. The key factor is that the

patient must feel that it is an appropriate environment for a stay of over four hours. These areas should be close to but distinctly separated from the main A&E department. They should not be included in the A&E department total time figures. It does not matter who is clinically in charge of the patient from the point of view of the time standard and clinicians can determine this locally, although it is likely that it will be the A&E consultant in most trusts.

16. Where these units exist at present they have a variety of names (observation wards, clinical decision units, assessment wards). At present, the provision of such facilities is varies between trusts. In order to achieve the four hour target and maintain high clinical standards, PCTs and trusts should urgently consider how they can make such facilities available to all A&E departments, with adequate bed capacity and staffing. The capacity of such facilities will be highly variable according to local practices and casemix. These facilities must not be used for "holding" patients who are known to require admission. The proper functioning of these assessment facilities must be based on the same principles as those described in the assessment unit checklist available at http://www.doh.gov.uk/emergencycare/emergencyassmentchecklist.htm and will often include a duration of stay limited to a maximum of 12 hours.

Next Steps

17. The BAEM, FAEM and RCN will develop clinically-based guidance regarding the functioning of these units and the exception reporting. This will ensure that clinical professionals have full ownership of clinical exceptions.

Conclusion

18. In summary, the target remains at 100% of patients leaving A&E within 4 hours. There is a very small group who will be excluded from being measured against the four hour target for clinical reasons. Others may be treated by the A&E team but in an environment more suited to prolonged clinical management than the main A&E department.