

# CLINICAL EXCEPTIONS TO THE 4 HOUR EMERGENCY CARE TARGET



## Introduction

1. This 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 Emergency Care Association. It represents the final and agreed version of the draft published for consultation on 11 September 2003.
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 emergency (i.e. A&E) department by 2004.

## Clinical responsibilities

4. It is vital that this target must not in any way jeopardise the quality of clinical care offered to patients. Clinicians, who are ultimately responsible for making these judgements in individual cases, are agreed that there are some circumstances where more than four hours care in the emergency department may be the most appropriate clinical care. However, if patients have to spend a longer period being assessed then they should, if clinically appropriate, be accommodated in the emergency department clinical decision unit/observation facility where they should have a planned and productive period of clinical care.

## Clinical exceptions and breaches of the target

5. The paper distinguishes between:
  - (a) clinical exceptions. Circumstances where the only considerations are clinical - that is, when the emergency department offers the only appropriate facilities and expertise that are suited to the patient's current condition. This represents an unpredictable set of circumstances where, in the judgement of the senior emergency department doctor and nurse involved, the patient's condition mandates a stay in the emergency department of greater than four hours; and
  - (b) breaches of the target. The cases where the emergency department is the best available option for the patient but only because equally appropriate alternative facilities are full, or out of action - for example, the only specialist bed is occupied. These represent failures of the system that are predictable and could be pre-empted, for example failure to generate available beds in time for the patients requiring admission.

6. Clinicians' decisions about the most appropriate care for patients must take priority whether or not this results in a patient spending over four hours in the emergency department. This means that:
  - (i) if a clinician decides that the safest place for a patient is the emergency department, the patient should remain there until it is safe to move them; and
  - (ii) patients should not be admitted solely to avoid a breach of the four hour target. Clinicians should admit patients only to appropriate facilities and only when it is appropriate to do so.
7. The standard expected for all patients who are not clinical exceptions, including all patients with less serious injuries or illness, remains that set out in the NHS Plan. Breaches of the target should become increasingly rare as, for example, more appropriate use is made of good quality clinical decision units or observation units.
8. To allow for clinical exceptions, for performance management purposes all providers of emergency care will be expected to maintain performance of at least 98% against the four hour target from 1 January 2005.
9. This paper delineates the clinical exceptions to the four hour target and associated issues. The information applies, as does the NHS Plan target, to all types of emergency departments, including minor injury units, although by definition it is unlikely to be relevant outside a department that deals with critically ill/injured patients.

Professor Sir George Alberti  
National Clinical Director for Emergency Access

John Heyworth  
BAEM

Lynda Holt  
RCN Emergency Care Association

Alastair McGowan  
FAEM

## **PATIENTS WHO SPEND MORE THAN FOUR HOURS IN AN EMERGENCY DEPARTMENT**

1. There are two main groups of patients who may clinically benefit from more than four hours of care by the emergency department team:
  - (a) those who need the facilities of the main emergency department, often the resuscitation room (true clinical exceptions - see paragraph 4);
  - (b) those who are cared for by Emergency Medicine specialists but do not need the specific facilities of the main department (i.e. best cared for in a ward environment, for example an observation ward or clinical decision unit that is adjacent to the main department. – see paragraph 8);
2. Clinicians agree that almost all patients attending an emergency department could be assessed and either discharged or admitted within four hours if appropriate systems and processes were in place.
3. If the delay in patients leaving the department is due to resource constraints rather than clinical reasons then it cannot be considered a clinical 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 the department for over four hours, this should not be counted as a clinical exception.
4. 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 optimize the patient's clinical state. The overriding principle must be that the extra time adds clinical 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 the emergency department after assessment due to a lack of community support services including, for example, 24 hour nursing and home care support.

### **Clinical Exceptions**

5. The number of patients who need to remain in the main emergency department for more than four hours for clinical reasons (true clinical exceptions) is very small – probably less than 1% of emergency department 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;

(b) patients who unexpectedly deteriorate and need the continued care of emergency department specialists.

(c) patients who, despite the efforts of the emergency department team are expected to die imminently, should not be moved.

6. **The only exceptions to the target are those cases where it is believed that clinical care is best undertaken in the main emergency department.**
7. The diversity of clinical situations where this occurs is too large to allow strict definitions. Neither does the Department of Health intend to require trusts that maintain performance of at least 98% to account for individual cases.
8. Nevertheless, trusts should develop a local system of auditing and peer review of such exceptions as outlined in paragraph 4 to allow continuous improvement to occur.

#### **Other patients spending over four hours in A&E**

9. The second group of patients are those needing clinical care beyond four hours but not within the main emergency department - see paragraph 1(b). Many of these patients will be able to be discharged safely following a period of observation or investigation in the emergency department clinical decision unit/observation ward (see paragraph 11). Those patients who are likely to require admission for more than 24 hours should be admitted to the acute assessment ward/admission area. This decision should be made by the senior clinical decision maker in the emergency department. 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 patient may be safer kept in the department overnight than traveling home in the middle of the night).

10. 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.

### **Ward environment**

11. The ward environment in which these patients (i.e. those described in paragraphs 9 and 10) 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 adjacent to the main emergency department and would normally be under the control of emergency department staff. They should not be included in the 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 emergency consultant in most trusts.
12. 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 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 emergency 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/emergencyassessmentchecklist.htm> and will often include a duration of stay limited to a maximum of 12 hours.