The four hour operational standard – is it safe?

Gemma Davies
Matron, Mid-Essex NHS Trust
What is it?

- Every ED has to see, treat and admit or discharge 95% of patients within 4 hours.
- Introduced in 2004 – for the next 5 years the overall nationally was 96% - 98% but has now dropped significantly (88% in 2014/15).
- 2 distinct pathways: Admitted
  Non-admitted
How

- Development of minor injury/walk-in-centers
- Early interventions
- Workforce planning
- Fast track access to services
Why?

- To drive up standards
- Right care, right place, right time
- Streamline services
- Prevent ‘avoidable’ harm’
Avoidable Harm

- Pressure ulcers
- Acute Kidney Injury
- Delirium/confusion
- Falls
Responsive

- Stroke services – pre-alert for thrombolysis/protected HASU
- Gynecology
- Ambulatory Care – pathway dependent
- Rapid Early Senior Assessment (RAT/ESAT models)
- Nurse led assessment
- Major Trauma Centers
- FFT
But are we safe?

The standard which was set in 2004 is now only being met by 10% of all Trusts across England and Wales. More Trusts are being placed in special measures with the focus on ED performance and what is termed ‘exit block’. No one really knows what the reasons are for this perceived ‘failure’

Data from NHS England shows that numbers have risen but not exponentially and that the non-admitted pathway is adhering to the standard but is the non-admitted pathway which is predominantly causing the failure.
The implications of ‘failure’

We know that if patients spend longer than 4 hours in our ED’s the risk of them coming to ‘harm’ is increased.
It also increases the amount of patients in the department with trolleys becoming blocked and ambulances queuing outside.
The workload of the department increases with patients not getting the reviews and clinical input they require.
Trusts suffer ‘reputational’ damage.
Media and external stakeholder scrutiny increases.
Some Trusts become part of improvement programs.
Harm

- Mortality (death)
- Morbidity
- Failure to diagnose and treat (sepsis)
- Sub-optimal care (nursing input/comfort rounds)
- Poor levels of documentation
- Missed diagnostics
- Delay in overall length of stay
Improving flow within the Trust

Initially the standard was seen as an ED standard but it is more widely accepted that it is a Trust standard.

- Better management of in-patient delays
- Improving relationships with social care
- Increased and timely access to diagnostics
- Working proactively and not reactively
- Tracking journeys
Improving flow within the ED

- Streaming
- Journey tracking
- Escalation tools and Trigger points
- Inter Professional Standards (IPS)
- Board rounds
- Creation of Observation Units/Frail Elderly Units
- Multi-disciplinary working (physio/Occupation Health)
- Development of Advanced /Care/Nurse Practitioners
So, do we cause harm?

- The most vulnerable are the patients being delayed
- To fully understand there would need to be a ‘deep dive’ through thousands of notes and a huge audit conducted:
  - Was the expected LOS exceeded
  - Did the patient develop PU/AKI whilst an in-patient
  - Did they die when it wasn’t expected

This has not been done as Trusts report to their local Trust Development Authorities and not nationally.