# ABSTRACT

**Aims and objectives.** To understand nurses’ views and experiences of four hour treatment targets in the emergency department and how this impacts clinical decision making throughout acute secondary care hospitals.

**Background.** In many countries national treatment targets in the emergency department have been introduced. However, research and a recent enquiry into poor clinical care in one hospital in the United Kingdom have highlighted that patient care may be compromised by the need to meet these targets.

**Design.** Qualitative descriptive study as part of a case study approach.

**Methods.** Semi-structured interviews with 31 nurses working in UK secondary care hospitals which had an emergency department. Nurses were purposively sampled from three specialties: emergency arenas (emergency department, n=5; medical assessment n=4 surgical receiving n=2) (n=11), surgical wards (n=11) and medical wards (n=9).

**Results.** Nurses in emergency arenas reported considerable burden, in terms of a very high workload and pressure from senior staff to meet the target. This had a negative impact on patient care for the majority of patients, excluding the most sick, who emergency arena nurses reported they ensured were treated appropriately, regardless of breaching treatment targets. Around half of the nurses working outside emergency arenas felt pressure and amended their work practices to enable colleagues in emergency arenas to meet treatment targets.

**Conclusions.** Four hour targets were not viewed as clinically helpful by the majority of nurses, some of whom questioned their appropriateness for patient care.

**Relevance to clinical practice.** Policy makers and senior managers should consider the suitability of treatment targets in the emergency department, particularly in relation to working conditions for nurses and other health professionals and its potential for negative impacts on patient care. Whilst targets remain in place, senior nurses and managers should support nurses who breach the target in order to provide optimum clinical care.

**Key words:** emergency care; Emergency Department; nurses; nursing care; health care; health care administration; work environment; qualitative; targets; discretion.

**What does this paper contribute to the wider global clinical community?**

* Nurses in emergency arenas bear a disproportionate amount of the burden of meeting treatment targets.
* Nurses reported that they actively resisted four hour targets when patients were critically ill, in order to ensure patient safety. Patients who were moderately ill sometimes received sub-optimal treatment in order to meet targets.

**INTRODUCTION**

Over the past thirty years, government initiatives within many western countries have become increasingly target-driven, and this has been clearly apparent in health care policy (Ham, 2009). As part of this agenda, targets for treating, transferring and discharging the majority of patients in a particular timeframe from Emergency Departments (EDs) have been introduced in many English speaking countries. Treatment targets range from a maximum of four hours in the UK (Department of Health, 2001) and Australia (Queensland Government, 2014), six hours in New Zealand (Ministry of Health, 2014) to twelve hours in Canada (Ministry of Health and Long-Term Care, 2014). The official rationale for such targets was severe overcrowding within Emergency Departments (EDs), which resulted in patients waiting for too long to be treated within EDs or, following a decision to be admitted, awaiting further treatment in corridors (Mason *et al.,* 2012; Weber *et al*., 2012; Moskop *et al.,* 2009)**.** However, in an era of evidence based policy the use of a treatment time target which varies between countries has been controversial, as there does not appear to be any empirical evidence as to why particular targets have been chosen (Mason *et al.,* 2012).

It has been reported that these targets are regularly breached, and here has been much media attention on this performance measure within hospitals (see for example: Triggle, 2013). Moreover, there has been an increased focus on four hour targets in United Kingdom’s NHS hospitals[[1]](#footnote-1) since the enquiry into poor nursing care at Mid Staffordshire NHS Trust (Francis, 2013). Despite their increasing prominence worldwide, little research has been conducted into the implications of these targets for front-line nursing staff. Drawing on 31 semistructured qualitative interviews with nursing staff from a large UK inner city hospital, this article explores how nurses viewed four hour targets and the influence this target had on their day-to-day work.

# BACKGROUND

The study of how front line workers used discretion began in the 1980s (Lipsky, 1980). Within this academic context, discretion was defined as front line workers having the power to determine access to public services, including publically funded medical treatment, and often providing immediate, face-to-face decisions (Lipsky, 1980). It has been argued that discretion is necessary as part of clinical judgement and to retain patients’ confidence (Armstrong, 2002), although challenges to nurses’ discretion have been noted (Kramer et al., 2007). However, there has been a dearth of research examining how health professionals use discretion and navigate targets. Research has found that nurses were most likely to follow local guidance and clinical guidelines if they were adequately resourced (Wells, 1997), clear, and fit with both local practice (Bregen, 2005) and the nurses’ own beliefs (Provis and Stack, 2004; Kramer *et al*. 2007). Accordingly, the extent to which nurses follow targets can be related to factors within themselves, local teams and local and national policies, and this will impact the way in which targets are implemented when nurses are required to make quick decisions and use their clinical autonomy.

Within the UK NHS, nationally determined targets dictate organisation strategy, resource allocation and evaluation of performance (Som, 2009). The introduction of a four hour target for ED waiting times can be seen as an example of this type of policy making. Official statistics reported that 94% of patients were seen within the four hour target set for EDs within Scotland in 2013 (Scottish Government, 2013). However, it has been suggested that hospitals have employed dubious management tactics and suspicions have been raised that hospitals were dishonest in their reporting (Hughes, 2010; Mason *et al.,* 2012; Weber *et al.,* 2012). In addition, there were cases which suggested that patients were moved to clinical decision units[[2]](#footnote-2) (CDU), incoming patients were waiting in ambulances, patients were admitted unnecessarily or discharged inappropriately early and that data was miscoded (Bevan& Hood, 2006; Gubb, 2007; Mayhew *et al.,* 2008).

The effect of four hour targets on patient care is contested. Mortimore and Cooper (2007) reported that the target was an overall success in reducing waiting times, but found there were concerns regarding the imposed nature of the target, workload pressures and quality of care. Whilst Kelman and Freidman (2009) were unable to find any evidence of a negative effect of the target, others have found that the targets distorted clinical needs (Gubb, 2009), devalued the patient experience (Bevan & Hood, 2006); resulted in unusual discharge timings and that time to clinician had not decreased (Freeman *et al*., 2010). Research within England found that of all clinicians, nurses were most actively involved in attempting to meet the target, although interviewees reported that the organisation of the hospital, which nurses have little control over, was central to being able to meet the target *(*Weber *et al*., 2010).

During 2013, the four hour ED target was brought to the UK public’s attention as a result of serious concerns regarding treatment at the Mid-Staffordshire Hospital Trust, which was investigated by a Public Inquiry. Within the inquiry’s report (Francis, 2013) it was suggested that patients within the ED were prioritised by the nurse in charge according to the amount of time they had been waiting, as opposed to their clinical need, to avoid breaching the four -hour target within a considerably understaffed and high pressured environment. Significant problems were reported within the ED, where staff reported being asked to inaccurately record the time that patients were within the department, or to subsequently alter the paperwork, if the patient had breached the four hour target. The Francis report highlighted that “there was generally a lack of evidence of appreciation of the potential unintended consequences for individual patients of implementing policies, for instance in relation to targets” (Francis, 2013: 20.17).

The Francis report in its recommendations for nurses focused on the training of nursing staff, and leadership. It suggested that there needed to be a focus on caring, compassionate and considerate nursing. However, there was no mention of the impact of targets or management decisions on the workloads of the nursing staff. In the UK Nursing and Midwifery Council response to the Francis report, the issues of workload pressures and meeting targets within the workplace were also not reported (NMC, 2013). The government response stated that: ‘**Targets or finance must never again be allowed to come before the quality of care.**’ (Department of Health, 2014: 7, emphasis original). However, the report did not consider removing the four hour target, but instead sets a requirement for reporting of staff levels and a further target for undertaking appraisals with staff. The Nuffield Trust (2014) report that in the year since the Francis report, little progress has been made in changing the culture within UK hospitals.

# DESIGN

**Aims**

To explore nurses’ views and experiences of four hour treatment targets in the emergency department and how this impacts clinical decision making throughout acute secondary care hospitals.

## Participants

We used a flexible approach for gaining access to and recruiting participants, as is often the case when recruiting professionals (Feldman *et al.,* 2003), including health professionals (author 2, self citation, 2013), into qualitative research. This meant some participants were recruited by us approaching individuals on the wards and asking for participation. In other areas, the Ward Manager disseminated information sheets and then provided us with the details of those willing to participate. The clinical areas included in the study were acute medical and surgical wards along with ED, surgical receiving and acute medical receiving.

All 31 participants were front-line nursing staff based in five departments with a large inner city hospital in Scotland, UK. Interviewees were registered nursing staff who were employed as nurses on the Agenda for Change pay scale between Band 5 (the lowest role exclusively available to qualified nurses) and Band 7 (a role including significant managerial duties, for example, managing a ward), Table 1 shows participant demographics.

INSERT TABLE 1 ABOUT HERE

## Data collection

We used a case study approach (Yin, 2013) to understand relationships between managers, staff and patients in acute hospital settings. The “case study method allows investigators to focus on a “case” and retain a holistic and real-world perspective…” (Yin, 2013: 4). Thus in our research, the “case” was a single hospital in Scotland, from which we generated empirical insights which can be tested in other hospitals around the world in which a treatment time target has been adopted. A semi-structured interview guide was developed and used during the face-to-face individual interviews. Topics of interest were focused around six key themes identified from the literature on health policy, managerial practices and the sociology of work: the role of nursing and relationships with management; financial accountability; efficiency; impact of targets and monitoring; policies; working conditions and consumerism. The questions asked in relation to targets were:

* *Can you think of any targets that have been introduced in your work areas?*
* *In what ways can targets in your work environment be a positive thing?*
* *In what ways can targets in your work environment be a negative thing?*

The four hour target was not specifically asked about to remove the possibility of bias for nurses who did not feel that the target impacted on their clinical practice, but was a salient theme which was discussed by the majority of participants, and at length by those working in the ED.

Staff were interviewed by (author 1) at the hospital site during a three month period in 2010. Interviews varied in length from 20 minute to 1 hour, generally lasting around 45 minutes. Written consent was obtained once staff had been provided with full information on the project. Interviews were either audio recorded or comprehensive notes were taken at time of interview (if consent for recording was not given, as occurred in three interviews). In keeping with legal requirements audio recordings were stored on a secure encrypted database. Transcripts were anonymised, and a code system used to identify the participants. Ethical approval was obtained from both a university ethics committee and the UK NHS Research Ethics Committee (ref: 09/S0709/75) and had all appropriate UK NHS governance clearances. Within this article all participants will be referred to as female to protect anonymity.

## Data analysis

Data were analysed using thematic analysis (Braun & Clarke, 2006). A preliminary analysis of the data was integrated within the data collection process as part of a process of continual reflection by (author 1). Once fieldwork had been completed, a set of thematic categories were developed based on the literature and (author 1’s) analytical memoranda. Initially the themes were quite broad and required further refinement; also further themes were identified through the analysis process as we became more familiar with the data. This meant that development of thematic categories was an emergent and iterative process, which allowed first insight into connections between themes. QSR Nvivo 8 was used by (author 1) as a data management tool at this stage of analysis. Data relating specifically to the code ‘targets’ were then subjected to more detailed thematic analysis by (author 1) and (author 2), within the context of the interviewees’ accounts of their work behaviour. Themes relating to the literature were used to inform a coding framework. In addition to this, further codes were added as appropriate during analysis, allowing an inductive and deductive approach to be utilised. During this stage of analysis, coding was agreed by both authors to ensure validity. To facilitate this, ATLAS.ti 7 was used as a data management tool.

# RESULTS

Findings will be discussed in relation to pressure on nurses, the impact on patient care and the use of alternative treatment areas. The emotional impact for nurses is described throughout. Inconsistencies between nurses working in different departments will be described. Approximately half (medical n=5; surgical n=5) of the non-emergency department nurses did not discuss the four hour target at all in their interview. This shows the low importance of the four hour target in their work. Instead, these nurses discussed infection control, hand hygiene and discharge times. For the other half of non-emergency department nurses, there was variation in the importance given to the four hour targets in their descriptions, and this will be outlined in more detail below.

## Pressure

### Nurses from all departments described various ways in which the 4 hour target put pressure on their work. This theme was encountered more than any other during analysis, and was particularly salient in accounts from ED nurses. The ED nurses noted that they felt pressured by a demanding work load and inadequate levels of staff to meet the target:

...we work as fast as we can...we’re like working our socks off and trying to get them coming in as quickly as possible, and it’s just not enough - it’s never enough, you know...(ED nurse 5)

In addition to this, all five of the ED nurses reported consistent pressure from monitoring of their performance, such as reporting to senior nurses on the ward and regular phone calls from managers. Two of the nurses explicitly related this to the managerial structure that was in place, which required serious breaches of the four hour target to be relayed to the Scottish Government.

Whilst four of the ED nurses were concerned about the consequences of breaching the target, ED nurse 4 reported that she was not concerned about the impact if the patient did breach the target because of a sound clinical reasoning or a lack of resources. This approach of acknowledging but refusing to be panicked by the pressure was more common among nurses who worked in departments that received patients but were not ED (AMU and surgical receiving). These nurses also reported being under consistent pressure to help contribute toward meeting four hour targets, including moving their patients to other wards as soon as possible.

Only four of the twenty nurses who did not work in EDs reported feeling pressure to ensure patients were discharged quickly, including receiving telephone calls from ED staff to request beds, routinely planning surgical discharges on the day of admission and attempting to discharge patients as quickly as possible:

Sometimes we have people coming in fasted that day for procedures as well and you’re trying to get a bed available for them. So you’re trying to discharge somebody and then you’re getting them in admitting and them in and it’s quite hard sometimes [laugh]. And before you know it you turn around and the porters are standing there with a trolley and you’re like ‘I’m not ready’. So it’s very stressful [laugh]. (surgical nurse 10)

An emotional burden was explicitly reported from this pressure to move or discharge patients earlier than desired by one medical receiving nurse and one surgical nurse. By contrast, one medical nurse did not appear to experience pressure to contribute toward meeting the four hour target:

I don’t really know much to do with, like, the four hour waiting time or anything like that, but they always kind of talk about they’ve breached and all that down in casualty and all that sort of thing... (medical nurse 4)

## Impact on patient care

Participants described the impact of attempting to meet four hour targets for patient care at considerable length. The majority of interviewees reported that the target benefited patients who were not acutely ill, who would be seen more quickly than they would have been prior to the introduction of the target. Many nurses contrasted the benefits and costs of the target for patients, including three who directly compared the costs and benefits:

I mean, if I was a user and you were in ED then aye definitely. When you're coming in it might be positive, but if you're sitting there and you're maybe not ready to go home yet they're maybe pushing you, so it can be negative at the other side of it kind of thing. (medical nurse 6)

Despite the benefits for non-acute patients, ED nurses reporting having less time to support the sickest patients. One ED nurse stated that patient care did have to be compromised sometimes to meet the target, although she reported that she ensured the most ill patients did not have their care compromised:

And the thing is, as much as I think we do compromise some patients’ care, but I don’t think we compromise it… I think that ill people, the people that are really acutely unwell we do recognise, and I think that we do take care of (them). (ED nurse 5)

Moreover, despite the pressure reported above, ED nurses noted that they would resist moving unstable patients or those for whom a suitable bed could not be found, regardless of if they would breach the four hour target:

you shouldn’t rush the decision making because that can be important, and if somebody is unstable they shouldn’t be moved anyway - whether it’s four hours or six or eight hours, if they’re not fit to be moved, they’re not fit to be moved. (ED nurse 1)

...because there's a bed in Ward (x), ‘why can he not go to the bed in Ward (x)?’ But to me that's downstream and there's no back up medical care down there except for the Junior House Officer and he ain't suitable. He's not going there... (ED nurse 3)

## Use of Clinical Decision Units (CDUs) and Other Assessment Areas

To meet the target, ED nurses noted that patients were routinely moved to assessment units for further investigations. Three of the ED nurses were critical of the practice, which was not seen as beneficial for patient care, but simply a way of meeting a target that was not realistic:

they’re trying to avoid breaching these four hour targets, but they’re just trying to find… it’s more just finding a way about the four hour targets, that’s the whole point of the new department, is they're building it because the four hour targets are unrealistic anyway. So they’re trying to avoid it by splitting up the department almost so they can try to deal with it, which is the best way, I suppose, you can deal with it, because they're so unrealistic, that’s the only way that you can deal with it is to get patients in separately and to try and reduce the times. (ED nurse 5)

In addition to this, the use of assessment units was criticised by a medical nurse, as she stated that it did not make patient care any more efficient:

It was things like we had an assessment unit, so patients would come into A&E and as long as they got up onto the assessment unit within the four hours then the paperwork looks good. But then that patient could be sitting in the assessment unit for anything. The worse case scenario, anything up to seven or eight hours, to be seen. So it’s like it didn’t actually improve patient care but it improved the figures. (medical nurse 2)

# DISCUSSION

Our research found that nurses working in one hospital in Scotland stated that they worked hard to attempt to meet the four hour target, showing that a national target was affecting clinical practice (Som, 2009). In trying to meet the target nurses carried a considerable burden, as highlighted by the Francis Report (2013). This was evident in two ways: an inability to meet demand because of high numbers of patients compared to nursing staff, and pressure from senior staff to meet the four hour target. This burden was most apparent among those working in emergency arenas (including the ED, and other departments that received patients). Lipsky’s (1980) research on the use of discretion among front line workers highlights these challenges as central to public organisations, as inadequate resources are available to meet demand. However, Wells (1997) research on community mental health nurses found that compliance with targets was lower when they were inadequately resourced, showing a continuum of inadequacy. It may be that the pressure to meet the target from managers, very clear guidance (Bergen & While, 2005), and reporting directly to the Scottish Government for serious breaches mitigated this factor.

For interviewees, the main reported impact of the target was on patient care. It was noted that non-emergency cases were dealt with more quickly than prior to the introduction of the target. However, ED nurses reported having less time to spend with patients, including those who were very sick, showing that clinical priorities were distorted by targets. This could lead to a further, emotional, burden which had not previously been explored in the literature on nurses and discretion. Some ED nurses reported active resistance to the target, where nurses refused to move patients who were not seen as clinically ready to leave the ED. This resistance aligns with the existing literature which has found strong support for nurses rejecting targets that did not fit with their beliefs (Wells, 1997; Provis and Stack, 2004; Bergen & While, 2005; Kramer *et al*., 2007), and thus contrasts Hunters’ (2003). However, the research was based on interviews with nurses, and it may be that a more ethnographic approach, including observations of practice within the ED, would have uncovered further insights, as has occurred in research on nurses professional relationships (Allen, 1997). Accordingly, to truly understand the impact of these targets on nurses, there is a need for ethnographic research within EDs, including ways in which nurses behave to meet the majority of targets, and minor and major acts of resistance to the target.

In non-emergency areas, staff were aware of the four hour target, but half did not consider it to be a target that affected them, and those who did reported experiencing less direct pressure than their ED colleagues. Moreover, the majority of nurses from non-emergency areas did not appear to understand the impact of their discharge decisions on the four hour target. Accordingly, if ED treatment targets are to remain, there is a need for considerable health service reform in order to optimise systems and approaches throughout hospitals. This should aim to redistribute pressure to meet targets more evenly throughout all hospital wards.

# CONCLUSION

For the last thirty years, many Western health services have become increasingly monitored on their ability to meet targets. As health service budgets in developed countries fail to keep pace with demand, the way in which nurses behave to *prima facie* meet targets is of considerable interest. To date, the way in which targets for waiting times in ED are managed by nurses has been an under-researched area. Our study of Scottish nurses found that whilst the four hour wait target in ED was met in the majority of cases, this was often as a result of considerable pressure being placed on ED staff. Moreover, the spirit of the target was sometimes lost, with ED nurses reporting that assessment areas were used to move patients who were not ready to be moved to a ward. Nurses reported that they felt able to maintain an acceptably high standard of patient care, although ethnographic insight would be valuable to independently verify the effects on patient care. Additional research should be undertaken in other countries in which treatment time targets are in place, in order to understand their effects internationally. Moreover, investigation should be undertaken in hospitals which are funded in ways which are different to the UK NHS, which is funded through taxation and free at the point of use.

**RELVEVANCE TO CLINICAL PRACTICE**

Within the UK Francis inquiry, no mention of the impact of targets of management decisions on workloads of nursing staff was made. Likewise, the NMC response to the Francis Report (NMC, 2013) did not focus on workload pressures or meeting targets within the workplace. The UK Government response stated that quality of care needed to come before targets and finances, but then proposed further reporting requirements and targets alongside additional training with an aim to make nurses more compassionate. This has not offered solutions to the high workload pressures felt by staff in trying to achieve the four hour treatment targets. Health care professionals within EDs should to be able to make the most appropriate decision for their patients, regardless of targets. This would ensure that patients are not moved inappropriately to meet targets which lack an empirical basis.

We suggest that governments that have introduced treatment time targets (UK, Australia, New Zealand, Canada), should pool their experiences in order to develop an understanding of best practice. Moreover, wherever treatment targets are in place, senior nurses should have the authority to breach the target whenever clinically appropriate without fear of negative consequences to ensure accurate reporting. More generally, in order to meet treatment time targets, hospital systems should be designed in such a way to redistribute pressure more evenly around hospital departments, to reduce pressure in ED, which may contribute to staff burnout and long-term sickness absence. In countries in which treatment time targets have not yet been introduced, consideration of how to reduce the negative impacts of such targets within local or national contexts should be undertaken before policy is implemented.

More generally, there needs to be further consideration of the workload pressures that are faced by nursing staff in their daily work and how targets impact on these workloads. Ensuring that there is a balance and that targets are appropriate and do not detract from good quality care is essential to reducing staff sickness and to retaining a highly motivated workforce.

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## Table 1: Participant Demographics

|  |  |  |
| --- | --- | --- |
| Characteristic | Group | Count |
| Gender | Male  Female | 6  25 |
| Age | 21-30  31-40  41-50  51-65 | 10  9  6  6 |
| Length Qualified | 1-2 years  3-5 years  6-10 years  11-15 years  >15 years | 1  11  6  0  13 |
| Nursing Grade | Band 5  Band 6  Band 7 | 20  4  7 |
| Area: emergency | ED | 5 |
| Area: non- emergency | Medical Assessment  Surgical Receiving  Medical Wards  Surgical Wards | 4  2  9  11 |

1. The United Kingdom (UK) National Health Service (NHS) provides a network of primary and secondary care facilities, which provide treatment free of charge to all who seek treatment. The NHS is funded via National Insurance contributions from those working in the UK and general taxation. [↑](#footnote-ref-1)
2. Clinical Decision Units (CDUs) have been introduced in the UK in order to meet four hour targets in patients who continue to need emergency care. They often provide care that is identical to EDs and are sometimes staffed by the same nurses. [↑](#footnote-ref-2)