When should waiting time become a quality of care issue in the paediatric emergency department?

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In emergency department (ED) patient satisfaction surveys, waiting time is one of the most frequently mentioned concerns of patients and parents. In almost all studies it ranks above any concerns with actual treatment received or problems with staff communication (1). The waiting time is especially of concern for those patients who have less urgent or nonurgent problems and it is evident that the expectation of the public is that all care in an ED should be provided rapidly. At the same time, studies have shown that the perception of waiting times by parents and patients are often longer than the reality (2,3).

This month's issue of *Paediatrics & Child Health* contains an article entitled "Pagers in a busy emergency waiting room: A randomized controlled trial" (pages 422-426). This study makes us reflect on the issue of waiting times in the ED; namely, what solutions we can provide to alleviate the problem, what the waiting time standards should be, and where waiting times should fit in an ED quality assurance or risk management process.

I would first like to look at this particular study. The objective of this study is to evaluate the use of pagers to help reduce parental anxiety in dealing with long waiting times. The paper is a novel approach to a long-standing problem. The authors are to be applauded for thinking 'outside the box' and for having a patient- and parent-centred satisfaction focus.

However, there are concerns in the implementation of this study, many of which the authors have acknowledged in the paper. In this study, the average waiting time was between 1.5 h and 2 h. An inclusion criteria for entry into the study was that all patients had to have waited at least 1h before enrollment. Assuming it took at least 10 min to 15 min to teach the parents about the study and obtain consent, this would mean that parents actually had the pager for an average length of time of between 15 min and 45 min. If the hypothesis that long waiting times are what is producing the problem, the population studied was not appropriate, given the relatively short wait and intervention

times (the length of time the patients actually had the pager). It would have been helpful if the author had reported how long the parents actually had the pager.

The study may not be generalizable to other EDs. Most Canadian hospitals do not have many attractive options for patients to wander outside the ED, especially in off-hours. There are no comments about the possibility of patients leaving the hospital with pagers and long distances may make timely return to the ED a problem. A cost analysis would need to be done to determine if this is a financially feasible undertaking, given that less urgent and nonurgent patients can include up to 62% of the ED population in a paediatric ED (4).

Aside from the details of this study, the study does remind us that waiting times are a real focus for the patients and staff of a hospital ED. We need to continue to look for solutions and to think 'outside the box'.

We also need to look at realistic expectations for ED waiting times from the perspective of the parents, patients and ED staff. The issue has been put in the forefront by the publication of the Canadian Triage Acuity Scale for Paediatrics (PaedsCTAS) (5). The PaedsCTAS is a triage system for paediatric patients seen in general hospital EDs across Canada. It has become the recognized standard of care in Canada.

The goal of an effective triage system is to identify those patients that need to be evaluated and treated rapidly to avoid potential morbidity or mortality. It is the most difficult task in the department. Paediatric triage is especially difficult, given that most anxious parents feel that their child is severely ill and must be seen immediately. In addition, signs and symptoms are often quite vague and the history is often provided by third parties (parents or caregivers) who are acting as interpreters for their children. In the past, experienced nurses with a good 'sixth sense' were assigned this task. This approach is fraught with lack of objectivity.

The PaedsCTAS has two components. One is a description of five levels of acuity defined by the child's historical

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and clinical parameters. The second component outlines the standards for time to receive medical care in each triage category. Time guidelines are as follows: resuscitation patients to be seen immediately, emergent patients within 15 min, urgent patients within 30 min, less urgent patients within 60 min and nonurgent patients within 120 min.

The attempt to objectify the assignment of triage categories is welcomed. It provides a tool that will improve the consistency of care within EDs and across Canada. It has the potential to improve quality of care by identifying a group of patients with high levels of acuity needing immediate assessment and treatment to prevent morbidity and mortality. It can be a useful educational tool, a quality of care critical indicator for the higher triage categories (I, II, III), and can be used for research purposes. As with all guidelines, they will be controversial and continuously under revision. The critical appraisal and evaluation of the guidelines will be an exciting challenge for the paediatric emergency medicine community.

While the paediatric emergency medicine community, including department directors, are in agreement with the utility of uniform paediatric triage guidelines, there is much discussion among the group about the introduction of the precise time guidelines that have been set for the less urgent and nonurgent patients. As the guidelines have been constructed, the goal is that at least 80% of all nonurgent cases presenting to the ED with any problem will receive medical care within 2 h. The concerns from some of the ED community are two-fold. Firstly, given the resources currently available, this is an unrealistic goal and is a set up for failure, and will only antagonize an already beleaguered ED staff. Secondly, for the less-urgent or nonurgent patient, time-to-be-seen is not a good indicator of quality of care or patient outcome. The health benefits of a short time-to-be-seen for this group have not been demonstrated in the literature.

The triage process and time guidelines have become a major focus of discussion for groups with very different agendas. These groups include physicians and nurses who feel overwhelmed and want to make certain that acutely ill patients are not missed in the onslaught of patients arriving at their doorstep, parents who desire immediate service regardless of the acuity level, hospital administrators responding to parental complaints, hospital foundations concerned about the impact on fundraising by dissatisfied 'customers', insurance agencies wishing to avoid malpractice suits, and governments who want to reassure the population that the health care system is under control and working well. The groups above would suggest that not meeting the guidelines is a reflection of poor patient care. Upon publication of this standard, community groups expect and demand this kind of service because they have been told that this is now the standard of care.

A more positive approach would be to think that if a centre is unable to meet these guidelines, this would provide them with the hard evidence to prove that the centre requires more resources in the form of nurses, physicians, support staff, equipment or facilities.

Unfortunately, over the past 10 years, most of us have not been reassured that the funds or resources will be forthcoming to solve these problems, even when the evidence exists for a need. Even if these funds are supplied, the result may be an inadvertent increase in the number of patients arriving to the ED with nonurgent problems because they will receive a speed of care not available elsewhere in the community 24 h a day.

While the time guidelines are intended to be a continuous quality improvement tool, do not be fooled; the final time standards have already been set and published for public consumption by administrators, politicians and our own associations.

The work done by Canadian Association of Emergency Physicians and the Canadian Paediatric Society's paediatric emergency medicine sections is to be applauded. The primary mission of the ED should be excellence of care for those children who are acutely ill and injured. This should include rapid identification by a validated paediatric triage tool along with rapid assessment and treatment of the patient.

I would suggest that no time guidelines be given for the less urgent and nonurgent patients as time is not a measure of quality of care in this group of patients. As currently constructed under these guidelines, the ED will be the only area of the health care system where a patient can be guaranteed to be seen within two hours no matter the urgency of the problem. As constructed, under the new triage emergency guidelines, the ED will be expected to solve too many of the problems of a health care system in difficulty.

The well-being of the ED tends to reflect the well-being of the health care system as a whole. Forcing the emergency staff to see nonurgent cases within a two-hour time-guideline is not a realistic solution to current problems of the health care system and we should not give the public a false expectation that we can meet these objectives. This will only serve to increase patient and staff dissatisfaction.

REFERENCES

1. Bursch B, Beezy J, Shaw R. Emergency department satisfaction: What matters most? *Ann Emerg Med* 1993;22:586-91.
2. Harris N, Hostetler M. Parental expectations of care and charges in tertiary care pediatric ED. *Am J Emerg Med* 2002;20:601-3.
3. Thompson DA, Yarnold PR, Admas SL. How accurate are waiting time perceptions of patients in the emergency department? *Ann Emerg Med* 1996;28:652-6.
4. DeAngelis K, Farmer B, Brewer K, Reeder T. Use of an ED by nonurgent patients. *Am J Emerg Med* 2002;20:370-1.
5. PaedsCTAS. *Can J Emerg Med* 2001;3(Suppl):S1-27.