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Clinical Responsibility for Patients within the Emergency Department

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Introduction

This section defines which clinical team has responsibility for a particular patient
Please also see section Referral for Inpatient Care Standards.

Standards

1. It is essential for patient safety and continuity of care of patients in the Emergency Department (including ED observation units/ CDU) that it is always clear which team has clinical responsibility for each patient.
2. Once a patient has been referred onto a specialty, it is the responsibility of that specialty to organise ongoing care. It is not safe, reasonable or appropriate to refer a patient back to the emergency medicine service. Declining referrals is not appropriate, as this does not ensure patients receive the necessary ongoing care [1].
3. Whilst waiting for specialty teams to respond to a referral the patient in question remains the responsibility the ED team, this includes reacting to changes in the patient's clinical condition and investigation results. However, specialties should have arrangements in place for sufficiently experienced staff to assess emergency patients within 30 minutes of referral and must not insist on investigations that do not contribute to the immediate management of the patient. [2].
4. Once a patient in the ED is seen by a specialty team then that patient becomes the responsibility of the specialty team. The Emergency medicine service team will continue to provide clinical support to patients who deteriorate and require emergency care, and within the resuscitation area.
5. EDs must have clear policies / guidance with regards to the action staff should take and who to escalate their concerns to in the event of a patient under the care of a specialty team deteriorating; this will likely depend on the degree of deterioration (eg. NEWS2 score).
6. Handover of clinical responsibility must be clearly delineated and accurately documented in real time.
7. Patients must be aware of the clinical teams caring for them and of the responsible clinicians. Similarly, clinical staff must be aware of who has clinical responsibility for their patients.
8. Specialty patients placed on Observation Wards / CDUs due to capacity issues within the rest of the hospital (i.e. not ED patients) must remain under the care of that specialty team and clear policies must be in place to ensure that these patients are reviewed regularly by their appropriate specialty team.
9. When patients are transferred from the Emergency Department, there must be a re-assessment to determine whether the clinical status has changed, especially in cases where a delay has occurred.

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Recommendations

1. Where there is concern regarding the quality of a referral, this should be addressed with the duty ED Consultant.

2. Concerns about the clinical management of patients under the care of specialty teams who continue to reside in the ED should be escalated to a senior doctor in that specialty. If concerns persist after completion of this action escalation should be to the senior ED doctor on duty and where these concerns are significant then this should be discussed with the duty ED consultant.

3. In specific circumstances, such as Trauma Calls, it is expected that the ED team will lead the team and co-ordinate initial care, however clear local guidance needs to be in place regarding which specialty team will take overarching responsibility of patients requiring multiple specialty input. Whilst 'Exit Block' or lack of suitable bed may dictate that the patient remains in the ED beyond 4 hours, these patients need to need to be under the care of a named in-patient specialty team, even if awaiting transfer to another centre.

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Background

Fellows and members of RCEM have raised concerns around the potential for a lack of clarity to exist as to which clinician has overall responsibility for a patient who is physically in the Emergency Department (ED) but who has been referred to a specialty team. Delays (often a result of crowding [3] can occur in the acute pathway, including transfer from ED (increasingly, patients are transferred to alternative hospitals or sites for ongoing care), and waiting to see specialty team. At times of high hospital bed occupancy rates, beds in Clinical Decision Units (CDUs) or observation units may be used for specialty patients awaiting a bed on a specialty ward. Issues around whose care these patients are under can cause delay in patient care, patient review and patient discharge, and could result in clinical incidents.

If the patient is in the ED (or ED observation unit/CDU) they are being cared for by the ED nursing team. The ED nursing team have ready access to the ED clinician team 24/7 but this is not always the case for those patients being managed by the specialty teams. One of the consequences of ED crowding / 'Exit block' is that some patients who are referred to a specialty team never actually get admitted to a ward or an assessment area and have their entire episode of care in the ED, often having to spend a considerable amount of this time in a non-clinical space (e.g. a corridor), before being discharged by a specialty team.

References

1. *The Standards in Emergency Departments. RCEM. 2016.* www.rcem.ac.uk/rcemguidance

2. *Making internal professional standards work. NHSE. 2023.* https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-making-internal-prof-standards-work.pdf. Accessed 11.07.2023

3. *Tackling Emergency Department crowding. RCEM. 2015.* https://rcem.ac.uk/wp-content/uploads/2021/10/ED_Crowding_Overview_and_Toolkit_Dec2015.pdf . Accessed 11.07.2023