Referral for Inpatient Care Standards

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Introduction

This section defines what is expected when a patient is referred for inpatient care.

Standards

1. Hospitals must maintain an up to date digital on-call rota of all specialties who receive referrals from the emergency medicine service. Contact details must be obvious.
2. There must be agreed internal professional standards in each hospital.
3. 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.
4. 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.
5. Once a patient in the ED is seen by a specialty team then that patient becomes the responsibility of the specialty team. See 'Clinical Responsibility for Patients within the Emergency Department'.
6. In case of dispute, the Medical Director of a hospital must delegate specialty admission decisions to the on-call Emergency Medicine Consultant.
7. Where a patient is referred to a different site, a copy of the patient emergency department attendance must accompany the patient.
8. Where an inpatient specialty provides only remote advice, this must be made clear in the patient notes.
9. Emergency Department IT systems must be capable of recording the date and time of referral to a specialty team.

Recommendations

1. The referring clinician should be clear whether a referral is for advice or for admission.

2. Use of names rather than roles improves communication and accountability.

3. The referring clinician should clarify the urgency of the referral, whether time critical or urgent.

4. Automated referrals, through electronic health records for straightforward admissions should be encouraged to minimise unnecessary delays.

5. For severely ill or injured patients, a structured guide such as SBAR should be used.

Background

Referring a patient, and receiving a referral safely, is an important function of emergency medicine practice. Emergency Medicine clinicians frequently report that referring patients to inpatient teams is time consuming, inefficient, prone to dispute and potentially unsafe. An optimal referral quickly communicates the urgency of the patient's condition, the anticipated needs and expectations of care.

Referral pathways for common emergency department presentations and diagnoses that require hospital admission should be agreed and communicated. There are a number of presentations, such as head injury, rib fractures and poisoning where clarity about the admitting specialty can save a lot of dispute and time.

Internal professional standards signal that there is a whole hospital commitment to emergency work. These should be set by the Medical Director's office. An example, which can be adapted for local use is shown below.

Recommended Internal Professional Standards

1. An emergency medicine clinician will see new patients on or as close to arrival as possible in the ED.
2. The emergency medicine speciality team should not admit a patient likely to be able to go home just to avoid a breach of the emergency care standard.
3. Inpatient specialities will have arrangements in place for sufficiently experienced staff to assess emergency patients within 30 minutes of referral and should not insist on investigations that do not contribute to the immediate management of the patient.
4. Patients referred from primary care (or any other clinical service) should be routed directly for specialty assessment. If this does not occur and the patient attends the emergency department, the patient should be transferred to the specialty considered most appropriate by the emergency medicine team unless immediate medical intervention is required.

Recommended Internal Professional Standards

1. Patients will only be sent to the emergency department as a result of advice by speciality teams if immediate clinical intervention is required, as all other patients should normally be seen in the designated assessment areas. In this situation, the emergency medicine team will continue to provide clinical support to patients within the resuscitation area, and then refer to the most appropriate specialty for on-going management of the current clinical problem.
2. No inpatient speciality doctor should refuse a request to assess any patient referred by the emergency medicine service. If subsequently it is considered that an alternative speciality would provide more appropriate care, it is the responsibility of the first speciality (and not the emergency medicine team) to arrange the transfer.
3. The Emergency medicine service team should continue to provide clinical support to patients who deteriorate and require emergency care, and within the resuscitation area.
4. The Emergency medicine service team should highlight any patient recently discharged from an inpatient admission, or under current investigation, or treatment for assessment by the suitable specialty. This should help the speciality team to avoid unnecessary admissions.
5. If there is a failure for different specialties to agree on accepting a patient, the ED consultants should have the authority to admit any patient to any level one bed in the speciality that they consider best able to meet that patient's clinical needs.