Referral of Patients from Emergency Department (ED) to Inpatient Teams

[THIS TEMPLATE WAS DEVISED AT SALISBURY AND HAS PROVED OF IMMENSE VALUE TO TRAINEES AND IMPROVED PATIENT CARE. FELL FREE TO ADAPT AS APPROPRIATE FOR YOUR ED]

Appropriate and good referral to another specialty team is an important skill for all doctors. *See GMC – Good Medical Practice sections on: Working in Teams, Respect for Colleagues, Sharing Information with Colleagues, Delegation and Referral.*

- **Emergency/Urgent treatment & Investigations** required must always have been commenced prior to making a referral.
- Make the referral to another specialty team as soon as possible after the decision to refer has been made. This avoids inappropriate delays in both patient care, and flow through the ED.
- Do **not** wait for the results of outstanding investigations if they will not change the decision to refer.

Whom to refer to in each specialty

Specialty	*Contact*
Medicine	e,g call SHO (or the registrar if patient complex and you also need advice). acute medicine consultants can usually also be contacted for advice from XXXX to XXXX hours (Bleep XXXX)
Surgery	
Urology	
Orthopaedics	
Opthamology	
Plastics	
Paediatrics	
O&G	
Psychiatry	
Haematology & Oncology	
Out of Hours (OOHs)	

The bleep numbers are on the daily on call list

"SHO" refers to either F2, GPVTS, or ST1/2 etc.

Sometimes doctors are unable to answer their bleeps immediately. If the doctor bleeped does not respond in an appropriate amount of time, (suggested within about 5 minutes), they should be bleeped once again. If again they don't respond then try another member of the team, the consultant if necessary. The time of all attempts of contact should be recorded in the notes.

To make a referral

The Trust uses the SBAR (Situation Background Assessment Recommendation) system for handovers. A similar approach can be used for referrals. Have the patient notes with you when making the referral. A conversation such as outlined below is normally appropriate:

Situation

- It is Dr. xxxx, ED F2/GPVTS (and confirm the name and grade of who you are speaking to).
- I have a referral for you
- *I have already discussed this patients care with /this patient has already been review by with Dr./Mr. xxxx my consultant. (Not all patients need to be discussed/reviewed prior to referral but they often will have been).*

- His/her name is xxxx
- Their name/dob/hospital number are xxxx.

Background & **A**ssessment

- They are an xx year old male/female with xxxx (condition/diagnosis).
- Summary of History / Exam (including vital signs) / Ix / Rx so far (use the ABCD format if appropriate)
- They have the following Ix outstanding.
- Their in-patient notes have been requested
- The patient is currently in cubicle x/ majors / minors / the waiting room / SSEU

Recommendation

- Where would you like to see the patient?
- Roughly how long will you be?
- If there is going to be a significant delay in attending ED I will try to get the patient to the ward/back out to the ED waiting room, is that OK with you? I will make sure you are informed if the patient is moved from ED.
- Is there anything else you think I should be doing for this patient from an ED perspective?
- Would you like me to give you their details one more time.
- (Record time and to whom referred in ED notes.)

General points about referrals include:

- As well as Emergency/Urgent treatment & Investigations having been commenced, patients should have received or be in the process of receiving sufficient analgesia (+/- splintage PRN) prior to referral.
- Some patients will not have a definitive diagnosis at the time of their referral. This is the nature of Emergency Medicine. Descriptions such “an acute abdomen” / “collapse ? cause” / “off legs” can be used, but ensure you have tried to look for all relevant specific causes of such. ED only has 4 hours from arrival to try to make a diagnosis, investigate and start initial management. It is not uncommon for admitting teams to require several days to make the correct diagnosis for some less clear cut patients.
- Sometimes you may contact another specialty for advice. If so make it clear at the beginning of the consultation that this is for advice, not as a referral (accepting that the advice may be that the patient needs referring). Document clearly the advice given and the time & name/grade/speciality of doctor giving this advice. Try to avoid asking advice from a doctor of the same grade as yourself, and if you do then at the beginning of the conversation ask them to let you know if they feel the level of advice requested is beyond their area/level of competency.
- Non urgent Ix / Rx can normally also be provided by the ED. There will however be times when the balance of workload for ED compared to an on call specialty is such that it is more appropriate for you to ask them to do these. Help your colleagues when you can and ask them to help you out when you feel necessary.
- Once referred the other specialty team should endeavour to see the patient and make a decision about their management plan as soon as is possible. In-Patient teams should aim do have made an initial management decision for patients within a maximum of 60 minutes of the referral (30 minutes for those requiring to be in resus), and patients transferred out of the ED a maximum of 90 minutes after referral, or before 4 hours total, which ever is the earliest.
- However if a patient is still in the ED still waiting to see the inpatient team, and they require further urgent Ix/Rx this is the responsibility of the ED clinical team to deliver, (it may also be necessary to chase the inpatient team). Once the patient has left the ED ongoing clinical care is the responsibility of the team referred to.
- Once a referral has been made further non urgent Rx, arranging of Ix, and chasing of results are the responsibility of the In-Patient team. Again a balanced approach is appropriate, ED will endeavour to help other specialties if its workload allows.
- All healthcare professionals at times feel under stress. This is particularly common whilst working in a busy ED, or whilst on call for another specialty or for H@NT. This does not excuse unprofessional behaviour. Communication should, at all times, remain polite and courteous (but firm if necessary).

If not, then please let an ED consultant know at the next available opportunity, using email PRN if doing the night shifts.

Disagreement between clinicians**:**

There maybe infrequent times when the doctor receiving the referral feels that the referral is not warranted. If this is the case listen to that doctors concerns, accepting that avoiding a hospital admission is sometimes best for a patient, and also that the trust has a finite bed capacity. Remain polite and courteous (see above), then take the following action:

- If the patient has already been discussed or reviewed by the ED consultant then reiterate this and ask the doctor involved to either accept the referral, or to discuss the patient with their consultant, whom may then contact the ED consultant to discuss the patient further PRN.
- If the patient has not already been discussed or reviewed by the ED consultant, and the ED consultant is available - then tell the other speciality doctor you will discuss the patient with your consultant, raising any reasons the In-patient team has made against referral, and that you will only get back to them if the consultant feels they need referring.
- If the patient has not already been discussed or reviewed by the ED consultant, and the ED consultant is not available (either not in the department OR significantly tied up in resus and likely to be for a considerable time) – then firmly insist that a professional referral has been made, and that you do not feel that you can safely discharge the patient. If they are unhappy with this ask them to contact their consultant, discuss the patient, and then if their consultant feels necessary the consultant may contact the ED consultant to discuss further.
- It is sometimes useful to remind the in-patient team that there may be some patients that, once seen by their own specialty, a decision to discharge the patient directly from the ED maybe made. This is not a failing of the ED medical staff, but simply good medical practice in involving other specialty expertise in the decision making process surrounding safe discharge. In this case, the team referred to will write their findings and their management plan in the ED notes and sign and date those notes appropriately.
- Beware of placing patients on SSEU under the care of ED at the request of other specialties. The SSEU ED care pathways all have well laid out inclusion & exclusion criteria (see Appendix 1), if the patient does not fit the pathway do not use it.
- If the specialty being referred to feel a patient would be more appropriately admitted by another specialty ask for their reasons for this (these will often be correct). Then, (after discussing with ED consultant if available), contact the other specialty. Explain you have a referral to make but the specialty who you initially tried felt their specialty would be more appropriate for the reasons given. If there is then disagreement go back to the initial specialty. It is then their responsibility to liase with the other specialty about who will be the initial admitting team. This is usually best done at registrar or consultant level. If no agreement can be reached between themselves the default for patient safety is the initial specialty. If the initial team feel they can not immediately discharge the patient safely, and subsequently still feel that patient care would best be served by another specialty, an inpatient referrals can be made in the normal manner.

Once referred to an inpatient team from the ED the following must be recorded on the ED card:

- Time of referral
- Name of doctor to whom referred
- Grade of doctor to whom referred
- Referral team specialty

Also

- In “real time” click the referral box on Symphony.
- For surgical specialities place the ED notes in the correct coloured plastic folder (Green = Ortho, Red = all others).
- For SSEU, majors & resus patients ring the patient name on the white board with the appropriate colour pen (Blue = Medicine, Green = Ortho, Red = all others surgical specialities), let the nurse in charge & the nurse looking after the patient know ASAP. Place the complete ED notes back in the correct cubicles slot.

- For minors patients, if possible let the Minors nurse and or the ENP know. Place the completed notes in the slot labelled “Waiting Room & Chairs”. If the patient in suitable ask them to go and wait back in the waiting room.
- Ensure the patient knows they have been referred to a different specialty (see below for nomenclature) and give them some idea what will happen next and when will this be.

Nomenclature – sometimes patients can be confused by the terminology we use for specialty teams. As part of good communication skills consider the patient you are talking to and the following:

- Referring to the “medics” may make some patients concerned as to whether you are in fact a “medical doctor”. Terms such as “the physicians/doctors who look after patients on the wards” may be better.
- Beware of telling a patient, who you do not know definitely needs an operation, that you are referring them to a “surgeon” (of any specialty). This sometimes causes concern/misunderstanding that they are going to have an operation. It is usually best to caveat this with “although you may not need an operation this is the team of doctors who look after patients with your condition on the wards. If they feel you would benefit from an operation they will discuss the pros and cons with you before asking your consent”.
- Orthopaedics is not universally understood. Backing this up with “the bone doctors/surgeons” is sometimes appropriate.
- Max Fax .. enough said. Consider “facial / dental surgeons”
- O&G / Obs and gobs do NOT use.
- Even paediatrics sometimes causes confusion. Consider “children’s doctors”.
- Finally remember that for the Emergency Department/ED terms such as “A&E” and “casualty” are still common place (by both patients and other specialties), do not take offence. Although the College of Emergency Medicine has tried to move away from these titles, it is a term that most still understand and use, and UK road signs refer to hospitals as being with or without “A&E”. You may sometimes even hear people refer to us as the “ED department”, smile inside if you do.