

RCEM Position Statement Clinical Responsibility for Patients within the Emergency Department

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Background

Fellows and members of RCEM have raised concerns about 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 has been referred to a specialty team. Delays (often a result of crowding [1]) 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 delays 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 has 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. Some departments report that this can affect as much as a quarter of all their referrals.

Recommendations

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.

Once a patient in the ED is seen by a specialty team, then that patient becomes the responsibility of the specialty team.

If, following a referral of a patient in the ED, a specialty team feels it is inappropriate for them to look after that patient, then it is their responsibility to refer to a more appropriate team. Declining referrals is not appropriate, as this does not ensure patients receive the necessary ongoing care. Where there is concern regarding the quality of a referral, this should be addressed with the duty ED Consultant.

Whilst waiting for specialty teams to respond to a referral, the patient in question remains the responsibility of 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]. Every hospital should have published Internal Professional Standards (set by the Medical Director) that outline the responsibilities of all specialties in providing effective emergency care.

EDs should 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 (e.g. NEWS2 score).

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.

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

Handover of clinical responsibility should be clearly delineated and accurately documented in real time.

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.

Diverting expected specialty patients to the ED should only occur for clinical reasons related to patient acuity e.g. the likely requirement for patients to be managed in the resuscitation room. If this occurs, the ED should undertake any emergency management measures necessary to stabilise the patient before the prompt arrival of the relevant in-patient team. Diverting specialty expected patients to the ED as a consequence of capacity issues within assessment areas (including the ability to deal with specific infection prevention and control measures around certain presentations such as diarrhea and vomiting) should be a last resort with the understanding that the inpatient specialty team should prioritise the assessment and management of these patients within 30 minutes of their arrival in the ED.

Specialty patients placed on Observation Wards / CDUs due to capacity issues within the rest of the hospital (i.e., not ED patients) should remain under the care of that specialty team. Clear policies should be in place to ensure that these patients are reviewed by the appropriate specialty team at regular intervals and when requested for patient deterioration as per any other hospital ward patient.

When patients are transferred from the Emergency Department, there should be a re-assessment to determine whether the clinical status has changed, especially in cases where a delay has occurred. A transfer checklist could be used.

References

1. The Royal College of Emergency Medicine (UK). Tackling Emergency Department crowding. Published 2015. [https://rcem.ac.uk/wp-content/uploads/2021/10/ED Crowding Overview and Toolkit Dec2015.pdf](https://rcem.ac.uk/wp-content/uploads/2021/10/ED_Crowding_Overview_and_Toolkit_Dec2015.pdf) . Accessed 11.07.2023
2. <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-making-internal-prof-standards-work.pdf>. Accessed 11.07.2023