The Royal College of Emergency Medicine

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Position Statement

Clinical Responsibility for Patients within the Emergency Department

29 November 2016

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[i]) 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) maybe 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.

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 necessary ongoing care[ii].

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

Whilst waiting for specialty team 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.

Concerns about the clinical management of patients under the care of specialty teams who continue to reside in the ED should be escalated 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 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.

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.

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 and clear policies should be in place to ensure that these patients are reviewed regularly by their appropriate specialty team.

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 should be used.

References

[i] The Royal College of Emergency Medicine (UK). Crowding in Emergency Departments. Revised June 2014, available at www.rcem.ac.uk/rcemguidance

[ii] The Royal College of Emergency Medicine (UK). Referral Standards in Emergency Departments. Published 2016, available at www.rcem.ac.uk/rcemguidance