Clinical responsibility of speciality patients boarding within the Emergency Dept.

1. Introduction

Boarding within the emergency department is defined as those "patients who are awaiting admission, but who are still in the Emergency Department (ED) beyond agreed service standards". The current trust agreed standard is patients should be moved to the ward within 30 minutes of referral.

The purpose of this document is to provide a framework based on both local and national guidance to standardise the referral and handover of clinical responsibility from the Emergency Department to inpatient specialities. As well as the providing clear clinical escalation routes for patient needs.

Whilst it is useful to have the below documented principles, ultimately patient care and experience must be the focus of what we do. Therefore, we anticipate that if there are any concerns around clinical responsibility, the primary principle is these will be dealt with by mutually respectful and helpful direct conversations between senior clinical decision makers. This is to ensure good teamworking across specialties and that the right care is delivered, by the right team, in the right place.

2. Aims & Objectives

- Standardised referral procedure and handover of clinical responsibility
- Consistent approach to assessing Clinically Ready to Proceed
- Clear and documented handover of responsibility
- Clear escalation routes depending on patient requirements.
- Agreed referral pathways for clinical issues.

3. Transfer of Clinical Responsibility

Clinical Responsibility will move from the Emergency Department to speciality when ALL points are complete:

I. **Patient is Clinically Ready to Proceed**
II. **Referred to in-patient speciality and ANY of:**
    a. Patient has been physically reviewed by speciality
    b. Over 30 minutes from documented referral
    c. Clinically stable GP/Clinic/Hot-line referrals
III. **On the correct site** – for those specialities who are primarily based on the other site to the ED where the patient has presented, and the team cannot attend, or assess, immediately.

4. Clinically Ready to Proceed

Clinically Ready to Proceed this the domain of the ED ST4+

- **Emergent/Time-Critical treatments** - completed (examples below not exhaustive)
    - Initial resuscitative treatments of organ failures

    - Analgesia given for moderate/severe pain
    - Antibiotics in sepsis
- **Emergent investigations -** completed
    - Only those investigations required for emergent treatment
- **Identification of most appropriate in-patient speciality**

5. Referral

Referral Principles remembering asking for speciality advice is not referral and should be taken from a speciality senior.

- **Default response is YES**, if questioning the referral this must be a senior-senior conversation and will ultimately be the decision of the On-site ED senior.
- **Dispute**, if after conversation with the ED senior and review of the patient the initial referral team feel the patient would be best placed under an alternate speciality.
    - This referral is the responsibility of that team and must be documented.
    - If speciality seniors cannot agree the responsibility remains with the initial team.
- **Diverted patients** from GP/Clinic/Hot-line to the ED will be referred to the parent team as follows:
    - **GP's –** the designated speciality if a valid referral letter is sent (whether the team has accepted the referral or not)
    - **Clinics** – the referring speciality team unless a referral is documented.
    - **Hot-lines** – the base speciality of that hot line.
    - **Repatriation** – the accepting speciality.

6. Base Specialities within CHFT

Problem	First Speciality Referral
Frail/Social admissions without significant pathology unsuitable for immediate discharge	Acute Medicine
Patients with pubic rami # or groin pain requiring cross-sectional imaging (i.e. no fracture on x-ray but non-mobile)	Acute Medicine
Requires imaging for potential Cauda Equina (non-MSCC) unavailable as OOH	Orthopaedics
Back Pain: MSCC or severe pain and all reasonable options exhausted	Acute Medicine
Poorly differentiated abdominal pain, requiring admission and inpatient investigation	Under 16 - Paeds Pregnant <16/40 – Gynae Pregnant ≥16/40 - Obs Not pregnant – Gen Surg
All Medical Specialties (Except Haem/Onc.)	Acute Medicine
Out of Trust specialities - requiring local admission but not transfer to LTH/BRI etc. • **Chest Injury** • **Vascular (non-operative – eg ruptured AAA, acute limb ischaemia for palliation, Diabetic Foot Infection only requiring antibiotics)**	 General Surgery Acute Medicine

7. Clinical Escalation for boarding patients within the Emergency Department

Clinical Responsibility in ED – once criteria met this must clearly be documented within EPR
Escalation will be judged by nursing team:

- **Emergent need** – Escalate to ED senior for review and initial management.
    - ED senior will inform specialty of any deterioration, ongoing need or support required.
- **Non-Emergent need** – Escalate to speciality senior.
    - Specialities will be expected complete tasks in a timely manner
    - If the responsible speciality is off site, and the task cannot be completed remotely by the speciality team. This should be escalated to the ED senior.
    - If concern remains despite speciality input escalate to ED senior.

Graded escalation to speciality should:

1. Initially to speciality middle grade
2. No/Inadequate response from Middle Grade - escalation to on-call speciality consultant.
3. No/Inadequate response from consultant - escalation to on-call manager

https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/delegation-and-referral/delegation-and-referral
https://rcem.ac.uk/clinically-ready-to-proceed/