Policy

EMERGENCY MEDICINE

Transition of Patient Care from Emergency Medicine to the Care of On-call Specialty Consultants

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Summary	This document describes a standard national policy for the transition or handover of care of patients who have completed their episodes of Emergency Medicine care and who are referred for admission under the care of on-call specialty Consultants.
Authors	National Emergency Medicine Programme
Contact	emp@rcsi.ie
Applies to	All hospitals with Emergency Medicine services.
Audience	Acute hospital CEOs/General Managers/Operational Managers, Clinical Directors, Directors of Nursing, Consultants who provide on-call services to acute hospitals, Consultants in Emergency Medicine and Emergency Department nursing, clinical and administrative staff; Health Information and Quality Authority.
Approved by	Draft document for consultation with the HSE, Clinical Strategy and Programmes Directorate and Quality and Patient Safety Directorate and Unscheduled Care Governance Group, Special Delivery Unit, Department of Health).
Document status	Draft (for implementation when approved)
Review date	TBC
Contents	Policy for the Transition of Patient Care from Emergency Medicine to the care of On-call Specialty Consultants: Appendix A: Guidance on referral for specialty consultation in the ED.
Associated documents	Emergency Department Admissions Decision Framework – sample template to be circulated with this policy.

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Document outline

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1. Purpose

- To optimise patient safety and quality of care during the handover of care between Emergency Medicine (EM) and on-call or admitting specialty Consultant teams.
- To ensure that patients who are referred by EM teams to on-call or admitting specialty teams have a named Consultant responsible for their care at all times, as recommended by the *Health Information and Quality Authority Report of the investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute adm*ission,
- To ensure that all patients have a named admitting Consultant within two hours of referral for admission from the ED.
- To support a standardised approach to ED referrals that is consistent across the acute hospital system.

2. Introduction

Timely and efficient handover of clinical care of admitted patients from EM to in-patient or on-call specialty Consultant teams is essential for the safe and effective care of each patient and for the effective operation of the Emergency Department (ED).[1] This is a key patient safety issue.[2] The HSE Quality and Patient Safety Directorate supports the need for clarity regarding transfer of patient care in the ED and recommends that

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all health service organisations have clear, comprehensive and flexible access and transfer protocols that are agreed with all partners.[3] The *Health Information and Quality Authority (HIQA) Report of the investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute adm*ission, 8th May 2012[4] includes a specific recommendation that *"All hospitals must have the necessary arrangements in place to ensure that there is a named consultant clinically responsible and accountable for a patient's care at all points in the patient journey and throughout their hospital stay."* High standards of clinical handover must be valued, supported and embedded[4] in clinical practice. The National Emergency Medicine Programme Report 2012[5] outlines recommendations for patient referrals for admission from the ED.

3. Key definitions

Clinical Handover: Clinical Handover refers to the transfer of information from one health care provider to another when a patient has a change of location or venue of care and/or when the care of / responsibility for that patient shifts from one provider to another.[6]

Clerking: Clerking is a formal admission process that involves the detailed recording of the patient's presenting complaints, past history, medication and a general physical examination. It is a much lengthier process than the focussed history and examination performed by an experienced clinical decision maker to determine the patient's immediate clinical needs.

4. General principles

Quality of care: The patient's safety, clinical needs and experience of care must be the primary consideration in all matters relating to transition of care. There must be systems in place to monitor and assure the quality of transitions of care in all hospitals and hospital groups.

Governance: It is the hospital's responsibility to ensure that EM and on-call specialty services are available to meet patients needs, either provided on-site or through networked arrangements with other hospitals. HIQA[4] states "*The Chief Executive, and the Executive Management Team, should ensure that the implementation of the organisation's strategy, and the operational running of the business, is specifically and effectively aligned to the delivery of good quality and safe care within the available resources"* and that *"All hospitals should have the appropriate implementation and monitoring arrangements in place to ensure that on-call clinical teams are available to see patients in the Emergency Department"*.

Referral from EM to other specialties: The principal reason for patient referral is a perceived need for hospital admission and/or recognition that the patient's clinical needs cannot be met solely by the specialty of EM. Consultants in EM have a breadth of knowledge and experience that enables them to best identify which specialty best matches an emergency patient's needs. Consultants in EM must carefully manage their

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professional responsibility to all patients in an ED, recognising the limits of their specialty knowledge and the need to refer appropriate patients for greater depth of specialty care. They must also balance the execution of their duty of care to patients who have been referred for admission but may still be in the ED with their duty of care to other ED patients, particularly those who are awaiting initial assessment. The overarching principle for EM is to optimise the safety of all patients in the ED.

Referral response times: The patient's clinical condition will determine the appropriate response time to a referral call from the ED. An *immediate response* may be required (e.g. an airway problem requiring anaesthesia/critical care support); a *rapid response* may be indicated by the patient's condition (e.g. a patient who requires time-critical specialty treatment including surgery) and for all less urgent referrals, the patient must be seen by the on-call team within a timeframe that ensures that patient assessment is completed within 2 hours of referral (e.g. a patient who is physiologically stable and for whom all urgent treatment has been completed). This policy directs that the maximum response time for an on-call specialty team ensures that patient assessment is completed within 2 hours of referral.

5. Admission Decision Framework

Each hospital that has an ED or other emergency unit must have an Admission Decision Framework document endorsed by the hospital management team. This framework will consist of:

a. a list of clinical conditions for which the hospital is able to provide in-patient care and the clinical team/on-call specialty that provides inpatient care for each listed condition;
b. a list of conditions for which on-site in-patient care cannot be delivered and the appropriate networked hospital to which patients with these conditions should be transferred;
c. guidance as to the most appropriate on-site specialty under whose care patients with conditions listed in (b) above should be admitted whilst awaiting transfer if a bed at the appropriate networked hospital is not immediately available and the patient's condition not of sufficient clinical urgency to mandate immediate transfer to the ED of the receiving hospital;
d. an agreed protocol for the admission process for patients presenting with co-morbidities, undifferentiated illness that cannot be easily aligned to a particular specialty or conditions involving more than one in-patient clinical team;
e. a clear procedure whereby differences of opinion as to the most appropriate admitting team for a patient are resolved in a timely manner and are not allowed to delay patient admission;
f. an agreed mechanism whereby there is structured, formal retrospective review of cases in which disagreement may have arisen with regard to patient admission processes and/or presenting problems that were not covered by the framework. Learning from these events will inform future revisions of the framework document;
g. clear direction as to the time of changeover of on-call shifts and any specific on-call arrangements for weekends, Bank Holidays and other holiday periods;

h. local protocols to enable patients referred for admission to be assessed in appropriate clinical areas out-with the ED such as specialty assessment units.

6. Emergency Medicine referral processes

Referral for admission should be made as soon as the need for admission is identified. Following EM assessment and the commencement of emergency treatment, an EM doctor will:

a. decide if the patient requires admission;

b. determine the working diagnosis(es) or clinical problems necessitating admission;

c. determine the specialty team to which the patient should be referred, according to the Admission Decision Framework;

d. contact the appropriate fully registered doctor on the on-call specialty team to arrange referral for admission;

e. communicate handover information in an effective manner, ideally using a structured approach (e.g. ISBAR) and indicate the on-call response required – either immediate (for resuscitation cases), a rapid response determined by the patient's condition or a response with assessment to be completed within 2 hours;

f. record the time of the first call to the on-call team in the patient's clinical notes and on the ED Information System (EDIS). Any delays (> 5mins) in response should also be documented.

g. explain to the patient and their family or carers as appropriate, the plan of care and referral arrangements that have been made.

7. On-call team responsibilities

a. The hospital must ensure that on-call teams are enabled to meet their on-call responsibilities in a timely manner, as per HIQA recommendations;[4]

b. The hospital and the on-call Consultant must ensure that a doctor with appropriate experience and clinical competencies is available to provide on-call specialty care to ED-referred patients, under the delegated clinical authority of the Consultant on-call;

c. The decision to admit is a clinical one and need not depend, for instance, on the results of blood tests or other clinical investigations. Admitting teams should not delay assessing a referred patient until the results of clinical investigations are available;

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d. Referral for admission requires assessment of the patient by an on-call team clinician and telephone advice is not an acceptable substitute;

e. If a referral is made by an EM clinician to an on-call specialty doctor, it is the responsibility of the on-call doctor who was contacted to pass details of the referral to the doctor taking their place when they are going off on-call duty.

f. The time and date of the assessment by the on-call team and the name, Medical Council Registration Number and pager number of the doctor who assessed the patient should be recorded in the patient's clinical notes. The time of assessment completion should be recorded in the EDIS.

g. On-call specialty teams should facilitate protocols for the transfer of patients to assessment units and other appropriate clinical areas, where admission assessments can be carried out. Patients must not be delayed unnecessarily in EDs;

h. On-call teams should adapt their work practices to ensure that as many referred patients are assessed in as timely a manner as possible and that patients are prioritised according to clinical acuity. Rapid assessment by experienced on-call clinicians, with subsequent full clerking is likely to be more effective than consecutive full clerking of referred patients according to their times of presentation.

8. Patient safety and quality of transition of care

a. EM staff will, where required, be involved in the resuscitation of any patient in the ED irrespective of which Consultant team is responsible for them;

b. EM doctors will escalate any clinical concerns or referral problems to the most senior EM doctor available in the ED or the on-call Consultant in EM;

c. Consultants from specialty teams, other than EM, will hold primary clinical responsibility for patients whose care has been accepted by their teams prior to the patient's arrival in the ED e.g. patients transferred from another hospital, patients referred directly to specialty teams from triage in cases where a GP has specifically arranged assessment by a speciality service and patients whose care they have accepted from EM, as per this policy. The EM team will provide resuscitation care, as required, for all patients in the ED.

d. If agreement is not achieved between the EM clinician and the on-call specialty with regard to a referral, discussion should take place at the most senior clinical level possible, ideally at Consultant level. Any failure to immediately resolve referral issues at Middle Grade level must be immediately escalated to Consultant level on a 24/7 basis;

e. If the hospital's Admission Decision Framework does not cover the patient's presenting problems, the most senior EM clinician who has seen the patient will determine the most appropriate specialty to which

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the patient should be referred. All such cases will be subsequently reviewed, as per the Admission Decision Framework;

f. All assessments by on-call teams must be finished within two hours of the time of first call by an EM doctor so that transition of care to the on-call specialty Consultant is complete, irrespective of whether the patient is transferred to a non-ED area or remains in the ED.

g. If the on-call team to which the patient has been referred requires a "second opinion" from another specialty or wishes to refer the patients onwards to another specialty, the on-call team assumes responsibility for this referral and the patient's care during this transition of care. The patient will not default back to the care of EM at any stage as this would be detrimental to ensuring the onward progress of the patient's pathway of care in addition to potentially compromising the care of new patients attending the ED.

h. In cases where the on-call assessment has not been completed within a two hour time-frame and acceptance of care has not been confirmed, the patient's care will default to the appropriate Consultant on-call (according to the hospital's Admission Decision Framework) unless the Consultant in EM agrees with the Consultant on-call to defer transfer of care for a specific reason and for an agreed period.

i. The hospital manager or their delegate must be immediately informed of any case in which the transition of Consultant responsibility has not been agreed according to this policy. The manager will act to ensure that the hospital fulfils its duty of care to the patient. The hospital manager will contact the on-call specialty Consultant considered by the Consultant in EM to be the most appropriate specialist to care for the patient (according to the Admission Discharge Framework or patient-specific criteria that are not covered by the Framework). The on-call specialty Consultant may elect to accept the patient's care or to see the patient and having done so take personal professional responsibility for discussing with and arranging admission under another Consultant.

j. The Clinical Director will be subsequently informed of all cases where referral difficulties have arisen. The Clinical Director, in conjunction with the hospital management team, will review all such cases and consider amendments, if necessary, to the hospital's Admission Decision Framework. The Clinical Director will ensure optimal clinical governance for the hospital's ED admission procedures.

k. Should the patient subsequently require transfer to another hospital or clinical unit after referral, the admitting team will arrange this.

l. The follow-up care of any patient discharged from the ED after assessment by an on-call specialty team remains the responsibility of that specialty team Consultant.

m. Where the patient's care requires the immediate combined efforts of multiple on-call teams (e.g. major trauma resuscitation) the Consultant in EM will, in collaboration with the on-call teams involved,

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determine the most appropriate on-call Consultant under whose care the patient will be admitted, as per the hospitals Admission Decision Framework.

References and Resources

1. Emergency Department - Direct Admission to Inpatient Wards. New South Wales Health. Accessed 3rd July 2012 at http://www.health.nsw.gov.au/policies/pd/2009/pdf/PD2009_055.pdf.

2. Communication during patient handovers. WHO Collaborating Centre for Patient Safety Solutions http://www.ccforpatientsafety.org/common/pdfs/fpdf/presskit/PS-Solution3.pdf

3. Achieving excellence in clinical governance, towards a culture of accountability. HSE Quality and Patient Safety Directorate, July 2010. Accessed 19th August 2012 at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Quality_and_Patient_Safety_Documents/CLINGOV.pdf

4. Health Information and Quality Authority (HIQA) Report of the investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute admission, 8th May 2012. Accessed 3rd July 2012 at http://www.hiqa.ie/press-release/2012-05-17-tallaght-hospital-investigation-report-published-health-information-and-qua.

5. The National Emergency Medicine Programme Report 2012. Accessed 5th July 2012 at http://www.hse.ie/emergencymedicine

6. Clinical Handover – Standard Key Principles. New South Wales Health. Accessed 3rd July 2012 at http://www.health.nsw.gov.au/policies/pd/2009/pdf/PD2009_060.pdf

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Appendix A – Guidance on Specialty Consultation in the Emergency Department

1. A consult is a request for a specialist opinion to be provided by a senior doctor where overall responsibility for care remains with the Consultant requesting the consult. For the purpose of a consult, a senior doctor is ideally a Consultant but this role may be delegated by the Consultant to a relatively experienced doctor at Specialist Registrar, Registrar or Middle Grade.

2. A senior opinion for all EM patients should be provided by a Consultant in EM or a Middle Grade doctor in EM in the first instance.

3. ED consults should ideally be requested by Consultants or Middle Grade doctors in EM.

4. It should be clearly communicated to on-call teams whether a consult or a referral for admission is occurring. It is not acceptable for on-call specialty teams to interpret a referral for admission as a consultation and hand back the referred patient's care the EM team. It is the responsibility of on-call teams to arrange the further care of all patients who are referred for admission.

5. ED consults are expected to be completed within two hours of request, as per admission referrals.

6. Consults should not be necessary for patient referral to rapid access out-patient clinics and pathways of care for such referrals should be developed.

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