Australasian College for Emergency Medicine

Responsibility for care in emergency departments

V5 P18

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Document Review

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Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V1	Mar-1999	Approved by Council
V2	Mar-2012	Reviewed and approved
V3	Jan-2017	Revised
V4	Nov-2020	Revised significantly, new publication style applied. Reclassified as a Policy (P18) rather than a Statement (S18)
V5	Mar-2024	Merged with P46 Definition of an Admission and references updated

Revision History

This Policy should be read in conjunction with the following ACEM documents:

- S12: Statement on the Role Delineation of EDs and Other Hospital-based Emergency Care Services
- S57: Statement on ED Overcrowding
- G36: Guidelines on Clinical Handover in the ED
- P55: Policy on Emergency Medicine Consultation Standards of Care
- S127: Statement on Access Block
- P02: Policy on Standard Terminology
- P67: Extended Role of Nursing and Allied Health Practitioners Working in Eds

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1. Purpose and scope

This policy provides guidance to emergency departments (EDs) and hospitals in Australia and Aotearoa New Zealand on the roles and responsibilities of EDs in delivering care to patients within the ED, including those with delayed admissions or transfers where shared care may be required.

In scope for this Policy are all clinical and administrative hospital staff who see, assess, treat, manage, and refer patients and/or receive referrals of patients, or who manage issues around clinical governance in Australian and Aotearoa New Zealand hospitals with EDs. This includes staff who primarily work in EDs under the authority of ED medical and/or nursing directorates, as well as non-emergency staff such as inpatient medical teams with formal clinical privileges within the hospital, community providers referring patients to EDs, and administrators who have responsibility for patient outcomes, resource provision and governance.

2. Definitions

Admission

An admission is determined by the need for interventions, investigations, monitoring, or other management that would not be considered part of an ED attendance. An admission should only be determined and designated on clinical grounds.

Admission occurs when a medical decision for the need for inpatient care is made by an appropriately qualified decision maker, a patient is accepted by a hospital inpatient specialty service for ongoing management, and the patient is administratively admitted to the hospital. The decision to admit a patient may be made by a referring specialist prior to the patient's arrival to the ED, by the emergency physician, by an inpatient service, or mutually agreed by some or all these medical providers.

Emergency departments play a key role in the admission of patients to hospital. The decision to notify an inpatient specialist medical practitioner or their delegate that a patient is ready for admission to hospital from the ED should be made by an emergency physician or their delegate. Arrangements for admitting rights, responsibilities, timeliness of referral and acceptance, responsibilities during handover of care, and dispute resolution, should be clearly delineated in hospital procedures documentation.

Definition of ED metrics such as 'Admission Delay Time' and 'Inpatient Bed Request Time' can be found in the ACEM document P02: *Policy on Standard Terminology*. ACEM also has advice on the responsible use of admission data.[1]

Departure

Departure from the ED refers to the transfer of responsibility and accountability for a patient's care upon leaving the ED. A patient may be admitted to an inpatient ward, transferred to another facility, or discharged back to the community. Prior to departure from the ED, but after admission has occurred and while a patient awaits transfer to an inpatient bed, there will be a period of shared responsibility for ongoing care of the patient between the ED and the inpatient team. See Sections 4 and 5.4.

Definition of ED metrics such as 'Departure (Physically Leaves) Time' and 'Ready for Departure Time' can be found in the ACEM document P02: Policy on Standard Terminology.

Emergency department

An ED is a dedicated hospital-based facility specifically designed and staffed to provide 24-hour emergency care. An ED cannot operate in isolation and must be part of an integrated health delivery system within a hospital both operationally and structurally. The minimum standards for the different levels of EDs are defined in *S12 Statement on the Role Delineation of EDs and Other Hospital-based Emergency Care Services*.

[1] Analysis of the relationship between ED overcrowding, access block and hospital bed availability is conducted using data pertaining to overnight admissions only, with an overnight admission defined as a formally admitted patient who is admitted and discharged from hospital on different dates. Admission status is not recommended for the purposes of the evaluation of ED case-mix. Patient decade of age, mode of arrival (ambulance vs non ambulance) and source of referral (medical practitioner vs non- medical practitioner) are recommended as alternative non-gameable case-mix evaluation criteria.

Emergency medicine

The practice of emergency medicine (EM) is concerned with the prevention, diagnosis, and management of acute and urgent aspects of illness and injury among patients of all ages presenting with a spectrum of undifferentiated physical and behavioural disorders. Emergency medicine is recognised as a principal specialty. The specialty further encompasses pre-hospital and in-hospital emergency medical systems.

Emergency physician

An emergency physician is a registered medical practitioner trained and qualified in the specialty of emergency medicine. The recognised qualification of an emergency physician in Australia and Aotearoa New Zealand is the Fellowship of the ACEM (FACEM). Other acceptable terms include staff specialist in emergency medicine, specialist in emergency medicine, specialist emergency physician and consultant in emergency medicine.

Director of Emergency Medicine

The Director of Emergency Medicine (DEM) has overall clinical and administrative responsibility for all patients in the ED. All staff in the department are responsible to the DEM on operational and clinical matters. This does not preclude matters of policy and ethical responsibility which multidisciplinary team members have to others in the hospital.

Referral

Referral occurs when an emergency physician consults another non-EM specialty service for either an opinion on patient management or asks the non-EM clinician to take over a patient's clinical management, on an inpatient ward (as an admission) or as an outpatient. When required, referral of ED patients will occur as soon as possible. The reason for referral will be communicated to the consulting service, including whether admission to hospital is required, and the outcome of this referral will be documented in the medical record, including the time of referral and to whom the referral was made.

Shared care

Shared care within the ED refers to the joint responsibility for clinical care of a patient by EM and one (or more) other specialty service/s. Most often, shared care will occur in circumstances where:

- a patient has been admitted and is awaiting transfer to an inpatient bed;
- the ED is providing acute medical management of patients who present with behavioural health concerns simultaneous with an acute medical condition;
- a patient is waiting for retrieval or inter-hospital transfer and consultation has occurred or is ongoing with a specialty service at the accepting hospital, or state based critical care, trauma, burns, spinal, toxicology or other quaternary services; or
- a patient has been referred to the ED in lieu of any other available space for an urgent clinical review by their treating clinical service who will also undertake clinical management in the ED.

3. Key messages

ED clinical staff have primary responsibility for the emergent care and stabilization of patients in the ED and are ultimately responsible to the designated senior ED medical and nursing personnel for adhering to ED policy. Emergency care and stabilization may involve other hospital personnel (for example rapid response for trauma, stroke, or as specifically negotiated locally). However, the primary responsibility for appropriate emergency care resides with the ED. In a situation where there are no senior staff the primary responsibility for care and appropriate systems must be determined by the hospital. See Section 5.6.

At the point where an admission decision is made, handover of primary responsibility for care to another specialty service will occur, and a patient will depart the ED. Where a patient remains in ED pending transfer to an inpatient bed, the responsibility for clinical care is shared with the other specialty service (the 'admitting team'). The non-EM specialty service is responsible for ongoing definitive management plans, full medication review and reconciliation, specialist care and planning of non-ED procedures and investigations.

While ED teams will assist in co-ordination where possible, the ED remains responsible only for primary management (assessment, commencement of initial therapies, documentation of interim medication, fluid, and clinical management orders so that a patient will receive appropriate care until inpatient team review) and ongoing immediate response to unanticipated sudden deterioration, where the ED team will provide immediate stabilization until the inpatient team can respond. The ED must prioritise its resources to ensure it retains capacity for immediate response to new arrivals.

Directors of Emergency Medicine should ensure that all staff in their departments understand the organisational structure of the ED, and the full extent of their responsibility for care until the patient is safely transferred and handed over to another clinical area or discharged.

4. Policy

4.1 Emergency departments

Emergency departments play a pivotal role in providing the public with access to 24-hour acute health care. As part of shared care arrangements, EDs cannot operate in isolation and are both structurally and operationally part of an integrated health delivery system within a hospital or health service network.

Patients who do not require ED medical assessment or resuscitation, but do require hospital admission for further care, should not be admitted via the ED. Similarly, patients for whom another community or hospital service can provide the required care should access that service directly. In general, transferring patients from one ED to another for repeated assessment or admission represents an inefficient use of health service resources and should be avoided. If a health service, for local reasons, decides to use an ED to provide non-ED services, this must be made explicit within service agreements and through the appropriate resourcing of that ED.

4.2 Responsibility for care

The primary responsibility for the management of ED patients who are undergoing emergency care rests with the designated clinical lead on duty in the ED at the time. The DEM has ultimate responsibility for providing an appropriate and safe environment to ED patients undergoing emergency medical care. This responsibility extends until the patient physically leaves the ED (i.e. disposition) and includes making clear the expected responses and responsibilities of inpatient teams and administrators in facilitating timely management decisions and definitive care.

Following disposition from the ED, a degree of shared patient care remains between the ED and the specialist clinician to whom the patient is referred, as ED staff are required to ensure appropriate interim management is documented and understood – by the patient, the accepting inpatient unit staff and/or the transferring staff, until specialty service review can occur.

4.3 Emergency department overcrowding

Emergency department overcrowding refers to a situation where ED function is impeded because the number of patients exceeds either the physical and/or staffing capacity of the ED, whether they are waiting to be seen, undergoing assessment and treatment, or waiting for departure. When EDs are overcrowded emergency physicians have a responsibility to inform senior hospital executives that patient care could be compromised. See *ACEM Statement on ED Overcrowding* (S57) for more information.

4.4 Handover and shared care

Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. The transfer of clinical and professional responsibility at the end of a shift is an important medical duty that is vital to ED patients' continuity of medical care. Systems are required to ensure adequate clinical handovers occur, and that they are documented and well-resourced with appropriately constructed rosters. Systems must be in place that clearly enable hospital staff to identify the treating ED doctor for all patients within the ED.

When a patient is waiting to be transferred to another hospital unit, EDs are responsible for emergent care, stabilisation, and preparation of the patient in conjunction with the other inpatient specialty team to which the patient has been referred. The non-EM specialty team is responsible for ongoing definitive management plans, full medication review and reconciliation, specialist care and planning of ongoing procedures and investigations.

4.5 Consultation

It is common for other specialists to be consulted about patients undergoing emergency care in the ED. Consultations may involve advice on investigations or treatment provided via telephone and/or telehealth services, or the clinician to whom the referral for consultation has been made personally attending the patient in the ED. In some circumstances, consultation may extend to the performance of procedures on the patient in the ED. All consultations must be documented.

The clinician providing advice or care is responsible for the outcome within the scope of that consultation. However, when the patient remains in the ED, the primary responsibility for care resides with ED medical staff.

4.6 Discharge to Community

For patients being discharged to the community, responsibility for care extends to the point at which the patient leaves the ED. Thereafter, responsibility for care will be shared to varying degrees between the ED, consulting specialists involved in the discharge process, the patient and practitioners or organisations in the community to whom referral for follow-up may have been arranged.

5. Specific considerations

5.1 Admitted but no inpatient bed (Access blocked)

When a patient is assessed in the ED as requiring admission as an inpatient, a bed should be made available at the delegated receiving unit as soon as possible. The hospital executive is responsible for establishing and maintaining a bed management system that minimises any delays that lead to access block for ED patients requiring admission to an inpatient unit. The ED is not an appropriate environment for the ongoing management of patients who require inpatient medical care. Retention of admitted patients in the ED is a failure of access to care and is detrimental to ED functions. Procedures should be in place to monitor and action circumstances where admitted patients remain in the ED for prolonged periods[2].

Occasions will arise where the emergency care process is complete, and the need for admission determined and administratively complete. However, transfer to the relevant inpatient clinical area cannot occur due to lack of bed capacity. The patient will have been referred to the inpatient unit and a consultation of varying complexity may have occurred. This process must be documented in the clinical record.

In this circumstance, shared care between the ED and the non-EM specialty service will occur. The ED retains the primary responsibility for the initial and emergency management of the patient including observation, medication administration, nursing care, and the immediate response to any emergent situation. The admitting unit is primarily responsible for the timely development, documentation, and communication of a treatment plan, and for related drug/medication orders. The admitting inpatient unit is responsible for:

- the outcome of those elements of the investigation or treatment plan it has prescribed;
- assisting the bed management system to locate an appropriate bed;
- appropriate periodic review of the patient including regular documented updating of the ongoing treatment plan, and

[2] 'Prolonged period' is that which exceeds jurisdictional targets as defined by ACEM policy on hospital access.

— responding to any emergent situation notified by the ED. Full transfer of responsibility occurs when the patient arrives at the inpatient clinical area and implementation of the treatment plan is taken over by the medical and nursing staff of that inpatient unit.

5.2 Transfer to ward prior to formal assessment by the receiving unit

A decision to admit a patient to an inpatient ward may be made by the ED or by a specialty service prior to the patient's arrival, within the policy and procedure framework of the treating hospital. In this situation, a ward bed may become available for transfer of the admission prior to a patient being formally assessed by the inpatient specialty team. In such circumstances, it is the responsibility of the ED medical staff to communicate directly with the receiving unit medical staff, hand over clinical care, agree the timeframe for review of the patient, and explain and agree the interim management that has been arranged.

It is also the responsibility of ED staff to prepare and document, in discussion with the admitting team, an interim plan and orders for the ward care of the patient until the planned review time by the receiving unit, and to take reasonable care and appropriate steps to ensure the clinical safety of the patient until reviewed.

Where a patient is an 'expected' admission arranged by a non-EM specialty service, or a direct referral from an outpatient clinic, and does not require emergent stabilization but has been directed to ED solely due to inpatient bed availability issues, the inpatient service is responsible for documentation of the interim and ongoing orders and clinical management plan for the patient.

5.3 Transfer team

In some hospitals, critical care units will send a team to the ED to transfer the patient to their intensive care unit. Medical and nursing handover then occurs in the ED and transfer of responsibility occurs at that point. The same principle applies when the emergency medical system provides specialised retrieval teams to undertake inter-hospital transfers.

5.4 Multidisciplinary teams and advanced allied health and nursing roles

It is not uncommon for EDs to establish advanced allied health and nursing roles and a system of multidisciplinary teams to manage all or part of the emergency care process for certain presentations, for example major trauma, cardiac arrest, or sexual assault. As the designated clinical lead in charge of the ED, the DEM is accountable for the clinical and operational performance of the ED and retains primary responsibility for patient care irrespective of who participates in the ED model of care.

While specific team leadership may be determined by seniority, experience, agreement or hospital policy, the command and control of the ED infrastructure cannot be passed to others who are not credentialed in emergency medicine. Further, command and control cannot be passed to those not in a position to have an overview/oversight of the needs of all ED patients in the department when determining priorities.

The objective of advanced allied health and nursing roles and multidisciplinary teams is to increase the expertise available in the ED to manage complex cases. It is therefore incumbent on ED staff with primary responsibility to carefully consider the advice of all team members in managing the emergency care process.

See *P67 Extended Role of Nursing and Allied Health Practitioners Working in EDs* for more information.

5.5 Statutory exceptions

There may be some statutory exceptions to the principle that patients in the ED are the responsibility of the ED. These might include patients in custody, as well certain mental health crises and public health emergencies, where patients are detained under applicable legal instruments.

5.6 No senior staff

In some EDs, there may be times when there are no specialists, senior medical officers, or advanced emergency medicine trainees on duty in the ED. ACEM does not believe that primary responsibility for the care of emergency patients in designated EDs can be vested in junior medical staff. Therefore, in those circumstances, while there must always be a medical officer in charge of the ED, the primary responsibility for care and appropriate systems must be determined by the hospital. These arrangements must be clearly published and made known to those involved. The hospital has overall responsibility for system control and errors.

5.7 Did not wait

Patients who present for care to the ED and subsequently fail to wait for care, or who leave after commencement of care, may be at some risk after leaving. The ramifications of a decision not to wait for care fundamentally resides with the patient or responsible guardian (where this person does not have the capacity to make a rational decision) and the patient and their guardian may decide to leave at any point during their ED stay. Where possible, it is expected that ED staff will provide information to enable the patient or carer to make a fully informed decision, and to encourage the patient or carer to return to the ED at any time should they change their decision.

Where a patient declines to wait or absconds and is considered at significant clinical risk, it is the responsibility of the ED staff to notify ED or hospital management according to locally agreed processes (or in appropriate cases, any relevant statutory authority having responsibility for the patient) to facilitate appropriate follow-up of the patient. EDs should monitor 'did not wait' and 'left before treatment complete' patients, using a risk- based approach, and implement systems to detect patients who may be at significant risk following departure from the ED.

Some hospitals will require ED staff to complete appropriate 'did not wait or absconded' pro-formas which are countersigned by the patient or guardian to indicate understanding of potential risk. Irrespective of such documentation, ED staff should fully document in the patient notes their discussions with patients (and carers) who chose to leave, briefly outlining the explanation and understanding of risk, advice for ongoing care, and invitation to return to ED.

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