Who is in charge of patient care when the wards are full?

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vercrowding in emergency departments (EDs) is increasingly common. Part of the problem is what is called ‘exit block’, where patients who need to be admitted have been referred to a specialist team, but a place on a ward cannot be found so they remain in the ED. Such situations can cause confusion over who has responsibility for these patients.

New guidance from the Royal College of Emergency Medicine (RCEM) aims to bring greater clarity to the issue.

Patients who come to the ED will usually be assessed soon after arrival. If a referral to a specialty team is needed, staff will do that and the patient should be seen within 30 minutes by the specialty team.

Where appropriate, a bed on a ward should be found. Waits of more than four hours to get a bed on the ward are considered unacceptable.

Over the past year, one in three patients who needed to be admitted to hospital experienced delays of more than four hours while waiting for a bed on a ward – an increase from one in six before the pandemic.

New patients

Royal College of Nursing emergency care forum member Sara Morgan says the scale of the problems is making working life difficult for ED nurses.

‘Nurses will have new patients arriving all the time and having patients put into temporary areas, side rooms, clinical decision units (CDUs) and medical assessment units (MAUs) just adds to the workload.

‘It is not uncommon for patients to spend more than 24 hours waiting to get on a specialist ward.

‘ED nurses are highly skilled and can provide care to many different patients, but they won’t have the specialist knowledge and access to all the tests and investigations that a patient may require. That patient may miss out on other support, such as from dietitians, occupational therapists and physiotherapists, that they would otherwise get. With winter approaching the fear is it is only going to get worse.’

Position statement

The RCEM position statement, which was updated in October 2023, makes recommendations about what should happen once a referral is made by the ED.

It says that while waiting for a specialist team to respond, the patient remains the responsibility of the ED team. That includes ordering any tests that are needed and monitoring and responding to deterioration. But the statement makes it clear that once a patient has been seen by a specialty team they then become the responsibility of that team – even if that patient remains in the ED or in linked areas such as CDUs and MAUs.

There should be a clear and accurately documented handover between teams in real time, it says. The ED should have IT systems that document who is clinically responsible for each patient, whether that is the ED team or a specialty team.

Referrals should not be declined by the specialty team, the RCEM says. If the team feels the patient should be treated elsewhere, it is their responsibility to make that referral.

To aid clarity, every hospital should have published internal professional standards, set by the medical director, that outline these principles in detail, the RCEM says.

ED nurse and RCEM advanced care practitioner
Forum chair Ashleigh Lowther says there is much variation in how hospitals manage this, with not all having clear standards in place. ‘Even when there is clarity, ED staff still face challenges,’ she says. ‘For some patients it may not be clear which specialty they need to be referred to. Patients with complex conditions could fall under a number of specialties. And in smaller hospitals there may not be a specialist ward for a certain patient – some may need to be transferred to another hospital.’

Another problem ED staff face, says Ms Lowther, is that it can be difficult to refer to specialties without having results from certain tests. ‘This can add to the delay for a patient in the ED.’

Junior doctor strikes
She contrasts those delays with how things are managed during exceptional events, such as the junior doctor strikes. With reduced numbers of junior doctors, consultants from other wards had to make final decisions on patients – something that was made possible by postponing large amounts of routine work while the strikes took place. ‘This meant that decisions were made quickly and the patient got to the right place quicker,’ says Ms Lowther.

Despite the guidance, there remains the problem of what happens should a patient’s condition deteriorate.

The guidance says that should be policies in place to alert and escalate to the specialist team once they have clinical responsibility for the patient. But Ms Morgan says: ‘After a decision to admit to a specialty team it can be difficult to contact the relevant on-call team – particularly out of hours – and it can take them time to respond.

The specialist teams may have a ward on-call team and an admission on-call team and nurses can find themselves bounced between the two. It is making things difficult for ED teams.’

This means it is still ED nurses who have to respond, says Ms Lowther. ED nurses are overwhelmed and while the debate is happening with clinicians over who should be clinically responsible for these patients, it’s the ED nursing team that will be looking after the patient’s nursing needs regardless.

The harm of having unassessed patients in ambulances is greater than the harm of boarding patients who have been assessed by a specialty team

‘Even when a specialist team has seen a patient, if the patient is still in the ED care often falls to the ED nurse, unless the specialty team responds quickly.’ When there is overcrowding in the ED, boarding or continuous monitoring. Ms Lowther says: ‘I am a fan of boarding in the right context. It shares the risk of having too many patients across the organisation rather than putting it all on the ED.

‘I can see why wards do not like it, they might look at the ED and see we have lots of nurses and they may only have two, but you have to consider just how many patients are in ED and how many are waiting outside in ambulances. We need to look more at nurse per patient ratios.

‘Different trusts have different policies on boarding and sometimes it comes down to who is on shift – the matron or senior managers may have the final call. ED nurses have very little say in this.’

Who is responsible for patients in the emergency department?

» Once a patient in the emergency department (ED) is seen by a specialty team, the patient is their responsibility
» While waiting for specialty teams to respond to a referral, the patient remains the responsibility of the ED team, who should continue to react to changes in the patient’s clinical condition and results
» For patients under the care of specialty teams that continue to reside in the ED, concerns about clinical management should be escalated to a senior doctor in that specialty. If concerns persist they should be discussed with the senior ED doctor on duty
» If a specialty team feels it is inappropriate to look after that patient, it is their responsibility to refer to a more appropriate team
» Specialty patients placed on observation wards due to capacity issues should remain under the care of that specialty team
» The ED team may be expected to coordinate care in specific circumstances, such as trauma calls

Source: RCEM (2023)