



STATEMENT ON RESPONSIBILITY FOR CARE IN EMERGENCY DEPARTMENTS

1. INTRODUCTION

The objective of this document is to provide guidance to the staff of Emergency Departments on their role and responsibility in the provision of care to the patients in their facilities, and the transfer of responsibility for care upon admission to, or discharge from, hospital.

This statement is based on the principles of modern organisation management, precedent and advice. Where an individual hospital wishes to have alternative administrative arrangements, these should be formally documented to ensure that appropriate accountability is created.

2. THE EMERGENCY DEPARTMENT

Emergency Departments (ED's) comprise distinct physical facilities and organisational structures established in hospitals to deliver emergency medical care to the acutely ill and injured. Emergency Departments are similar to other hospital clinical units and will typically have an organisational structure including a director and senior medical and nursing staff who are credentialed and who are ultimately accountable to the hospital executive for the performance* of the Department. The organisation of work in the Emergency Department must bring together the elements of physical facility, clinical equipment and other technology and human resources to create a care process which meets appropriate quality standards:

- Reception
- Triage
- Initial assessment and resuscitation
- Detailed assessment and investigation
- Transitional evaluation and monitoring
- Disposition

* Performance may be conceived as the casemix and quality adjusted volume of services delivered for the budget provided.

3. RESPONSIBILITY FOR CARE

The primary responsibility for the management of patients physically within the Emergency Department and undergoing this care process rests with the medical practitioner designated in charge of the Emergency Department at the time. This responsibility extends until the conclusion of the emergency care process when the patient and their clinical record are physically delivered to another clinical area (ward, ICU, OR etc) and a referral and appropriate 'handover' between medical, and between nursing staff, has occurred.

4. DANGEROUS OVERCROWDING

Emergency Departments are built and staffed to meet predefined patient loads. When emergency departments are overcrowded or have patient loads which exceed their physical or staffing capability, emergency physicians have a responsibility to inform hospital management that patient care could be compromised and hospital management has a responsibility to restore a safe working environment.

5. HANDOVER

The end-of-shift transfer of clinical responsibility is an important medical duty that is vital to the continuity of the medical care of patients within the Emergency Department. Systems are required to ensure adequate clinical handovers occur, are documented, and are resourced in terms of appropriately constructed rosters.

Systems must be in place within the Emergency Department that clearly enable staff to identify the treating Emergency Department doctor for all patients within the ED.

5. CONSULTATION

It is common for other specialists to be consulted about patients undergoing the care process in an Emergency Department. Such consultation must be documented, and may involve advice on investigation or treatment provided by telephone, or may involve the clinician to whom the referral for consultation has been made personally attending the patient in the emergency department. In some circumstances, this consultation may extend to the performance of procedures on the patient in the Emergency Department.

The clinician providing such advice or care is responsible for the outcome within the scope of the consultation but provided the patient remains physically in the Emergency Department, the primary responsibility for care still resides with the Emergency Department medical staff.

6. DISCHARGE

For patients being returned to the community, the responsibility for care extends to the point at which the patient leaves the Department. Thereafter, responsibility for care will be shared to varying degrees between the Emergency Department, any consulting specialists which may have been involved in the discharge process, the patient and any practitioner or organisation to whom referral for follow up may have been arranged.

7. SPECIAL CIRCUMSTANCES

7.1 ADMITTED, BUT NO INPATIENT BED

The hospital executive is responsible for the establishment and maintenance of a bed management system that minimises access block for emergency patients requiring admission to an inpatient unit.

Occasions will arise where the emergency care process has been completed, and the need for admission determined and administratively completed but transfer to the relevant inpatient clinical area cannot occur because of the lack of an available bed. 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, the Emergency Department retains the primary responsibility for the management of the patient including observation, medication administration, nursing care, and the immediate response to any emergent situation. The admitting unit is responsible for the timely development, documentation, and communication of a treatment plan, and for related drug orders. The admitting inpatient unit is responsible for the outcome of those elements of the investigation or treatment plan it has prescribed, for assisting the bed management system to locate an appropriate bed, for appropriate periodic review of the patient including regular documented updating of the ongoing treatment plan, and to respond to any emergent situation notified by the ED. Full transfer of responsibility occurs when the patient arrives at the inpatient clinical area and the treatment plan implementation is taken over by the medical and nursing staff of that unit.

7.2 TRANSFER TO WARD PRIOR TO RECEIVING UNIT FORMAL ASSESSMENT

A decision to admit a patient to an inpatient ward may be made by the Emergency Department within the policy and procedure framework of an organisation. In this situation, a ward bed may become available for transfer of the admission prior to a patient being formally received by the inpatient unit. In such circumstance it is the responsibility of the Emergency Department medical staff to communicate directly with the receiving unit medical staff, to hand over clinical care, to specify the timeframe for review of the patient, and to explain interim treatments which have been ordered. It is the responsibility of the Emergency Department staff to prepare 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 and appropriate steps to ensure the clinical safety of the patient until reviewed.

7.3 TRANSFER TEAM

In some hospitals, critical care units will send a team to the ED to transfer the patient to their intensive care facility. The medical and nursing handover then occurs in the ED and the transfer of responsibility occurs at that point.

The same principle applies where the emergency medical system provides specialised retrieval teams to undertake interhospital transfers.

7.4 MULTIDISCIPLINARY TEAMS AND ADVANCED ALLIED HEALTH AND NURSING ROLES

It is not uncommon for Emergency Departments 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 types of patient eg major trauma, cardiac arrest, sexual assault etc. As the designated medical practitioner in charge of the ED is accountable for the clinical and operational performance of the ED at any point in time, they retain primary responsibility for patient care irrespective of who participates in the model of care within the ED.

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 and who are not in a position to have an overview of the needs of all patients in the ED when determining priorities.

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

7.5 STATUTORY EXCEPTIONS

There may be some statutory exceptions to the principle that patients in the Emergency Department are the responsibility of the Emergency Department. This might include patients in custody as well certain mental health and public health emergencies.

7.6 NO SENIOR STAFF

In some Emergency Departments, there may be times when there are no specialists, senior medical officers or advanced trainees in emergency medicine on duty in the ED. ACEM does not believe that primary responsibility for the care of emergency patients in designated ED's can be vested in junior medical staff. Therefore, in the 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.

7.7 DID NOT WAIT

Patients who present for care to the Emergency Department and subsequently fail to wait for care, or who leave after commencement of care, may be at some risk after leaving. The ramifications of such a decision not to wait for care fundamentally reside with the patient or responsible guardian where this person is able to make a rational decision. It is expected that Emergency Department staff will provide information where possible to enable the patient or carer to make a fully informed 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 management (or in appropriate cases, any relevant statutory having responsibility for the patient) to facilitate appropriate follow up of the patient. Emergency Departments should monitor 'did not wait' patients and implement systems to detect patients who may be at significant risk following departure from the ED.

Where possible to gain compliance, Emergency Department staff should complete appropriate 'did not wait or abscond' proformas which are countersigned by the patient or guardian to indicate understanding of potential risk.

8. SUMMARY

The primary responsibility for the care of patients in the Emergency Department lies with the senior medical and nursing staff of the ED so long as the patient is physically treated there. While some sharing of responsibility for aspects of the emergency care process may occur when other clinical units are consulted, the emergency department remains responsible for primary management, including resource prioritisation.

In the circumstance where the emergency care process has been completed and the patient has been administratively admitted, but remains physically in the ED due to the lack of an inpatient bed, the ED staff retain primary responsibility for the delivery of care, while the inpatient unit is responsible for the development and maintenance of the ongoing treatment plan through appropriate periodic review.

Directors of Emergency Departments 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 delivered and handed over to another clinical area.