

[HOSPITAL / HEALTH AUTHORITY NAME]

EMERGENCY DEPARTMENT CONSULTATION AND ESCALATION PROTOCOL

*Protocol 8: Referral, Specialist Response, Chain of Command, Clinical Responsibility, and
Resolution of Disputes*

DRAFT FOR CLINICAL, NURSING, SPECIALTY, GOVERNANCE, AND PATIENT-SAFETY REVIEW

Important: This protocol establishes a common process for consultation and escalation. It does not override national law, professional scope, medical-staff bylaws, specialty admission rules, emergency transfer agreements, or the duty to provide immediate stabilizing care. Response targets and transfer-of-responsibility rules require formal local approval.

Document owner	Emergency Department / Medical Staff Office / Nursing Services / Clinical Governance
Policy number	ED-PRO-008
Version	Draft 1.0
Status	Draft for local consultation and validation
Draft date	June 2026
Effective date	[Insert after approval]
Review date	[Insert; normally within 12 months of implementation]
Approved by	[Medical Director / Nursing Director / Hospital Executive / Governance Committee]
Related documents	ED Protocols 1–7; admission, transfer, deterioration, critical-care, safeguarding, and specialty pathways

1. Purpose

To ensure that every request for clinical advice, specialist assessment, admission, procedure, critical-care support, or interfacility transfer is made clearly, acknowledged promptly, acted upon according to urgency, escalated when delayed or disputed, and documented with unambiguous clinical responsibility.

2. Scope

This protocol applies to all Emergency Department clinicians, nurses, allied health professionals, specialty teams, diagnostic and support services, bed-management staff, administrators, and external clinicians involved in a patient's consultation, referral, admission, transfer, or escalation from first clinical contact until the patient physically leaves the Emergency Department and responsibility has been safely transferred.

3. Core policy statements

- Emergency treatment and stabilization shall not be delayed while seeking consultation, completing routine investigations, negotiating specialty ownership, or locating a bed.
- Every consultation shall have a clear purpose: advice, bedside assessment, procedure, admission, critical-care support, safeguarding action, or transfer.
- The referring clinician shall state the urgency, the clinical question, the most important findings, current treatment, and the action requested.
- Urgent and time-critical referrals require direct, closed-loop communication with a named recipient; an unacknowledged message or electronic referral is not sufficient.
- The receiving clinician shall acknowledge the referral, clarify the plan, identify who will attend or act, and provide a realistic expected response time.
- No patient shall be placed at risk by repeated rejection, specialty-to-specialty “bouncing,” hierarchy, interpersonal conflict, or administrative delay.
- Clinical responsibility shall be explicitly identified and documented at all times, including while the patient remains physically in the Emergency Department.
- Deterioration, new critical results, failure to respond to treatment, or staff/patient/caregiver concern shall trigger immediate reassessment and escalation regardless of the original referral priority.
- Any staff member may activate the safety escalation pathway when a concern is not acknowledged or resolved. Escalation in good faith shall not attract retaliation.
- Where resources or specialty services are unavailable, the senior ED clinician shall activate the approved remote-advice, interfacility-transfer, or overseas-referral pathway without avoidable delay.
- The patient and caregiver shall be kept informed about the responsible team, expected next steps, delays, and changes in plan, subject to consent, privacy, and capacity.
- All significant referral, advice, acceptance, delay, dispute, escalation, and transfer-of-responsibility events shall be documented in real time or as soon as clinically practicable.

A referral is not complete when a call is placed. It is complete when the right person has received and understood the request, urgency and plan are agreed, responsibility is clear, and the next action is tracked.

4. Definitions

Term	Operational definition
Consultation	A request for clinical advice or specialist input that may or may not involve transfer of responsibility.

Term	Operational definition
Referral for assessment	A request for a named service or clinician to examine the patient and provide a documented assessment and plan.
Referral for admission	A request for an inpatient or specialty team to accept ongoing care because discharge from the ED is not appropriate.
Advice only	Guidance provided without bedside assessment or formal acceptance of ongoing responsibility; it must be documented as remote advice.
Acceptance	Explicit agreement by a named clinician or service to provide the requested assessment, procedure, admission, or transfer.
Clinical responsibility	Accountability for the active clinical plan, review of deterioration and results, treatment decisions, communication, and disposition.
Transfer of responsibility	A documented, closed-loop handover in which the receiving team accepts ongoing clinical responsibility.
Time-critical referral	A request in which delay creates imminent risk of death, permanent disability, loss of organ/limb, or loss of a time-dependent treatment opportunity.
Urgent referral	A request requiring prompt assessment because deterioration, treatment delay, or diagnostic uncertainty may cause harm.
Standard referral	A referral for a currently stable patient whose care still requires timely specialty assessment or disposition.
Escalation	A deliberate increase in urgency or authority to obtain review, action, resources, or resolution when ordinary processes are insufficient.
Chain of command	The approved sequence of increasingly senior clinical and operational leaders contacted until the safety issue is resolved.
Closed-loop communication	The sender states the message and requested action; the recipient acknowledges and confirms understanding; completion is reported back.
Disputed referral	A referral in which the appropriate service, admission destination, urgency, or responsibility is not agreed.
Remote consultation	Advice or assessment delivered by telephone, secure messaging, video, image review, or another telehealth method without physical attendance.

5. Roles and accountability

Role	Minimum accountability
Hospital executive / Medical Director	Approves internal professional standards, specialty response requirements, dispute-resolution authority, and accountability for repeated system failure.

Role	Minimum accountability
ED medical lead	Owns the consultation pathway, ensures a senior ED decision-maker is available, maintains specialty agreements, and reviews delays, disputes, and incidents.
ED nursing lead / shift coordinator	Ensures deterioration and nursing concerns are escalated, tracks delayed responses, coordinates patient safety while awaiting review, and activates operational escalation.
Referring clinician	Stabilizes the patient, identifies the clinical question and urgency, communicates the referral, records the recipient and plan, follows up response, and continues care until responsibility transfers.
Receiving clinician / specialty team	Acknowledges the referral, clarifies urgency, provides advice or timely assessment, identifies the responsible senior, documents the plan, and arranges onward specialty transfer if needed after accepting responsibility.
Senior ED clinician	Supports difficult referrals, resolves immediate uncertainty, escalates delayed or disputed cases, and exercises locally delegated admission/transfer authority where applicable.
On-call specialty consultant / senior	Provides senior decision-making, responds to escalation, resolves disagreement, and ensures the service has a safe response system.
Nurse responsible for patient	Continues observations, treatment and safety care; reports deterioration; verifies the current responsible team; and escalates unresolved concerns independently.
Bed manager / administrator on call	Addresses bed, staffing, transport, equipment, and operational barriers without substituting administrative judgment for clinical decisions.
Medical records / information technology	Maintains referral timestamps, electronic routing, downtime procedures, auditability, and current contact directories.
All staff	Use respectful communication, speak up for safety, apply the Two-Challenge Rule/CUS when needed, and report hazards or repeated failures.

6. Consultation and escalation pathway

Stage	Required action
1. Recognize need	Identify the clinical question, required service, risk of delay, and whether the patient needs advice, bedside assessment, procedure, admission, or transfer.
2. Stabilize first	Address immediate ABCDE threats, analgesia, infection control, antidotes, time-dependent treatment, and monitoring. Do not wait for consultation to begin essential care.
3. Set priority	Classify as time-critical, urgent, or standard using current physiology, trajectory, red flags, treatment window, and resource need.

Stage	Required action
4. Prepare referral	Confirm identity; summarize history, findings, vital-sign trend, working diagnosis, dangerous alternatives, treatment, key results, and explicit request.
5. Contact named recipient	Use the approved directory. Urgent referrals must be verbal or otherwise directly acknowledged. Record name, role, time, method, and response.
6. Close the loop	Recipient confirms the request, urgency, plan, who will act, expected response time, and responsibility while awaiting review.
7. Continue care and track	Monitor, reassess, act on results, and update the receiving team if the condition changes. A referral does not pause ED care.
8. Escalate delay or disagreement	Repeat contact, call a more senior clinician, involve the senior ED doctor, and activate administrative/medical leadership according to risk.
9. Transfer responsibility	Complete direct handover, document acceptance and responsible team, update patient/caregiver and nursing staff, and confirm monitoring and next actions.
10. Review system failure	Report harmful or recurrent delays, disputed ownership, directory failure, communication breakdown, or resource gaps for governance action.

7. Indications for consultation or escalation

- Need for expertise, procedure, intervention, or disposition decision beyond the treating clinician's competence or authorized scope.
- Potential need for hospital admission, critical care, emergency operation/procedure, obstetric delivery, psychiatric containment, specialist treatment, or interfacility transfer.
- Time-dependent emergency pathway, including but not limited to major trauma, stroke, acute coronary syndrome, sepsis, ruptured ectopic pregnancy, testicular torsion, threatened limb, airway emergency, neurosurgical emergency, severe poisoning, or neonatal/paediatric deterioration.
- Persistent diagnostic uncertainty where a dangerous condition cannot be safely excluded or managed in the ED.
- Failure to improve, unexpected deterioration, recurrent instability, escalating oxygen/vasopressor needs, critical result, or need for a higher level of monitoring.
- Conflict between the apparent needs of the patient and the available service, bed, equipment, transport, blood product, medication, or staffing.
- Safeguarding, abuse, neglect, violence, sexual assault, self-harm, impaired capacity, or social circumstances requiring multidisciplinary action.
- Patient or caregiver concern that the current plan is unsafe or that deterioration has not been addressed.
- Any situation in which the clinician or nurse is uncomfortable proceeding without senior input.

8. Preparing a safe referral

The referral shall be proportionate to urgency. For a crashing patient, contact the appropriate senior and summon bedside support immediately while resuscitation continues. For a stable patient, prepare a concise, clinically useful referral before calling.

- Use at least two patient identifiers and confirm current location.

- State your name, role, service, and a callback number or communication channel.
- State whether the request is for advice, assessment, procedure, admission, transfer, or critical-care support.
- State the urgency in the first sentence and explain the risk of delay.
- Give the relevant history, examination, physiological trend, working diagnosis, dangerous alternatives, treatment already provided, response, and key results.
- State important allergies, anticoagulation, pregnancy status, isolation requirements, capacity/safeguarding issues, and treatment limitations where relevant.
- Ask a specific question or make a specific request rather than simply “letting the specialty know.”
- Do not delay referral to complete tests that are not required for immediate management or specialty decision-making.
- Have the record, medication list, ECG/images/results, and transfer documents available where practicable.
- Anticipate immediate questions, but do not allow the conversation to become an obstacle course when the need for assessment is clear.

9. Referral priority and response expectations

The following categories are proposed for local validation. The patient’s condition, not departmental workload or professional seniority, determines urgency. Local policy may adopt a single maximum bedside-response target for all inpatient referrals if that is safer and operationally feasible.

Priority	Typical situation	Proposed response	Escalation
TIME-CRITICAL	Imminent threat to life, organ, limb, pregnancy, neurological function, or a narrow treatment window.	Immediate direct senior-to-senior contact; receiving team mobilized without delay; proposed bedside response within 10 minutes when on site.	Activate resuscitation / emergency call; escalate immediately if contact or attendance is not confirmed.
URGENT	Current or potential instability, severe symptoms, significant diagnostic/treatment risk, or need for prompt admission/procedure.	Direct acknowledged referral; proposed bedside assessment within 30 minutes.	Escalate at once for deterioration; otherwise escalate when target is breached or a safe plan is absent.
STANDARD	Stable patient requiring specialty assessment, admission decision, or advice without an immediate threat.	Acknowledged referral; proposed assessment within 60 minutes or locally approved standard.	Continue care and escalate before the target is exceeded if risk, crowding, or uncertainty is increasing.

Local validation required: response targets must be reconciled with specialty staffing, on-call location, transport time, national requirements, and the hospital’s internal professional standards. A target is a maximum, not a reason to wait.

10. Initiating and receiving the referral

10.1 Approved communication methods

- Time-critical and urgent referrals: direct telephone, emergency call system, radio, secure voice/video channel, or face-to-face communication with a named recipient.
- Electronic referral systems may support standard referrals and documentation but must provide visible acknowledgement and escalation for non-response.
- Personal messaging applications shall not be used unless formally approved, secure, auditable, and compliant with confidentiality rules.
- Pager, switchboard, or indirect messages do not complete an urgent referral until a responsible clinician confirms receipt.

- The on-call directory shall be current, accessible at all times, and tested regularly.

10.2 Structured referral using ISBAR/SBAR

- Identification: patient identifiers and location; your name, role, service, and callback.
- Situation: immediate problem, current stability, urgency, and exact request.
- Background: relevant history, comorbidity, medications, allergies, pregnancy, events, and treatment limitations.
- Assessment: examination, vital-sign trend, working diagnosis, dangerous alternatives, treatment response, and key results.
- Recommendation/Request: what you need, by when, expected destination, and contingency if the patient deteriorates.

10.3 Duties of the receiving clinician

- Identify themselves by name and role and confirm they are the correct recipient or arrange immediate redirection without abandoning the referral.
- Acknowledge the clinical question and urgency and repeat back critical information when needed.
- Provide clear interim advice that is within competence and consistent with current patient information.
- State whether advice is remote only, whether the patient is accepted for assessment/admission, and whether responsibility has transferred.
- Identify who will attend, their seniority, expected response time, and what should occur if the patient deteriorates before arrival.
- Escalate within their own service when the request exceeds their authority or competence.
- Avoid requiring nonessential investigations before assessment where they do not contribute to immediate management.
- Document their assessment and plan when they attend, including admission/discharge responsibility and follow-up of pending results.

11. Advice-only consultation

Remote or informal advice may be appropriate when the patient can remain under the ED clinician's care and the clinical question can be safely answered without specialist examination. Advice does not automatically transfer responsibility.

- The ED clinician shall document the adviser's name, role, date/time, information provided, advice received, limitations of the advice, and how it affected the plan.
- The adviser shall be told when information is incomplete, images are unavailable, or the patient has not been examined by them.
- If the adviser believes bedside assessment, admission, or transfer is required, the interaction becomes a formal referral and must follow the relevant pathway.
- If the ED clinician remains concerned after advice, they shall request direct assessment or escalate to a senior clinician; advice is not a barrier to escalation.
- A patient shall not be discharged solely on undocumented remote advice when the treating clinician believes discharge is unsafe.

12. Clinical responsibility and transfer of care

The hospital shall approve and publish a local responsibility model. The following draft model is recommended for validation because it keeps responsibility visible during the high-risk interval between referral and specialty review.

Stage	Responsibility standard
Before referral	ED treating clinician and nurse remain responsible for assessment, treatment, monitoring, results, and disposition.
Referral sent but not acknowledged	ED retains responsibility. Referral must be tracked and escalated; no transfer has occurred.
Referral acknowledged; awaiting attendance	ED retains immediate clinical responsibility, including deterioration and new results, while the receiving service is accountable for meeting the agreed response plan.
Specialty assessment completed and patient accepted	Responsibility transfers to the named specialty team when acceptance and handover are explicitly documented and communicated to ED nursing staff and the patient/caregiver.
Advice only	Responsibility remains with the ED clinician unless a different arrangement is explicitly agreed and documented.
Multiple specialties	A single lead team/consultant shall be identified. Each specialty remains responsible for its defined tasks, but the patient must not be left without an overall decision-maker.
Patient boarding in ED after acceptance	The accepting specialty owns the ongoing plan and disposition. ED nursing and clinicians continue immediate emergency support under the locally agreed shared-care arrangement.
Transfer to ward/other facility	Responsibility transfers after direct handover, receiving acceptance, appropriate escort/monitoring, and physical transfer according to local policy.
Responsibility must be documented in real time. “Referred,” “seen,” “accepted,” “admitted,” and “bed requested” are not interchangeable terms.	

13. Delayed response or no response

The referring team shall not wait passively when a response target is at risk or breached. The escalation interval shall be shortened when the patient is deteriorating or the consequence of delay is severe.

1. Repeat direct contact and confirm the correct on-call clinician, urgency, and callback details.
2. Contact the next more senior clinician within the receiving service and state that this is an escalation for patient safety.
3. Inform the senior ED clinician and nurse coordinator; increase monitoring and update the treatment/contingency plan.
4. Escalate to the on-call specialty consultant and, where needed, the duty medical administrator/Medical Director or hospital executive.
5. Activate critical-care, anaesthesia, surgical, obstetric, paediatric, transfer, or emergency response resources according to the patient’s actual need rather than waiting for ownership to be settled.
6. Document each attempt, recipient, time, response, reason for escalation, interim care, and effect on the patient.
7. Submit a patient-safety report when delay caused or could reasonably have caused harm, or when the failure is recurrent.

14. Deterioration while awaiting consultation

- Return immediately to ABCDE assessment and treat life-threatening problems.

- Activate the appropriate resuscitation or emergency response and summon the most relevant senior clinician directly.
- Increase monitoring and move the patient to a higher-acuity area when feasible.
- Notify the receiving service that the clinical priority has changed; do not assume the original referral remains adequate.
- Escalate simultaneously through ED and specialty senior lines when delay is dangerous.
- Record the change in condition, time of escalation, response, treatment, and current responsible clinician.
- Reconsider destination, level of care, transport mode, and need for interfacility transfer.

15. Disputed referrals and specialty disagreement

Disagreement shall be resolved clinician-to-clinician and senior-to-senior without transferring the burden to the patient, family, junior staff, or switchboard.

- The receiving clinician shall hear the referral and identify the specific point of disagreement: diagnosis, urgency, need for admission, appropriate service, required investigation, or resource availability.
- The referring and receiving clinicians shall focus on the patient's needs and agree immediate safety actions while the dispute is resolved.
- Junior clinicians shall not be required to repeatedly negotiate a contested admission beyond their authority. Escalate early to senior clinicians.
- If the first specialty believes another service is more appropriate after assessing/accepting the patient, it shall arrange senior-to-senior onward referral according to the local responsibility model.
- A specialty may request clinically relevant information but shall not use nonessential tests or administrative prerequisites to defer necessary assessment.
- Where two or more specialties are required, a lead service shall be designated based on the dominant immediate problem and required level of care.
- If agreement is not reached promptly, the senior ED clinician shall activate the hospital's delegated dispute-resolution authority, with Medical Director/administrator escalation as required.
- The patient shall continue to receive treatment, monitoring, symptom relief, and communication throughout the dispute.

16. Safety advocacy and chain of command

Any staff member who believes a patient is at risk shall speak up clearly and respectfully. The concern must be acknowledged and addressed, not merely heard.

- Use an assertive statement: identify the concern, evidence, anticipated harm, and requested action.
- Use CUS when needed: "I am Concerned"; "I am Uncomfortable"; "This is a Safety issue."
- Apply the Two-Challenge Rule: state the concern; if unresolved, restate it more explicitly and request acknowledgment; then escalate through the chain of command.
- Use "stop the line" language when an imminent safety breach is occurring.
- Nurses and allied health staff may bypass ordinary hierarchy when delay would endanger the patient.
- Professional disagreement shall be managed away from the patient where possible and without hostile, humiliating, or retaliatory conduct.
- The organization shall protect good-faith escalation and review reports for system learning rather than blame.

17. Multiple-specialty and complex cases

- Identify the dominant immediate threat and the service best positioned to lead overall care.
- For major trauma or resuscitation, the ED/resuscitation team shall coordinate initial stabilization according to the local activation plan until a lead specialty assumes responsibility.

- Hold a brief multidisciplinary huddle for complex cases, with a documented lead clinician, problem list, task allocation, time-critical actions, and contingency plan.
- Each consultant shall document the scope of their advice and responsibility; conflicting plans require senior reconciliation.
- Bed destination shall reflect the required monitoring, staffing, procedure access, infection precautions, and level of care—not merely bed availability.
- Where no single local service can safely provide care, initiate external transfer early while continuing stabilization.

18. Specialty unavailable, remote advice, and teleconsultation

- Confirm that the service is genuinely unavailable and identify the most appropriate alternate local or external clinician.
- Use approved secure communication methods and protect patient confidentiality.
- Transmit only necessary clinical information and verify patient identity before sharing images, ECGs, or records.
- Document whether the consultant examined the patient remotely, reviewed images/results, or provided advice based solely on the verbal summary.
- Record the consultant's location, name, role, advice, limitations, follow-up requirements, and whether transfer was accepted.
- Remote advice shall not delay transfer when definitive care is unavailable locally.
- If the remote recommendation appears unsafe or does not resolve concern, seek a second opinion or escalate through senior clinical leadership.

19. Interfacility and overseas referral

- The referring clinician shall identify the service and level of care required and contact a clinician authorized to accept the patient.
- Acceptance shall include the receiving clinician/facility, destination, clinical priority, required pre-transfer treatment, documentation, transport mode, escort, and contingency plan.
- Administrative, financial, immigration, or transport arrangements shall proceed in parallel and shall not delay stabilizing treatment.
- The patient shall be reassessed immediately before departure, especially after any delay.
- Send the ED record, referral letter, results, images or access instructions, medication/infusion chart, consent/capacity information, and contact details.
- The sending clinician retains responsibility for preparation and stabilization until handover to the transport team; the transport service assumes responsibility during transit according to local agreement.
- Document departure, condition, escort, equipment, medications, destination, and confirmation of arrival when available.

20. Admission decisions, boarding, and operational escalation

- A clinical decision to admit shall be separated from bed allocation. Lack of a bed does not reverse the need for admission.
- Patients accepted for admission but remaining in the ED shall have a named specialty team, active orders, review schedule, monitoring plan, pending-result owner, and escalation pathway.
- Bed-management and administrative leaders shall be alerted when delay creates risk, crowding, privacy loss, infection risk, prolonged fasting, missed medicines, or inability to monitor.
- Operational escalation shall address beds, staff, transport, diagnostics, theatre, blood products, equipment, and isolation capacity while clinical teams continue care.
- Repeated system-level delay shall trigger executive review and corrective action rather than normalization.

21. Patient and caregiver communication

- Explain why a consultation or admission is needed and which team has been contacted.
- Identify the current responsible clinician/team and update this when responsibility changes.
- Provide realistic information about expected review, tests, admission, or transfer and acknowledge delays honestly.
- Invite the patient/caregiver to report deterioration, pain, unmet needs, or concerns about the plan.
- Use an interpreter or communication aid when required; do not rely on children or unsuitable relatives for critical interpretation.
- Respect confidentiality, consent, capacity, and safeguarding requirements.
- Document significant discussions, refusal, disagreement, or preference affecting referral or transfer.

22. Documentation requirements

The clinical record shall make the referral timeline and responsibility understandable to a clinician who was not present.

- Date and time consultation was requested and urgency category.
- Reason, clinical question, requested action, and relevant patient status.
- Name, role, service, and contact method of the recipient.
- Information communicated, advice received, read-back/check-back when relevant, and interim plan.
- Whether the request was advice only, assessment, procedure, admission, or transfer.
- Whether and when the referral was acknowledged, accepted, attended, or declined/disputed.
- Expected response time and actual arrival/review time.
- Clinical responsibility before and after review, including the named lead team.
- Each failed contact and escalation attempt with times and responses.
- Deterioration, critical results, treatment, and updates sent after the original referral.
- Patient/caregiver communication and any consent, refusal, capacity, or safeguarding issue.
- Final disposition, receiving location, handover, and outstanding tasks or results.

23. Shift handover and outstanding consultations

- Outstanding referrals shall be included in structured shift handover with urgency, time sent, recipient, current responsible team, response target, patient trajectory, pending results, and escalation status.
- The outgoing clinician shall not assume an electronic list alone transfers responsibility; the incoming clinician shall acknowledge the case.
- The nurse coordinator shall identify patients awaiting delayed specialty review, admission, critical-care placement, or transfer.
- A named clinician shall follow up each outstanding referral after handover.
- Patients with unresolved ownership or breached response targets shall be highlighted to the senior ED clinician at every shift change.

24. Incident reporting and governance review

- Report consultation delays, inability to contact an on-call clinician, unsafe advice, unacknowledged deterioration, disputed ownership, specialty bouncing, transfer failure, or communication breakdown that caused or could have caused harm.
- Immediate clinical action and disclosure/communication with the patient take precedence over completing an incident form.
- Review should examine system design, staffing, rota accuracy, response standards, hierarchy, workload, bed/transport capacity, information systems, and training—not only individual behaviour.

- Serious events require the hospital's formal patient-safety and duty-of-candour processes as applicable.
- Repeated low-level failures shall be trended because they may signal a high-risk system defect.

25. Quality indicators

Indicator	Suggested measure
Referral documentation completeness	Percentage of referrals with time, urgency, named recipient, purpose, response, and responsibility documented.
Acknowledgement time	Median and 90th-percentile time from referral to named recipient acknowledgement, by specialty and priority.
Assessment time	Median and 90th-percentile time from referral to bedside/remote specialist assessment, by specialty and priority.
Response-target compliance	Percentage of referrals assessed within locally approved target.
Escalation reliability	Percentage of breached targets with documented escalation and interim safety plan.
Responsibility clarity	Percentage of boarded/admitted patients with a named responsible specialty and lead clinician documented.
Disputed referrals	Number, rate, duration, specialties involved, patient impact, and resolution level.
Harm related to delay	Incidents, deterioration, ICU transfer, delayed operation/procedure, prolonged pain, or other harm associated with consultation delay.
Directory reliability	Percentage of sampled on-call contacts that are correct and reachable.
Patient communication	Percentage of sampled cases documenting patient/caregiver update about plan and responsible team.

26. Training and competency

- Orientation for all ED and receiving-service clinicians on referral categories, local response standards, responsibility transfer, escalation chain, and documentation.
- Training in ISBAR/SBAR, closed-loop communication, check-back, advocacy/assertion, CUS, and the Two-Challenge Rule.
- Simulation of time-critical referral, non-response, disputed admission, deterioration while boarding, remote consultation, and interfacility transfer.
- Competency assessment for junior clinicians and nurses, including when and how to escalate beyond hierarchy.
- Periodic multidisciplinary case review using audit data and patient feedback.
- Annual testing of the on-call directory, switchboard process, backup contacts, and downtime procedures.

27. Implementation requirements

Implementation domain	Minimum action
Governance	Approve clinical-responsibility model, dispute authority, response targets, scope, and non-retaliation provisions.

Implementation domain	Minimum action
Specialty agreements	Publish referral pathways, accepting services, minimum seniority, procedures, and admission rules for common presentations.
Contact system	Maintain one authoritative 24/7 directory with primary and backup contacts; ensure switchboard access and downtime plans.
Information system	Record referral time, priority, recipient, acknowledgement, acceptance, attendance, escalation, and responsible team.
Staffing	Ensure sufficiently experienced ED and specialty decision-makers are available or rapidly accessible.
Education	Train all relevant staff before launch; provide pocket cards and electronic templates.
Audit	Run a baseline audit, then monthly for three months and quarterly thereafter, with specialty-level feedback.
Review	Revise after incidents, service changes, legislation, transfer agreements, or evidence updates.

Annex A. One-page consultation and escalation workflow

Step	Bedside action
1. STABILIZE	Treat immediate threats, provide analgesia and monitoring, and activate emergency pathways.
2. DEFINE	Advice, assessment, procedure, admission, critical care, safeguarding, or transfer?
3. PRIORITIZE	Time-critical, urgent, or standard. State the consequence of delay.
4. PREPARE	Identity, situation, relevant background, assessment/trend, treatment/results, explicit request.
5. CONTACT	Named recipient using approved method; urgent referrals require direct acknowledgement.
6. CONFIRM	Recipient repeats urgency/request; agrees plan, response time, interim care, and responsibility.
7. TRACK	Continue monitoring/treatment, review results, update for any change, and record timeline.
8. ESCALATE	No response, delay, deterioration, or dispute: repeat, go senior, involve ED lead and hospital leadership.
9. HAND OVER	Named accepting team; direct handover; responsibility and pending tasks documented.
10. LEARN	Report harmful or recurrent failure and audit response data.

Do not wait in silence. If the patient is getting sicker or the response is not safe, escalate now.

Annex B. Proposed referral priority card — local approval required

Priority	Say this first	Response expectation	If no response
TIME-CRITICAL	“This is a time-critical referral. Delay risks [specific harm]. I need [service/action] now.”	Immediate senior contact and mobilization; proposed bedside response ≤10 min when on site.	Escalate simultaneously to specialty senior, senior ED clinician, resuscitation/critical-care resources, and administrator as needed.
URGENT	“This is an urgent referral for [reason]. I need assessment/action within 30 minutes.”	Direct acknowledged referral; proposed assessment ≤30 min.	Repeat contact, go to next senior, notify ED lead and nurse coordinator; escalate sooner if condition worsens.
STANDARD	“This is a stable patient requiring [assessment/admission/advice].”	Acknowledged referral; proposed assessment ≤60 min or local standard.	Track actively and escalate before/at breach when risk or crowding is increasing.

Annex C. ISBAR referral template

I — Identification	Patient name / identifier / age / location; caller name, role, service, callback.
S — Situation	Current problem; stability; urgency; exact purpose of consultation.
B — Background	Relevant history, comorbidity, medications, allergies, pregnancy, procedures, treatment limitations.
A — Assessment	ABCDE, vital-sign trend, examination, working diagnosis, dangerous alternatives, treatment/response, key results.
R — Recommendation / Request	What action is required, by when, expected destination, interim plan, and contingency for deterioration.
Check-back	Recipient repeats or confirms urgency, requested action, response time, and responsibility.

Annex D. Consultation and referral record

Patient identifiers / ED location	_____
Date and time of referral	_____ Priority: <input type="checkbox"/> Time-critical <input type="checkbox"/> Urgent <input type="checkbox"/> Standard
Purpose	<input type="checkbox"/> Advice <input type="checkbox"/> Assessment <input type="checkbox"/> Procedure <input type="checkbox"/> Admission <input type="checkbox"/> Critical care <input type="checkbox"/> Transfer <input type="checkbox"/> Other
Service / named recipient / role	_____
Method and contact number/channel	_____
Clinical question / request	_____
Key status and risk of delay	_____

Advice / agreed actions	_____
Expected response time / clinician attending	_____
Responsibility while awaiting review	_____
Acknowledged / accepted / seen	Times: _____
Escalations and responses	_____
Responsible team after review	_____
Referring clinician signature / ID	_____

Annex E. Chain-of-command escalation card

Level	Action
Clinical concern identified	State concern, evidence, anticipated harm, and requested action.
First challenge	Ask for clarification/action and confirm the message was heard.
Second challenge	Restate more explicitly: "I remain concerned because... This is a safety issue. I need..."
Specialty escalation	On-call clinician → senior/registrar → consultant/service lead.
ED escalation	Treating clinician/nurse → senior ED clinician → duty ED consultant/medical lead.
Operational escalation	Nurse coordinator/bed manager → administrator on call → executive/Medical Director.
Emergency override	Activate resuscitation/critical-care/emergency transfer resources immediately when delay threatens life or function.
Record and report	Document times and responses; file safety report for harmful or recurrent failure.

Annex F. Disputed referral resolution algorithm

1. Keep treating and monitoring the patient; identify the immediate safety risk.
2. Clarify the exact disagreement and what information or decision is missing.
3. Referring and receiving clinicians agree interim actions and who is responsible now.
4. Escalate junior-to-senior within both ED and specialty teams.
5. For competing specialties, identify the dominant immediate problem and hold a senior multidisciplinary discussion.
6. Apply the locally delegated decision authority if agreement is not reached within the clinically safe timeframe.
7. Document decision, lead team, pending tasks, and patient/caregiver update.
8. Report recurring or harmful disputes for governance review.

Annex G. Transfer-of-clinical-responsibility checklist

- ☐ Patient identity and current location confirmed.
- ☐ Receiving clinician/team named and acceptance explicit.

- ☐ Current condition, vital-sign trend, treatment, response, and deterioration risks handed over.
- ☐ Allergies, medications/infusions, procedures, lines/drains, isolation, capacity, safeguarding, and treatment limitations communicated.
- ☐ Investigations reviewed; pending/critical results and owner identified.
- ☐ Monitoring frequency, review schedule, medication plan, destination, and contingency agreed.
- ☐ Receiving clinician has opportunity to ask questions and confirms understanding.
- ☐ Nursing staff and patient/caregiver informed of responsible team.
- ☐ Time and transfer of responsibility documented.
- ☐ Patient reassessed before physical transfer.

Annex H. Remote consultation / teleconsultation record

Patient and location	_____
Remote clinician / service / location	_____
Date, time, and modality	<input type="checkbox"/> Telephone <input type="checkbox"/> Video <input type="checkbox"/> Secure image/ECG <input type="checkbox"/> Other: _____
Information available	<input type="checkbox"/> Verbal history/exam <input type="checkbox"/> Results <input type="checkbox"/> Images <input type="checkbox"/> Live video exam <input type="checkbox"/> Record access
Clinical question	_____
Advice and limitations	_____
Need for bedside assessment/transfer	_____
Responsibility and follow-up	_____
Consent/privacy considerations	_____
Documented by	_____

Annex I. Interfacility / overseas referral checklist

- ☐ Required service and level of care identified.
- ☐ Named accepting clinician and facility; acceptance date/time documented.
- ☐ Patient stabilized as far as possible; time-dependent treatment not delayed.
- ☐ Pre-transfer advice and required investigations/treatment completed or limitations documented.
- ☐ Transport priority, modality, escort competence, equipment, oxygen, medications, fluids/blood, batteries, and contingencies arranged.
- ☐ Consent/capacity, family communication, financial/administrative steps, and travel documentation addressed in parallel.
- ☐ ED record, referral letter, results, images/access, medication chart, and contact details prepared.
- ☐ Infection-control and safeguarding risks communicated.
- ☐ Reassessment immediately before departure documented.
- ☐ Departure time, condition, escort, destination, and arrival confirmation recorded.

Annex J. On-call directory and pathway readiness checklist

- ☐ One authoritative directory available 24/7 in ED, switchboard, and electronic system.
- ☐ Each service lists primary, backup, consultant, and escalation contacts.

- ☐ On-call location and expected travel/response time known.
- ☐ Referral scope, admission destination, common pathways, and exclusions published.
- ☐ Critical-care, anaesthesia, theatre, obstetric, paediatric, mental-health, safeguarding, radiology, laboratory, blood bank, transport, and overseas-referral contacts included.
- ☐ Downtime and failed-device process displayed.
- ☐ Contacts verified at least monthly and after rota/service changes.
- ☐ Failed contacts logged and corrected immediately.

Annex K. Consultation and escalation audit tool

Patient / date / specialty	_____
Priority documented correctly	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Purpose / explicit request documented	<input type="checkbox"/> Yes <input type="checkbox"/> No
Named recipient and time documented	<input type="checkbox"/> Yes <input type="checkbox"/> No
Referral acknowledged	<input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____
Assessment within approved target	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Interim plan and responsibility clear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deterioration / new results communicated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Delay/dispute escalated appropriately	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Transfer of responsibility documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Patient/caregiver updated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Harm or near miss	<input type="checkbox"/> No <input type="checkbox"/> Yes — incident reference: _____
Learning / action	_____

Annex L. Local configuration table

Local element	Approved specification
Approved time-critical response target	[Insert]
Approved urgent response target	[Insert]
Approved standard response target	[Insert]
Time to first escalation after no response	[Insert by priority]
Specialty chain of command	[Insert names/roles/contact route]
Senior ED escalation route	[Insert]
Administrator / Medical Director escalation	[Insert]
Delegated authority for disputed admissions	[Insert]
Point at which responsibility transfers	[Insert approved local rule]

Local element	Approved specification
Shared-care model for admitted patients boarding in ED	[Insert]
Approved electronic referral platform	[Insert]
Approved secure remote-consultation tools	[Insert]
Interfacility / overseas transfer coordination contact	[Insert]
Incident-reporting system	[Insert]
Audit owner and frequency	[Insert]

Annex M. References and source tools

World Health Organization. Emergency Care Toolkit. <https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/emergency-and-critical-care/emergency-care-toolkit>

World Health Organization / International Committee of the Red Cross. Basic Emergency Care: approach to the acutely ill and injured. <https://www.who.int/publications-detail-redirect/basic-emergency-care-approach-to-the-acutely-ill-and-injured>

World Health Organization. Communication during patient handovers. <https://www.who.int/publications/m/item/communication-during-patient-hand-overs>

Agency for Healthcare Research and Quality. TeamSTEPPS 3.0 and TeamSTEPPS Pocket Guide: SBAR, closed-loop communication, advocacy/assertion, CUS, and Two-Challenge Rule. <https://www.ahrq.gov/teamstepps-program/index.html>

Royal College of Emergency Medicine. Referral for Inpatient Care Standards. <https://rcem.ac.uk/wp-content/uploads/2025/04/Referral-for-Inpatient-Care-Standards.pdf>

Royal College of Emergency Medicine. Clinical Responsibility for Patients within the Emergency Department: Position Statement. https://rcem.ac.uk/wp-content/uploads/2023/10/RCEM_Positon_Statement_Clinical_Responsibility_for_Patients_within_the_Emergency_Department.pdf

The Joint Commission. National Performance Goal: Culture of Safety. <https://www.jointcommission.org/en-us/standards/national-performance-goals/culture-of-safety>

Local medical-staff bylaws, on-call rosters, admission rules, critical-care and theatre activation plans, transfer agreements, telehealth policy, safeguarding policy, and national legal requirements. [Insert local sources]

Reference note: External guidance supports the principles in this draft. Before approval, reconcile all response targets, specialty responsibilities, admission authority, communication methods, documentation rules, and transfer arrangements with local law, resources, staffing, and medical-staff governance.

Local approval and sign-off

Approval role	Name / title and signature	Date
Prepared by	_____	_____
ED medical lead	_____	_____
Nursing lead	_____	_____
Specialty / medical staff representative	_____	_____
Clinical governance / patient safety	_____	_____
Medical Director / approving authority	_____	_____