

EMERGENCY DEPARTMENT ADMISSION AND WARD TRANSFER PROTOCOL

Protocol 10: Acceptance, Stabilization, Clinical Handover, Boarding, and Safe Transfer to Inpatient Care

DRAFT FOR CLINICAL, NURSING, PHARMACY, BED-MANAGEMENT, GOVERNANCE, AND PATIENT-SAFETY REVIEW

Important: Admission is not complete when a bed is requested. It is complete only when the receiving service has accepted responsibility, the patient is fit for the intended destination, essential information and treatment have been handed over, and the receiving nurse has assumed care.

Document control	Details
Document owner	Emergency Department / Nursing Services / Inpatient Services / Bed Management / Clinical Governance
Policy number	ED-PRO-010
Version	Draft 1.0
Effective date	[Insert after approval]
Review date	[Insert - normally within 12 months of implementation, then at locally approved interval]
Supersedes	New protocol
Related protocols	ED Protocols 1-9; local admission, patient-flow, infection-control, medication, transport, safeguarding, and specialty policies
Approval bodies	[Medical Director / Nursing Director / Pharmacy / Quality and Safety Committee / Executive Management]
Applies to	All ED, inpatient, diagnostic, transport, pharmacy, bed-management, and support staff involved in admission or internal transfer

1. Purpose

To establish a safe, timely, and accountable process for admitting a patient from the Emergency Department and transferring that patient to an inpatient ward, critical-care area, theatre, procedure area, maternity service, mental-health service, or other internal destination. The protocol is designed to prevent deterioration, loss of information, omitted treatment, medication error, unidentified pending results, unsafe transport, and ambiguity about clinical responsibility during the transition.

2. Scope

This protocol applies from the documented decision to admit until the receiving clinical area has accepted the patient, completed the required handover, and assumed responsibility. It applies whether the patient moves immediately or remains in the ED because of bed, staffing, isolation, transport, or operational delay. Interfacility and overseas transfer are governed primarily by the separate transfer protocol, but the stabilization, handover, result, medicine, and responsibility principles in this document also apply.

3. Core policy statements

- Admission shall be based on clinical need and the safest available care setting, not on administrative convenience, bed-pressure targets, social status, personal connections, or ability to pay.
- A patient shall not leave the ED until the intended destination can safely provide the required level of observation, treatment, oxygen, equipment, isolation, staffing, and clinical expertise.
- The receiving medical service and receiving nursing area shall be clearly identified. “Admit to hospital” without a named team and destination is not an adequate plan.
- Clinical responsibility must be explicit at every stage. Referral, acceptance, physical movement, and nursing handover are distinct events and shall each be documented.
- The ED remains accountable for active emergency care until responsibility has been formally accepted under the locally approved model. After acceptance, the inpatient team owns the ongoing specialty plan, while ED staff continue immediate emergency support for deterioration occurring within the ED.
- A structured verbal handover with an opportunity for questions shall accompany written or electronic information. Sending records alone is not a complete handover.
- The patient shall be reassessed immediately before transfer, particularly after any delay, treatment, sedation, procedure, change in symptoms, or abnormal observation.
- Outstanding investigations, critical results, medicines, fluids, infusions, oxygen, devices, isolation precautions, safeguarding concerns, and time-critical actions shall be transferred with named ownership.
- Boarding patients remain active inpatients in a temporary location. They require an inpatient plan, monitoring, medication administration, nursing care, senior review, and escalation - not passive waiting.
- Transfer shall be stopped when the patient has deteriorated, the destination is unsafe, essential information or equipment is missing, or the receiver has not accepted responsibility.
- Patients and caregivers shall be told the reason for admission, responsible service, expected destination, delays, immediate plan, and how to raise a safety concern.
- All delays, disputes, failed handovers, deterioration, and safety incidents shall be documented and used for system improvement rather than individual blame.

4. Definitions

Term	Operational definition
Decision to admit	A documented clinical decision that the patient requires ongoing hospital care that cannot be safely delivered through discharge or short ED treatment alone.
Referral	A request from the ED clinician for another service to assess, advise on, or assume ongoing care. Referral does not by itself prove acceptance.
Acceptance	Explicit agreement by an authorized receiving clinician or service to take responsibility for the patient, subject to the locally approved responsibility model.

Term	Operational definition
Bed allocation	Assignment of a specific inpatient bed or destination. Bed allocation is an operational action and is not equivalent to clinical acceptance.
Clinical handover	A structured exchange of current condition, uncertainty, treatment, risks, pending actions, and contingency plans, together with transfer of authority and responsibility.
Ward transfer	Physical movement of the patient from the ED to an inpatient area after readiness checks and receiving-area confirmation.
Boarding	Holding a patient in the ED or another temporary location after the decision to admit or transfer has been made.
Fit for destination	The patient is sufficiently stable and the destination has the staff, monitoring, equipment, isolation, and competencies required for the anticipated risk.
Time-critical action	A treatment, observation, investigation, review, or intervention that must occur within a defined period to prevent avoidable harm.
Closed-loop communication	The receiver acknowledges the message, confirms or reads back critical details, and both parties resolve uncertainty before ending the exchange.
Transfer of nursing responsibility	The point at which the receiving nurse has received bedside or direct handover, confirmed patient identity and immediate needs, and accepted care.
Transfer of medical responsibility	The point defined in the locally approved responsibility model at which the receiving medical service assumes ongoing clinical decision-making.

5. Roles and accountability

Role	Minimum accountability
Hospital executive / Medical Director	Approves the hospital-wide admission, patient-flow, boarding, dispute-resolution, and clinical-responsibility framework; ensures that bed pressure does not override patient safety.
Nursing Director / inpatient nursing leadership	Ensures receiving wards have clear acceptance, staffing, isolation, equipment, handover, escalation, and surge processes.
ED medical lead	Owns the clinical admission standard, referral quality, pre-transfer reassessment, deterioration response, and audit programme.
ED nursing lead	Ensures transfer readiness, nursing handover, medicines and devices continuity, transport safety, and boarding-care standards.

Role	Minimum accountability
Admitting / receiving clinician	Assesses or reviews as required, accepts or clearly redirects the patient, establishes the inpatient plan, identifies level of care, and documents time-critical actions and contingencies.
Receiving nurse / nurse in charge	Confirms bed and staffing readiness, receives structured handover, verifies identity, observations, medicines, devices, isolation, and immediate priorities, and assumes nursing care.
Bed manager / patient-flow coordinator	Coordinates bed allocation and escalation, tracks delays, identifies capacity risk, and activates the hospital surge pathway without making clinical decisions outside scope.
ED treating clinician	Stabilizes the patient, completes the admission decision and referral, provides medical handover, reviews results, documents uncertainty and pending actions, and reassesses before transfer.
ED bedside nurse	Maintains monitoring and treatment, prepares the patient and records, gives nursing handover, verifies transfer equipment, and escalates deterioration or unsafe transfer.
Pharmacy / medicines-management team	Supports medication reconciliation, time-critical therapy, infusion continuity, high-alert medicines, and ward access to required medicines.
Porter / transport staff	Moves only patients assigned an appropriate transport mode and escort, follows infection-control and equipment instructions, and stops when a safety concern arises.
All staff	Use two identifiers, communicate concerns, challenge an unsafe transfer, document actions, and escalate unresolved risk through the chain of command.

6. Admission and ward-transfer pathway

Stage	Required action
1. Decide and document	Record why admission is required, working diagnosis, severity, current needs, anticipated level of care, and alternatives considered.
2. Stabilize and investigate	Treat immediate threats, complete investigations needed for safe disposition, and do not delay essential treatment while awaiting a bed.
3. Refer and obtain acceptance	Contact the appropriate receiving clinician using structured communication; record name, time, advice, acceptance status, and unresolved issues.
4. Request destination	Specify required ward, monitoring, isolation, oxygen, equipment, staffing, and specialty needs. Bed management allocates only an appropriate destination.

Stage	Required action
5. Continue active care	Maintain observations, medicines, fluids, nursing care, comfort, nutrition, toileting, pressure care, and reassessment while waiting.
6. Confirm transfer readiness	Reassess the patient, review results and treatment response, confirm that immediate actions are complete, and verify the destination is ready.
7. Complete handover	Give medical and nursing handover using ISBAR or an approved equivalent, transfer documents and pending-action ownership, and allow questions/read-back.
8. Transport safely	Use the correct mode, escort, oxygen, monitoring, medicines, equipment, records, and infection precautions.
9. Receive and reconcile	Receiving staff verify identity, observations, current condition, medicines, devices, pending actions, and responsibility; discrepancies are resolved immediately.
10. Close the loop	Record departure, arrival, receiver, acceptance of care, and any event during transfer. Escalate delay or harm for review.

7. Decision to admit

The treating clinician shall document the clinical basis for admission and the intended level of care. The decision should reflect the patient's physiological risk, diagnostic uncertainty, treatment requirements, functional status, safeguarding and social circumstances, ability to follow an outpatient plan, and the resources available at the proposed destination.

- State the working diagnosis or presenting syndrome and the immediate risks that require inpatient care.
- Identify whether the patient requires a general ward, monitored bed, high-dependency or critical care, theatre, maternity, paediatric, mental-health, isolation, or another specialized environment.
- Record significant comorbidities, baseline function, frailty, cognitive status, pregnancy, allergies, escalation plan, and known treatment limitations.
- Do not admit solely to avoid a time target, complete a low-value test, resolve an administrative issue, or transfer responsibility for a patient who is clinically suitable for safe discharge.
- Do not discharge a patient who requires admission because a bed is unavailable. Activate the boarding and hospital-capacity escalation process.

8. Referral, acceptance, and bed allocation

8.1 Referral content

- Use two patient identifiers and state the current location.
- Give the situation and urgency first, including instability or time-critical need.
- Provide relevant background, working diagnosis, key uncertainty, comorbidities, allergies, medications, and recent admission or specialty involvement.
- Give current observations and trends, examination findings, investigations, treatment and response.
- State what is requested: advice, bedside assessment, acceptance, level of care, procedure, or immediate intervention.
- Identify pending results and time-critical actions.

- Confirm the name and grade/role of the receiver, advice, expected response, and whether the patient is accepted.

8.2 Acceptance requirements

Acceptance shall be explicit. Silence, an unanswered message, “put the patient on the list,” a bed request, or an assumption that a specialty usually takes such cases shall not be treated as acceptance. The accepting clinician must be authorized under local policy and must identify the responsible service and immediate plan.

- Where the receiving clinician believes another service is more appropriate, the concern shall be discussed clinician-to-clinician without abandoning the patient between teams.
- The first receiving service that has assessed and accepted the patient shall coordinate any subsequent internal specialty transfer unless local policy states otherwise.
- No service shall require investigations that do not contribute to immediate management merely as a precondition for assessment or acceptance.
- Disagreement shall be escalated promptly to senior ED and receiving clinicians and, when unresolved, to the Medical Director or designated executive authority.

8.3 Bed allocation

The requested bed type shall be based on clinical need. Bed management shall verify the destination, bed status, sex/age or cohorting requirements, isolation status, staffing, monitoring capability, and availability of required equipment. A physically empty bed is not necessarily a clinically ready bed.

9. Clinical responsibility during the transition

Safety rule: At every moment, staff must be able to answer: “Which medical team is responsible now, which nurse is responsible now, and who must act if the patient deteriorates?”

The hospital shall approve one explicit responsibility model. The draft model below is recommended for local adaptation and must be reconciled with law, credentialing, staffing, and existing medical-staff rules.

Transition point	Draft responsibility model - requires local approval
Before referral	The ED medical and nursing teams hold responsibility for emergency assessment, treatment, monitoring, and disposition.
Referral sent but not accepted	The ED retains responsibility. The receiving service must respond within the locally approved timeframe. Delay is escalated under Protocol 8.
Patient assessed and accepted by receiving medical service	The receiving medical service assumes responsibility for the ongoing specialty plan and admission orders. The ED continues nursing care and immediate emergency/resuscitation support while the patient remains physically in the ED.
Bed assigned but handover not completed	Responsibility does not transfer solely because a bed exists. Current responsible teams continue care until handover is completed.
Medical handover completed but patient remains in ED	The accepted inpatient service reviews deterioration, results, medicines, and plan according to the boarding standard; ED staff respond immediately to emergencies and notify that service.
Patient arrives on ward and nursing handover is accepted	Ward nursing responsibility begins. Receiving medical responsibility continues under the admitting service.

Transition point	Draft responsibility model - requires local approval
Transfer stopped or patient returned to ED	Responsibility must be explicitly re-established and documented; the patient shall never be left in an unowned state.

10. Stabilization before transfer

Transfer shall occur only after immediate life-, limb-, organ-, pregnancy-, or function-threatening problems have been treated to the degree reasonably possible and the destination is appropriate for residual risk. The need for admission must not be used to defer essential ED treatment.

- Airway is patent or secured, with a documented airway plan and required equipment.
- Breathing is adequately supported; oxygen delivery, ventilation, chest drains, and monitoring are stable and compatible with the destination.
- Circulation is supported; bleeding is controlled; vascular access, fluids, blood products, vasopressors, and infusion plans are safe for transport and destination.
- Altered mental status, seizures, glucose disturbance, pain, agitation, and temperature problems have been addressed.
- Required immobilization, wound care, splinting, pressure-area protection, and fall precautions are in place.
- Time-critical antimicrobials, antidotes, insulin, anticoagulation reversal, analgesia, bronchodilator, steroid, anti-seizure therapy, or other urgent treatment has been administered or explicitly handed over with due time.
- The escalation and treatment-limitation plan is known and available.
- The patient is not transferred simply to create ED capacity when the receiving area cannot manage current instability.

11. Final reassessment immediately before departure

A clinically meaningful reassessment shall occur as close as reasonably possible to departure and after any material delay. The reassessment may be focused but shall reflect the patient's current state rather than the condition at the time admission was first decided.

- Confirm symptoms and overall trajectory: improving, unchanged, fluctuating, or deteriorating.
- Record current observations and relevant early-warning score, including oxygen and level of consciousness.
- Repeat focused examination for the presenting problem and any new concern.
- Review treatment response, urine output, pain, mobility, falls risk, nutrition/hydration, cognition, and behaviour as applicable.
- Review all new laboratory, imaging, ECG, microbiology, or specialist results since acceptance.
- Confirm that the proposed ward and escort remain appropriate.
- Update the receiver about any change. Material deterioration requires renewed acceptance and may require a higher-acuity destination.
- Document the reassessment, name of clinician, date/time, and decision to proceed or stop.

12. Receiving-area readiness

- A specific bed or treatment space is confirmed and available.
- The ward nurse in charge is aware of the patient and has confirmed readiness to receive.
- The area can provide the prescribed observation frequency, oxygen, suction, telemetry, isolation, pressure care, mobility support, and staff skill level.

- Required equipment, medicines, pumps, bariatric aids, paediatric items, or emergency resources are present or travelling with the patient.
- Infection-control and cohorting requirements are understood.
- Any need for immediate clinician review, procedure, blood product, antidote, or time-critical medicine on arrival is communicated.
- The receiving service knows about safeguarding, behavioural, capacity, communication, interpreter, or security needs.
- When readiness is uncertain, transfer is paused and escalated rather than sending the patient into an unsafe environment.

13. Medical handover

The sending clinician shall give direct verbal handover to the receiving clinician or other person authorized by local policy. Written or electronic records support but do not replace the conversation for unstable, high-risk, complex, or time-critical patients.

13.1 Minimum ISBAR content

Element	Required content
Identification	Patient name, date of birth or unique identifier, current location, sending and receiving clinicians/services.
Situation	Reason for admission, urgency, current stability, required level of care, and immediate concern.
Background	Relevant history, baseline function, recent admission, comorbidities, allergies, medicines, pregnancy, safeguarding and treatment limits.
Assessment	Working diagnosis and uncertainty; current observations/trends; key examination, tests, treatment, response, and complications.
Recommendation	Immediate plan, monitoring frequency, medicines and due times, pending results, required reviews/procedures, escalation triggers, and contingencies.
Read-back / questions	Receiver confirms critical details, accepts responsibility under the local model, and identifies unresolved issues before the handover ends.

14. Nursing handover and bedside transfer

- Confirm two patient identifiers and allergies.
- State diagnosis or presenting problem, current condition, observation frequency, early-warning score, oxygen and escalation triggers.
- Review medications administered, next doses due, infusions, blood products, pain control, allergies, and adverse reactions.
- Review lines, drains, catheters, wounds, dressings, splints, pressure areas, mobility, falls risk, skin integrity, and personal care needs.
- Communicate fluid balance, oral intake, urine/stool, glucose, nutrition, fasting status, and specimen requirements.
- Communicate cognition, delirium, communication needs, interpreter, behaviour, capacity, restraints, self-harm risk, security, and safeguarding concerns.

- Identify pending results, specimens, consultations, repeat tests, and time-critical actions.
- Transfer property, valuables, medications, prostheses, mobility aids, and documentation according to policy.
- At the receiving bedside, verify identity, oxygen, monitoring, infusions, devices, bed safety, call bell, and immediate comfort needs before the sender leaves.

15. Medicines and treatment continuity

- Complete or update medication reconciliation as soon as clinically possible, including regular, recently changed, over-the-counter, herbal, and patient-owned medicines.
- Document medicines given in the ED, last dose, next dose due, omitted or withheld medicines, reason, and monitoring requirements.
- Time-critical medicines shall not be omitted because the patient is awaiting a bed or in transit. Responsibility for the next dose must be named.
- High-alert medicines, concentrated electrolytes, insulin, anticoagulants, opioids, sedatives, vasopressors, and infusions require clear concentration, rate, route, compatibility, monitoring, and independent-check information.
- Patient-owned medicines shall be labelled, secured, reconciled, and transferred according to policy.
- The receiving area shall confirm availability of essential medicines. Pharmacy is contacted early for unusual, restricted, or unavailable products.
- Medication discrepancies discovered on arrival shall be resolved immediately with the sending clinician, pharmacy, or admitting service.

16. Investigations, results, and pending actions

- All available results relevant to admission and destination shall be reviewed before transfer.
- Critical or unexpected results shall be communicated directly and acted upon; the receiving team shall not be expected to discover them passively in the record.
- List pending tests, cultures, imaging reports, pathology, send-away tests, repeat bloods, ECGs, specialist reviews, and specimens not yet collected.
- Name the clinician or team responsible for review and action, expected timeframe, notification method, and contingency.
- Clearly identify preliminary, amended, discrepant, or incidental findings.
- Send images, tracings, reports, and relevant paper documents when the electronic record is unavailable or inaccessible at the destination.
- If transfer occurs during a diagnostic process, document whether the patient should proceed to the ward, imaging area, theatre, or remain under observation until the test is complete.

17. Devices, infusions, oxygen, and equipment

- All lines, drains, tubes, catheters, dressings, and devices are secured, labelled where required, patent, and documented.
- Oxygen source and estimated supply are adequate for the journey and foreseeable delay; cylinder contents are checked.
- Infusion pumps have sufficient battery and volume, correct settings, labelled lines, compatible fluids, and spare medication where required.
- Portable monitoring is appropriate to risk and alarms are audible and set to clinically appropriate limits.
- Required suction, airway equipment, emergency medicines, personal protective equipment, splints, or mobility aids accompany the patient.
- Equipment ownership and return arrangements are known so treatment is not interrupted at the ward door.
- No patient is transported with unsafe improvised equipment or by staff untrained to manage the devices in use.

18. Infection prevention and isolation

- Screen for suspected or confirmed communicable infection before bed allocation and transport.
- Notify the receiving nurse and infection-prevention team of required transmission-based precautions.
- Use an appropriate route, timing, personal protective equipment, source control, and environmental cleaning plan.
- Do not move an infectious patient to an area unable to provide required isolation unless an authorized risk assessment and mitigation plan is documented.
- Communicate multidrug-resistant organisms, exposure events, pending infectious tests, and public-health notification requirements.
- Clean and decontaminate transport equipment after use according to policy.

19. Internal transport

19.1 Transport-risk assessment

The sending clinician and nurse shall determine the transport mode, escort, monitoring, oxygen, equipment, and route based on current risk rather than convenience.

Risk level	Illustrative transport requirement - local validation required
Low risk	Stable patient; wheelchair or trolley as clinically appropriate; trained porter may transport after nurse confirms readiness and receiving area acceptance.
Moderate risk	Recent instability, oxygen, infusion, significant pain, confusion, falls risk, or need for repeated observations; nurse or appropriately trained clinical escort.
High risk	Airway risk, haemodynamic instability, vasoactive infusion, non-invasive or invasive ventilation, active bleeding, recurrent seizure, high oxygen requirement, or likely deterioration; appropriately skilled clinician and nurse with continuous monitoring and resuscitation equipment.
Special risk	Paediatric, neonatal, obstetric, behavioural, bariatric, infectious, security, or safeguarding needs require the locally approved specialist transport arrangement.

- Confirm destination and route before departure.
- Do not leave a patient unattended in a corridor, lift lobby, imaging holding area, or ward entrance.
- The escort remains responsible until the receiving nurse accepts care.
- If deterioration occurs, stop, summon help, treat immediately, and move to the nearest safe clinical area. Notify both sending and receiving teams.
- Document departure time, escort, monitoring, oxygen, events, arrival time, and receiver.

20. Special populations and circumstances

Population / circumstance	Additional safeguards
Children and adolescents	Use age- and weight-appropriate observations, medicines, equipment, escort, safeguarding, and caregiver communication. Transfer to an area capable of paediatric monitoring and resuscitation.

Population / circumstance	Additional safeguards
Pregnancy and postpartum	Confirm gestation/postpartum status, fetal/maternal monitoring needs, haemorrhage and hypertension risk, blood availability, and whether obstetric or general critical care is required.
Older adults, frailty, delirium, or dementia	Communicate baseline cognition/function, falls and pressure risk, sensory aids, medication burden, hydration/nutrition, caregiver information, and delirium plan.
Mental-health or behavioural emergency	Complete medical assessment, capacity and risk evaluation, observation level, medication and restraint information, security plan, ligature/environmental risk, and legal status.
Intoxication or poisoning	Communicate substance, dose/time, toxidrome, decontamination, antidote, ECG/laboratory trends, observation period, mental-health assessment, and recurrent toxicity risk.
Trauma	Maintain spinal, haemorrhage, neurovascular, wound, splint, imaging, and operative plans; identify lead specialty and responsibility where multiple teams are involved.
Communicable infection	Use isolation-ready destination, route and PPE; communicate tests, treatments, exposures, and public-health requirements.
Safeguarding / violence / self-harm	Use confidential handover, restrict information where legally required, protect the patient from unsafe visitors, and communicate observation and security arrangements.
Bariatric or severe mobility limitation	Confirm safe bed, lifting equipment, staffing, pressure care, transport route, doorway/lift limits, and dignity.
Treatment limitation / end-of-life care	Transfer current goals, resuscitation status, symptom medicines, family communication, spiritual/cultural needs, and the plan for deterioration or death.

21. Boarding after the decision to admit

Boarding is a clinical-risk state, not a pause in care. The hospital retains responsibility for providing ward-equivalent essential care in the safest available location while eliminating the delay.

- Assign a named responsible medical service and named bedside nurse.
- Create and document an inpatient management plan, including observations, medicines, fluids, nutrition, mobility, pressure care, toileting, infection precautions, and escalation limits.
- Continue regular medical and nursing review at locally approved intervals and whenever condition changes.
- Administer all due medicines and time-critical treatments; do not defer routine care because the patient remains in the ED.
- Review results and update the diagnosis and plan. The accepting service should review newly available information relevant to inpatient management.
- Provide privacy, dignity, sleep, communication, food, hydration, mobility, and family access as safely as possible.

- Track boarding duration and risk. Escalate prolonged delay to bed management, nursing leadership, on-call executive, and hospital incident command as locally defined.
- Reassess the required bed type if the patient improves or deteriorates.
- Record harms or near misses associated with boarding for governance review.

22. Deterioration before or during transfer

- Stop the transfer and begin immediate ABCDE assessment and treatment.
- Activate the emergency response or resuscitation team according to severity.
- Notify the responsible inpatient service and senior ED clinician immediately.
- Reconsider the destination and level of care; arrange critical-care, theatre, obstetric, paediatric, or other escalation as needed.
- Repeat handover and acceptance after stabilization. A previous ward acceptance does not authorize transfer of a newly unstable patient to an unsuitable ward.
- Document the event, treatment, revised plan, responsibility, and communication with the patient/family.
- Report significant delay-related deterioration, unplanned return to ED, or transfer-related harm through the incident system.

23. Delayed, disputed, or refused admission

- The patient shall remain clinically owned and actively treated while disagreement is resolved.
- Escalate delayed response or refusal through the senior clinician chain defined in Protocol 8.
- Disputes about specialty, bed, payment, residency, administrative eligibility, or resource ownership shall not delay emergency stabilization.
- When two services disagree, senior clinicians should speak directly and identify the service best able to meet the dominant current clinical need.
- When no agreement is reached within the locally approved period, the designated senior ED clinician or Medical Director shall assign the responsible service under hospital policy.
- A receiving ward may pause transfer for a specific safety deficiency, such as lack of oxygen, isolation, monitoring, staffing, or essential information. The deficiency and corrective action shall be explicit and urgently escalated.
- Staff shall not use informal workarounds, undocumented “temporary” placement, or transfer without acceptance to bypass a dispute.

24. Communication with the patient and caregiver

- Explain why admission is recommended and the expected benefits, risks, alternatives, and degree of diagnostic uncertainty.
- Identify the responsible service and expected destination in plain language.
- Explain delays honestly and provide updates at reasonable intervals.
- Discuss what will happen next, including tests, procedures, fasting, medicines, monitoring, and possible changes in destination.
- Use an interpreter and accessible communication method when needed.
- Invite the patient or caregiver to raise deterioration, medication concerns, allergies, safeguarding issues, or information that may have been missed.
- Where capacity is impaired, involve the legally appropriate decision-maker while respecting the patient’s rights, preferences, privacy, and best interests.
- Document refusal of admission or transfer and manage under the refusal / leaving-before-completion procedure.

25. Documentation requirements

The health record shall create an auditable timeline from decision to admit through arrival on the ward.

- Decision to admit: date/time, clinician, reason, working diagnosis, level of care, and immediate plan.
- Referral: date/time, person contacted, information given, urgency, response, and expected review.
- Acceptance: receiving clinician/service, date/time, plan, destination, and point of responsibility transfer under local policy.
- Bed allocation and readiness confirmation.
- Current observations, early-warning score, final reassessment, and fitness for destination.
- Treatments, medicines, infusions, oxygen, devices, allergies, and next actions due.
- Available and pending investigations, named result owner, and critical-result communication.
- Medical and nursing handover: giver, receiver, date/time, questions/read-back, and unresolved issues.
- Transport mode, escort, monitoring, oxygen, equipment, departure and arrival times, and events in transit.
- Patient/family communication and any refusal, concern, capacity, safeguarding, or interpreter issue.
- Delay, boarding reviews, escalation actions, disputes, deterioration, incidents, and revised plans.

26. Quality indicators and audit

Indicator	Suggested definition / local target
Documented decision-to-admit time	Percentage of admitted ED records with an explicit decision time and responsible clinician.
Acceptance documentation	Percentage with named accepting service/clinician and acceptance time.
Pre-transfer reassessment	Percentage with current observations and documented reassessment immediately before departure.
Structured handover	Percentage with medical and nursing ISBAR/equivalent handover and identified receivers.
Pending-result ownership	Percentage of admissions with pending results that name a reviewer and action plan.
Medication continuity	Percentage with medication reconciliation and no avoidable missed time-critical dose during boarding/transfer.
Boarding duration	Median and 90th percentile time from admission decision to ward arrival, stratified by acuity and destination.
Deterioration while boarding	Rate of resuscitation, critical-care escalation, or significant deterioration after decision to admit.
Transfer incidents	Falls, line/tube dislodgement, oxygen interruption, medication error, wrong destination, incomplete handover, and unplanned return to ED.
Patient experience	Percentage of admitted patients/caregivers who report understanding the reason, responsible team, and next steps.
Equity review	Compare delays and adverse events by age, sex, disability, language, socioeconomic or payment status, and other locally lawful equity measures.

Indicator	Suggested definition / local target
Action on findings	Evidence that leaders review results, assign corrective actions, and re-audit.

27. Education, competency, and implementation

- All relevant staff shall receive orientation to the responsibility model, admission pathway, ISBAR handover, boarding standard, transfer-risk assessment, and stop-transfer authority.
- Competency assessment should include simulated unstable transfer, high-alert infusion, isolation transfer, paediatric or obstetric case, and disputed responsibility scenario.
- Bed management and inpatient teams shall participate; this is a hospital-wide protocol, not an ED-only requirement.
- Admission forms, electronic fields, handover templates, and dashboards shall be configured before launch.
- The hospital shall publish an up-to-date specialty contact directory, escalation chain, bed-capability matrix, isolation map, and transport/escort standards.
- Implementation should begin with baseline audit, a short pilot, staff feedback, correction of workflow hazards, and formal approval before full enforcement.
- Serious events shall trigger multidisciplinary review of system factors, not only individual compliance.

28. References and source frameworks

1. World Health Organization. Communication during patient hand-overs. Patient Safety Solutions, Volume 1, Solution 3. 2007.
2. World Health Organization. Emergency Care Toolkit and standardized emergency-care resources.
3. World Health Organization. Prehospital Toolkit: acute referral and transfer tools, including the Acute Transfer Checklist, Acute Referral Form, and Interfacility Acute Transfer Checklist.
4. Agency for Healthcare Research and Quality. TeamSTEPPS: Handoff tool and communication curriculum.
5. The Joint Commission. National Performance Goals effective January 2026 for the Hospital Program, including patient flow, boarding, handoff communication, alarms, and deterioration response.
6. Royal College of Emergency Medicine. Referral for Inpatient Care Standards. 2025.
7. Royal College of Emergency Medicine. Clinical Responsibility for Patients within the Emergency Department. 2025.
8. Royal College of Emergency Medicine. Guidelines for the Provision of Emergency Medical Services. December 2024 / January 2025 publication.
9. Local legislation, professional codes, formulary, infection-control standards, safeguarding policy, bed-management policy, and specialty admission pathways.

Annex A. One-page admission and ward-transfer workflow

Step	Bedside action
DECIDE	Document why admission is required, working diagnosis, severity, and required level of care.
STABILIZE	Treat immediate threats and complete essential time-critical care; do not wait for a bed.
REFER	Use ISBAR; state urgency, request, uncertainty, results, treatment response, and pending actions.
ACCEPT	Record named receiving service/clinician, acceptance time, plan, and responsibility point.
ALLOCATE	Confirm a clinically appropriate, staffed, equipped, and isolation-ready destination.
CARE WHILE WAITING	Continue observations, medicines, fluids, comfort, nursing care, review, and result follow-up.
REASSESS	Record current observations and condition immediately before departure. Stop if deteriorated.
HAND OVER	Medical and nursing verbal handover with questions/read-back; transfer pending-action ownership.
TRANSPORT	Correct mode, escort, monitoring, oxygen, equipment, records, and infection precautions.
RECEIVE	Verify identity, condition, medicines, devices, priorities, and responsibility at the bedside.
CLOSE	Record departure/arrival, receiver, incidents, and any revised plan.

Annex B. Admission readiness checklist

Check	Yes / No / N/A and details
Decision to admit documented, including working diagnosis and level of care	
Named accepting clinician and service documented	
Appropriate bed/destination confirmed and ready	
Immediate threats stabilized and essential treatment completed	
Current observations and early-warning score recorded	
Final clinical reassessment completed	
All available results reviewed; critical findings communicated	

Check	Yes / No / N/A and details
Pending results/actions listed with named owner and timeframe	
Medication reconciliation completed; next time-critical doses identified	
Oxygen, infusions, devices, drains, wounds, and equipment safe	
Isolation, safeguarding, behavioural, mobility, falls, and pressure risks communicated	
Medical and nursing handovers accepted	
Transport mode, escort, monitoring, and route appropriate	
Patient/caregiver informed of admission plan and delay	
Departure and arrival times / receivers documented	

Annex C. ISBAR medical handover template

Field	Record
I - Identification	Patient identifiers; current location; sending clinician/service; receiving clinician/service.
S - Situation	Reason for admission; urgency; current stability; required level of care; immediate concern.
B - Background	Relevant history, baseline function, comorbidities, allergies, medicines, pregnancy, recent admission, safeguarding, treatment limits.
A - Assessment	Working diagnosis and uncertainty; observations/trends; examination; tests; treatment and response; complications.
R - Recommendation	Immediate plan; monitoring; medicines and due times; pending results; required reviews/procedures; escalation triggers and contingencies.
Receiver confirmation	Name/role; acceptance time; questions; read-back; unresolved issue; responsibility transferred according to local model.

Annex D. Nursing transfer and bedside receipt checklist

Domain	Required confirmation
Identity and allergy	Two identifiers, wristband, allergy status, alerts.
Current condition	Observations, early-warning score, symptoms, pain, cognition, oxygen, escalation triggers.

Domain	Required confirmation
Medicines	Given, due, omitted/withheld, infusions, high-alert medicines, patient-owned medicines.
Devices and wounds	IV/IO access, drains, catheters, tubes, dressings, splints, pressure areas, skin integrity.
Function and care	Mobility, falls, pressure care, nutrition, fasting, toileting, fluid balance, communication, sensory aids.
Risk	Infection/isolation, behaviour, self-harm, safeguarding, security, capacity, restraint.
Pending work	Results, specimens, repeat tests, consultations, procedures, reviews, time-critical actions.
Property	Valuables, clothes, medication, aids, documents transferred per policy.
Bedside safety	Identity rechecked; oxygen/monitoring connected; infusions running; bed/call bell safe; immediate needs met.
Acceptance	Receiving nurse name, signature/identifier, date/time; discrepancies resolved.

Annex E. Boarding safety round

Review item	Minimum question
Responsibility	Which medical team and which nurse are responsible now?
Clinical status	Has the patient changed? Are observations and early-warning score current?
Treatment	Are all medicines, fluids, oxygen, nutrition, pain relief, and procedures on time?
Results	Are new results reviewed and acted upon? Are pending actions owned?
Basic care	Hydration, food/fasting, toileting, mobility, pressure care, sleep, dignity, communication.
Environment	Is location, monitoring, isolation, visibility, and security safe?
Destination	Is the requested bed still appropriate? What blocks transfer and who is resolving it?
Escalation	Has duration/risk crossed the local threshold for senior or executive escalation?
Patient/family	Do they understand the delay and plan? Have they raised a concern?

Annex F. Stop-transfer criteria

Any staff member may stop the transfer when an essential safety condition is not met. The concern shall be resolved or escalated immediately; staff shall not be penalized for good-faith safety action.

- New or worsening airway, breathing, circulation, neurological, bleeding, pain, agitation, or obstetric concern.
- Observations or early-warning score indicate a higher level of care than the destination can provide.
- Receiving service or nurse has not accepted the patient or is unaware of the transfer.
- Required oxygen, monitoring, medicines, infusion pump, equipment, isolation, staffing, or escort is unavailable.
- Patient identity, allergy, documentation, or destination is uncertain.
- Critical results or time-critical treatment have not been communicated or acted upon.
- Unsafe route, lift, bed, transport device, bariatric limitation, infection-control issue, or security threat.
- The patient or caregiver identifies a material change or unresolved safety concern.

Annex G. Admission and transfer audit tool

Audit item	Compliant / Not compliant / N/A
Decision to admit, reason, time, and clinician documented	
Named accepting service and clinician, with acceptance time	
Clinical responsibility clear at all stages	
Destination appropriate and readiness confirmed	
Pre-transfer observations and reassessment documented	
Medical ISBAR handover completed and receiver identified	
Nursing handover and bedside acceptance completed	
Medication reconciliation and next-dose continuity documented	
Pending results/actions have named ownership	
Transport risk, escort, oxygen, monitoring, and equipment appropriate	
Patient/caregiver communication documented	
Boarding reviews and escalation completed when applicable	
Delay, deterioration, dispute, or incident documented and reported	

Annex H. Local configuration table

Local decision required	Approved configuration
Point at which medical responsibility transfers	[Insert locally approved model]
Point at which nursing responsibility transfers	[Insert locally approved model]
Authorized clinicians who may accept admission	[Insert roles]
Specialty response and acceptance time standards	[Insert by urgency]
Decision-to-admit to bed-request target	[Insert]
Bed-ready to ED-departure target	[Insert]
Boarding review intervals by acuity	[Insert]
Thresholds for operational / executive escalation	[Insert]
Ward capability matrix and monitored-bed criteria	[Insert location]
Transport and escort standards	[Insert]
After-hours contact and escalation directory	[Insert location / owner]
Required admission and handover forms / EHR fields	[Insert]
Audit frequency and committee	[Insert]

Annex I. Approval and sign-off

Role	Name	Signature	Date
ED Medical Lead			
ED Nursing Lead			
Inpatient Medical Services Lead			
Inpatient Nursing Services Lead			
Pharmacy Lead			
Bed Management / Patient Flow Lead			
Infection Prevention Lead			
Quality and Patient Safety Lead			
Medical Director			
Nursing Director			
Chief Executive / Authorized Approver			

Implementation note: This draft becomes operational only after local review, completion of all configuration fields, approval of the clinical-responsibility model, staff education, and publication of the required contact, bed-capability, transport, and escalation resources.