**Pressure Resilience in Emergency Medicine 5 Plus Guidance**

1. **Clinical Care – Initial Assessment, Critically Ill Patient and Deteriorating Patient**

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| Initial Assessment | Critically Ill Patient | Deteriorating Patients | Additional evidence of safety |
| Initial assessment must be safe, including clear governance for safeguarding incorporating mental health and domestic abuse processes. | Evidence of standardised practice based on national guidance, for example: RCEM/NICE clinical pathways.  RCEM/National safety alerts are displayed, acted upon and audited. | A system for monitoring and review of deteriorating patients is in place including speciality patients. | **Initial Assessment**  Initial assessment should be within 15 mins but acutely unwell patients should be seen as soon as their condition determines. Unwell patients should not be left sat in the waiting room.  **Critical Medicines**  Are they given in an appropriate timeframe? These include current medication not just as required medication.   * Pain relief * Insulin * Parkinson’s medicines * Epilepsy medicines   **Sepsis**  How is it identified?  How is it treated?  How is end-to-end care ensured?  How is learning undertaken and how do you know how teams are doing (audit etc)? |
| Initial assessment must be reliable with a clear methodology which can be easily replicated based on the model not the user.  (Inter and Intra Operability) | Evidence of senior clinical review at Consultant or ST4 and above.  Clear documentation of care and treatment should be in place using a reliable IT system.  A reliable handover process must be in place. | Patients are monitored for signs of deterioration. They are visible-patient vital signs are recorded. For example NEWS2/PEWS/MEOWS.  Vital signs are regularly repeated with a robust single recording system. |
| Initial assessment must be patient focused and improve the patient experience. | Staff work in line with Professional and clinical standards. For example speciality review time or time to treatment. | Evidence of senior clinical involvement at Consultant or ST4 or above, which is clearly recorded including care and treatment. |
| Initial assessment must be sustainable and achieved 24/7. It must be able to cope with surges in demand. | Patient outcomes are monitored, for example:   * Sepsis audit and action plan * Serious incidents * Mortality review * RCEM audits and guidelines, for example VTE in leg fractures. | Evidence that the patient is escalated a clinical decision maker when there are signs of deterioration and this is recorded, acted upon and audited. |
| Initial assessment must be part of clinical governance processes and regularly audited. | Medicines Management   * Effective delivery of time critical medication, for example antibiotics in sepsis. * Correct dose and correct route. * Processes audited and learning acted upon | Review at least 10 patient records (including safeguarding). |
|  | Tertiary pathways are robust and timely. For example trauma, MI, stroke. |  |

1. **Infection Prevention and Control (IPC) and Infrastructure**

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| Evidence of review of the environment to provide an up-to-date IPC response to high-risk patients attending the ED considering isolation. |
| Use of personal protective equipment (PPE) that meets national guidance.  Sufficient clean and maintained equipment, with processes for assuring cleaning has taken place.  Regular audits and cleaning equipment and environment are available and have taken place. |
| Timely testing for infectious diseases according to the national guidance with access to prompt reporting. |
| Evidence of education and training in IPC for all staff. |
| Audits and actions plans of IPC processes. |
| Use of accepted national guidance of IPC, for example NHS England National infection prevention and control manual for England (NIPCM) July 2023 Version 2.6. |

1. **Flow**

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|  | Additional evidence of safety |
| Are there appropriate governance processes and risk assessments for ambulance queues in or outside the ED including accountability. | **Speciality Reviews**  Are these undertaken in a timely manner.  **Trolley Waits**  No patients over 65 years of age will be on an ED trolley for more than 12 hours. A system needs to be in place to monitor length of time on a trolley and to provide a suitable bed for the patient even if that means the patient remains in ED. |
| Are there effective initial assessment processes providing safe and efficient care through ED.   * Time to initial assessment * Time to see a doctor/decision maker * Time to treatment |
| Are there appropriate and safe systems to redirect patients to alternative pathways from ED at initial assessment.   * SDECs * GPs * Pharmacy * Social support services, for example alcohol/drugs * Specialities * Frailty |
| Are there efficient processes to support flow through the ED.   * Diagnostics/Radiology/POCT * Senior ED review * Time to speciality review * Length of wait over 4 and 12 hours * Total time in the ED |
| Are there appropriate escalation policies and routes to support patient flow and how is this escalated both internally and externally.   * Site meetings * OPEL scoring and Full Capacity Protocols * Command structures such as bronze, silver and gold |
| What systems and processes are in place to support and manage the flow within ED when there are increasing numbers of transfer of care and no reason to reside patients that result in increased bed occupancy levels, and issues with moving patients through the Emergency Departments. |

1. **Workforce**

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|  | Additional evidence of safety |
| Are there appropriate numbers of medical and nursing staff in place with the correct skill mix?  Are there regular reviews of staffing taking place linking staffing with demand and acuity?  Do staffing levels meet those that have been planned?  Is there evidence of a staffing management tool. | **Safe Staffing** |
| Is there evidence of teaching training and clinical supervision across all staff groups? |
| What is the percentage of locum, bank and agency usage across all staff groups? |
| Is there evidence of an innovative staff rota?  Is there evidence of innovative staff recruitment and retention programmes?  Is there flexibility with staff groups to meet surges in demand? |

1. **Leadership and Culture**

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| Is there evidence of effective operational leadership? |  |
| Is there evidence of strategic leadership? |  |
| Is there evidence of a culture of:   * Safety * Learning * Team-including health and well-being of staff |  |
| Is there a robust review of clinical governance and risk management processes including mortality and morbidity (M&M) reviews and harm reviews. |  |
| Is there evidence of patient involvement and action as a result of the findings. |  |