Lothian NHS Board

Lothian NHS Board
Mainpoint
102 Westport
Edinburgh
EH3 9DN
Main Switchboard: 0131 242 1000

www.nhslothian.scot

Date 23/01/2026
Your Ref
Our Ref 10939

Enquiries to Richard Mutch
Extension 35687
Direct Line 0131 465 5687
loth.freedomofinformation@nhs.scot
richard.mutch@nhs.scot

Dear

FREEDOM OF INFORMATION – PATIENT CARE AND INFECTION

I write in response to your request for information in relation to patient care and infection.

Question:

1. In the financial years 2020 - 2021, 2021 - 2022, 2022 - 2023, 2023 - 2024, 2024 - 2025, please provide the total number of patients who received care or clinical attention in corridors or other non-designated clinical areas. Please breakdown by financial year if possible.

2. In the financial years 2020 - 2021, 2021 - 2022, 2022 - 2023, 2023 - 2024, 2024 - 2025, please provide the total number the total number of hours patients collectively spent receiving corridor care. Please breakdown by financial year if possible.

3. In the financial years 2020 - 2021, 2021 - 2022, 2022 - 2023, 2023 - 2024, 2024 - 2025, please provide the longest individual recorded duration a patient spent receiving care in a corridor or non-designated area during each year. Please breakdown by financial year if possible.

Answer:

Corridor Care is something that NHS Lothian does not practice, so we are unable to provide you with the information requested

Question:

4. In the financial years 2020 - 2021, 2021 - 2022, 2022 - 2023, 2023 - 2024, 2024 - 2025, please provide copies of any risk assessments, safety reviews, or incident reports specifically relating to the use of corridor care. Please breakdown by financial year if possible.

Answer:

Please see enclosed. Our ED OS has this as a central feature understanding ED pressure, and there is guidance in continuous flow policies also. It was also a central part of the HIS visits during 2023.

Due to the specific nature and location we cannot release safety reviews or incident reports as these would be highly identifiable evn if redacted. These contain information about specific

cases which could lead to the identification of the patients involved. However, SAERs are shared directly with patients and/or their families.

The information is regarded as exempt under Section 38(1)(b)(d) of the Freedom of Information (Scotland) Act 2002 – personal information.

Question:

5. In the financial years 2020 - 2021, 2021 - 2022, 2022 - 2023, 2023 - 2024, 2024 - 2025, please provide the total number of patients who presented with **Catheter-Associated Urinary Tract Infections (CAUTIs)** whilst in your care. Please breakdown by financial year if possible.

6. In the financial years 2020 - 2021, 2021 - 2022, 2022 - 2023, 2023 - 2024, 2024 - 2025, please provide the total number of patients who presented with **Surgical Site Infections (SSIs)** whilst in your care. Please breakdown by financial year if possible.

7. In the financial years 2020 - 2021, 2021 - 2022, 2022 - 2023, 2023 - 2024, 2024 - 2025, please provide the total number of patients who presented with **Central Line-Associated Bloodstream Infections (CLABSIs)** whilst in your care. Please breakdown by financial year if possible.

8. In the financial years 2020 - 2021, 2021 - 2022, 2022 - 2023, 2023 - 2024, 2024 - 2025, please provide the total number of patients who presented with **Clostridioides difficile (C. diff) Infections)** whilst in your care. Please breakdown by financial year if possible.

9. In the financial years 2020 - 2021, 2021 - 2022, 2022 - 2023, 2023 - 2024, 2024 - 2025, please provide the total number of patients who presented with **Methicillin-Resistant Staphylococcus aureus (MRSA)** whilst in your care. Please breakdown by financial year if possible.

Answer:

I am advised that this information is not held in a centrally extractable format. Under the Freedom of Information Act NHS Lothian is not required to create new records to enable it to respond to your enquiry. This information is not collated or held in aggregate form and it would be necessary to review all case files relating to patients over the period you have requested to assemble the information you seek. Even if NHS Lothian did this – and there would be significant cost implications in doing so – it would be unable to respond in full to your request. The information requested is therefore exempt under section 12.1 – Cost.

Laboratory data will not differentiate between colonisation (presence of an organism in the absence of clinical infection) and infection which requires treatment. Further review would be required to differentiate those who presented to hospital because of these infections

(community associated infection), those who had a healthcare or hospital associated infection (HCAI, HAI)_ and those who admitted witha pre-existing infection and admission for an unrelated cause. Providing lab data will only demonstrate how many samples tested positive for defined organisms over the period requested (this will be thousands).

National mandatory infection surveillance programmes were suspended across NHS Scotland during COVID so there will also be incomplete national published and local data available for this period, and this should be interpreted with caution due to changes in bed occupancy.

Published data for MRSA SAB and CDI is available via Guidance, protocols and reports | National Services Scotland. This provides data for Board performance against these specific indicators in line with mandatory reporting requirements.

We cannot provide SSI data requested because we do not have data for all surgeries and mandatory programmes have not resumed post pandemic. Please see the last published ARHAI SSI reports and benchmarking available via Surgical site infection | National Services Scotland

This information is exempt under Section 25 of the Freedom of Information (Scotland) Act 2002 - Information otherwise accessible.

(1) Information which the applicant can reasonably obtain other than by requesting it under section 1(1) is exempt information.

Surveillance methodology and reporing for CLABSI surveillance in critical care settings is also under review and therefore data is not currently available.

I hope the information provided helps with your request.

If you are unhappy with our response to your request, \you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive
Enc.

Edinburgh office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

0131 623 4300

Glasgow office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.healthcareimprovementscotland.org

28 March 2023

Mr Calum Campbell
Chief Executive
NHS Lothian
(Via email ChiefExecutive@nhslothian.scot.nhs.uk)

Dear Mr Campbell

Formal Escalation – serious issues identified during a Safe Delivery of Care inspection of Edinburgh Royal Infirmary Emergency Department.

Thank you for your response letter dated 24 March 2023, setting out the actions that NHS Lothian have taken to date in response to the serious concerns raised about safety and quality of care at Edinburgh Royal Infirmary Emergency Department.

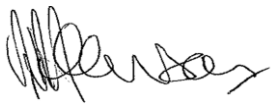
We welcome the actions already undertaken and the actions in progress contained within the '*RIE Directorate of Emergency, Acute & General Medicine Response to HIS document*'. We note the two external senior staff recruited to provide additional support, guidance, oversight and assurance of your plans.

We will now consider the assurances you have provided as part of the assessment of our inspection findings and to inform the recommendations we make in our inspection report. We will also seek assurance on progress with planned improvement actions at a future date in accordance with our published inspection methodology.

Please be aware that we have also advised the Health and Safety Executive (HSE) of our concerns in respect of aspects of patient safety within the emergency department in accordance with the requirements in our established Memorandum of Understanding with the HSE.

Thank you again to you and your colleagues for your contribution to this inspection and to your response to the serious concerns that we have escalated.

Yours sincerely



Robbie Pearson
Chief Executive

Copied to Prof John Connaghan CBE, Chair, NHS Lothian

NHS SCOTLAND

RIE ED Operational Status (EOS) escalation Policy v2.2

Aug 2024 Update

(1) All NHSL services, including RIE ED should have an escalation policy to objectively report operational service capability in real-time. [1]

(2) This 'ED Operational Status' (EOS) escalation policy objectively describes – via a composite score – RIE ED's resilience to provide safe and effective *ED critical services*.

(3) This composite score describes in real-time the '*risk of harm despite best-care available in the ED*' to patients, and mitigation actions the ED should take at corresponding scores.

(4) This policy forms part of NHSL 'preparedness status' policy & score informing how RIE services (and the wider NHSL community) should respond to escalating risk of harm to unscheduled NHSL emergency patients in the ED.

(5) *ED critical services* are:

i. **To provide immediate resuscitation for undifferentiated critically ill patients** [2]

ii. **To provide effective assessment for emergency undifferentiated patients** [3]

iii. **Maximise efficiency and minimise delay to emergency ambulance off-load**

iv. **Respond to significant incidents - Major Incident, HCID patients and HAZMAT/CBRN incidents.**

(6) The ED leadership team (CD, CNM, CSM and GM) are jointly, accountable for the ED EOS escalation policy.

(7) The NIC & EPIC are jointly responsible for day to day delivery of this policy, including:

i. Recording scores & corresponding actions taken

ii. Recording site escalation and response

(8) The EOS score is the sum of key categories that influence delivery of critical ED services:

- ***Capacity*** – a measures of the number of patients with active ED management relative to the EDs designed capacity.

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[1] As part of an escalation policy as per RCEM crowding toolkit 2015 (full capacity escalation policy)

[2] Including regional centre national targets for emergency Stoke, Major Trauma, and Coronary Care

[3] Timely triage and management of patients in most need to those in least need who present to the ED

- ***Effectiveness*** – a measure of how well the ED can carry out rapid assessments of emergency undifferentiated patients relative to national standards.
- ***Acuity*** – a measure of the number of critically unwell patients being actively managed relative to the ED's designed capability.
- ***Crowding*** – a measure of ED crowding severity relative to the ED's designed maximum optimum effective capacity.
- ***Triage and Staffing*** – a measure of how well patients are being triaged versus national standards, and a measure of workforce versus demand.

(9) The EOS score is calculated by adding up points from each category (1 to 5 below), the minimum score is 0 and the max score is 25. The score generated will correspond to a descriptive LEVEL of risk of harm to patients (and staff) despite best care available in the ED. The score in the ED should be calculated 15 minutes ahead of the ED safety pause. This should give adequate time to alert senior manager or site director to attend the safety pause if indicated.

SCORING SYSTEM – ED Operational Status (EOS) Escalation Score

	0	1	2	3	4	5
Total ED Patients [4]	≤ 31 **85% capacity**	32-47	48-62	63-77	78-93	≥ 94 **250% capacity**
Time to clinician [5] **(hr)**	<1	1-2	2-3	3-5	5-8	≥ 8
Resus patients [6, 7]	≤ 1	2	3	4	5	6
Hospital Boarders [8] **≥ 1hr from request to admit**	0	1-7	8-14	15-28	29-47	≥ 48+

Triage & Staffing (Max. 5 pts)

TRIAGE:

- Self-presenters: 1 point per 45min to triage & / or per 18 patients waiting triage.
- Emergency Ambo: 1 point per 30min to triage & / or per 5 patient waiting triage

STAFFING

- 1 point per 2 nursing staff less than min. no.s & / or, per 1 health care providers less than min. no.s

Total score corresponds to the following increasing levels of *risk of harm to patients (and / or poor experience for staff) from the best-care available*:

- No increased risk of harm — 0 – 4 — **Green (normal business)**
- Additional risk of harm — 5 – 9 — **Yellow**
- Substantial risk of harm — 10 – 14 — **Amber**
- **Severe risk of harm** — **15 – 19** — **Red**
- **CRITICAL risk of harm** — **20 – 25** — **BLACK**

THE ED SHOULD BE REGARDED AS UNSAFE IF EOS TOTAL SCORE > 9, OR IF ANY INDIVIDUAL CATEGORY HAS A SCORE ≥ 4. INTERNAL AND EXTERNAL ACTIONS SHOULD BE OUTLINED/AGREED

[4] Not including Hospital boarders, patients awaiting triage, patient in either ED Obs. Ward, or in MIU.

[5] The 90th centile time to HCP is used as a more representative time to 1st assessment.

[6] Including patients in Resus for procedures requiring advanced monitoring (e.g., sedation, chest drains etc.)

[7] *EXTRAORDINARY acuity*: add 1 point for an enhanced trauma, and add 2 points per code red trauma.

[8] 1 point per 5 hospital borders with LOS in ED ≥ 12hrs. GIRFT data

IMPORTANT MESSAGING RE SAFETY (or risk of harm to patients)

1. DO CHALLENGE ANY PERCEPTION THAT A ***'LOW'*** EOS SCORE IS OK.

The ED can provide excellent & zero harm outcomes for patients, staff and the organisation, including ≥ 95% emergency access standard, even when the ED is at capacity – EOS score 0 to 4. A score of 4 is the ED at capacity. If, however, the total EOS score increases to ≥ 5, there will be a corresponding increase in risk of harm and poor outcomes for patient, staff and NHSL.

2. AT EOS ≥ 9, THE ED MAY HAVE TO DELIVER LESS THAN OPTIMAL STANDARD CARE TO SOME AREAS TO RESOURCE AREAS UNDER GREATER DEMAND/HIGHER ACUITY.

As EOS increases and demand, acuity and crowding outstrip available resource in ED, the EOS policy may suggest actions that worsen resource in another part of the ED. In these situations, a dynamic risk assessment should be made to establish the best worst option available, and actions should be reviewed at 60 mins and a decision made whether to continue with the action. If it is not possible to get resource from elsewhere (other areas of the ED or even other sites in NHSL), as a guide, the hierarchy of risk should be considered as:

RESUS > TRIAGE > TIME TO 1ST CLINICIAN > BOARDERS

3. THE ED SHOULD STANDARDISE HOW IT RECORDS & RESPONDS TO AN INCREASINGLY UNSAFE DEPARTMENT

In the safety pause, do escalate and run through suggested actions with a designated person to complete the action – note these down, and come back to these at the next safety pause.

WHEN GENERAL & SPECIFIC ED ACTIONS SHOULD BE ENACTED

If the **total EOS score is ≥ 10**, there is at least ***SUBSTANTIAL RISK OF HARM***; if despite ED actions outlined below, the EOS stays at this level (or worsens) through 1 safety pause, a dynamic assessment of the need for escalation should occur. ***ESCALATION*** should follow the ***chain of command*** outlined below.

Staffing support for 1-2hrs from the site may be helpful to support TRIAGE / RESUS. Also, consider staff support from MIU in hours / H@N in OOH period. At critical EOS level, request support in ED from specialties.

Chain of command <u>IN HOURS</u> (Mon – Fri 0800 – 1800)

1. Level 1: ED NIC & EPIC
2. Level 2: ED CMT (ED CD/CNM/CSM)
3. Level 3: General Manager and / or the AMD for ED/AM/GM via the ED CMT
4. Level 4: Site Director on call via the GM or AMD

Chain of command <u>OUT OF HOURS</u>

1. Level 1: ED NIC & EPIC
2. Level 2: Senior Manager on call
3. Level 3: Director on call via the Senior Manager on call

GENERAL ED ACTIONS TO TAKE

EOS score 10 – 14 SUBSTANTIAL RISK OF HARM

The 4hr emergency access standard and other key performance indicators will be compromised due to prioritisation of clinical need.

ED Actions:

1. NIC & EPIC will assess if escalation in chain of command is required.
2. At discretion of the ED team, non-time critical procedures, may be delayed or deferred to in-patient teams (procedures may occur in exceptional cases if non-ED staff are provided. It will be expected that the patient is managed by the specialty team.
3. Review the need to cohort ambulances.
4. Review & agree **<u>specific</u>** actions for EOS categories with score **≥ 4**.

EOS score 15 – 19 SEVERE RISK OF HARM

F*urther compromises in care may occur. The 4hr emergency access standard and other key performance indicators will be compromised due to prioritisation of clinical need.*

ED Actions:

1. NIC & EPIC will assess if escalation in chain of command is required.
2. At discretion of the ED team, non-time critical procedures, may be delayed or deferred to in-patient teams (procedures may occur in exceptional cases if non-ED staff are provided. It will be expected that the patient is managed by the specialty team.
3. Review the need to cohort ambulances.
4. Review & agree **specific** actions for EOS categories with score **≥ 4**.
5. Team leading ED response should:
    i. Assess appropriateness of GP flow and ensure non-urgent transfers have occurred (where possible, moved to other sites).
    ii. Review / authorise patient moves when specialties are breeching IPS SOP.
    iii. Dynamic assessment & optimise staffing across front door to mitigate risk of harm.

EOS score ≥ 20 CRITICAL RISK OF HARM

The *ED may need to prioritise critical service only, without intervention, risk of harm to patients is likely. The 4hr emergency access standard and other key performance indicators will be compromised due to prioritisation of clinical need.*

ED Actions:

1. NIC & EPIC will assess if escalation in chain of command is required.
2. At discretion of the ED team, non-time critical procedures, may be delayed or deferred to in-patient teams (procedures may occur in exceptional cases if non-ED staff are provided. It will be expected that the patient is managed by the specialty team.
3. Review the need to cohort ambulances.
4. Review & agree **specific** actions for EOS categories with score **≥ 4**.
5. Team leading ED response should:
    i. Assess appropriateness of GP flow and ensure non-urgent transfers have occurred (where possible, moved to other sites).
    ii. Review / authorise patient moves when specialties are breeching IPS SOP.
    iii. Dynamic assessment & optimise staffing across front door to mitigate risk of harm.
6. Team leading ED should:
    i. Ensure appropriate PREP STAT steps have been actioned.
    ii. Make a dynamic risk assessment to restart 'Flowthian' SOP if not being followed
    iii. Review diverting SAS options (agree which patient come to RIE, e.g., major trauma)
    iv. In the OOH period, assess if H@H can expand capacity.
    v. Approve, if following triage, category 4/5 patients can return to ED tomorrow.
    vi. Dynamic risk assess if a site level business continuity incident should be enacted - Follow *RIE Tactical Resilience Plan*. Aim to maximise flow / minimise ED Boarders
    vii. Complete Datix – highlight EOS score & breakdown scores of categories.

SPECIFIC ED ACTIONS TO TAKE

I**ndividual EOS category score ≥ 4 out of 5** represents at least ***severe risk of harm*** and is a trigger to ensure specific actions outline below have been reviewed / enacted.

When demand, acuity and crowding outstrip available resources (available in ED or other areas in NHSL) to enact actions outlined below, make a dynamic risk assessment to prioritise actions (review hourly). As a guide, the hierarchy of risk in the ED is:

RESUS > TRIAGE > TIME TO 1ST CLINICIAN > BOARDERS

Staffing support for 1-2hrs from the site may be helpful to support TRIAGE / RESUS. Consider staffing support from MIU in hours / H@N in OOH period. At critical EOS level, request support from specialties (EMERGE team may be asked to help in extremis).

RESUS

1) Review & enact step downs as per RESUS Step-down pathway.
2) Expedite moves to 116/118. Alert ED leadership to expedite this.
3) Agree where the next resus. case will go & how it will be staffed. If to a POD, the SDM / POD coordinator are responsible for the case in addition to usual workload.
4) If staffing support cannot be supported within ED, request help from the site.

TRIAGE

1) Add an extra triage nurse & CSW
2) Add extra senior nurse band 6 or 7
3) Review the triage queue, prioritise anyone of clinical concern (e.g. elderly with severe abdo pain, or ≥ 30YO with cardiac chest pain).
4) Add a senior decision maker
5) NIC assess if any pod(s) has capacity to support triaging patients.
6) If staffing support cannot be supported within ED, request help from the site.

TIME TO 1st CLINICIAN

1) Ensure all direct referrals to specialties & redirection are enacted.
2) Maximise space in PODs
3) Ensure front-load, time-critical investigations are enacted.
4) Request dedicated porter (+/- CSW) to expedite patient movement
5) Snr decision maker and POD coordinator to:
    a. Review patients waiting to be seen / up-triage patients of concern.
    b. Repeat previous step when 1st assessment reaches 3hrs, 6hrs, 9hrs etc.
    c. Review pending CT investigations – prioritise/liaise with radiology appropriately.

BOARDING PATIENTS

GIRFT data: 1 unnecessary death for every 82 patients delayed in ED by 6-8hrs.

1) Ensure appropriate specialty teams are aware of their boarding patients (highlight unreasonable IPS breeches to EPIC/NIC).
2) Boarders in ED should have:
    a. An assigned up to date responsible clinician
    b. A clearly documented working diagnosis & management plan
    c. Critical treatments prescribed as per Kardex SOP
3) POD coordinator to ensure as a minimum:
    a. Observations have been completed within the last 4 hours
    b. Care rounds as per SOP have been completed within the last 4 hours
    c. Boarders who remain in the ED >12hrs (& 12hrly thereafter) should have a SDM documented review (as per boarders SOP (\bwcon))

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Improvement Action Plan

Healthcare Improvement Scotland:

Unannounced acute hospital safe delivery of care inspection

Royal Infirmary of Edinburgh, NHS Lothian

20 – 22 February 2023

Follow up Inspection 18th and 20th September 2024

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: _____

Full Name: _____

NHS board Chief Executive

Signature: _____

Full Name: _____

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Date: _____

Requirement/ Recommendation	Action Planned	Timescale to meet action	Responsibility for action	Progress	Date Completed/Due for Completion	RAG
Requirement 1	Detailed and effective plans are in place to ensure safe fire evacuation of patients and staff within overcrowded areas	June 30th 2023	ED Triumvirate General Manager RIE Fire Safety Officer	RIE staff fire training programme progressed including tabletop exercise around evacuation during May date to be confirmed. Tabletop exercise completed June 23.	June 2023	
				ED Emergency Fire Action Plan refreshed. Evacuation plan developed and available within department it will be reviewed annually to ensure they are relevant. EFAP now produced and communicated. Train trainers in place and exercises and training carried out for staff within dept.	June 2023	

				RIE Fire safety plan has been updated and is going through governance process via Health and Safety (Nov 23). All local EFAPs will be updated by Dec 2023. Ongoing fire drill training (Training Note 9) across all clinical areas. 2 Train the trainers now in place for the unit. 81% nursing compliance March 2024. Face to face training ongoing with fire trainers. Evacuation default exercise March 2024 of C D E.	Nov 2023	
				Dedicated Band 7 Flow Co-ordinator now in post as of May 15th to oversee safe and timely patient movement in line with Emergency Access Standard (EAS). Role is part of a test of change and is currently being evaluated. Review of permanent role for flow now underway.	June 2023 May 2024.	
				Specific for ED – All 6 funded Band 7 SCN posts now recruited into. Changed focus for the SCN role where they are in charge of the department for a significant proportion of their week with dedicated supervisory time. There is ongoing review of the nursing leadership requirements in ED and AMU, in response to DATIX themes, trends and staff feedback.	June 2023	
Requirement 3	Ensure that patient's privacy and dignity is always maintained, and all patients have access to a	May 31st 2023	Senior Charge Nurses ED & AMGM Triumvirates	Temporary call bells functioning in ED Pod C	June 2023	
				New buzzer system now in place October 2023 completion in all PODS.	October 2023	

	call bell (action specific to ED/AMU)			AMU Base 6, temporary buzzers in place.	June 2023	
				AMU full call bell solution being pursued, and work is planned to commence mid-September. First stage is complete and SBAR in place for next phase of works awaiting a date.	September 2023	
				Ensure that curtains are drawn to maintain privacy and dignity, monitored through assurance reviews. Recent assurance visits have shown this is embedded within practice.	June 2023	
				Daily checks/logs in place, this is monitored through assurance reviews.	June 2023	
	Requirement for mixed sex bays to be risk assessed if and when this occurs.			AMU is a continuation of emergency and urgent care and therefore mixed sex bays exists due to challenges of flow and monitoring patients. Privacy and dignity always maintained through curtains and individual toileting facilities. Currently wards do not mix sex unless for very short periods of time or higher levels of care and monitoring are required where there is one bay of an HDU/ITU unit Draft flow chart prepared by DAND and AND for site and this was discussed through nurse directors October 2023 meeting. This needs to take cognisance of the changing demography and equality acts for gender needs for all	October 2023	

				patients. There will be an opportunity to test guidance at the RIE and inform the way forward.		
Requirement 6	Ensure safe intravenous line care practice to prevent the risk of infection and to ensure effective intravenous fluid management.	May 31st 2023	Senior Charge Nurses Clinical Nurse Managers Clinical Directors Quality lead nurses Associate Nurse Director IPCN	Posters in place within ED and AMU to raise awareness of need to report lines which are running dry or the infusion is complete.	May 2023	
				Awareness raised at safety huddles and safety pauses around safe line care.	June 2023 and ongoing	
				Education around line care ongoing monitored within LACAS and assurance walk rounds.	August 2023	

				Monitoring at weekly and monthly assurance visits, reports available if required. Site wide SLWG to be convened. site wide audit has taken place October 23 by BD suppliers of cannula to site. Results meeting scheduled for Thursday 23rd November led by DAND and CNM. IPCN and DATCC colleagues invited to feedback. Action plan to follow monitored through SLWG and fed back through site CMG to acute CMG and ICC forums. Meeting held and work s now under way to enact action plan education and training support to be given to site by BD and the follow up meeting is 1st February 2024. SLWG in place and training dates arranged for April actions in plan complete and training and review will be an ongoing process throughout the rest of this year and is a focus of the whole site for improvement.	Ongoing January 2024. Extension to date for assurance March 2024	
Requirement 7	Ensure accurate assessment of patients care needs and make sure fundamental care needs are met within ED. This includes pressure area care, food, fluid and nutrition	Commenced February 2023	Senior Charge Nurse & ED POD Co-ordinators ED Triumvirate Site Triumvirate	Assurance and improvement support in place, reported weekly to ED & AMGM Governance, Site Triumvirate and EAS programme board. Standard reporting templates for assurance visits used and uploaded onto a shared drive, tracking of progress is also monitored by the Acute Nurse Director. Care rounding document currently being reviewed as now been in place for a year. Assurance visits continue.	June 2023	

	and assistance with mobility.			Dedicated ED meal co-ordinator in place every shift, all coordinators wear green badges and are named at handover based in POD C.	June 2023	
				Badges in place to identify key leadership roles in ED	June 2023	
				Roles & Responsibilities for every shift have been agreed and are discussed at handover and made explicit on white board/use of green badges.	June 2023	
Requirement 9	Ensure patients safety when cared for on trolleys for extended periods of time	Commenced February 2023	Senior Charge Nurses & ED POD Co-ordinators ED Clinical Nurse Manager	Beds and bedding available in ED for patients awaiting admission for prolonged periods.	June 2023	

			ED Clinical Director Associate Nurse Director	Level 2 and 3 assurance visits in place and demonstrating good evidence of compliance.	June 2023	
				Care Rounding assurance tool in place, compliance monitored weekly.	June 2023	
				Risk assessment for use of trolley rails in place ongoing assurance being sought through assurance visits and immediate feedback audit snap shots required work ongoing. Ongoing variable compliance, tools in place and audit to monitor compliance and additional educational support for staff. Discussion held regarding POD models and change of function to ambulatory and non-ambulatory to allow assessment to be easier and more patient centred. This is recent work through EASPB and from external recommendation. New proposed operational model for ED being worked through.	January 2023 Work is ongoing and improvements noted extension to date for assurance and continued monitoring March 2024	

				I believe this action to be complete the trolley risk assessments are in place and on the assurance document. Assurance visits continue within the ED and compliance remains partial. Operational model is written and pending governance approval via PSOB.		
				POD pauses are in place but further work required to ensure consistency in completion audit tool being developed and close monitoring through assurance reviews. POD pauses happen within the department and led by nursing team I believe this to be partially complaint and not 100% but there is documentation that this is reviewed on the assurance visit templates. Implementation of NEWS on TRAK will allow a safer safety pause once we have the oversight board to highlight high acuity patients and where within the department they are and observations etc are being complete. Work and education is ongoing and POD pauses continue to be sporadically carried out within the nursing staff.	Ongoing New due date March 2024	
				ED safety pauses identify at risk patients for discussion with Emergency Physician in Charge, Nurse in Charge & Site and Capacity in relation to prioritisation of move out of department or onto hospital beds	June 2023	

Requirement 10	Ensure staff carry out hand hygiene and change PPE in line with current guidance	May 31st 2023	Senior Charge Nurses Clinical Nurse Managers Associate Nurse Director Infection Prevention & Control	Hand Hygiene monitoring is in place and local feedback processes exist to ensure areas for improvement are noted and actioned.	January 2024	
				Hand Hygiene audits feed into the LACAS assurance process with results and improvement actions displayed on QI boards. Compliance monitoring and corrective action managed through clinical governance processes and IPC monitoring and process. I believe this action to be complete and the assurance work continues with variable results throughout the ED and the site.	January 2024 Ongoing monitoring in place extension to date March 2024 for assurance	
				Constant challenge and education around appropriate PPE use at all forums and escalation through Site Infection Control Committee. Engagement with IPC colleagues regarding site wide hand hygiene campaign initial meeting held October 2023. Target campaign towards critical moments of hand hygiene and reduction of inappropriate use of gloves. Feedback to whole site nursing teams via safety huddles and CNM forums. September 2023 and at ICC forums.	January 2024 January 2024	
Requirement 13	Ensure effective senior management oversight and support to reduce the risks for staff	June 30th 2023	General Manager	RIE Escalation Plan approved by EAS PB in May 2023, and through the NHSL Resilience Team in June 2023. Escalation plan in place and used.	June 2023	

	and patients receiving care at times of extreme pressure within the emergency department		Associate Medical Director Associate Nurse Director Site Director	Full refresh of the RIE site Escalation Plan following external review. This will be linked to three risk assessments, FLOWthian, ED full Capacity and Ring Fencing of Orthopaedic Beds. Focus will be on developing a consistent application of the escalation plan and agreed actions across this Hospital Site and feeding this into the NHSL daily Conference Calls.	December 2023	
Requirement 14	NHS Lothian should also make sure there are facilities to allow locking away of all hazardous cleaning products.	December 2023	CNM SCN AND	Wards and departments will be reminded of the need to keep all hazardous substances for cleaning within lockable cupboards in sluice areas through safety briefs and walkrounds. Assurance visits confirm that adequate supplies of cleaning materials are available	December 2023	
Recommendation 2	Prioritise repeating the professional judgement tools for emergency medicine specialty staffing to better understand their	Tool run scheduled for 24th of July for 2 weeks	Workforce team NHSL ED Triumvirate General Manager	Workforce tool now complete and further adjustments to staffing paper being completed to go through governance routes for approval. Work force review has been completed for ED and benchmarked new staffing levels 20+9 with increased Band 7 numbers and Band 3 support for fundamentals of care.	November 2023	

	workforce requirements		Associate Nurse Director	There is a review underway of leadership ratios within ED to support staff psychological safety and patient safety. An SBAR has been taken to the Emergency Access Programme Board detailing scope, which will be evidenced with the outputs form the tool.	Due November 2023 Extended to January 2024 due to the change in operational model of ED	

HIS Inspection - Immediate Actions for RIE Emergency Department

The following table sets out immediate actions required for ED to support the safe delivery of fundamentals of care. These are immediate actions that will be taken by NHS Lothian in response to the significant concerns raised during the inspection on the 20th – 23rd of February.

Issue	Action	Lead	Status
Feedback to staff	Communicate with the Team the areas of good practice and areas for improvement, ensure there is a process for sharing widely	Site Leadership team	Discussion with the team 23rd and 24th February – wider sharing with MDT through department communications
Co- ordination of Care	Provide senior leadership oversight re allocation of roles and task through safety pauses and make necessary changes in action. Roles within Pods described and implemented.	Jen Watters /Ray Middlemiss	Initial scoping 23rd of February and agreement to revisit the Pod role descriptors and circulate by 3rd March
Care Rounding	Identifiable Uniform and badge for the HCSW who are responsible for care rounding. Two allocated to every shift fundamentals of care the key focus of their role. Including patients having blankets and bed tables for FFN	Jen Watters/Ray Middlemiss	Polo shirts ordered 23rd February. Rosters being reviewed. Highlight the use of blankets. Bed tables now available
Care Rounding Education/Audit	Lead Nurse for QI and Standards to be based in ED to support this on a daily basis. Audit tool to be completed weekly to provide assurance.	Maggie Higgins/Ray Middlemiss	Agree from Friday 24th of February Lead Nurse will work in ED to support the education and communicate expectations.

Call Bells	Temp buzzer system - use system that is in place when the buzzer system goes down as test of change.	Jen Waters/Chris Connelly	Test of available system Thursday 23rd February and an assessment of suitability for longer term use.
IV Infusions PVC	Education back to basics Pod leaders to take responsibility All staff including ANP's, Medical Staff, Research Nurses and Visiting Nurses to the department to support a **See it/Stop it/Report it** initiative re IV fluids.	Jen Watters / Ray Middlemiss/ Site Leadership Team	Poster development and communication with the team commenced agree to have in place by Monday 27th of February.
Cleaning of Near Patient Equipment	Ensure SOP for cleaning between patients is clear and communicated to all staff, audit of near patient equipment and cleaning with ED daily	SCN ED/ Ray Middlemiss	Review of SOP to be actioned, Awareness of cleaning near patient equipment raised at Safety pauses
Communication and shared Learning	Share actions and learning with other sites across NHSL	Gillian McAuley	Complete by Friday 24th of Februa

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Improvement Action Plan

Healthcare Improvement Scotland:

Unannounced acute hospital safe delivery of care inspection

Royal Infirmary of Edinburgh, NHS Lothian

20 – 22 February 2023

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: _____

Full Name: _____

Date: _____

NHS board Chief Executive

Signature: _____

Full Name: _____

Date: _____

Healthcare Improvement Scotland | Inspections and reviews
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Require Recommend	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Require 1	Detailed and effective plans are in place to ensure safe fire evacuation of patients and staff within overcrowded areas	June 30th 2023	ED Triumvirate General Manager RIE Fire Safety Officer	RIE staff fire training programme - underway including tabletop exercise around evacuation during May date to be confirmed. ED Emergency Fire Action Plan refreshed. Evacuation plan being developed at present and will be reviewed annually to ensure the are relevant. Dedicated Band 7 Flow Co-ordinator coming into post on May 15th to oversee safe and timely patient movement in line with EAS	June 2023 June 2023 EFAP now produced and communicated. Train trainers in place and exercises and training carried out for staff within dept. June 2023 PT and requires evaluation of role.
Require 2	Learning from incident reporting improves safety and outcomes for patients and staff; and improve feedback to staff on incidents raised through DATIX	June 30th 2023	ED & AMGM Triumvirates	ED & AMGM Weekly Governance group established Clinical Governance Boards on order for AMGM Directorate	June 2023 Board now in place and feedback being

			ED & AMGM Weekly Governance Group RIE PSEAG Associate Nurse Director Clinical Nurse Managers	areas, used weekly to support communication and feedback to staff. Staff forums in place across site at all grades where safety is discussed including safety huddle at site levels and ward level meetings. Written records available to evidence progress Representatives from Directorates at PSEAG Specific for ED – All funded 6 Band 7 posts now recruited to. Ongoing discussion with Finance in relation to additional funding support for enhanced nursing leadership in ED and AMU in response to DATIX themes and trends and staff feedback.	used constructively to populate. Newsletter now produced and available quarterly for staff about learning from incidents CD and AMD and AND all present at PSEAG Band 7 posts recruited to June 2023 band 7 Nurses in charge of department 90% of time.
Require 3	Ensure that patient's privacy and dignity is always maintained, and all patients have access to a call bell (action specific to ED/AMU)	May 31st 2023	Senior Charge Nurses ED & AMGM Triumvirates	Temporary call bells in ED Pod C Field visit completed for a wifi based system awaiting quote for whole department trial of POD C buzzers wont work in main dept. AMU Base 6, buzzers in place	June 2023 June 2023

				Long term solutions for ED & AMU under consideration Ensure that curtains are drawn to maintain privacy and dignity, monitored through assurance reviews. Recent walkrounds have shown this is embedded within practice.	June 2023 June 2023
Require 4	When patients are cared for in mixed sex bays and where there is reduced access to shower facilities, this is regularly risk assessed and suitable mitigations are put in place to maintain patient dignity and quality of care	June 30th 2023	Senior Charge Nurses Clinical Nurse Managers	Patients made aware they are moving to mixed sex areas. Flexible space in AMU (Base C) can be utilised for single sex where available. When required this will be risk assessed by the nurse in charge and noted on patients documentation.	May 2023
Require 5	Ensure appropriate policies and procedures are in place for instances where it may be appropriate for ward doors to be locked	May 31st 2023	Senior Charge Nurses Clinical Nurse Managers Clinical Service Managers Associate Nurse Director	Protocol development and going through CMG, signage in place. Patient leaflet also in place. Doorbell in situ in base 6 for access and egress. Now through HMG leaflet published and printed and in use. Control of movement measures discussed at safety pauses Daily checks/logs in place	May 2023 June 2023 June 2023

Require 6	Ensure safe intravenous line care practice to prevent the risk of infection and to ensure effective intravenous fluid management	May 31st 2023	Senior Charge Nurses Clinical Nurse Managers Clinical Directors Quality lead nurses Associate Nurse Director IPCN	Posters in place, ED & AMU to raise awareness of reporting when lines are seen to be running dry or completed infusion Awareness raised at safety huddles and safety pauses around safe line care Education around line care ongoing captured within LACAS and assurance walk rounds.	May 2023 Ongoing Ongoing
Require 7	Ensure accurate assessment of patients care needs and make sure fundamental care needs are met within ED. This includes pressure area care, food, fluid and nutrition and assistance with mobility.	Commenced February 2023	Senior Charge Nurse & ED POD Co-ordinators ED Triumvirate Site Triumvirate	Assurance and Improvement support in place, reported weekly to ED & AMGM Governance, Site Triumvirate and EAS programme board Dedicated ED meal co-ordinator in place every shift Badges in place to identify key leadership roles in ED Roles & Responsibilities for every shift discussed at handover and made explicit on white board/use of green badges	June 2023 June 2023 all coordinators wear green badges and are named at handover based in POD C June 2023

Require 8	Ensure the appropriate management and monitoring is in place to support the safe administration of medicine within ED.	May 31st 2023	ED Clinical Nurse Manager ED Clinical Director ED Pharmacy Lead	SOP drafted, test of change underway and awaits endorsement at NHSL Drugs & Therapeutics in May 2023 as per Executive Medical Director, evidence and monitoring through LACAS. Business Case for Omnicell medication dispensing system in progress for both ED & AMU	June 2023 June 2023 ongoing through governance and finance channels
Require 9	Ensure patients safety when cared for on trolleys for extended periods of time	Commenced February 2023	Senior Charge Nurses & ED POD Co-ordinators ED Clinical Nurse Manager ED Clinical Director Associate Nurse Director	Beds and bedding available in ED for patients awaiting admission for prolonged periods Level 2 and 3 walkrounds in place and demonstrating good evidence of compliance. Care Rounding assurance tool in place, compliance monitored weekly Risk assessment for use of trolley rails in place	June 2023 June 2023 June 2023 Ongoing variable compliance tools in place and audit to look at compliance variable further

				ED safety pauses identify at risk patients for discussion with EPIC & Site and Capacity in relation to prioritisation of move out of department or onto hospital beds	education required. June 2023
Require 10	Ensure staff carry out hand hygiene and change PPE in line with current guidance	May 31st 2023	Senior Charge Nurses Clinical Nurse Managers Associate Nurse Director Infection Prevention & Control	Ensure that Hand Hygiene monthly monitoring is robust and that improvement actions are implemented. Hand Hygiene audits in place and feed into the LACAS assurance process with results and improvement actions displayed on QI boards Compliance monitoring and corrective action managed through clinical governance processes and IPC monitoring and process. Constant challenge and education around appropriate PPE use at all forums and escalation through Site Infection Control Committee.	May 2023
Require 11	Ensure patient equipment is clean and ready for use and that the care environment is maintained to support effective cleaning	May 31st 2023	Senior Charge Nurses Clinical Nurse Managers	Cleaning checklists are in place in all areas, and these are monitored through assurance	May 2023

				processes recent walkrounds have shown evidence of compliance with these schedule and the department is uncluttered clean and orgnised. Adequate supplies of cleaning materials are available	
Require 12	Ensure consistent reporting and recording of staff risks as well as robustly recording mitigations and recurring risks in line with good governance processes	Action Complete	ED Triumvirate Senior Charge Nurses Clinical Nurse Managers General Manager Associate Medical Director	Weekly ED & AMGM Governance Groups in place, all DATIX, complaints, feedback from staff and patients is discussed at these groups, themes and trends identified. Site Safety Huddles and departmental pauses in place Flow Triumvirate established to manage site flow daily – available to staff for all escalations regarding safety. RIE Escalation Plan approved by EAS PB in May 2023, for onward discussion at NHSL Resilience in June 2023 On site documentation kept for nursing mitigation and safe care live encouraged to match movement across site. Site and capacity left with staffing plan overnight.	June 2023 and ongoing.

				Staffing is in risk register at highest level for nursing and medical staff. Risk register discussed at MDT HMG meeting and reviewed quarterly at-risk management meeting. Staffing level is included within escalation protocol. Any other staffing gaps including AHP team within the site causing risk an update will be given at 1030 site safety pause.	
Require 13	Ensure effective senior management oversight and support to reduce the risks for staff and patients receiving care at times of extreme pressure within the emergency department	June 30th 2023	General Manager Associate Medical Director Associate Nurse Director Site Director	RIE Escalation Plan approved by EAS PB in May 2023, for onward discussion at NHSL Resilience in June 2023 – test of change underway on Site Medical Co-ordinator role Focus now is on the consistent application of the escalation plan and agreed actions as in action cards.	Escalation plan in place and used. June 2023
Recommend 1	Raise awareness of current guidance regarding the use of fluid-resistant face masks or face coverings in non-clinical areas		IPC Team Senior Charge Nurses Clinical Nurse Manager	Monitoring of this through SCN and CNM, assurance processes and walk rounds Constant challenge and education around appropriate PPE use at all forums and escalation	Face masks no longer required change of guidance May 23 and compliance with guidance

				through Site Infection Control Committee. Speed read for changes in guidance and awareness raised in governance forums and at safety huddles.	now much improved. Ongoing 2023
Recommend 2	Prioritise repeating the professional judgement tools for emergency medicine specialty staffing to better understand their workforce requirements	Tool run scheduled for 24th of July for 2 weeks	Workforce team NHSL ED Triumvirate General Manager Associate Nurse Director	Preparation work for the tool run will commence 26th of June for four weeks. A review of leadership ratios within ED to support staff psychological safety and patient safety has commenced.	ongoing
Recommend 3	Include the emergency department within the quality assurance framework (LACAS) to support fundamental care delivery	December 2023	Head of Nursing Quality Improvement and Standards Associate Nurse Director	Short life working group to be set up, to take for the development and implementation of standards for ED.	ongoing
Additional	Delivery of the Emergency Access Standard to reduce overcrowding within the Emergency Department	26 Week programme	A comprehensive programme board has been established progressing work across a number of workstreams	Project plans established with six sprints agreed and being progressed. Performance monitoring through programme board.	Oversight board runs weekly and workstreams are ongoing it is a 26 week programme.

RIE ED Operational Status escalation (EOS) Policy

INTRODUCTION

(1) All NHSL services, including RIE ED should have an escalation policy to objectively report operational service capability in real-time.[1]

(2) This 'ED Operational Status' (EOS) escalation policy objectively describes – via a composite score – RIE ED's resilience to provide *ED critical services*. This composite score describes in real-time the '*risk of harm despite best-care available in the ED*' to patients, and mitigation actions the ED should take at corresponding scores.

(3) *ED critical services* are:

i. To provide immediate resuscitation for undifferentiated critically ill patients [2]
ii. To provide effective assessment for emergency undifferentiated patients [3]
iii. Maximise efficiency and minimise delay to emergency ambulance off-load
iv. Respond to significant incidents - Major Incident, HCID patients and HAZMAT/CBRN incidents.

(4) This policy is part of NHSL 'preparedness status' policy informing how RIE services and the wider NHSL community respond to escalating risk of harm to patients despite best care.

(5) The ED leadership team (CD, CNM, CSM and GM) are jointly, ultimately accountable for the ED EOS escalation policy.

(6) The NIC & EPIC are jointly responsible for day to day delivery of this policy, including:

i. Recording scores & corresponding actions taken
ii. Recording site escalation and response

(7) The EOS score is the sum of key categories that influence delivery of critical ED services:

i. ***Busyness*** – a measures of the number of patients with active ED management relative to the EDs designed capacity.
ii. ***Effectiveness*** – a measure of how well the ED can carry out rapid assessments of emergency undifferentiated patients relative to national standards.

[1] As part of an escalation policy as per RCEM crowding toolkit 2015 (full capacity escalation policy)
[2] Including regional centre national targets for emergency Stoke, Major Trauma, and Coronary Care
[3] Timely triage and management of patients in most need to those in least need who present to the ED

iii. ***Acuity*** – a measure of the number of critically unwell patients being actively managed relative to the ED's designed capability.

iv. ***Capacity*** – a measure of ED crowding severity relative to the ED's designed maximum optimum effective capacity.

v. ***Resources*** – a measure of key resources required for effective ED service delivery.

(8) The EOS score is calculated by adding up points from each category (1 to 5 below), the minimum score is 0 and the max score is 25. The score generated will correspond to a descriptive LEVEL of risk of harm to patients despite best care available in the ED. The score in the ED should be calculated 30 minutes ahead of the safety pause. This should give adequate time to alert senior manager or site director to attend the safety pause if indicated.

SCORING SYSTEM - EOS

	0	1	2	3	4	5
1. Total ED Patients [4]	≤ 31	32-47	48-62	63-77	78-93	≥ 94
2. Time to clinician [5] (hr)	<1	1-2	2-3	3-5	5-8	≥ 8
3. Resus patients [6]	0-1	2	3	4	5	≥ 6
4. Hospital Boarders (>1hr from decision to admit) [7]	0	1-7	8-15	16-28	29-47	≥ 48+
5. Other issues (Max. 5 pts) • 1 pt per 45 min delay to time to triage & / or per 18 patients waiting for triage • 1 pt per 30 min delay to emergency ambo off-load & / or per 5 ambos waiting to off load • Add 1 point per 4 operational cubicles out of use [8] • Add 1 point if IT downtime > 2hrs • Add 1 point per 2 nursing staff and / or, per 2 care providers less than minimum numbers • Add 1 point per 3 severely disruptive & / or per 3 high acuity cat. 2 patients						

(9) Total score corresponds to the following levels of *risk of harm from the best-care available* to patients:

- Insignificant 0 – 4 **Green**
- Minor 5 – 9 **Yellow**
- Moderate 10 – 14 **Amber**
- **Major** **15 – 19** **Red**
- **CRITICAL** **20-24** **Black**
- **CATASTROPHIC [9]** **25** **Assess for Tactical Hospital Incident**

	1. Total ED Patients	2. Time to clinician	3. Resus patients	4.ED Boarders	5. Other Issue	**Total Level of RISK**
0845						
1430						
2100						
0200						

(10) At the safety pause, total score, actions planed, should be reviewed/agreed. Also record rationale for actions not taken

[4] Not including: Boarders, patients awaiting triage / in ED obs. Ward, or in MIU (31 = 85% & 93 = 250% ED occupancy)
[5] Use average of longest 5 waits. Add 1 point per 25 patients awaiting clinician (not including untriaged patients).
[6] Don't include patient If ready for step down/is a Boarder. Extra point(s): if medic 1 active and per code red.
[7] Extra point per 5 bed waits patients with LOS in ED ≥ 12hrs. GIRFT data: 1 unnecessary death for every 82 patients delayed in ED by 6-8hrs (574 hours)
[8] Operational cubicles out of use does not include cubicles occupied by bed waits (includes out of use for damage, or awaiting terminal cleaning etc.)
[9] EPIC/NIC to request Site director (or deputy) to assess if a capacity business resilience incident should be activated

GENERAL ACTIONS ED WILL TAKE AT **MAJOR** AND **CRITICAL** LEVEL OF RISK OF HARM DESPITE BEST-CARE AVAILABLE IN THE ED

GENERAL

(1) EOS at **major**/**critical** level of risk of harm, EPIC / NIC to:

i. Exemplify and set the tone – remind all staff to promote civility

ii. Alert all staff of the EOS level and its implications [10]

(2) EOS at **critical** level of risk, NIC to:

i. Complete DATIX (include EOS score, associated incidents, and actions ED/Site)

ii. Communicate situation to waiting room (ensure safety-netting)

iii. In the OOH period, call cons on call to assess if return to department required

(3) EOS at **critical** level of risk, EPIC to outline to:

i. Care providers a lower threshold to discharge patients (ensure safety-netting)

ii. Triage Team to lower threshold to send patients away without assessment

GENERAL – PROCEDURES

(4) EOS at **major** or **critical** level of risk of harm, EPIC to alert respective specialties that:

i. Biers block list will be deferred, and patients rescheduled [11]

ii. Only MUAs with NV compromise or severe pain will be carried out [12]

iii. Only unstable cardioversions / chest-drains will be carried out in ED [12]

iv. Only time critical invasive procedures will be carried out in the ED [12]

GENERAL – RECORD AND REPORT [13]

(5) EOS at **major** level of risk of harm, EPIC/NIC are responsible to

i. Report EOS to senior manager & request they attend next ED safety pause

ii. At the safety pause, record actions completed / planned [14]

(6) EOS at **critical** level of risk of harm, Senior Doc/NIC are responsible to:

i. Report EOS to site director & request they attend next safety pause.

ii. At the safety pause, record actions completed / planned. [13]

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[10] Clarify processes that may be used e.g., lowering discharge threshold, MUA for NV compromised fractures.

[11] EPIC to offer orthopaedics the opportunity to arrange a pop-up alternative non-ED service for the day.

[12] If EOS is at **major** level, NIC/EPIC to make dynamic assessment if a fully independent specialty/anaesthetic team can use a space in ED to carry out a procedure.

[13] Record EOS score 30 mins prior to the safety pause to give time for managers to attend if required

[14] Record responsible person for planned actions – record if action is complete (if not, why not) at next pause

SPECIFIC ACTIONS ED WILL TAKE TO AVOID WORSENING LEVEL OF RISK OF HARM DESPITE BEST-CARE AVAILABLE IN THE ED

SPECIFIC – RESUS

(1) EPIC / NIC to ensure:
   i. Where next resus patient will go and how the resus will be staffed [15]
   ii. Timely / appropriate step down [16]

SPECIFIC – TRIAGE

(2) Prioritise high risk patients & emergency patients, these include:
   i. Emergency patients brought by SAS [17]
   ii. > 65 with severe abdo pain & / or > 30YO with cardiac chest pain
   iii. Patient where there is clinician concern

(3) Following dynamic risk assessment, NIC allocates at:
   i. > 45mins to triage & / or > 18 patients waiting – extra nurse & CSW
   ii. > 90mins to triage & / or > 36 patients waiting – Snr Doc, 2 extra nurses & 2 CSWs [18]
   iii. > 135 mins to triage and/or > 54 patients waiting triage – switch from Manchester Triage to major Incident SIEVE triage [19] (Once < 45mins to triage or less than 18 patients waiting triage, restart Manchester triage – re triage the SIEVED patients)

SPECIFIC – TIME TO CLINICIAN

(4) EPIC / NIC assess if / commence use of ambulatory majors [20]

(5) POD Coordinators and Snr doc to maximise space [21]

(6) When rime to clinician is > 3hrs assess patients in triage rather than time order [22]

(7) POD Sn Doc to liaise with EPIC to prioritise CTs. EPIC to liaise with Radiology.

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[15] Rationalise staffing ratios with NIC/ EPIC following dynamic risk assessment of ED
[16] Activate lower threshold to step-down but agree with NIC/EPIC best POD to go to spread workload & risk
[17] If assessed as non-emergency, SAS to book patient in & seen in time order with self-present patients
[18] ANPs and ENPs can be used to support this
[19] TRAK triage colour to reflect triage category.
[20] Consider when time to clinician is > 3hrs, (balance decision against other key ED categories that influence delivery of critical ED service)
[21] Ensure fit to sit and utilising all possible cubicles.
[22] Snr doc and POD coordinator to review queue and triage up together

(8) POD coordinator to ensure min 2hrly observations for patients of concern [23]

SPECIFIC - BOARDING PATIENTS [24]

(9) POD Snr Doc ensures all BOARDING [25] patients have a documented working diagnosis and treatments for the next 12hrs including critical regular medications [26]

(10) POD coordinator ensures min set of care standards every 4hrs (or sooner if required)

i. Observations (including GCS or BM if indicated)
ii. A note of Food/Drink offered/consumed (IVF if NBM or assistance if required)
iii. Offer toilet, commode or bed pan
iv. Ensure Family / NOK aware patient is in the ED

(11) A Senior doctor review should be documented every 12hr [27]

SPECIFIC – OTHER RESOURCE ISSUES

(12) Reallocation of other liaison ED staff [28]

[23] Patient waiting assessment, and those highlighted as a concern
[24] GIRFT data: 1 unnecessary death for every 82 patients delayed in ED by 6-8hrs (574 hours)
[25] > 1hr from decision to admit
[26] Inc. treatments, reg. medications (insulin, anti-seizure, Parkinson's medications and IVF (if patient NBM)
[27] Additionally, document if suitable to board, DNAR status, and ensure correct care provider.
[28] Dynamic assessment – close MIU and deploy staff in main ED. Ask for help for 1hr from EMERGE team.