SPSP Maternal Deterioration Change Package

2023 Maternal Deterioration Driver Diagram

Healthcare Improvement Scotland | Scottish Patient Safety Programme

What we are trying to achieve…	We need to ensure…	Which requires…
To reduce harm from deterioration in acute hospitals by improving the recognition, response and review of the deteriorating woman / birthing person ** *By [locally agreed %] by 31st March 2023*	Person centred care* considers the Continuity of Carer approach	Women / birthing people and families are listened to and included in all care decisions Person centred care planning Inclusive care pathways which provide equitable and culturally appropriate access and treatment
	Recognition of acute deterioration	Observation using MEWS (Scotland) Action on staff concern Action on women / birthing people / family concern
	Standardised structured response and review	Timely review by appropriate healthcare practitioner Assessment for causes of acute deterioration Escalation Regular review and assessment
	Safe communication*	Effective communication in different situations Use of standardised tools for communication Interdisciplinary teamwork and collaboration
	Leadership to promote a culture of safety at all levels*	Psychological safety Staff wellbeing System for learning Safe staffing

Essentials of Safe Care

****Measurements include existing Excellence in Care data***

Core programme measures

To reduce harm from deterioration in acute hospitals by improving the recognition, response and review of the deteriorating woman / birthing person *

By [locally agreed %] by 31st March 2025

Percentage of Maternity Early Warning Score (MEWS) charts completed and frequency met

Percentage compliance with MEWS chart escalation pathway

PPH rate – over 1.5 litre

Balancing measure – number of maternity admissions to ITU

Measurements include existing Excellence in Care data

Primary Driver

Person centred care considers the Continuity of Carer approach

Secondary Driver	Change ideas						
Women / birthing people and families are listened to and included in all care decisions	Local process to escalate women / birthing people concerns – asking what matters to you	Person centred language is promoted and used (e.g. RCM Re:Birth) in all settings	Use of a universal wellbeing assessment which identify vulnerability and protected characteristics				
Person centred care planning	Implement CoC model of care	1: 1 care in labour and birth and immediate postnatal period	Women / birthing people identified as high risk have a co-produced person centred care plan with a focus on deterioration	Women / birthing people identified as at risk of PPH have a person centred care plan which includes a PPH risk assessment			
Inclusive care pathways which provide equitable and culturally appropriate access and treatment	Co-produced person centred care plans consider ethnicity, deprivation and individual communication needs	Social determinants addressed through onward referral to appropriate services	Staff afforded flexibility to provide care proportionate to need for those experiencing severe and multiple disadvantage	Staff able to identify, challenge and change the values, structures and behaviours that perpetuate systemic racism	Local education for staff to enable support for those experiencing severe and multiple disadvantage	Provision of timely interpretation services support	

Primary Driver

Recognition of acute deterioration

Secondary Driver	Change ideas		
Observations using Maternity Early Warning Score (MEWS)	Use of MEWS for all pregnant or post partum women / birthing people	Access to staff education, tools and resources to support use of MEWS	Locally agreed process to notify maternity services when pregnant or post partum woman / birthing person admitted to hospital
Action on staff concern	Locally agreed process to escalate clinical concern out with MEWS trigger		
Action on woman / birthing person / family concern	Locally agreed process for women / birthing people / families to escalate concerns	Women / birthing people / families informed of process to escalate concerns	

Primary Driver

Standardised and structured response and review

Secondary Driver	Change ideas		
Timely review by appropriate healthcare practitioner	Process for timely clinical review from identification of deterioration	Use of standardised structured ward rounds	
Assessment for causes of acute deterioration	Implementation of PPH 4 stage approach	Implementation of Sepsis 6	Use of structured A-F assessment
Escalation	Locally agreed process for escalation	Locally agreed process for timely transfer to appropriate care setting	Agreed common language used for escalation
Regular review and assessment	Local escalation process incudes follow up patient review	Locally agreed roles and responsibilities in relation to review and reassessment	

Primary Driver

Safe communication

Secondary Driver	Change ideas			
Effective communication in different situations	Daily MDT review for critically ill person embedded in practice	Identifying people at risk of maternal deterioration at site safety huddles	Ward level / unit safety brief informed by site safety huddle	
Use of standardised tools for communication	Use of SBAR tool for escalation / all transitions of care			
Interdisciplinary teamwork and collaboration	Develop local process for MDT hot and cold debriefs	Use of MDT hot and cold debriefs	Sharing of learning from reviews / debriefs	Agreed local workplan for staff trained in SAER

Primary Driver

Leadership to promote a culture of safety at all levels

Healthcare Improvement Scotland

Every Person Every Time – Scottish Patient Safety Programme

Secondary Driver	Change ideas							
Psychological safety	Access to clinical supervision	Create forums to allow staff to identify areas for improvement	Visible supportive leadership	Structured 1:1 time	Staff aware of mechanisms available to support speaking out (including key contacts and feedback loop)			
Staff wellbeing	Staff supported to celebrate success	Access to peer support	Local process to support and learn from safety walk rounds	Promotion of National Wellbeing hub				
System for learning	Local process to keep policies and guidelines up to date and communicated timeously to staff	MDT training for emergencies E.G. SCOTTIE/ Prompt/REACTS	Standardised approach to MDT review and learning	Process for local review of maternity related Scottish Intensive Care Society Audit Group (SICSAG) data	Locally agreed midwifery education should include acute deterioration / caring for critically ill women / birthing people	Information from DATIX/SAER/PMRT /complaints used to inform learning and improvement	Establish links with local QI support	
Safe staffing	Staff education and awareness of staffing legislation and wider workforce planning principles	Efficient and safe rostering / CoC model implemented	Real time staffing risk assessment, escalation and mitigation	Local maternity workforce data, including staffing levels, skill mix, experience etc. used to identify focus for improvement work	Perinatal service staffing levels regularly reported and discussed at site level during safety huddles			

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