SPSP Paediatric Programme Deteriorating Child & Young Person Change Package

Reviewed July 2024: evidence, tools and resources updated

Introduction

Welcome to the deteriorating child and young person change package.

The aim of the deteriorating child and young person change package is to support teams to improve the recognition, response and review of the deteriorating child and young person. A change package consists of a number of measures supported by activities that, when tested and implemented, bring about improvement. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

Why have we developed this change package?

This change package is for paediatric teams participating in deteriorating child and young person improvement work. It will support teams to use quality improvement methods to improve the recognition, response and review of the deteriorating child and young person.

How was it developed?

This change package was co-designed with clinical and quality improvement experts from NHS boards. The clinical experts were from a range of disciplines. Expert Reference Groups (ERG) were convened in March 2023 with representation from across NHS Scotland.

Contents and how to use the package

What is included in this change package?

- Driver diagram
- Change ideas
- Guides, tools and signposts to the supporting evidence and examples of good practice
- Guidance to support measurement

Guidance on using this change package

- This change package is a resource to support NHS boards with improvement in the recognition, response and review of the deteriorating child and young person. It is not expected for teams to work simultaneously on all aspects of the driver diagram. It is designed to assist teams in identifying areas for improvement relevant to their local context. The change ideas and measures are not exhaustive, and it is expected that teams will develop their own to support their identified areas for improvement. We would encourage teams to seek support from their local quality improvement teams in the development of additional measures if required.

Using this package

- This is an interactive document; clicking on the primary/secondary driver will take you to additional information, including tools and resources relating to that driver. At the top of each page of the secondary drivers, there is an arrow  and  home button. The arrow button will take you back to the primary driver page, and the home button will take you to the main Driver Diagram page.

Project aim

Setting a project aim

All quality improvement projects should have an aim that is **S**pecific, **T**ime bound, **A**ligned to the NHS board's objectives and **N**umeric (STAN).

The national aim for SPSP Paediatric Deteriorating Child & Young Person is:

To reduce harm from deterioration by improving the recognition, response and review of the deteriorating child and young person**

By [locally agreed %] by 31st March 2025

Core programme measures

To reduce harm from deterioration by improving the recognition, response and review of the deteriorating child and young person

Locally agreed measures should include:

- Use of correct age-related PEWS chart**
- Reliable use of PEWS observations**
- Reliable scoring of PEWS**
- Reliable response to children and young people who trigger PEWS**

***This data is already collected as part of an existing Excellence in Care measure**

Driver diagram and change ideas

What is a driver diagram?

A driver diagram visually presents an organisation or team's theory of how an improvement goal will be achieved. It articulates which parts of the system need to change in which way and includes ideas of how to make this happen. It is used to help plan improvement projects and ensure team engagement.

The primary drivers are the key components of the system that need to change to deliver the aim. The secondary drivers are the processes that influence the primary drivers. Changing the processes outlined in the secondary drivers should change the primary drivers and deliver the aim.

Change ideas

Change ideas are specific practical changes the project team can make to alter the processes in the secondary drivers. The following pages provide change ideas to support improvement in the recognition, response and review of the deteriorating child and young person. They are grouped by the primary driver that they influence. Project teams should select change ideas to test. A range of change ideas will be needed to ensure there are changes to all primary drivers.

This change package does not contain an exhaustive list of change ideas. Project teams can also generate their own change ideas that will help drive change in the secondary drivers. One way to generate ideas is to ask, "How might we?" For example, "How might we engage with children and young people and their families to improve the experience of care when in hospital?"

2023 Deteriorating Child & Young Person Driver Diagram

What are we trying to achieve…

To reduce harm from deterioration by improving the recognition, response and review of the deteriorating child and young person**

By [locally agreed %] by 31st March 2025

Essentials of Safe Care
****Measurements may include existing Excellence in Care data***

We need to ensure…

- Person-centred care*
- Recognition of acute deterioration
- Standardised, structured response and review
- Safe communication across care pathways*
- Leadership to support a culture of safety at all levels*

Which requires…

- Patients, families and carers are listened to and included
- Person-centred care planning
- Anticipatory care planning & CYPADM
- Discussions with families are well managed
- Observations using PEWS (Scotland)
- Action on staff concern
- Action on patient, family and carer concern
- Timely review by appropriate decision maker
- Assessment for causes of acute deterioration
- Escalation
- Regular review and assessment
- Interdisciplinary teamwork and collaboration*
- Use of standardised communication tools*
- Effective communication in different situations*
- Psychological safety for staff*
- Staff wellbeing*
- Safe Staffing*
- System for learning*

Primary Driver
Person-centred care

Secondary drivers	Change ideas				
Patient, families and carers are listened to and included	Access to tools, resources and education to support compassionate care	Use of 'what matters to me?'	Use of patient passports	Principles of Trauma Informed Practice included in local education programmes	Use of standardised tools to include the voice of the child/young person
Person-centred care planning	Local method for documenting unique physiological baseline	Local mechanism to discuss environmental needs of the child/young person	Use of specialist resources to support care-experienced young people		
Anticipatory care planning & CYPADM	Use of tools for anticipatory care planning e.g. ReSPECT, CHAS	Use of tools & resources for setting and reviewing goals & treatment plans	CYPADM and anticipatory care plans discussed in huddles and handovers		
Discussions with families are well managed	Access to tools and resources to support difficult conversations	Identified area to hold sensitive conversations	Local process to help families identify key clinicians		

Person-centred care

Secondary drivers	Change ideas				
Patient, families and carers are listened to and included	Access to tools, resources and education to support compassionate care	Use of 'what matters to me?'	Use of patient passports	Principles of Trauma Informed Practice included in local education programmes	Use of standardised tools to include the voice of the child/young person

Evidence and Guidelines:

Heath G, Montgomery H, Eyre C, Cummins C, Pattison H, Shaw R. Developing a Tool to Support Communication of Parental Concerns When a Child is in Hospital Healthcare (Basel). 2016 Jan 13;4(1):9.

Tools and Resources:

Children with Exceptional Healthcare Needs (CEN) Managed Clinical Network. Communicating with Children. 2019: Available from: https://tinyurl.com/4n29t84b. Accessed 8 July 2024.

Children with Exceptional Healthcare Needs (CEN) Managed Clinical Network, NHS Education for Scotland. eLearning Modules. 2023: Available from: https://learn.nes.nhs.scot/60619. Accessed 8 July 2024.

Healthcare Improvement Scotland. What matters to you? 2023: Available from: https://www.whatmatterstoyou.scot/. Accessed 8 July 2024.

NHS Education for Scotland. National trauma training programme 2023: Available from: https://learn.nes.nhs.scot/37896. Accessed 13 July 2023.

PAMIS: promoting a more inclusive society. PAMIS Digital Passports 2023: Available from: https://pamis.org.uk/services/digital-passports/. Accessed 8 July 2024.

Royal College of Paediatrics and Child Health. RCPCH &Us: Available from: https://www.rcpch.ac.uk/work-we-do/rcpch-and-us. 8 July 2024.

The Highland Council Comhairle na Gàidhealtachd. Tools for gathering the views of children and young people. 2020: Available from: https://tinyurl.com/4tt9due7. Accessed 8 July 2024.

Person-centred care

Secondary drivers	Change ideas		
Person-centred care planning	Local method for documenting unique physiological baseline	Local mechanism to discuss environmental needs of the child/young person	Use of specialist resources to support care-experienced young people

Evidence and Guidelines:

Department of Health and Social Care. Equity in medical devices: independent review - final report. 2024: Available from: https://tinyurl.com/ytjanppy. Accessed 8 July 2024.

Health Foundation. Person-Centred Care Made Simple. 2016; Available from: https://tinyurl.com/32wvwdk5. Accessed 8 July 2024.

Tools and Resources:

Healthcare Improvement Scotland. National Paediatric Early Warning Score Chart Training Package. 2017; Available from: https://tinyurl.com/yp66eedv. Accessed 8 July 2024.

NHS Education for Scotland, PAMIS: promoting a more inclusive society. Your Posture Matters. 2023; Available from: https://learn.nes.nhs.scot/60811. Accessed 8 July 2024.

Who Cares? Scotland. Who Cares? Scotland Resource Library. 2022; Available from: https://tinyurl.com/yc8er3bp. Accessed 8 July 2024.

Person-centred care

Secondary drivers	Change ideas		
Future care planning & CYPADM	Use of tools for future care planning e.g. ReSPECT, CHAS	Use of tools & resources for setting and reviewing goals & treatment plans	CYPADM and future care plans discussed in huddles and handovers

Evidence and Guidelines:

National Library of Medicine. Harrop EJ, Boyce K. Beale T, et al. Fifteen-minute consultation: developing an advance care plan in partnership with the child and family. Arch Dis Child Educ Pract Ed. 2018;103:282-287.

Social Care Institute for Excellence. Mental Capacity Act: Care Planning, Involvement and Person-centred Care 2017: Available from: https://tinyurl.com/579wbvsc. Accessed 8 July 2024.

Tools and Resources:

CHAS: Children's Hospices Across Scotland. End of life care 2023: Available from: https://www.chas.org.uk/how-we-help/medical-care/end-of-life. Accessed 8 July 2024.

Healthcare Improvement Scotland. Anticipatory Care Planning toolkit. 2021: Available from: https://tinyurl.com/muu6eyxz. Accessed 8 July 2024.

NHS Education for Scotland. Anticipatory Care Planning [online]: Available at: https://learn.nes.nhs.scot/60446 . Accessed 8 July 2024

NHS Inform. Anticipatory Care Planning [online]; Available from: https://tinyurl.com/4cuuzv25. Accessed 8 July 2024.

Resuscitation Council UK. ReSPECT. 2023; Available from: https://www.resus.org.uk/respect. Accessed 8 July 2024.

Person-centred care

Secondary drivers	Change ideas		
Discussions with families are well managed	Access to tools and resources to support difficult conversations	Identified area to hold sensitive conversations	Local process to help families identify key clinicians

Evidence and Guidelines:

Linney M, Hain RDW, Wilkinson D, et al. Achieving consensus advice for paediatricians and other health professionals: on prevention, recognition and management of conflict in paediatric practice. Arch Dis Child. 2019;104:413-416.

Martin AE, Beringer AJ. Advanced care planning 5 years on: An observational study of multi-centred service development for children with life-limiting conditions. Child Care Health Dev. 2019 Mar;45(2):234-240. PMID: 30693557.

Tools and Resources:

NHS Education for Scotland, Dr Lara Mitchell. Difficult Conversations. Why we need to talk about dying 2023: Available from: https://tinyurl.com/38bb49x8. Accessed 8 July 2024.

Royal College of Paediatrics and Child Health. Health Inequalities Tool 2: Develop Clinical Skills in Talking with Families [online]. Available from: https://tinyurl.com/3y3rfn8p . Accessed 8 July 2024.

Primary Driver

Recognition of acute deterioration

Secondary drivers	Change ideas		
Observations using PEWS (Scotland)	Reliable use of PEWS	Consideration of digital P EWS or E-Obs	Locally agreed education & training for PEWS
Action on staff concern	Locally agreed escalation process that considers clinical judgment as well as PEWS		
Action on patient, family and carer concern	Discussions with families enable them to recognise and report deterioration	Clear, structured system for families to escalate concerns	Use of tools for children/young people with communication difficulties

Recognition of acute deterioration

Secondary drivers	Change ideas		
Observations using PEWS (Scotland)	Reliable use of PEWS	Consideration of digital PEWS or E-Obs	Locally agreed education & training for PEWS

Evidence and Guidelines:

Chong SL, Goh MSL, Ong GYK, Acworth J, Sultana R, Yao SHW, et al. Do paediatric early warning systems reduce mortality and critical deterioration events among children? A systematic review and meta-analysis. Resuscitation Plus. National Library of Medicine: 2022;11:100262.

Kramer AA, Sebat F, Lissauer M. A review of early warning systems for prompt detection of patients at risk for clinical decline. J Trauma Acute Care Surg. 2019;87(Suppl 15):S67–S73.

Tomasi JN, Hamilton MV, Fan M, Pinkney SJ, Middaugh KL, Parshuram CS, et al. Assessing the electronic Bedside Paediatric Early Warning System: A simulation study on decision-making and usability. International journal of medical informatics (Shannon, Ireland) 2020 Jan: 133:103969.

Tools and Resources:

Healthcare Improvement Scotland. National Paediatric Early Warning Score Chart Training Package. 2017; Available from: https://tinyurl.com/yp66eedv. Accessed 8 July 2024.

Healthcare Improvement Scotland. Paediatric Early Warning Score (PEWS). 2021: Available from: https://tinyurl.com/34hke4t4. Accessed 8 July 2024.

Royal College of Nursing. Standards for Assessing, Measuring and Monitoring Vital Signs in Infants, Children and Young People: Available from: https://tinyurl.com/592febzm. Accessed 8 July 2024.

Recognition of acute deterioration

Secondary drivers	Change ideas
Action on staff concern	Locally agreed escalation process that considers clinical judgment as well as PEWS

Evidence and Guidelines:

Jensen CS, Lisby M, Kirkegaard H, Loft MI. Signs and symptoms, apart from vital signs, that trigger nurses' concerns about deteriorating conditions in hospitalised paediatric patients: A scoping review. Nursing O5pen 2021-11-10;9(1):57.

Velhuis LI, Ridderikhof ML, Bergsma L, et al. Performance of early warning and risk stratification scores versus clinical judgement in the acute setting: a systematic review. EMJ. 2022; 39:918-923

Tools and Resources:

Royal College of Paediatrics and Child Health. Safe System Framework for Children at Risk of Deterioration. 2022: Available from: https://tinyurl.com/4ye8vub6. Accessed 8 July 2024.

Recognition of acute deterioration

Secondary drivers	Change ideas		
Action on patient, family and carer concern	Discussions with families enable them to recognise and report deterioration	Clear, structured system for families to escalate concerns	Use of tools for children/young people with communication difficulties

Evidence and Guidelines:

Albutt AK, O'Hara JK, Conner MT, et al. Is there a role for patients and their relatives in escalating clinical deterioration in hospital? A systematic review. Health Expect. 2017;20:818–825.

Albutt A, Roland D, Lawton R, Conner M, O'Hara J. Capturing Parents' Perspectives of Child Wellness to Support Identification of Acutely Unwell Children in the Emergency Care. J Patient Safe. 2022 Aug 1;18(5):410-414/.

Allen D, Lloyd A, Edwards D, Grant A, Hood K, Huang C, et al. Development, implementation and evaluation of an early warning system improvement programme for children in hospital: the PUMA mixed-methods study. Health and Social Care Delivery Research 2022 Jan;10(1):1-308.

Gaskin KL, Smith L, Wray J. An improved congenital heart assessment tool: a quality improvement outcome. Cardiology in the young 2023 Apr 01,;33(4):551-556.

Gill FJ, Leslie GD, Marshall AP. Parent escalation of care for the deteriorating child in hospital: A health-care improvement study. Health Expect 2019;22(5):1078.

Tools and Resources:

Congenital Cardiac Nurses Association. Congenital Heart Assessment Tool E-Resource. 2022: Available from: http://www.ccn-a.co.uk/events/chat-tool. Accessed 8 July 2024.

Hunter New England Local Health District. REACH - Patient and Family Activated Escalation. 2023: Available from: https://tinyurl.com/bdzabj9h. Accessed 8 July 2024.

Institute of Child Health, Royal College of Nursing Institute O. Paediatric Pain Profile. Available from: https://ppprofile.org.uk/. Accessed 8 July 2024.

Starship Child Health. Kōrero Mai (Talk to me). 2019; Available from: https://starship.org.nz/guidelines/korero-mai-talk-to-me/. Accessed 8 July 2024.

Primary Driver

Standardised, structured response & review

Secondary drivers	Change ideas			
Timely review by appropriate decision maker	Locally agreed process for timely review	Education programmes to include trigger, escalation and response process	Use of locally agreed watchers bundle	Use of standardised structured ward rounds
Assessment for causes of acute deterioration	Use of evidence-based tools e.g. Sepsis 6			
Escalation	Locally agreed process for escalation	Use of existing evidence based guidelines e.g. bronchiolitis	Use of hospital huddles to escalate care	Admission information includes how to use call system effectively
Regular review and assessment	Local escalation process includes follow-up clinical review			

Standardised, structured response & review

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Allen D, Lloyd A, Edwards D, Grant A, Hood K, Huang C, et al. Development, implementation and evaluation of an early warning system improvement programme for children in hospital: the PUMA mixed-methods study. Health and Social Care Delivery Research Jan 2022;10(1):1-308.

National Institute for Health and Care Excellence. Chapter 28 Structured ward rounds. 2018: Available from: https://www.nice.org.uk/guidance/ng94/evidence/. Accessed 8 July 2024.

Tools and Resources:

Royal College of Paediatrics and Child Health. Safe system framework for children at risk of deterioration. 2022: Available from: https://www.rcpch.ac.uk/resources/safe-system-framework-children-risk-deterioration#education-and-training. Accessed 8 July 2024.

Standardised, structured response & review

Secondary drivers	Change ideas
Assessment for causes of acute deterioration	Use of evidence-based tools e.g. Sepsis 6

Evidence and Guidelines:

Academy of Medical Royal Colleges. Statement on the initial antimicrobial treatment of sepsis. 2022; Available from: https://www.aomrc.org.uk/reports-guidance/statement-on-the-initial-antimicrobial-treatment-of-sepsis. Accessed 8 July 2024.

National Institute for Health and Care Excellence. Suspected sepsis: recognition, diagnosis and early management. 2024: Available: from: https://www.nice.org.uk/guidance/ng51. Accessed 8 July 2024.

Tools and Resources:

Resuscitation Council UK. Paediatric Advanced Life Support Guidelines 2021: Available from: https://www.resus.org.uk/library/2021-resuscitation-guidelines/paediatric-advanced-life-support-guidelines. Accessed 8 July 2024.

Royal College of Paediatrics and Child Health. Clinical Guideline Directory. 2024: Available from: https://www.rcpch.ac.uk/resources/clinical-guideline-directory#sepsis. Accessed 8 July 2024.

Standardised, structured response & review

Secondary drivers	Change ideas			
Escalation	Locally agreed process for escalation	Use of existing evidence based guidelines e.g. bronchiolitis	Use of hospital huddles to escalate care	Admission information includes how to use call system effectively

Evidence and Guidelines:

National Institute for Health and Care Excellence. NICE Guidance: Children and Young People. 2023; Available from: https://www.nice.org.uk/Guidance/population-groups/children-and-young-people. Accessed 8 July 2024.

Tools and Resources:

Healthcare Improvement Scotland. Paediatric Early Warning Score (PEWS). 2021: Available from: https://tinyurl.com/34hke4t4. Accessed 8 July 2024.

Healthcare Improvement Scotland. Understanding the key components of effective morning Hospital Huddles. 2021: Available from: https://tinyurl.com/t7cadenp. Accessed 8 July 2024.

Royal College of Paediatrics and Child Health. National guidance for the management of children in hospital with viral respiratory tract infections. 2023: Available from: https://tinyurl.com/3dsb8tab. Accessed 8 July 2024.

Standardised, structured response & review

Secondary drivers	Change ideas
Regular review and assessment	Local escalation process includes follow-up clinical review

Primary Driver

Safe communication across care pathways

Secondary drivers	Change ideas			
Interdisciplinary teamwork and collaboration	Use of hospital huddles to improve situational awareness	Use of MDT shared documentation	Locally agreed system of communication between teams	Scotstar watchers bundle
Use of standardised communication tools	SBAR tool			
Effective communication in different situations	MDT ward/unit safety huddles & briefs	Procedures in place for communication between centres	Mid-shift check ins	

Safe communication across care pathways

Secondary drivers	Change ideas			
Interdisciplinary teamwork and collaboration	Use of hospital huddles to improve situational awareness	Use of MDT shared documentation	Locally agreed system of communication between teams	Scotstar watchers bundle

Evidence and Guidelines:

Stocker M, Pilgrim SB, Burmester M, Allen ML, Gijselaers WH. Interprofessional team management in pediatric critical care: some challenges and possible solutions. J Multidiscip Healthcare. 2016 Feb 24;9:47-58.

Theilen U, Leonard P, Jones P, Ardill R, Weitz J, Agrawal D, Simpson D. Regular in situ simulation training of paediatric medical emergency team improves hospital response to deteriorating patients. Resuscitation. 2013 Feb;84(2):218-22.

Tools and Resources:

Healthcare Improvement Scotland. Understanding the key components of effective morning Hospital Huddles 2021: Available from: https://tinyurl.com/t7cadenp. Accessed 8 July 2024.

Institute for Healthcare Improvement (IHI): Sustaining and Strengthening Safety Huddles 2018: Available from: https://tinyurl.com/47fs7uda. Accessed 8 July 2024.

Safe communication across care pathways

Secondary drivers	Change ideas
Use of standardised communication tools	SBAR tool

Evidence and Guidelines:

Royal College of Nursing. Standards for Assessing, Measuring and Monitoring Vital Signs in Infants, Children and Young People 2. 2017.

Tools and Resources:

NHS Education for Scotland. Structured Handover Education Project: Available from: https://learn.nes.nhs.scot/704/patient-safety-zone/structured-handover-education-project. Accessed 8 July 2024.

NHS Education for Scotland. SBAR. Available from: https://learn.nes.nhs.scot/3408. Accessed 8th July 2024.

Safe communication across care pathways

Secondary drivers	Change ideas		
Effective communication in different situations	MDT ward/unit safety huddles & briefs	Procedures in place for communication between centres	Mid-shift check ins

Evidence and Guidelines:

Joseph MM, Mahajan P, Snow SK, Ku BC, Saidinejad M. Optimising Paediatric Patient Safety in the Emergency Care Setting. Journal of emergency nursing 2022 Nov;48(6):652-665.

Tools and Resources:

Healthcare Improvement Scotland. Critical Situations: Management of Communication in Different Situations [online]: Available from: https://tinyurl.com/mr27b7d3. Accessed 8 July 2024.

Institute for Healthcare Improvement (IHI). Patient Safety Essentials Toolkit [online]. Available from: https://tinyurl.com/3kmstzwz. Accessed 8 July 2024.

NHS Education for Scotland. Leading for the Future: Communication Skills Resources [online]. 2018: Available from: https://tinyurl.com/yc4erx6b. Accessed 8 July 2024.

NHS Scotland Workforce. Guide to Supportive and Difficult Conversations [online]: Available from: https://tinyurl.com/34nh9bzk. Accessed 8 July 2024.

Primary Driver

Leadership to support a culture of safety

Secondary drivers	Change ideas					
Psychological safety for staff	Visible supportive leadership	Create forums to allow workforce to generate improvement ideas	Local mentoring system			
Staff wellbeing	Use of standardised feedback tools e.g. iMatter	Celebrate success	Use of what matters to me	Access to mental health first aiders	Access to Peer Support	Hot and cold debriefs
Safe Staffing	Staff education & awareness about safe staffing act (2019)	Effective rostering	Real-time staff risk assessment	Clinical supervision	Mechanism to identify staff operating out with their usual area	
System for learning	Use of tools and resources to support patient safety e.g. NES Safety Culture Cards	Involvement of resuscitation teams in improvement work	Local system for learning and support for complaints e.g. care opinion	Local system to learn from adverse events e.g. M&M, SAER's, Child Death Reviews	Create opportunities to learn from excellence	Use of simulation training

Leadership to support a culture of safety

Secondary drivers	Change ideas		
Psychological safety for staff	Visible supportive leadership	Create forums to allow workforce to generate improvement ideas	Local mentoring system

Evidence and Guidelines:

Edmondson A. Psychological Safety and Learning Behavior in Work Teams. Administrative Science Quarterly. 1999 Jun;44(2):350-383.
NHS Providers. Psychological Safety and Why It Matters [online] 2020: Available from: https://nhsproviders.org/news-blogs/blogs/psychological-safety-and-why-it-matters. Accessed 8 July 2024.

Tools and Resources:

Healthcare Improvement Scotland. The Essentials of Safe Care: Psychological Safety. 2021: Available from: https://tinyurl.com/7awj9r2f. Accessed 8 July 2024.

NHS Education for Scotland. Psychological Safety. [online]. 2024; Available at: https://learn.nes.nhs.scot/60999. Accessed 8 July 2024.

NHS Education for Scotland. How Do You Create Psychological Safety at Work? [online] 2024: Available at: https://learn.nes.nhs.scot/61001. Accessed 8 July 2024.

NHS Horizons. A practical guide to the art of psychological safety in the real world of health and care 2021: Available at: https://tinyurl.com/ytt836ts. Accessed 8 July 2024.

Leadership to support a culture of safety

Secondary drivers	Change ideas					
Staff wellbeing	Use of standardised feedback tools e.g. iMatter	Celebrate success	Use of what matters to me	Access to mental health first aiders	Access to Peer Support	Hot and cold debriefs

Evidence and Guidelines:

The kings fund. The courage of compassion supporting nurses and midwives to deliver high-quality care. 2020: Available from: https://www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives. Accessed 8 July 2024.

Tools and Resources:

Healthcare Improvement Scotland. The Essentials of Safe Care: Staff Wellbeing. 2021: Available from: https://tinyurl.com/8faerrv3. Accessed 8 July 2024.

Healthcare Improvement Scotland. What matters to you? 2023: Available from: https://www.whatmatterstoyou.scot/. Accessed 8 July 2024.

NHS Education for Scotland. Psychological First Aid and Debriefing - COVID 19. 2020: Available from: https://learn.nes.nhs.scot/29206. Accessed 8 July 2024.

NHS Greater Glasgow & Clyde. Peer Support Network 2023: Available from: https://tinyurl.com/45uan3j4. Accessed 8 July 2024.

Royal College of Paediatrics and Child Health. Wellbeing as paediatricians - Creating Environments Where We Can Thrive at Work 2023: Available from: https://www.rcpch.ac.uk/news-events/news/thrive-at-work-podcast. Accessed 8 July 2024.

Leadership to support a culture of safety

Secondary drivers	Change ideas				
Safe Staffing	Staff education & awareness about safe staffing act (2019)	Effective rostering	Real-time staff risk assessment	Clinical supervision	Mechanism to identify staff operating out with their usual area

Evidence and Guidelines:

Burton CR, Rycroft-Malone J, Williams L, Davies S, McBride A, Hall B, et al. NHS managers' use of nursing workforce planning and deployment technologies: a realist synthesis. Health Serv Deliv Res. 2018;6(36).

Griffiths P, Recio-Saucedo A, Dall'ora C, Briggs J, Maruotti A, Meredith P, et al. The association between nurse staffing and omissions in nursing care: A systematic review. J Adv Nurs 2018 -04-23;74(7):1474.

Tools and Resources:

Healthcare Improvement Scotland. Workforce Capacity and Capability [online] 2021: Available from: https://tinyurl.com/ywjpbcru. Accessed 8 July 2024.

Healthcare Improvement Scotland. Inclusion and involvement. [online]. 2021: Available from: https://tinyurl.com/rahzm6nc. Accessed 8 July 2024.

Healthcare Improvement Scotland. Staffing level (workload) tools and methodology. [online]: Available from: https://tinyurl.com/4f8rrsyj. Accessed 8 July 2024.

NHS Education for Scotland. Clinical Supervision Resource. 2023: Available from: https://learn.nes.nhs.scot/3580/clinical-supervision. Accessed 8 July 2024.

NHS Education for Scotland. Health and Care Staffing in Scotland. [online]. 2019: Available from: https://learn.nes.nhs.scot/61827. Accessed 8 July 2024.

Leadership to support a culture of safety

Secondary drivers	Change ideas					
System for learning	Use of tools and resources to support patient safety e.g. NES Safety Culture Cards	Involvement of resuscitation teams in improvement work	Local system for learning and support for complaints e.g. care opinion	Local system to learn from adverse events e.g. M&M, SAER's, Child Death Reviews	Create opportunities to learn from excellence	Use of simulation training

Evidence and Guidelines:

Kolovos NS, Gill J, Michelson PH, Doctor A, Hartman ME. Reduction in Mortality Following Paediatric Rapid Response Team Implementation. Paediatric Critical Care Med. 2018 May:19(5):477-482.

Theilen U, Fraser L, Jones P, Leonard P, Simpson D. Regular in-situ simulation training of paediatric medical emergency team leads to sustained improvements in hospital response to deteriorating patients, improved outcomes in intensive care and financial savings. Resuscitation. 2017 Jun;115:61-67.

Tools and Resources:

Care Opinion 2023; Available from: https://www.careopinion.org.uk/. Accessed 8 July 2024.

Healthcare Improvement Scotland. Quality Management System. 2023; Available from: https://tinyurl.com/5nff793s . Accessed 8 July 2024.

Healthcare Improvement Scotland. Supporting parents, families and carers in Scotland with the child death review process 2023: Available from: https://tinyurl.com/atv3vjj. Accessed 8 July 2024.

Healthcare Improvement Scotland. The Essentials of Safe Care: System for Learning. 2021: Available from: https://tinyurl.com/a4xdk7c7. Accessed 8 July 2024.

NHS Education for Scotland. Safety Culture Discussion Cards 2023: Available from: https://tinyurl.com/4bsapcu8. Accessed 8 July 2024.

Measurement

Measurement is an essential part of improvement as it helps the project team understand if the changes they are making are leading to improved care. Below you will see an outline of three types of measures used in improvement and a link to the measurement framework.

Outcome measures

Outcome measures are used to understand if the changes are resulting in improvements towards the aim.

Process measures

Process measures demonstrate that change ideas are improving the underlying processes that contribute to the recognition of and response to deterioration.

Balancing measures

Balancing measures are used to determine if the changes are affecting things elsewhere in the system (unintended consequences).

More detailed information can be found in the measurement framework on the SPSP Paediatric website.

Contact details

- Contact us at his.spsppp@nhs.scot
- Subscribe to the SPSP Paediatric mailing list
- Visit the SPSP Paediatric Programme website
- Visit the Essentials of Safe Care website

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