Healthcare Improvement Scotland

SPSP Paediatric Programme Deteriorating Child & Young Person Change Package

Reviewed July 2024: evidence, tools and resources updated

Leading quality health and care for Scotland

NHS SCOTLAND

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***

2023 Deteriorating Child & Young Person Driver Diagram

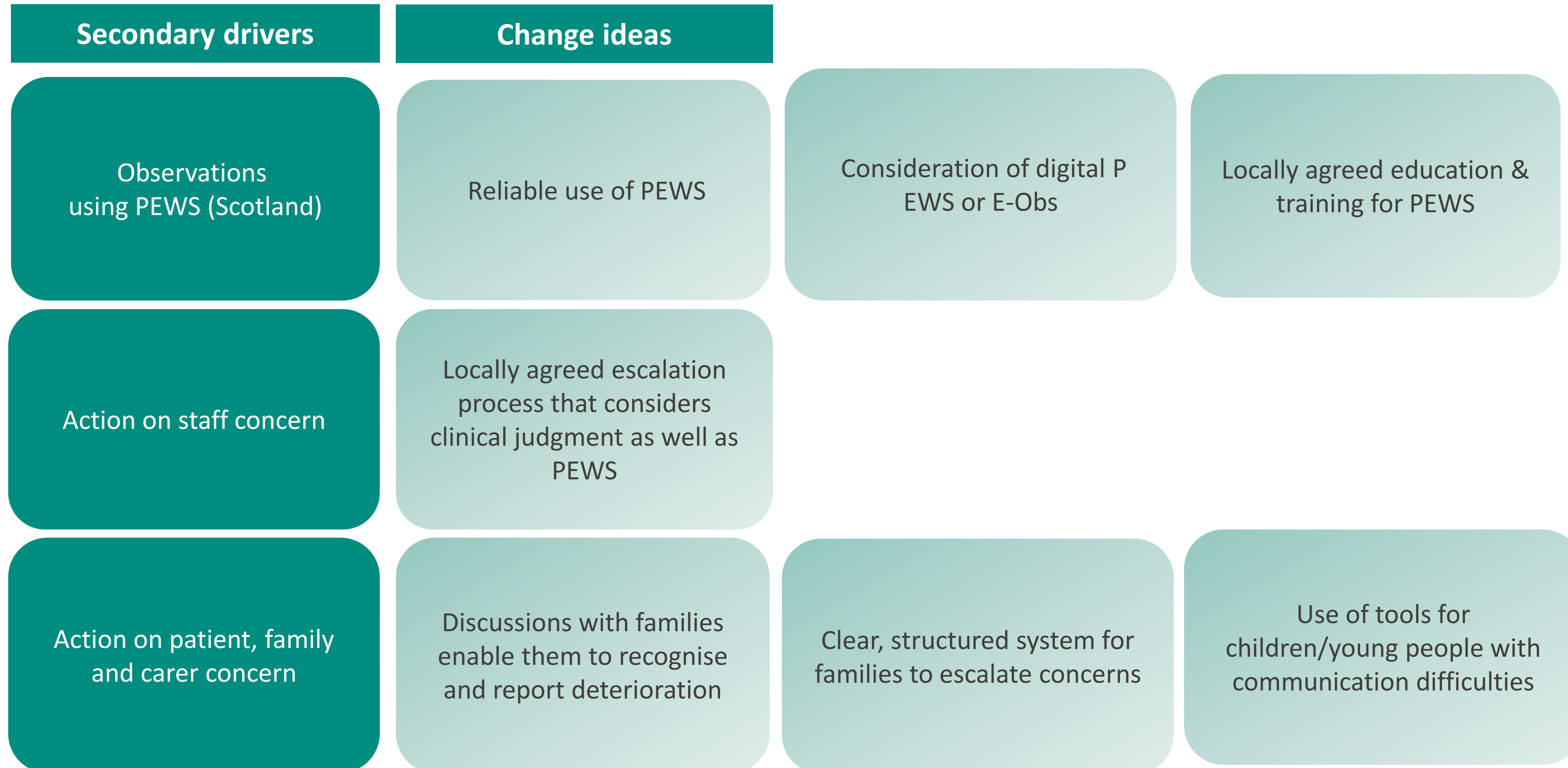
What are we trying to achieve…	We need to ensure…	Which requires…
To reduce harm from deterioration by improving the recognition, response and review of the deteriorating child and young person** By [locally agreed %] by 31st March 2025	Person-centred care*	Patients, families and carers are listened to and included Person-centred care planning Anticipatory care planning & CYPADM Discussions with families are well managed
	Recognition of acute deterioration	Observations using PEWS (Scotland) Action on staff concern Action on patient, family and carer concern
	Standardised, structured response and review	Timely review by appropriate decision maker Assessment for causes of acute deterioration Escalation Regular review and assessment
	Safe communication across care pathways*	Interdisciplinary teamwork and collaboration* Use of standardised communication tools* Effective communication in different situations*
	Leadership to support a culture of safety at all levels*	Psychological safety for staff* Staff wellbeing* Safe Staffing* System for learning*

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

Primary Driver
Person-centred care

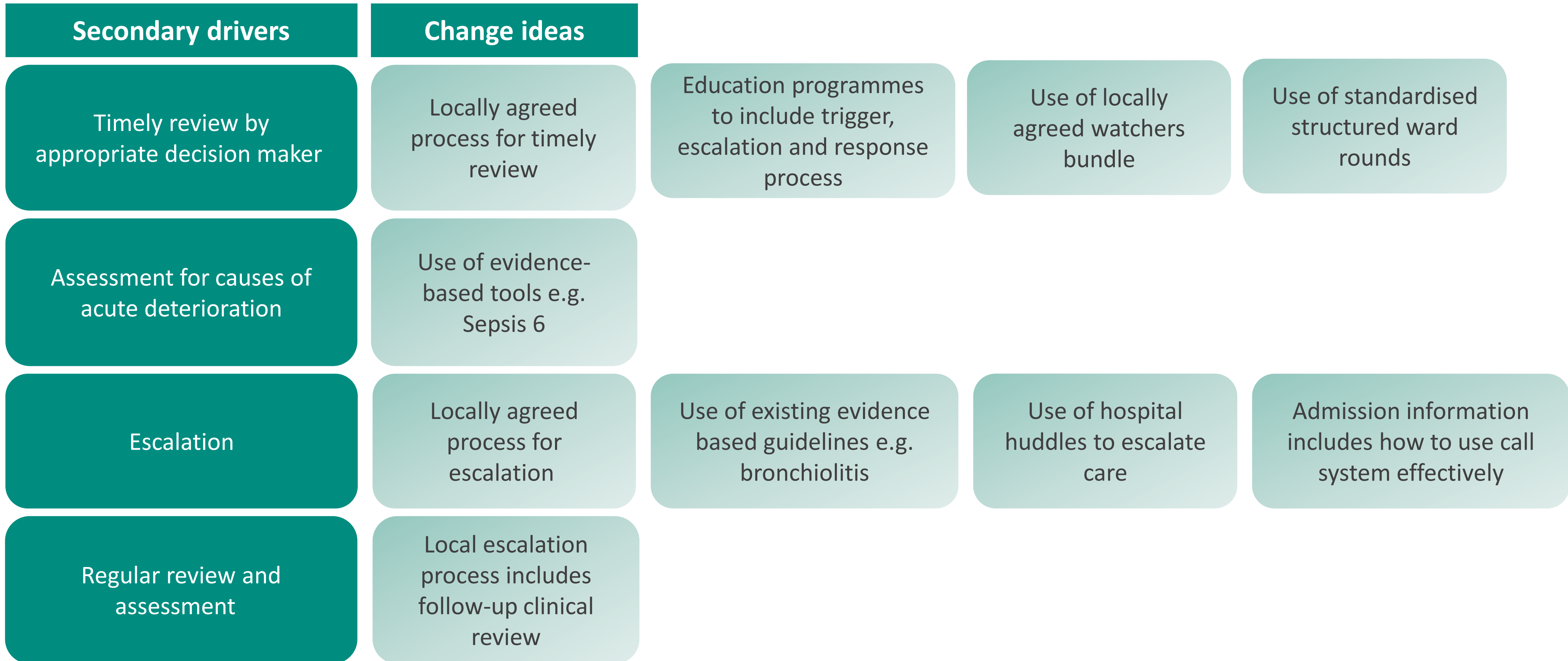
Secondary drivers	Change ideas				
Patient, families and carers are listened to and included	Access to tools, resources and education to support compassionate care	Use of 'what matters to me?'	Use of patient passports	Principles of Trauma Informed Practice included in local education programmes	Use of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

Primary Driver
Recognition of acute deterioration



Primary Driver

Standardised, structured response & review



Primary Driver

Safe communication across care pathways

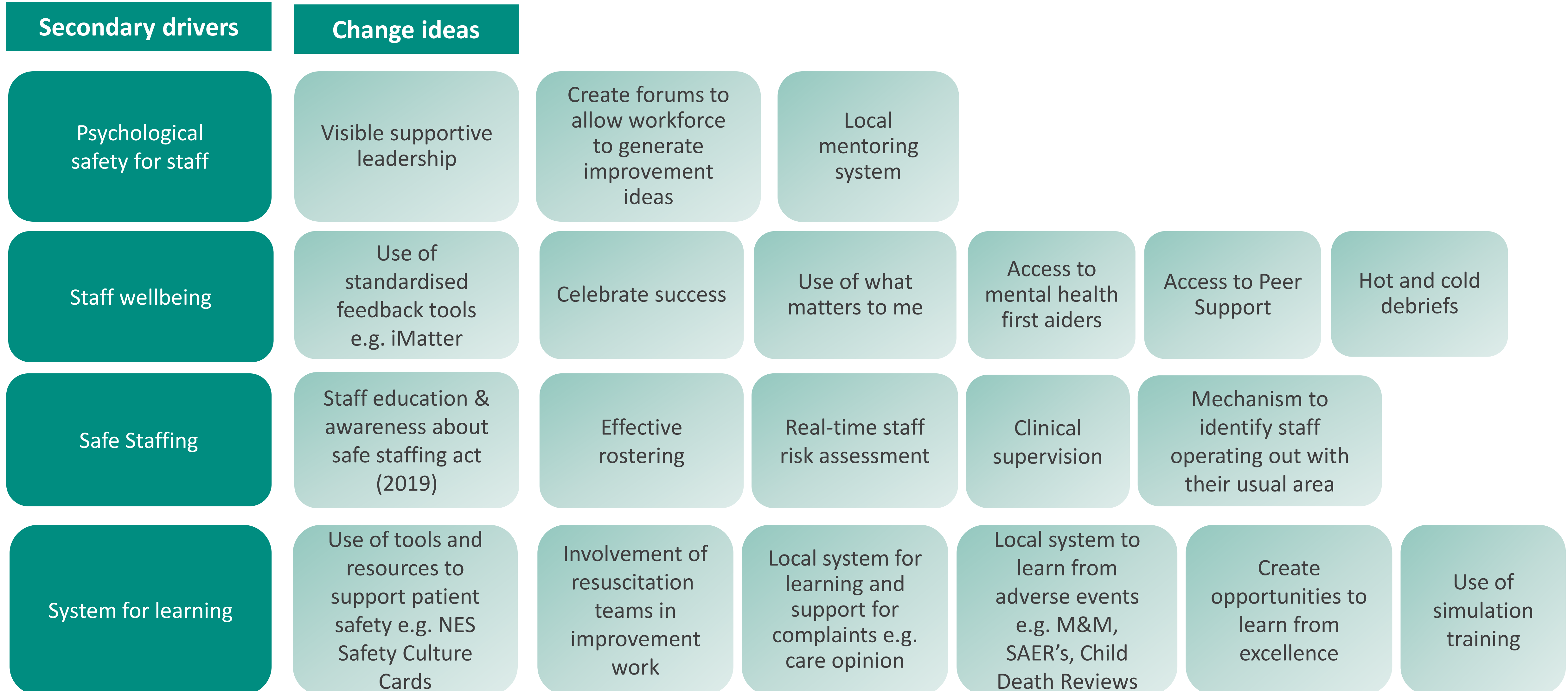
Secondary drivers	Change ideas			
Interdisciplinary teamwork and collaboration	Use of hospital huddles to improve situational awareness	Use of MDT shared documentation	Locally agreed system of communication between teams	Scotstar watchers bundle
Use of standardised communication tools	SBAR tool			
Effective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

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

Primary Driver

Leadership to support a culture of safety



Contact details

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