

Managing Deterioration

#### **Managing Deterioration Workstream**

Karen Verrill
PSC Learning Event - Ensuring our Patients are Safe: Meeting the needs of our local population
9th June 2021



@NatPatSIP / @MatNeoSIP

www.improvement.nhs.uk

Delivered by:

The AHSN Network
Managing Deterioration
Patient Safety Network

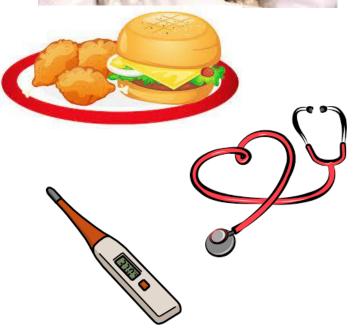
Led by:

NHS England NHS Improvement









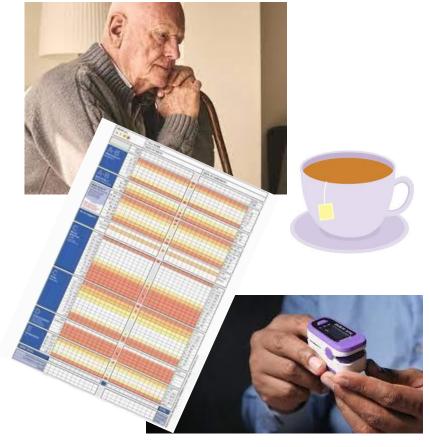
Early signs of physical "unwellness" can be recognised intuitively by physical healthcare practitioners as evidenced by staff saying "I know something is wrong, I just don't know what".

Even people without training, but who are familiar with someone's usual behaviour and habits, can often sense a problem resulting in them reporting that the relative, resident or child in their care "just isn't themselves".

Cooper, G. (2020) Using Soft Signs to Identify Deterioration.

Wessex Patient Safety Collaborative white paper. Wessex

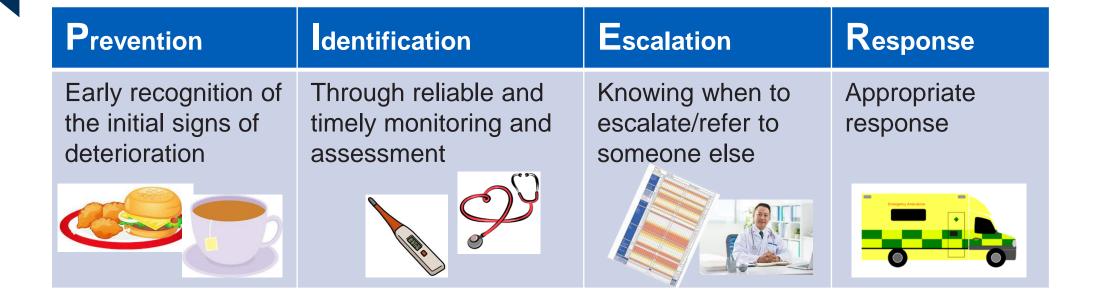
Academic Health Science Network (Available on https://wessexahsn.org.uk)





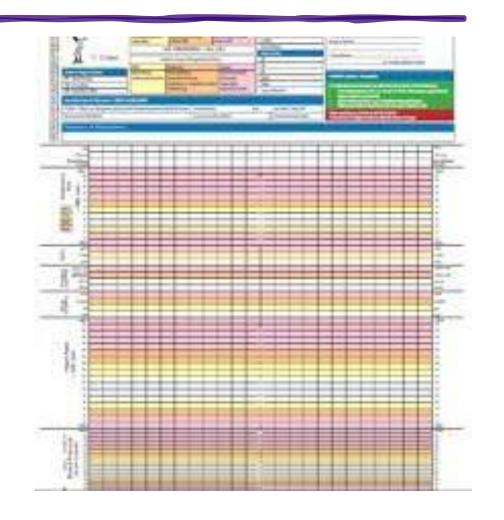


# Managing Deterioration: The PIER Framework



### Paediatric Early Warning System (PEWS)

- No single national validated system in England for Children and Young People
- Most acute hospitals have their own version to improve recognition and response to deterioration.
- Ambition to build on work done re NEWS2 and develop similar standardised chart for children and young people BUT recognise they are a very different population group with very different needs.
- 3 Pilots in the region: Newcastle (Great North Children's Hospital, Sunderland and James Cook) across 3 settings
- Important element parental input



# Adults: Deterioration Tools & Personalised Care and Support Plans

Support the increase in the adoption and spread of deterioration tools and personalised care tools in non-hospital settings across health and social care

**IMRU Tool** 



## **Appropriate Response? – taking into account the person's wishes**



#### Ralph's Story

Ralph had been ill for some time. He had made it clear that he <u>did</u> <u>not wish to be readmitted</u> to hospital or receive cardiopulmonary resuscitation (CPR). However, when he became breathless and collapsed, his care home staff called an ambulance. Because Ralph's <u>wishes were not written down in a suitable format</u>, the paramedics had no choice but to start CPR and admit him to hospital. He died soon after arriving.

Northern Cancer Alliance – 'Your life, your choice' leaflet <a href="http://www.northerncanceralliance.nhs.uk/deciding-right/">http://www.northerncanceralliance.nhs.uk/deciding-right/</a>

Advanced Care planning



Treatment Escalation Plans

End of Life Care

Shared decision making



Have the public's 'health seeking behaviours' changed during COVID?

Suggestions on

how to engage

with the public and patients? Existing networks/groups?

Pause for Thought / **Discussion** 

Any experiences to share? p<sub>ersonal or</sub> professional?

How can we spread awareness of Managing Deterioration interventions?,

What are the barriers to parents/families expressing concern

