Case Study: Royal Manchester Children's Hospital

BACKGROUND

Martha's Rule component 2 centers around all staff being able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.

In line with this component, the pilot site team aims to strengthen existing deterioration escalation processes while applying M.R. escalation process as a 'break glass' pathway. This centered around building on staff knowledge of existing escalation pathways through learning packages and rigorous review of escalation calls

SOLUTION

Design and implementation of a two-stranded learning approach to:

Develop a learning package to be delivered internally by ward-based educators.This entails:

- A self-learning slide deck designed for support (bands 5-7) staff at two pilot wards. Material covers an explanation of M.R and its components, its application at RMCH, expectations from staff and the expected outreach teams response.
- Separate slide decks for nursing teams, medical staff, and consultants
- Development of an in-depth slide deck for outreach teams covering governance and flow sheets detailing points of contact at various stages.

Develop a formal hospital-wide e-learning package, through an external company, for staff at all levels, to:

- Provide information on M.R and the impact of the three components on staff, patients and their family and carers.
- Provide detailed breakdown of existing escalation processes, including 'Speak to Sister Chat to Charge Nurse'.
- Balance how extensive the package will be. Will be using it across all services. There was a question initially on how much time you spend on something if it won't be a long-term solution. Simpler option initially to work out kinks and issues, Gain feedback. Will then be in better position to give the team developing the long-term package.

Case Study:

CHALLENGES

- Difficult to assess the effectiveness of the learning packages.
- Using mortality as a marker can be problematic due to current mortality rate being 3-5 deaths per month across RMCH (universal across pediatrics).
- Resource available to review unplanned admissions into critical care and review these for learning around escalation processes.
- Potential poor staff engagement with self-directed learning package
- Timescale variability as unplanned admissions are not necessarily comparable.

LEARNING

- Increased scope for staff requesting for M.R. review in accordance with component 2 the aim is that M.R. is used as a 'break glass' process for when existing escalation processes are not adhered to.
- Importance of developing resource for reviewing efficacy of existing escalation processes and understand the causes for an M.R. escalation being used.
- Scope for further developing self-directed learning slide decks and more specifically, charts outlining the different escalation processes and contacts, for different staff groups.
- Need to provide clarity around expectations on staff during escalation processes. This is currently in development.
- Consider looking at unexpected deteriorations on the ward e.g. cardiac arrest and complaints from patients, families and carers
- Potential M.R escalation calls may be low because of existing mechanisms or because of staff, patients and families/carers not being well informed about it.

CONCLUSION

Based on existing feedback from patients, families/carers and staff, there is a need to reframe M.R. as a 'break glass' process of escalation when existing escalation processes fail. In this respect, M.R. is MR process used as quality test for existing escalation processes. In this respect, M.R.is a balancing measure in that the more M.R. related escalation calls that are received, the more of an indicator it is that existing measures and processes are not working as well as they ought to.