Patient Activated Rapid Response & a National pilot for Martha's Rule:

Revolutionising hospital safety by collaborating with patients & families

Henrietta Hughes[1], Merope Mills[2], Chris Subbe[3]

[1]Patient Safety Commissioner, England

[2]Martha's Mum, Senior Editor, The Guardian, UK

[3]Physician, Ysbyty Gwynedd & Bangor University, Bangor, UK

00:00 Welcome & Introduction

Content	Who?	Comments
Introduction of speakers Conflicts of interest Slide with learning outcomes from submission	HH, MM & CPS	

Conflicts of Interest

- CPS:
  - Member of the advisory board of the International Society for Rapid Response Systems
  - Funded in parts through an Improvement Science Fellowship with the Health Foundation
  - Member of Safe-Care-Collaborative Improvement Cymru
- MM
  - Senior Editor, The Guardian, UK

Please note

The content of the workshop contains potentially distressing information and may bring back some difficult experiences with loved one's in hospital.

Please take some time out if you want or need to.

In this session we will ...

1. Explore opportunities for collaborating with patients and families to enhance patient safety in hospital.
2. Understand global variation in drivers for and impact of patient activated rapid response systems.
3. Identify behavioural drivers of patient safety using the COMB model and apply those to clinical deterioration in hospital.
4. Map local barriers and enablers for working with patients to improve safety in hospitals through implementation of Patient Activated Rapid Response systems.

In this session we will …

1. Explore opportunities for collaborating with patients and families to enhance patient safety in hospital.

- Participants Experience
- Literature – Patient Powered Safety – EHRs / Surgical Checklist Bergen / Apps

In this session we will …

2. Understand global variation in drivers for and impact of patient activated rapid response systems.

Victoria: Patient and Family Activated Escalation System (PFAES)

Queensland: Ryan’s Rule – Helpline

New-Zealand: ‘Korero Mai’ – Rapid Response

South Carolina: Lewis Blackman Patient Safety Act

In this session we will …

3. Identify behavioural drivers of patient safety using the COMB model and apply those to clinical deterioration in hospital.

Capability, Opportunity, Motivation – what makes you ask & escalate / what would make your patient ask & escalate ?

	You	Your patients / families
Knowledge		
Skill		
Physical Opportunity		
Social Opportunity		
Reflective Motivation		
Automatic Motivation		

In this session we will ...

4. Map local barriers and enablers for working with patients to improve safety in hospitals through implementation of Patient Activated Rapid Response systems.

SEIPS (System Engineering Initiative for Patient Safety)

- What tools?
- What tasks?
- What people?

00:05 Group 1: Participants experience

Content	Who?	Comments
Icebreaker Testing of Mentimeter interactivity Getting participants to talk to each other and share	HH & CPS	

Mentimeter I – Getting to know you

A. From which country are you: Netherlands / UK / Europe – other / Outside of Europe

B. What is your role: Doctor / Nurse / Operational management / Academic / Patient Representative

Breakout groups – Your experience

Have you been to hospital (as a patient or to see a loved one):

What did you see? How did it feel? Did you feel listened to?

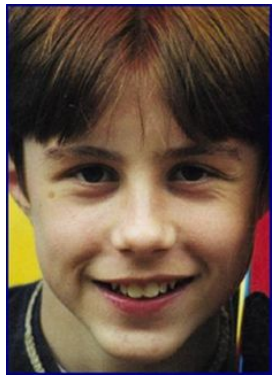
[For consideration]

- CQUIN Indicator questions from the Picker Survey
- Were you involved as much as you wanted to be in decisions about your care and treatment? 1 Yes, definitely 2 Yes, to some extent 3 No
- Did you find someone on the hospital staff to talk to about your worries and fears? 1 Yes, definitely 2 Yes, to some extent 3 No 4 I had no worries or fears
- Were you given enough privacy when discussing your condition or treatment? 1 Yes, always 2 Yes, sometimes 3 No

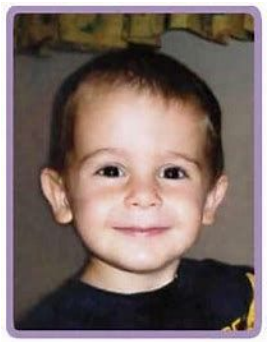
00:15 Input 1 – PARR

Content	Who?	Comments
Principles of Rapid Response History of Patient Activated Rapid Response Video from Martha Mills	CPS MM	

18-month-old Josie King died from medical errors in **2001**. ‘If I would have been able to call a rapid response team, I believe Josie would be here today,’ Sorrel King.



Lewis Blackman Act (**2005**) 15yrs old, died following elective surgery despite concerns being raised by mother.



Ryan’s Rule – developed in response to the death of Ryan Saunders (**2007**) – parents concerns not being acknowledged.

Hayley Fullerton died **2009** at Birmingham, days after being transferred from intensive care to a general ward.

www.heal-trust.org

Evan Smith, 21yrs old, dialled 999 from hospital to raise alarm he was deteriorating; died **2019**, with Sepsis and Sickle cell crisis following a routine operation.

Martha Mills – 13yrs old – died **2021**, after contracting sep sis; Parents concerns were dismissed.

Mandy Odell sets up Call-4-Concern in **2010** in Reading.0.8% of CCOT calls. .

CALL 4 CONCERN©
Tîm Ymyrraeth Aciwt
Acute Intervention Team
Blïp/Bleep 206

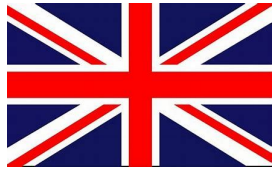
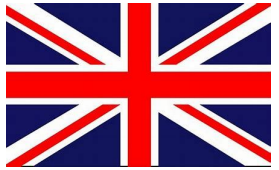
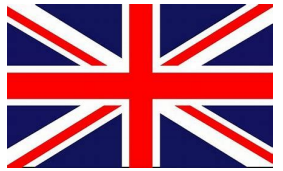
Assumptions

- Most things go right !
- Failure to rescue is rare ....

- But: 3.0% of deaths in hospital > 50% chance of avoidability.
  - 7,964 potentially avoidable deaths / year
  - 5 / months / Trust in England

Hogan H et al. BMJ. 2015.
Rodwin BA et al. J Gen Intern Med. 2020.



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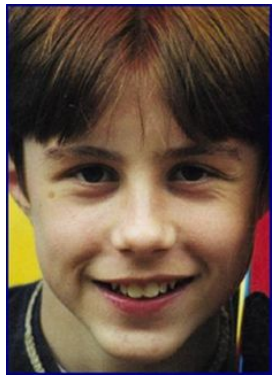
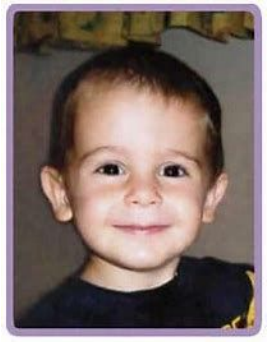



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?

Martha

(click on link)

Meso-systems

UK: Call-4-Concern

Helen Haskell

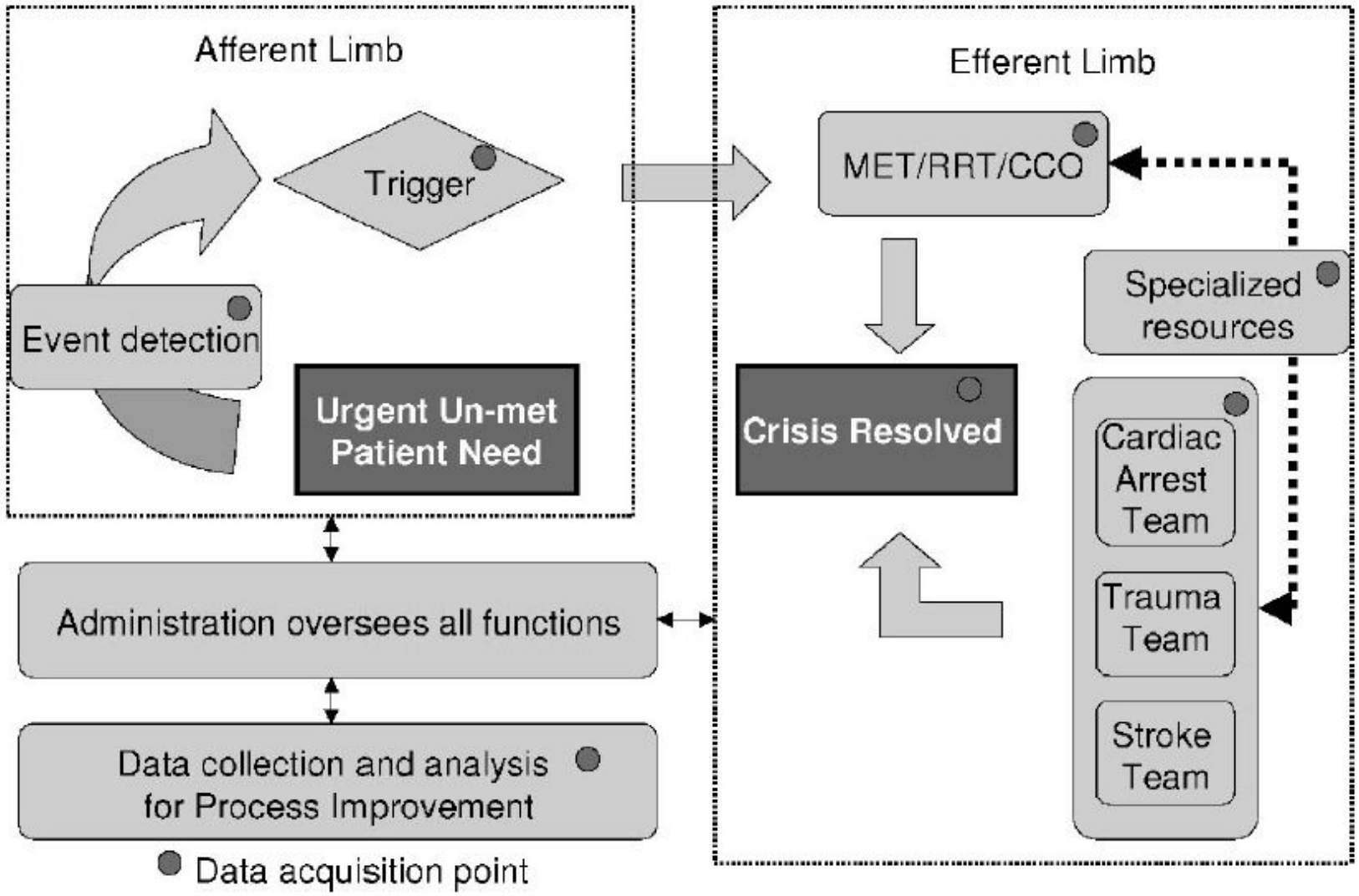
- Lewis Blackman Patient Safety Act

Mandy Odell

- Royal Berkshire Hospital
- Experience from 7 years
- Template for other UK units

CALL 4 CONCERN©

Tîm Ymyrraeth Acíwt
Acute Intervention Team
Blîp/Bleep 206



DeVita et al. Crit Care Med 2006; 34:2463-78

RESUSCITATION 141 (2019) 1–12

Available online at www.sciencedirect.com

Resuscitation

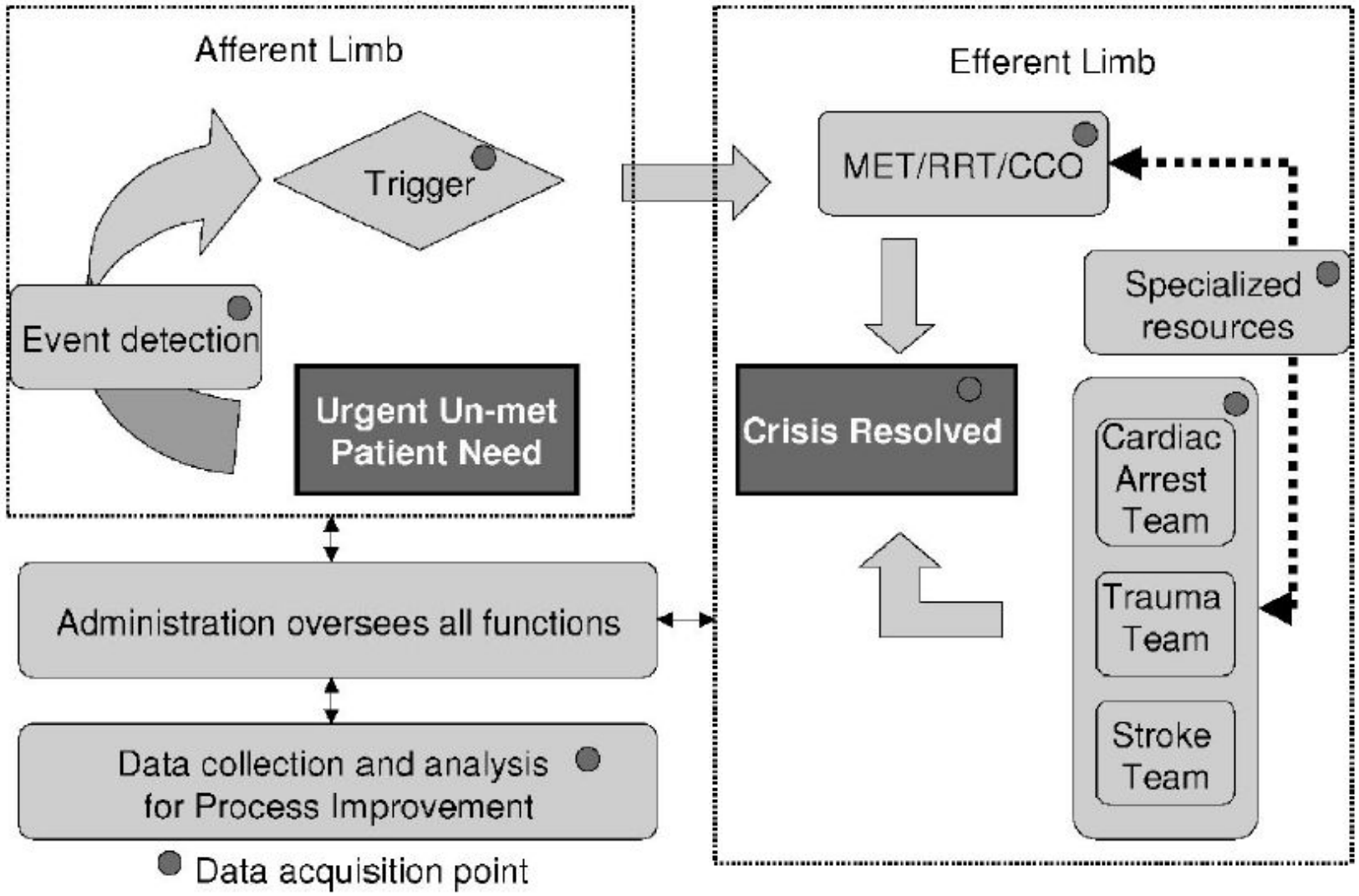
journal homepage: www.elsevier.com/locate/resuscitation

Statement paper

Quality metrics for the evaluation of Rapid Response Systems: Proceedings from the third international consensus conference on Rapid Response Systems

Patient Centred metrics

7. Patient / Family Activated System (Essential)
8. Proportion of calls by patient/family (Optional)



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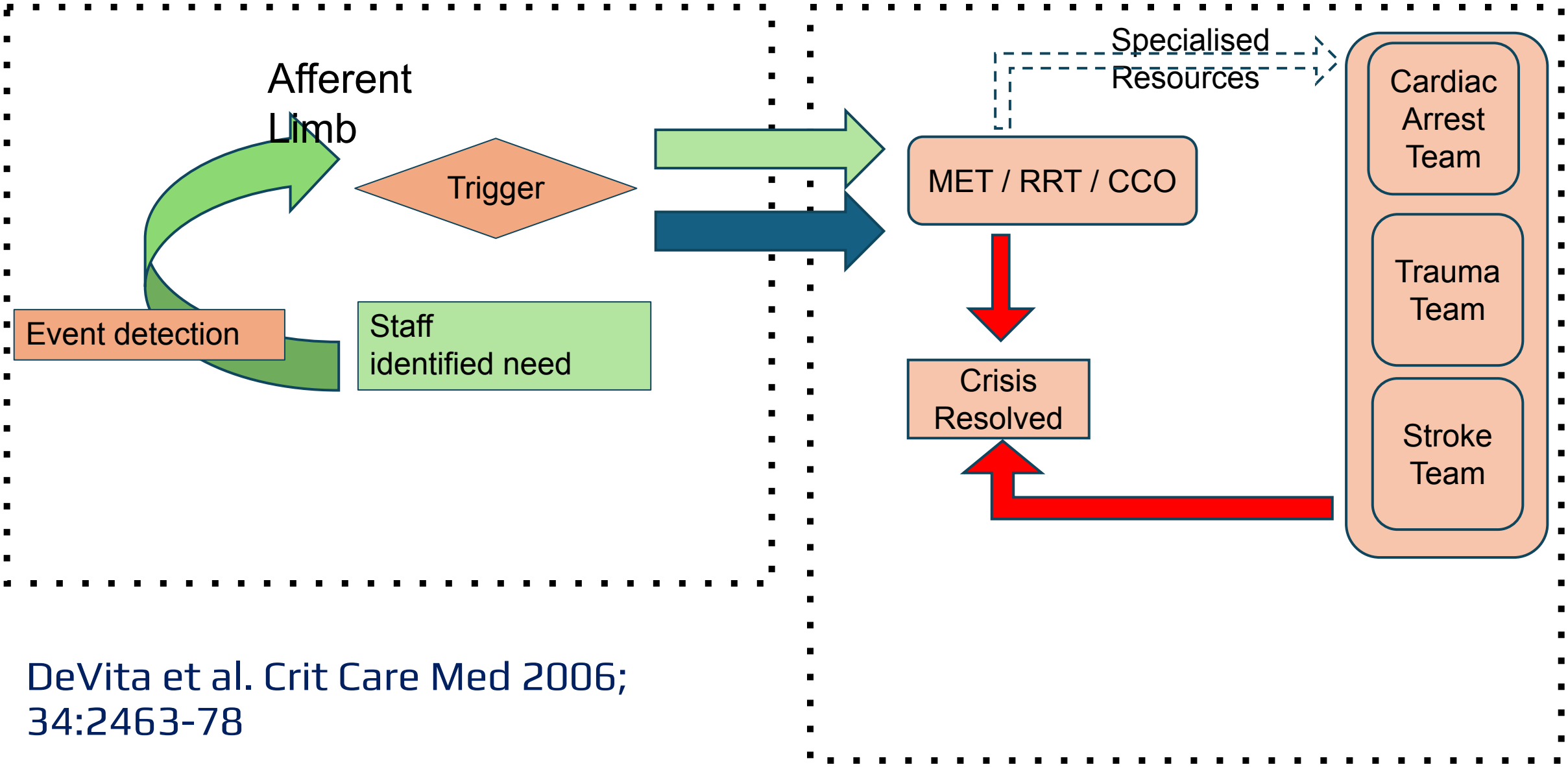

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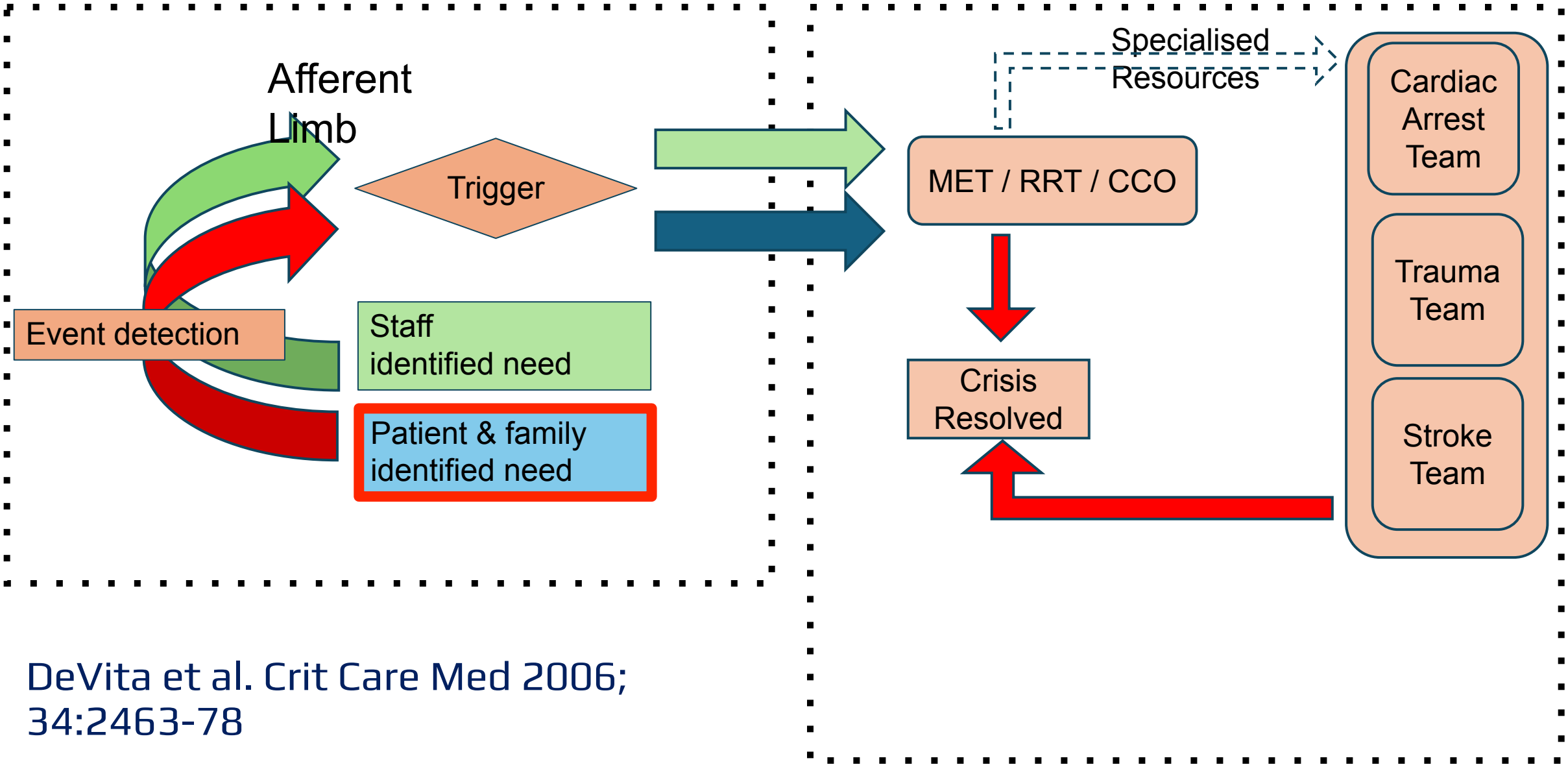

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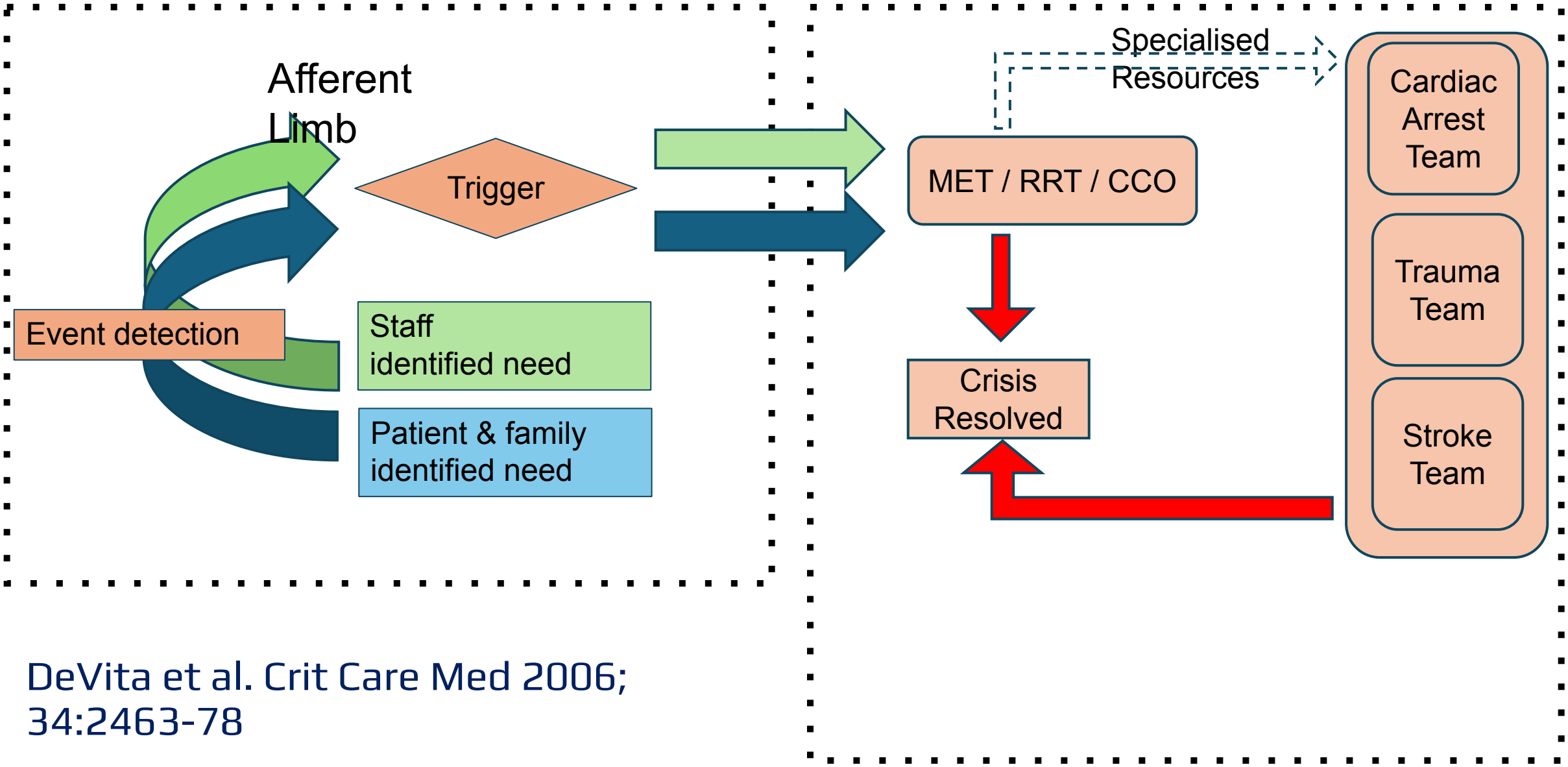

DeVita et al. Crit Care Med 2006; 34:2463-78

Systems

Victoria: Patient and Family Activated Escalation System (PFAES)

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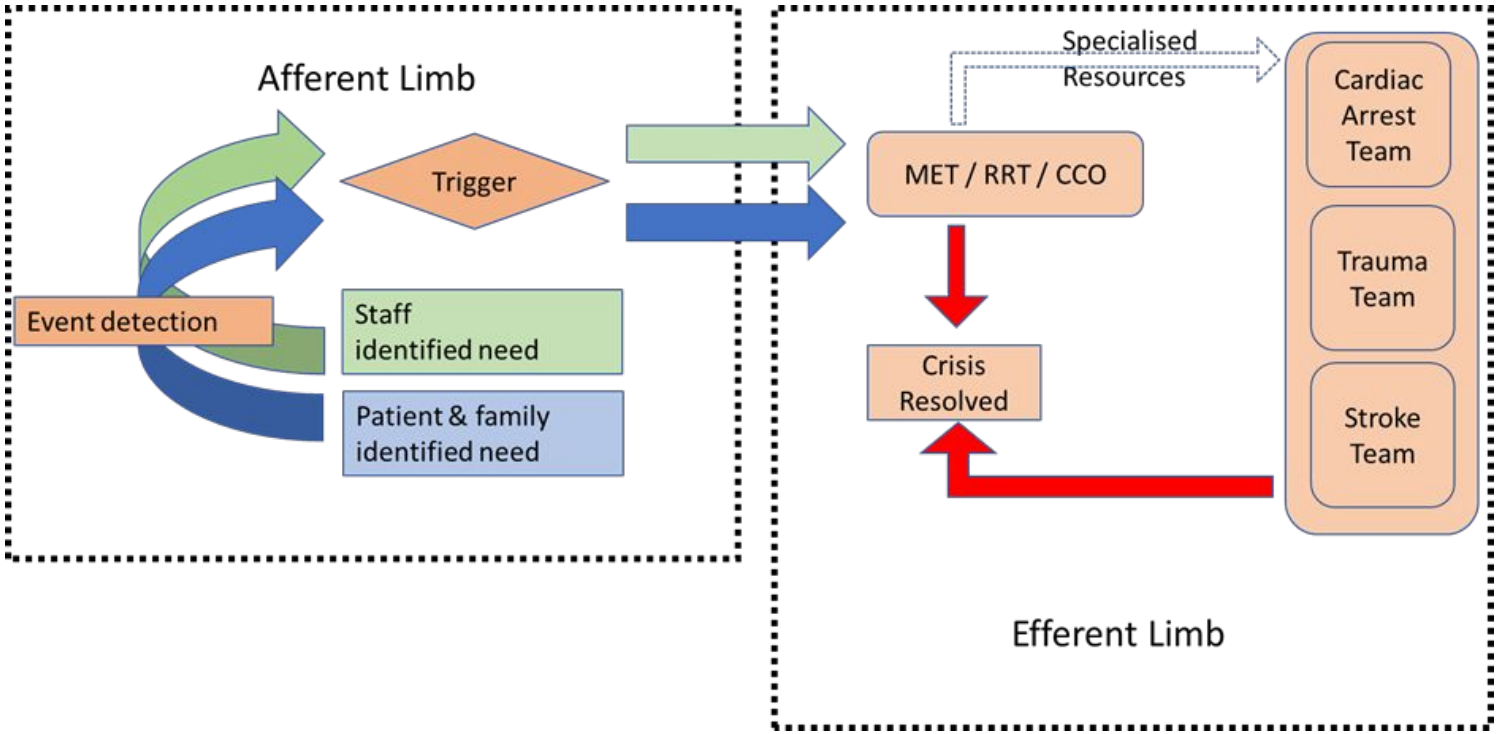
New-Zealand: ‘Korero Mai’ – Rapid Response

South Carolina: Lewis Blackman Patient Safety Act



Rapid Response System Afferent and Efferent limbs incorporating patient and staff identification of deterioration and the response from a Critical Care Outreach team or equivalent

00:25 Input 2 – Martha's Rule development

Content	Who?	Comments
Martha's Rule history Video with Merope Mills Policy work	HH	

Macro-systems

Martha’s rule

- Structured approach to information relating to patient’s condition directly from patients & their families
- 24/7 ability to escalate to CCOT
- 24/7 CCOT in all hospitals

Developing Martha's Rule – a collaboration involving 20++ organisations, including...

NHS England

NHS Confederation

DEMOS

BACCN British Association of Critical Care Nurses

NHS University College London Hospitals NHS Foundation Trust

NHS East Sussex Healthcare NHS Trust

NHS Royal Berkshire NHS Foundation Trust

NHS Providers

Great Ormond Street Hospital for Children NHS Foundation Trust

CareQuality Commission

Patient Safety Commissioner Listening to Patients

Department of Health & Social Care

Parliamentary and Health Service Ombudsman

NICE National Institute for Health and Care Excellence

the patients association

NHS Guy's and St Thomas' NHS Foundation Trust

NHS Confederation

nmc Nursing & Midwifery Council

YQSR Yorkshire Quality and Safety Research Group

Bradford Institute for Health Research

NHS Bradford Teaching Hospitals NHS Foundation Trust

General Medical Council

RCPCH Royal College of Paediatrics and Child Health *Leading the way in Children's Health*

Health Services Safety Investigations Body

....and many many others.

Developing and implementing Martha's Rule – in numbers...

- **4** policy sprint sessions to develop ideas for implementation of Martha's Rule
- **3** key recommendations to the Secretary of State for Health & Social Care
- **20** (at least) presentations during which PSC has talked about Martha's Rule
- **3** regulators (CQC, NMC, GMC) jointly pledging support to ensure the successful implementation and oversight of Martha's Rule.
- **100** pilot sites set as the target for Martha's Rule rollout in 2024/25
- **143** pilot sites identified following an NHSE-led expression of interest process
- **12** Martha's Rule Oversight Group meetings
- **14** guest speakers to inform the Oversight Group's thinking
- **573** calls made to escalate concerns about deterioration in September and October 2024
- **286** of the **573** calls required a clinical review for acute deterioration
- **57** of the 286 calls led to a change in the patient's care, such as receiving potentially life-saving antibiotics, oxygen or other treatment
- **14** of the calls resulted in a patient needing urgent transfer to an intensive care unit

....and many more important actions by everyone involved to help get us to where we are today.

SCCM Good Practice Guidelines ‘24

on Recognizing and Responding to Clinical Deterioration Outside the ICU

- Recommendations for Recognition & Response to clinical deterioration
- Voting 25-member panel
- PICO statements
- Strong vs Conditional recommendations

1. Vital sign acquisition timely & accurate
2. Focused education for non-ICU staff
3. Patient/family opinion for escalation & concern included in early warning systems
4. Hospital wide RRT / MET call-out criteria
5. Skills include setting of Tx goals
6. Process of Quality Improvement

- Not: Continuous vital signs, team composition, palliative care etc

Society for Critical Care Medicine, February 2024

00:45 Input 3: Behaviour change theory

Content	Who?	Comments
COMB model of behaviour change & application to patient safety	CPS	

Micro-systems

21/05/2025

Chain of survival

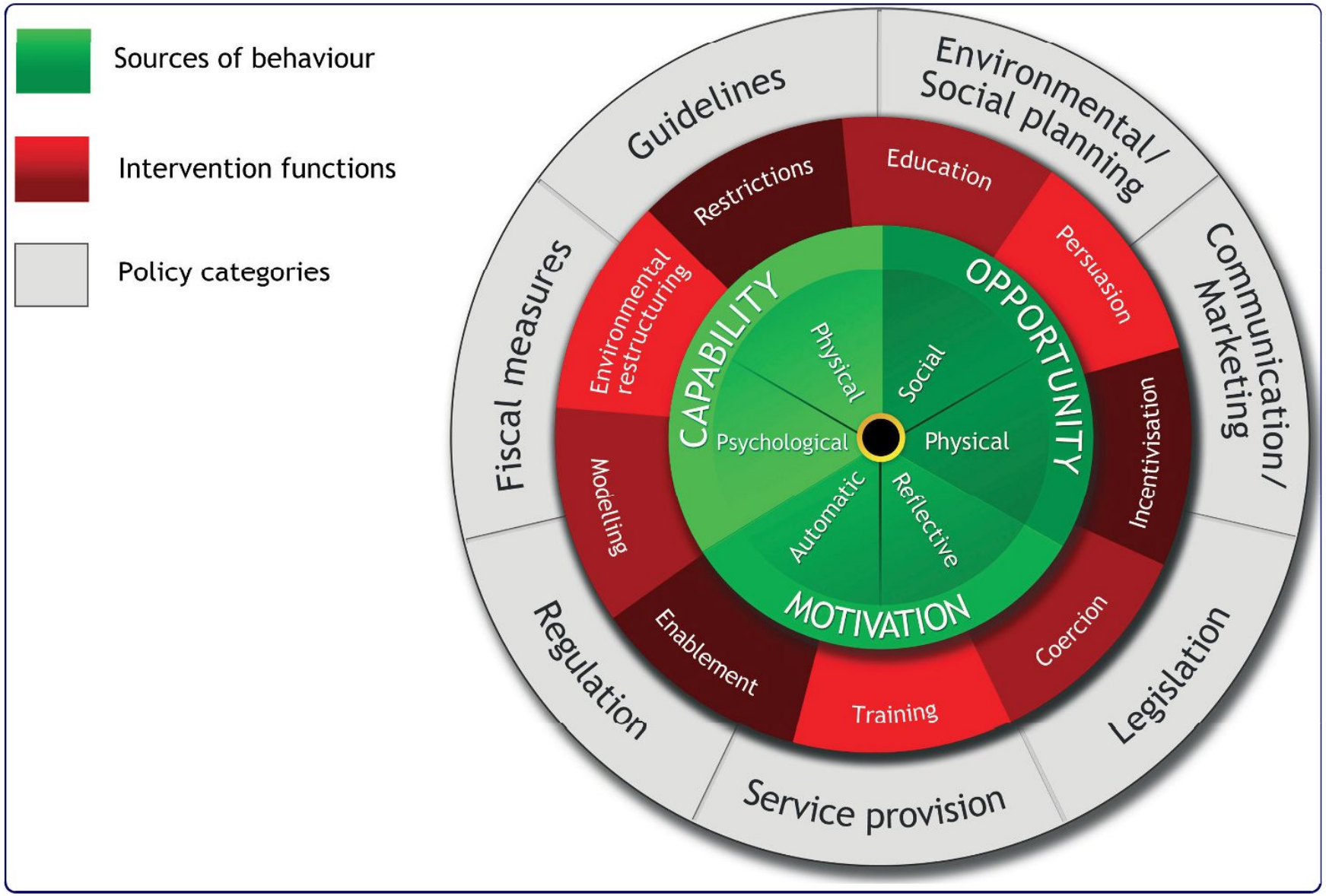
Record - Recognize - Report - Respond - Repeat

Subbe CP, Welch J, J Pat Safety & Risk Management, 2013

How do we know it is an improvement?

Subbe CP, Welch J, J Pat Safety & Risk Management, 2013

COM-B Method



Michie S et al. Implementation Science. 2011; 6:42

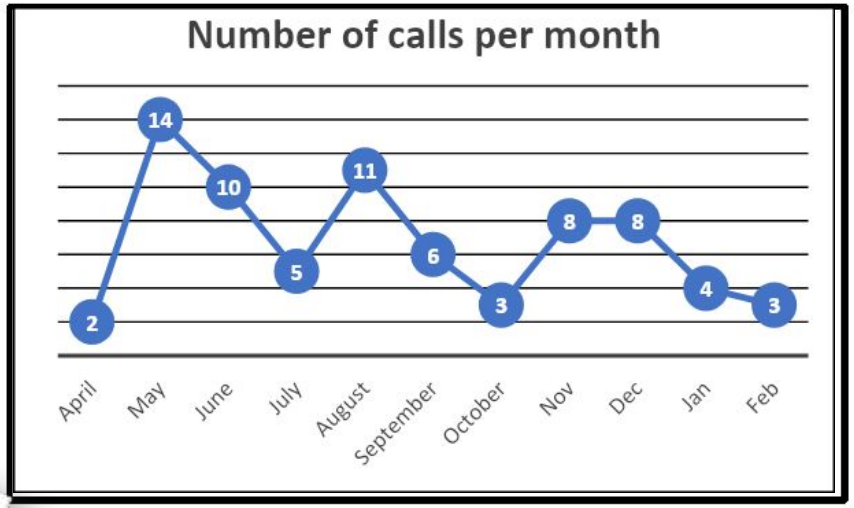
Capability Opportunity Motivation

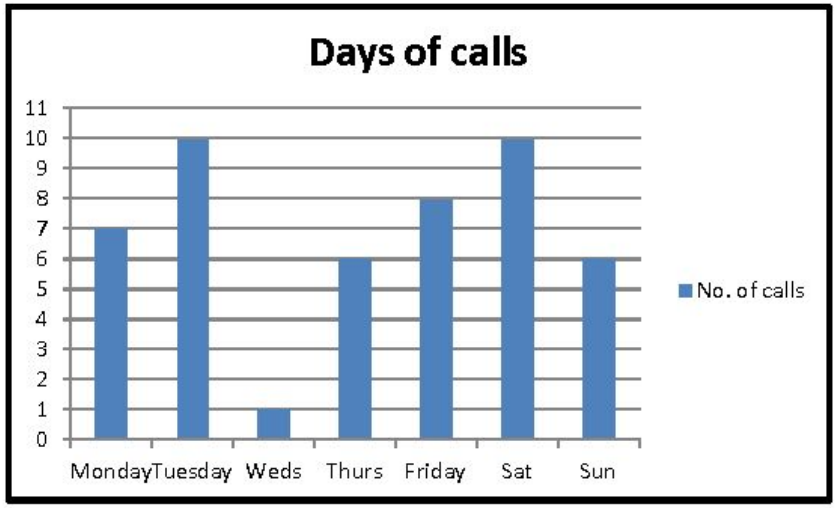
Capability Opportunity Motivation

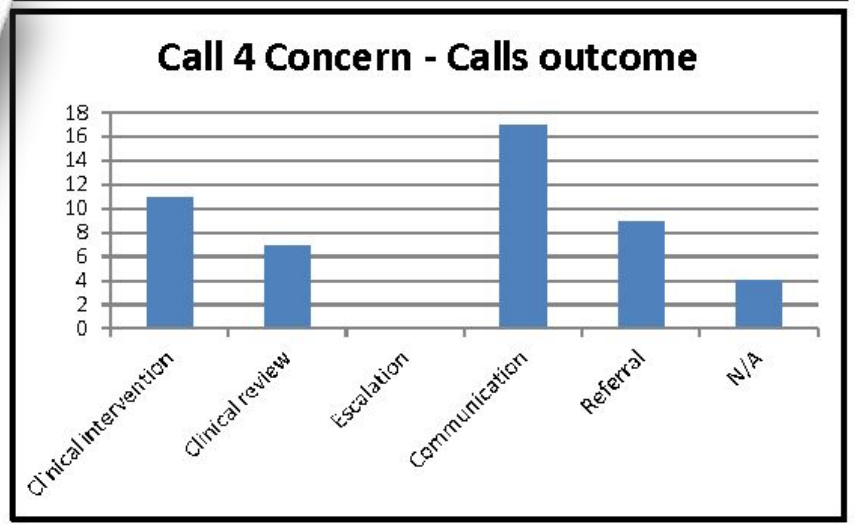
Call-4-Concern
©Mandy Odell

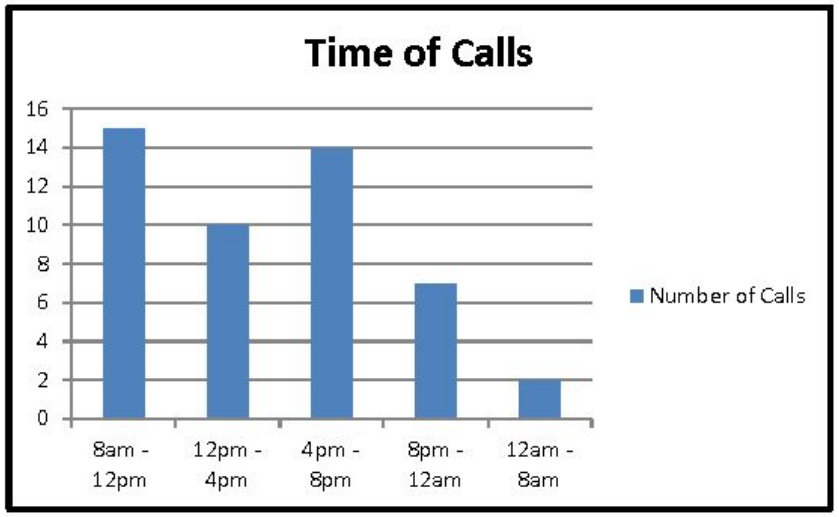
Call-4-Concern

6 months data (April – September 2023)









21/05/2025

Top 6 metrics for evaluation

Type	Name	Definition	Ease x Impact
Structural	**Escalation pathway available**	Does the hospital have a patient / family activated rapid response system?	5x5=25
Structural	**Evaluation system available**	Review of data from escalations & report on learning at least annually?	5x5=25
Process	**Patient awareness of escalation pathway**	Weekly: % of sample of patients with capacity with understanding of escalation system	4x4=16
Process	**Family awareness of escalation pathway**	Weekly: % of sample of visitors with understanding of escalation system	4x4=16
Process	**Use of escalation pathway**	Weekly: count of escalations initiated by patients/families as % of escalations	5x4=20
Outcome	**Cardiac arrest & Unplanned transfer to ICU / HDU**	Cardiac arrests & Unplanned transfers with triggers such as NEWS2 >4 for > 1 hour	5x3=15

00:35 Group 2: Rapid Response locally

Content	Who?	Comments
Exploring local Rapid Response – what is perception of gap?		

Barriers & Enablers: For patients / for staff

SEIPS (System Engineering Initiative for Patient Safety) 101

- What tools?
- What tasks?
- Which people?
- What systems?

Barriers & Enablers

What gaps and barriers have you identified?

What might help you to enable patients in your system?

Please post at least one thing that might be a barrier and one that might be an enabler?

Breakout groups: Barriers as Opportunities ?

A. Classify your barrier
B. Have you accounted this barrier in another clinical area before? How was it overcome?
C. How could behaviour change theory help you to address these?

	You	Your patients / families
Knowledge		
Skill		
Physical Opportunity		
Social Opportunity		
Reflective Motivation		
Automatic Motivation		

00:60 Summary & Feedback

Content	Who?	Comments
Where we would like to take things? Metrics & International perspective Thank you & acknowledgements: Merope & Paul Future events Feedback question on Mentimeter: Would you prefer to be in a hospital that has PARR or not?	HH & CPS	

Your next steps

Mentimeter III – your next steps

A. Does your hospital have already PARR?
B. Are you planning to launch a PARR in the next 12 months
C. How would you measure success (ranking of metrics)
D. Assuming you or a loved one need admission to hospital: All other things being equal – would you prefer to be admitted to a hospital with PARR / hospital without PARR / not sure

The changing role of patients & families

Summary: Martha's Rule Implementation

- Micro-systems:
  - Patient Activated Rapid Response is helpful for individuals
  - Limitation: usage by patients
- Meso-systems
  - System level effects not yet clear
  - A more equitable culture ?
  - More psychological safety & less complaints ?
- Macro-systems
  - Synergies between providers and patient safety organisations
  - Competitive advantage

Thank you !

Helen Haskell,
Mandy Odell,
Merope Mills & Paul Laity,
Eirian Edwards,
Merveille Ntumba,
John Welch

“Everybody should be allowed to call for help – even in hospital.”

Alison Philips – patient representative

Thank you

Patient Safety Commissioner
Listening to Patients

Website: www.patientsafetycommissioner.org.uk
Bluesky: bsky.app/profile/pscommissioner.bsky.social
LinkedIn: linkedin.com/in/henrietta-hughes-psc
Email: Commissioner@PatientSafetyCommissioner.org.uk