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Implementing Martha's rule:Part 1&2

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‘We had such trust, we feel such fools’: how shocking hospital mistakes led to our daughter’s death

Martha was 13; her whole life stretched out ahead of her. But our faith in doctors turned out to be fatal. This is what I wish I’d known

by Merope Mills

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Outline

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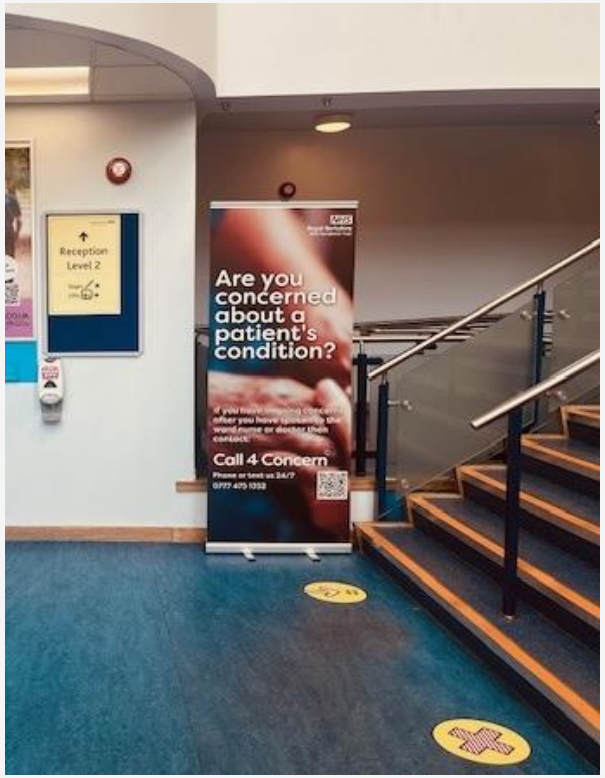
Components of Martha's Rule:

- All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient
- All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.
- The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

Our experience



Call 4 Concern: patient and relative activated critical care outreach

Mandy Odell, Karin Gerber, Melanie Gager

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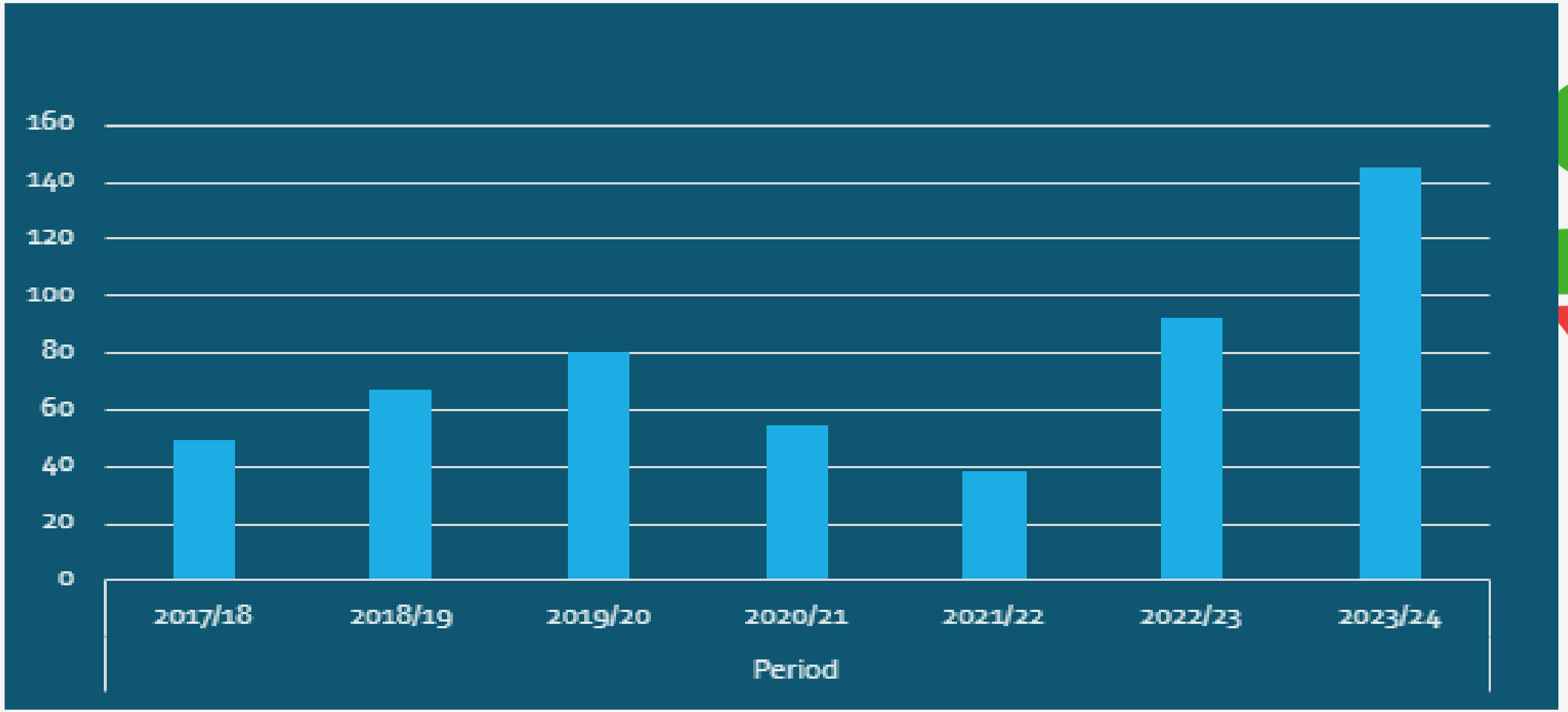
The Good

- Established service
- No stipulations who can use the service
- Several options as to how to make contact
- Call is returned within 4 hours

C4C referrals since 2017/18



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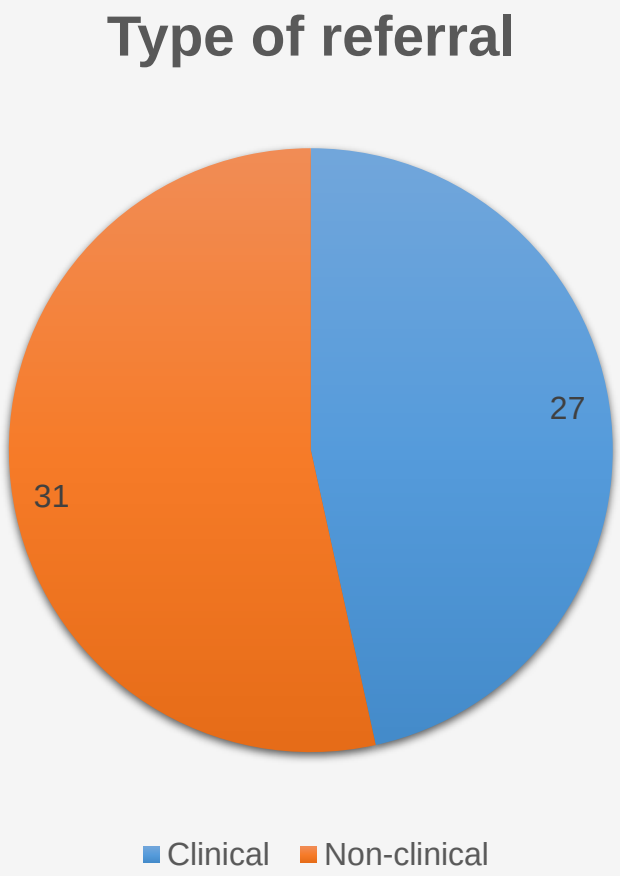
Q1 2024 referrals



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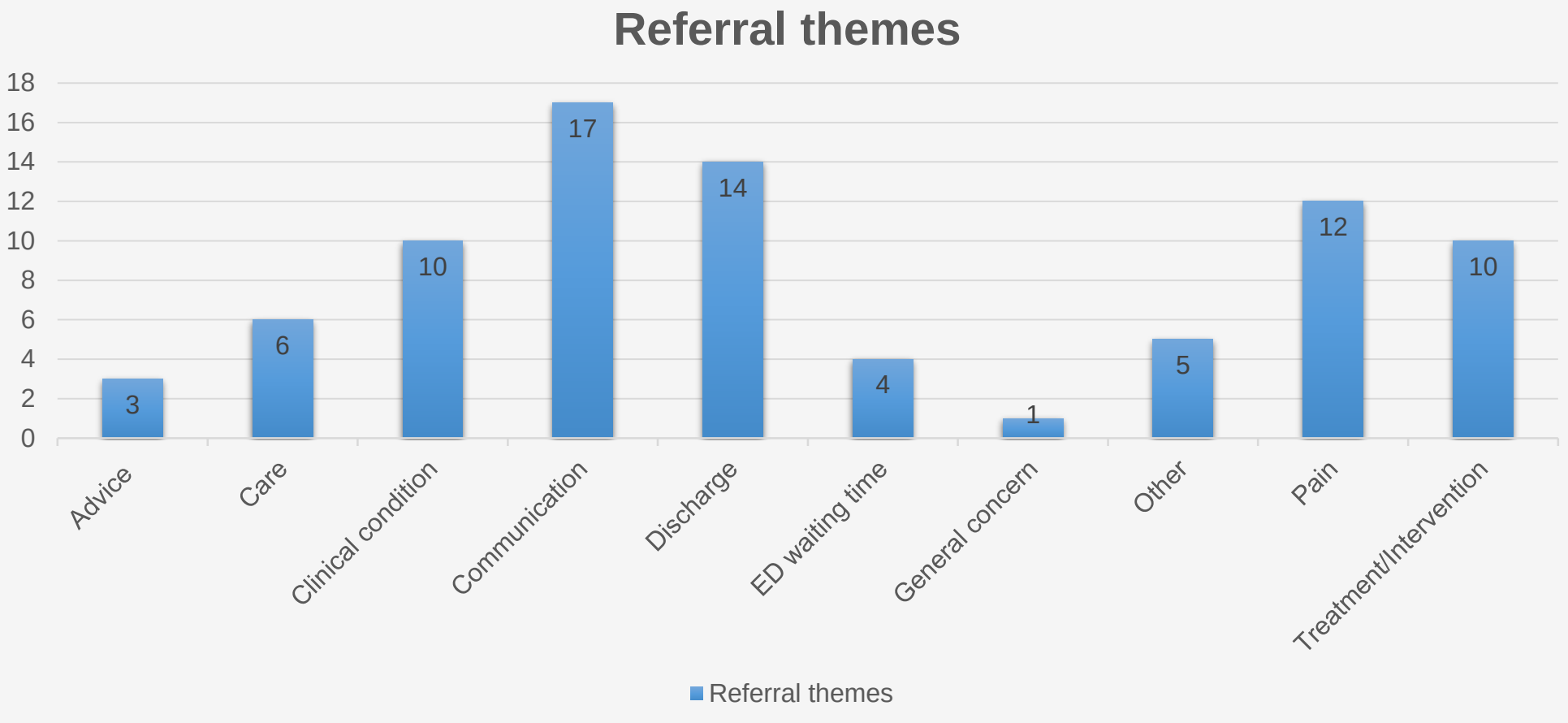

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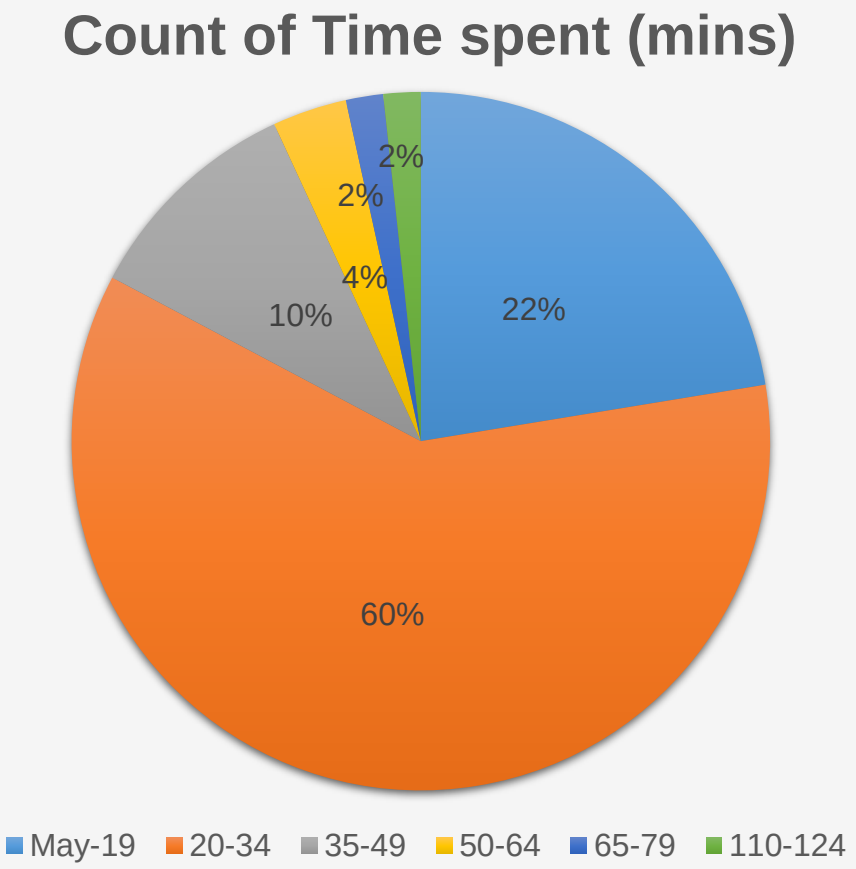

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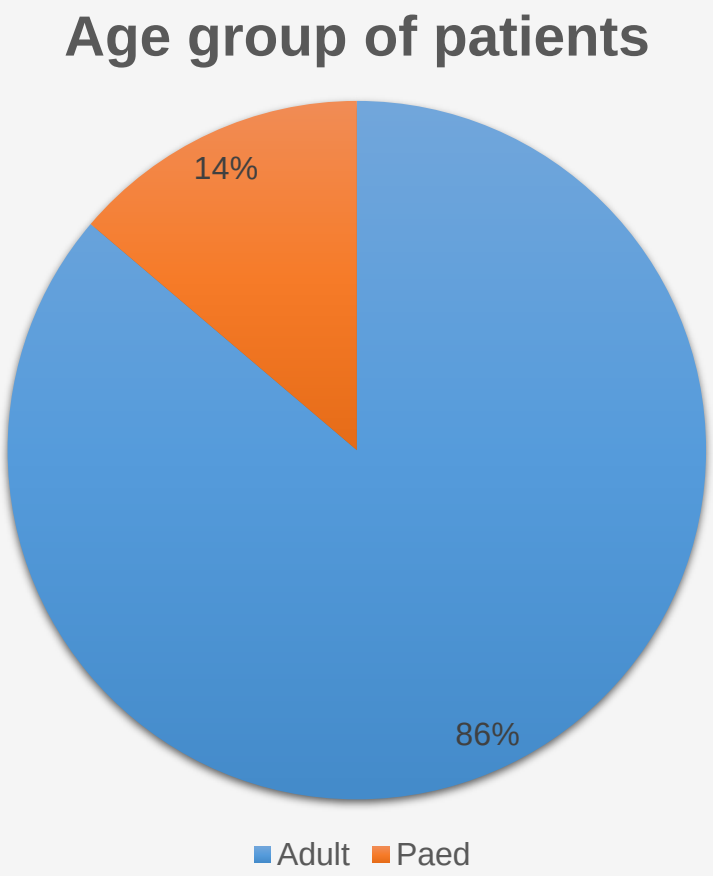

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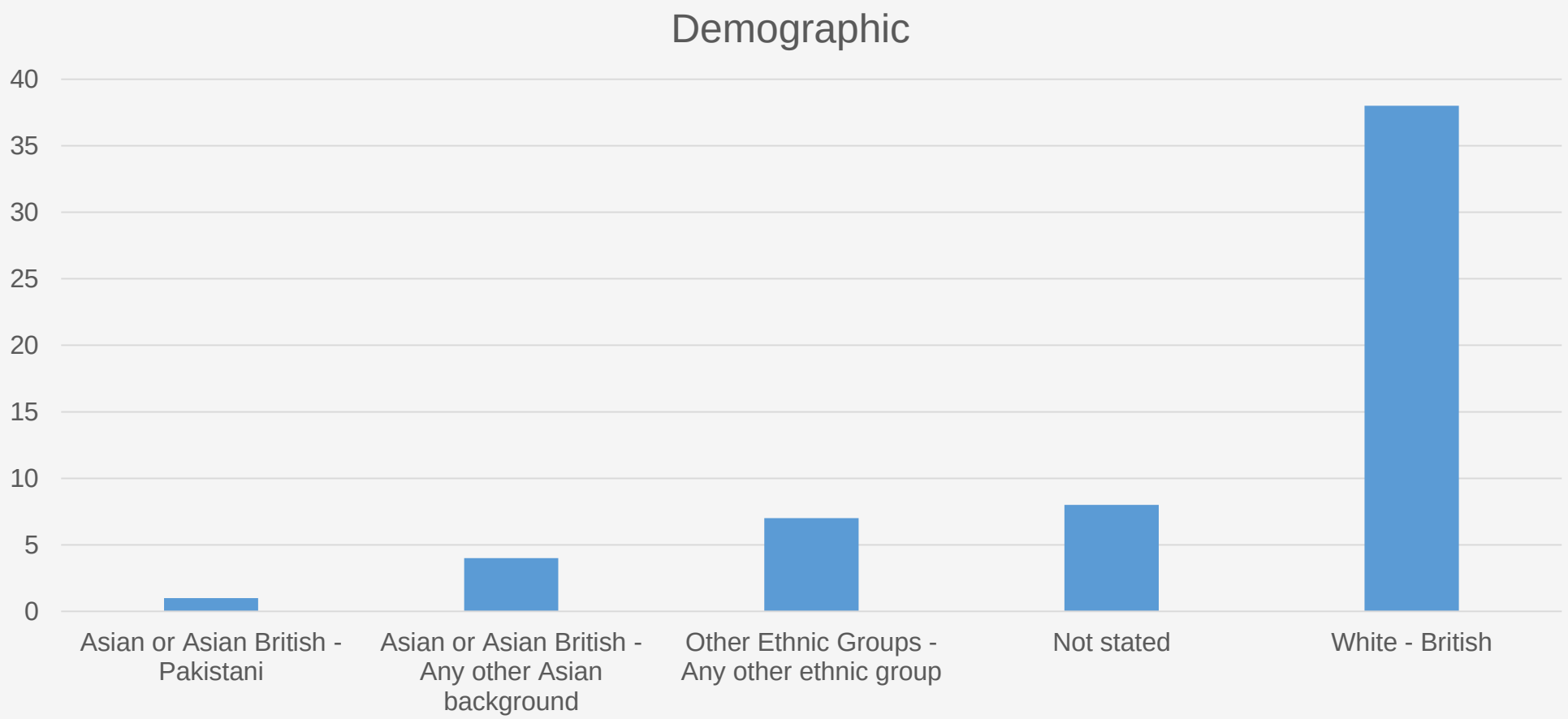

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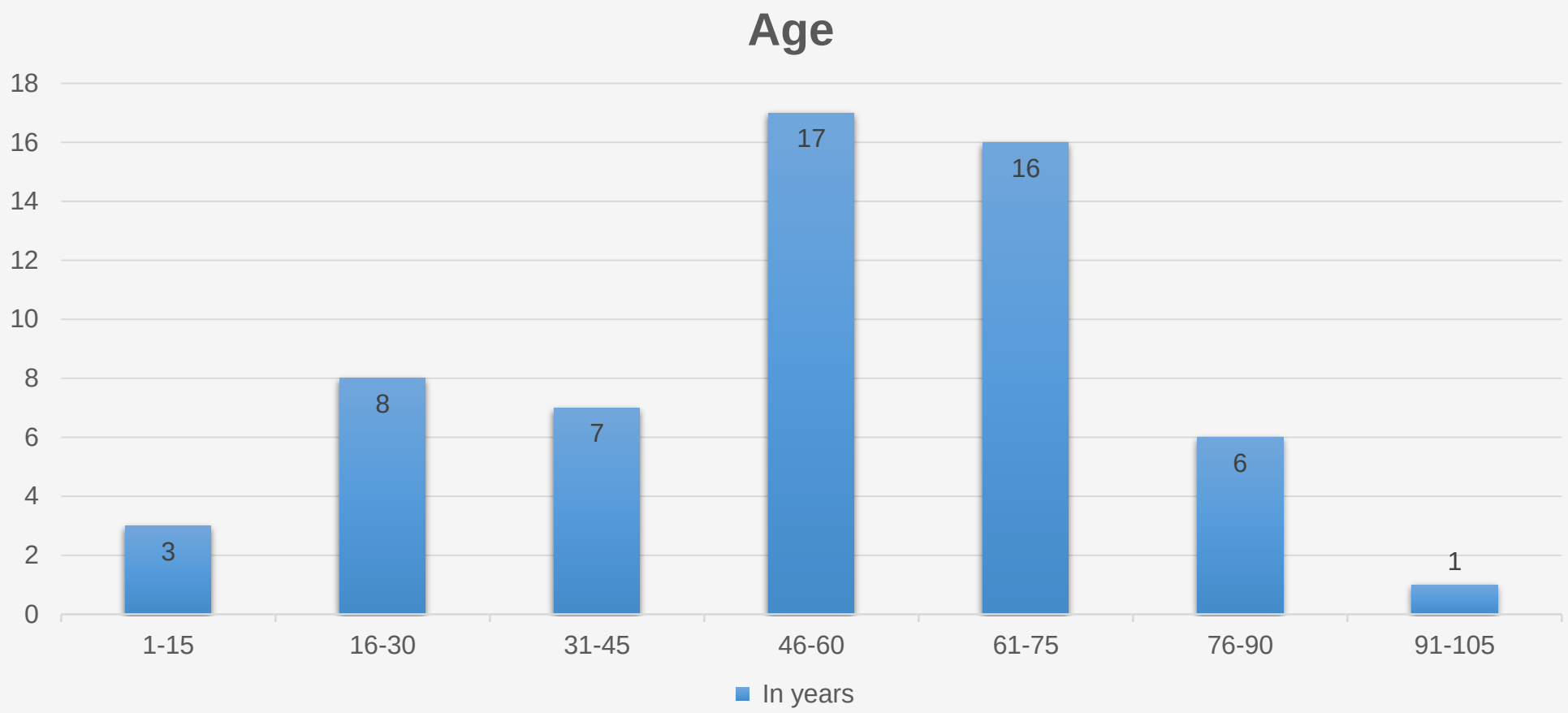

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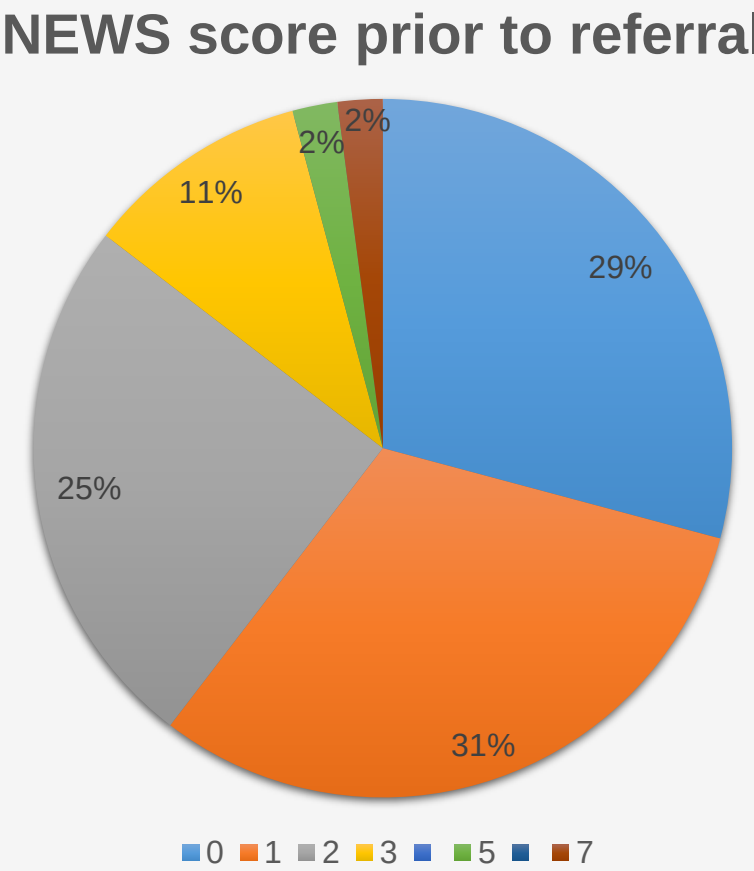

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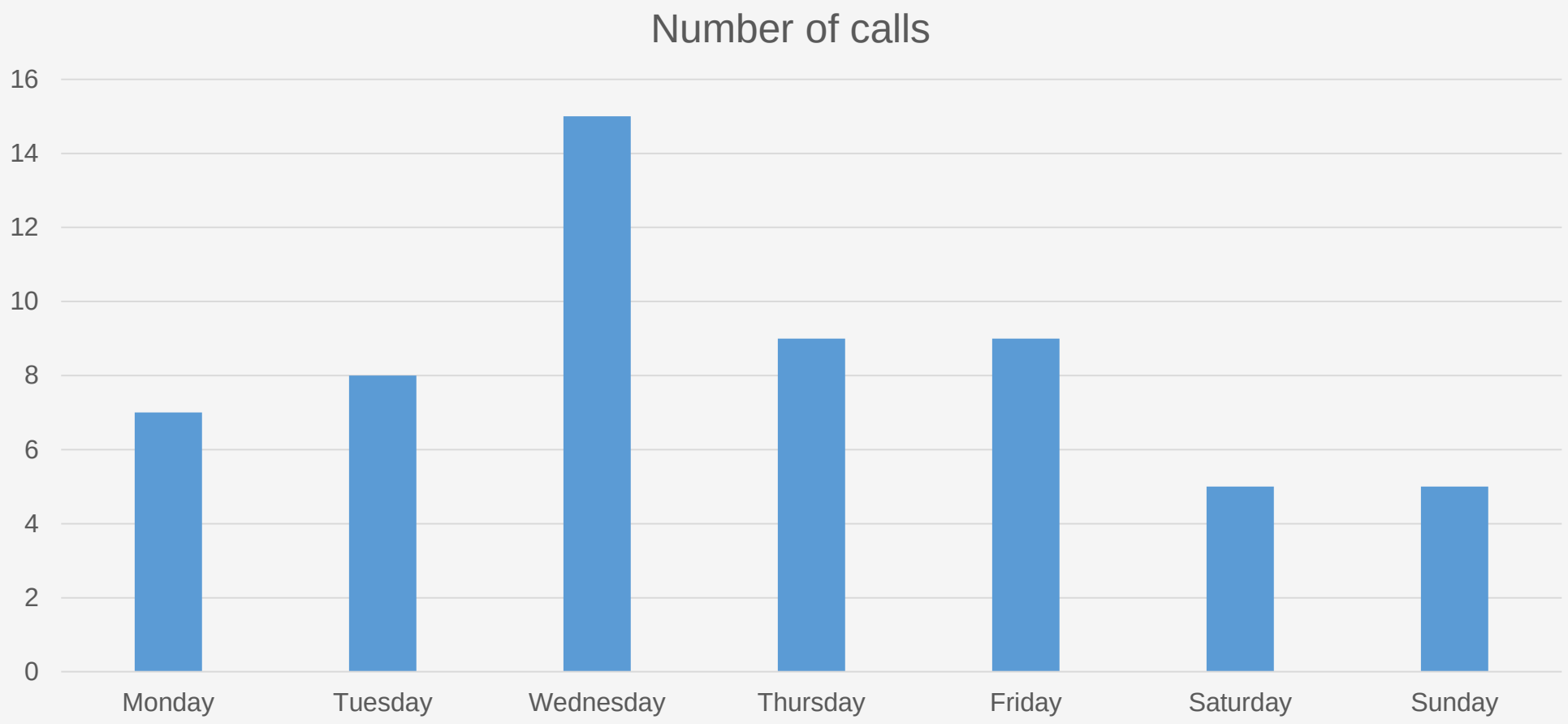

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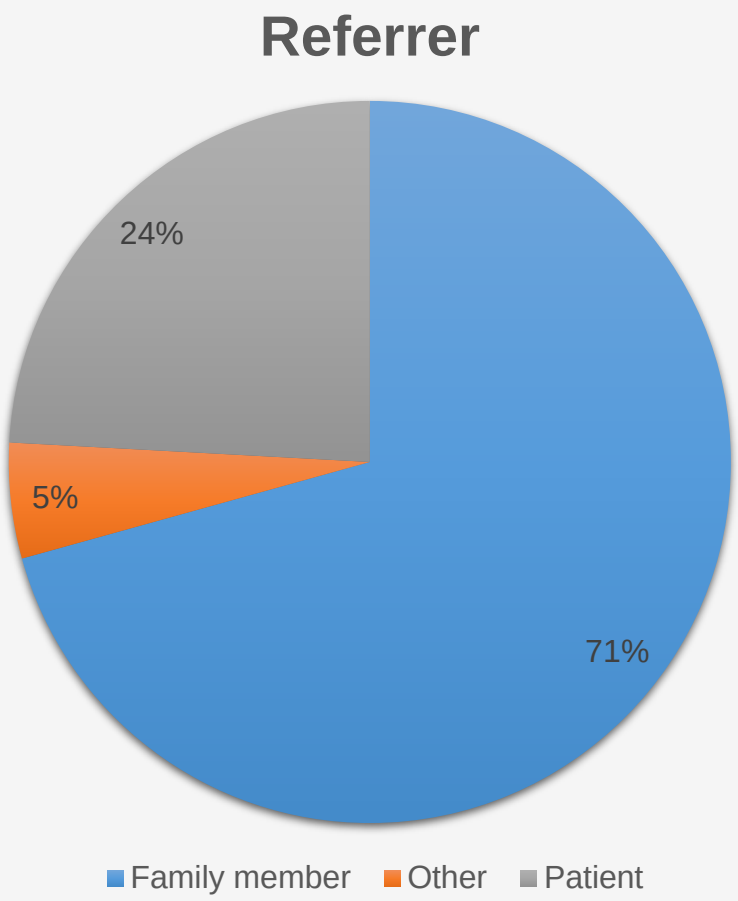

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Mother's feedback

"As parents we did not anticipate this coming, as our child has always been very fit and well. So when we were told that the operation was successful however she is recovering in ICU, It was heart breaking as we already knew that it was beyond just a key hole surgery as per plan. However we were pleased and grateful to God that the operation was successful and that she was alive….

The outreach team were excellent. Mark, Jenny were on duty when our child was transferred to surgical unit and came twice a day."

Jenny's feedback

"We are the middlemen. It is easy for us to approach the home team as we are not just coming from a place of heightened emotion. We are there to substantiate/evidence that very real clinical concern.

There are often undercurrents of power relationships and in this case it was very difficult for her as both a mother and a nurse. They are both traumatised by the admission."

The Bad

- Analysis of over 2,000 patient safety incidents found mismanagement of deterioration is the most common reason for patient safety related deaths
- 50% of my RCAs include a theme of deteriorating patients
- Despite the longevity of the scheme, it has not reached every area successfully

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Emergency Department

- **Aims**: Calls originating from the Emergency Department (ED) have been relatively low. Consequently, the Critical Care Outreach Team (CCOT) has directed efforts towards promoting the Call for Concern service in the ED to enhance awareness.
- **Methods:**
- **Posters:** Posters were introduced in the ED waiting room and each cubicle
- **Patient Leaflets:** Informative leaflets were provided in visible areas
- **Staff Education:** Staff awareness of the service was increased through educational initiatives
- **Results:** January 2024 there were 4 calls made

Challenges:

- Health literacy
- Literacy
- Accessibility
    - Translators within 24 hours
- Self-selecting group of English speakers
- Patients without an advocate
- Lack of funding

Technology

- Lack of qualitative data – QR code
    - Did patients or those close to them raise concerns?
    - Were there delays in recognition, escalation, or response to deterioration?
- Translation services
- Capturing the third component of Martha's Rule – metrics

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Summary

- Tragically there are, and will be many more Marthas
- Vital signs are not always predictive – Worry and Concern element
- Extra points in triangulation

Conclusion

It can't be used as a sticking plaster for a less positive culture – that is missing the point
Steve McManus

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