Martha’s Rule Pilot project proposal

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**Project Leads: (specify if these differ for each element of the pilot)**

[*Name of persons leading*]

[*Trust/ Site address*]

[*Contact emails*]

**Project Team:**

[*Name of team i.e. Critical Care Outreach Team/ Rapid Response Team/ Deteriorating Patient Team*]

**Summary of project**

The aim of the project is to introduce and evaluate all elements of the NHS England Martha’s Rule pilot. The pilot will focus on implementing elements two and three, this is because element one has already been established (24/7 CCOT service).

Element Two will be addressed by implementing Call for Concern**©** (C4C) [*or alternative* name] service that will provide patients and relatives with direct access to the Critical Care Outreach (CCO) team, to give patients and relatives more choice about who they can consult with about their care and facilitate the early recognition of the deteriorating ward patient.

Element Three will be addressed by implementing Patient Wellbeing checks *[or alternative method]* into routine clinical practice. This emphasises direct and routine engagement with patients and their families. This approach mandates that healthcare staff obtain information about the patient’s condition directly from the patient and their family at least once a day.

The project will be rolled out trust wide, available for all adult in-patients [*amend for paediatrics/maternity*]. There will be time allocated for planning, promoting, implementing, embedding, and evaluating. After a year of implementation, the service will be evaluated through collection of multi-faceted data and feedback.

**Introduction**

In the ever-evolving landscape of healthcare, the recognition and timely treatment of deteriorating patient remains critical to preventing avoidable deaths. In 2022, there were 251,595 deterioration related deaths in English NHS hospitals, of which around 3% may have been avoidable (Hogan, et al ,2019). A thematic review of over 2,000 deaths seen to be as a result of unsafe care identified contributary factors relating to variations in the management and monitoring of deterioration in nearly 70% of these (Donaldson et al 2014).

Much of this deterioration can be signaled in the patient’s physiological signs, such as pulse, blood pressure and respiratory rate: or symptoms, such as a deteriorating mental state (Schein et al., 1990; Bedell et al., 1991; Franklin and Mathew, 1994). Studies have reported that ward staff can often miss, mis-interpret or mis-manage patient deterioration (McQuillan et al., 1998; Smith and Wood, 1998; McGloin et al., 1999; Hodgetts et al., 2002). In order to try and address these issues, initiatives such as rapid response systems (RRS) that consist of early warning scoring and pre-emptive critical care teams, medical emergency teams and critical care outreach (CCO), have been developed and implemented in acute hospital settings (DeVita et al., 2006). However, even when these RRSs are in place, ward staff do not necessarily comply with the referral criteria protocols and continue to fail to note or adequately manage the patients’ deterioration (NICE, 2007; NPSA, 2007).

One resource in the early detection of deterioration that has been largely overlooked to date is the contribution that patients and relatives can make. The involvement of patients and their families in deterioration, recognition and escalation could address some of these professional barriers. As well as having an intimate knowledge of a patient's ‘normal’ demeanor, families and the patients have a unique and singular interest in their wellbeing that is unaffected by professional constraints (Miceli and Clark, 2005).

Recent investigations into barriers preventing timely escalation and response have pinpointed three key factors: organisation culture, professional hierarchies, and leadership dynamics within healthcare environment. These factors often lead to a reluctance to raise concerns about deteriorating patients. Addressing these barriers requires clear leadership that models multidisciplinary teamwork, values the expertise of all stakeholders, and emphasises a person-centered approach. Such leadership can cultivate psychologically safe working cultures where raising worries and concerns is encouraged and supported.

**Background**

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha’s family’s concerns about her deteriorating condition were not responded to promptly, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier. Martha’s family have dedicated their time campaigning ‘Martha’s Rule’ and collaborating to help the NHS improve the management of patients experiencing acute deterioration.

The Martha’s Rule pilot, commissioned by the Secretary of State for Health and Social Care in response to the tragic death of Martha Mills and other similar cases, aims to ensure that critical concerns from patients and those who know them best are acknowledged and acted upon. The pilot includes three key elements designed to improved patient safety and care:

1. **24/7 Access to Rapid Review:** All staff in NHS trusts must have around the clock access to a Critical Care Outreach Team for rapid review if they have concerns about a patient’s condition.
2. **Patient, Family and Loved Ones Access to Rapid Review:** Patient’s families, carers, and advocates must also have 24/7 access to a Critical Care Outreach Team, through clearly advertised mechanisms.
3. **Daily Wellness Information Gathering:** The NHS must adopt a structured approach to gather information about the patient’s condition directly from the patient and their family at least once a day. (NHS England, 2024)

The concept of ‘Call 4 Concern©’ (C4C) was introduced at the Royal Berkshire Hospital in 2009 (Odell, 2009; 2019) which was inspired by Condition H(elp) system at the University of Pittsburgh’s Medical Centre (UPMC) in the United States. Condition H(elp) was set up in 2005 (Greenhouse et al., 2006) as a result of an 18-month-old child, Josie King, who tragically died in 2001 due to hospital errors and poor communication (www.josieking.org). These systems allow patients and their relatives to directly summon the rapid response team when they have concerns about the patients’ condition.

In the UK, there have been similar tragic cases that have prompted campaigns led by patients and relatives. In 2013, Alison Phillips suffered multi-organ failure and severe sepsis, requiring emergency surgery and a long-complicated stay in intensive care. Alison’s deterioration was missed despite Alison, her family and friends all voicing their concerns. Alison Phillips survived her ordeal and now regularly speaks at patient safety conferences about her story, campaigning for patient/ relative triggered escalation. Patient/ relative triggered rapid response is being widely adopted within NHS trusts although the availability of this service varies across the UK. There is increasing recognition and recommendation for the service in several reputable publications such as-

**Resuscitation Journal, 2019: Quality Metrics for the Evaluation of Rapid Response Systems: Proceedings from the third international consensus conference on Rapid Response Systems.**

‘It is recommended that hospitals have means by which patients, family members, visitors, or others not directly responsible for a patient’s care can activate the RRT when they are concerned about the clinical status of a ward patient.’

**Intensive Care Society, 2022: Guidelines for the provision of Intensive Care service**s.

‘As part of a multi-trigger system, other triggers such as urine output/ acute kidney injury alerts, cause for concern and patient/carer Call 4 Concern, should be considered as they will enhance the recognition of the deteriorating patient.’

**National Outreach Forum: Quality and Operational Standards for the Provision of Critical Care Outreach Services**

‘A system for patient and carers (patient/family-activated escalation) to trigger a review if any concern should be implemented’.

Regular communication and conversations with patients and their families about the patient’s clinical condition can significantly aid in the early identification of deterioration. This, in turn, prompts timely prevention, identification, escalation and response (PIER) potentially preventing critical illness. Implementing these measures may deter the need for escalation by healthcare professionals, patients, or their relatives to refer to Critical Care Outreach teams. Moreover, there is clear evidence that communication failures are one of the most common reasons why patients and their relatives directly refer to Critical Care Outreach teams (M. Odell, 2019; L. Cornell & K. Datson, 2023). Therefore, improving communication between ward staff, patients and their relatives may reduce the need for secondary help, enhancing overall patient and relative experience, preventing deterioration, and reducing avoidable deaths.

Studies where patients were routinely asked about how they felt and whether they felt better or worse have demonstrated that self- reported wellness can be a direct predictor of their clinical condition. For instance, patients who self-reported feeling better tended to improve, while those who reported feeling worse often experienced clinical deterioration (A. Albutt et al, 2021). This aspect of Martha’s Rule underscores that patients know their bodies best and that relatives can detect subtle changes early in deterioration.

Although healthcare professionals routinely ask about how the patient is feeling, the aim is to formalise this process, thoroughly investigate the answers, and provide guidance on subsequence actions. It is important to note, however, that patient self-reported wellness has limitations, particularly regarding the patient’s capacity and ability to answer questions accurately. In such cases, ward staff must assess the patient’s capacity and document when wellness checks cannot be conducted, potentially relying on family input to complete these assessments. (NHS England, 2024; A. Albutt et al., 2021)

**Project Outline**

Element Two

The patient or relative/ loved one can call Critical Care Outreach directly on a dedicated mobile phone. If unavailable at that time, the referrer will be able to leave a voicemail with contact details which the team will return the call when able. When the Critical Care Outreach team receive the call, they will obtain the patient’s details, as well as a brief description of the problem. The team will then triage the call, following the referral flow chart (draft in appendix), ensuring the referrer has first contacted the ward team or signpost if a non-deteriorating call to appropriate services such as ward manager and/ or PALs. They will prioritise the urgency of the problem, the team will visit the ward to discuss the concerns with patient +/or relative and assess the situation. The Critical Care Outreach team will liaise with the ward team and other healthcare professionals as needed, ensuring a robust plan is in place, aiding communication, and clear documentation of the interactions. Patient consent must be obtained prior to communication with family/ relative, if patient lacks capacity this should be assessed and documented as per trust guidelines and communication should be directed through the documented next of kin.

Every C4C call taken will be documented on the patient’s electronic record [*amend as per system* used] regardless of whether a review was needed, or advice/signposting given to aid documentation. CCOT will document, as per routine practice, in the patients notes when a review has taken place. CCOT will also use ‘Medicus Outreach’ [*amend as per system used for CCOT data* reporting] as a secure data recording system which assists with real-time quality-indicators, in-depth data analysis and reports.

It is anticipated that ward staff may have concerns about C4C. The aims and objectives of the project will be widely disseminated before its commencement, and ward staff could be given the opportunity to raise their concerns through Q+A/ Sister’s forums etc [*add/ delete as appropriate*]. We will give staff assurance that C4C is an enhancement to patient care, and not aimed at uncovering poor practice or to undermine the parent team or overturn plans/ decisions of care.

We will evaluate and disseminate findings using the data collected, sharing with trust staff to hopefully aid engagement and support of the service. Results and themes will then be shared through the organisations governance process, with the wider organisation and with the Health Innovations Network.

**NB: -** **A referral to C4C is not an automatic request for a Critical Care admission; the referral will be taken and followed as per the flow chart attached. If the reviewed patient is considered by CCOT to require high levels of care they will be escalated to the ITU doctor as per routine process.**

Element Three

Effective communication between healthcare professionals, patients, and their families is paramount in ensuring high-quality patient care. A structured approach to achieving this involves the implementation of element three of Martha’s Rule. This emphasises direct and routine engagement with patients and their families. This approach mandates that healthcare staff obtain information about the patient’s condition directly from the patient and their family at least once a day. Studies have shown that encouraging more staff to genuinely engage with patients is crucial for improving detection of deterioration. By routinising conversations that illicit communication about changing wellness, this method fosters a more open dialogue between staff and patients. This process extends to all adult inpatient areas [*amend for paediatrics/maternity*]. Given the projects impact across all adult inpatient departments and divisions, the project owners must have comprehensive oversight. Thus, it has been agreed that this aspect of the pilot be managed by the organisations *[insert relevant team here i.e., Deteriorating Patient team and/or Quality Improvement team].*

The Patient Wellness checks will be fulfilled by completion of *[Patient Wellness Charts/ Checks/ Surveys]* available by ward staff in *[digital format/ paper format].* Patient Wellness rounds should be carried out by any of the ward clinical staff members with the patient and/or their relatives at least *[once/ twice per day].* If the patient is deemed not to have capacity at that point, a capacity assessment must be completed and documented in the patient’s notes. The Wellness Round must then be completed with the patient’s relatives. The *[Patient Wellness Charts/ Checks/ Surveys] should be [filed with the patients nursing care notes/ saved on EPR].*

As with element two, there will be a process for evaluation and reflection. This element will need to be embedded into a *[deteriorating patient audit programme].* Results and themes will then be shared through the organisations governance process, with the wider organisation and with the Health Innovations Network.

**Data Reflections and Predictions of a C4C service**

[Delete as appropriate]

*The provision of CCO service is adult based and therefore predominately practitioners are adult trained. Although all members the team are equipped to respond to paediatric emergencies, there would need to be further formal paediatric training and experience to ensure adequate competence and knowledge prior to considering offering C4C to paediatrics. And therefore, this will be taken into consideration when collating predictive activity. Provision of patient/ relative activated second review service in paediatrics will be considered by the trust separately.*

*Or*

*The provision of CCO service covers adult, paediatric and obstetric inpatients. And therefore, this will be taken into consideration when collating predictive activity.*

Volume of calls

Using other services as an example, the predicted percentage of C4C calls in addition to usual activity is between 0.8-2.13%.

[*Enter hospital/site name*] receive on average [*number of referrals*] per year. Using the data presented, we would expect to receive between [*0.8% of total number of referrals – 2.13% total number of referrals*]. Therefore, C4C would probably impact CCO on a miniscule level.

Time of day

As could be expected, the greatest number of referrals occurred during the day between 8am and 9pm, which correlates with when referrers are expected to be awake or have visitors. CCO are an established 24 hour, 7 days a week service and so would be able to accommodate referrals from patients/ relatives out of hours.

Reasons for receiving C4C referral

Data collected by other hospitals as to reasons for receiving C4C referrals were categorised into themes. For both, the most common was for clinical condition. Which fits with the aims of the C4C service. The second highest C4C category was communication issues, which was as expected.

Referral Outcomes

The majority of patients seen by the CCO teams at other hospitals following a C4C referral were discharged from their services with an appropriate plan in place. Followed by a smaller number that had interventions initiated by the CCOT practitioner that improved the patient’s condition and/or further specialist review. Only 1-3% of C4C required admission to higher levels of care. A number of patients referred, reviewed by CCOT who initiated treatments, improved as a direct result of the C4C referral.

Assessing the value and impact of C4C as a resource and service is complex and therefore it cannot be solely measured quantitatively. One of the key aims for the service is to improve patient and relative experience. Other forms of evaluation can be obtained through service user feedback. Feedback collected by other NHS trusts has been largely positive. Some typical phrases used by respondents included ‘wonderful service’,‘ listened to my concerns’, ‘kind, positive and efficient’ and ‘helped us at a difficult time’.

Other NHS trusts with C4C services reported that despite initial reservations, there has been positive feedback from the medical workforce, reporting that C4C helps them to manage patient/relative concerns.

**Project Potential Costs [outline in this section how the organisation plan to spend the £40,000 funding]**

Staffing resources -

* The CCOT are already established as a 24/7 service. If predicted activity only increases by 0.8-2.13% as predicted, this could be absorbed into current activity with little impact.
* The pilot will be funding a project manager/ data analyst to ensure efficient implementation of the project objectives [include proposed hours/ costings]

Bed Costs

* There are no anticipated additional costs for high level care beds as referral to C4C service does not equate to automatic review from Critical Care or admission to ITU. As with any referral to CCOT, reviewed patients considered to require higher level care will be escalated as per routine process.

Equipment resources-

* The CCOT will require a Trust mobile phone which can facilitate voicemail messages; this would be used to take C4C referrals. [*amend if CCOT already have trust mobile phone with appropriate facilities to receive calls and voicemails*]
* Printing of Patient Wellness Charts/Checks/Surveys

[Add if purchasing any other digital systems or equipment]

Communications/ advertisement resources [add in other ways it has been agreed to promote if that comes with an additional cost]

* There would be some costs required for service leaflets, stands, and banners. However, this virtual advertisement could be explored further.
* Service promotion will be published virtually which will be undertaken by the CCOT and trust communications team

**Monitoring and Evaluation**

Baseline Status

To effectively measure improvement and assess the impact of changes, establishing a baseline is crucial. The team have agreed on specific measures and baselines, considering current services and available data.

*[Delete/ add to suggested key measures]*

* **Staff Experience:** Use surveys to assess staff perceptions of safety culture pre- and post- change.
* **Prevalence of In-Hospital Cardiac Arrests:** Track the incidence rates to evaluate if there is a reduction post implementation.
* **Unplanned Transfers to Higher Levels of Care:** Monitor these events as an indicator of prevention of unplanned admission to Critical Care following change.
* **Incident and Complaint Reports:** Analyse reports and complaints relating to failure to rescue deteriorating patients, collaboration with patient experience teams would be beneficial.

Ongoing monitoring

Ongoing monitoring and frequent evaluation of the new services within the pilot is crucial to ensure that the service is meeting its intended goals and is on the trajectory to delivering the desired outcomes. It will help identify any issues or inefficiencies early, allowing for timely escalation, support, and solutions. Evaluating will provide valuable insights that will inform decision- making and strategic planning for the future of the service and at a national level. There will be an element of continuous monitoring to foster accountability and transparency, ensuring engagement and support from stakeholders. It will support ongoing learning and development, enabling the team and other organisations to refine and enhance the service based on evidence and feedback.

The owners of the project will be responsible for providing data, reflections, and evaluations to the organisations through governance processes. Additionally, the team will work closely with the Health Innovation Networks and Adult Critical Care Network establish a system to ensure these inputs are conveyed to the Health Innovation Networks, who will, in turn, inform NHS England on the progress on the pilot.

Element Two: Minimum Dataset

Obtaining data is crucial for analysing and evaluating the impact of the service and informing the future of Martha’s Rule pilot. There will be a standard minimum data set, which will facilitate effective comparison and analysis. NHS England will provide a required minimum data set; the list below can be used to complement any required data NHS England request. *[NHS England yet to confirm what their KPIs and dataset will be suggested measures for data collection below]*

|  |  |
| --- | --- |
| * Date and time of referral | * Date and time of response/ first review |
| * Name of referrer | * Response to referral |
| * Number/ contact details of referrer | * Asked to contact ward manager/ parent team |
|  |  |
| * Relationship of referrer to patient | * Clinical review |
| * Name of patient | * Verbal advice/ reassurance |
| * Location of patient | * Signpost to another service/ team |
| * Member of staff taken the call | * Other - add to comments |
| * Reason for referral/ concern | * Overall patient outcome |
| * Clinical condition | * Patient improved as a result of review |
| * Communication issue | * Current ward care adequate |
| * Non-clinical (parking/ visiting/ hygiene etc) | * Transfer to higher level of care |
| * Other - add to comments | * End of life care |
| * NEWS at time of referral | * ­Not applicable/ unknown |
| * Feedback survey sent + date | * Other - add to comments |
| * Date and time discharged from service |  |

Service User/ Referrer Feedback System

Assessing the value and impact of the pilot as a resource and service is complex and therefore it cannot be solely measured quantitatively. One of the key aims for the pilot is to improve patient and relative experience. Other forms of evaluation should be through obtaining service user feedback. An online survey link could be sent to the referrer’s mobile phone via text alongside a standard message following the discharge of the patient from the service. Feedback surveys could also be conducted randomly at ward level in relation to Patient Wellness Checks. Any feedback should be provided anonymously; however, recipients can be given the option to provide contact details and consent to be contacted in the future for further testimonials.

PALs may also be able to provide data on number of complaints related to clinical condition and/or communication concerns. A reduction of these complaints after the service launch will be used as an indicator for service effectiveness.

Element three: Compliance Audit

Monitoring compliance with the implementation of the Patient Wellness Rounds is crucial to ensure the practice is effectively embedded into routine care. Following the initial implementation, regular audit will be conducted to assess adherence. These audits will be carried out routinely by *[enter responsible team i.e. audit team/ QI team/ deteriorating patient team]* and will evaluate the frequency and completion of rounds as well as the appropriateness of escalation actions taken. The findings from these audits should be reported directly to the ward team and align with the trust’s governance processes. This approach not only helps identify areas needed further support and improvement but also serves as an opportunity to recognise and share instances of good practice, thereby fostering a culture of continuous improvement.

Suggested measures of audit -

* Has the Patient Wellness Round been completed at least once a day? (Y/ N/ NA)
* If no, how long since the last Patient Wellness Round been completed?
* If NA, why was it not completed?
* Was the Patient Wellness Round completed with the patient or relative?
* If not the patient, why?
* If the patient did not have capacity at the time of the Patient Wellness Round, was this formerly assessed and documented in the patients notes?
* What was the NEWS 2 score at the time of the Patient Wellness Round?
* What was the Patient Wellness score?
* Was the total Patient Wellness score calculated correctly?
* What was the level of escalation (Green, Amber or Red)?
* Was the correct escalation pathways follow as per trust protocols and matrix?
* Was the Patient Wellness Round fully completed (no gaps)?
* What position was the person completing the Patient Wellness Round?

Deep Dive Audit

Conducting deep dives into specific cases will provide invaluable insights into the patient’s clinical condition in relation to their self-reported wellness score. This analysis may help identify whether there is a link between self-reported wellness as a predictor for deterioration. It will also clarify the escalation processes in response to concerns and interventions carried out, highlighting cases where the wellness round prompted timely escalation and intervention, potentially preventing further deterioration, or facilitating early access to higher levels of care. As with any clinical audit, the process should identify areas needed further support and improvement but also serves as an opportunity to recognise and share instances of good practice, thereby fostering a culture of continuous improvement.

**Criteria for deep dive audit -**

Patient Wellness score >6 Escalation Pathway >Amber

Suggested measures of audit -

* Compliance audit as above
* Patient demographics (age/ sex)
* Ward (Medical/ Surgery/ Acute Assessment/ Respiratory/ Liver/ Oncology etc.)
* Outlier bed (Y/N)
* Date of hospital admission
* Reason for hospital admission
* Previous high NEWS >5 (Y/N)
* If yes, what was the previous high score?
* Escalation plan in place (Y/N)
* If yes, details of escalation status (full escalation/ treatment limitations)
* DNACPR status
* Was the appropriate healthcare professional escalated to within 1 hour of the Wellness Round score? (Y/N/NA)
* If no, provide details
* What grade/ speciality was healthcare profession that was escalated to?
* Was the patient reviewed by the appropriate healthcare professional within 1 hour of the escalation? (Y/N/NA)
* If no, provide details
* What grade/ speciality was healthcare profession that reviewed the patient?
* What interventions were carried out following the review?

|  |  |  |  |
| --- | --- | --- | --- |
| Bloods | | Medication (details which) | |
| ECG | | Oxygen | |
| Xray chest/ abdo/ pelvis/ limb | | Transfer to another ward (details which and why) | |
| ABG/VBG | | CT head/chest/thorax/abdo/pelvis | |
| Referral to another speciality (detail which) | | Review of escalation plan | |
| Patient/ relative update | | Review of resuscitation status | |
| Other (further detail) |  | |

* NEWS score following escalation, review and interventions
* When was the next Patient Wellness round completed (minutes/hours)?
* What was the Patient Wellness Score on the next round?
* Did the patients clinical condition improve following these events? (Y/N/NA)

If no, what else was done?

**Discussion**

Implementation of change initiatives are notoriously challenging within health care. Multiple factors can influence the success of changes, including leadership, motivation, timescales, organisational cultures, and finance, among others (Carvalho et al, 2019; NICE, 2023). For healthcare-based change initiatives to succeed, it is vital to ensure there is a shared vision throughout the organisation, preventing resistance from members of the workforce that may jeopardise the success of the project (Ogbonna and Wilkinson, 2003).

Predicted activity is based upon data provided by other hospitals, however this may differ due to local demographics, organisational, structural, and cultural factors. Despite these potential limitations, the evaluation of the service is mirrored by others who have either studied this type of service or have adopted it within their own trusts, who agree that services such as C4C are essential tools that enhance patient safety (Miceli and Clark, 2005; Greenhouse et al, 2006; Ray et al, 2009; Vorwerk and King, 2016; Odell, 2019; Bucknall et al, 2021; Cornell and Datson, 2023).

**Conclusion**

Martha’s Rule is a crucial component of the NHS Patient Safety Strategy (2019), which aims to continuously improve patient safety by building on the foundations of safe cultures and safer systems. The strategy intends to support staff and providers in sharing safety insights and empowering patients and staff with the skills, confidence and mechanisms needed to enhance safety. Getting this right, the first time could save lives and alleviate financial burdens on the NHS. The pilot aims to provide valuable insights, foster involvement, and drive improvement by engaging all key stakeholders, including local ICBs, organisational executive teams, services leads, healthcare professionals, and importantly, patients and their relatives. This collaborative approach is essential for creating a safer healthcare system and leading the advancements of safety practices throughout the NHS nationally.

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Call 4 Concern Referral Flow Chart

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Take referral from caller:

 Name of referrer

 Contact details of referrer

 Relation of referrer to patient

 Location of patient

 Brief description of concerns

**Have these concerns been raised with the ward or parent team yet?**

 Advise referrer to contact ward team.

(Contact details overleaf)

 Update nurse in charge

 Make entry on electronic record for the patient

Yes

No

Is the concern related to a patient’s clinical condition and/or unclear plan of care?

Yes

No

If the concern is regarding unresolved non-clinical issues, consider signposting to PALS

[Add PALS telephone number and email]

 Update nurse in charge

 Make entry on electronic record for the patient

Assess whether-

Telephone advice

OR

If a physical review is needed

Inform the referrer of your plan

Advice Only

Physical review of patient

Establish consent from patient to disclose information to C4C referrer.

If patient lacks capacity to consent, ensure you are speaking to the documented NOK.

(If C4C referrer not NOK, direct them to discuss concerns with NOK first.)

Once advice given please ensure you;

 Call nurse in charge on ward to update them

 Make entry on electronic record for the patient

 Enter details on CCOT data system

 Give C4C referrer the link to provide feedback, either via text or email (use work phone)

Establish consent from patient to disclose information to C4C referrer.

If patient lacks capacity to consent, ensure you are speaking to the documented NOK.

(If C4C referrer not NOK, direct them to discuss concerns with NOK.)

Conduct a physical review of the patient, review of notes and investigations. Complete the following action points:

 Document review and findings in medical notes

 Update nurse in charge

 Update C4C referrer

 Enter details on CCOT data system

 Give C4C referrer the link to provide feedback, either via text or email (use work phone)

If patient is in maternity/paediatric redirect to appropriate team

[delete if CCOT cover obstetrics/paediatrics]

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