Introducing Being Open
Maternity and neonatal services in NHS Lothian have been chosen to lead national work to improve communication with patients and families about adverse events. A one-year pilot project is looking at how best to implement the national guidelines in *Being Open: Communicating patient safety incidents with patients, their families and carers*, NPSA, 2009.

In particular, the pilot is developing and testing sensitive and effective processes for engaging with patients/families and a communication training model for staff.

The pilot is being funded by Healthcare Improvement Scotland (HIS) and the project findings and resources will be shared locally and nationally.

Progress report
So far we have:
- Held focus groups and interviews to identify issues to be addressed in the training and process redesign work. We have drafted a report on this scoping work and circulated it to the staff and patients who participated for sanity checking.
- Developed an evidence-based process for communicating with patients and their families about adverse events
- Started testing aspects of the process using service improvement methodology (small tests of change).
- Organised two initial multidisciplinary communication workshops to develop the format and content of the training.
- Drafted a patient information leaflet about adverse events and the review process and circulated it to patients for their feedback.

Testing and learning
We are testing our evidence-based process for communicating with patients and their families about adverse events using service improvement methodology (small tests of change). Here are two examples of the tests we have run in neonatal services. There have also been tests in obstetrics.

Explaining the review process
The draft process involves having a ‘personal conversation’ with the patient and family to express concern, explain the review process, invite questions/concerns to be considered in the review and agree arrangements for keeping in touch (including the appointment of a member of staff to act as the key contact during the review process.)

In an early test of the ‘personal conversation’, a Neonatal Consultant had a personal conversation with a bereaved mother. As the parents left hospital quickly after the death of their son, this test conversation took place by phone rather than face-to-face in the hospital.
The phone call was well received by the bereaved mother.
The consultant’s question about how the woman was doing elicited the response that she was very confused by the information (including a pathology report) from various sources. The consultant arranged for her to have an immediate appointment with an Obstetrician rather than waiting for the usual 6 weeks. This appointment allowed the Obstetrician to reassure the woman that the adverse event wouldn’t affect her ability to have another child.
The mother didn’t have any immediate questions for the review but thought that she might think of something later.

**What did we learn from the test?**
- The mother wasn’t able to think of any questions immediately. In future we will reassure patients that we don’t expect them to come up with questions right away and that they can take time to think.
- The Consultant noted that the parents were not sure who to go (GP? Health Visitor? Hospital?) if they had general questions.

**Supporting staff**
We know that adverse events cause distress to staff as well as to patients and we have been testing whether getting staff together before the end of the shift to talk about what has happened is a useful form of support.

- Following the traumatic and unexpected death of a baby, the lead Neonatal Consultant arranged for all the staff to sit down together in a room on the unit.
- The Consultant hadn’t expected to be involved in testing this kind of staff debriefing session and didn’t follow a specific format, but previous discussions with colleagues about the principles informed her approach.
- Staff said afterwards how much they had appreciated the debriefing session.

**What did we learn from the test?**
- The meeting didn’t take very long.
- An informal approach seems to work well – simply getting everyone together before the end of the shift, thanking staff and asking them how they are.
- The Lead Consultant felt that it was easier to go back to the staff involved and ask them how they were because they had shared in the immediate brief.

**What next?**
The next things for us to do are to:
- publish the final version of the report on the initial scoping work on the Being Open Intranet page.
- carry out further tests of the process within maternity and neonatal services.
- test whether the process for engaging with patients and families is transferrable to a different setting – Medicine of the Elderly at the Royal Victoria Hospital.
- run three more communications training workshops in Feb/Mar.