Being Open: Communicating well with patients and families about adverse events

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Edile Murdoch
Project aims

• To develop and test **sensitive, effective and reliable processes** for communicating openly with patients and families about adverse events and involving them throughout the review process.

• To develop and test a **model of clinical communication training** that enables staff to have effective, supportive discussions with patients and families and within their teams.

• To inform discussions nationally on the **scalability** of a training package across boards in Scotland and the infrastructure required at a local and national level.
Feedback 1

We were really impressed by the way the hospital handled things afterwards - they were all upfront and honest, they weren’t trying to hide anything that had gone wrong, so it was really good. They were really honest, and that’s all we really wanted from it.

[Patient]
I think patients and families find it very positive, which is bizarre when it can be something very negative that’s happened to them. But from my experience, they don’t expect you to be so honest and open with them and when you are, I think they truly value that, and I think they trust you more because they feel you’re not hiding anything from them. I think that’s key, that they don’t think anything is being kept from them.  

[Midwife]
Feedback 3

My impression is, very, very positive, very positive actually, and certainly, looking at how people are now, there’s a big difference in how people are compared to a year or two ago, and I’m sure this is part of it, I’m sure its not the only factor but I think it’s a big part of it.  

[Senior Manager]
Feedback 4 (Staff)

• It enables the team to work better together and I think that’s one of the main things - people talk to each other more – whereas I think in the past when an incident happened it would be some time, and then we would think, right, what will we do, who will do it – I just think it works more cohesively.

• I’ve definitely seen a more honest and open approach.

• The permission to say “sorry”, it’s OK, it doesn’t mean you’re admitting any error has made it easier to say “sorry”.
Methodology

Scoping

Training

Process
Building blocks

- Reliable adverse event review process
- MCQIC / SPSP – culture survey work
Adverse event review process

- Reviewed / developed 2012
- Support from senior management / Quality Improvement
- Reviewing adverse events is ‘routine’
- Weekly case review (3.5 hours)
- Multidisciplinary
- Training
- 12 Chairs
Maternity & Neonatal Services Datix Management System, Adverse Event Review Process & Learning

Local Reporting on Datix

All Datix Management Process

Maternities & Neonatal Services Datix Management System, Adverse Event Review Process & Learning

MDT Triage Risk Review Meeting

Mother

PPH > 2500mls, Hysterectomy Ruptured uterus, ICU Admission, Unplanned return to theatre, Eclampsia

Baby

Hypoxic-ischaemic encephalopathy Grades II and III
Unplanned term admission to NNU – needing ventilation or fluid resuscitation

Death

Still Births, Neonatal deaths

Confidential multi-disciplinary review

Team:
Consultant obstetrician, consultant neonatologist, clinical manager (one of these three acts as Chair)
Consultant anaesthetist, SPSP midwife, charge midwife, SoM, risk manager

Suggested minimum attendance = 1 midwife (NOT SoM) + 1 consultant obstetrician + 1 consultant neonatologist + 1 consultant anaesthetist.

Timetable of attendees to be compiled in advanced and Chair agreed.

Pre-work

• Case listing is compiled by risk manager

• Notes made available and demographics completed by admin staff

Meeting

• Pause at start to ensure (i) all clear on who is present & in which role and (ii) for any involvement in any of the cases to be declared.

• Timeline and brief summary of the case is prepared and allocated to team member(s)

• Only review team members to be present.

• Discussions are confidential

• Standard template to be completed by nominated scribe

Key questions are:

• Are there any care deliver problems that required further investigation?

• What is the key learning?

Maternity TRAK

Women's Clinical Governance

- Trend data – reviewed by Women’s Clinical Governance.
- Random samples (e.g. Reviewed through SPSP Programme.

Women's Healthcare Governance Group

Themes & quarterly risk management reports

Key messages into safety brief
(Weekly)

Chairs/RM

Link to improvement & teaching programmes

- use cases as examples (Weekly)

Chairs/RM

Individual feedback (Weekly)

Educational supervisor/SoM/Line manager

21 October 2014

Full Investigation

As per NHS Lothian policy

Lead commissioned NHS Lothian template completed

If Yes, risk manager & chair to email chief midwife/clinical director/AMD/GM

If investigation is needed:

GM – General Manager

AMD – Associate Medical Director

Yes

No
Scoping

Consultant Obstetricians

Hospital Midwives

Service Managers

Consultant Neonatologists

Community Midwives

Consultant Anaesthetists

Junior Doctors

Hospital Chaplains
Scoping

Someone letting you know, rather than you chasing information is needed ... We said we would like to review what had happened to our baby, we initiated it, and we’ve only just got answers two years down the line. It’s been a long, long, unacceptably long time, if I’m honest.

[Patient]
Scoping

Once the family have gone home, it’s not clear who continues that communication so potentially they do go home and it could be six weeks of silence – or it could be a lot longer – six weeks would be the minimum.

[Consultant]
Scoping

Often you do hear it from the women in the first instance, because you are debriefing on the first visit on how the whole event has been and that can be quite embarrassing. Unfortunately we don’t always know, and I go in feeling very vulnerable and shocked because actually nobody told me.

[Community Midwife]
Training – Feedback 1

The training was really helpful in terms of giving you an opportunity to think about even the small nuances of things that you say routinely – so it did make you sit down and reflect about the kind of language that you use, so that was really helpful.
Training – Feedback 2

I feel I’ve always been a team player but I think it just really brought it home to everybody that we all need to be together as a team, definitely – one person can’t do it on their own – that was the big impact for me.
Training – Feedback 3

Because you do the course together - the fact that we were working with the medical staff - courses like that help, and they break down barriers.
Training - What surprised participants most?

How involved in the scenario we got.

How many staff members, including senior management, find the same things difficult!

People don’t respond in the way you think they will.

How subtle changes in language can have a profound effect on patients.
<table>
<thead>
<tr>
<th>Key steps</th>
<th>Key staff</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Rapid initial communication with patient / family</td>
<td>Most senior health professional available</td>
<td>ASAP ≤ 1 hr</td>
</tr>
<tr>
<td>Early staff co-ordination &amp; support</td>
<td>Co-ordinated by senior clinician on duty</td>
<td>≤ 18 hrs</td>
</tr>
<tr>
<td>Early support and information for patient and family</td>
<td>Senior clinician</td>
<td>≤ 7 days (or before discharge)</td>
</tr>
<tr>
<td>Initial engagement of patient and family with review process</td>
<td>Led by senior clinician + support staff (eg midwife)</td>
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<tr>
<td>Ongoing support and involvement</td>
<td>Nominated key contact</td>
<td>3-4 months</td>
</tr>
<tr>
<td>Sharing findings of review</td>
<td>Senior manager &amp; 1-2 consultants (review lead, key contact, minute secretary)</td>
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Rapid initial communication

<table>
<thead>
<tr>
<th>Communication</th>
<th>Documentation</th>
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<tr>
<td>• Express regret / concern</td>
<td>• Update patient record</td>
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<tr>
<td>• Share known facts</td>
<td></td>
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<tr>
<td>• Avoid blaming anyone</td>
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<tr>
<td>• Explain update will follow</td>
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# Early staff co-ordination / support

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<th>Communication</th>
<th>Documentation</th>
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<tr>
<td>• Arrange staff support debrief</td>
<td>• Update patient record</td>
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<tr>
<td>• Establish unified summary of event</td>
<td></td>
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<tr>
<td>• Alert clinical manager on duty</td>
<td></td>
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<tr>
<td>• Alert community health team</td>
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<tr>
<td>• Provisional choice of key contact</td>
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Early support and information

<table>
<thead>
<tr>
<th>Communication</th>
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<tbody>
<tr>
<td>• Express regret / concern</td>
<td>• Update patient record</td>
</tr>
<tr>
<td>• Share updated information</td>
<td></td>
</tr>
<tr>
<td>• Outline next steps</td>
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### Initial engagement about review process

<table>
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<tr>
<td>• Express regret/sympathy/concern</td>
<td>• Update patient record</td>
</tr>
<tr>
<td>• Explain review process</td>
<td>• Update review record</td>
</tr>
<tr>
<td>• Provide leaflet</td>
<td>• Letter to patient/family summarising meeting</td>
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<tr>
<td>• Ask about initial thoughts / concerns for review to consider</td>
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<tr>
<td>• Agree plan for keeping in contact</td>
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Ongoing support and involvement

<table>
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<tr>
<td>• Check ongoing support needs</td>
<td>• Update patient record</td>
</tr>
<tr>
<td>• Signpost to sources of support</td>
<td>• Update review record</td>
</tr>
<tr>
<td>• Check for new questions/ concerns</td>
<td>• Email any questions from patient/family to</td>
</tr>
<tr>
<td>• Discuss preferred feedback from review</td>
<td>review co-ordinator</td>
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Effective Communication for Healthcare

NHS Lothian

Healthcare Improvement Scotland
# Sharing findings of review

<table>
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<tr>
<th>Communication</th>
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<tr>
<td>- Discuss report findings and any questions/concerns</td>
<td>- Update review record</td>
</tr>
<tr>
<td>- Discuss any ongoing support needs</td>
<td>- Copy of final report to patient/family</td>
</tr>
<tr>
<td>- Discuss improvement plan / next steps</td>
<td>- Letter to patient summarising meeting</td>
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Resources

- Communication guide
- Patient leaflet about adverse event reviews
- Intranet
We’re much more open with the women about the SAE review process – we tell them it’s happening for a start, we don’t just do it and then whatever the results are, if it’s going to go to investigation or whatever, then tell them. We tell them it’s part of the process to find out what we could have done differently, better, or whatever, and they get a copy of that, they’re actually totally part of the process – I think that’s a very positive thing.

[Midwife]
It’s nice to have such a clear structured technique so that you know exactly what you’re saying to the parents about where the follow-up will be, so I think that’s definitely an improvement – there’s no ambiguity – it’s a very clear process that’s easy to communicate, and in some ways that helps with, sort of, wrapping up a meeting, which is sometimes a bit difficult.

[Consultant]
Learning points – Cultural change

• Implementation was an enabler for culture change

• Co-production – initial scoping work and involving staff in developing the training scenarios

• Quality improvement methodology crucial ... but resource intensive

• Convincing staff of value of a systematic and reliable process

• Conversations about adverse events are part of good clinical communication
Learning points – Infrastructure

• Single point of contact for patients & families – ‘Key Contact’
• Established process for managing adverse events
• Co-ordinator for adverse event reviews + communication with patients and families
• Using local systems for documentation and communication
Learning points – Staff support

• Establish trust of staff - to share sensitive information and experiences during focus groups and testing
• Specialist communication training – to build confidence and competence
• ‘Being Open’ Communication Guide
• Early debriefs after distressing events
What’s different about this project?
Key ingredients

• Health board buy-in
• Engagement of whole service
• Project team
• Understanding staff and patients views / needs
• Training
• 18-24 month project
• Sustained delivery group
Being Open ... in practice

When it came to the review feedback meeting I thought the parents could potentially be angry because they were aware that there was a delay in intervention prior to delivery, due to high levels of activity.

In fact they were pleased to have had a chance to read the report in detail prior to our meeting. Their questions were very focused and easy to answer. And they were pleased that we had been open and honest with them.

[Senior Consultant]