Effective Communication about Adverse Events in Maternity Units

A guide to talking with parents, families and staff
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Being open about adverse events means sharing information about what happened and why, what was done or not done, and acknowledging the effects of those actions. Sharing information in supportive and effective ways helps everyone involved adjust to what happened and its impact.
Introduction

• This is a Guide to communicating in supportive and effective ways with parents, families and staff when an adverse event happens and throughout the subsequent review process.

• We have defined an adverse event as a situation where the outcomes of treatment and care are unexpected and unwelcome. This includes any such events and not just those where ‘avoidable harm’ occurred.

• A significant adverse event (SAE) is one where major harm or death has occurred.

• The content of the Guide is based on a number of sources:
  - Research and clinical practice evidence about effective communication
  - Good practice recommendations from Healthcare Improvement Scotland and other organisations
  - Focus groups and interviews with parents, families and staff
  - Simulation workshops with members of the multidisciplinary team
  - Structured testing in clinical practice with feedback from parents, families and staff

• The Guide aims to help all members of the multidisciplinary team work together to improve the way we handle these potentially difficult conversations and discussions.

• Each stage of a person’s care journey affects what happens next so the Guide is laid out in chronological order.

• Key goals are described with suggested ways to address these. The words and phrases included are suggestions that must be individualised and used sensitively, effectively and in the right context. Everyone is different and there are many effective ways to communicate. Approaches that may be less helpful are also highlighted.
Shared decision-making about treatment and care options

- Ongoing, shared decision-making discussions are important throughout pregnancy, delivery and in the postnatal period.
- People need to be prepared for unexpected events and decisions that may be needed as a result of a change in the health of the mother or her baby.
- Effective shared decision-making reduces the risk of later regrets about treatment choices.
- Fundamental to the relationship between people receiving care and professionals is the requirement that each person with capacity to decide must be informed about the available treatment options, the risks and benefits of each option and be supported to make their choice about which option meets their needs.
- Helpful approaches to shared decision-making include:
  - Personalised information in accessible formats
  - Shared decision tools and resources, including pictures and diagrams
  - Written summaries and recordings
  - Asking people to summarise what they have understood about a decision and the available options in their own words.

Shared decision-making interview

- Build a relationship of trust and encourage participation and partnership.
- Check what the people involved know and understand about the situation and any decisions to be made.
- Find out how much information is needed and think about how best to present it.
  - Is there a decision aid or tool available for this situation?
- Clarify the roles and responsibilities of those involved: the expectant parent(s), wider family and the professionals.
- Find out about the person’s goals, values and preferences, expectations and everyone’s understanding of the decision and the options. What is most important for this person at this time and in the future?
- Provide tailored information and evidence applicable to this individual.

Remember Chunks + Checks with Pauses

- Discuss the available options, including no treatment/ action, or making a decision later.
- Discuss the benefits and harms of the options, and how likely they are to occur.
- Check understanding and address any further questions/concerns.
- Offer appropriate recommendations or explain the need to take “best interest” decisions informed by clinical judgment and known personal preferences if for any reason the person later lacks capacity for a decision.
- Agree a decision and a clear action plan; offer further resources/ information
- Ask them to reflect again on the personal/ family impact of their choice(s) and any likely complications; confirm the decision and their understanding; make follow-up arrangements.

Talking about decisions that might need to be made in advance and providing information about options, risks and benefits supports effective shared decision-making.
Rapid initial communication with the mother/ family

As soon as a potential adverse event is identified, treatment and care are likely to change and these changes should be shared with the mother/ family.

- Explain changes in the care plan, the reasons and next steps, in a timely way.
- It is better if one professional takes the lead in sharing this information and helpful to introduce yourself by name, use people’s names when talking with them and maintain good eye contact (eg in theatre).
- Share information about what is known so far; acknowledging uncertainty. It is better to say that we do not know yet than ‘I cannot answer your question.’
- Explain when more information will be available, and from whom.
  ✓ It is difficult to know yet what will happen but as soon as (professional’s name) comes back they will be able to tell us more.
- Offer support and respond to emerging questions and concerns while also giving clear instructions about the need for action to protect the health of the mother and baby.
  ✓ We don’t know how (your baby/baby’s name) is yet, he is (say where) which is the best place for him just now. The team are giving him all the care he needs.
- AVOID premature reassurance. It is better to talk about what is happening and what we are doing about it.
  ✓ I hope he will be alright but we’re not sure what the situation is yet.
- Ensure all professionals use clear, focused communication with the mother / family and each other.

If the event involves harm to the baby:

- Talk about the baby in a personal way and use the baby’s name if the parents have chosen one (your baby, your son/ daughter).
- Keep the parents informed about how their baby is doing and explain what treatments are being given and why.
- It is helpful to tell the parents what to expect when they see their baby. AVOID evaluative descriptions of the baby’s appearance (eg big, beautiful) before the parents have seen their baby as some parents may feel they have a loss of ‘ownership’ of their child.
- If the baby dies or is stillborn, we care for and speak about and to that child as we would a live born baby.

Effective escalation and professional communication: urgent ‘SBAR’ discussions

Being able to identify when additional support, expertise and advice is needed is essential for all staff. A structured handover of key concerns and a clear request for help is important.

Before calling a senior clinician, have all the relevant information available.

S Situation
- Identify yourself and the site/unit you are calling from; say what time it is.
- Check you have the right senior colleague; PAUSE (The senior clinician may be asleep or busy and needs a few minutes to focus on your call.)
- Identify the patient by name; briefly summarise the specific clinical situation including key information such as age, treatment, vital signs.
- Describe your concern and say what help you think you need and how urgently; PAUSE
- Enable the senior colleague to build up a rapid picture of the situation. (Allowing the senior to ask questions about the Background & Assessment can be quicker and more effective, particularly in a phone call.)

B Background (may include)
- Reason for admission.
- Significant medical/ obstetric history.
- Diagnosis, date of admission, prior procedures, current medications/ treatment, allergies, laboratory/ monitoring results and other relevant diagnostic results.

A Assessment
- Vital signs, monitoring, blood loss etc.

R Recommendations:
- Agree what needs to be done now.
- Clarify who will do what, and how they will do it.
- Agree the next steps/ review plan.
- Check relevant contact details are correct (bleep/ phone number/ ward number).
- Document the plan.
Early co-ordination and staff support

When – during or before the end of a shift (allow about 10 minutes).
Why – supports staff after a stressful incident/ episode of care.
Who – led by a senior staff member; all staff involved take part, if possible.

Goals

• Offers early support and a short debriefing opportunity for the staff directly involved in the event. Make sure everyone knows each other at the start.
• Allows everyone to be part of sharing the feelings of concern and distress that will affect the whole team and start to support each other. Try not to focus attention on any one individual team member or they may start to feel they are most at fault.
• Gives staff an opportunity to start to raise areas for improvement (listen and acknowledge these but don’t probe or start to evaluate what happened).
• Helps make sure that all the team members involved in the event are identified for support and later feedback about any future review.
• Senior staff can give additional, immediate support to anyone who needs it and check everyone is OK to continue working now/ on their next shift:
  ✓ Thanks for joining in this brief review and for all your efforts to work as a team.
  ✓ First of all, I/ we just want to find out how everyone is…
  ✓ It’s been a very difficult/ stressful shift for us all…. We’ve been looking after a mother who/ a baby who…. The baby/mother is (give a brief summary of how they are now).
  ✓ It’s important for us to make sure everyone is OK …. How is everyone feeling?
  ✓ Does anyone have any initial thoughts they’d like to share at this stage….? 
  ✓ That’s a good point; it might be important for us to look at … a bit more.
  ✓ Things didn’t work out the way we expected/ hoped so we’ll need a review of the care of (names of mother & baby) …. Are there any safety problems we need to deal with right now?
  ✓ We’ll make sure everyone gets the feedback from the case review and if we do go on to a full review – what that shows. Is there anyone else who should be included?
  ✓ I’m staying around if anyone wants to speak to me now or later on.

Medical/ nursing staff follow-up

Ongoing, informal mutual support at work helps. (How are you doing…?)
Offer opportunities for informal individual discussions with senior team members.

Different disciplines will have their own arrangements for following up junior staff. For medical trainees, consider a planned, case-based discussion at 4-6 weeks. This should be a private meeting with their supervisor and have a clear agenda stated at the start.

Aim: to offer the person support and to review what happened together by looking at what went well and what can be done differently and learnt for the future.

• Acknowledge this was a difficult experience for this person and the wider team.
• Explain the purpose of this meeting is to review the case with them, hear about any concerns or questions they have and plan the next steps.
• Check if they know how the mother and baby are now. If not, update them.
• Find out what the person is thinking and feeling now about what happened.
• Ask if there are specific aspects of what happened they’d like to discuss.
• Share the multidisciplinary team review findings in chunks with pauses to allow a response, outlining what ‘went well’ first.
• Ask what ideas the person has about improvement/ learning for the team or themselves. Ask what you can do to help or support them with this.
• Talk about positive attributes this person brings to their role and a plan for them to return to work or be supported at work.
• Agree and document an action plan and when there will be a review of this plan.

“Because we’d talked about how we were all feeling before the shift ended, it seemed quite natural to ask people how they were doing when I next saw them.”

Senior Consultant
Chairing case review meetings

**Aims**

- Constructive and effective review of the whole patient journey, treatment and care; gather available data and perspectives, identify gaps in information.
- Identify and address any urgent clinical risks and staff support/ training needs.
- Decide whether a formal SAE Review is needed.

**Structure**

- Chaired by a senior professional who is:
  - In a leadership role and has experience of chairing meetings
  - Responsible for directing the structure and conduct of the meeting
- The chair makes sure that all participants are aware of the structure of the meeting and their responsibility for contributing effectively to a constructive, professional discussion at the start.
- **Chair’s introduction**
  - Asks everyone to introduce themselves by name and role.
  - Summarises the purpose, structure and duration of the meeting.
  - Objective review of the care of (patient name).
  - Look at what aspects of care went well and why.
  - Find out what did not go as planned/ expected and why.
  - Look at key learning and further actions to be taken by the team.

**Acknowledge that this is a difficult situation**

- Everyone in the team feels upset when things do not go well for a mother/ baby and it is particularly difficult for those directly involved.
- That means we all need to look at the information available and make objective observations about what happened and why.
- It is also important listen to what everyone can contribute to our discussion of this case.
- Is that OK with everyone?

**Use collaborative language**

- It would be helpful for us to look at that in more detail.
- We need to work through this in stages… We need more information about…
- Do we think there was a problem with…?
- As a group, are we saying that…
- So what I am hearing is that, x went well but then y happened…
- It sounds as if that was done as we would expect…
- Avoid negative language like ‘she/he should have’ and ‘why didn’t you’?....

Case review framework

<table>
<thead>
<tr>
<th>Clinical summary</th>
<th>Factual presentation of case, investigations, monitoring, clinical outcome (keep to facts only).</th>
</tr>
</thead>
</table>
| What went well & why | What did the team do well?  
What adverse outcomes were avoided or limited?  
Did we work well together? What were the team members well trained/ prepared for? |
| What did not go as planned/ expected & why | What difficulties were expected/ unexpected?  
What things were the team less well prepared for?  
What caused us problems? (Equipment, time, communication, leadership/ decision-making etc.)  
Were there any avoidable errors? |
| Key learning & further actions | What do we need to change/ improve?  
What needs further investigation?  
What can we do now?  
Who will take forward these actions? |

**Use constructive, behavioural language:**

- Can we talk through what happened…?
- What did the doctor do at that point; what was the effect?
- Can you describe what the communication between the midwife and the anaesthetist was like when……?
- What were staff/the team aiming to achieve by doing X….?
- What was the effect of doing Y….?
- How could we manage that situation differently in future?
- What options do we have for improving that?
• Keep the meeting on track
  ✓ Can I just stop you there please…?
  ✓ We are reviewing what happened and the impact of our actions so that we can see what we need to do to improve; it would be helpful if you could describe what you saw/ heard at that point…?
  ✓ We will be looking at individual training and support that may be important in due course but we are not discussing that today.
  ✓ Can we just get back to what we are here to discuss today please?
  ✓ Everyone will get a chance to speak so can you just let X finish please?

(Some participants may need several polite but firm interruptions and even raising a hand to get them to stop being critical. If they do make a constructive, behavioural observation, thank them for it. People who are not familiar with behavioural feedback may be unaware of the negative way in which they can come across.)

• Chair’s closing summary
  § Thanks everyone for taking part.
  § Summarises good practice, followed by agreed actions to address improvements.
  § A written record is usually made of such meetings.

Meetings with the mother/ family after an adverse event

The number and content of conversations with the parents/ family will depend on the nature of the adverse event and the circumstances of the parents/family.

A) Early support after a stressful/ complex delivery

• If the delivery has been stressful/ distressing for the mother/ family, an early opportunity to talk about what happened can help reduce later distress.
• This meeting can be led by an experienced doctor or a senior midwife.
• Make it clear to them at the start that the meeting is offered as part of routine care to anyone who has had a complicated delivery and it is not happening because something went wrong. The mother and baby may have no problems now or a full recovery is expected.
• Express regret/sympathy/ concern about what has happened.
  ☑ We are really sorry that you (had a big bleed after baby’s name was born).
  ☑ Listen and offer help and support if they wish it now.
  ☑ This must have been very stressful/ worrying/ upsetting for you (you both) and your family….PAUSE
  ☑ How are you (you both) now?
  ☑ Is there anything in particular about what happened that you’d like to talk about today?
  ☑ Are you getting help with that/ would you like help with that?
• Offering a later opportunity for a further discussion is often helpful.
  ☑ We will be letting your community midwife and GP know about what happened so you can talk to them if you have any worries or questions.
  ☑ We will see you in 6 weeks at the postnatal outpatient clinic so if you think of anything you’d like to talk about we will be able to do that then.
B) Initial involvement of the woman/family in the review process

If there is already clear evidence that there has been major harm, an apology will be offered and the facts that are already known about what happened will be shared with an explanation that establishing the reasons and actions to be taken will need a formal SAE review.

• Initial involvement of the woman/family in the review process may be possible in one interview or may need to happen as a series of conversations (eg initially on the ward and then later as a phone call). Sometimes there is too much for the mother/family to take in and respond to or they may want an early discharge home.

• If the baby has died, parents have said they would like to be offered an opportunity to talk about what will happen to their baby’s body and how long a post-mortem might take.

• Specific information needs (timing and content) will vary.

Plan the meeting in advance

These meetings are usually led by a senior professional the parents/family already know.

1. Agree who will take part and who will say what. Staff continuity is important.

2. Clarify and summarise the clinical information that is available now and what explanations about the clinical situation and care have been given to the mother/family already. Decide who will cover which aspects.

3. Prepare the family by explaining that we would like to arrange an opportunity to have a personal discussion about what happened with one or two of the doctors and the midwife caring for the mother. The meeting should be at a time that suits the family.

4. Plan to meet in an informal setting: a comfortable, private room on or near the ward.

Conducting the meeting

Express genuine regret/sympathy/concern about what has happened.

- We are very sorry that (brief summary of what happened) eg – (baby’s name) had to go to the special care baby ward. You had a big bleed and had to go to theatre...

Verbal and non-verbal expression of concern:

- This must have been very difficult/stressful/worrying/upsetting for you and your family….PAUSE

- Can I ask how you are now?

- Is there anything in particular about what happened that you’d like to talk about with us today, or that we can help with?

- What have you been told so far?

- What are you expecting to happen over the next few days/weeks?

If the baby is unwell and likely to have ongoing problems, information may have been shared already about the current situation and possible outcomes. Balance hope and realism when things are uncertain.

- It’s early days yet and we hope things will improve, but we are worried about (describe condition). PAUSE

- We will be doing our best to look after him as well as possible and support you and your family.

If a baby has died, offer more information (if this was not discussed earlier).

- Sometimes people want to know a bit more about what will happen to their baby’s body … Is that something you would like to talk about just now, or later on? What would you like to know about just now?

Decide if the family are ready for the next part of the conversation today.

- Explain that this discussion is about a review of care, including the experiences of the woman and her family.

- It is very important for all of us to know why this happened, and if there is anything that could have been done differently.

- Do you know anything about what we do when something like this happens?

If there is already clear evidence of avoidable harm, share this as ‘bad news’:

- We have already started to look at what we know about what happened.

- (Warning) I am very sorry to say that …
• Give information in short chunks; no jargon (clinical or managerial); use language that is clear, unambiguous and easy to understand.)  
  
• Acknowledge emotions (anger, distress, regret) and respond to these.
  
  ✓ It is understandable that you feel….
  
• Listen to their responses, thoughts, concerns and any questions. Summarise so they know these have been heard.
  
• Respond to their key concerns with the information that is available so far (keep this clear, easy to understand and neutral).
  
• Ask what they think would help at this stage. Then ask: how can we help?

Go on to explain the review process when they are ready.

• If the patient asks if they could have contributed in any way, reflect the question back and check why they might think that before replying.
  
  ✓ Can I ask why you think that …?
  
  ✗ AVOID premature reassurance or attributing blame without evidence.
  
  ’No, it wasn’t your fault’ (This can lead to the person asking: whose fault was it?)

• If asked whether any aspect of care, or a person, was at fault and there is still doubt about that:
  
  ✓ That is an important question for us too. At this stage we do not know enough about what happened to say but we want to find out.

• Introduce the review process.
  
  ✓ Whenever a mother or her baby is unwell or has complications, we always try to find out what happened by looking at the treatment and care the mother and baby had throughout the pregnancy, labour and delivery.

Full SAE Review
  
  ✓ We are going to do a full review. We do this as quickly as possible but it can take several months to do properly.

Other types of review
  
  ✓ Explain when and how the review will be carried out.

• Find out about any thoughts and concerns of the mother and those close to her at this stage.
  
  ✓ It is still quite soon after your delivery so you’ll need time to think about all this.
  
  ✓ It is important for us to know if there is anything that you and your family want the review to look at…..
  
  ✓ Is there anything you’ve thought about already? Sometimes people have things they are going over in their head and wondering about … how about you?
  
  ✓ If the mother/family talk about a concern, respond by saying that we think it is important and will look into it in the review.
  
  ✓ We will make sure that you can talk with us later on about any other things you think of when you want to do that….. is that OK?
  
  ✗ At this stage AVOID asking directly if they have ‘any questions’ as people can find it difficult to formulate specific questions when they are still struggling to come to terms with what happened.

• Explain the applicable review process and provide an information leaflet.

  Full SAE Review

  Explain the plan for ongoing contact with the mother/family from a named professional ‘key contact’.
  
  ✓ We want to keep in touch with you and your family while we are doing the review so your community midwife (name) will be doing that. I’ve written her/his name and a phone number on this information leaflet so that you can contact her/him. If you agree, (key contact name) would like to keep in touch with you by phone to see how you are getting on and to find out if you have thought of anything else you’d like us to look at. She/he will phone you in about 2 weeks’ time.
  
  ✓ When we have all the information we need and have spoken to all the staff involved, we will be able to tell you what we have found and what will happen next. Some people like to come into the hospital to meet with the senior staff members who are leading the review, other people choose to speak to them by phone. (Key contact name) will talk with you about what you would like to do nearer the time.
Other types of review

Explain that you will get in touch after the review meeting to let the family know what the review found and how you will contact them.

- Explain what information will be shared and how.
  - We will be speaking to your community midwife and we will let your GP know about what is happening too. They will be able to help with any problems or worries you have about your health (or baby’s name) when you go home.

Information about confidentiality is in the leaflet so does not need discussed unless the family asks about this.

- Summarise the discussion so far including their key concerns; check for any other thoughts, concerns or support needs.

“*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.*”

Parent

Ongoing contact with the family during the review

If the ‘key contact’ is not someone the family know already then he/she should meet the family before the mother goes home. The first follow-up contact is likely to be made by the key contact phoning the mother at home so it is important to try to build up rapport.

- Speaking with the person as you would a ‘patient’ and avoiding professional or management language helps relationships. Imagine you are talking to the person face to face, and try to visualise them.
- Your tone of voice has much greater impact on the phone.
- Talk more slowly and in short chunks to allow time for the other person to respond.
- Tell the person who is calling and where you are phoning from.
- Check you are speaking to the right person or ask for them.
- Check this is a convenient time; if not arrange when to phone back.
- Check if the mother wants their partner or another person there during the call.

- Use short sentences and a ‘chunk with checks’ approach for phone conversations.
  - Is that (mother’s name)? This is (your name). Is this a good time for me to speak with you? I can phone back at another time if that would be better?
- Ask how things are going; check if they would like any additional help/support.
  - How have you and (baby’s name or partner’s name as appropriate) been getting on since you went home/ since the last time I spoke with you…?
- Listen and summarise the key concerns, then talk about help and support.
  - It sounds as if you are worried about (...) and having some problems managing (...).
  - Are you getting help with that/ would you like help with that? Offer help or that you will find out more about who can help with any problems raised.

They may ask about what is happening with a post-mortem, when the results might be available or where the baby is at this time so be prepared to answer.

- Ask about any new questions or concerns to be addressed by the review
  - Is there anything else you’ve thought about, you’d like to ask me?
  - Have you thought of anything else it is important for the review to look at?

Invite people to talk about what they think is important – they may find it difficult to formulate any specific questions they would like answered at this early stage.
• Handle uncertainty and difficult questions effectively.
  ✓ Try to find out more about what they would like to know.
  ✓ Make it clear you can see that these are important questions.
  ✓ Discuss who might be the best person to provide more information/ an answer.
  ✗ AVOID saying ‘I can’t answer your question’.

• When the review is complete, discuss and plan the arrangements for the feedback back the findings to the family:
  ✓ Ask if they would like a copy of the report or key findings in advance?
  ✓ Ask if they would prefer to come to a different area in the hospital?
  ✓ Who would they like to bring - a family member/ friend?
  ✓ Say that, if they wish, their ‘key contact’ will come to the meeting.
  ✓ Explain who else will be at the meeting.
  ✓ Outline what to expect.

Sharing the findings of the review with the family

Plan the meeting in advance
The meeting is chaired by a senior professional or manager. Key clinicians from the specialties involved will often attend to help share information and respond to questions about their area. If the family wishes, the key contact will also attend to support them. An administrator records the meeting content/ discussion.

• Set out the room to facilitate a discussion. Arrange the chairs in a circle or around a table with the meeting Chair sitting opposite the family and the key contact beside the family.
• Clarify and summarise the clinical information available and what explanations/information have been given to the family by any professionals already.
• Decide who will cover which aspects of the discussion.
• Each senior clinician present will be asked by the Chair to talk through the events/actions that were their area of responsibility so that the Chair is able to manage the meeting and avoid doing too much talking.

Open the meeting
• Chair: greeting/ introductions and thanks to family for coming. The Chair shakes hands with them.
  ✓ Thank you for coming in to meet with us today so that we can talk about what the full review of your care and delivery has shown.
• Apology for what happened and outcome.
  ✓ Before I introduce everyone, I want say how very sorry we are that (…) has happened to you/ to your baby, (use the baby’s name).
• Introduce and explain the roles of the other participants; outline the meeting’s purpose and structure; explain that a written summary will be made of everything that is discussed and sent to them.
  ✓ We are meeting today so that we can go through what the review has found out about exactly what did happen. We hope we can answer your questions, talk about what things might have contributed to an outcome none of us would have wanted and see what we need to learn to improve care in the future.

The key contact acts as the link professional for a family:
• Offers support and someone to call for information or advice.
• Helps make sure questions and concerns from the family are passed to the review team.
• Keeps the family informed about how the review is going and makes plans with them for sharing the findings and attending the final review meeting.
Consider enquiring about how things have been going recently for you, baby (use name) and partner or any other close family we know are involved.

(This can help the Chair make a personal connection with family and links acknowledgment of the impact of the event with the review findings and response.)

✓ I know key contact (name) has been in touch with you by phone, but we’d like to know how things have been going for you recently (you both) and (baby’s name)?

✗ AVOID asking ‘How are you?’ or ‘How are you feeling?’ which are harder questions to answer at this point and may provoke emotional distress for the family.

Discuss the report using any family questions as the framework

• Summarise any concerns and questions they have raised; check for any more questions or concerns.
  ✓ When we have been talking with you about the review, you have told us it is important to find out………………
  ✓ (Key contact) has told us you also want to know………..
  ✓ Is that right? Is there anything else you want us to talk about today?
  ✓ Having seen the summary of the report, are there any thoughts or questions you’d like us to talk about first?

• Each person present then shares further information about the review findings.

• Give information in short chunks with pauses to allow them to think and respond. Focus on responding to their concerns and questions. Try to avoid technical language or ‘managerial terminology’ – this can have a distancing effect.

• Clear and genuine expressions of regret in the context of what happened are essential and can be repeated, if appropriate, while the findings are being discussed:
  ✓ We are so sorry about what happened. I am so sorry that...

• Ways to express regret and accept responsibility include:
  ✓ …..we accept/ acknowledge that…..
  ✓ …..was not to the standard we would expect
  ✓ …..could have taken that decision earlier
  ✓ …..did not happen as it should have
  ✓ …..was a missed opportunity to do ….  
  ✓ …..was not in line with our usual practice

• Express genuine concern about the impact of this discussion.

• Acknowledge emotions (anger, distress, regret) and respond to these.
  ✓ This must be very difficult/ upsetting/ sad to hear….
  ✓ This is a lot to take in….

• Address any new questions and concerns at the pace of the family.

• Explain what actions have been taken/ what is changing as a result of this event.
  ✓ Making sure that this does not happen again is very important, although we realise it does not change your situation.

• Check all family’s questions and concerns have been aired and addressed.

• Depending on the outcome of the review and the circumstances of the mother and baby, it may be appropriate to mention financial support and other help to enable the child to be well cared for. How to talk about ‘compensation’ may be an undisclosed concern that it is helpful to be open about.

  ✓ In this sort of situation, sometimes people want to ask about how to get some extra support and financial help if their child is likely to need extra care in the future. Please tell us if you would like advice about that.
  ✓ We will be sending you a full summary of what we have talked about today and you already have a copy of the review report. Please let us know if you need any other information.

Closing the meeting

• Explain when the summary letter will be sent to the family.

• Clarify if a further meeting or contact is wanted by the family.

• Close with a relevant summary, including repeating an apology.

• Make arrangements to communicate the report findings and a summary of the meeting to relevant professionals including: the GP, the named consultant for the woman/baby, the midwifery manager, management, and the team members involved.
**Resources**


- The Adverse Events Community of Practice website (www.knowledge.scot.nhs.uk/adverse-events.aspx) supports care providers in sharing learning for improvement following adverse events reviews.