A Guide for
Family Practitioner Staff

- **General Medical Practices**
- **General Dental Practices**
- **General Ophthalmic Practices**
- **Community Pharmacies**

Engagement / Communication with the Service User / Family / Carers following a Serious Adverse Incident

Directorate of Integrated Care, HSCB

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Contents

The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see Appendix 1 for further guidance).

1.0 Introduction

Communicating effectively with the service user / family / carer (hereafter referred to as service user) is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to a continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user can add valuable information to help identify the contributing factors, and should be integral to the investigation process, unless they wish otherwise.

At the outset of any SAI, practices/pharmacies should appoint a lead investigator. This may or may not be the same individual who can lead on the family / user / carer engagement aspect of the investigation.

2.0 Purpose

The purpose of this guide is to provide a framework for FPS Contractors and DOIC staff to ensure that following an SAI, there is effective communication with the service user / family / carer and that it is undertaken in an open, transparent, informed, consistent and timely manner.
Please note that in certain circumstances, e.g. cases of criminality, child protection or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users, it may not be appropriate to communicate with the service user. HSCB staff can provide assistance in making the decision about when service user engagement may not be appropriate.

The HSCB has a responsibility to review the robustness of service user engagement.

3.0 Principles of Being Open with the Service User

Being open and honest with the service user involves:

- Acknowledging, apologising and explaining that the practice/pharmacy wishes to review the care and treatment of the service user. It is important to **remember that saying sorry is not an admission of liability and is the right thing to do**
- Once classified as an SAI, explaining that the incident has been categorised as such and describing the investigation process to them
- Advising them how they can contribute to the investigation process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process. A leaflet is available from the HSCB http://www.hscboard.hscni.net/download/PUBLICATIONS/QUALITY%20AND%20SAFETY/02-2015-Guidance-on-communication-following-a-Serious-Adverse-Incident.PDF
- Providing / facilitating support for those involved, including staff, and acknowledging that there may be physical and psychological consequences of what happened.

DOIC staff will be available to provide additional advice and support to Contractors where they feel this might be helpful

3.1 Acknowledgement

All AIs should be reported to the local HSCB office using the AIF1 Form as soon as they are identified. Reports will be acknowledged by the local office. (Please click on attached links for your Service).

- General Medical Services
  http://primarycare.hscni.net/risk_management.htm

- General Dental Services:
  http://www.hscbusiness.hscni.net/services/2631.htm

- General Ophthalmic Services:
  http://www.hscbusiness.hscni.net/services/2563.htm

- Community Pharmacy:
  http://www.hscbusiness.hscni.net/services/2632.htm

Once the HSCB advises that an incident has been classified as an SAI, the service user should be informed as soon as possible that an SAI has

occurred. In very exceptional circumstances, where a decision is made not to inform the service user / family / carer, this decision should be reviewed and agreed by the investigation team, the HSCB informed of the reasons for this and the decision kept under review as the investigation progresses. The rational for this decision should be clearly documented in the AI form / SAI Checklist that is submitted to the HSCB (see Appendix 1).

3.2 Apology, Truthfulness, Timeliness and Clarity of Communication

Information regarding an SAI should be given to the service user in a truthful and open manner by an appropriately nominated person. It is suggested that those involved in service user engagement:

- Offer a meaningful apology for the harm / distress that the incident has caused as soon as possible, relevant to the context of the SAI. Delays are likely to increase the service user / family / carer's sense of anxiety, anger or frustration.
- Be open and transparent
- Ensure communication is timely
- Ensure that the service user / family / carer get additional information as it becomes available
- Provide information based on facts
- Avoid using health service jargon
- Provide the service user / family / carer with a single point of contact for any questions / requests they may have.

3.3 Recognising the Expectations for the Service User

The service user / family / carer should expect to be fully informed of the facts, consequences and learning regarding the SAI

- Appropriate support should be offered according to their needs
- Requests by the service user / family / carer for their legal advisor to be present should be facilitated
- Practice staff should ensure that the legal advisor is aware that the purpose of the meeting / report is to learn from the SAI and not to apportion blame or liability.

3.4 Confidentiality

- Practices are advised to maintain confidentiality and obtain the appropriate consent where appropriate.
- In most circumstances it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest or for the protection of third parties. Refer to Appendix 1 for further information.
- It is good practice to inform the service user about those involved in the investigation and who the investigation report will be shared with.

3.5 Maintaining Communication

If the service user decides to seek care from an alternative service provider, the Contractor should take all reasonable steps to establish whether the service user wishes to be kept informed of the outcome of the SAI.

4.0 The Engagement Process

There are 5 stages in the engagement process:

- Stage 1: Recognition
- Stage 2: Communication
- Stage 3: Initial Meeting
- Stage 4: Follow Up Discussions
- Stage 5: Process Completion

The duration will depend on the level of SAI investigation being undertaken. Please note that there are a number of different types of SAI investigations and not all will require the same level of family engagement. In some cases, the preliminary discussion may be the only engagement with the service user prior to communicating the findings of the investigation, provided that they are content that they have been provided with all the information. The HSCB will provide advice to practices/pharmacies on this when they are notifying them that an SAI has occurred.

Record Keeping

Practices/pharmacies should keep appropriate records of all communication with the service user. Documenting the process is essential to ensure continuity and consistency regarding the information

that has been relayed to the service user. Additionally, the information contained therein may be used during the course of the investigation. Documentation which has been produced in response to an SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents to ensure that only fact s are stated.

4.1 Stage 1: Recognition

4.1.1: Preliminary Discussion with the Service User

The lead professional / practitioner responsible for the care of the service user should have a discussion with the service user, advising that an SAI occurred and that there is a need to review the circumstances around the incident, including the care, service or treatment provided. This preliminary discussion (which could be a telephone call) is likely to be in addition to the formal initial meeting with the service user / family / carer.

As described above, not all SAI investigations will require the same level of family engagement. In some cases, the preliminary discussion may be the **only** engagement with the service user prior to communicating the findings of the investigation, provided that they are content that they have been provided with all the information.

4.2 Stage 2: Communication

When notifying the service user where known to practice:

4.2.1 Timing of Initial Communication with Service User

The initial discussion with the service user should occur as soon as possible after being advised of the SAI.

- Practices should take account of any known family circumstances when making the initial contact.

4.2.2 Choosing the Practice/Pharmacy lead for Communication

- The person nominated to lead on any communications should be someone who is fully aware of the facts of the case.
- If required an additional person can assist with meeting / engaging with the service user. The person (s) nominated to engage could also be members of the investigation team (if already set up).

4.3 Stage 3: Initial Meeting with the Service User

4.3.1 Preparation Prior to the Meeting

- The service user should be given the leaflet 'What I Need to Know about an SAI' (see Appendix 2)

4.3.2 During the Initial Meeting

The content of the initial meeting with the service user should cover the following:

- Service user informed that an SAI investigation is being carried out, that the purpose of the SAI is around learning and that there may be other processes running in parallel
- The facts that are known to the investigating team
- Where a service user has died, advising the family that the Coroner has been informed (where there is a requirement to do so) and any other relevant organisation / body
- Listening to the service user's / understanding of what happened
- Consideration and formal noting of the service user's views and concerns
- Explanation of what will happen next and expected timescales
- Offer of practical and emotional support for the service user
- Advising who will be involved in the investigation and who the investigation report will be shared with
- Advising that all SAI information will be treated as confidential

If it becomes clear during the initial discussion that the service user would prefer to speak to a different healthcare professional, these wishes should be respected and the appropriate action taken.

During the initial meeting try to avoid:

- Speculation
- Attribution of blame
- Denial of responsibility
- Expressing personal opinions
- Provision of conflicting information from different health and social care individuals.

The service user may be anxious, angry and frustrated, even when the meeting is appropriately conducted. It may therefore be difficult for the

practice/pharmacy to ascertain if the service user / family / carer have understood fully everything that has been discussed at the meeting.

However, it is essential that the practice/pharmacy is assured that the service user leave the meeting fully aware that the incident is being investigated as an SAI and knowing that the practice will continue to engage with them as the investigation progresses, so long as the service user / family / carer wish to engage.

Appendices 1-3 provide information which may be of some assistance.

4.4 Stage 4: Follow Up Discussions

These are dependent on the needs and wishes of the service user. The following may assist in aiding effective communication:

- Update the service user if there are any delays and provide an explanation
- Advise the service user if the incident has been referred to any other relevant organisation / body
- Provide feedback on progress to date, including provision of the Terms of Reference of the review and membership of the review panel
- There should be no speculation or attribution of blame. It is advisable not to criticise other organisations or pass judgements on other professions outside your area of expertise
- Keep a written record of the discussion and share a copy with the service user.

4.5 Process Completion

4.5.1: Communicating Findings of Investigation / Sharing Investigation Report

The report should include:

- Chronology of clinical and other relevant factors that contributed to the incident
- Details of the service user's / family's / carer's concerns
- Outcomes of the investigation
- Information on learning from the investigation
- Service user should be provided with a copy of the final draft of the report to ensure that any comments or concerns they may have had have been addressed. They should be assured that lines of

communication will be kept open should further questions arise at a later stage and a single point of contact identified.

It is expected that in most cases there will be a completed discussion of the findings of the investigation and that the final investigation report will be shared with the service user. However, in some cases information may be withheld or restricted:

- Where communicating information will adversely affect the health of the service user
- Where specific legal / Coroner requirements preclude disclosure for specific purposes
- If the deceased service user's health record specifies that he/she did not wish access to be given to his / her family

Practices may wish to seek further clarification from their Defence Union regarding disclosure.

There may be occasions where the service user does not agree with the information provided. In these instances Appendix 1 will provide additional assistance.

When the investigation is complete and the report is being finalised, Practices should ensure that the SAI checklist outlined in Section 6.0 has been undertaken.

Once the final report has been received, it is then forwarded to the Designated Review Officer (DRO) for review and if further information is required, the HSCB will contact the practice.

For information purposes a short summary of the role of the DRO is outlined below:

4.5.2 Role of the DRO

The DRO will discharge the HSCB/PHA role with support from relevant colleagues. The DRO provides professional advice and support and oversees the SAI in question. Once content with the case report containing any identified action(s) and /or learning, the DRO will close the incident.

In particularly complex or high profile incidents, the HSCB and PHA may need to establish an internal incident team chaired at Assistant Director or Director level. The team would oversee the incident by receiving updates from, and meeting with the Trust.

4.5.3: Communicating Changes to Staff

The HSCB will notify practices of any learning that is shared across the wider HSC system. In addition to any potential learning identified at practice level, practices will wish to share any identified learning across their practice teams.

5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist practices.

Information on being open is freely available through an e-learning tool for all HSC organisations:
www.npsa.uk/beingopen and www.nris.npsa.nhs.uk/beingopen/

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at:
www.dhsspsni.gov.uk/sudden-death-guidance.pdf

6.0 Checklist for Practices

1. Has the practice appointed an investigation lead?
2. In cases requiring service user / family / carer involvement, has the practice appointed a single point of contact within the practice to liaise with user / family / carer?
3. Has an apology for distress / harm caused by incident been offered?
4. Has the process been described to service user/family/ carer?
5. Have Terms of Reference been shared?
6. Has the service user's / family's / carer's views / input / experience been sought?
7. Has the service user/family/carer been invited to participate in meetings / process?
8. Have meetings / contacts been appropriately documented?
9. Has the service user / family / carer been kept up to date with any findings / delays?
10. Has final report been shared?
11. Have support services been offered where appropriate?

7.0 List of Acronyms and Abbreviations

AI – Adverse Incident

DOIC – Directorate of Integrated Care

DRO – Designated Review Officer

FPS – Family Practitioner Services

HSC – Health and Social Care

HSCB – Health and Social Care Board

RCA – Root Cause Analysis

NPSA – National Patient Safety Agency

SAI – Serious Adverse Incident

SEA – Significant Event Audit