**NHS Education for Scotland**

**Talking about Bereavement Podcast Series – Transcript of ‘When things go wrong in healthcare: Understanding what matters to patients, families and staff’Podcast**

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**LI:** Hello and welcome to the Talking about Bereavement podcast, which is brought to you by the Bereavement Education programme in NHS Education for Scotland. I'm Lynne Innes, one of the educators in the team and in the podcast, I'm going to be talking about bereavement with our guests who will be sharing and reflecting some of the work and learning they're involved in as they talk about bereavement.

**LI:** Hi, and welcome to this episode of the podcast. I'm delighted to introduce my guest today, Jean McQueen. Jean, De Jean McQueen is an occupational therapist and following 15 years of clinical work, was commissioned to write a review for the Scottish Government on forensic mental health. This led to a career that's been engaged in research, education and quality improvement. Currently she is the principal educator for person-centred care in NHS Education for Scotland and part of her role involves leading training and research on patient and family engagement, putting patients and their families at the heart of patient safety. Jean has published extensively in peer reviewed journals. Her most recent research paper entitled ‘What matters to Patients and Families in Adverse Events Reviews’ was published in the BMG Open and is currently in the top 5% for altimetric research impact. Hello, Jean and welcome to this podcast.

**JM:** Thank you Lynne, and thank you so much for the invitation to come and join you. I'm, I'm looking forward to our chat this afternoon.

**LI:** Thank you, me too and we've chatted a wee bit before, so it's really nice to be able to chat a bit more in this, in this context. I suppose I've given you, I've given you a very, a very official biography there of, of what you've done, but I wondered if you would like to expand on that at all about, expand on the introduction. Tell us a bit more about what you know how you've kind of got to where you are in your, in terms of your, your kind of life and your work.

**LM:** Sure. Yeah. So, so as you said, Lynne, my background's occupational therapy. I'm amazingly proud to be an occupational therapist, although you don't need to be an occupational therapist to do the job that I currently hold as principal educator in person-centred care, but I absolutely do use a lot of my occupational therapy skills in my role currently. So how did I arrive at NES or, or what was my journey? I think that was your, your question. So, I spent a lot of my early clinical career working in the NHS in various places. So, rehabilitation, forensic mental health before completing my PhD and then I moved into research and education within the university sector, looking a lot around public health. So, a lot of public health research and got the fabulous opportunity to teach on a range of, of programmes. Particularly highlight was the professional doctorate programme because we could have great debates and discussion because the students were, were at that place in their career, but also taught on the master’s in advanced research methods and in undergraduate healthcare degree courses. So, so that was my journey to NES from clinical to Scottish Government to higher education and now delighted to work in person-centred care and NES and I’ve been here since 2020.

**LI:** And, and that's quite a varied career that you've had combining clinical and kind of academic and education, I suppose I wonder what, what tell me a wee bit about what your job kind of looks like on a day-to-day basis here in, in NES.

**JM:** Yeah. So, what does on a day-to-day basis, I can be involved in, in lots of things, lots of teaching. So, I'm hopefully going to chat a bit about the compassionate communication skills programme that I work on. So, we run workshops on that, there can be design and delivery of online modules around duty of candour about being open and honest when things have gone wrong in healthcare, how to handle complaints, compliments and feedback. The care experience improvement model is also part of my portfolio. So, it can be very varied. And I think that's one of the things I really enjoy about NES is, and that opportunity, although I'm not a clinician, there is still an opportunity to make a difference. And through all of the research and teaching that I do, what I'm very mindful of is making sure that it's relevant to patient care and that whatever I'm involved in, whether it's teaching, education, research, that people can take it back into practice. And that's what motivates me and that's where my passion comes from. So, it's making sure that it, although I don't see patients myself anymore, I feel I still can make a difference to, to patients on the front line.

**LI:** And that, that sounds like something that's really important to you and actually fundamentally part of your values.

**JM:** Absolutely, yeah. And I suppose it is for many healthcare professionals, you go into that role to, to make a difference.

**LI:** Yeah, yeah. And, and still being able to make a difference in a different context is, is really important and really matters. And, you know, my own career, I've done something similar, I’ve come back into practice, into clinical practice. And, but it, it feels good to be able to kind of make a difference in whatever aspect of healthcare that we work in.

**JM**: Yeah, yeah. Isn't it good we can move across…

**LI:** Yeah.

**JM:** …different sectors?

**LI:** Yeah, yeah.

**JM:** I feel very privileged to be able to do that and, and what you said actually reminded me of what one of my line managers had said to me when I worked in a practice development role. And she said, you know, your role is to provide your like somebody who works behind the scenes at the theatre, you're providing the props and the do you know, the, the stage, all the things that people need to so that the clinicians can go out and perform and do their role very well. And I think that's probably very true to NES is that we can provide a lot of the education and the training and the props that people need behind the scenes to go and, and do a, a good job on the front line. So, I thought that…

**LI:** Yeah.

**JM:** …was a nice way of describing it.

**LI:** Yeah, that's a really good analogy actually. I hadn't really thought about it like that, but, but yeah, it's a really good analogy. So, in terms of your, obviously this podcasts, it's about bereavement, it's for the bereavement education programme. So, we're looking to do exactly what you've just been talking about, providing education resources for, for the clinicians and practitioners and staff that work in, in healthcare. I wonder how does your role then in terms of supporting people who are bereaved or anticipating loss and bereavement, how does your role kind of do that?

**JM:** Yeah, so I'm, I'm going to bring in, in relation to that question, Lynne, a bit about the work that I've been involved in, in terms of what matters to patients and families when things have, have gone wrong in healthcare. In the NHS, sadly, we can't save everyone and patient safety events do sometimes happen and people can die as, as a result or may need additional treatment. But what we do after that and how we respond can make a huge difference and can mean everything to the people involved. And by that, I mean how do we show that kindness and compassion? How do we make sure that we learn so that we can ensure that it doesn't happen to anyone else? And really how do we support those involved, both the staff, the patients and, and their family? And how do we communicate and share the learning as well so that we can close that loop and, and make sure that here's what we've learned from this and here's what we'll do to make sure that it doesn't happen again. So, so that's where I think the, the work that I do comes in to, to bereavement and, and the reasons for, for this podcast.

**LI:** And, and you said you mentioned your compassionate listening. I think that was, is that right? Course…

**JM:** Compassionate communication skills.

**LI: …**yeah, yeah, sorry, compassionate communication skills. And, and I suppose I wonder how that fits into all of that.

**JM:** Yeah. So, I think compassion and compassionate communication skills kind of came about through listening to patients and families and realising that we weren't always getting it right when things had gone wrong in healthcare. We weren't including them and listening to them as well as we could. And actually, in some cases, this was causing more trauma for the people who'd already experienced something horrendous, you know they've, something's gone wrong with a healthcare procedure that they thought was going to help them or their loved one. And how we respond and how we show compassion is really important. But often what was happening because we've got a SEARS - a serious adverse event review process, we've got procedures, we've got timelines. It was becoming very procedurally based. Patients and families were feeling, do you know they were a second thought or treated more as a statistic rather than a, a person. And we'd kind of lost that human connection and compassion in the review process. And these people can actually help with our learning as well because often they're the only people that feel seen the full journey of care. So, they might have seen when the ambulance was called, when someone was admitted to hospital, when they were discharged. As healthcare professionals, we only see parts of it. So actually, if we can include them and support them and listen to them and show compassion and kindness, it's a win, win for everybody. Hopefully those involved feel it helps with their healing or reconciliation. But also, for, for us as healthcare providers, it can help to learn because they may have vital pieces of information that they can add to that jigsaw to make sure that we, we do learn and we don't ensure the same things happen to others.

**LI:** And you mentioned there, I've just written it down there, how, how, how we show compassion. And, and I suppose I wondered how, what, what, what does that enable them to do? I suppose what's, how does that enable a different way of showing compassion? Or if, does it need to be a different way of showing compassion or, or is it, you know, what, what, what, what enables that differently, I suppose.

JM: Yeah, I suppose it's the how is it, is it the how do we, how do we do this? Well, I think it's really important to stress that when things go wrong in healthcare, it's not easy for anybody involved. It's not easy for the staff, and it's certainly not easy for the patients and the family. But in terms of that compassion there, there are some key things that, that people can do that really can make a difference. And I guess it's about how we respond to another person's suffering, how we show that person-centred human side of it. And a lot of that is about listening. And listening comes into that a lot. It's about listening to what matters to the, to the people involved, to the patient, the family and the staff. For the families it’s about apologising where we have made a mistake and, and doing that as early as possible because that then shows that there's been some acknowledgement of, of what has happened. And that can be really important as well. And people may choose to be involved in different ways in terms of the adverse event review process and that might help with their healing if they feel that they are helping other people. But that's very much a choice. And that's where listening comes in. And, and I have to say that it's about listening carefully without judgement. And it's about that communication. Being kind, listening to understand and remaining empathic if you can. Even in situations where the emotions might be running high, it can be quite fraught. There might be anger or frustration and from the healthcare professional’s perspective, I think it's about being open to hear personal criticisms without becoming defensive. It's all about avoiding judgement and maintaining that improvement focus. And if you really listen deeply to what the people involved are telling you, that is showing compassion. And, and that's really important to people who have been involved in an adverse event review where perhaps a loved one has, has died as a, as a result of this or someone's lost a, a baby, a neonatal death, all of those things are, it's so important to have that human connection and not just go through the process of the SEAR the, the serious adverse event review.

**LI:** It's interesting that you're, you know, I was thinking a lot of what you've said obviously resonates in terms of what, what I do in my role as a kind of healthcare chaplain, often talking to people about the importance of listening, but listening to understand rather than listening to reply, that kind of thing. And always quite amazed that I'm, or maybe not amazed is not the right word, but always, always surprises me that we need to help people to listen. And I, you know, I kind of find myself wondering why we, why we struggle with that, you know, and I, you know, I count myself in that sometimes I'm aware that I'll listen to reply as well so, on occasion, why is that? So why is, why do we find that so hard to listen?

**JM:** Yeah, I wonder because I often have the same thoughts when we're, when we have the compassionate communication skills workshops. I think this isn't, this isn't rocket science. Do you know how, how is this, how is this landing with the people who are coming along to participate in, in the training because it does seem it's it should be second nature that we should just like you say, be able to listen and really be fully present and then use that information to shape how we respond. But you're right, we, we don't, we don't do that all the time. And, and why is that I wonder? I suppose when it comes to adverse events, we, there's a lot of the research out there that says, do you know, sometimes we worry about saying the wrong thing. So therefore, we, we don't engage on that human, human level. We worry about saying the wrong thing or we worry about making things worse. But in actual fact probably the worst has already, has already happened for these people. And if you listen and really connect with them, you can make such a difference. And that's what we've been hearing from the, the patients and families that we have the privilege to, to talk to. So why is it so, so difficult. I wonder, I mean, it's not easy when, when something's gone wrong in healthcare or someone's died, It's absolutely not easy. Maybe we don't talk about it, maybe we don't talk about death enough. That's definitely comes out in, in the research or one of the things we find helps so on the training, we have a range of participants, which actually makes it really great because it's true interprofessional learning where we learn with, from and about each other. So, we have risk adverse event reviewers, child death reviewers. We have clinicians, consultants, GPs, pharmacists, nurses, allied health professionals and it's interesting to see some people have come into these rules from a non-clinical background. So, they've come from admin and then gone into governance roles and others have come from a more clinical role. And it's interesting that they all find that they can struggle sometimes when, it’s that rabbit in the headlights do you know what do I say to this family. What, how do I, how do I find the right words? So, we do a lot of thinking about what can be in your toolkit do you know maybe…

**LI:** Yes.

**JM:** … some, some phrases you might use, maybe using scenarios and, and things like that.

**LI:** I suppose what I was wondering as well, when you were talking there was from the research that you've done, and you may not have gathered this information, but do people, do the, do the family say that we can make it worse by the things that we say? And obviously there are things that we'd say that would make it worse. But, but you know.

**JM:** We, we didn't hear that.

**LI:** Right.

**JM:** What we heard was that actually when you just send me a leaflet or a letter and you don't engage with me, you don't ask what matters to me, that is actually what makes it worse. And the professionals that are involved in the review don't mean to cause any harm or offence by sending a leaflet first or a letter or, or not engaging. It's just that they don't, they don't know how to do it or they find it really difficult. So that's where the need for the training I guess came from is that patients and families were saying, well, we want you to reach out, we want to talk to you on the phone, we want you to have a meeting with us. We want to tell our side of the story…

**LI:** Yeah.

**JM:** …more often than not. They're happy because they want to make a difference. So, it's about having how to have those conversations and how to say things like, I'm so sorry to be meeting you under these circumstances.

**LI:** Yeah.

**JM:** Do you know, these, these kind of phrases can make a difference or even when someone tells you something, it can be, well, I, I don't really know what to say right now, but I'm so, I'm, I'm so glad you told me these things because then we can, we can learn or we can do you know, we can take these things back to, to the workplace. So, it's about how you respond. It's just back to what you were saying Lynne, it's that active listening, isn't it? That's what is so important. So, did they say, did the patients and families tell us that we could say the wrong thing? Well, there's one scenario maybe kind of springs to mind or one quote that we use in the paper, and it's following the death of this man's son. And he was, he was given a phone call by the person who was leading the, the review who had basically just said on the phone, there's going to be a serious adverse event review. We're going to send you a leaflet and a letter. And there was no time for any checking in, how are you? I'm so sorry for your loss. The, the, it was all very factual and procedural and that's where we, that's where we could get it wrong or that in his, his mind was he, I think his exact words were I've just lost my son…

**LI:** Yeah.

**JM:** …but you're going to send me a leaflet and a letter.

**LI:** And it becomes very transactional, doesn't it? And it feels transactional and that feels then cold and, and not compassionate and, and all the things that we kind of want to see or hear at that time. And actually, the things like you were just saying there, you know, how are you really sorry that your, your, your, your son has died don't seem that hard to say. They seem quite kind of just little things to say, but they make such a huge difference.

**JM:** Yeah, yeah.

**LI:** Don’t they, yeah.

**JM:** And they don't take long to say as well.

**LI:** Yeah, yeah.

**JM:** I think that's the thing. It doesn't.

**LI:** Yeah.

**JM:** We look at some of the work that Stephen Trzeciak does about compassion and compassionomics. And I think he, his research takes 40 seconds to…

**LI:** Oh really.

**JM:** …show a bit of compassion and or add compassion into your conversation. And just like what you said there Lynne, it didn't take long, but those words just make, make a difference. And almost that first conversation can set the tone for everything that comes next. So, you either…

**LI:** Yeah.

**JM:** …open the door to a, a healing and, and reconciliation or you close the door to something then that might become quite adversarial. And do you know, people then then struggle and that's when relations breakdown…

**LI:** Breakdown yeah.

**JM:** …between the family and, and the health, the health service.

**LI:** So, you're running these courses and they're for healthcare staff. Is that right?

**JM:** So yeah, it's for, for healthcare and social care professionals. We also have some colleagues from the prison service who've joined us …

**LI:** Oh right, right.

**JM:** …recently for, for, for some of the training sessions. So yeah.

**LI:** Okay. And, and how often do you run the, the courses?

**JM:** So, we tend to do a few cohorts a year. I think this year we're aiming for three cohorts like this financial year, but interesting what we are doing because we recognise that there, there's a need for this and it’s boards would like to be much more agile in terms of offering it to staff when they need it rather than waiting for a NES training course to come up. So, we are piloting a train the trainers programme so that we can train…

**LI:** Ah right…

**JM:** …people up in local boards who will deliver it. And very excited that we've got four boards who are looking to join us on that pilot and really try out that approach for us. So, yeah, it's going to, going to be interesting I think to see…

**LI:** Ah right okay.

**JM:** …how we can spread and, and grow.

**LI:** Yes, yeah, yeah, yeah which would be really, be really good. And that would kind of be able to, to kind of spread, you know, spread out as you see and grow it across, across Scotland, wouldn't it?

**JM:** Yeah, and just to get, it's not rocket science, but we just need to get it out there because we haven't been getting, we haven't been getting it right all of the time for, for people…

**LI:** Yeah, yeah.

**JM:** …who've experienced, do you know, adverse events or, or the death of a loved one through, through an adverse event in Scotland. So, we, we can definitely do better. And that's where the training and I suppose one of the really nice things is we do hear back from people about the difference it's made to them and their practice, just that they feel more confident. Sometimes they've also had positive feedback as well from people who've been through the most horrendous experience. But the fact that they've said thank you to the people who've been involved in the review and who've communicated and, and included them…

**LI:** Yeah, yeah.

**JM:** …that's something we wouldn't maybe have got before.

**LI:** That, that sounds really good. Before I came to this, to record this today, I'd actually been at our, our own health board grand rounds, which was about significant adverse events just by chance. It wasn't deliberate. And a lot of the things that you've said today, one, there was a doctor speaking about a particular event that had happened. And a lot of the things you've said today is really kind of echoing and resonating around the way in which this, this doctor had communicated with the family within this situation and, and how compassionate he sounded and how kind he sounded. And he spoke about, you know, duty of candour within that. And, and it was, it kind of felt like a master class in someone who had done this really well. And I was noticing in myself, how I was kind of sitting feeling kind of proud that that, that, that that was happening here. And you know it's good that we're, we're doing that. But I'm really interested in kind of your compassion course and wondering perhaps if you would share some details on it and we can maybe add that on to the, the end of the podcast if that was okay or a link actually, signpost to the link. I know you've got your, your information on Turas, so perhaps we can do that because I think it'd be really good.

**JM:** That would be really helpful,yeah. And, and can I say how lovely it is to hear that, that story that you've just told about the, the consultant. And it's nice when we, when we are reaching out and being kind and compassionate when something has gone, has not gone well in healthcare. So, I hope that it really helped the, the people, the patients who were involved in, in that situation to, to help with their healing a little bit after something really traumatic.

**LI:** Yeah, hope so too. I suppose one of the questions I was going to ask you or I was thinking about as well was how do we do this even better? But I think actually you're doing this, you know that's what you're doing. You're, you're trying to do this even better. You're, you've put your course in place, you've done the research around it. You're doing train the trainer. But I wondered, or you're hoping to do your pilot in train the trainer. I wondered if there was any, anything else you wanted to add into that around how you know what, what you're doing in terms of your work that you've not said that you kind of were keen to, to get over?

**JM:** Yeah. So, I suppose from my perspective, there's, there's definitely a huge thank you to the patients and families who I was privileged to speak to. It wasn't just myself. There were a few of my colleagues involved. So, it's probably good to mention them. So, we had Moira Manson, who's the head of reviews at Health Improvement Scotland, and Kyle Gibson, who's an intensive care doctor in NHS Lothian and, and Morag Francis, who's a reviewer for NHS Assure. So together we had the privilege of speaking to patients and families and following that, those discussions, we co-produced the APICCTHS model, which is how we then, how we structure our compassionate communications. And I guess it's really, it is simple. It's like it's how you go from the A is like apology. So how you would word a really person-centred apology. Then the P is about being, being that person-centred and responding to what matters to the people involved. It’s about being inclusive and asking the patient and family. So, including them rather than excluding them from the review. It's about how we communicate with that kindness and, and empathy and remaining that we, even though, do you know, it might be difficult or there might be emotions running high. And then one of the really important things, which I think we maybe were guilty of not doing very well was the C, which is closing the loop. So, the second C and that means sharing what we've learned with that patient and that family. So, here's what we've learned from this or here's what we'll do to avoid it happening again. And, and communicating that in a way that fits with that patient or family as well. So, I mean, not using jargon and, and making sure that they've, we have closed the loop and doing it timely as well. We're, we're very bad at these things drag on for such a long time. So, if we can provide regular updates and put people at the heart of what we do. And I suppose the final thing is the model, the S, which I think we chatted about early, which is a support for staff, which is where your, your role as a, a healthcare chaplain comes in. And do you know how we support staff as second victims who didn't come into work to be involved in, in an adverse event. And how we focus on do you know what was it in the system and the environment and the tools that contributed to the event rather than saying the doctor could have or the nurse should have. And, and how we use the, the, the language is really important around that and how we, how we take care of the people involved.

**LI:** Yeah. And that's it, that was part of today's grand round as well, was talking about how we support the staff after an adverse event and, and the, the processes that, that we've got in place here in Fife, although we're at the early stages of that as well because it's been a pilot. But the, the importance of that, yeah. I quite like…

**JM**: And as a healthcare chaplain, you'll, you'll have a really, a real important role in, in that I think in supporting staff who are maybe devastated by whatever's happened. And but we need to keep all the good staff we've got. And if that means…

**LI:** Absolutely.

**JM:** …they're able to do you know, be supported and, and try and move forward and, you know, come back to work or continue working, then you've done a really good, a really good thing. Yeah.

**LI:** Yeah, yeah. That's so, so kind of fundamentally important. It's a wee bit somebody else was saying earlier, it seems like I can't remember what they were talking about. But it was something like, it seems really obvious that that's what we've been needing to do for all these years. And yet, it's taken us to now to realise how, how fundamentally important it actually is. But we've got there, haven't we? And that's good. And we're, we're doing it and we're really cognisant of it. But yeah, I was just going to say I really like the APICCTHS model. I can see kind of that being used. I can see myself using that in terms of what I do as well. And, and, and I wonder how transferable that is across other areas.

**JM:** Yeah, absolutely. I mean, I think there's there, there could definitely be some, we'd love to be shared and to be used in practise and to be out there. So yeah, if people are interested, you can google Turas Learn and APICCTHS model which is API double C THS. Someone said it sounds a bit Greek, but that was, that was the best we could, when we were co-producing with our patients and families, we wanted to capture what was important to them and that was…

**LI:** Yeah.

**JM:** …absolutely what, what they told us.

**LI:** I just want to say thanks so much Jean for, for taking the time to do this. And you know, before we finish off, I just want to make sure that we've captured everything that you, you would have liked, you would like to say and that I haven't missed anything that’s really important to you.

**JM:** Yeah, no, I think, I think we've had we've had a great chat this afternoon. I've enjoyed sharing and, and sharing the similarities, I suppose in the, in the work that we do as well and interesting that you've just been to a grand round and we're, we're talking about these, these very things as well…

**LI:** Same thing.

**JM:** …isn't it?

**LI:** Yeah, yeah.

**JM:** It's fate how things all, all collide together. So, it's been…

**LI:** Yeah.

**JM:** …it's been really good to chat with you.

**LI:** Yeah, and you too. And thank you so much for, for sharing what you, the work that you're doing. And we will signpost to some of the things you've spoken about. So, that people can find that easily if they want to find out more about it, which is, it's great to have that resource as well. So, thank you so much, Jean. Thank you for, for doing this. It's been great to chat to you.

**JM:** Thank you. It's been, it's been lovely to chat this afternoon. Thanks Lynne for the opportunity.

The podcast was recorded in September 2024 and can be found at <https://www.sad.scot.nhs.uk/podcast/> or [https://open.spotify.com/show/11AORpjHqbsYwgg1DJUtLk?si=687dba351d1f45d4](https://open.spotify.com/show/11AORpjHqbsYwgg1DJUtLk?si=687dba351d1f45d4 )

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