Yorkshire Ambulance Service NHS Trust

Patient Story – 'Saying the right thing'

The Incident

One morning during August 2012, a 999 call was made at 07:37 to attend a 53 year old male who had fallen, was unconscious and breathing. The patient, Bob* had left the house for work and shortly afterwards Bob's wife, Sheila*, and son, Luke* were called into the street outside their house. Bob had collapsed and a group had gathered around him. During this time a member of the public had started to provide basic life support.

A double crew ambulance (DCA) arrived on scene at 07:43 and acknowledged that the patient was in cardiac arrest. They immediately began full CPR (cardio pulmonary resuscitation) and requested back up. A rapid responder vehicle (RRV) then arrived at 07:50. During the resuscitation a ventricular fibrillation (VF) rhythm was detected and appropriately managed, however this was unsuccessful.

Although a good deal of time has elapsed from this incident, the crew recalls that they found it difficult to ascertain a clear history of the events leading to the patient's collapse. They recall noticing that Sheila and Luke (seven years old) were understandably distressed and that Luke asked if his Dad would be OK. The crew recall their response to Luke was something like "*he'll be alright; we just need to look after him*".

At 08:19 Bob was transported by the ambulance to hospital. The RRV paramedic also travelled in the same ambulance to provide resuscitation support. Sheila and Luke travelled separately.

At 08:27 the ambulance arrived at hospital where resuscitation continued but shortly afterwards it was pronounced that Bob had passed away.

Request for Support during the Bereavement Process

In January 2014 the YAS Patient Relations Department were contacted by a bereavement support charity worker who was providing support to Luke (now nine years old):

"*Hello, I wonder if you can help me. I am a bereavement support worker working with children and young people. I am working with a nine year old boy whose father died very suddenly in 2012, and an ambulance was called to the scene – in which he was present. He recalls some confusion during this moment and often becomes upset about some of the conversations he had with the ambulance crew, and some of the decisions they made. I have explored these things several times with him, and tried to reassure him and explain procedures and how things are very difficult in crisis*

situations. However, this appears to not be helping, and from the work we have done together he has identified that he would like to speak to a member of the ambulance service about his experience, as he has some questions and comments that he would like to share. He has become 'stuck' on this, and quite fixated upon it, and I feel that a meeting with someone from your team may help resolve some of this, and help him to move forward. I feel what this child is really looking for is to be heard and acknowledged, in order to achieve some resolution. Is this something you could possibly help with?"

The Patient Relations Department identified and contacted the members of staff who attended the incident. These staff provided their recollections of what happened, albeit a considerable time had elapsed since the incident, and offered to meet with Luke to help in any way they could. On reflection, after speaking with Luke's mum and the Bereavement Support Worker, it was felt that an impartial member of staff could provide an independent clinical view of the events surrounding Luke's father's death. It was hoped this would maintain a focus on what actually happened rather than on individual members of staff. An operational manager, Philip*, agreed to facilitate this request.

The Meeting

A meeting was arranged for Philip to meet Luke during March 2014. Luke's Bereavement Support Worker, his mum and a teacher were also present. The meeting took place where Luke felt safe; at his school.

The meeting began with Philip introducing himself "*hello my name is Philip. I am a paramedic and I have an understanding of what should happen when someone collapses*." Philip also explained that he would like to try and answer any questions which Luke had.

Luke was very open regarding his feelings and emotions and expressed that he felt upset and angry. Luke used phrases such as "*I felt like they* (the ambulance crew) *killed my spirit*", "*they* (the ambulance crew) *gave me false hope*", "*I want my voice to be heard*" and "*I don't want others to feel like this or to go through the same thing*".

Luke asked these questions:

"*Why did the ambulance man say that my Dad would be ok?*" Philip explained that the ambulance men were trying to keep Luke calm and that, at that point, the ambulance crew felt there was still a chance they could help his Dad. He explained that they did everything they could to help his Dad.

"*Why didn't they* (the ambulance crew) *let Mum go in the back of the ambulance? If Dad heard Mums voice he may have tried harder to live*". Mum explained to Luke that the ambulance crew wanted Luke to have someone with him and that at that point she felt that Dad had already passed away. Everyone at the meeting expressed that it would have been more upsetting for Luke to continue to see his Dad being treated on the way to hospital. Philip explained that Dad wouldn't have been able to hear Mum and that Dad could not have tried any harder to live.

Luke also recalled that, whilst the ambulance crew were performing CPR in the street, his Dads face moved and he heard his Dad saying "*I love you*".

The meeting wasn't given a time to end and finished at a logical point when Luke confirmed that he felt he had been listened to and received some answers. Philip said that he hoped this meeting had helped Luke to better understand what had happened. Philip also assured Luke that his comments would be used to consider ambulance crew response in similar situations. Luke suggested that a good phrase for ambulance crews to use in similar situations could be "*we are doing our best.*"

How are things now?

Since this meeting Luke's Bereavement Support Worker has confirmed that Luke found the meeting very useful and feels much better about what happened during his father's care.

Luke and his mum are keen to be able to help others in similar situations and are arranging to undertake CPR training.

**names anonymised*

Lessons Learnt for YAS

- The impact our words can have on those involved or effected by an incident.
- The significance of being open with patients' relatives.
- The value in assisting patients' relatives during the grieving process.
- The inspiration and positive value of sharing service-user feedback with YAS clinicians.

This anonymised story will be used in staff training. In particular it will be used when relating to:

- The YAS Dignity Code:
  - Point **1)** "remembering that many care activities can leave people feeling vulnerable (physically, emotionally or psychologically)"
  - Point **2)** "demonstrating respectful verbal and non-verbal communication
  - Point **4)** "supporting people with the same respect you would want for yourself or a member of your family"
  - Point **6)** "treating everyone as being of worth, in a way that is respectful of them as valued individuals".

- The YAS We Care values:
  - **W**orking together for patients – we work with others to give the best care we can
  - **E**veryone counts – we act with openness, honesty and integrity – listening to and acting on feedback from patients, staff and partners
  - **C**ommitment to care – we always give the highest level of clinical care
  - **A**lways compassionate – our staff are professional, dedicated and caring
  - **R**espect and dignity – we treat everyone with dignity, courtesy and respect
  - **E**nhancing and improving lives – we continuously seek out improvements