

## Being Open Policy

Effective: September 2010

Review: October 2012

### 1. Introduction

- 1.1 Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

### 2. Scope of this policy

- 2.1 The policy is aimed at all healthcare staff responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident, complaint or claim
- 2.2 This policy is based on guidance from the NPSA, *Seven Steps to Patient Safety, Involve and Communicate with Patients and the public* (2004) the National Health Service Litigation Authority (NHSLA) circular 02/02 and the NPSA , *Being Open, Communicating patients safety incidents with patients and their carers* (2005)
- 2.3 The Chief Medical Officer's consultation document, *Making Amends*, also outlines processes to encourage openness in the reporting of adverse events (DH, 2003).

### 3. Key Elements of Being Open

- 3.1 Effective communication with patients begins at the start of their care and should continue throughout their time with the Trust. This should be no different when an incident occurs. Openness about what happened and discussing incidents promptly, fully and compassionately can help patients cope better with the after-effects.

Patient safety incidents also incur extra costs through litigation and further treatment; openness and honesty can help prevent such events becoming formal complaints and litigation claims. Openness when things go wrong is fundamental to the partnership between patients and those who provide their care.

### 4. Links to other Policies

The Being Open Policy links with:

- Incident Investigation Procedure
- Management and Reporting of Accidents and Incidents
- Disciplinary Policy and Procedure

- Consent for Examination or Treatment (with reference to the Mental Capacity Act 2005)
- Confidentiality and Security
- Hospital Discharge Policy
- Supporting Staff Involved in Traumatism/Stressful Incidents, Complaint or Claims
- Freedom of Information Act and Environmental Information Regulations Policy
- Claims Management Policy
- Concerns and Complaints Policy

These policies are available on the Trust's intranet

<http://intranet/Policies/policies.asp>

## 5. Principles of Being Open

*Being Open* is a process rather than a one-off event. The following principles involved in the communication of patient safety incidents are essential to support the policy

- acknowledgement
- truthfulness, timeliness and clarity of communication
- apology
- recognising patient and carer expectations
- professional support
- risk management and systems improvement
- multidisciplinary responsibility
- clinical governance
- confidentiality
- continuity of care

## 6. The "Being Open" Procedure

### 6.1 Incident Detection and Recognition

The *Being Open* process begins with the recognition that a patient has suffered harm, as a result of an patient incident.

A patient incident may be identified by:

- a member of staff at the time of the incident
- a member of staff retrospectively when an unexpected outcome is detected
- a patient and/or their carers either at the time of the incident or retrospectively
- a formal or informal complaint
- a litigation claim
- incident detection systems such as incident reporting or medical records review
- other sources such as identification by other patients, visitors or non-clinical staff.

As soon as an incident is identified, the main priority is maintenance of appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur as soon as reasonably practicable after discussion with the patient and with appropriate consent. The Incident Reporting Policy and possibly the Serious Untoward Incident Policy should be implemented. This would include:

- acknowledgement and apology
- completion of an incident report
- a Root Cause Analysis investigation.

#### 6.1.1 Patient incidents occurring elsewhere

A patient incident may have occurred in another organisation. The individual who first identifies the possibility of an earlier patient incident should notify their Directorate Manager and the Risk Manager who will then contact their equivalent at the organisation where the incident occurred and establish whether:

- the patient incident has already been recognised
- the process of *Being Open* has commenced
- if incident investigation and analysis is underway

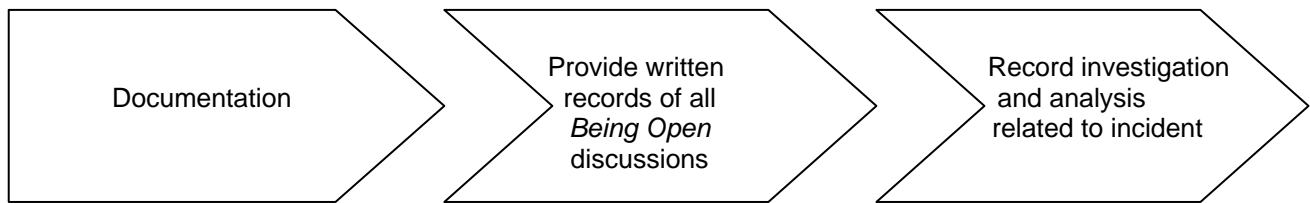
#### 6.1.2 Criminal or intentional unsafe act

Patient incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, the Directorate Manager and Risk Manager should be notified immediately.

### 6.2 The process for "being open"

#### Overview of the Being Open Process

Incident detection or recognition	Preliminary team discussion	Initial Being Open discussion	Follow-up discussion	Process completion
Detection and notification through appropriate systems	Initial assessment	Verbal and written apology	Provide update on known facts at regular intervals	Discuss findings or investigation and analysis
	Establish timeline	Provide known facts to date		Inform on continuity of care
Prompt and appropriate clinical care to prevent further harm	Choose who will lead communication	Offer practical and emotional support	Respond to queries	Share summary with relevant people
		Identify next steps for keeping informed		Monitor how action plan is implemented
				Communicate learning with the staff



Being Open. Communicating patient safety incidents with patients, their families and carers (NPSA, 2009)

### 6.2.1 Preliminary analysis

The incident investigator should:

- establish the basic facts
- assess the incident to determine the level of immediate response
- identify who will be responsible for discussion with the patient and/or their carers
- consider the appropriateness of engaging patient support at this early stage. This includes the use of a facilitator, a patient advocate or a healthcare professional who will be responsible for identifying the patient's needs and communicating them back to the healthcare team
- identify immediate support needs for the healthcare staff involved
- establish a process for collation of evidence on the investigation

In addition to this, it will be an advantage to provide facilities for formal and informal debriefing of the clinical team involved in the incident, where appropriate, as part of the support system and separate from the requirement to provide statements for the investigation. Staff may also benefit from individual feedback about the final outcome of the patient incident investigation.

### 6.2.2 Initial assessment to determine level of response

All incidents should be initially assessed by the investigator to determine the level of response required. The level of response to a patient incident depends on the nature of the incident.

#### **Insignificant/Minor incidents**

Unless there are specific indications or the patient requests it, the communication, investigation, analysis and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the patient's care and the patient and/or their carers. The incident and investigation process will be reported on the Trust Datix reporting system.

## Moderate, Major or Catastrophic incidents

A higher level of response may be required in these circumstances. If the incident is thought to be serious and/or untoward then the Clinical Governance and Risk Department should be informed as soon as possible.

### 6.3 Timing

The initial *Being Open* discussion with the patient and/or their carers should occur as soon as possible after recognition of the incident. The clinical and emotional condition of the patient should be considered and the availability of the patient's family and/or carers and key staff involved.

### 6.4 Choosing the individual to communicate with the patient and/or carers

This should be the most senior person responsible for the patient's care and/or someone with experience and expertise in the type of incident that has occurred. This could either be the patient's consultant, clinical director, directorate manager, modern matron or nurse consultant. They should have received training in communication of patient incidents.

They should:

- have a clear understanding of the facts relevant to the incident
- be senior enough or have sufficient experience and expertise in relation to the type of patient incident to be credible to patients, carers and colleagues
- have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand and avoiding excessive use of medical jargon
- be willing and able to offer an apology, reassurance and feedback to patients and/ or their carers
- be able to maintain a medium to long-term relationship with the patient and/or their carers, where possible, and to provide continued support and information
- be culturally aware and informed about the specific needs of the patient and/ or their carers

#### 6.4.1 Consultation with the patient regarding the healthcare professional leading the *Being Open* discussion

If for any reason it becomes clear during the initial discussion that the patient would prefer to speak to a different healthcare professional, the patient's wishes should be respected. A substitute, with whom the patient is satisfied, should be found.

#### 6.4.2 Involving healthcare staff who made mistakes

Some patient incidents that resulted in moderate, high and extreme harm or death will result from errors made by healthcare staff while caring for the patient. In these circumstances the member(s) of staff involved may or may not wish to participate in the *Being Open* discussion with the

patient and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the patient and/or their carers with those of the healthcare professional concerned. In cases where the healthcare professional who has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting.

## **7. Content of the initial *Being Open* discussion with the patient and/or their carers**

7.1 With the patient's agreement, carers/relatives can be included in the discussions and decision making. If the patient is unable to participate or has died, then the carers or relatives may be provided with limited information in order to make decisions, but this should be done with regard to confidentiality and any patient instructions. The patient/carer should also be given a leaflet on the *Being Open* process so that they know what to expect (see Appendix A)

- The patient and/or their carers should be advised of the identity and role of all people attending the *Being Open* discussion before it takes place. This allows them the opportunity to state their own preferences about which staff should be present
- Where there is lack of clarity, communication about specific matters should be deferred until after the investigation has been completed. The patient and/or their carers should be informed that an incident investigation is being carried out and more information will become available as it progresses
- It should be made clear to the patient and/or their carers that new facts may emerge as the incident investigation proceeds
- The patient's and/or carer's understanding of what happened should be taken into consideration, as well as any questions they may have
- There should be consideration and formal noting of the patient's and/or carer's views and concerns, and demonstration that these are being heard and taken seriously
- Appropriate language and terminology should be used when speaking to patients and/or their carers. For example, using the terms 'patient safety incident' or 'adverse event' may be at best meaningless and at worst insulting to a patient and/or their carers. If a patient's and/or their carer's first language is not English, or they have other communication difficulties, their language needs should be addressed
- For individuals whose first language is not English an interpreter should be used rather than reliance on a member of the family
- An explanation should be given of the investigation process and incident analysis findings
- Information on likely short and long term effects of the incident (if known) should be shared. The latter may have to be delayed to a subsequent meeting when the situation becomes clearer
- An offer of practical and emotional support should be made to the patient and/or their carers. This may involve giving information on third parties such as charities and voluntary organisations to the patient/carer, as well as offering more direct assistance.

Information about the patient and the incident should not normally be disclosed to third parties without the patient's consent

- The patient/carer should be given the contact details of one member of staff who will act as a contact point for them. Their role will be to provide both practical and emotional support in a timely manner
- The patient should be reassured that they are entitled to continue to receive all usual treatment with respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere
- Patient/carers should be given information on the complaints procedure and offered assistance if necessary
- It should be recognised that patients and/or their carers may be anxious, angry and frustrated even when the *Being Open* discussion is conducted appropriately.

**It is essential that the following does not occur:**

- speculation
- attribution of blame
- denial of responsibility
- provision of conflicting information from different individuals.

The initial *Being Open* discussion is the first part of an ongoing communication process. There should be repeated opportunities for the patient and/or carer to obtain information.

## 7.2 Notification

7.2.1 In cases of serious and/or untoward incidents the incident should be reported onto the Trust Datix system and the Clinical Governance and Risk Department informed. Where an incident is evolving towards a complaint the appropriate Matron should be informed and the complaints team if the situation is thought likely to develop into a formal complaint. Where an incident is thought potentially to develop to a claim the litigation team should be informed.

### 7.2.2 The Coroner

All cases of untimely, unexpected or unexplained death or suspected unnatural deaths should be reported to the coroner. A coroner may request the case is not discussed with other parties until the facts have been considered. However this should not preclude a verbal and written apology, or expression of regret where appropriate. In this situation it should be made clear to the family that a full discussion of the circumstances and any residual concerns will be arranged at a date to suit both parties after the coroner's assessment is finished. It should also be recognised that coroner investigations are stressful for patients, families, carers and staff. Bereavement counselling and advice on professional support groups should be offered at the outset of a coroner's investigation.

### 7.2.3 Relevant statutory bodies

The Incident Reporting Policy details which external agencies should be informed of a patient incident and when this should occur. The Clinical Governance and Risk Department is responsible for notifying the external agencies, such as National Health Service Litigation Authority or the Health and Safety Executive (for RIDDOR reportable patient incidents).

## 8. Documentation

### 8.1 General

The communication of patient incidents must be recorded. Required documentation includes:

- a copy of relevant medical information, which should be filed in the patient's medical records
- incident reports
- notes from review meetings
- copies of statements taken during the investigation (where possible statements should be obtained in the immediate period following an incident)
- records of the investigation and analysis process.

The incident report and record of the investigation and analysis process will be recorded on the Datix system. Associated documents should be filed with the incident report.

### 8.2 Written records of the *Being Open* discussion

There should be documentation of:

- the time, place, date, as well as the name and relationships of all attendees
- the plan for providing further information to the patient and/or their carers
- offers of assistance and the patient's and/or carer's response.
- questions raised by the family and/or carers or their representatives and the answers given
- plans for follow-up as discussed
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient and/or their carers
- copies of letters sent to patients, carers and any other third party for patient incidents not occurring within the Trust
- copies of any statements taken in relation to the patient safety incident
- a copy of the incident report.

## 9. Completing the process

### 9.1 Communication with the patient and/or their carers

After completion of the incident investigation, feedback should take the form most acceptable to the patient. Communication should include:

- a chronology of clinical and other relevant facts
- details of the patient's and/or their carer's concerns and complaints
- a summary of the factors that contributed to the incident
- information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the patient; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the patient will be informed of the reasons for the restrictions.

#### 9.2 Communication with the GP and other community care service providers for patient incidents not occurring in primary care

Wherever possible, it is advisable to send a brief communication to the patient's GP, before discharge, summarising the details of the incident.

#### 9.3 Communication of changes to staff

Effective communication with staff is a vital step in ensuring that recommended changes are fully implemented and monitored. It will also facilitate the move towards increased awareness of patient safety issues and the value of Being Open.

#### 9.4 Communication of lessons learned throughout the health service

The NPSA will publish patient safety alerts, safer practice notices and patient safety information notices through the Alert Broadcast System to highlight common factors that cause patient safety incidents. Information can be found at [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

### **10. Monitoring**

Compliance with this policy will be monitored by the Nurse Specialist Patient Safety, Patient Relations Manager and Legal and Committee Services Manager, who from analysis of incidents, complaints and claims related to failure to communicate or document communications as outlined in this policy, will provide an quarterly report on activity on a rolling programme to the Integrated Governance Group

The quarterly report will be presented to the Clinical Risk Group which will identify any areas for improvement in the form of actions and these will be monitored by the committee until all actions are completed. In addition, an annual audit of case notes, where known incidents have been identified, will be undertaken and presented to the Clinical Risk Group to identify any areas for improvement, establish action plans as appropriate and monitor until all issues have been resolved.

## 11. References

Making Amends, Department of Health, 2003  
Seven Steps to patient safety, National Patient Safety Agency, 2004  
“Being Open”, National Patient Safety Agency, 2005  
NHSLA risk Management Standards for Acute Trust, 2009/10  
Saying sorry when things go wrong, Being Open, National Patient Safety Agency, 2009

Further information and an e-learning module can be found at

<http://www.nrls.npsa.nhs.uk/resources/collections/being-open/>

**Author:** Nurse Specialist Patient Safety

### ***Being open – saying sorry when things go wrong***

Each day more than a million people are treated safely in the NHS. But, occasionally, something goes wrong and a patient is harmed.

Newcastle Upon Tyne Hospitals NHS Trust expects its staff to be open with people when mistakes are made. If a mistake seriously harms you, a family member or someone you care for, you will be able to expect one of the doctors or nurses treating you to apologise and explain clearly what went wrong. They should also tell you what they will do to stop the problem happening again.

### **A chance to talk**

*Being open* will mean that someone involved in your treatment should ask to arrange a meeting with you to talk about what went wrong. You should be able to choose who comes to this meeting. It will usually be the doctor or nurse treating you, but you can choose someone else if you'd prefer. You may want to bring a friend or relative along. You can also choose where you want the meeting to be. You may prefer to talk away from the hospital.

**At the meeting**, someone from the team treating you should:

- say sorry for what happened;
- explain exactly what went wrong and, where possible, why things went wrong;
- ask you what you think went wrong and why;
- tell you what they'll do to stop the problem happening again;
- let you ask any questions.

It can sometimes take weeks or months to investigate a problem. So it might be that at the first meeting no one can tell you exactly what went wrong. However, someone will keep you up-to-date with how the investigation is going.

**After the meeting** you will get a letter of apology. This letter will explain how and, if possible, why things went wrong with your treatment. If this information isn't available, you will be told how your case will be investigated and when you can expect more details. The letter may also say what the hospital will do to stop the problem happening again. You should also be offered support from a counsellor.

### **Improving the NHS**

The NHS can learn from people who have been harmed whilst in their care. Sharing your experience may help stop the same mistake happening to someone else. You may feel anxious about talking through your experience with the people who have been treating you, especially if you need further treatment. But people who have been harmed by treatment that has gone wrong often say that they cope much better once they get an apology and understand what went wrong.

**More information**

If you would like to know more about how our hospital deals with mistakes, please ask one of the people treating you.

**Further help and advice**

For more information on how the government handles the issue of patient safety contact the National Patient Safety Agency (NPSA) by visiting [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

The NPSA cannot investigate individual cases or complaints. The Trust has a formal Complaints Procedure and information on the procedure can be obtained from the leaflet, which is available on all wards and departments. Alternatively you can write directly to the Chief Executive, Mr. L Fenwick CBE, The Newcastle upon Tyne Hospitals NHS Foundation Trust, The Freeman Hospital Freeman Road, High Heaton, Newcastle upon Tyne NE7 7DN Tel: 0191 223 1000

Organisations that can help if you or someone you know has been involved in a case where someone has been harmed:

**Action against Medical Accidents (AvMA)**

AvMA is an independent charity, which promotes better patient safety and justice for people who have been affected by a medical incident. You can call their helpline on 0845 123 2352 or visit [www.avma.org.uk](http://www.avma.org.uk)

**Patient Advice and Liaison Service (England)**

You can contact them by:

- phoning the Trust on and asking for details of the PALS
- phoning NHS Direct on 0845 46 47

**Care Quality Commission**

If your issue is not resolved locally you can contact the Care Quality Commission

03000 616161 or visit [enquiries@cqc.org.uk](mailto:enquiries@cqc.org.uk)

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

**IMPACT ASSESSMENT – SCREENING FORM A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Being Open Policy	Policy Author:	Nurse Specialist Patient Safety
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		This policy does not discriminate against any individual on the basis of race, ethnicity, nationality, gender, culture, religion, sexuality, age or disability.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?		
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If “yes”, please answer sections 4(b) to 4(d)).</i>	NA	
4(b).	If so can the impact be avoided?		
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d).	Can we reduce the impact by taking different action?		

<b>Comments:</b>	<b>Action Plan due (or Not Applicable):</b> NA
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Name and Designation of Person responsible for completion of this form: Jo Coward Nurse Specialist Patient Safety Date: 12/10/2009

Names & Designations of those involved in the impact assessment screening process: Clinical Risk Group.....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)