

ISLINGTON HOUSE MEDICAL CENTRE

BEING OPEN AND TRANSPARENT POLICY

INTRODUCTION

The concept of an open approach to communication of patient safety incidents to patients, families and carers was first introduced into the NHS in 2005, and was further reviewed in 2008.

An updated "Being Open" guidance has now been issued to build on this along with a Patient Safety Alert dated 19th November 2009 which outlines actions required by the NHS, due for completion by November 2010 (see Resources below)

Background

An open dialogue with patients or their representatives following an incident can ease the impact, stress and concern. An effective method of formalised, honest, timely and open communication with patients, their families and carers is a vital part of the process of dealing with patient safety incidents in healthcare, helping patients to accept mistakes and medical errors and reach a state of forgiveness more readily. It will also:

- ensure that the communication with patients, their families and carers has been handled in the most appropriate way:
- enable the clinician to develop a good professional reputation for handling difficult situations well:
- improve the clinician's understanding of incidents from the perspective of the patient, their family and carers.

There are a number of key markers to the success of a policy of openness with patients:

- There is clear guidance on the procedure.
- Offer an immediate apology.
- The original clinicians are involved in the resolution process.
- Clinicians or staff have good communication skills and are able to relate to the patient or families.
- There is a meaningful dialogue in which the concerns of the patient are respected and listened to.
- Patients and families can have confidence in the process.
- There is careful pre-planning, responsive disclosure, a proper system of follow-up and internal, as well as independent, counselling support.

Patient safety incidents can have major consequences for patients, their families and carers, and can similarly be distressing for the clinicians involved. Being open and dealing with issues in the right way can help to prevent formal complaints and legal action.

Steps in Implementing an Open Policy

1. Acknowledge the incident

Patient safety incidents should be acknowledged and reported as soon as they are identified.

In cases where the patient, their family and carers inform healthcare staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all clinicians.

The recognition that a patient has suffered harm or has died as a result of a patient safety incident is a major event and rare in primary care. The incident may however arise elsewhere as a result of care in the practice. The Being Open process and the investigation and analysis of a patient safety incident should normally occur in the healthcare organisation where the incident took place, and inter-care cooperation may be required.

Take immediate action to prevent further harm or recurrence. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the patient and with appropriate consent.

2. Investigate the incident

Investigate in an open and non-threatening way. Encourage participation and document the findings.

The multidisciplinary team, including the most senior health professional involved in the patient safety incident, should meet as soon as possible after the incident to:

- Establish the clinical and other facts.
- Assess the incident to determine the level of immediate response.
- Nominate who will be responsible for discussion with the patient, their family and 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 clinical team.

- Identify immediate support needs for the staff involved.
- Ensure there is a consistent approach by all team members around discussions with the patient, their family and carers.

3. Ensure truthfulness, timeliness and clarity of communication

Information about a patient safety incident must be given to patients, their families and carers in a truthful and open manner by an appropriately nominated person with appropriate skills. Patients should be provided with a clear explanation of what happened delivered in a timely, open and honest way. Patients and their families / carers should be provided with information about what happened as soon as practicable.

Any information given should be factual as known the time, and be updated as new information may emerge as the matter is investigated. Establish one point of contact – a staff member who will communicate with them on all aspects.

4. Apologise where you need to

Provide a face-to-face apology delivered by the most appropriate member of staff to patients, their families and carers as soon as possible. Consider both seniority and the relationship to the patient, and experience and expertise in the type of patient safety incident that has occurred when nominating an individual.

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 own clinician or senior partner.

They should be:

- Known to, and trusted by, the patient, their family and carers:
- Have a sound knowledge of the incident.
- Be senior.
- Be able to offer an apology and an explanation of the facts.
- Be able to maintain a relationship with the patient or their family where possible.

The initial discussion is the first part of an ongoing communication process.

The patient, their family and carers should be advised of the identity and role of all people attending any open discussion beforehand, allowing them to state their own preferences about which staff they would prefer to be present, or omitted. The meeting may:

- Offer genuine sympathy and an apology.
- State the facts that are known as agreed by the multidisciplinary team. Where there is disagreement, this may be deferred until further investigations have taken place.
- Take patient's or family's views into account.
- Ensure that communication and terminology are appropriate to the needs of the family, with jargon avoided.
- Give an explanation about what will happen next in the short through to long-term treatment plan and investigation.
- Give information on likely short and long-term effects of the incident. The long term effects may have to be considered later.
- Offer support for the patient, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance.

Follow-up discussions with the patient, their family and carers will be required as part of the Being Open process. A written record of each discussion should be maintained, and a copy provided to the patient's representatives.

A written apology can follow, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, and what the next steps are, and should be issued quickly.

5. Recognise patient / family expectations

Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident in a face-to-face meeting with a representative from the practice, and this should be facilitated. Determine what expectations they have in the resolution process.

They should be treated sympathetically, with respect and consideration, and should be offered support appropriate to their needs.

6. Professional support

Practices should encourage a culture where staff feel able to report patient safety incidents without worry. Staff should also feel supported throughout the incident investigation process as they may be suffering or stressed by the events.

Staff should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration, however where there is potentially a reason to believe a member of staff has committed a punitive or criminal act, they should be advised at an early stage to enable them to

obtain separate legal advice and/or representation, perhaps from a defence organisation. This may be done in a supportive and sensitive way and should not be accusative.

7. Risk Management and Systems Improvement

The practice Significant Event Procedure [*] should be used to examine the underlying causes of a patient safety incident. These investigations should focus on improving systems of care and the discussion of learning points. Document the discussions and formalise changes to procedure. Communicate changes to the patient as part of the Openness policy.

8. Multidisciplinary Responsibility

All staff in the practice involved in patient care should be aware of the incident and the issues or changes arising. Major incidents often arise from a systems failure over a period of time or a culmination of minor lapses rather than from the single action of an individual.

Investigate and correct any deficiencies in practice systems or risk control measures which may have contributed to the error.

9. Clinical governance

Being open requires the support of clinical governance frameworks through which patient safety incidents can be investigated and analysed to find out what can be done to prevent their recurrence. These findings should be treated as learning points and discussed. Incorporate the risk and the resultant actions in the practice Risk Management Framework [*]

10. Confidentiality

Policies and should comply with the patient's, their family's and carers' rights, and also staff rights to privacy and confidentiality. Details of a patient safety incident should be considered as confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. Rules of confidentiality apply.

11. Continuity of care

Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, 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.

An Open Culture

A culture of openness is where:

- Staff are open about incidents they have been involved in.
- Staff are accountable for their actions.

- Staff feel able to talk to their colleagues about an incident.
- Organisations are open with patients, the public and staff when things have gone wrong and explain what lessons will be learned.
- Staff are treated fairly and are supported when an incident happens.

See also Blame Free Culture Policy ^[*]

Resulting Death

It is important to consider the emotions bereaved relatives. The patient's family and carers will probably need information on the processes that will be followed to identify the cause(s) of death. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counselling or assistance at any stage.

The Being Open discussion and any investigation may occur a coroner's inquest, but consider whether it may be better to wait until after the coroner's report, to help focus on the facts of the incident.

Disagreement

Relationships with the family may break down as a result of a perceived error. They may not accept information and may refuse to be involved in any discussion:

- Attempt to deal with this as soon as possible.
- Involve family where you can.
- Provide details of support services.
- Use an alternative clinician to mediate, e.g. another partner or external PCT or PALS liaison.
- Provide details of the formal NHS complaints procedure.

RESOURCES

[Being open: communicating patient safety incidents with patients, their families and carers](#)

[MDU encourages doctors to say sorry if things go wrong](#)

[NHS Litigation Authority](#)

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