Belfast Health and Social Care Trust

Reference No: SG 56/11

Title:	'*Being Open*' policy – saying sorry when things go wrong.		
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17/4/2014	V1.1	JRJ	S+G put into new template
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22/01/2015	V1.3	CM	Change to scope and Appendix 2b to reflect application of principles to minor incidents
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14/04/2015	V1.5	JRJ	Check Hyperlinks, Contents, appendices, 1.1.2

Contents

1.0 INTRODUCTION / PURPOSE OF POLICY

Harming a patient can have devastating emotional and physical consequences on the individuals, their families and carers, and can be distressing for the professionals involved.

'Being open' is a set of principles that healthcare staff should use when offering an explanation and apologising to patients and/or their carers when harm has resulted from an incident.

"saying sorry is not an admission of liability"

Being open' involves:

- acknowledging, apologising and explaining when things go wrong
- keeping patients and carers fully informed when an incident has occurred.
- conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.
- providing support for those involved to cope with the physical and psychological consequences of what happened.
- recognising that direct and/or indirect involvement in incidents can be distressing for healthcare staff, permission will be given to seek emotional support.

The BHSCT is committed to improving the safety and quality of the care we deliver to the public. This BHSCT '*Being open'* policy expresses this commitment to provide open and honest communication between healthcare staff and a patient (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of 'Seven steps to Service user Safety' (appendix 1).

1.1 Background

1.1.1 Openness and honesty towards patients are supported and actively encouraged by many professional bodies including the General Medical Council, the Royal College of Nursing, the Medical Defence Union and the Medical Protection Society.

The General Medical Council in their document Good Medical Practice sets out the principles and values on which good practice is founded. It contains a section on: Being open and honest with patients if things go wrong when:-

- If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.
- Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient's complaint to affect adversely the care or treatment you provide or arrange.

In September 2005 the National Patient Safety Agency (NPSA) called on all NHS organisations to develop local '*Being open'* policies. Their guidance was replaced in November 2009 by Being open: communicating patient safety incidents with patients, their families and carers in response to changes in the healthcare environment and in order to strengthen '*Being open'* throughout the NHS.

They also produced a *Being Open Framework* to act as a best practice guide on how to create an open and honest environment through:

- aligning with the Seven steps to patient safety (appendix 1) which outlines for leaders of healthcare organisations on how to create an open and fair culture.
- ensuring a '*Being open'* policy is developed that clearly describes the process to be followed when harm occurs. This relates directly to, and expands upon, step 5.
- committing publicly to '*Being open'* at board and senior management level.
- identifying senior clinical counsellors to mentor and support fellow healthcare professionals involved in incidents.

This BHSCT policy is based on the '*Being open'* Framework document.

From: Being Open Framework, NPSA, November 2009.

1.1.2 Francis report

In 2013, Robert Francis QC published the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Of the 290 recommendations detailed in the report, 12 were related to a requirement for 'openness, transparency and candour'.

These were defined as,

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;
- Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

Recommendation 180 of the report reads 'Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.'

This BHSCT policy is based upon adopting openness, transparency and candour throughout the organisation and is modelled on the NPSA *Being Open* policy. The duty of candour has received support through the Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

1.1.3 **A. Open and fair culture**

Promoting a culture of openness is vital to improving patient safety and the quality of healthcare systems. A culture of openness is one where healthcare:

- staff are open about incidents they have been involved in.
- staff and organisations are accountable for their actions.
- staff feel able to talk to their colleagues and superiors about any 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.

To achieve this goal of openness with the public, the BHSCT has adopted the nationally recognized seven steps to patient safety in their risk management strategy and will continuously strive to achieve these objectives contained within the steps (appendix 1).

B. 'Being Open' policy

A *'Being open'* policy that sets out the process of communication with patients, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

C. Staff and patient support

To ensure both staff and patients support the implementation of *'Being open'* it is vital that:

- Patients, their families and carers feel confident in the openness of the communication following a patient safety incident, including the provision of timely and accurate information;
- healthcare professionals understand the importance of openness and feel supported by their healthcare organisation in delivering it.

To implement '*Being open'* successfully, the BHSCT will have the following foundations:

A. a culture that is open and fair.
B. a '*Being open'* policy and mechanisms to raise awareness about it.
C. staff and patient support for '*Being open'.*

1.1.4 **Prevented and 'no harm' incidents**

The Trust encourages staff to report all patient safety incidents; even those that were prevented (i.e.' near misses'), insignificant and minor incidents. These are often the type of incidents, which if addressed promptly and taken seriously will lead to minimizing or preventing more serious incidents. This

monitoring of all incidents will lead to the achievement of a high quality safety culture.

It is not a requirement of these guidelines that prevented and no harm patient safety incidents are discussed with patients as this would cause undue and unnecessary anxiety. This does not absolve staff or their responsibility to report such incidents to ensure that they are recorded, monitored and reported through the Trust incident reporting system.

1.1.5 **Being open**

The main thrust of this 'Being open' policy is concerned with patient safety incidents which cause moderate, major or catastrophic harm (appendix 2). It describes the process of 'Being open' and gives advice on the 'do's and don'ts' of communicating with patients and/or their carers following harm.

The focus is on rapid and open disclosure and emotional support to patients and families who experience serious incidents. They also address ways to support and educate clinicians involved in such incidents.

The trust will approach these issues from the patient's point of view, asking, "What would I want if I were harmed by my treatment?"

While trust employees and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, "What is the right thing to do?"

1.1.6 **Definitions**

"Harm" is the condition of promoting injury or damage.

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances it can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death. It can be rated as insignificant, minor, moderate, major or catastrophic (appendix 2).

1.2 Purpose

This document is relevant to all board, executive, managerial and healthcare staff and by explaining the principles behind '*Being open'* it ensures that patients and families who experience incidents which have caused moderate, major or catastrophic harm receive rapid and open disclosure along with emotional support. It also addresses ways to support and educate staff involved in such incidents.

1.3 Objectives

This policy defines the BHSCT's commitment to '*Being open'* by establishing a culture where:

- patients and carers receive rapid and open disclosure and emotional support when they experience serious incidents which cause moderate, major or catastrophic harm.

- they receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again.
- ways to support and educate healthcare staff involved in such incidents are addressed.
- staff involved are treated justly and appropriately.
- healthcare professionals, managers, patients & carers are appropriately supported when things go wrong.
- Patients and carers receive timely information about the outcome of any investigation.

2.0 SCOPE OF THE POLICY

The BSHCT Adverse Incident Reporting and Management Policy encourages staff to report all patient and service user safety incidents, including those where there was no harm or it was a 'near miss' event.

The *'Being Open'* principles apply to any incident where any harm has occurred to a patient. The *'Being Open'* process outlined in the policy must be followed where incidents are of moderate, major or catastrophic severity as defined in appendix 2a+b and within steps 1+2 of the BHSCT Procedure for grading an adverse incident; incidents that are regarded as insignificant or minor do not require implementation of the Being Open process , although the principles should be applied (section 1.1.4).

This policy applies to all Trust employees.

This policy establishes a culture of openness as a basic principle of how we interact with patients which then underpins other policies. It sets the scene of openness as a founding principle behind:-

- Capability Policy and Procedure
- Complaints Policy
- Disciplinary Policy and Procedure
- Adverse Incident Reporting and Management policy and procedures
- Information Governance Policy
- Procedure for investigating Adverse Incidents
- Risk Management Strategy
- Consent Policy.

It also complements standards as set out by professional bodies e.g. GMC and NMC.

3.0 ROLES/RESPONSIBILITIES

This policy is aimed at all levels of healthcare staff working for or in the BHSCT. The following responsibilities and accountabilities reinforce the concept of this *'Being open'* culture of openness applying throughout the organization.

Trust Board

The Trust Board are responsible

- for actively championing the *'Being open'* process.
- by promoting an **open and fair** culture that fosters peer support and discourages the attribution of blame. This should result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Chief Executive
The Chief Executive is responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident that led to moderate, major or catastrophic harm.

Executive Directors
Medical Director/Director of Nursing/ Director of Adult Social & Primary Care
Overall professional responsibility for managing the '*Being Open'* process.

Service Directors
Responsibility within their own service directorate for managing the '*Being Open'* process.

Managers
- Ensuring all staff are aware of the "Being Open" policy.

- Supporting staff, particularly those who will have a key role in managing the being open process, in completing Being Open e-learning training available on the HUB http://elearning.belfasttrust.local/

- Supporting staff involved in patient and service user safety incidents, including advising on sources of appropriate support such as StaffCare.

- Notifying the
  - Associate Medical / Nursing / Co- Directors when an incident has caused moderate harm or more.

  - Medical Director } that the '*Being Open'* process has
    Nursing Director } been initiated for an incident
    Primary and Social Care Director } causing
    Service Director } major or catastrophic harm.

All Healthcare Staff
All staff working within the organisation will be expected to adhere to this policy and are responsible and accountable for:-
- ensuring that patient incidents are acknowledged and taken seriously.
- treating concerns with compassion and understanding.
- reporting as soon as they are identified.
- informing their line manager.
- participating in the investigation process.
- communicating in a timely, truthful & clear fashion.
- recording and documenting discussions with patients and families
- complying with the '*Being Open'* policy.

4.0 KEY POLICY PRINCIPLES

4.1 Key Policy Statement(s)

Patient safety incidents will be managed using the principles outlined in this BHSCT '*Being open'* policy. Each incident will trigger a 5 stage process as set out in appendix 5; with modifications in certain circumstances detailed in appendix 6.

4.2 The principles of 'Being Open' should also apply to the full spectrum of unexpected or unplanned clinical events. Especially where there is a risk of moderate, major or catastrophic harm, a rapid and open disclosure of these changes in a patient's medical condition e.g. C. Diff. infection, should be communicated and discussed with the patient and, where appropriate, their family.

Also, in keeping with the 'Being Open' philosophy, if a death certificate is needed it is the responsibility of the Consultant to ensure that it is completed accurately and that the details of the patient's illness, its treatment and the factors causing and/or contributing to the patient's death are discussed with the relatives and recorded in the clinical record.

4.3 All patient safety incidents will be **acknowledged** and reported as soon as possible in line with the BHSCT adverse incident reporting and management policy; denial of a concern makes further open and honest communication more difficult.

4.4 The most appropriate person must **communicate** with the patient about an incident in a truthful open and timely manner. Information must be based solely on the facts. Patients will not receive conflicting information from different members of staff.

4.5 Patients and/or their families [unless there are confidentiality issues] will receive a sincere **apology** and expression of sorrow or regret for the harm caused by a patient safety incident.

10 principles of 'Being open'

1. Acknowledge incident
2. Communicate – truthful, timely, clear
3. Apology
4. Patient, family & carer support
5. Support for Professions
6. Risk management
7. Multidisciplinary responsibility
8. Clinical Governance
9. Confidentiality
10. Continuity of care

Both verbal and written apologies will be given. Verbal apologies are essential because this allows face-to-face contact and they should be given as soon as staff are aware of the incident. Delay is likely to increase anxiety, anger or frustration.

The NI Ombudsman has issued a 'Guidance on Issuing an Apology' leaflet which provides helpful guidelines regarding issuing an apology (appendix 9).

4.6 Support for the Patient

A key part of 'B*eing open'* is considering the patient's needs, or the needs of their carers or family in circumstances where the patient has been involved in a serious patient safety incident or died. The Trust will ensure early identification of and provision for the patient's practical and emotional needs.

Patients and/or their carers can reasonably expect to be kept fully informed of the issues surrounding a patient safety incident in a face-to-face meeting. They will be treated sympathetically with respect and consideration. They will be provided with **support** in a manner appropriate to their needs.

This includes providing the names of people who can give assistance and support, and to whom the patient has agreed that information about their health care can be given. This person (or people) may be different to both the patient's next of kin and from people whom the patient had previously agreed should receive information about their care prior to the patient safety incident. The Trust will provide information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the patient identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.

Contact details will be provided of a staff member who will maintain an ongoing relationship with the patient, using the most appropriate method of communication from the patient's and/or their carer's perspective. Their role is to provide both practical and emotional support in a timely manner.

Public information statement
'*Being open*' if things go wrong:
We will

- tell you if we know something has gone wrong.
- listen to you if you see something is wrong.
- say sorry.
- find out what happened and why.
- keep you informed.
- answer your questions.
- work to stop it happening again.

It is important to identify at the outset if there are any special restrictions on openness that the patient would like the healthcare team to respect. It is also important to identify whether the patient does not wish to know every aspect of what went wrong, to respect their wishes and reassure them this information will be made available if they change their mind later on.

4.7 Support for Families, Carers

Patients and/or their carers may need considerable practical and emotional help and support after experiencing a patient safety incident. Support may be provided by patients' families, social workers, religious representatives, directorate and corporate governance leads. Details of the Patient Client Council should also be available among others. Where the patient needs more detailed long-term emotional support, advice should be provided on how

to gain access to appropriate counseling services, e.g. Cruse (the UK's largest bereavement charity).

A patient and/or their family may, at any time through this process wish to avail of advocacy or representation if they feel this would help them to understand and address issues.

4.8 Information on the 'B*eing open'* process in the form of a short leaflet explaining what to expect should also be provided along with information on how to make a formal complaint and/or any other available means of giving positive or negative feedback to healthcare staff involved in their care.

4.9 **Support for staff**

These guidelines apply to all staff that have a role in providing patient care. The Trust acknowledges that most incidents usually result from system failures and it is unusual that incidents arise solely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

When a patient safety incident occurs, healthcare professionals involved in the clinical care may also require emotional support and advice. Both the clinical staff who have been involved directly in the incident and those with the responsibility for '*Being open'* discussions should be given access to assistance, support and any information they need to fulfill this role.

To **support staff** involved the trust will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The trust will work towards a culture where blame is the enemy of learning and where human error is understood to be a consequence of flaws in the healthcare systems, not necessarily the individual.
- Create an environment in which staff are encouraged to report patient safety incidents. Staff should feel supported throughout any incident investigation process.
- Provide facilities for formal and informal debriefing of the clinical team involved in an incident separate from the requirement to provide statements for the investigation. Individual feedback about the final outcome of the patient safety incident will be available.
- Provide advice and training on the management of patient safety incidents.
- Provide counselling by professional bodies for staff distressed by patient safety incidents. Stress management courses for staff that have responsibilities for leading "Being open" discussion.
- Avail of the support services provided by staff representative organisations and ensure staff have access to the information they can provide.
- Recognise that there is a need for healthcare staff to develop the skills necessary to be effective when communicating with patients and/or their carers in these rare but very distressing circumstances. The Trust will provide training to assist communicating in these difficult situations.

4.10 Patient safety incidents will be investigated to uncover the underlying cause(s). Investigations should focus on improving systems of care. The '*Being Open*' policy is part of an integrated approach to addressing patient safety incidents. They are embedded in an approach to **risk management** that includes incident reporting, analysis of incidents and decision about staff accountability.

4.11 This policy applies to all members of the **multidisciplinary teams** that have key roles in providing the patient's care. This should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the '*Being open'* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

To ensure multidisciplinary involvement in the '*Being open'* process, it is important to identify clinicians, nurses and managers who will support it. Both senior managers and senior clinicians who are local leaders must participate in incident investigation and clinical risk management.

4.12 The guidelines will require support of patient safety and quality improvement processes through the assurance and **governance framework** in which patient safety incidents are investigated and analysed and to find out what can be done to prevent a recurrence.

The findings of any investigation should be disseminated to all relevant persons and monitored so they can learn from events. This will also facilitate the move towards increased awareness of patient safety issues and the value of '*Being open'*.

4.13 Full **confidentiality** of and respect for patients, carers and staff will be maintained. Consent will be sought from individuals prior to disclosing information beyond the clinicians involved in treating patients. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis.

4.14 Patients are entitled to expect, and the Trust will ensure, that they will receive **continuity of care** with all the 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 Trust will make every effort to make the appropriate arrangements unless it is clearly obvious not to be in the patient's best interests

5.0 IMPLEMENTATION OF POLICY

On line training "Being Open – Saying sorry when things go wrong" is suitable for all staff and is available on the HUB e-learning page at:

http://elearning.belfasttrust.local/

6.0 MONITORING

This policy will be audited through the Audit and Risk & Governance departments.

7.0 EVIDENCE BASE / REFERENCES

Legacy Trust Guidance
BSHCT Adverse Incident Reporting and Management Policy
BHSCT Risk Management Strategy 2008-11.
National Patient Safety Agency documents.
Australian Open Disclosure Framework

National Patient Safety Agency
1. Seven steps to patient safety: full reference guide – July 2004.
2. Being open: communicating patient safety incidents with patients, their families and carers
3. 'Being open' Framework – November 2009.

8.0 CONSULTATION PROCESS

Trust Service Group Directors & Staff Side
Standards and Guidelines Committee.
BHSCT Clinical Ethics Committee

9.0 APPENDICES / ATTACHMENTS

Appendix 1 = Seven Steps for Safety
Appendix 2a = NPSA grade and definition of patient safety incident
Appendix 2b = Grades and consequent actions following Patient Safety Incidents.
Appendix 3 = Benefits for patients
Appendix 4 = Benefits for Staff patients
Appendix 5 = The '*Being open'* process
Appendix 6 = Being open in particular circumstances
Appendix 7 = NPSA '*Being open'* safety alert November 2009
Appendix 8 = Comparison of BHSCT vs NPSA incident grading matrix.
Appendix 9 = Guidance on issuing an apology – NI Ombudsman.

10.0 EQUALITY STATEMENT

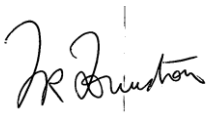
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☐

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



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Appendix 1

NPSA - Seven steps to patient safety.

National Patient Safety Agency. *Seven steps to patient safety*. *The full reference guide*. 2004.

Appendix 2a

BHSCT – Definitions for grading of Patient Safety Incidents

Insignificant

Incident prevented / Near Miss

Any patient safety incident that had the potential to cause harm but was prevented and no harm was caused to patients receiving NHS-funded care. Incidents that did not lead to harm but could have, are referred to as **near misses**. (*Doing Less Harm. NHS. National Patient Safety Agency 2001*).

Incident not prevented

Any patient safety incident that occurred but insignificant harm was caused to patients receiving NHS-funded care.

Minor harm

Any patient safety incident that required:

- *Minor injury or illness requiring first aid/intervention.*
- *Requiring increased patient monitoring.*
- *Increase in hospital stay by 1-3 days.*

Moderate harm

Any patient safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more patients receiving NHS funded care.

**Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, canceling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Major harm

Any patient safety incident that appears to have resulted in permanent harm* to one or more patients receiving NHS-funded care.

**Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*

Catastrophic

Any patient safety incident that directly resulted in the death* of one or more patients receiving NHS-funded care.

**The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.*

Appendix 2b

Grades and consequent actions following Patient Safety Incidents

BHSCT	Insignificant	Minor	Moderate	Major	Catastrophic
BHSCT definition	Not requiring first aid or any intervention.	Requires extra observation or minor treatment.	**Significant but not permanent harm - moderate increase in treatment.**	Permanent harm arising directly from incident.	Resulted in the death.
Example		Intervention required. Requires first aid Increased patient monitoring. Additional medication Increased hospital stay (1-3 days) No return to surgery No readmission	Semi-permanent physical / emotional injury / trauma / harm. Treatment given. Recovery expected within 1 year. Return to surgery, Unplanned readmission, Prolonged episode of care, Extra time in hospital (4-14 days) or as an outpatient, Cancellation of treatment, Transfer to another area e.g. ICU	Permanent physical / emotional injuries/trauma/harm Increased hospital stay >14 days.	The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.
Action	⬇	⬇	⬇	⬇	⬇
	Apply the principles of 'Being open'.		**Apply the 'Being open' process Stages I →V.**		
	1. Report the incident in line with the adverse incident reporting and management policy. 2. Review the incident to determine its cause and take local action to prevent it happening again. 3. The principles of the 'Being Open' policy apply but no documented actions are required**.**		A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the '*Being open'* process if required.		

Appendix 3

BENEFITS FOR PATIENTS

Being open when things go wrong has not always been part of the Health and Social Care culture. However evidence shows that being open and honest is fully supported by patients and they are more likely to forgive and understand healthcare errors when they have been discussed fully in a timely and thoughtful manner. Research and the feedback from those involved in a serious patient safety incident indicate that the patients would like:

- To know when a safety incident affects them;
- An acknowledgement of the distress that the incident caused;
- A sincere and compassionate statement of regret for the distress being experienced;
- A factual explanation of what happened;
- A clear statement of what is going to happen from then onwards;
- A plan about what can be done to repair or redress the harm done.

Appendix 4

BENEFITS FOR STAFF

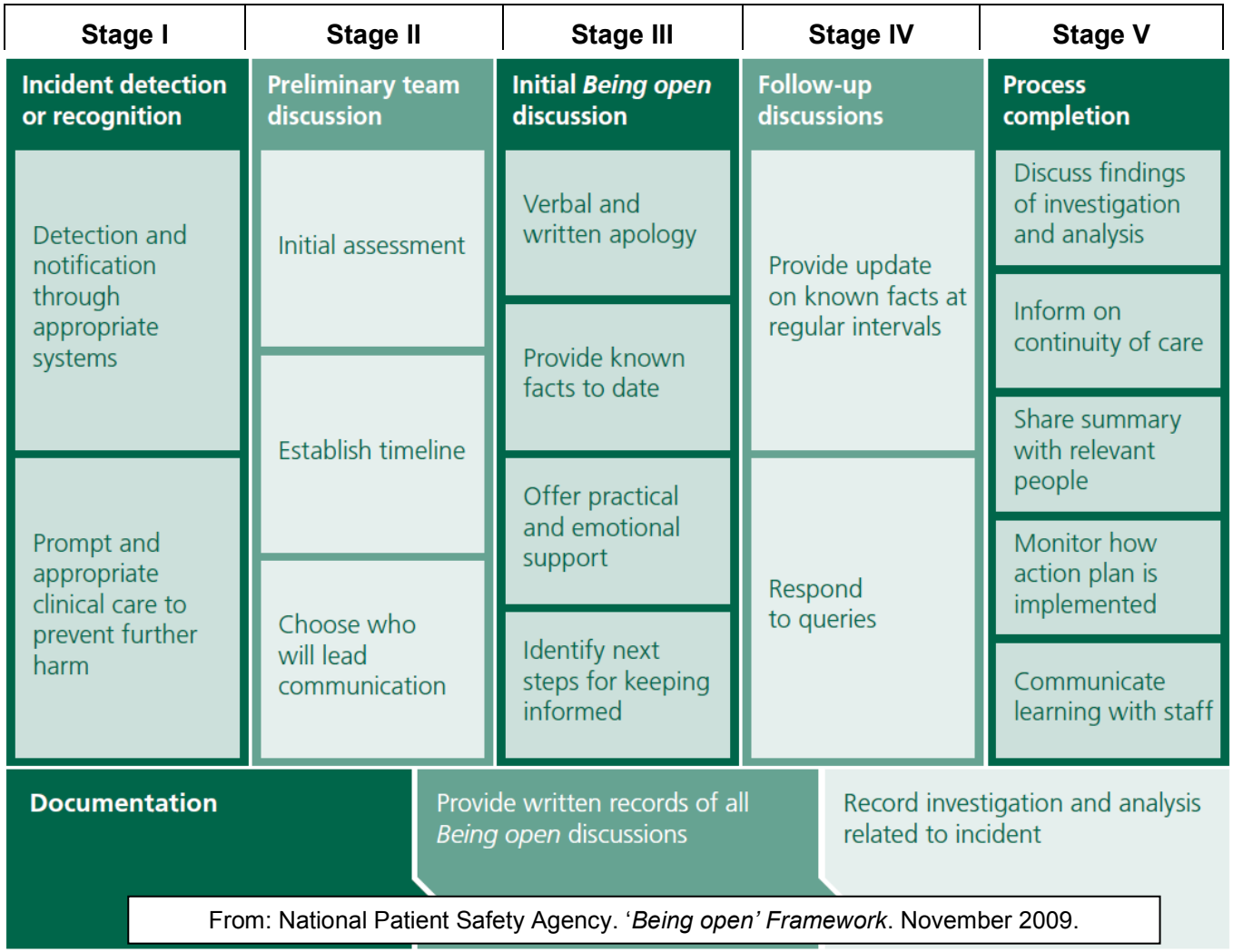
Being open has several benefits for healthcare staff including:

- Satisfaction that communication with patients and /or their carers following a patient safety incident has been handled in the most appropriate way;
- improving the understanding of incidents from the perspective of the patient and /or their carers;
- the knowledge that lessons learned from incidents will help prevent them happening again;
- having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

Appendix 5

'*BEING OPEN*' PROCESS

'Being open' is a process rather than a one-off event and can be considered in 5 stages with documentation being a constant feature throughout the process.



From: National Patient Safety Agency. '*Being open' Framework*. November 2009.

STAGE I: INCIDENT DETECTION AND RECOGNITION

The '*Being open'* process begins with the recognition that a patient has suffered moderate harm, major harm, or has died, as a result of a patient safety incident.

Detection of the incident

A patient safety 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 who expresses concern or dissatisfaction with the patient's healthcare either at the time of the incident or retrospectively.
- incident detection systems such as incident reporting or medical records review.
- other sources such as detection by other patients, visitors or non-clinical staff.

Priority

As soon as a patient safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the patient and with appropriate consent. An incident report form should be completed which will trigger the Trust processes for reporting and then investigating and analysing incidents. If the incident is considered to meet Serious Adverse incident criteria , the incident should also be escalated to the appropriate directorate senior manager and governance and quality manager to ensure timely appropriate management which may result in a serious adverse incident report to HSCB .

Patient safety incidents occurring elsewhere

A patient safety incident may have occurred outside the Trust. The individual who first identifies the possibility of an earlier patient safety incident should notify Corporate Governance. The same individual, or a colleague, should make contact with their equivalent at the organisation where the incident occurred and establish whether:

- the patient safety incident has already been recognized.
- the process of '*Being open'* has commenced.
- incident investigation and analysis is underway.

The '*Being open'* process and the investigation and analysis of a patient safety incident should occur where the incident took place.

Criminal or intentional unsafe act

Patient safety 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, Corporate Governance Department and the relevant Executive Director should be notified immediately.

The BSHCT Adverse Incident Reporting and Management Policy should be referred to.

STAGE II: PRELIMINARY TEAM DISCUSSION

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

- establish the basic clinical and other 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 = '*Being open'* coordinator.
- 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 that 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.
- ensure there is a consistent approach by all team members around discussions with the patient and/or their carers.

Assessment to determine level of response

All incidents should be assessed initially by the healthcare team to determine the level of response required. The nature and subsequent grading of the incident will determine the level of response.

Incident	Level of Response
Insignificant harm (including prevented patient safety incident)	It is not a requirement of this policy to communicate prevented patient safety incidents and insignificant incidents to patients and/or carers.
Minor harm	Unless there are specific indications or the patient requests it, the communication, investigation and 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. Reporting to the corporate governance department will occur through standard incident reporting mechanisms and monthly data will provided to Directorate teams for analysis to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. **Apply the principles of 'Being open' – locally.**
Moderate harm, **Major harm** **Death**	A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy. The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the 'Being open' process if required. **Apply the 'Being open' process – Stages I → V.**

Timing of discussion with patient and/or carers

Preliminary discussions with the patient and/or their carers should occur as soon as possible after recognition of the patient safety incident. Factors to consider when timing this and any future '*Being open*' discussions include:

- clinical condition of the patient.
- patient preference (i.e. meeting place and timing, who leads the discussion(s).
- availability of key staff involved in the incident and in the '*Being open'* process.
- availability of the patient's family and/or carers.
- availability of support staff e.g. interpreter, independent advocate.

The *'Being open'* coordinator role

It is essential to carefully consider the choice of the individual to communicate with patients and who informs the patient and/or their carers about a patient safety incident. Getting it right at the start of the process will reassure the patient and may lead to a favourable outcome. 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. They should:

- be known to, and trusted by, the patient and/or their carers.
- have a good grasp of the facts relevant to the incident.
- be senior enough or have sufficient experience and expertise in relation to the type of patient safety 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.

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 provided.

Use of a substitute healthcare professional for the 'B*eing open'* discussion

In exceptional circumstances, if the '*Being open'* coordinator, who usually leads the discussion cannot attend, they may delegate to an appropriately trained substitute. The qualifications, training and scope of responsibility of this person should be clearly delineated.

Assistance with the initial 'B*eing open'* discussion

The healthcare professional communicating information about a patient safety incident should be able to nominate a colleague to assist them with the meeting. Ideally this should be someone with experience or training in communication and '*Being open'* procedures.

Responsibilities of junior healthcare professionals

Junior staff or those in training should not lead the '*Being open'* process except when all of the following criteria have been considered:

- the incident resulted in insignificant or minor harm.
- they have expressed a wish to be involved in the discussions.
- the senior healthcare professional responsible for the care is present for support.
- the patient and/or their carers agree to their involvement.

Where a junior healthcare professional who has been involved in a patient safety incident asks to be involved in the '*Being open'* discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for junior staff to communicate

patient safety information alone or to be delegated the responsibility to lead a '*Being open'* discussion unless they volunteer and their involvement takes place in appropriate circumstances (i.e. they have received appropriate training and mentorship for this role).

Patient safety incidents related to the environment of care

In such cases a senior manager of the relevant service will be responsible for communicating with the patient and/or their carers. A senior member of the multidisciplinary team should be present to assist at the initial '*Being open'* discussion. The healthcare professional responsible for treating the injury should also be present to assist in providing information on what will happen next and the likely effects of the injury.

Involvement of healthcare staff who made the mistake

Some patient safety incidents result from errors made by the healthcare staff 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 that has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting and should be made aware of staff representation organization support.

In cases where the patient and/or their carers express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the patient and/or their carers during the first '*Being open'* discussion.

STAGE III: INITIAL 'BEING OPEN' DISCUSSION

Content of the initial 'B*eing open'* discussion

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 healthcare staff should be present.

The content of the initial '*Being open'* discussion with the patient, their family and carers should cover the following:

- An expression of genuine sympathy, regret and an apology for the harm that has occurred.
- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed.
- The patient, their family and/or their carers
    - should be informed that an incident investigation is being carried out.
    - understanding of what happened is taken into consideration, as well as any questions they may have.
    - provided with information on the complaints procedure if they wish to have it;
- Consideration and formal noting of the patient's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously.
- Patient's account of the events leading up to the patient safety incident are fed into the incident investigation for example, through Root Cause Analysis (RCA) whenever applicable.
- Provide carers and those very close to the patient with access to information to assist in making decisions if the patient is unable to participate in decision-making or if the patient has died as a result of an incident. This should be done with due regard to confidentiality and in accordance with the patient's instructions.
- Ensure carers are provided with known information, care and support if a patient has died as a result of a patient safety incident. The carers should also be referred to the coroner for more detailed information.
- Discussions with patients and/or their carers are documented and that information is shared with them;
- Appropriate language and terminology are used when speaking to patients, their families and carers.
- Assurance that an ongoing care plan will be developed in consultation with the patient and will be followed through followed by an explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.
- Assurance that the patient will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the patient and/or their carers and the healthcare team will not affect their access to treatment.
- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known.
- An offer of practical and emotional 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. Information about the patient and the incident should not normally be disclosed to third parties without consent.

STAGE IV: FOLLOW UP DISCUSSIONS

Follow-up discussions with the patient, their family and carers are an important step in the *'Being open'* process - there may be more than one.

- The discussion(s) should occur at the earliest practical opportunity.
- Consideration should be given to the location and timing of meeting, based on both the patient's health and personal circumstances.
- Feedback should be given on progress to date and information provided on the investigation process.
- Repeated opportunities should be offered to the patient and/or their carers to obtain information about the patient safety incident.
- There should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience. Tell the patient and family what happened. Tell *what* happened now; leave details of *how* and *why* to later i.e. Stage V.
- The patient and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- A written record of the discussion should be kept and shared with the patient and/or their carers.
- All queries should be responded to appropriately.
- If completing the process at this point, the patient and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the patient's records.
- The patient should be provided with contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals.

STAGE V: PROCESS COMPLETION

Communication with the patient, their family and carers

After completion of the incident investigation, feedback should take the form most acceptable to the patient. Whatever method is used, the communication should include:

- the chronology of clinical and other relevant facts including an explanation of details of *how* and *why.*
- details of the patient's, their family's and carers' concerns and complaints.
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety incident.
- 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.
- an ongoing clinical management plan. This may be encompassed in discharge planning policies addressed to designated individuals e.g. GP.
- reassurance that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the healthcare team. They should also be informed that they have the right to continue their treatment elsewhere if they prefer.

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.

Communication with the GP and other community care service providers

In certain circumstances, it may be prudent to communicate with the patient's GP, before discharge, describing what happened. When the patient leaves the Trust, the discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- the nature of the patient safety incident and the continuing care and treatment;
- the current condition of the patient;
- key investigations that have been carried out to establish the patient's clinical condition;
- recent results;
- prognosis.

DOCUMENTATION

Throughout the *Being open* process it is important to record discussions with the patient, their family and carers as well as the incident investigation.

Written records of the '*Being open'* discussions should consist of:

- the time, place and date, as well as the name and relationships of all attendees.
- the plan for providing further information to the patient, their family and carers.
- offers of assistance and the patient's, their family's and carers' response.
- questions raised by the patient, their family and carers, and the answers given.
- plans for follow-up meetings.
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient, their family and carers.
- copies of letters sent to the patient, their family and carers, and the GP.
- copies of any statements taken in relation to the patient safety incident.
- a copy of the incident report.

BEING OPEN IN PARTICULAR CIRCUMSTANCES

The approach to being open may need to be modified according to the patient's personal circumstances. The following gives guidance on how to manage different categories of patient circumstance.

When a patient dies

When a patient safety incident has resulted in a patient's death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The patient's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counseling or assistance at any stage.

"it may be appropriate to wait for the coroner's inquest before holding the '*Being open'* discussion"

Usually, the 'Being open' discussion and any investigation occur before the coroner's inquest. In certain circumstances the Trust may consider it appropriate to wait for the coroner's inquest before holding the 'Being open' discussion with the patient's family and/or carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the patient's death. In any event, an apology should be issued as soon as possible after the patient's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

Children

When a child reaches 16 years they acquire the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision-making.

Children younger than 16 years who understand fully what is involved in the proposed procedure can also give consent (Frazer competent). Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the 'Being open' process after a patient safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Patients with mental health issues

'Being open' for patients with mental health issues should follow standard procedures, unless the patient also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold patient safety incident information from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient. Except where exceptional circumstances prevail, it is inappropriate to discuss patient safety incident information with a carer or relative without the express permission of the patient; to do so may constitute an infringement of the patient's Human Rights and/or a breach of Data Protection legislative provisions.

Patients with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized a person to act on their behalf by an enduring power of attorney. In these cases, steps must be taken to ensure this extends to decision-making and to the medical care and treatment of the patient. The '*Being open'* discussion would be held with the holder of the power of attorney.

Where there is no such person the clinicians may act in the patient's best interests in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the patient to assist in the communication process.

Patients with learning disabilities

Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the patient is not cognitively impaired they should be supported in the '*Being open'* process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the patient, should be appointed. Appropriate advocates may include carers, family or friends of the patient. The advocate should assist the patient during the '*Being open'* process, focusing on ensuring that the patient's views are considered and discussed.

Patients with different language or cultural considerations

Reference must be made to the interpreting protocol when booking interpreters.

Patients with different communication needs

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Patients who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the '*Being open'* process. In this case the following strategies may assist to deal with the issue as soon as it emerges:

- Where the patient agrees, ensure their carers are involved in discussions from the beginning.
- Ensure the patient has access to support services.
- Where the senior health professional is aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team.
- Offer the patient and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management.
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution.
- Ensure the patient and/or their carers are fully aware of the formal complaints procedures.
- Write a comprehensive list of the points that the patient and/or their carer disagree with and reassure them you will follow up these issues.

Alert

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency

National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:

Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

worth repeating...

This Alert replaces the *Being Open Safer Practice Notice* (2005)

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Appendix 8

Comparison of BHSCT vs NPSA incident grading matrix.

BHSCT Grading	NPSA grading
Insignificant	None
Minor	Low
Moderate	Moderate
Major	Severe
Catastrophic	Death

Appendix 9.

Guidance on Issuing an apology – NI Ombudsman

Guidance on issuing an apology - Ombuds