Being Open Policy

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Document Change History:

Issue No	Page	Changes made (include rationale and impact on practice)	Date
Version 1	all	Complete re write following issue of NPSA guidance	June 2010
Version 2 - Rev 1	Monitoring table	Change to monitoring table only in line with NHSLA requirements	Nov 2011
Version 3	all	New reporting structures	October 2012

1.0 INTRODUCTION

> *The effects of harming a patient can be widespread. Patient safety incidents can have devastating emotional and physical consequences for patients, their families and carers and can be distressing for the professionals involved.*
>
> *"Being open" about what happened and discussing patient safety incidents promptly, fully and compassionately can help patients and professionals to cope better with the after effects*
>
> *NPSA 2009*

The promotion of a culture of openness is a prerequisite to improving safety and the quality of healthcare systems. This culture ensures communication is open, honest and occurs as soon as possible following a patient safety event or when a poor outcome has been experienced. It encompasses the communication between healthcare organisations, healthcare teams and patients, their families and carers.

Throughout the document the word incident has been replaced with the words "*patient safety event*" to ensure that the policy covers incidents complaints and claims.

1.1 Implementation of Being Open within Stockport NHS Foundation Trust

Stockport NHS Foundation Trust aims to implement the culture of Being Open by use of the National Patient Safety Being Open Framework. This framework will ensure that the culture of being open is strengthened within the Trust.

1.2 Being Open involves

- Acknowledging, apologising and explaining when things go wrong;
- Conducting a thorough investigation into patient safety events and reassuring patients, their families and carers that lessons learned will help prevent the patient safety event recurring;
- Providing support for those involved to cope with the physical and psychological consequences of what happened.

1.3 Openness and Honesty

An apology is not an admission of liability and is the right thing to do. Openness and honestly towards patients are supported and actively encouraged by many professional bodies including the Medical Defence Union (MDU), the Medical Protection Society (MPS), the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

1.4 National Guidance

This Being Open Policy and its objectives are consistent with the following guidance:

- National Patient Safety Agency (NPSA), *Patient Safety Alert: Being open* (2009). This alert outlines six actions for NHS organisations and replaces *Being open Safer Practice Notice* (2005).

- NPSA, *Being open*: *Communicating patient safety incidents with patients, their families and carers* (2009). This provides a best practice framework for all healthcare organisations to create an environment where patients, their families and carers, healthcare professionals and managers all feel supported when things go wrong and have the confidence to act appropriately.

- NPSA, *Seven Steps to Patient Safety* (2004) This best practice guidance outlines activities organisations can take to improve patient safety. *Being open* is a core part of *Step 5: involve and communicate with patients and the public*.

- National Health Service Litigation Authority (NHSLA), *Apologies and explanations. Letter to chief executives and finance directors* (2009). This encourages healthcare staff to apologise to patients harmed as a result of healthcare treatment and explain that an apology is not an admission of liability.

- General Medical Council (GMC), *Good Medical Practice* (2001). This guide contains a statement regarding a clinician's 'duty of candour'.

- Nursing and Midwifery Council (NMC), *The Code: Standards of conduct, performance and ethics for nurses and midwives,* (2008). This code of conduct includes standards of openness and honesty.

- Department of Health*, The NHS Constitution for England* (2009). This represents a major vehicle for improving candour in the NHS and incorporates the principles of *Being open* as a pledge to patients: "The NHS also commits when mistakes happen to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively" (p.8). There is also an expectation of staff responsibility: "You should aim to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation. You should contribute to a climate where the truth can be heard and the reporting of and learning from errors is encouraged" (p.11).

- Department of Health, *Listening, Responding, Improving - A guide to better customer care.* (2009). This guide outlines the new complaints process and is consistent with *Being open* principles.

2.0 PURPOSE

The purpose of this document is to ensure that patients, their families and carers, and staff all feel supported when patient safety events occur/things go wrong. This document also aims to improve the quality and consistency of communication with patients, their families and carers when patient safety events occur, so that they receive promptly the information they need to enable them to understand what happened; that a meaningful apology is offered; and they are informed of the action the organisation will take to try and ensure that a similar type of patient safety event does not recur.

This document aims to provide clear information to staff on what they do when they are involved and the support available to them to cope with the consequences of what happened and to communicate with patients, their families and carers effectively.

3.0 PRINCIPLES

The following principles will underpin our practice:

3.1 Acknowledgement

All patient safety events should be acknowledged and reported as soon as they are identified. In cases where the patient, their family and carers inform healthcare staff that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all staff. Denial of a person's concerns will make future open and honest communication more difficult.

3.2 Truthfulness, Timeliness and Clarity of Communication

Information about a patient safety event must be given in a truthful and open manner by an appropriately nominated person. Communication should also be timely, informing the patient, their family and carers what has happened as soon as is practicable, based solely on the facts known at that time. Explain that new information may emerge as the patient safety event investigation takes place and that they will be kept up to date. Patients, their families and carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

3.3 Apology

Patients, their families and carers should receive a meaningful apology - one that is a sincere expression of sorrow or regret for the harm that has resulted from a patient safety event. This should be in the form of an appropriately worded agreed manner of apology, as early as possible. Both verbal and written apologies should be given. Saying sorry is not an admission of liability and it is the right thing to do. Verbal apologies are essential because they allow face to face contact. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event, must also be given.

3.4 Recognising Patient and Carer Expectations

Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety event, and its consequences, in a face to face meeting with representatives from the organisation. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients, their families and carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information on the Patient and Customer Services team and other relevant support groups should be given as soon as possible.

3.5 Professional Support

The organisation will create an environment in which all staff are encouraged to report patient safety events. Staff should feel supported throughout the patient safety event investigation process; they too may have been traumatised by the patient safety event.

Using Root Cause Analysis Tools can help to ensure a robust and consistent approach to patient safety event investigation. The National Reporting and Learning Service, a division of the NPSA, has developed this tool and it can be found at www.npsa.nhs.uk. Where there are concerns about the performance of individual doctors, dentists of pharmacists the National Clinical Assessment Service (NCAS) can be contacted for advice. Where there is reason for the healthcare organisation to believe a member of staff has committed a punitive or criminal act, the organisation should take steps to preserve its position and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff should be encouraged to seek support from relevant professional bodies.

3.6 Risk Management and Systems Improvement

A Root Cause Analysis (RCA), should be used to uncover the underlying causes of patient safety events. This investigation should focus on improving systems of care, which will be reviewed for their effectiveness. This *Being open* document will be integrated into the Trust Risk Management Policy, the Procedure for Investigating Incidents Complaints and Claims, the Incident Reporting Policy, The Inquest Policy and the Serious Untoward Incident Policy.

3.7 Multi-Disciplinary Responsibility

The *Being open* policy applies to all staff who have key roles in patient care. Most healthcare provision involves multi-disciplinary teams. 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 patient safety events usually result from system failures and rarely from actions of an individual. To ensure multi-disciplinary involvement in the *Being open* process, it is important to identify clinical, nursing and managerial leaders who will support it. Both senior managers and senior clinicians must participate in the patient safety event investigation and clinical risk management.

3.8 Clinical Governance

Being open requires the support of patient safety and quality improvement through clinical governance frameworks, in which patient safety events are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability through the chief executive to the board to ensure that these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff so they can learn from patient safety events. Audits should be developed to monitor the implementation and effects of changes in practice following a patient safety event.

3.9 Confidentiality

Details of a patient safety event should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. Where this is not practicable or an individual refuses consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the patient safety event have statutory powers for obtaining information. Communications with parties outside of the clinical team should also be on a strictly need to know basis and, where practicable, records should be anonymous. It is good practice to inform the patient, their family and carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections.

3.10 Continuity of Care

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

4.0 Equality and Diversity Statement

All patients, employees and members of the public should be treated fairly and with respect, regardless of age, disability, gender, marital status, membership or non-membership of a trade union, race, religion, domestic circumstances, sexual orientation, ethnic or national origin, social & employment status, HIV status, or gender re-assignment

5.0 DEFINITIONS

5.1. Patient/Staff Safety Event

An event or circumstance that did or could have lead to harm loss or injury to a patient or patients or member of staff.

5.2 Incident

An event or circumstance arising that could have or did lead to harm, loss or damage, to staff, patient, visitors, public or Trust property

5.3 Complaint

This can refer to; both informal and formal complaints, made by the patient, their relatives, carers, or a person nominated by the patient to represent them.

5.4 Root Cause Analysis

Is a patient safety investigation which should be conducted at a level appropriate and proportionate to the incident, claim, complaint or concern examining the root causes of an incident.

6.0 “Being Open” Roles and Responsibilities

The *Being Open* policy is aimed at all healthcare staff responsible for patient care and for ensuring that the infrastructure is in place to support openness between healthcare professionals and patients, their families and carers following a patient safety event.

Trust Board

The designated member of the Trust Board who will take responsibility for the *Being Open Policy is* the **Director of Nursing** who will endeavour to be fully informed and assured that the principles are working and are being adhered to and will ensure that results of the monitoring of the “being Open Policy” are presented to the Trust Board.

Chief Executive

The Chief Executive Officer of Stockport NHS Foundation Trust is responsible for the process of managing and responding to the “*Being open”* process and for ensuring that this responsibility is delegated to appropriate personnel.

Associate Directors

Associate Directors are responsible for ensuring that there are identified persons within the business group who will take responsibility for adherence to policy; and for ensuring that monitoring of the policy, as required by this document is completed with any required Actions Plans being developed, actioned and monitored.

Chair of Serious Untoward Incident Meetings

Will ensure that the Being Open policy is adhered to when conducting a serious untoward incident meeting and ensure that all actions are taken in a timely manner.

Risk Manager and Inquest Coordinator

The Risk Manager (and deputy) and the Inquest Coordinator (and deputy) will ensure that all investigations into patient safety incidents and inquests will include consideration of the principles of *Being Open*

Head of Patient and Customer Services

The Head of Patient and Customer Services (and deputy) will ensure that the principles outlined in the policy document are adhered to in management of all patient complaints and will ensure that the procedures of being opened are followed throughout the Trust.

They will compile an annual report of adherence to the “Being Open Policy” with information collected from the business groups. This report will be presented to the Patient Experience & Workforce Assurance Committee along with an Action Plan developed by any business group where findings are that the policy is not being complied with. This Action Plan will be shared with the Governance and Risk Leads who will feed back to the business group quality board. The Annual report will also be shared with the Risk Manager(or deputy) who will present to the Patient Experience & Workforce Assurance Committee along with the agreed Action Plan.

Governance/Risk Leads within Business Groups

Will ensure that “Being Open” is considered for all patient safety incidents and that the standard operating procedure for “being open” is adhered to.

They will be responsible for performing an audit of the “being open” procedure for patient safety incidents within their business group annually and feed this information back to the Patient and Customer Services Manager for aggregation with all business groups.

They will receive the Annual Report on adherence to the Being Open policy from the Head of patient and customer services and present it along with an agreed action plan (developed within the business group) to the Quality Board.

Heads of Nursing/Clinical Directors/Matrons
All Heads of Nursing, Clinical Directors and Matrons will ensure that they are role models in the principles of being open, that they ensure all policies and procedures are followed with respect to *Being open* and that they:

- Attending relevant training on *Being open* and communicating with patients, their families and carers
- Attend where applicable meetings with patients involved in a patient safety event/ and/or their carer(s)
- Where relevant providing the patient, their family and carers with verbal and written apology
- Ensure that the patient has been provided with a contact name in the event of further queries or issues arising
- Arranging for transfer of care where the patient, their family and carer(s) request this
- Documenting the details of all discussion with the patient and/or their carer(s)
- Keeping in close communication with the event investigation leads to enable regular and informed communication with the patient, their family and carers
- Ensure that staff are at all times supported through the process of being open and are offered access to appropriate support/counselling via Occupational Health as required.

All Staff
All Trust staff are expected to adhere to the policy at all times. This will include adhering to all responsibilities as detailed in the procedure for *Being open*. When policy adherence is not possible a Datix Incident Form must be completed for monitoring purposes.

Patient Experience & Workforce Assurance Committee
This meeting will receive the Annual Report regarding adherence to the policy and agree an Action Plan to address any shortfalls in meeting the requirements.

7.0 Committee with Over Arching Responsibility for Monitoring Being Open Processes

The Patient Experience & Workforce Assurance Committee will be the committee with the overarching responsibility for the monitoring of the *Being open* policy and procedure.

The Policy is available to all staff and relevant stakeholders via the intranet on the Patient and customer service intranet site.

8.0 Monitoring

Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitorin g	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
<u>NHSLA Monitoring</u> Snapshot audit across all business groups of incident and complaints where the being open procedure would be required to ensure adherence to the following processes a. Process for encouraging open communication between healthcare organisations , healthcare teams, staff, patients and or their carers b. Process for acknowledging, apologising and explaining when things go wrong c. Requirements for truthfulness, timeliness and clarity of communication d. Provision of additional support as required e. Requirements for documenting all communication f. Process for monitoring compliance with all of the above	Business Group Governance Leads/Patient and Customer Services	Annual	Patient Experience & Workforce Assurance Committee	Patient Experience & Workforce Assurance Committee	Patient Experience & Workforce Assurance Committee

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Your local contact for more information is Patient and Customer Services at Poplar Suite, SHH, Tel: 0161 419 5678 or

www.stockport.nhs.uk

A free interpreting service is available if you need help with this information.
Please telephone Stockport Interpreting Unit on 0161 477 9000.
Email:eds.admin@stockport.gov.uk

如果你需要他人爲你解釋這份資料的內容，我們可以提供免費的傳譯服務，
請致電 0161 477 9000 史托波特傳譯部。

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