BEING OPEN

COMMUNICATING PATIENT SAFETY INCIDENTS
WITH PATIENTS AND THEIR CARERS

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1. **BACKGROUND**

NHS Lanarkshire is committed to improving communication with patients and/or their carers when a patient is moderately harmed, severely harmed or has died as a result of a patient safety incident. This is firmly part of our approach to risk management and involves open, honest and prompt communication between NHS Lanarkshire, healthcare teams and patients and/or their carers, together with an apology and explanation.

This policy document sets out the benefits of, and principles for, taking forward this commitment and is based on the National Patient Safety Agency report of the same name published in 2005.

It is important to state at the outset that an apology does not normally constitute an admission of liability. Indeed the offer of an apology when something has gone wrong is firmly part of NHS Lanarkshire’s separate complaints policy.

This policy does not require near misses or no harm incidents to be discussed with patients or their carers.

A Quick Reference Guide for staff can be found at Appendix I.

2. **KEY ELEMENTS OF THIS APPROACH**

2.1 **For NHS Lanarkshire**

Being open involves:
- Acknowledging, apologising and explaining when things go wrong
- Conducting a thorough investigation into the incident and reassuring patients and/or their carers that lessons learned will help prevent the incident recurring
- Providing support to cope with the physical and psychological consequences of what happened.

This policy is integrated with local and national incident reporting and risk management policies. Openness can help to build a reputation of respect and trust for the organisation and/or team.

2.2 **For Staff**

Being open has several benefits for 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.
2.3 **For Patients**

Research has shown that patients are more likely to accept medical errors when they have been discussed fully and promptly with them. Being open can decrease the trauma felt by patients following the incident. It has been found that patients would like:

- To be told about patient safety incidents that affect them
- An acknowledgement of the distress the incident caused
- A sincere and compassionate statement of regret for the distress they are experiencing
- 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 medically to repair or redress the harm done.

3. **KEY PRINCIPLES**

3.1 **Acknowledgement**

All patient safety incidents should be acknowledged and reported as soon as they are identified. In cases where the patient and/or their carers inform 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 staff. Denial of a patient’s concerns will make future open and honest communication more difficult.

3.2 **Truthfulness, timeliness and clarity**

Information about a patient safety incident must be given to patients and/or their carers in a truthful and open manner by an appropriately nominated person. Patients should be given a step-by-step explanation of what happened that considers their individual needs and is delivered openly.

Communication should be timely: patients and/or their carers should be provided with information about what happened as soon as practicable. It is also essential that any information given is based solely on the facts known at the time. Healthcare staff should explain that new information may emerge as an incident investigation is undertaken, and patient and/or carers should be kept up-to-date with the progress of an investigation.

Patients and/or their carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of medical jargon, which they may not understand, should be avoided.

3.3 **Apology**

Patients and/or their carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded and agreed manner of apology, as
early as possible. Both verbal and written apologies should be given. Based on local circumstances, senior clinical staff should decide on the most appropriate member of staff to issue these apologies to patients and/or their carers. The decision should consider seniority, relationship to the patient, and experience and expertise in the type of patient safety incident that has occurred.

Verbal apologies are essential because they allow face-to-face contact between the patient and/or their carers and the healthcare team. This should be given as soon as staff are aware an incident has occurred. It is important not to delay for any reason, including: setting up a more formal multidisciplinary discussion with the patient and/or their carers; fear and apprehension; or lack of staff availability. Delays are likely to increase the patient’s and/or their carers’ sense of anxiety, anger or frustration. Patients are more likely to seek medico-legal advice if verbal and written apologies are not delivered promptly.

A written apology, which clearly states that NHS Lanarkshire is sorry for the suffering and distress resulting from the incident, must also be given.

3.4 Recognising patient and carer expectations

Patients and/or their carers can reasonably expect to be fully informed of the issues surrounding a patient incident, and its consequences, in a face-to-face meeting with representatives from NHS Lanarkshire. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients and/or their carers should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as independent advice and support or an interpreter / translator.

3.5 Professional support

NHS Lanarkshire encourages its staff, whether directly employed or independent contractors, to report patient safety incidents. Staff should feel supported throughout the incident investigation process because they too may have been traumatised by being involved. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration.

Where there is reason for NHS Lanarkshire to believe that a member of staff has committed a punitive or criminal act, steps will be taken to preserve its position, and the member(s) of staff will be so advised at an early stage to enable them to obtain separate legal advice and/or representation.

NHS Lanarkshire encourages staff to seek support from their relevant professional body such as the General Medical Council, Royal Colleges, the MDDUS and the Nursing and Midwifery Council.
3.6 Risk management and systems improvement

Root cause analysis (RCA), significant event analysis (SEA) or a similar technique should be used to uncover the underlying causes of a patient safety incident. Investigations should focus on improving systems of care, which will then be reviewed for their effectiveness. Being open is one part of an integrated approach to improving patient safety following a patient safety incident.

3.7 Multidisciplinary responsibility

This policy on openness applies to all staff who have key roles in the patient’s care. Most healthcare provision involves multidisciplinary teams and communication with patients and/or their carers following an incident that led to harm should reflect this. This ensures consistency with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

3.8 Clinical governance

Being open is supported through NHS Lanarkshire’s local clinical governance frameworks, with accountability to the Board to ensure required changes are implemented and their effectiveness reviewed. Findings will be disseminated to staff so that they can learn from patient safety incidents. Continuous learning programmes and audits will be developed to allow NHS Lanarkshire to learn from the patient’s experience of the policy of being open. These will monitor the implementation and effects of changes in practice following a patient safety incident.

3.9 Confidentiality

The patient’s and/or their carer’s and staff privacy and confidentiality will be fully considered and respected. Details of a patient safety incident 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 to consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information. Communication with those outside the clinical team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous. In addition, it is good practice to inform the patient and/or their carers about who will be involved in the investigation before it takes place, and give them the opportunity to raise any objections.

3.10 Continuity of care

Patients are entitled to expect that they will continue to receive all usual treatment and will 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. MEETING THE NEEDS OF PATIENTS AND/ THEIR CARERS

In order to ensure that the needs of patients and their carers are met the following should be taken into consideration:

- Clear lines of communication should be agreed with the patient and/or their carers, including the degree of information the patient wishes to receive themselves, what support they may wish, arrangements for their continuing care, information about the complaints procedure and/or the incident reporting process
- Provision of information about advocacy and support services that may be available to them.

The above must take into account the circumstances of each particular incident eg, when the patient has died, when the patient is a child, when the patient has a mental health problem or learning disability, when the relationship with the health professional has broken down, when the patient has a language or other cultural requirement, and when the patient has particular communication needs.

5. MEETING THE NEEDS OF STAFF

NHS Lanarkshire will provide access to assistance, support and information to staff who have been directly involved in a patient safety incident and to those involved in subsequent discussions with patients and/or their carers.
Appendix I

Being Open

Communicating Patient Safety Incidents with Patients and their Carers

A Quick Reference Guide for Staff

1. General

Apologising and explaining when patients have been harmed can be very difficult. This guide is designed to help staff to follow best practice.

Patients and/or their carers should receive an apology as soon as possible after a patient safety incident has occurred and staff should feel able to apologise on the spot. Saying sorry is not an admission of liability and it is the right thing to do. Patients have a right to expect openness in their healthcare.

2. Preliminary meeting with the patient and/or their carer

Who should attend?

The lead person should normally be the most senior clinician responsible for the patient’s care and/or a clinician with experience and expertise in the type of incident that has occurred. He/she should:

- Ensure that those members of staff who attend the meetings can continue to do so as continuity is very important in building relationships
- Be supported by at least one other member of staff, such as the Associate Medical / Nurse Director, Risk Manager or member of the healthcare team treating the patient
- Ask the patient and/or their carers who they would like to be present
- Consider each team member’s communication skills: they need to be able to communicate clearly, sympathetically and effectively
- Hold a pre-meeting so that the team knows the facts and understands the aims of the meeting.

When should it be held?

The meeting should be held as soon as possible after the incident. The lead person should:

- Consider the patient’s and/or carer’s home and social circumstances
- Check that the patient and/or carer are happy with the timing
- Offer them a choice of times and confirm the chosen date in writing
- Not cancel the meeting unless absolutely necessary.
Where should it be held?

- In a quiet room where there will be no distractions or interruptions
- Away from the place where the incident occurred if this is likely to be difficult for the patient and/or their carers.

3. Discussion

How should you approach the patient and/or their carers?

- Speak with the patient and/or their carers as you would want someone in the same situation to communicate with a member of your own family
- Do not use jargon or acronyms: use clear, straightforward language
- Consider the needs of patient and/or carers with particular requirements, for example language or cultural needs, those with mental health problems or learning difficulties.

What should be discussed?

The lead person should:

- Introduce and explain the role of everyone present to the patient and/or carer and ask if they are happy with those present
- Acknowledge what has happened and apologise on behalf of the team and NHS Lanarkshire. Remember, expressing regret is not an admission of liability
- Ensure that the team sticks to the facts and assure the patient and/or carers that if more information becomes available it will be shared with them
- Ensure that the team does not speculate or attribute blame
- If appropriate, suggest sources of support and counselling
- Check that the patient and/or carers have understood what they have been told and offer to answer any questions
- Provide a named contact if they wish to speak with staff again.

4. Follow-up

The lead person should:

- Clarify in writing the information given, reiterating key points, recording action points and assigning responsibilities and deadlines
- Ensure that the patient’s notes contain a complete, accurate records of the discussion(s), including the date and time of each entry, what the patient and/or their carers have been told, and a summary of agreed action points
- Maintain a dialogue with the patient and/or their carers by addressing any new concerns, sharing any new information once available and providing information on counselling, as appropriate.