London Ambulance Service NHS Trust

Being Open Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document: This policy is designed to ensure that London Ambulance Service NHS Trust meets its obligations to patients, relatives and the public by being open and honest about any mistakes that are made in the way we care for and treat our patients.

Sponsor Department: Complaints and PALS

Author/Reviewer: Head of Patient Experience. To be reviewed by Oct 2011.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
29/09/08	2.0	Gary Bassett	
01/01/07	1.0		

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	**Date Approved**	**Version**
SMG	06/10/08	2.0
Ratified by:		

Published on:	**Date**	**By**	**Dept**
The Pulse	06/10/08	Victoria Smith	GDU

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
HS011	Incident Reporting Procedure	
	Patient Briefing, Being Open – 'saying sorry when things go wrong,' NPSA. 15th September 2005.	
	DOH Better NHS response for patients harmed by healthcare 13th October 2005	
	NHS Redress DOH Improving the response to patients November 2005	
	(LASSL 94) 4) Independent investigation of adverse events in mental health services, DoH, 15th June 2005.	
	Circular 02.2002, NHS Litigation Authority	
	CNST 2.1.2.	
	Making amends,	
TP/006	Serious Untoward Incidents	
HS018	Stress Management Policy	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Aim:

This policy is designed to ensure that London Ambulance Service NHS Trust meets its obligations to patients, relatives and the public by being open and honest about any mistakes that are made in the way we care for and treat our patients.

2. Scope:

All staff working within London Ambulance Service NHS Trust (LAS)

3. Introduction:

3.1 The National Patient Safety Agency, on 15th September 2005, advised all NHS organisations to implement a 'being open' policy.

3.2 This policy describes how London Ambulance Service NHS Trust will demonstrate its openness with patients and relatives when mistakes are made.

3.3 Our aim is to demonstrate a robust risk management system, which reflects, learning from mistakes with full transparency and openness.

3.4 We will achieve this by providing a proactive approach to dealing with clinical negligence through risk management processes and systems designed to identify incidents which require review, analysis and learning.

3.5 The LAS will work in partnership and communicate with all stakeholders, including other healthcare providers, organisations and teams, related to any incident, in accordance with the principles of the 'Making Experiences Count' programme.

3.6 This will promote a patient safety focused culture within a constant learning, improving, and changing organisation.

3.7 When mistakes are made patients/relatives/carers should receive an apology and explanation as soon as a patient safety incident has occurred and staff should feel able to apologise on the spot.

3.8 Saying sorry is not an admission of liability and it is the right thing to do.

3.9 A patient has a right to openness in their healthcare.

3.10 Staff do not intend to cause harm in the majority of cases, unfortunately incidents do occur.

3.11 Support for staff should be offered from the Trust including via the Linc scheme, welfare and occupational health schemes.

3.12 Within departments, individual line managers/supervisors/mentors/coaches should be aware that an individual or team might require support during the

investigation and through discussion with the individual/team, guide them to the appropriate support mechanism for them. This may involve external agencies in some instances.

3.13 The patient must be provided with assurances that their care will not be affected during the dispute between the patient/carer and their health care team.

3.14 The DOH amendment to guidance regarding investigation of a serious untoward incident states 'a management review within 72 hours of an SUI being reported should be undertaken.' (LASSL (94) 4) dated 15th June 2005. It specifically requires that senior members of staff are nominated to make contact with the victim, families and carers to ensure proper support is offered, and to identify with them any issues of concerns for them that may need to be investigated via the root cause analysis process. (RCA).

3.15 A single point of contact will be identified with the patient/carers/relatives to aid good communication and optimum information feedback.

3.16 **The NHS Litigation Authority** requires the Trust to demonstrate that, following a serious clinical incident, 'a cohort of staff has been identified to engage with service/users/relatives/carers/staff during the response to serious incidents".

3.17 This policy is to be implemented following all Patient Safety incidents where actual harm has occurred.

3.18 Serious near miss incidents resulting in no actual harm will be explored fully so that learning is embedded into the organisation with changes implemented. Endeavouring to try to give assurance that the same serious or near miss does not occur again.

3.19 This policy links to other risk management policies, for example: The Incident Reporting Policy to report an incident, The Serious Untoward Policy and The Trust's Risk Management Framework, the principles illustrated within this policy should be demonstrated by staff when a patient safety incident occurs. Guidance on how the incident should be investigated is available in the LAS Complaints Policy, Procedure and Guidance Notes and the principles within those documents apply to this Policy.

4. Definitions:

4.1 Patient Safety Incident:

'...any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare'
(Seven Steps to Patient Safety, NPSA 2003)

4.2 **Serious Clinical Incident**:
'...a situation in which one or more service users are involved in an event which is likely to produce a significant, legal media, or other interest and which if not properly managed, may result in loss of the Trust's reputation or assets.'
(Seven Steps to Patient Safety, NPSA 2003)

5. Key Principles and Process:

5.1 All staff working within the organisation will be expected to adhere to this policy.

5.2 The appropriate managers, including the Medical Director, Assistant Medical Directors and the Senior Clinical Advisor, will provide support to the member of staff that is nominated to meet with the patient/relatives and explaining what happened. Staff with appropriate clinical knowledge or other expertise may similarly be engaged to communicate that knowledge in an appropriate manner.

5.3 As soon as it is practical, following a Patient Safety Incident, it shall be the responsibility of the Head of Patient Experiences to ensure that:

5.3.1 The most appropriate staff are identified to meet with the patient and/or relatives.

5.3.2 The nominated lead staff member will normally be the most senior person responsible for the patient's care and/or someone with the experience and expertise in the type of incident that had occurred. This person will be supported by at least one other member of staff within the department, and links to risk management must be established at the earliest possible time.

5.3.3 The nominated staff and members will hold a pre-meeting to establish the facts and agree/understand the aims of the meeting with the patient and/or relatives. The patients and/or relatives may not in all instances be present at this pre-meeting but feedback must be given at the earliest opportunity once the actual facts are known, no miscommunication issues should arise by giving unsubstantiated facts as this can create anxiety.

5.3.4 A letter is to be sent as soon as possible to the patient and/or relatives inviting them to meet with the nominated staff, offering them a choice of venues and times.

5.3.5 The patient and/or the relatives will be given the opportunity to choose

- Whom they would prefer to meet with
- Where and when the meeting will be held.
- The patient and/or the relatives will also be informed that they may bring a friend to this meeting.
- Confirm the chosen date, time and venue in writing.

5.3.6 Ensure that the nominated staff can continue to liaise with the patient/relatives to support continuity of communication and relationship building.

5.3.7 The meeting should be held as soon after the incident as possible, taking into account the patient's and/or the relative's home and social circumstances.

5.3.8 The meeting should not be hosted near to the place where the incident occurred, if this is considered difficult for the patient or relatives.

5.3.9 Contact will be made with other care providers related to any incident, and the process of joint analysis, reporting and updating agreed with the medical director and the stakeholders involved.

6. Nominated Staff:

6.1 At the meeting with the patient and/or relatives, the nominated staff from the **involved team** should.

6.1.1 Say sorry for what happened.

6.1.2 If known, explain what went wrong and where possible, why it went wrong.

6.1.3 Give the patient and/or relatives an opportunity to ask for an explanation as to why they thought it went wrong.

6.1.4 Ask the patient and/or carer why they thought the error occurred.

6.1.5 Inform the patient and/or relative(s) what steps is/will be taken to prevent the incident reoccurring.

6.1.6 Provide opportunity for the patient and/or relatives to ask any questions.

6.1.7 Agree with the patient and/or relatives any future meetings as appropriate.

6.1.8 Suggest any sources of support and counselling with written information.

6.1.9 In the event that a full investigation is required, i.e. the incident has been coded as high or catastrophic, consideration will be given to utilising Root Cause Analysis framework .

6.1.10 The patient and relatives should be given this information and a contact person will be agreed with the patient and relatives. The contact person will be responsible for keeping the patient and relatives up-to-date with how the enquiry is progressing, maintaining a dialogue by addressing any new concerns, share new information once available and provide information on accessing counselling as appropriate.

6.1.11 A separate record must be kept which contains a complete and accurate record of all meetings and discussion(s) including date and time of each entry, what the patient and/or the relatives have been told and a summary of agreed action plans.

7. Follow Up & Monitoring:

7.1 All staff working within the organisation will be expected to adhere to this policy.

7.2 It will be the responsibility of the Medical Director and Assistant Directors of Operations (**ADOs**) to ensure that staff adhere to this policy.

7.3 The Head of Patient Experience or a delegated manager, should prepare reports for Clinical Governance Committee meetings and other monitoring groups as appropriate in each case.

7.4 The lead officer will be responsible for ensuring the nominated individuals involved in the process have access to support, coaching and debriefing, during and after the experience.

7.5 It is the role of the Risk Compliance and Assurance Group (RCAG) and the Clinical Governance Committee to ensure that any lessons learnt are shared throughout the service as appropriate and that action plans are managed by a nominated person within a defined time-frame.

7.6 The RCAG will also ensure compliance with external reporting requirements and contribution to stakeholder review panels.

7.7 The policy will be monitored by evaluating the effectiveness of the ‘being open’ process, through feedback from stakeholders during and after the activities outlined above (this will be an intrinsic part of the Making Experiences Count programme).

IMPLEMENTATION PLAN	
Intended Audience	For all LAS staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	
Monitoring	See section 7.

Appendix 1

Being Open Policy Flow Chart:

1. Apologise to patient/carer/relative.

2. Arrange a pre-meeting with all health professionals to ascertain the facts.

3. Agree verbal review of the facts, which can be fed back to patient/carer/relatives. Reinforce empathy regarding the incident and if incidents coded green or yellow on the Trust's Risk Assessment Matrix, arrange for a meeting with the family in a more formal manner if appropriate. Considering all points under section (e) of responsibilities. Sent a letter within 2 days acknowledging the incident and arranging a date and time to discuss this.

4. If the incident is coded orange or red risk (on the Trust's Risk management matrix) **the ADOs** must be involved at the earliest possible point, a full Root Cause Analysis and investigation may be appropriate and the relatives must be informed of this. Once an investigation is undertaken, a meeting with the family must be arranged dealing with the points under section (e) of responsibilities. It may be more appropriate that the Head of Legal Services feeds back to the relatives or an Executive member of the organisation depending on the outcome of the incident review and the patient/carer/relatives wishes.

5. (Legal Services Department staff must be informed of all patient safety incidents that may result in a claim against the LAS).

6. Within 14 days a report should be sent to the patient/carers/relatives which describes the incident, why the incident occurred, recommendations and any lessons learnt.

7. (Consider the need to inform the Communications department if the incident is likely to attract publicity).

8. All learning from incidents must be cascaded to the whole organisation, via the Trust Newsletter and/or **emergency bulletins**.