The Principles of *Being open*

In January 2009, the Department of Health launched The NHS Constitution for England this incorporates the principles of *Being open*. It is essential that a *Being open* policy meets the needs of the local organisation however, a number of legal and regulatory requirements must also be taken into account. The standards of openness outlined in the framework have been included in the Trust policies to ensure compliance with the accreditation and external assessment processes.

- National Health Service Litigation Authority
- Care Quality Commission
- NHS Contract

Open and effective communication with patients should begin at the start of their care and continue throughout their time within the healthcare system. This should be no different when a patient safety incident occurs. *Being open* when things go wrong is key to the partnership between patients and those who provide their care. Openness about what happened and discussing patient safety incidents promptly, fully and compassionately can help patients cope better with the after-effects. Patient safety incidents also incur extra costs through litigation and further treatment; openness and honesty can help prevent such events becoming formal complaints and litigation claims.
Staff may also be unclear about who should talk to patients when things go wrong and what they should say; there is the fear that they might upset the patient, say the wrong things, make the situation worse and admit liability. The Trust *Being open* policy 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.

The following ten principles underpin *Being open;*

1. **Acknowledgement** – when the Trust becomes aware of patient safety incidents the NHS contract stipulates that patients and carers should be informed if they have been involved in a moderate, serious or declared serious incident.

2. **Truthfulness, timeliness and clarity of communication** - Patients should be provided with a step-by-step explanation of what happened, that considers their individual needs and is delivered openly. Communication should also be timely; patients, their families and 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 professionals should explain that new information may emerge as an incident investigation is undertaken, and that patients, families and carers will be kept up-to-date with the progress of the investigation.

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 incident. This should be in the form of an appropriately worded and agreed manner of apology as early as possible. The Trust decides on the most appropriate member of staff to give both verbal and written apologies to patients, their families and 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, their family and carers and the healthcare team. This should be given as soon as staff are aware an incident has occurred. A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given.

4. **Recognising patient and carer expectations –** both should be treated sympathetically, with respect and consideration. They 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 an independent patient advocate or a translator.

5. **Professional support -** Healthcare organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged 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. To ensure a robust and consistent approach to incident investigation, healthcare organisations are advised to use the NRLS's Incident Decision Tree.

6. **Risk management and systems improvement** - Every healthcare organisation's *Being open* policy should be integrated into local incident reporting and risk management policies and processes. *Being open* is one part of an integrated approach to improving patient safety following a patient safety incident. It should be embedded in an overarching approach to risk management that includes local and national incident reporting and analysis of incidents using Root Cause Analysis.

7. **Multi-disciplinary responsibility -** The Trust policy on openness applies to all staff that have key roles in the patient's care, most healthcare provision is through multidisciplinary 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 incidents usually result from systems failures and rarely from the actions of an individual.

8. **Clinical Governance -** *Being open* requires the support of patient safety and quality improvement processes through clinical governance frameworks in which patient safety incidents are investigated and analysed to find out what can be done to prevent their recurrence. These findings should be disseminated to healthcare professionals so that they can learn from patient safety incidents.

9. **Confidentiality** - Communications with parties outside of the investigation 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 investigation before it takes place, and give them the opportunity to raise any objections.

10. **Continuity of care** - Patients are entitled to expect that they will continue to receive care and should be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made.

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[i] *Being open* – Communicating patient safety incidents with patients, their families and carers. National Patient Safety Agency. November 2009.