## Introduction

This document describes how Dot Medical implements "Being Open – Saying Sorry When Things Go Wrong" (National Patient Safety Agency (NPSA)), and Safety Alert 2009 and the Duty of Candour requirement 2013 (Department of Health).

Being Open is a fundamental process affecting integrated governance throughout the NHS. This document is integrated with the Incident, Serious Incident and Complaints processes and clinical governance framework. Being Open is part of the "no blame" culture which is striven for in the NHS. This culture is fundamental to learning from mistakes.

This document provides a framework for:

- patients/relatives/hospital staff to receive the open, accurate and timely communication, apology and support they need.
- Dot Medical staff to be encouraged to admit shortcomings and mistakes and learn from errors and be supported.
- root cause analysis, investigation and learning to occur systematically.



All moderate, severe harm and death incidents must have documented evidence of the Being Open process. This is referred to as the Duty of Candour and is a contractual requirement reflecting the Francis Report (2013) following the Mid Staffordshire Enquiry.

## Aim

A key aim of the document is to help all health professionals to feel they can be open and honest whenever mistakes are made, and to not be reluctant to apologise to patients.

The NHS Litigation Authority (NHSLA) litigation circular 02/2002 encourages health care staff to apologise and clarifies that doing so is not an admission of liability:

*"It seems to us that it is both natural and desirable for those involved in treatment which produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives and to express sorrow or regret at the outcome. Such expressions of regret would not normally constitute an admission of liability, either in part or in full, and it is not our policy to prohibit them, not to dispute any payment, under any scheme, solely on the grounds of such an expression of regret"*

The principles of this document apply to all communications with hospital staff, patients and their families when errors have been made. This applies to incidents as well as complaints. It applies in personal explanations and apologies as well as in local resolution meetings which are arranged to try to resolve remaining concerns following a formal complaint investigation. The principles also apply to internal inquiry meetings.

The NPSA website www.npsa.nhs.uk/advice contains the NPSA Being Open Framework 2009, on which this procedure is based. Information on Duty of Candour can be found on the DH website www.dh.gov.uk.

**Context of Document**

**Openness**

It is important that openness is shown whenever things go wrong with treatment and care. Without openness about incidents, patient consent for treatment can be made invalid.

The NPSA's "Being Open" policy does not require prevented patient safety incidents or "no harm" incidents to be reported to patients/relatives.



**Communications with Hospital Staff, Patients/Families**

All communications with hospital staff, patients/families must be timely, using understandable language. Being Open meetings must allow sufficient time for discussion and questions. Staff must demonstrate that they are approachable through written communications, the way they speak and their body language.

Openness is promoted by staff showing they are caring and sympathetic and providing several opportunities for hospital staff, patients/relatives to ask questions and gain information. The "At Our Best" behaviours support the Being Open process.

Disclosing to the patient that an incident has occurred, which they may be unaware of, has to occur **as soon as possible** (and within 10 working days of the incident) by a member of hospital staff with understanding and experience/support as part of a planned process. Face to face communication is best and Dot Medical will provide whatever information is required and be present if invited.

It is usual for hospitals to share the findings of investigations with the patient/family afterwards in a letter and a meeting. Patients/families are asked how they would prefer this to occur.

Being Open is based on evidence that this approach helps patients/relatives to have better outcomes following errors and a reduction of trauma. It also helps the company to prevent and resolve complaints

and reduces the risk of patients/relatives escalating their complaint to the Public Health Service Ombudsman. The Company's approach to complaints supports Being Open, with a flexible approach focused on addressing complainant's concerns and making real service improvement.

**Benefits**

Being Open is supported by the 7 Steps to Patient Safety (NPSA, 2003) initiative which describes a methodical approach to developing a patient safety culture in healthcare organisations.

Results of surveys of patients and relatives show that receiving an apology, followed by investigation and support, were considered more important than financial compensation or disciplinary action (MORI – Making Amends DH 2003).

In addition to this, there are benefits to staff from increased satisfaction that communication with patients and relatives has been handled appropriately and that the experience will increase their own professional development.



**1. Definition of Terms**

**Being Open**

Being Open is a specific process of actions and behaviours that have to be followed following any incident causing harm to a patient. These are summarised in Appendix A. The NPSA's Being Open policy does not require prevented patient safety incidents or "no harm" incidents to be reported to patients/relatives.

Organisations are said to be "open" when the prevailing culture visibly encourages key behaviours. These include honesty, openness, appropriate sharing of information and a willingness to learn from experience to change how the organisation functions.

**No Harm Incidents**

Any patient safety incident that had the potential to cause harm but was prevented resulting in no harm to people receiving NHS-funded care.

**Local Resolution Meetings**

Meetings arranged by hospitals with patients and their relatives to address complaints. The purpose of the meeting is to address issues and concerns raised in the complaint and to provide answers to questions. The

meeting is held in an honest and open manner and support provided to the patient and family. Dot Medical staff will participate if invited.

**Duty of Candour**

A contractual duty requiring hospitals to ensure that patients/families are informed of medical errors causing moderate, severe harm or death and provided with support. This includes receiving an apology, as appropriate, and the investigation findings and actions to prevent recurrence are shared. Gillick (or Frazer) Competent. Dot Medical embraces the principles behind the Duty of Candour and will assist hospitals to carry out their Duty of Care whenever required.

Children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention.

**2. Roles and Responsibilities**



**Managing Director / Registered Manager**

- To facilitate the Being Open/Duty of Candour and learning process within Dot Medical.
- To ensure and demonstrate commitment to Being Open principles and standards.
- To require all staff to meet Being Open standards and to learn from incidents.
- To ensure arrangements are in place for implementation of the Duty of Candour

**All Staff**

- To be aware of and apply the principles of Being Open and the Duty of Candour.
- To report incidents.
- To address concerns or complaints openly and honestly.
- To communicate with hospital staff/patients/families in line with this document.

**Registered Manager**

- To facilitate implementation of this document.
- To facilitate inclusion of Being Open and Duty of Candour in appropriate training e.g. induction and in training programmes for all staff involved in the follow up of incidents.

- To facilitate the planning of Duty of Candour discussions with investigators and clinicians, as required. To monitor the effectiveness of this document on an ongoing basis and report on this in routine governance reports.

**3. Process**

**Being Open Process**

A summary of the principles of Being Open are described in Appendix A

Staff are encouraged to apologise when things go wrong, offering sympathy and caring. Apology is not an admission of liability.

Being Open emphasises behaviours of caring, good communication and meeting the needs of patients and their families.

The Duty of Candour will apply to moderate, severe harm or death incidents– see Duty of Candour below.

Practical aspects of Being Open/Duty of Candour meetings are at Appendix C.



**Requirements of Truthfulness, Timeliness and Clarity of Information**

Being Open policy does not require prevented patient safety incidents or "no harm" incidents to be reported to hospital staff/patients/relatives. The decision of whether to communicate these to patients depends on local circumstances and advice should be sought from the senior health care professional concerned. Low harm incidents should be communicated to hospital staff who will decide whether to communicate it to patients/relatives.

All communications with patients should have the underlying principle of health care being a partnership between professional and patient, based on respect. It is most important that communication with the hospital staff/patients/family is open, honest, comprehensive and timely and maintained over the Being Open process and not delayed due to investigations etc. It is paramount that communication of moderate, severe harm or death incidents occurs as soon as possible with patients/families as part of the Duty of Candour.

Meetings convened as a result of registered complaints are designed to be non-intimidating and hospital staff/relatives/patients are given the opportunity to express themselves fully. The purpose of the meetings is to meet their needs for information, apology and acknowledgement.

In internal inquiry meetings, openness and a readiness to identify and learn from mistakes are fundamental principles.

Dot Medical addresses the importance of communication by holding Daily Briefs which will include discussions about mistakes/errors/concerns in a way which encourages two way communication to identify solutions.

As part of the Duty of Candour process, records must be made of all conversations, whether face to face, by telephone or letter. Complaint investigations are recorded separately in the complaint file.

**4. Training**

All staff should be aware of Being Open and Duty of Candour.



**5. Evidence Base**

- NPSA Being Open Framework 2009 "Being Open – Saying Sorry When Things go Wrong"
- Safe care: The National Patient Safety Agency (NPSA) 'Being open' framework: NHS Midlands and East
- NPSA Safety Alert 2009: Being Open – Supporting Information
- NHSLA 2009: Apologies and Explanations
- NPSA 2004: Incident Decision Tree
- NPSA 2010: Medical Error: What to do if things go wrong: A guide for junior doctors
- Royal College of Surgeons 2010 Openness and Transparency in Surgery
- Medical error. What to do if things go wrong: a guide for junior doctors
- NPSA 2003 - Seven Steps to Patient Safety
- NHS Litigation Authority (NHSLA) litigation circular 02/2002
- MORI – Making Amends DH 2003
- Implementing a "Duty of Candour"; A new contractual requirement on providers – DH 2012

**Appendix A**

**The Principles of Being Open**

It is unlikely that Dot Medical staff will be meeting with patients or their families without the presence of hospital staff. The following items are for information only so that should Dot Medical staff be invited to a meeting, they will understand what is being required by the Duty of Candour.

A summary of the key actions of the NPSA' Being Open Framework. This can be used in planning meetings with staff and patients following incidents, complaints or claims. Actions are grouped under the following Principles:



**1. Principle of acknowledgement**

- Acknowledge and report all incidents, complaints promptly as per Incident Reporting Procedure and Complaints Policy and Procedure.
- Take seriously any reports of incidents/concerns from patients/carers.
- Take notice of a patient's concerns.

**2. Principle of truthfulness, timeliness and clarity of communication**

- Be truthful and give information in an open manner.
- Person giving information to be appropriately nominated.
- Give a step by step explanation of events.
- Timely communication – as soon as possible.
- Information to be based on known facts at the time.
- Explain that investigation may reveal more information.
- Tell hospital staff/patients how they will be updated on the progress of investigation.
- Provide a single point of contact for information, avoiding conflicting information from different staff.

### 3. Principle of apology

- Express sincere regret or sorrow as soon as possible and make an apology verbally and in writing. Written apology must clearly state that Dot Medical is sorry for the suffering and distress caused.
- The most appropriate member of staff to make apology must be identified considering seniority, relationship to patient, experience and expertise regarding incident.

### 4. Principle of recognising patient and carer expectations

- Patients/carers expect a face-to-face meeting with representatives of the organisation.
- Maintain confidentiality.



### 5. Principle of professional support

***For staff***

- Encourage reporting of incidents by all staff.
- Help staff feel supported throughout process as they may have been traumatised.
- Provide formal and informal debriefing of clinical team, separate from the requirement to provide statements for the investigation. Support your staff.
- Provide individual feedback on the final outcome of the investigation.
- Avoid disciplinary action wherever possible.
- Provide advice and training on managing incidents.
- Provide information on support systems for staff distressed by incidents e.g. counselling, stress management, mentoring. Include staff who lead discussions and the Being Open/Duty of Candour process.

### 6. Principle of risk management and systems improvement

- Carry out Root Cause Analysis to uncover underlying causes of an incident.
- Focus on improving systems of care.
- Review the changes made to ensure they are effective.

## 7. Principle of multi-disciplinary responsibility

- Involve all staff who had key roles in patient's care in root cause analysis and investigation.
- Communicate findings at multi-disciplinary meetings.
- Identify Being Open policy champions in all staff groups.

## 8. Principle of clinical governance

- Investigate and analyse incidents that are moderate, severe or lead to death.
- Identify clear accountabilities from Managing Director to all staff to ensure investigations, and action plans are implemented and the effectiveness of the process reviewed.
- Give information to health care staff on findings/learning from investigations.



## 9. Principle of confidentiality

- Details of an incident are confidential.
- Seek consent of individual before disclosing information to others.
- Need to know basis for communications outside the clinical team.
- Anonymous records.
- Inform the patient/carers who will be undertaking the investigation before it takes place to allow them the opportunity to raise any objections.

**Appendix B**

**Patient Issues – Being Open/Duty of Candour**

It is unlikely that Dot Medical staff will be meeting with patients or their families without the presence of hospital staff. The following items are for information only so that should Dot Medical staff be invited to a meeting, they will understand what is being required by the Duty of Candour.

The points below summarise action points from the NPSA Being Open document.

*Patients who do not agree with the information provided:*
If the relationship with the healthcare professional breaks down, consider these strategies:

- Deal with the issue as soon as it emerges.
- Where patient agrees, involve carers in discussions from the start.
- Ensure access to support services.
- Provide alternative mechanisms for communication e.g. patient expressing concerns to other members of clinical team where senior health professional is unaware of difficulties.
- Offer a different contact person.
- Use a mutually acceptable mediator to help identify issues and solutions.
- Ensure awareness of formal complaints procedure.
- Write a comprehensive list of points disagreed upon.
- Reassure patient/carers you will follow these up.

**Appendix C**

**Being Open/Duty of Candour – Points to Consider**
**Includes communication, documentation and meeting requirements**

It is unlikely that Dot Medical staff will be meeting with patients or their families without the presence of hospital staff. The following items are for information only so that should Dot Medical staff be invited to a meeting, they will understand what is being required by the Duty of Candour.

Anyone involved in the process needs to read and use these practical guidelines and see www.npsa.nhs.uk/advice for further information.



**1. Communication**

Open and effective communication with the patient or family is likely to include the following aspects:

- Early on identify and seek to meet patient's practical and emotional needs e.g. the names of people who can provide assistance and support to the patient (patient's consent would be required before information can be given).
- Any special restrictions on openness that the patient would like the healthcare team to respect.
- Identifying whether the patient does not want to know every aspect of what went wrong: respect their wishes and reassure them this information will be made available later on should they change their mind.
- Provide repeated opportunities for the patient and family to ask for information about the incident.
- Provide information in written and verbal form.
- Provide assurance that an ongoing care plan will be formulated with the patient.
- Facilitate inclusion of the patient's family in discussions, if the patient wishes.
- Information may need to be given more than once and at different times to allow the patient and family to understand.
- Ensure the patient's account of events leading up to the incident is fed into the incident investigation.
- Provide information on how improvements will be made as a result of learning from the incident.

**Before the meeting**

Preliminary multi-disciplinary team discussion should be held as soon as possible after the event, including the most senior health professional involved. Basic plans should be made about who does what and how patient needs will be met.

The timing of the Being Open discussion should be planned, holding it as soon as possible after the incident whilst considering relevant factors. An appropriate individual should be chosen to communicate with patients/carers and inform them about the incident. This should be the most senior person responsible for the patient's care and/or someone with appropriate experience and expertise. They should have the training and skills needed and be acceptable to those involved. A substitute for the most senior person involved should only be used exceptionally and that person must have the required skills and information.

The healthcare professional conducting the discussion should be able to nominate a colleague to assist them with the meeting. If it is clear the patient would rather speak to someone else, a substitute should be provided.



Normally, junior staff should not lead the Being Open process. If they ask to be involved, they should be accompanied and supported by a senior team member.

Where the incident relates to the environment of care (e.g. an injury), a senior manager should communicate with the patient/carers.

Regarding incidents arising from errors by healthcare staff, the involvement of the staff involved must be considered individually balancing the needs of the patient/carers with those of the healthcare professional concerned. Guidelines are given on meeting both sets of needs and the use of written apologies.

The incident must be reported via the Dot Medical incident reporting system. The NPSA are then notified through the National Reporting and Learning System (NRLS).

The patient's General Practitioner should be informed by the Consultant or identified clinical lead.

The coroner should be informed of all cases of untimely, unexpected or unexplained death and suspected unnatural death. Involvement of the coroner should not prevent apologies where appropriate. Other statutory bodies may need to be informed.

**2. The meeting**

The content of the Being Open discussion should include:

- Those involved.
- Expressions of sympathy or regret or apologies.
- Handling the facts and when disagreement about them occurs.
- Understanding and noting the views of patients and carers.
- Appropriate language and terminology.
- Explaining what happens next in terms of treatment plan and incident analysis findings.
- Information on effects of the incident.
- Offering practical and emotional support.
- Recognising that patients/carers may be angry or frustrated.
- Avoiding speculation, attribution of blame, denial of responsibility and conflicting information.
- Arrangements for subsequent discussions.
- Copy of investigation report may be offered once available.



**3. Documentation**

All staff managing Being Open meetings must be aware of the following document requirements:

- Copy of incident report or complaint and root cause analysis.

A written record of all Being Open – Duty of Candour discussions/meetings is made in the health records:

- "Being Open – Duty of Candour meeting" – heading in health records
- Date, time, place, date and name and relationships of all attendees
- Plan for providing further information to patient and family
- Offers of assistance and the patient's and family's response
- Questions raised by the patient and family/issues for consideration in the investigation
- Plans for follow up meetings
- Progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient and family
- Copies of letters sent to the patient and family and the GP for patient safety incidents not occurring in primary care.
- Written record of the discussions (a summary should be shared with the patient).

## 4. Preliminary Follow-Up

Follow-up discussions should be planned, carried out and recorded. These should occur at the earliest practical opportunity.



## 5. Completing the Process

Feedback – this should be given in a form acceptable to the patient after completion of the incident investigation, usually through discussion. Communication should include a chronology, details of concerns and complaints, apology and any shortcomings, factors that contributed and what has been and will be done to prevent recurrence, with monitoring arrangements.

Arrangements for continuity of care need to be made and information given to patients on their clinical management plan. Reassurance should be given that the dispute will not affect their care and their right to continue their treatment elsewhere.

Communication with the GP and other community care service providers is required including a description of the implications of the incident.

A Learning from Experience Action Plan should be made for monitoring the implementation of changes to prevent recurrence.

Changes as a result of learning must be communicated with staff. This is a vital step to prevent recurrence.

## 6. Document Review

This policy will be reviewed every three years as detailed in QSP-051.

| | Name | Position | Signature | Date |
|---|---|---|---|---|
| **Prepared by:** | Ian Rankin | Managing Director | | 2 FEB 2023 |
| **Reviewed by:** | Denise Rankin | Company Secretary, Registered Manager | | 2 FEB 2023 |
| **Approved by** | Shirley A Foster | QA Manger | | 03 Feb 2023 |

MASTER DOCUMENT

| Revision Number | Author | Description of changes | Document Change Request Note Number | Effective Date |
|---|---|---|---|---|
| 0 | I Rankin | New Document | 2020-037 | 16-Oct-2020 |
| 1 | I Rankin | To review policy and change the document review period to 3 years, to bring the policy in line with QMS documentation. | 2023-02 | 01 Feb 2023 |