

Appendix 1

Principles of Being Open

1. Principle of 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 healthcare 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 healthcare staff.

2. Principle of truthfulness, timeliness and clarity of communication

Information about a patient safety incident must be given to patients, family and/or carers in a truthful and open manner by an appropriately nominated person. 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, family and/or 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 patients, family and/or carers will be kept up-to-date with the progress of an investigation.

Patients, family and/or 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. Medical jargon, which they may not understand, should be avoided.

3. Principle of apology

Patients, family and/or 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 apology, as early as possible.

Both verbal and written apologies should be given. The decision on which staff member should give the apology 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. A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given.

It is important not to delay for any reason, including; setting up a more formal multidisciplinary *Being open* discussion with the patient and/or their carers; fear and apprehension; or lack of staff availability. Delays are likely to increase the patient's, family's and/or their carer's sense of anxiety, anger or frustration. Patient and public focus groups reported that patients were more likely to seek medico-legal advice if verbal and written apologies were not delivered promptly.

4. Principle of recognising patient and carer expectations

Patients, family and/or carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident and its consequences, in a face-to-face meeting. They should be treated sympathetically, with respect and consideration. Patients, family and/or 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 an independent patient advocate or a translator. When appropriate, information on accessing the Patient Advisory and Liaison Service (PALS) and other relevant support groups like Cruse Bereavement Care and Action against Medical Accidents (AvMA) should be given to the patient as soon as it is possible.

5. Principle of professional support

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 as 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 National Reporting and Learning Service (NRLS) Incident Decision Tree.

Where there is reason for the 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.

6. Principle of risk management and systems improvement

Root cause analysis (RCA) 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 and audited for their effectiveness.

Every 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, analysis of incidents using Root cause Analysis or Significant Event Audit, decision-making about staff accountability using the Incident Decision Tree and an organisational approach that follows the NPSA's "*Seven steps to patient safety*" (2009).

7. Principle of multidisciplinary responsibility

Any policy on openness applies to all staff that 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 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.

To ensure multidisciplinary involvement in the *Being open* process, it is important to identify clinical, nursing and managerial leaders that will support it. Both senior managers and senior clinicians who are opinion leaders must participate in incident investigation and clinical risk management.

8. Principle of clinical governance

Being open has the support of patient safety and quality improvement processes through the clinical governance framework, in which patient safety incidents 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 these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff so that they can learn from patient safety incidents.

These actions are monitored to ensure that the implementation and effects of changes in practice following a patient safety incident. Continuous learning programmes and audits should be developed that allow healthcare organisations to learn from the patients' experience and that monitor the implementation and effects of changes in practice following a patient safety incident.

9. Principle of confidentiality

Full consideration of, and respect for, should be given to the patient's and/or their carer's and staff's privacy and confidentiality. 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.

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. 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.

10. Principle of 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.