

PROCEDURE ON COMMUNICATING PATIENT SAFETY EVENTS: BEING OPEN AND THE DUTY OF CANDOUR

PROCEDURE REFERENCE NUMBER:	CPG36
VERSION NUMBER:	1
KEY CHANGES FROM PREVIOUS VERSION	EPUT format
AUTHOR:	Assistant Director Quality and Practice
CONSULTATION GROUPS:	Learning Lessons Oversight and Scrutiny Committee, Identified Leads, Community and Mental Health staff
IMPLEMENTATION DATE:	1 July 2017
AMENDMENT DATE(S):	N/A
LAST REVIEW DATE:	N/A
NEXT REVIEW DATE:	May 2020
APPROVAL BY CLINICAL GOVERNANCE & QUALITY COMMITTEE:	26 May 2017
RATIFICATION BY QUALITY COMMITTEE:	15 June 2017
COPYRIGHT	© Essex Partnership University NHS Foundation Trust 2017. All rights reserved. Not to be reproduced in whole or part without the permission of the copyright owner

PROCEDURE SUMMARY

This policy and associated guidance aims to ensure that the Trust has an open, honest and consistent approach to communication with patients, relatives, staff or relevant others in the event of any patient safety incident, complaint or claim. The guidance describes the process for acknowledging, apologising and explaining when things go wrong and also outlines the professional, contractual and statutory Duty of Candour to which staff must comply to ensure that when cases of severe or moderate harm occur patients and relatives are fully informed and involved in the investigation process.

The Trust monitors the implementation of and compliance with this procedure in the following ways;

Monitoring of implementation and compliance with this policy and associated procedural guideline will be undertaken by the Trust Safeguarding Group and the Mental Health and Safeguarding Committee.

Services	Applicable	Comments
Trustwide	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this procedure is Executive Director of Mental Health & Deputy CEO

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE ON COMMUNICATING PATIENT SAFETY EVENTS 'BEING OPEN'

CONTENTS

THIS IS AN INTERACTIVE CONTENTS PAGE, BY CLICKING ON THE TITLES BELOW YOU WILL BE TAKEN TO THE SECTION THAT YOU WANT.

- 1.0 INTRODUCTION**
- 2.0 FOUNDATIONS AND GENERAL CONSIDERATIONS OF THE "BEING OPEN" PROCESS**
- 3.0 BEING OPEN PROCESS**
- 4.0 REQUIREMENTS FOR DOCUMENTING ALL COMMUNICATION**
- 5.0 PATIENT ISSUES TO BE CONSIDERED**
- 6.0 ASSOCIATED DOCUMENTS**

APPENDICES

APPENDIX 1 – BEING OPEN PRICIPLES

APPENDIX 2 – BENEFITS OF BEING OPEN/ DUTY OF CANDOUR

APPENDIX 3 – BEING OPEN/DUTY OF CANDOUR PROCESS

APPENDIX 4 – CONTACT RECORD TEMPLATE

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE ON COMMUNICATING PATIENT SAFETY EVENTS 'BEING OPEN'

1.0 INTRODUCTION

- 1.1. This procedure outlines clear processes regarding the principles of *"Being Open"*, which involves;
 - Acknowledging, apologising and explaining when things go wrong;
 - Conducting a thorough investigation into the incident and reassuring service users, their families and carers that lessons learned will help prevent the incident recurring;
 - Providing the support for those involved to cope with the physical and psychological consequences of what happened.
- 1.2. For the purpose of this guidance the term incident will refer to any type of incident including a complaint, claim or a patient safety event.
- 1.3. Following a patient safety event staff must ensure the procedures described within CP3 Serious Incident Policy including Adverse Events are followed. When a complaint from a service user, relative and or carer is received staff must follow procedures described within CP2 and CPG2 Complaints Policy and Guidelines. Trust guidelines regarding claims are found within CP10 Claims Policy.

2.0 FOUNDATIONS AND GENERAL CONSIDERATIONS OF THE "BEING OPEN" PROCESS

- 2.1. The Trust promotes a culture of openness and considers it vital to improving service user safety and the quality of healthcare systems. This procedure for encouraging open communication is reflected and supported by the 'Ten Principles of Being Open' as identified in the National Patient Safety Agency's document 'Being Open: communicating patient safety incidents with patients and their relatives/carers' (NPSA 2009). These are included within Appendix 1.
- 2.2. *"Being Open"* when things go wrong is key to the partnership between service users and those who provide their care. See Appendix 2 for the benefits to service users their families and carer's healthcare staff and healthcare organisations.
- 2.3. Staff may be unclear about who should talk to service users when things go wrong and what they should say; there is a fear that they might upset the service user, say the wrong things or make the situation worse and admit liability. These procedural guidelines set out the processes of communication with service users and raising awareness about this provides staff with the confidence to communicate effectively following an incident.

3.0. BEING OPEN AND DUTY OF CANDOUR PROCESS

3.1 The table below outlines the minimum response required for patient safety incidents by level of severity.

Patient Safety Incident Severity Level	Response
No harm / near miss / no injury	Patients are not usually involved in investigations and these types of incidents are outside the scope of the Being Open and Duty of Candour policy. However, it is within the scope of the healthcare professional’s accountability and responsibility to hold a discussion with the patient and/or relative, should this prove appropriate.
Minor / Low harm	Unless there are specific indications or the patient requests it, the communication, investigation, analysis and the implementation of changes will happen at service delivery level with the participation of those directly involved in the incident. Again it is within the scope of healthcare professional’s accountability and responsibility to hold a discussion with the patient and/or relative, in the spirit of being open and transparent, including them in all aspects of care delivery and governance.
Moderate harm, Severe harm or death	<p>A higher response is required in these circumstances; Duty of Candour process as outlined in this document should be applied.</p> <p>Notification should be in accordance with the Trust’s incident reporting procedure. A member of the Serious Incidents Team will be available to provide support and advice during the Duty of Candour process. The patient (if possible) and their family/relatives/carers must be kept informed of investigative procedures, outcomes and action planning.</p>

3.2 A flowchart that illustrates the stages of the Duty of Candour process is contained within Appendix 3.

3.3. Stage 1: Incident detection or recognition.

3.3.1 The “*Being Open/Duty of Candour*” process begins with recognition that a service user has suffered harm or has died as a result of a patient safety event. As soon as a patient safety event is identified the top priority is prompt and appropriate clinical care and prevention of further harm. Following a patient safety event staff must ensure the procedures described within CP3 Serious Incident Policy including Adverse Events are followed. If the patient safety event is determined as being the result of a criminal act the risk manager and the chief executive must be informed.

3.4. Stage 2: Preliminary Team discussions.

3.4.1 The Multidisciplinary team MDT, including the most senior health professional involved in the patient safety event should meet as soon as possible after the event to:

- Establish the basic clinical and other facts;
- Check recorded consent and next of kin details;
- Assess the incident to determine the level of immediate response;
- Identify who will be responsible for discussion with the service user, their family and carers. The allocation of a family liaison officer could be considered here (see Serious Incident Policy and Procedure CP3). Where ever possible a substitute or appropriate deputy should be identified to act in the nominated contact person's absence.
- Consider the appropriate support for the service user (if any). This includes the use of a facilitator, advocate or healthcare professional.
- Identify immediate support needs for staff involved (see Employee Wellbeing Procedure, HRP26B);
- Ensure there is a consistent approach by all team members around the discussions with the service user, family and carers.

3.5 Stage 3: The initial "Being Open/Duty of Candour" discussion.

3.5.1. The initial discussion with the service user their family and carers should occur as soon as possible after recognition of the patient safety event. Factors to be considered include:

- Clinical condition of the service user;
- Service user preference for where the meeting takes place and which healthcare professional leads the discussion;
- Service user privacy and comfort;
- Availability of the service users family and or carers;
- Availability of key staff involved in the incident and in the "Being Open" process;
- Availability of support staff, for example a translator or independent advocate, if required;
- Arranging the meeting in a sensitive location.

3.5.2. Those identified to conduct the initial meeting should be mindful that service users, their families and carers may be anxious, angry and frustrated even when the discussion is conducted appropriately.

3.5.3. The content of the initial discussion should cover the following;

- An apology and acknowledgment of what happened.
- The facts as they are known and agreed by the MDT.
- Service Users/family/carers are to be informed that an incident investigation is being carried out and more information will become available as it progresses.
- The service user/family/carers understanding of what happened is taken into consideration, as well as any questions or concerns they may have.
- If a service user's first language is not English then arrangements need to be made for appropriate translators to be present at the meeting. Avoidance or an explanation of clinical jargon is required at this meeting.

- An explanation of what will happen next in terms of the short through to the long term treatment plan and incident analysis findings.
- Information on likely short and long term effects of the incident (if known). Long term effect may be communicated at later meetings when more is known.
- An offer of practical and emotional support for the patient, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance.

3.5.4. It is essential that the following does not occur during the discussion:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different individuals;
- Lack of clarity whether a patient safety incident, or the degree of harm, has occurred, is not a reason to avoid disclosure.

3.5.5. This verbal discussion, or any attempt, must be documented using the Contact Record Template in Appendix 4.

3.6. Stage 4: Written Communication

3.6.1. For cases of moderate, severe harm or death, written notification must follow the initial discussion outlined above. The member of staff identified to take this forward should contact the Serious Incidents Department who are responsible for supporting this stage of the process.

3.6.2. The written correspondence must be provided within 10 working days of the incident and include:

- Re-iterate the apology and acknowledgement of the incident as applicable;
- Outline the process of investigation and potential timescales;
- Provide relevant contact details;
- Invite further involvement and contact which includes an offer to share the findings of the investigation once completed and a meeting with a Senior Manager or the Family Liaison Officer to further discuss how learning will be taken forward.

3.7. Stage 5: Follow up discussions/meetings.

3.7.1. Follow up discussions with the service user their family and carers are an important step in the “*Being Open*” process. Depending on the seriousness of the incident and the timeline for the investigation there may be more than one follow-up discussion.

3.7.2. The following guidelines will assist in making the communication effective.

- The discussion occurs at the earliest practical opportunity.
- Consideration is given to the timing and location of the meeting, based on both the service user’s health and personal circumstances.
- Feedback is given on progress to date and information provided on the investigation process.
- No speculation or attribution of blame.

- A written record of the discussion is kept and shared with the Service user their family and carers if requested.
- All queries are responded to appropriately.
- If completing the process at this point the service user, their family and carers should be asked if they are satisfied with the investigation and a record of this is made in the patient's records.
- The service user is provided contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals or an agreed substitute.

3.8. Stage 6: Process completion.

3.8.1. After completion of the incident investigation, feedback should take the form most acceptable to the service user/family/next of kin. Whatever method is used, the communication should include:

- The chronology of clinical and other relevant facts;
- Details of the service user their family and carers concerns and complaints;
- A repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety event ;
- A summary of the factors that contributed to the incident;
- Information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.

3.8.2. It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may have to be withheld or restricted; in these cases the service user must be informed of the reasons for restriction.

3.8.3. Continuity of care: When a service user has been harmed during the course of treatment and requires further therapeutic management or rehabilitation, they should be informed of the ongoing management plan. Reassurance will need to be given that they will continue to be treated according to their clinical needs, even in circumstances where there is dispute between them and the healthcare team. They should also be informed that they have the right to be treated elsewhere if they prefer.

3.8.4. Wherever possible it is advisable to send a brief communication to the patient's GP or appropriate community care service before discharge, describing a summary of the patient safety event, the current condition of the patient and key investigations that have been carried out. It may be valuable to include the GP in one of the follow up discussions either at discharge or at a later stage.

3.8.5. Monitoring: The Risk manager or equivalent should develop a plan for monitoring investigation recommendations for system improvements and practice changes and the implementation and effectiveness of those recommendations.

3.8.6. Effective communication with staff is a vital step in ensuring that the recommended changes are fully implemented and monitored. It will also facilitate the move towards increased awareness of patient safety issues and the value of "*Being Open*".

4.0 REQUIREMENTS FOR DOCUMENTING ALL COMMUNICATION

- 4.1. Throughout the “*Being Open*” process it is important to record discussions with the patient, their family and carers as well as the incident investigation using the template in Appendix 4.
- 4.2. Copies of all correspondence and record forms must be saved in the patient’s file and on Datix.
- 4.3. In addition to the details provided in the Contact Record Template (Appendix 4), other written documentation that should be kept on record are:
 - Copies of letters sent to the service user, their family and carers; and GP;
 - Copies of any statements taken in relation to the patient safety event ;
 - A copy of the incident report.
 - A copy of the original complaint (where appropriate)
 - A copy of the original claim (where appropriate)

5.0 PATIENT ISSUES TO BE CONSIDERED

- 5.1. Patients death.

When a patient safety event involves a service user’s death, it is even more crucial that communication is sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. A Family Liaison Officer must be appointed and contact offered. Establishing open channels of communication may also allow the family/carers to indicate if they need bereavement counselling or assistance at any stage. In any event an apology should be issued as soon as possible after the service user’s death, together with an explanation that the coroners’ process has been initiated and a realistic timeframe of when the family and carers will be provided with more information.
- 5.2. Patients with cognitive impairment.

Where a service user has a condition(s) that limit their ability to understand what is happening to them and they have an authorised person to act on their behalf by an enduring power of attorney, then the being open discussion should be held with them. The Mental Capacity Act (2005) Code of Practice (2007) clearly states that all those working with people who may lack capacity are legally required to “have regard to” relevant guidance in the Code of Practice. This means that all those working for Trust must be aware of the Code of Practice when acting or making decisions for someone who lacks capacity to make a decision for themselves. Clinicians will need to adhere to the Trust Policy MCP2 Mental Capacity Act 2005 / DoLS Policy, to determine the most appropriate person to discuss the incident with and hold “*Being Open*” discussions. Where ever possible the person with cognitive difficulties should be involved.
- 5.3. Patients with Learning Difficulties.

Where a service user has difficulties expressing their opinions verbally and they are not cognitively impaired, they should be supported by alternative communication methods, (writing questions down etc.) and an advocate should be appointed. Appropriate advocates may include carer’s family or friends of the service user, who should focus on ensuring that the views of the service user are considered and discussed.

5.4. Service users with different language or cultural considerations.

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss patient safety event information. It would be worthwhile to obtain advice from an advocate or translator before the meeting on the most sensitive way to discuss the information. The service user's family or friends should not be used to translate and the employment of professional translators is required.

5.5. Service users with different communication needs.

A number of service users will have particular communication difficulties, such as hearing impairment. Plans for the "Being Open" meetings should fully consider these needs.

5.6 Children.

The legal age of maturity for giving consent to treatment is 16 years old. At this age the young person has the right to make decisions about their treatment and their right to confidentiality is vested in them rather than their parents or guardians. It is however considered good practice to encourage children to involve their families in decision making.

The courts have stated that children who fully understand what is involved in a proposed procedure can also give consent (Gillick competence or the Fraser guidelines). Where a child is judged to have cognitive ability and the emotional maturity to understand the information provided they should be involved directly in the "Being Open" process after a patient safety incident.

The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

5.7. Patients who do not agree with the information provided.

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the service user, their family or carers and the nominated healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the "Being Open" process. In this case, the following strategies may assist.

- Deal with the issue as soon as it emerges;
- Where appropriate and consent is in place, involve family and carers from the initial discussion stage;
- Maintain comprehensive records, using the template in Appendix 4
- Write a comprehensive list of the points that the service user; their family and carers disagree with and reassure them you will follow up these issues;
- Ensure the Line managers and the MDT are made aware of the difficulties at all times so that appropriate decision making can be made.
- Offer the service user; their family and carers another contact person with whom they may feel more comfortable with.
- Ensure the service user; their family and carers are fully aware of the formal complaints procedures;

- Use and appropriate mutually acceptable mediator to help identify the issues between the healthcare organisation and the service user and to look for mutually agreeable solution.

6.0 ASSOCIATED DOCUMENTS

6.1. The Trust's documents of Policy and Procedural Guidance associated with this policy are:

- CP2 and CPG2 Complaints Policy and Guidelines.
- CP10 NHS Litigation Authority Claims Policy
- CP3 Adverse Incident Reporting including Serious incident Policy
- CG28 Clinical Risk Assessment and Management Clinical Guideline
- CP53/ CPG53 Raising Concerns Policy (Whistleblowing Policy)
- HR32/ HRPG32 Maintaining High Professional Standards Conduct & Capability Policy for Medical and Dental Staff
- MCP2/ MCPG2 Mental Capacity Act 2005 & DoLS Policy
- HR26/ HRPG26 Employee Wellbeing and Sickness Absence Policy

6.2. This Trust Policy and Associated Procedural Guidelines is consistent with the following professional and government bodies' guidance:

- National Patient Safety Agency (NPSA), Patient safety Alert; Being open, 2009.
- National Patient Safety Agency (NPSA), Being open safer Practice Notice, 2005.
- National Patient Safety Agency (NPSA), Being open; communicating patient safety events with patients their families and carers. 2009.
- National patient safety Agency (NPSA), Seven Steps to patient Safety. 2004.
- NHS Litigation Authority Apologies and explanations. Letter to Chief Executives and finance directors. 2009.
- General Medical Council, Good Medical Practice. 2001
- Nursing and Midwifery Council, The Code: standards of conduct, performance and ethics for nurses and midwives.
- Department of Health, The NHS Constitution for England. 2009.
- Department of Health, Listening, responding, improving – A guide to better customer care. 2009.
- The Mental Capacity Act 2005.

END