Being open when patients are harmed

Being open simply means apologising and explaining what happened to patients and/or their carers who have been involved in a patient safety incident.

Communicating effectively with patients and/or their carers is a vital part of the process of dealing with errors or problems in their treatment. In doing so, NHS organisations can mitigate the trauma suffered by patients and potentially reduce complaints. Effective communication, however, is not always provided.

As the Department of Health's 2003 Making Amends consultation document states, “The individual who has suffered harm as a result of the healthcare they have received must get an apology.” The principles of Being open are fully supported by a wide range of royal colleges and professional organisations.

Action for the NHS

To improve the quality and consistency of communication when patients are involved in an incident, all NHS organisations (including Foundation Trusts) providing patient care in England and Wales should:

1. Develop a local policy, based on the NPSA's Being open policy, but adapted to suit local requirements, by June 2006. Local policies should be integrated with existing risk management and clinical governance structures. Organisations with policies already in place are encouraged to review their policy in line with Being open.

2. Raise awareness of the local policy amongst healthcare staff and provide them with the appropriate information and support. The NPSA has developed tools to help. See page 3.

For response by:
- All NHS organisations (including Foundation Trusts) providing patient care in England and Wales

For action by:
- Clinical governance leads

We recommend you also inform:
- Directors of nursing
- Medical directors
- HR directors
- Heads of medical training/induction
- Clinical directors
- Risk managers
- Communications leads
- Bereavement officers/counselling teams
- Complaints management
- Patient Advice and Liaison Service (PALS) staff
- Claims managers
- Your solicitors
- Patient and public involvement leads

The NPSA has informed:
- Chief executives and chairs of NHS organisations in England and Wales
- Chief executives and clinical governance leads of strategic health authorities (England) and Regional Offices (Wales)
- Healthcare Commission
- Healthcare Inspectorate Wales
- General Social Care Council
- Commission for Social Care Inspection
- Social Services Inspectorate for Wales
- Social Care Institute for Excellence
- Association of Directors of Social Services
- Care Standards Inspectorate for Wales
- NHS Litigation Authority
- Welsh Risk Pool
- General Medical Council
- Royal colleges, societies and defence unions
- NHS Direct
- Relevant patient organisations and Community Health Councils in Wales
- Health Service Ombudsman
- Cruse bereavement care
- Independent Healthcare Forum
- NHS Clinical Governance Support Team
- Clinical Government Support and Development Unit (Wales)
- The Commission for Patient and Public Involvement in Health
- Quality Improvement Scotland and DHSSPS Northern Ireland
Being open when patients are harmed

It is essential that all healthcare staff are aware of the need for effective communication with patients and/or their carers involved in a patient safety incident, and feel supported and empowered to provide this. The NPSA has developed a policy to help healthcare organisations and their staff communicate to a patient and/or their carers what happened in an incident that led to moderate harm, severe harm or death.

It is not a requirement of this policy to communicate prevented patient safety incidents, or ‘no harm’ incidents to patients and/or their carers. The decision to do this comes under the jurisdiction of local healthcare organisations and will depend on local circumstances, although healthcare organisations should consider the advantages of discussing these incidents with patients. Benefits include raising awareness of incidents amongst patients and/or their carers so that they can intervene to prevent similar incidents happening again. For low harm incidents we advise that an apology and explanation is given by staff providing care locally.

Existing guidance

There is already some excellent practice within the NHS in this area. The aim of this safer practice notice is to consolidate that good work and promote consistency.

This safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular 02/2002 and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment, and explained that an apology is not an admission of liability. For example, both documents contain the following statement:

‘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, nor to dispute any payment, under any scheme, solely on the grounds of such an expression of regret.’
Furthermore, the importance of being open is emphasised in the Clinical Negligence Scheme for Trusts 2.1.2, Risk Pooling Scheme for Trusts 4.9 standards, the Making Amends duty of candour proposals, and the General Medical Council’s Good Medical Practice. Being open is also supported and actively encouraged by many professional bodies and medical defence unions.

Next steps

The NPSA recognises that there is a need for healthcare staff to develop the skills necessary to be effective when communicating with patients and/or their carers following a patient safety incident. With this in mind, the NPSA has developed a Being open e-learning tool and a video based training workshop. These training tools use incident scenarios from primary care, acute, mental health and ambulance settings to create an interactive learning environment in which healthcare professionals can develop the skills required for holding Being open discussions. Both training tools will be rolled out to the NHS later in 2005.

NPSA review of actions implemented

In 2006 the NPSA will review how the action points have been implemented through the SABS in England. Alternative arrangements will be made for Wales. Where actions have not been implemented, the NPSA will expect the relevant strategic health authority or regional office to provide a full explanation.

Resources from the NPSA

To help NHS organisations raise awareness of Being open, the NPSA has developed the following resources:

These resources are available to download from the NPSA website at www.npsa.nhs.uk/advice

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| Communications toolkit:  
  • syndicated materials (for staff publications);  
  • quick reference guide to Being open (see pages 5-6) | Communications leads  
  Clinical directors  
  Service managers  
  Departmental managers (as appropriate) | Healthcare staff                                  |
| Being open charter template  
  (to be displayed in public areas, demonstrating organisational commitment) | Clinical directors  
  Service managers  
  Departmental managers (as appropriate)  
  PALS and patient and public involvement leads  
  Community health councils | Patients and the public                          |

Staff leading on the development of a local policy can order up to ten printed copies of the Being open policy by calling 08701 555455.
Background and research

Evidence shows that Being open is fully supported by patients. The Australian Open Disclosure Project, in which there was consultation with a wide range of patients and carers, found that they would like:

- to be told about patient safety incidents which affect them;
- acknowledgement of the distress that the patient safety incident caused;
- a sincere and compassionate statement of regret for the distress that they are experiencing;
- a factual explanation of what happened;
- a clear statement of what is going to happen from then onwards;
- a plan about what can be done medically to repair or redress the harm done.

Openness can also decrease the trauma felt by patients following a patient safety incident. Research has shown that patients will forgive medical errors when they are disclosed promptly, fully and compassionately.

In England, a MORI survey, commissioned for the Department of Health’s consultation document Making Amends (Department of Health, 2003), interviewed 400 people who had been harmed as a result of their healthcare treatment. Results showed that an apology (followed by investigation and support) was the most desired response to a patient safety incident, and that this was considered more important than financial compensation or disciplinary action.

A listening exercise carried out by the NPSA on the draft Being open policy supported these findings. Patient and public focus groups emphasised the importance of an apology and consideration of the patient’s and/or their carer’s needs when organising a Being open discussion. Healthcare professionals reported that they were cautious about apologising for incidents and did not always feel supported in doing so; hence there is a need to raise awareness that saying sorry is not an admission of liability, and to provide staff with the right information and support.
Openness has benefits for healthcare staff. These include satisfaction that communication with patients and/or their carers has been handled in the most appropriate way; developing a good professional reputation for handling a difficult situation properly; and improving their understanding of incidents from the perspective of the patient and/or their carers. Openness is also beneficial for the reputation of the healthcare organisation.


Further information on the Department of Health’s Making Amends consultation can be found at www.dh.gov.uk/assetRoot/04/06/09/45/04060945.pdf

References
1  C. Vincent. ‘Caring for patients harmed by treatment’ Qual Health Care. 1995;4:144–150
2  Crane M. ‘What to say if you made a mistake’ Medical Economics. 2001;78(16):26–8, 33–6
Quick reference guide to being open

Apologising and explaining when patients have been harmed can be very difficult. You may have already considered some or all of the recommendations below, but this guide will help ensure that you follow best practice. Do also refer to your organisation’s local policy before proceeding.

Patients and/or their carers should receive an apology as soon as possible after a patient safety incident has occurred and staff should feel able to apologise on the spot. Saying sorry is not an admission of liability and it is the right thing to do. Patients have a right to expect openness in their healthcare.

Stage 1: preliminary meeting with the patient and/or their carer

Who should attend?

• A lead staff member who is normally the most senior person responsible for the patient’s care and/or someone with experience and expertise in the type of incident that has occurred.

• Ensure that those members of staff who do attend the meetings can continue to do so; continuity is very important in building relationships.

• The person taking the lead should be supported by at least one other member of staff, such as the risk manager, nursing or medical director, or member of the healthcare team treating the patient.

• Ask the patient and/or their carers who they would like to be present.

• Consider each team member’s communication skills; they need to be able to communicate clearly, sympathetically and effectively.

• Hold a pre-meeting amongst healthcare professionals so that everyone knows the facts and understands the aims of the meeting.

When should it be held?

• As soon after the incident as possible.

• Consider the patient’s and/or their carer’s home and social circumstances.

• Check that they are happy with the timing.

• Offer them a choice of times and confirm the chosen date in writing.

• Do not cancel the meeting unless absolutely necessary.

Where should it be held?

• Use a quiet room where you will not be distracted by work or interrupted.

• Do not host the meeting near to the place where the incident occurred if this may be difficult for the patient and/or their carers.
Stage 2: discussion

How should you approach the patient and/or their carers?

• Speak to the patient and/or their carers as you would want someone in the same situation to communicate with a member of your own family.
• Do not use jargon or acronyms: use clear, straightforward language.
• Consider the needs of patients with special circumstances, for example, linguistic or cultural needs, and those with learning disabilities.

What should be discussed?

• Introduce and explain the role of everyone present to the patient and/or their carers and ask them if they are happy with those present.
• Acknowledge what happened and apologise on behalf of the team and the organisation. Expressing regret is not an admission of liability.
• Stick to the facts that are known at the time and assure them that if more information becomes available, it will be shared with them.
• Do not speculate or attribute blame.
• Suggest sources of support and counselling.
• Check they have understood what you have told them and offer to answer any questions.
• Provide a named contact who they can speak to again.

Stage 3: follow-up

• Clarify in writing the information given, reiterate key points, record action points and assign responsibilities and deadlines.
• The patient’s notes should contain a complete, accurate record of the discussion(s) including the date and time of each entry, what the patient and/or their carers have been told, and a summary of agreed action points.
• Maintain a dialogue by addressing any new concerns, share new information once available and provide information on counselling, as appropriate.

This quick reference guide is available to download as a separate document for briefing staff at www.npsa.nhs.uk/advice
A safer practice notice strongly advises implementing particular recommendations or solutions.

This safer practice notice is written in the following context:

It represents the view of the National Patient Safety Agency, which was arrived at after consideration of the evidence available. It is anticipated that healthcare staff will take it into account when designing services and delivering patient care. This does not, however, override the individual responsibility of healthcare staff to make decisions appropriate to local circumstances and the needs of patients and to take appropriate professional advice where necessary.

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