Lincolnshire Community Health Services NHS Trust

Open and Honest Care (incorporating Duty of Candour) Policy

Reference No:	P_CIG_16
Version:	4
Ratified by:	LCHS Trust Board
Date ratified:	9 November 2021
Name of originator/author:	Quality Assurance Managers
Name of responsible committee/individual	Clinical Safety and Effectiveness Group
Date issued:	November 2021
Review date:	November 2023
Target audience:	All LCHS staff
Distributed via	LCHS Website

Chair: Elaine Baylis QPM
Chief Executive: Maz Fosh

Lincolnshire Community Health Services
Version Control Sheet

Open and Honest Care (incorporating Duty of Candour) Policy

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
1		New LCHS Policy	March 2015	M. Leggett /J. Anderson/
2	All	Designation changes: Governance Leads to Quality Assurance Manager	July 2017	J Gooch/R Higgins
		Designation changes: Chief Nurse to Director of Nursing, AHPs and Operations	July 2017	J Gooch/R Higgins
3	Front Sheet	Committee change from Quality Scrutiny Group to EPAG	June 2019	J Gooch/K Rossington
3	Dissemination	Removal of 'organisation staff newsletter'	June 2019	J Gooch/K Rossington
3	Training requirements	Removal of NPSA training resources, no longer available	June 2019	J Gooch/K Rossington
3	Appendix C Duty of Candour Flowchart	Full Review Removal of 'unavoidable/avoidable; in relation to pressure ulcers	June 2019	J Gooch/K Rossington
4	Appendix C	Duty of Candour process updated to reflect communication with patients who have a cognitive impairment	July 2021	Joanne Gooch
4	Appendix E	EIA tool updated	July 2021	Joanne Gooch
5				
6				
7				
8				
9				
10				

Policy Statement

Open and Honest Care (incorporating Duty of Candour) Policy

Background

The Open and Honest Care (incorporating Duty of Candour) Policy has been developed in line with the National Patient Safety Agency (NPSA) guidance, 'Saying Sorry When Things Go Wrong'. The 'Duty of Candour' places a legal duty on all NHS provider bodies registered with the Care Quality Commission, to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The Open and Honest Care (incorporating Duty of Candour) Policy provides a framework for all staff within Lincolnshire Community Health Service NHS Trust, to ensure the appropriate management and review of organisation wide risks and the embedding of lessons learned, to prevent mistakes happening again.

Statement

The Open and Honest Care Policy aims to deliver a culture of openness and mutual learning with patients and relatives of patients involved in untoward incidents. Being open is a set of principles that healthcare staff should use when communicating with patients their families and carers following a patient safety incident.

Central to the National Patient Safety Agency's (NPSA) strategy to improve patient safety, is a commitment to improving communication between healthcare organisations and patients, their families/ carers when a patient has been moderately harmed, severely harmed, has died or suffered prolonged psychological harm as a result of a patient safety incident. This is defined by the current classification within the National Reporting and Learning Service with addition of prolonged psychological harm. This policy is LCHS's localised interpretation of the National Patient Safety Agency's policy.

This policy aims to meet the requirements of the Equality Act 2010 and ensure that no employee or patient receives less favourable treatment on the grounds of gender, sexual orientation, transgender, civil partnership/marital status, appearance, race, nationality, ethnic or national origins, religion/belief or no religion/belief, disability, age, carer, pregnancy or maternity, social status or trade union membership.

Responsibilities

Chief Executive, all Directors, Deputy Directors,
General and Corporate Managers, All Staff working within LCHS either employed or on an agency basis.

Training

All new members of staff will be introduced to the 'Open and Honest Care (including Duty of Candour) Policy' and the organisation's procedures for management of complaints, during the organisation Induction Programme. Up-dates will be provided as part of the Mandatory Training Programme

Dissemination

Website

Resource implication

Existing resources.

Consultation

Consultation will be undertaken with all managers within the service lines of the organisation.

Open and Honest Care (incorporating Duty of Candour) Policy

CONTENTS

1. Introduction

1.1 Lincolnshire Community Health Services NHS Trust is committed to the provision of high-quality health care. As part of this objective, the Trust has a duty to limit the potential impact of clinical and non-clinical risks and put in place robust and transparent systems to make sure that all incidents which might cause actual or potential harm to patients, visitors and staff are identified, investigated and rectified, with lessons learned identified.

1.2 The effects of harming a patient can be widespread and can have devastating emotional and physical consequences for patients, their families and carers as well as being distressing for the professionals involved. Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment, wherever they have received care from the Trust. It also involves apologising and explaining to staff or visitors who have suffered harm. It encompasses communication between healthcare organisations, healthcare teams and/or their carers, staff and visitors and makes sure that openness, honesty and timeliness underpins responses to such incidents.

1.3 The culture of "Being Open" should be fundamental in relationships with and between patients, the public, staff, other healthcare organisations and external agencies as appropriate e.g. Care Quality Commission, independent Safeguarding Board, Coroner and the Police. The Duty of Candour is the contractual requirement to ensure that the Being Open process is followed when a patient safety incident results in moderate harm, severe harm, death or prolonged psychological harm.

The NHS Constitution for England 2009 states:

"The NHS also commits when mistakes happen to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively"

1.4 Guiding principles:

- Acknowledging, apologising and explaining when things go wrong
- Conducting a thorough investigation into the event and assuring patients, their families and carers, that lessons learned will help to prevent the reoccurrence of the event.
- Providing support for those involved-patients, families, carers or staff-to cope with the physical psychological consequences of what happened.

1.5 The benefits of Open and Honest Care are widely recognised and supported by policy makers, professional bodies, litigation and indemnity bodies.

Remember: 'Saying Sorry' is not an admission of liability and it is the right thing to do.

2. Purpose

2.1 This policy provides a best practice framework to create an environment where patients, their families and carers, healthcare professionals and managers all feel

supported when care goes wrong and have the confidence to act appropriately. The framework offers guidance on how to develop and embed the Open and Honest Care (including Duty of Candour) Policy and is one which fits the organisations local circumstances.

2.2 This policy also offers advice on how to communicate with patients, their families and carers, based on evidence from research literature and the experience of other countries.

2.3 The guiding principles of Open and Honest Care / Duty of Candour apply to all events when communication with patients, their families and carers is required. This can be as a result of an adverse event.

3. Scope of Policy

3.1 The scope of this document is Trust wide, and applies to all permanent, locum, agency, bank and voluntary staff of Lincolnshire Community Health Services; whilst acknowledging that for staff other than those directly employed by the Trust the appropriate line management will be taken into account.

3.2 The policy outlines how the Trust will be 'Open and Honest' with patients, their families and carers, however, implementation does not replace the personal responsibilities' of staff with regard to issues of professional accountability for governance.

3.3 This policy will ensure that the principle of Open and Honest Care / Duty of Candour are applied to incidents and / or harm that is identified in retrospect, i.e., following the mortality review process.

3.3 In the case of a near miss or no harm incident, patients are not usually contacted or involved in investigations and these types of incidents are outside the scope of this policy.

4. Duties and Responsibilities

Trust Board	The Trust Board retains corporate responsibility for the Open and Honest care (incorporating Duty of Candour) Policy. Ensuring this is in place and fully implemented throughout the organisation.
Chief Executive	The Chief Executive has overall responsibility for Open and Honest Care / Duty of Candour within the Trust, ensuring that the principles and policy are embedded in the organisation and that the infrastructure is in place to support this. In conjunction with the Trust Board, the Chief Executive is responsible for actively championing the Being Honest and Duty of Candour culture and process by promoting an open, honest and fair culture that fosters peer support.
Directors and Non-Executive Directors	Regulation 5 (CQC), imposes the requirement for 'Fit and Proper Persons' to undertake the role of Directors within NHS Bodies.
Non-Executive Directors	The chair of the Quality and Risk Committee is responsible for ensuring that the Being Open principles incorporating Duty of Candour policy is embedded in the organisation.
Medical Director	The Medical Director will be made aware of all serious incidents and will promote the culture of Open and Honest care and Duty of Candour within the organisation

Director of Nursing, AHPs and Operations	The Director of Nursing, AHPs and Operations has responsibility for the strategic implementation of this policy and has overall operational responsibility for all serious incidents that occur in the Trust.
Head of Clinical Services, Matrons and Clinical Team Leaders	Have responsibility for ensuring that Being Open and Duty of Candour requirements are appropriately implemented and supported in the Clinical Services Areas and for fostering a culture of learning, including any required changes in practice identified as a result of the Duty of Candour process. On notification of an adverse incident the senior manager, must ensure that all appropriate steps have been taken and that the situation has been made safe. They must ensure that the Incident reporting policy, the Procedure for Investigation of Incidents, Complaints and Claims and where appropriate the Serious Untoward Incident policies are followed in conjunction with the Being Open / Duty of Candour policy. They are accountable for ensuring that all staff are provided with opportunity to access short term and long-term support following a patient safety incident, complaint or claim. This would be undertaken in conjunction with HR Advisors / Senior HR Business Partners.
Line Managers	On notification of an adverse incident the line manager, must ensure that the situation has been made safe and the incident is managed in line with Trust policies and procedures. **I**t is expected that, in the event of a serious situation, the most senior healthcare professional involved in the patient's care will be the individual who has primary communication with the patient As a line manager they have responsibility for ensuring that all staff reportable to them have adequate immediate and ongoing support following a patient safety incident, complaint or claim.
Investigation Lead	An investigation lead will be identified for each serious incident investigation. The lead investigator will be a member of staff who has undertaken incident investigation training or has the equivalent experience. They are responsible for ensuring the robust investigation of an incident and for ensuring that Being Open / Duty of Candour policy forms an integral part of the incident management process.
Risk Management/Quality Team	Has responsibility for providing support and advice to managers and staff to ensure that this policy is implemented across the Trust.
Being Open Advisors	Have the responsibility for the provision of mentorship and support to colleagues. A being Open Advisor should only be asked to lead Being Open discussions when appropriate. Their primary role is to provide support to their colleagues in implementing Being Open / Duty of Candour
All Staff	The Open and Honest care (including Duty of Candour) policy applies to all staff.
Complaints Team	Are responsible for highlighting patient safety incidents to senior managers, which are uncovered through the complaint procedure. Ensuring that the principles and processes described in this policy are considered as part of the management of complaints.

5. Definitions

- **Apology:** A sincere expression of regret offered for harm sustained.

- **Being Open / Open and Honest Care:** Open communication of events that resulted in moderate or severe harm or the death of a patient whilst receiving healthcare.

- **Death and Severe Harm:** This is qualified in that they only apply when death or severe harm is 'related to the incident rather than the actual case of the service user's illness or underlying condition.

- **Harm:** Injury (physical or physiological), disease, suffering, disability or death. Either harm we could have prevented (avoidable) or harm we could not have prevented (unavoidable)

- **'Never Event':** Defined as serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.

- **Prolonged Psychological Harm:** is taken from the CQC Regulations 2009. 'Psychological harm which a service user has experienced or is likely to experience for a continuous period of at least 28 days.

- **Root Cause Analysis (RCA):** A systematic approach in which contributing factors to any event are identified, and in which understanding of the underlying causes and environmental context of the event is sought.

- **Serious Harm:** 'A permanent lessening of bodily, sensory, motor, physiological or intellectual functions, including removal of wrong limb or organ or brain damage'.

- **Serious Incident Requiring investigation:** One where serious actual harm has resulted.

- **Senior Clinician:** The most senior healthcare clinician involved in the patients' care and would have primary communication with the patient

6. Key Elements of Open and Honest Care

6.1 Effective communication with patients begins at the start of their care and should continue throughout their relationship with the care provider. This should be no different when a patient safety incident occurs. Openness about what happened and discussing patient safety events promptly, fully and compassionately can help patients, families and carers cope better with the aftereffects. 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. Openness when things go wrong is fundamental to the partnership of trust between patients and those who provide their care.

6.2 For Patients Open and Honest Care is important because:

- It is the right thing to do
- It acknowledges the distress the patient safety event may have caused
- Patients are more likely to forgive medical errors if they are discussed fully, in a timely and thoughtful manner
- Open and Honest Care can decrease the trauma felt by patients following a Patient Safety Event

6.3 For LCHS, Open and Honest Care Involves:

- Acknowledging, apologising and explaining when things go wrong
- Conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident reoccurring
- Providing support to cope with the physical and psychological consequences of what happened

6.4 For Healthcare Staff, Open and Honest Care has several benefits, including:

- Satisfaction that communication with patients, their families and carers following a patient safety event has been handled in the most appropriate way
- Improving the understanding of incidents from the perspective of the patient, their families and carers
- The knowledge that lessons learned from incidents will help prevent them happening again
- Having a good professional reputation for handling a difficult situation well and earning respect amongst peers and colleagues

7 The Principles of Being Open / Open and Honest Care

The following set of principles has been developed to help healthcare organisations create and embed a culture of Open and Honest Care.

7.1 Acknowledgement

All patient safety incidents should be acknowledged and reported as soon as they are identified.

7.2 Truthfulness, Timeliness and Clarity of communication.

Information about a patient safety incident must be given to patients their families/carers in a truthful and open manner by an appropriate person. Patients want 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/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 their families/carers should be kept up to date with the progress of an investigation.

Patients their families/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 and use of medical jargon which they may not understand should be avoided.

7.3 Apology

Patients and/or their carers should receive a sincere expression of 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. Both verbal and written apologies should be given.

Based on the circumstances, clinical teams and/or, in the case where a patient has suffered severe harm or death, the incident investigation lead will decide on the most appropriate member of staff to issue these apologies to patients and/or their carers. The decision should consider seniority, relationship to the patient, 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. It is important not to delay for any reason, including: fear, apprehension; lack of staff availability or the need to set up a more formal multi-disciplinary Open and Honest care discussion with the patient and/or their carers. Delays are likely to increase the patient's, their families/carers sense of anxiety, anger or frustration.

A written apology, which clearly states the Trust is sorry for the suffering and distress resulting from the incident, must also be offered. Whether accepted or declined, this must be recorded and should be provided within a maximum of 10 days from the incident being reported on Datix.

7.4 Recognising Patient and Carer Expectations.

Patients and their families/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 with representatives from the Trust. They should be treated sympathetically, with respect and consideration, whilst ensuring the maintenance of confidentiality. Patients their families/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.

Where appropriate, information on the Patient Advisory and Liaison Service (PALS) in England, the Community Health Councils (CHC) in Wales (and other relevant support groups like Cruse Bereavement Care (www.crusebereavementcare.org.uk/) and Action against Medical Accidents (AvMA) should be given to the patient as soon as it is possible.

7.5 Professional Support.

The Trust supports an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. Staff should expect to feel supported throughout the incident investigation process because they too may have been traumatised by the nature of their involvement. Staff should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration. Trust policies and procedures will be followed during

the investigation of any identified incident. Appropriate actions i.e. disciplinary action will only be taken following a full investigation and this is indicated in accordance with the findings.

To ensure a robust and consistent approach to incident investigation, the Trust advocates the use of the National Agency's incident decision tree (IDT). The IDT has been developed as an aid to improve the consistency of decision making about whether human error or systems failures contributed to an incident. It is designed for use by anyone who has the authority to exclude a member of staff from work following a patient safety incident (including medical and nursing directors, chief executives and human resources staff.

Where there is reason for the healthcare organisation to believe a member of staff has committed a punitive or criminal act, the trust will 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.

The Trust also encourages staff to seek support from relevant professional bodies such as the General Medical Council, Royal Colleges, the Medical Protection Society, the Medical Defense Union and the Nursing and Midwifery Council and the Health and Care Professions Council.

7.6 Risk Management and Systems Improvement.

Root cause analysis (RCA), or similar techniques 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 for their effectiveness.

7.7 Multidisciplinary Responsibility.

Where multi-disciplinary teams are involved, communication with patients their families/ 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 sole action of an individual.

7.8 Clinical Governance.

Being Open requires the support of patient safety and quality improvement processes that are managed through clinical governance frameworks, to ensure patient safety incidents are investigated and analysed, to ensure vital lessons are learned to prevent any further recurrence of an event.

7.9 Confidentiality.

The procedures for Open and Honest Care must give full consideration of, and respect for, the patient's their families/carers and maintain staff privacy and confidentiality. Communications with parties outside of the clinical team should be on a strictly need-to-know basis and, where practicable, records should be anonymous. Details of a patient safety incident should at all times be considered confidential. In addition, it is good practice to inform the patient their families/carers about who will be involved in the investigation before it takes place.

7.10 Continuity of Care

Following any incident patients can expect to receive all usual treatment and continue to be cared for 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. A key part of Open and Honest care is considering the patient's needs or the needs of their family/carers in circumstances where the patient has died.

8 Open and Honest Care Advisors

8.1 The NPSA requires that Trusts identify individuals to mentor and support fellow clinicians. The Quality Assurance Leads, Director of Nursing, AHPs and Operations / Deputy Director of Nursing, AHPs and Operations and the Medical Director can be contacted for advice and support with the Open and Honest / Duty of Candour process. In the event of severe harm or death of a patient resulting from a patient safety incident, advice should always be sought prior to any Open and Honest communication.

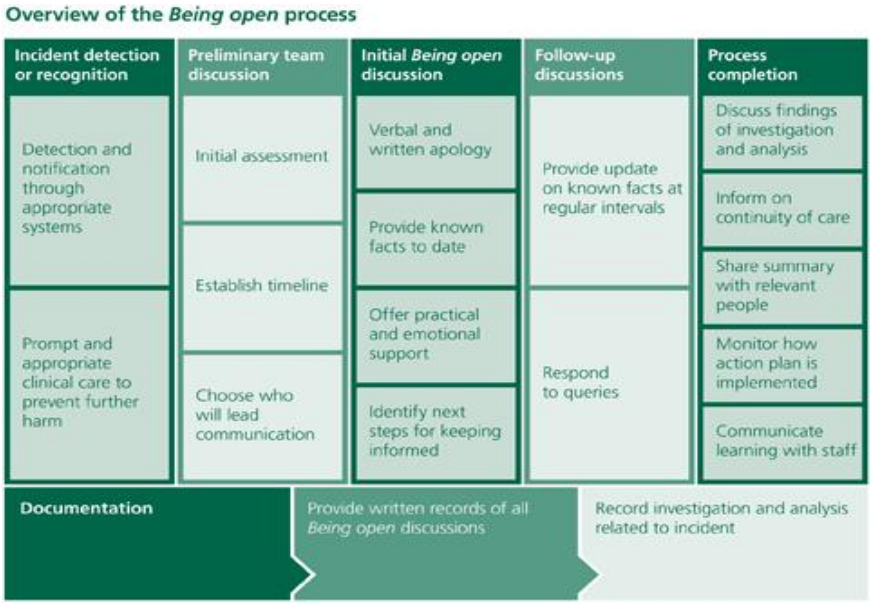
An Open and Honest Advisor should only be asked to lead Being Open discussions when appropriate. Their primary role is to provide support to their colleagues in implementing the Open and Honest (Duty of Candour) policy.
Open and Honest Care, Advisors should:

- Support fellow healthcare professionals with Being Open by:
  - mentoring colleagues during their first Being Open discussion;
  - advising on the Being Open process;
  - being accessible to colleagues prior to initial and subsequent Being Open discussions;
  - facilitating the initial team meeting to discuss the incident when appropriate;
  - signposting the support services within the organisation for colleagues involved in Being Open discussions;
  - facilitating debriefing meetings following Being Open discussions;
  - mentoring colleagues to become Being Open advisors
- Support fellow healthcare professionals in dealing with patient safety incidents by:
  - signposting the support services within the organisation for colleagues involved in patient safety incident discussions;
  - advising on the reporting system for patient safety incidents.
- Practice and promote the principles of Being Open.

Further details can be obtained by accessing NRLS information via the link on the LCHS website: **www.lincolnshirecommunityhealthservices**

The Open and Honest Care Process (Being Open)

Figure 1.



9 Incident Detection and Recognition

The Open and Honest Care process begins with the recognition that a patient has suffered moderate or severe harm, or has died, as a result of an unexpected incident whilst receiving care. The recognition may be by the following:-

- A member of staff at the time of the incident;
- A member of staff retrospectively when an unexpected outcome is detected;
- Outside the incident reporting process usually by way of a complaint, legal claim, Coroner's Officer or media interest;
- A patient, their family/ carers who express concern or dissatisfaction with the patient's healthcare either at the time of the incident or retrospectively;
- Incident detection systems such as incident reporting or medical records review;
- Other sources such as detection by other patients, visitors or non-clinical staff(for example, researchers observing healthcare staff)

As soon as an event is identified, the top priorities are prompt and appropriate clinical care and prevention of further harm.

If the event is considered to have caused avoidable, moderate or severe harm or caused the death of a patient or prolonged psychological harm, then it will be subject to Duty of Candour requirements - guidance detailed in **Appendix A.**

Incidents that give rise to events of this kind are almost always unintentional, however if at any stage it is determined that harm may be the result of a criminal or intentionally unsafe act, the Director of Nursing, AHPs and Operations or in their absence the Deputy Director of Nursing, AHPs and Operations must be notified immediately to ensure that the appropriate action is taken.

As soon as a patient safety incident is identified, the top priority is prompt and appropriate clinical care. The incident should be reported in line with the Incident Management Policy.

9.1 Patient Safety Incidents which have occurred elsewhere

A patient safety incident may have occurred in an organisation other than the one in which it is identified. The individual who identifies the possibility of an earlier patient safety incident should complete an electronic incident form (Datix). The quality team and health and safety teams will then contact their equivalent at the organisation where the incident occurred.

The Being Open process and the investigation and analysis of a patient safety incident should normally occur in the healthcare organisation where the incident took place and is the responsibility of the most senior clinician associated with the service.

9.2 Initial assessment to determine level of response

All incidents should be assessed initially by the healthcare team to determine the level of response required, the level of response to a patient safety incident depends on the nature of the incident.

Figure 2. Grading of patient safety incidents to determine level of Open and Honest Care response

Incident	Level of response
No harm (including prevented near miss patient safety incidents)	Patients are not usually contacted or involved in investigations; these types of incidents are outside the scope of the Being Open policy.
Low harm - short term injury resolved in about 1 month	Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur at local department level with the participation of those directly involved in the incident. Reporting to the Manager will occur through the incident reporting system which will allow for analysis to detect themes. Review will occur through local investigation as described within the Procedure for Investigating Incidents. Communication should normally take the form of an open discussion between the staff providing the patient's care and the patient, their family and carers • Apply the principles of Being Open • Summary of Being Open communication should be documented on the corresponding incident form.
Moderate harm - semi-permanent injury that will take up to a year to resolve, includes emotional, psychological or physical harm.	A higher level of response is required in these circumstances. Being Open discussions will normally take the form of an open discussion between the staff providing the patient's care and the patient, their family. The Trust Being Open advisors (Quality Assurance Managers, Director of Nursing, AHPs and Operations, Deputy Directors and Medical Director) **can** be contacted prior to any Being Open communication taking place. • Apply the principles of Being Open • Summary of Being Open communication should be documented on the corresponding incident form.

Severe harm or death – long term or permanent harm, such as brain damage or disability.	Patient safety incidents resulting in severe harm or death are reported and managed as Serious Incidents in line with the Serious Untoward Incident policy. The Trust Being Open advisors (Quality Assurance Managers, Director of Nursing, AHPs and Operations, Deputy Directors and Medical Director) **must** be contacted prior to any Being Open communication taking place. The Executive Lead and Lead Investigator will be responsible for overseeing the Being Open process. • Apply the principles of Being Open • A summary of Being Open communications will be included within the incident investigation report.

Any incident that occurs outside normal working hours would automatically trigger a discussion directly with the on-call manager as per existing processes.

9.3 Preliminary Team Discussion

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

- Establish the basic clinical and other facts;
- Assess the incident to determine the level of immediate response;
- Identify who will be responsible for discussion with the patient, their family/carers. In the case of severe injury or death the Executive lead and Lead investigator for the Serious Incident will be responsible for overseeing the Being Open process and will agree who will meet with the patient, their family/ carers;
- Consider the appropriateness of engaging patient support at this early stage. This includes the use of a facilitator, a patient advocate or a healthcare professional who will be responsible for identifying the patient's needs and communicating them back to the healthcare team;
- Identify immediate support needs for the healthcare staff involved;
- Ensure there is a consistent approach by all team members around discussions with the patient, their family/carers.
- Identify and ensure liaison with any other organisation/external agencies.

9.5 Use of a substitute Senior Clinician for the 'Open and Honest Care' discussion

In exceptional circumstances, when the most senior clinician who usually leads the 'Open and Honest Care' discussions cannot attend, they may delegate this role to an appropriately trained and experienced substitute, who is fully informed of the details of the event. Alternatively, it may be that the patient, their families/carers would prefer to speak to someone other than the senior healthcare professional who was responsible for their care. The Director of Nursing, AHPs and Operations and the Deputy Director of Nursing ad Quality, can provide advice and support in this regard.

9.6 Choosing the individual to communicate with patients, their families or carers

The seniority of this person will be dependent on the severity of the issue. However, they should:

- Ideally be known to and trusted by the patient, their families/carers;
- Have a good grasp of the facts relevant to the event;

- Be senior enough or have sufficient experience and expertise in relation to the type of event to be credible to the patient, their families/carers;
- Have excellent interpersonal skills, including being able to communicate in a way that can be easily understood and avoids excessive use of medical jargon;
- Be able and willing to offer a meaningful apology, reassurance and feedback;
- Be able to maintain a medium to long term professional relationship with the patient, their families/carers

9.7 Responsibilities of junior healthcare professionals

Junior staff or those in training should not lead the Open and Honest Care Process and should defer to a more senior colleague for advice and support.

9.8 Involving healthcare staff who made mistakes

Some events will have resulted from errors made by healthcare staff. In these circumstances the member(s) of staff may or may not wish to participate in the Open and Honest Care discussion with the patients and their carers.

Every case where avoidable harm has occurred needs to be considered individually, balancing the needs of the patient, their families and their carers. In cases where the healthcare professional who has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout. In cases where the healthcare professional is not present, it is advised that a personal written apology is handed to the patient, their families and carers during the first Open and Honest Care discussion.

There will be an obligation on behalf of the member of staff involved to attend any meeting if requested to do so by the family. In recognition that these could be challenging circumstances, it is incumbent upon the senior clinician dealing with the incident to provide an appropriate level of support.

9.9 The initial 'Open and Honest Care' discussion

The initial Open and Honest Care discussion with the patient, their families/carers is the first part of an ongoing communication process and should occur as soon as possible after recognition of the event. Many of the points raised in the initial meeting should be expanded on during subsequent discussion.

Where moderate or severe avoidable harm is deemed to have occurred, this should be verbal or face to face where possible but must take place with 10 working days of the incident being declared, to satisfy conditions relating to Duty of Candour requirements.

This process is fully detailed in **Appendix A and shown as a flowchart in Appendix B.**

The patient, their family and carers should be advised of the identity and role of all people attending the Open and Honest discussion before it takes place. This allows

them the opportunity to state their own preference about which healthcare staff they want to be present.

If for any reason it becomes clear during the initial discussion that the patient would prefer to speak to a different healthcare professional, the patient's wishes should be respected. A substitute person with whom the patient is satisfied should be provided.

It should be recognised that patients, their families and carers may be anxious, angry and frustrated, even when the Open and Honest Care discussions are conducted appropriately.

Factors to consider when planning the discussion include:

- Clinical condition of the patient
- Patient preference-in terms of when and where the meeting takes place and which healthcare professional leads the discussion
- Privacy and comfort for the patient
- Availability of the patient's family/ carers
- Availability of support staff. For example: a translator or advocate
- Availability of key staff involved in the Open and Honest Care discussion

In cases where it is inappropriate for the member of staff to attend the meeting in person, consideration should be given to them providing a letter of apology to be given to the patient, their families/ carers, during the initial discussion/meeting.

The discussion should cover the following:

- There should be an expression of genuine sympathy, regret and a meaningful apology for the avoidable harm that has occurred.
- The patient, their families/carers should be informed that an incident investigation is being carried out, and more information will become available as it progresses. This will include time frames for communication and an agreed continuing point of contact for the patient, their families and carers.
- The patient's, their families/carers understanding of what happened will be taken into consideration, as well as any questions they may have. These must be fed into the investigation, so that an informed response can be given.
- The explanation of what happened will be delivered using the facts available at the time and in a way that the patient, their families/carers can understand with an indication of what will happen next.
- An offer of practical and emotional support, for example from local charities and voluntary organisations where applicable.
- Information on services offered by all the possible support agencies (including their contact details), in order to ensure a high level of emotional support is maintained. This will support the patient to identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.
- Ongoing contact details of the member of staff who will maintain a relationship with the patient, using an appropriately agreed method of communication from the family's and carers perspective.

It is essential that the following does not occur:

- Speculation
- Attribution of blame
- Denial of responsibility
- Provision of conflicting information from different individuals

9.10 Continuity of Care

When a patient has been avoidably harmed during the course of treatment and requires further therapeutic management or rehabilitation, they should be informed of the ongoing clinical management plan.

Patients, their families and carers should be reassured that they will continue to be treated according to their clinical need. They should also be informed that they have the right to continue their treatment under the care of an alternative healthcare professional.

10 Follow-up Discussion

Follow-up discussions with the patient, their family and carers are an important step in the Open and Honest process, providing updates on known facts and responding to any queries, it should be agreed at the initial 'Open and Honest' meeting how this will be relayed, a point of contact and the frequency of communication. Depending on the incident and the timeline for investigation there may be more than one follow-up discussion.

11 Process Completion

Following the investigation, feedback must be given, and this should be articulated by the patient their families and carer. Whatever method is used to communicate the investigation findings, a written summary will be provided and include the following:

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

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 be withheld or restricted, for example, in very rare cases, where communicating information will adversely affect the health of the patient; where investigations are pending; or where specific legal requirements preclude disclosure for specific purposes. It is expected

that these situations will be extremely rare and the judgment will be authorised at Executive Officer level.

For all avoidable harm events to comply with the Duty of Candour, once the investigation is concluded and closed by the Trust a copy of the final investigation report must be provided to the patient or their families or carers within ten working days.

12 Documentation

Throughout the Open and Honest Care process it is important to record and retain discussions with the patient, their families/carers. The amount of documentation that is required will be dependent upon the severity of the incident. For more serious issues, particularly when a full investigation has taken place, a full written record of the 'Open and Honest Care' discussions should be made. A template is available for use in these circumstances at **Appendix C**.

The documentation will be held within the specific locality by the respective Head of Clinical Service

13 Patient Issues to Consider

13.1 Communication

For open and effective communication following patient safety incidents, staff responsible for undertaking Being Open discussions should:

- Ensure early identification of, and consent for, the patient's practical and emotional needs, including:
    - the names of people who can provide assistance and support to the patient, and to whom the patient has agreed that information about their healthcare can be given. This person (or people) may be different to both the patient's next of kin and from people who the patient had previously agreed should receive information about their care prior to the patient safety incident;
    - any special restrictions on openness that the patient would like the healthcare team to respect;
    - identifying whether the patient does not wish to know every aspect of what went wrong; respect their wishes and reassure them that this information will be made available if they change their mind at a later date.
- Provide repeated opportunities for the patient, their family and carers to obtain information about the patient safety incident.
- Provide information to patients in verbal and/ or written format.
- Provide assurance that an ongoing care plan will be developed in consultation with the patient and will be followed through.
- Provide assurance that the patient will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the patient, their family and carers and the healthcare team will not affect their access to and quality of treatment.
- Facilitate inclusion of the patient's family and carers in discussions about a patient safety incident in agreement with the patient.
- Provide the patient's family and carers with access to information to assist in making decisions if the patient is unable to participate in decision making or if the

patient has died as a result of an incident. This should be done with regard to confidentiality and in accordance with any prior instructions.

- Awareness that there may be a need to repeat this information to the patient at different times to allow them to comprehend the situation fully.
- Ensure that the patient's family and carers are provided with known factual information, care and support if a patient has died as a result of a patient safety incident. The carers should also be referred to the Coroner for more detailed information.
- Ensure that discussions with the patient, their family and carers are documented and that information is shared with them.
- Ensure that the patient, their family and carers are routinely provided with information on how to access the complaints procedure.
- Ensure that the patient, their family and carers are provided with information on the incident reporting process.
- Ensure that the patient's account of the events leading up to the patient safety incident is fed into the incident investigation, whenever applicable
- Ensure that the patient, their family and carers are provided with information on how improvement plans derived from investigations will be implemented and their effects monitored.
- Ensure that the patient, their family and carers are provided with information in their first language i.e. face to face interpreter/telephone interpretation and translated documents.

13.2 Advocacy and Support

Patients, their families and carers may need considerable practical and emotional help and support after experiencing a moderate / severe patient safety incident. The most appropriate type of support may vary among different patients, their families and carers. It is therefore important to discuss with the patient, their families and carers to allow for their individual needs. Support may be provided by patients' families, social workers, religious representatives and healthcare organisations such as the Patient Advice and Liaison Service (PALS). Where there is requirement for more detailed long-term emotional support, advice should be provided on how to gain access to appropriate counselling and support services, for example, from Cruse Bereavement Care.

13.3 Particular Patient Circumstances

The approach to Being Open may need to be modified according to the patient's personal circumstances. The following gives guidance on how to manage different categories of circumstance.

13.4 When a Patient Dies

When a patient safety incident has resulted in a patient's death, it is crucial that communication is sensitive, empathic and open with consideration to cultural needs. 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. The patient's family and carers will need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counselling or further assistance at any stage of the process.

Usually, the Open and Honest discussion and any investigation occur before the coroner's inquest. But in certain circumstances the healthcare organisation may

consider it appropriate to wait for the coroner's inquest before holding the Being Open discussion with the patient's family and carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the patient's death. In any event an apology should be issued as soon as possible after the patient's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and carers will be provided with more information.

The investigation team will facilitate contact with the Coroner's Officer allocated as liaison to the family, to discuss the most appropriate method of managing the Being Open discussion.

13.5 Children

The legal age of maturity for giving consent to treatment is 16 years old. It is the age at which a young person acquires the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. This is sometimes known as Gillick competence or the Fraser guidelines25. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she 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. More information can be found on the Department of Health's website www.dh.gov.uk

13.6 Patients with Mental Health Issues

Open and Honest care for patients with mental health issues should follow normal procedures, unless the patient also has cognitive impairment – please also refer to section 13.7Patients with cognitive impairment.

The only circumstances in which it is appropriate to withhold patient safety incident information from a patient with mental health issues, is when advised to do so by a Consultant Psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another Consultant Psychiatrist) would be needed to justify withholding information from the patient.

Apart from exceptional circumstance, it is never appropriate to discuss patient safety incident information with a carer or relative without the express permission of the patient. To do so is an infringement of the patient's human rights.

13.7 Patients with Cognitive Impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorised a person to act on their behalf by an enduring

Power of Attorney. In these cases, steps must be taken to ensure that this extends to decision making, medical care and treatment of the patient.

The Open and Honest Care discussion would be conducted with the holder of the Power of Attorney. Where there is no such person, the clinicians may act in the patient's best interest in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened.

An advocate with appropriate skills would be available to the patient to assist in the communication process.

13.8 Patients with Learning Disabilities

Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above).
If the patient is not cognitively impaired, they should be supported in the *Open and Honest Care* process by alternative communication methods e.g. given the opportunity to write questions down. An advocate, agreed on in consultation with the patient, should be appointed and the role may include carers, family or friends of the patient. The advocate should assist the patient during the *Open and Honest Care* process, focusing on ensuring that the patient's views are considered and discussed.

13.9 Patients who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient, their families/carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the Open and Honest Care process. In this case the following strategies may assist:

- Deal with the issue as soon as it emerges
- Where the patient agrees, ensure their families/carers are involved in discussions from the beginning
- Ensure the patient has access to support services
- Where the senior health professional is not aware of the relationship difficulties; provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team
- Offer the patient their families/carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management
- Use a mutually acceptable mediator, to help identify the issues between the healthcare organisation and the patient and to seek a mutually agreeable solution
- Ensure the patient, their families/carers are fully aware of the formal complaint procedure
- Write a comprehensive list of the points that the patient and/or their carer disagree with and provide reassurance that they will be followed up. If families/carers disagree, then consider the mental capacity of the patient, pursuing Best Interest and Advocacy routes.

13.10 Patients with a Different Language or Cultural Considerations

The need for translation and advocacy services, and consideration of special cultural needs (such as for patients from cultures that make it difficult for a woman to talk to a male about intimate issues), must be taken into account when planning to discuss patient safety incident information. A recognised translation service will be used to ensure sensitive issues and advice gained is properly delivered. The use of 'unofficial translators' and/or the patient's family or friends should be discouraged as they may distort information by editing what is communicated. Please see Interpretation and Translation Policy.

NB. Advocates are not usually used in the translating process, but maybe used in situations such as mental health or people with learning difficulties.

The following guidance is available on the staff website under policies and guidance, 'A Staff Guide to the Needs of Ethnic-Religious Minority Communities', this document provides further support including the needs of end of life patients and care after death for people of different religions.

13.11 Patients with Different Communication Needs

A number of patients will have particular communications difficulties such as a hearing impairment. Plans for the meeting should fully consider any necessary need. Knowing how to enable or enhance communications with a patient is essential to facilitating an effective Open and Honest Care process, focusing on the needs of all individuals involved by demonstrating care and respect. **Appendix D** outlines additional guidance on the 3 proposed phases of discussion that should be undertaken with a patient or their carer.

14 Supporting Staff

When a patient safety incident occurs, healthcare professionals involved in the patient's clinical care may also require emotional support and advice. For further information please refer to the Trust Policy Supporting Staff Involved in Incidents Complaints or Claims. Where staff experience particular difficulties as a result of any event, managers should consider referring the staff member(s) to the Occupational Health Department or the Practitioner Performance Team, in accordance with the 'Supporting Staff Involved in a Traumatic Incident, Complaint or Claim Policy' (LCHS). Staff may also self-refer to Occupational Health Department

15 Training Requirements

The principles and concept of '*Open and Honest Care'* are included on Induction and / or mandatory training programmes.

16 References and Associated Documentation

16.1 External

- Department of Health 209. The NHS Constitution www.dh.gov.ukNational Patient Safety Agency (2004). *Seven Steps to Patient Safety. The Full Reference Guide.* Available at www.npsa.nhs.uk/sevensteps

- Great Western Hospitals NHS Foundation Trust, Being Open Policy, July 2014.
- Lincolnshire County Council Protecting People from Abuse Guide 2014 www.Lincolnshire.gov.uk
- National Health Service Litigation Authority, April 2011, Risk Management Standards www.nhsla.com
- National Health Service Litigation Authority, April 2011, Clinical Negligence Scheme for Trusts- Clinical Risk Management Standards-Maternity www.nhsla.com
- National Patient Safety Agency (2009). *Being Open.* Patient Safety Alert NPSA/2009/PSA/003. (www.npsa.nhs.uk)
- National Patient Safety Agency 2009, Root Cause Analysis Investigation Tools.
- National Patient Safety Agency, Building a memory: Preventing Harm, reducing risks and improving patients safety (July, 2005) www.npsa.nhs.uk
- Nursing and Midwifery Council www.nmc-uk.org
- Equality Act (2010)
- NHS Resolutions Saying Sorry Saying sorry (duty of candour) - NHS Resolution

16.2 Internal

• Pressure Ulcer Prevention and Management Policy	G_CS_33
• Serious Incident Policy	P_RM_06
• Safe and Secure Handling of Medicines Policy	P_CIG_04
• Safeguarding Children Policy	P_CS_01
• Safeguarding Adults Policy	P_CS_30
• Interpretation and Translation Policy	P_HR_38

17 Monitoring Compliance

Being Open is a general concept and the specific delivery of 'Being Open' communications will vary according to the severity grading, clinical outcome and relative arrangements for each specific event. In exceptional case information may need to be withheld or specific legal requirements might preclude disclosure. Equality records of communications with patients and families would not normally be shared in the public domain. For these reasons monitoring of compliance and effectiveness will be via a confidential planned audit using an appropriately sampled population. As a minimum the following elements will be monitored.

Element to be monitored	Lead	Tool	Frequency of report of compliance	Governance arrangements	Lead(s) for acting on recommendations
Duty of Candour requirements are completed in 100% of cases	Director of Nursing, AHPs and Operations	Datix	Monthly	Quality and Risk Committee Trust Board	Director of Nursing, AHPs and Operations

Appendix A: Duty of Candour Requirements

- Of primary concern is ensuring that the patients, their families/carers are told about events causing harm that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with consequences.

- Duty of Candour applies to events that result in avoidable moderate or severe harm, but this does not negate the requirements to inform the patient of appropriate incidents relating to their care.

- The patient, their relative/carers must be informed within 10 working days of the incident being confirmed as either avoidable moderate or severe harm.

- The initial explanation must be verbal or, where possible, face to face, conducted in person by one or more representatives of the Trust. It is important to consider any circumstances that will affect the ease of communication with patient (language barriers, communication difficulties, or relevant disability.

- This initial contact with the patient, their families/carers must include the following:

    1. A sincere apology
    2. A step-by step explanation of what happened in plain English based on known facts, which can be an initial view pending an investigation
    3. An offer of a written notification
    4. Any further information that results from the investigation, or is subsequent to the initial explanation, must be offered to be provided to the patient, their families/carers promptly and on a regular basis as the investigation progresses.

- Once the investigation has been concluded and 'signed off' by the Head of Clinical Services, as closed by the Trust a copy of the final investigation report must be provided to the patient, their families/carer within 10 working days, unless this has been expressly declined.

- Full written documentation of all contact, either verbal or face to face, must be maintained according to the principles in the Open and Honest Care Policy (**Appendix B**). This should be stored in a secure electronic folder as is the complaints process documentation. If the patient, their families/carers declines any offers of meetings or to have information provided this must also be clearly recorded within the electronic folder.

- Information should be shared with other Health Care Professionals or relevant bodies with the permission of the patient / family as appropriate e.g the Coroner.

Lincolnshire Community Health Services NHS Trust

Appendix B - Record of implementation of Open and Honest Care Policy

Patient Name:		Patient's NHS number:	
Contact's name (if not patient):		Relationship of contact to patient:	
Address for correspondence:		Telephone number of patient or contact:	
Date of incident:		Time of incident:	
Datix ref:		STEIS ref:	
Location of incident:		Ward/team:	
Nominated Lead Clinician:		Person responsible for communications:	
Please specify if any other team/organisation has been informed e.g. Police, Safeguarding, Coroner			
Brief overview of event			
Record of initial explanation to the patient (please specify whether face to face or phone contact):			

Date		Time		Method of contact:	Face to face:		Telephone:

Please detail those present:

Name:	Designation:

Please provide written summary of conversation (including apology given):

Record of subsequent meetings/conversations/correspondence - detailed record of discussion for each contact:

Date:		Time:		Venue:	

Please detail those present:

Name:	Designation:

Please provide written summary (including any concerns raised by patient/relative):

Patient informed of investigation outcome and action plan progress to date (please detail below):

Plan of next stage in process agreed with Patient/Family/Carers (please detail below):

Appendix C – Duty of Candour process

Duty of Candour process

Duty of Candour applies to incidents that result in moderate or above harm, this includes all Category 3 and Category 4 pressure ulcers that are acquired whilst patients are in LCHS care

On detection of incident, the contact with the patient must include an apology and an explanation of the known facts pending an investigation

Any further information that results from the investigationmust be offered to be provided to the patient, their families/carers promptly and on a regular basis as the investigation progresses. A record must be made if this is not required

Incident recorded on Datix

Document in patient's record that Duty of Candour applies

A written apology expressing regret of harm must be sent

If the patient has a cognitive impairment, the letter should be sent to the holder of the Powerof Attorney. Where there is no such person, the clinicians may act in the patient's best interest in deciding who the appropriate person is to discuss incident information with

Documentation of all discussions must be kept (see Appendix 1)

Share findings with patients/relatives/carers if requested

Duty of Candour process for pressure damage

Duty of Candour applies to incidents that result in moderate or above harm, this includes all Category 3 and Category 4 pressure ulcers that are acquired whilst patients are in LCHS care

On detection of incident, the contact with the patient must include an apology and an offer to notify the patient of the investigation outcome.

Any further information that results from the investigation must be offered to be provided to the patient, their families/carers promptly. A letter will be given to the patient at the next visit which confirms whether or not they wish to be notified of the outcome of the investigation. This must be recorded on Datix in the Openess and Transparancy section.

If the patient has a cognitive impairment, the letter should be sent to the holder of the Powerof Attorney. Where there is no such person, the clinicians may act in the patient's best interest in deciding who the appropriate person is to discuss incident information with.

However, the patient with a cognitive impairment should, where possible, be involvedrectly in communications about what has happened.

Document in patient's record on S1 that Duty of Candour applies

Documentation of any further discussions regarding Duty of Candour must be recorded in Datix

If investigation findings are requested, please document on Datix who and when this has been shared.

Appendix D: Open and Honest Care Discussion Guidance

First Phase - Open the Explanation

The *Open and Honest Care* Lead should consider the process and key objectives when opening the initial discussion.

Key 'Dos'

- Do come to the meeting properly prepared
- Do advise the patient, their family/carer of the identity and role of all people attending the *Open and Honest Care* Discussion before it takes place (this allows them the opportunity to state their own preferences about which healthcare staff should be present)
- Do introduce everyone present
- Do reiterate each person's role and ask the patient/family/carer if they are happy with who is involved
- Do start off the discussion by acknowledging that an incident has occurred and then express your sincere regret and sympathy
- Do apologise on behalf of the team and the organisation for what has happened- remember that patients expect and deserve an apology and an explanation following an incident
- Do outline the purpose of the discussion from the organisation perspective
- Do ask the patient/family/carer what else they would like to discuss in the meeting that may not be covered by the agenda outlined
- Do formally note the patient/family/carer views and concerns to demonstrate that these are being heard and taken seriously
- Do use appropriate body language and eye contact from the outset of the discussion
- Do alleviate any immediate concerns, reassure the patient/family/carer that the harm done will be medically redressed, if appropriate

Key 'Don'ts'

- Don't deny responsibility
- Don't be defensive or treat the patient as an adversary
- Don't use technical medical jargon
- Don't say 'No Comment' or go 'Off the record'

Second Phase - Explanation of the incident

The '*Open and Honest Care'* Lead should consider the process and key objectives when discussing the incident.

Key 'Do's'

- Do provide reassurance that the matter is being taken seriously and that everything possible will be done to make sure that the same incident does not happen again
- Do establish what the patient/family/carer knows about the event already, so you can clarify or provide further information appropriate to their needs (e.g. can you tell me what happened from your point of view?)
- Do communicate the facts of the incident as they are known at the time, giving an honest account of what happened
- Do stick to the facts of the incident as they are known at the time
- Do emphasise that more information may come to light as the investigation progresses
- Do answer any questions as you discuss the incident as well as asking if they have any further questions when you have finished explaining what happened
- Do acknowledge the patient/family/carer's views and concerns and keep a written record of them to demonstrate that these are being heard and taken seriously.
- Do check and verify that the patient has understood what you have told them- asking them to recount what has been said is usually the best way to check how much information they have taken in, however be mindful that this may be too distressing at the time
- Do record key action points and assign responsibilities and deadlines

Key 'Don'ts'

- Don't exaggerate or speculate
- Don't blame or criticise your colleagues
- Don't be defensive or treat the patient as an adversary
- Don't use technical medical jargon
- Don't withhold information (unless, in very rare circumstances, information regarding an event is likely to put the patient at additional risk)
- Don't provide conflicting information from different individuals
- Don't say 'no comment' or go 'off the record'

Third Phase - Outlining Next Steps

Key 'Dos'

- Do provide reassurance that the matter is being taken seriously and that everything possible will be done to make sure that the same incident does not happen again
- Do explain the incident investigation process clearly and in simple terms that the patient/family/carer can understand
- Do emphasise that more information may come to light as the incident investigation progresses
- Do state what outcome the patient can expect form the incident investigation process
- Do provide reassurance that the investigation process will be open and fair and that the final report will be available for them to see
- Do explain what will happen next in terms of the long-term treatment plan (as appropriate) and incident analysis findings
- Do share information on the likely short term and long-term effects of the incident if they are known (this may have to be delayed to a subsequent meeting when the situation becomes clearer)
- Do check and verify that the patient has understood what you have told them- asking them to recount what has been said is usually the best way to check how much information they have taken in, however be mindful that this may be too distressing at the time
- Do offer the patient/family/carer support and counselling which would include bereavement counselling, where appropriate
- Do remember many patients and their families are unsure of what to ask so always ask If they have any further questions
- Do assign a healthcare professional to liaise with the patient throughout the investigation process and confirm their point of contact at the end of the meeting
- Do reiterate your role in the *Open and Honest Care* process and offer contact details if necessary and if different from the healthcare professional assigned to liaise with family
- Do emphasise to the patient that *Open and Honest Care* is a process and not a one-off event and if they have more questions do not hesitate to contact the *Open and Honest Care* Lead
- Do record key action points and assign responsibilities and deadlines
- Do clarify in writing the information given and reiterate the key points discussed at the meeting

- Do ensure that on-going communication takes place, the next steps are carried out and the *Open and Honest Care* process is completed

Key 'Don'ts'

- Don't use technical medical jargon

- Don't forget that the initial *Open and Honest Care* discussion is the first part of an ongoing communication process and many of these points may be expanded in subsequent meeting

Appendix E: Equality and Health Inequality Impact Assessment

This tool has been developed by the Equality, Diversity and Inclusion Leads for use in the NHS Provider organisations in Lincolnshire. The tool is designed to ensure due regard is demonstrated to the Equality Act 2010, the Public Sector Equality Duty and potential health inequalities are also identified and addressed (as outlined in the Health and Social Care Act).

A. Service or Workforce Activity Details	
1. Description of activity	This policy outlines the duty of the Trust to limit the potential impact of clinical and non-clinical risks and put in place robust and transparent systems to make sure that all incidents which might cause actual or potential harm to patients, visitors and staff are identified, investigated and rectified, with lessons learned identified and to ensure the contractual requirement of The Duty of Candour is being met where applicable
2. Type of change	Revision of policy and amendment
3. Form completed by	Joanne Gooch
4. Date decision discussed & agreed	1 September 2021
5. Who is this likely to affect?	✓ Service users ✓ Staff ✓ Wider Community If you have ticked one or more of the above, please detail in section B1, in what manner you believe they will be affected.
B. Equality Impact Assessment	
Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty / deprivation, geographically isolated (e.g. rural), carers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g. sex workers), use substances etc. Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality (e.g. it is recognised that older men from a BAME background, with one or more comorbidities and living in deprivation are more at risk of a poorer outcome if they contract CV-19).	
1. How does this activity / decision impact on protected or vulnerable	Neutral

groups? (e. g. their ability to access services / employment and understand any changes?) Please ensure you capture expected positive and negative impacts.	
2. What data has been/ do you need to consider as part of this assessment? What is this showing/ telling you?	The above-named policy has been considered and does not require a full equality analysis.
C. Risks and Mitigations	
1. What actions can be taken to reduce / mitigate any negative impacts? (If none, please state.)	Not applicable
2. What data / information do you have to monitor the impact of the decision?	Not applicable
D. Decision/Accountable Persons	
1. Endorsement to proceed?	Yes
2. Any further actions required?	None
3. Name & job title accountable decision makers	Joanne Gooch Quality Assurance Manager/Quality Team
4. Date of decision	01/09/2021
5. Date for review	September 2023