East Sussex Healthcare NHS
NHS Trust

Being open with our patients

Our staff work hard to deliver the highest standards of healthcare to the people of East Sussex.

We provide safe and effective care to many thousands of people every year but sometimes, despite our best efforts, things can go wrong. By 'being open' we make a commitment to our patients, their families and carers to:

- Respect your privacy and confidentiality
- Explain exactly what went wrong, and where possible, why things went wrong
- Let you tell us about your experience and ask questions.
- Acknowledge any distress the incident may have caused and offer a sincere and compassionate apology for what has happened.
- Discuss what is going to happen next and tell you what we will be implementing to prevent it from happening again.
- Offer support and counselling services that may be able to help.

You may feel anxious about talking through your experience with the people who have been treating you, especially if you need further treatment. We assure you that this will not have a negative impact on your future care and you will continue to be treated with respect and compassion.

Talking through the issues may help you cope better in dealing with what has gone wrong if you understand why it went wrong in the first place.

If you do not feel comfortable discussing your concern with the staff involved with your care you can contact our Patient Advice and Liaison Service (PALS).

Conquest Hospital, The Ridge, St. Leonards-on-Sea, TN37 7RD. Telephone: (01424) 758090. Email: esh-tr.palsh@nhs.net

Eastbourne District General Hospital, Kings Drive, Eastbourne, BN21 2UD. Telephone: (01323) 435886. Email: esh-tr.palse@nhs.net

Ten Principles of Being Open

1. Principle of Acknowledgement

All patient safety incidents should be acknowledged and reported as soon as they are identified. In cases where the patient, family and/or carers inform healthcare staff when something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all staff. Denial of a person's concerns will make future open and honest communication more difficult.

2. Principles of Truthfulness, Timeliness and Clarity of Communication

Information about a patient safety incident must be given in a truthful and open manner by an appropriately nominated person. Communication should also be timely informing the patient, family and/or carers what has happened as soon as is practicable, based solely on the facts known at that time. Explain that new information may emerge as the incident investigation takes place and that they will be kept up to date. Patients, family and/or carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

3. Principle of Apology

Patients, family and/or carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded agreed manner of apology, as early as possible. Verbal apologies are essential because they allow face to face contact. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the incident, must also be given. Both verbal and written apologies should be given. Saying sorry is not an admission of liability and it is the right thing to do.

4. Principle of Recognising Patient and Carer Expectations

Patients, family and/or carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident, and its consequences, in a face to face meeting with representatives from the Trust. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients, family and/or carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information on the Patient Advisory and Liaison Service (PALS) and other relevant support groups should be given as soon as possible.

5. Principle of Professional Support

The Trust must create an environment in which all staff are encouraged to report patient safety incidents. Staff should feel supported throughout the incident investigation process; they too may have been traumatised by the incident. To ensure a robust and consistent approach to incident investigation the NPSA has developed an Incident Decision Tree (ICT). Where there is reason for the healthcare organisation to believe a member of staff has committed a punitive or criminal act, the organisation should take steps to preserve its

position and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff should be encouraged to seek support from relevant professional bodies.

6. Principle of Risk Management and Systems Improvement

Root cause analysis (RA) or similar techniques should be used to uncover the underlying causes of patient safety incident. Investigation should focus on improving systems of care, which will be reviewed for their effectiveness.

7. Principles of Multi-Disciplinary Responsibility

The “‘Being open’” policy applies to all staff that have key roles in patient care. Most healthcare provision involves multi-disciplinary teams and communication with patients, family and/or 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 system failures and rarely from actions of an individual. To ensure multi-disciplinary involvement in the “‘Being open’” process, it is important to identify clinical, nursing and managerial leaders who will champion it. Both senior managers and senior clinicians must participate in the incident investigation and clinical risk management.

8. Principles of Clinical Governance

“‘Being open’” requires the support of patient safety and quality improvement through clinical governance frameworks, in which patient safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability through the Chief Executive to the Board to ensure that these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff so they can learn from patient safety incidents. Audits should be developed to monitor the implementation and effects of changes in practice following a patient safety incident.

9. Principle of Confidentiality

Details of a patient safety incident should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. Where this is not practicable or an individual refuses consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information. Communications with parties outside of the clinical team should also be on a strictly need to know basis and where practicable records should be anonymous. It is good practice to inform the patient, family and/or carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections.

10. Principle of Continuity of Care

Patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a patient expresses a preference for their

healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

Acknowledgement: ‘Being open’, www.npsa.nhs.uk