Duty of Candour Month – Week 3

Being open at a glance

The effects of harming a patient can be widespread. Patient safety incidents can have devastating emotional and physical consequences for patients, their families and carers, and can be distressing for the professionals involved.

Being open about what happened and discussing patient safety incidents promptly, fully and compassionately can help patients and professionals to cope better with the after-effects[1]. Openness and honesty can also help to prevent such events becoming formal complaints and litigation claims[2].

What does *Being open* mean?

Being open 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 recurring;
- providing support for those involved to cope with the physical and psychological consequences of what happened.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The principles

The following set of principles[1] has been developed to help healthcare organisations create and embed a culture of *Being open*:

1. Acknowledgement
2. Truthfulness, timeliness and clarity of communication
3. Apology
4. Recognising patient and carer expectations
5. Professional support
6. Risk management and systems improvement
7. Multidisciplinary responsibility
8. Clinical governance
9. Confidentiality
10. Continuity of care

The process

Being open about a patient safety incident is more than a one-off event; it is a communication process with a number of stages, as outlined in the diagram opposite, and on page 18.

The duration of the process will depend on the incident, the needs of the patient, their family and carers, and how the investigation into the incident progresses.

Implementing *Being open*

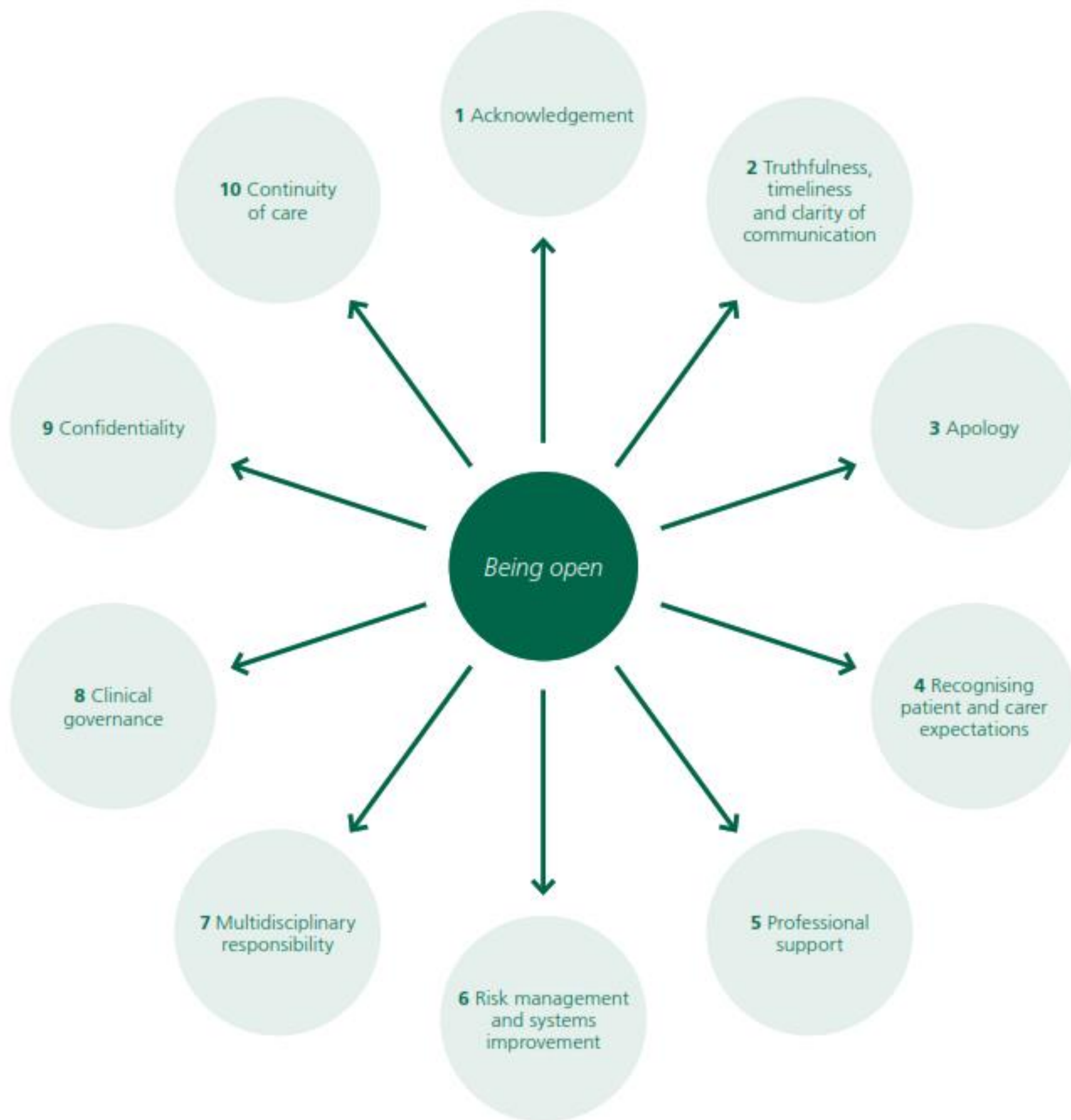
The National Patient Safety Agency (NPSA) has developed this updated framework to demonstrate how to strengthen the culture of *Being open* within healthcare organisations.

This framework provides best practice guidance on how to create an open and honest environment through:

- aligning with the *Seven steps to patient safety*[3];
- ensuring a *Being open* policy is developed that clearly describes the process to be followed when harm occurs;
- committing publicly to *Being open* at board and senior management level;
- identifying senior clinical counsellors to mentor and support fellow healthcare professionals involved in incidents.

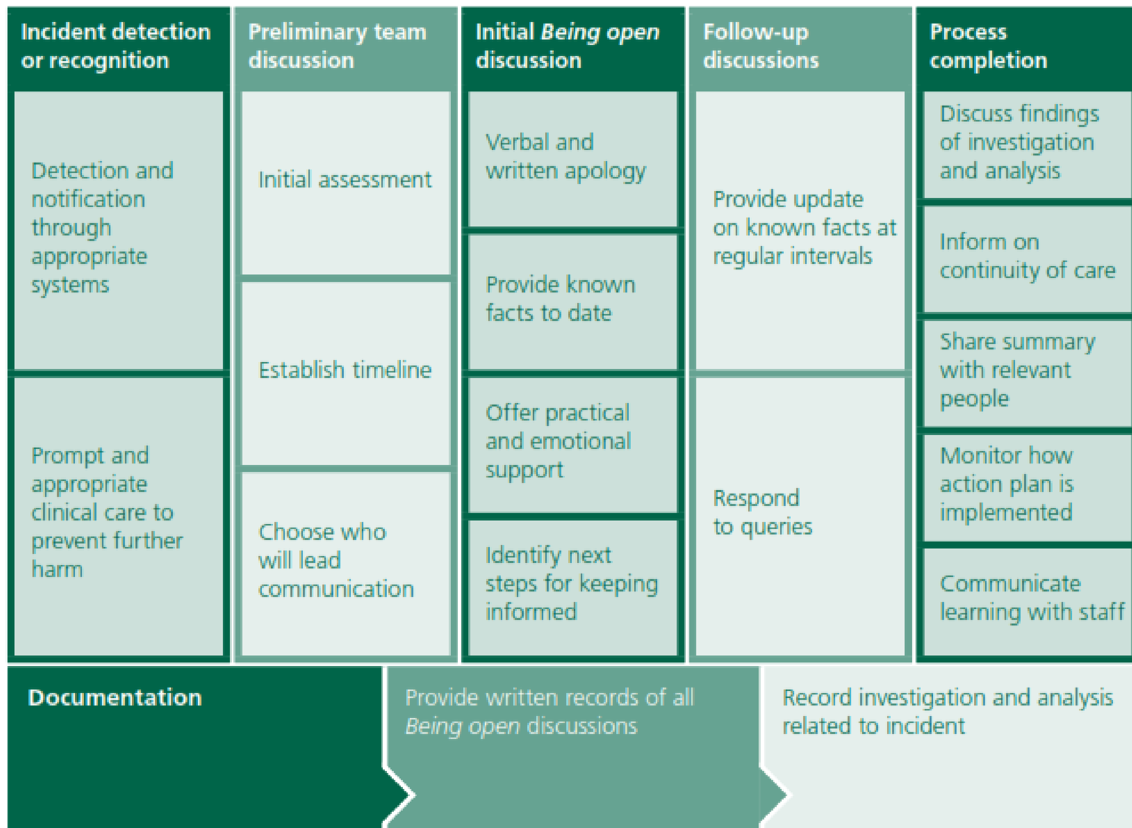
Boards and senior managers within all healthcare organisations have a crucial role in ensuring the *Being open* framework and principles are embedded.

The following principles underpin *Being open*. They can be adapted to meet the needs of individual healthcare organisations as a criteria for developing local policies and procedures on openness.



Being open is a process rather than a one-off event. There are a number of stages in the process (Figure 3). The duration of the process depends on the incident, the needs of the patient, their family and carers, and how the investigation into the incident progresses.

Figure 3: Overview of the *Being open* process



The full document from the National Reporting and Learning Service can be found here https://www.hsj.co.uk/download?ac=1293677