**Being Open: guidance on communicating with patients, their families and carers and supporting staff when things go wrong.**

1. **Introduction**

In line with the Significant Adverse Event (SAE) Policy, a nominated senior healthcare professional and member of the SAE review team will be identified to meet with patients, their family/carers and staff to provide initial and ongoing communication about the event and any subsequent review. This single point of contact for the patient and their family/carers will agree review expectations and arrangements for remaining in contact during the review.

NHS Forth Valley’s Communication Strategy also highlights the importance of open, honest and timely communications and the Communications Department should be consulted before any public/external communication or comment is made. Wherever possible, patients, their family/carers and/or staff should be informed before details of the adverse event are released proactively to the media or other external organisations. If, however, the organisation is contacted directly by the media a decision may be taken to issue a general statement to confirm facts and respond to specific questions or allegations. In these circumstances, the confidentiality of patients would be respected at all times and no specific identifiable information would be released.

NHS Forth Valley supports the principles described in the National Patient Safety Agency framework, *Being Open: saying sorry when things go wrong* published in 2009. The following guidance has been adapted from this framework. An Information Leaflet is available to support *Being Open* with patients, their families and carers ([Form 1a](#) in the toolkit).

2. **Being Open**

Being open simply means apologising and explaining what happened to patients and/or their carers who have been involved in an adverse event.

*Being open* involves:

- acknowledging, apologising and explaining when things go wrong;
- conducting a thorough review into the event and reassuring patients, their families and carers that lessons learned will help prevent the event recurring;
- providing support for patients, their families and carers and staff 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.

Communicating effectively with patients, their families and carers is a vital part of the process of dealing with adverse events. Strongly linked to this is the need to ensure that staff are also adequately supported through this process.

Research has shown that patients are more likely to forgive medical errors when they are discussed in a timely and thoughtful manner and that being open can decrease
the trauma felt by patients following an adverse event. Openness also has benefits for healthcare professionals as it can: help to reduce stress through the use of a formalised, honest, communication method; alleviate the fear of ‘being found out’; and improve job satisfaction by:

• ensuring that communication with patients, their families and carers has been handled in the most appropriate way;
• helping the healthcare professional to develop a good professional reputation for handling a difficult situation properly; and
• improving the healthcare professional’s understanding of events from the perspective of the patient, their family and carers.

*Being open* about an adverse event is more than a one-off event. The duration of the communication process will depend on the event, the needs of the patient, their family and carers, and how the review into the event progresses.

### 3. Principles of *Being open*

#### Acknowledgement

All adverse events should be acknowledged and reported as soon as they are identified. In cases where the patient, their family and carers inform healthcare staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all healthcare professionals.

#### Truthfulness, timeliness and clarity of communication

An appropriately nominated person must give information about an adverse event to patients, their families and carers in a truthful and open manner. In line with the NHS Forth Valley Significant Adverse Event Policy, a senior healthcare professional that is part of the SAE Review Team will be identified to provide initial and ongoing communication with the patient, their families and carers.

Patients should be provided with 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 and carers should be provided with information about what happened as soon as practicable. It is also essential that any information given be based solely on the facts known at the time. The senior healthcare professional should explain that new information may emerge as an event review is undertaken, and that patients, their families and carers will be kept up-to-date with the progress of a review. Patients, their families and carers should receive clear, unambiguous information and as described above they will 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 the use of medical jargon, which they may not understand, should be avoided.

#### Apology

Patients, their families and carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has resulted from an adverse event. This should be in the form of an appropriately worded and agreed manner of apology as early as possible. Verbal apologies are essential because they allow face-to-face contact between the patient, their family and carers and the healthcare team. This should be given as soon as staff are aware an event has occurred. A written apology, which clearly states that NHS Forth Valley is sorry for the suffering and distress resulting from the event, must also be given.
Recognising patient, family and carer expectations

Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding an adverse event, and its consequences, in a face-to-face meeting with the senior healthcare professional nominated from the Review Team or with other representatives from NHS Forth Valley, if appropriate. They should be treated sympathetically, with respect and consideration. They 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.

Staff support

NHS Forth Valley encourages all staff, whether directly employed or independent contractors, to report adverse events. It is important that all staff are fully supported both in terms of dealing with the event and throughout the review process. A nominated senior healthcare professional and member of the SAER Team will be identified as the Staff Contact Person.

Staff should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration. The Occupational Health Service is available to support staff and this should always be offered as an option to staff involved in a significant adverse event. Staff engaged in the review process through interview are entitled to be accompanied by a representative of their choice to provide support. It is also important that once a review has concluded a debrief is held for staff involved to advise them of the findings and outcomes. This should be co-ordinated via the Lead Reviewer.

Multidisciplinary responsibility

This guidance on Being Open applies to all staff in NHS Forth Valley. Most healthcare provision is through multidisciplinary teams and this should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the Being Open process is consistent with the philosophy that events usually result from systems failures and rarely from the actions of an individual.

Confidentiality

Details of an adverse event should at all times be considered confidential.

Continuity of care

Patients will continue to receive all usual treatment and continue to be treated with dignity, 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.

4. References


http://www.nrls.npsa.nhs.uk/beingopen/