

Lister House Surgery Being Open Policy

Document Control

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B. Document Details

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Introduction

Although a rare event, when a medical related incident occurs in which a patient suffers harm or dies, entering into an open dialogue with the patient, their carers or their representatives can significantly reduce the impact, stress and worry for all concerned. An essential part of handling patient related incidents effectively is following an established procedure of honest and open communication with them, their carers or their families.

Benefits of a Being Open Policy

- Assisting patients to acknowledge and accept that mistakes and errors can occur;
- Helping patients understand how and why a specific mistake or error took place;
- Helping ensure that the communication procedure has been appropriate to the situation;
- Enhancing the clinician's understanding of how the incident affected the patient, their family and carers from their point of view;
- Improving the clinician's ability to handle difficult situations effectively;
- Reducing the likelihood of a formal complaint and the incidence of costly legal action.

The following elements should be part of an effective Being Open Policy

- All Practice staff and clinicians likely to be involved in such incidents have received appropriate communication-skills training, including the ability to relate to the patient, their carers or their families;
- The Policy itself has been carefully drafted and incorporates a realistic response timeline, an effective investigative, analysis, feedback and follow-up system, as well as appropriate counselling support should this be required;
- Guidance on the procedure to be followed is clear and all relevant Practice staff and clinicians have been made familiar with its processes and understand its requirements;
- The patient, their carers or their families have confidence in the process because:
 - An apology is offered as soon as it is practically possible to do so;
 - The clinician(s) involved in the incident are actively involved in the discussions with the patient, their carers or their families;
 - The concerns of the patient, their carers or their families are always respected and listened to.

Steps in Implementing an Open Policy

1. Recognise and report that an incident has occurred as soon as possible.

- When Practice staff are advised of an incident by a patient, their carers or their family, it must be always be taken seriously, with all concerns expressed being met and responded to with compassion and understanding, as well immediate action being taken to avert additional harm or such an event being repeated.
- Any additional required treatment should take place as soon as possible, after discussing the situation and obtaining consent from the patient, their carers or their family.

2. Conduct a thorough, impartial investigation into the incident.

- As soon as possible after the incident, convene the team (involve all relevant parties), to ascertain and record the full clinical and non-clinical facts in an impartial manner.
- Consider the severity / scale of the incident and the appropriate level of immediate response.
- Allocate responsibility to the most suitable member of staff for being the point of contact with the patient, carers or their family and get them to arrange the initial discussion. Consider whether initiating third party patient liaison and support (who would identify the patient's needs and feed them back to the team) would be worthwhile.
- Consider the Practice staff involved in the incident and initiate any immediate support needs they may have.

3. The initial discussion – the first stage in the communication process

- Liaise with the patient; carers or family to ensure this initial discussion takes place as soon as possible, at a mutually convenient time and at a suitable venue, with convenient access and where privacy without interruption is assured.
- The incident may impact on patient, carers or family to such an extent that relations between the two parties may collapse to such an extent that they may well refuse to take part in any discussion. Should this situation arise:
 - Try to resolve it as soon as possible;
 - Consider using an impartial, suitably qualified person to act as a go between;
 - Ensure you provide details of the NHS complaints procedure, including PALS, ICAS.
www.nhs.uk/choiceintheNHS/Rightsandpledges/complaints/Pages/NHScomplaints.aspx
- The nominated staff member should lead it but other practice staff can attend if relevant. If this is the case, before the discussion takes place, ensure the patient, carers or family know the identity and role of all people who propose to attend, and encourage them to state their own preferences about which staff they would prefer to be present, or not.
- The discussion should be delivered at a level that is clearly understood by the patient, carers or their family, avoiding jargon and using appropriate medical terminology.
- It should be a truthful, factual explanation of exactly what happened.
- Explain what is likely to happen next, both in the investigation and any treatment plan.
- Confirm that they will be kept up-to-date as the investigation progresses and new information comes to light. Advise them of the name of the practice member of staff who will do this.
- Explain the probable short (and long-term effects if known at this time) of the incident. This is especially important if the incident has resulted in death, as the procedure(s) to identify the causes of death will probably need to be fully explained.
- Treat the patient, carers or family with respect, compassion and consideration. Ensure that their views are taken into account and try to ascertain any expectations they have from the resolution process.
- Consider offering the patient, carers or family appropriate additional support (e.g. help from charities or voluntary organisations, or bereavement counselling in the event of a death), as well as more direct assistance.
- If you need to, offer genuine sympathy and make a face-to-face apology!
 - The content of the apology should be carefully considered beforehand and ideally made by the most senior person responsible for the patient's care (or alternatively someone with experience of this type of incident) as they are known and trusted and best placed to maintain a relationship with the patient, carers or family.
 - If a face-to-face apology is made, it should be quickly followed up with a written one, reiterating the verbal apology and explaining the next steps.
- Make an accurate written record of the initial and any subsequent discussion and provide a copy to all the patient's representatives.

[Reporting the Death of a Patient to the CQC](#)

The surgery is required to notify the CQC without delay of the death of a patient when:

- a) The death occurred whilst a regulated activity was actually being carried out (e.g. during a GP's home visit, or during the patient's visit to your surgery),
Or
- b) The death occurred as a result of a regulated activity being carried out,
And
The Patient had seen their GP in the two weeks before the death,
And
The death was avoidable / related to inappropriate care and treatment.

Ruban Sivasoruban at the surgery is responsible for notifying the CQC immediately upon the death of a person who uses the surgery's services.

Where Ruban Sivasoruban is unavailable, for any reason, the duty GP or the Deputy Practice Manager will be responsible for reporting the death to the CQC.

4. Providing support to Practice staff

- So far, the focus of this Policy has been on the effect of the incident on the patient, carers or family. However, it is essential that Practice staff be actively supported throughout the incident investigation, as they may be suffering from stress as a result of it.
- We, as a surgery should operate an open culture where staff feel able to:
 - Receive and report patient safety incidents without undue worry;
 - Be accountable for their actions;
 - Discuss an incident they have been involved in with colleagues (whilst considering Confidentiality requirements).
- If disciplinary action is deemed necessary, the Practice Disciplinary Procedure contained in their Employee Handbook should be invoked. If their action is proved and they are found guilty of gross misconduct, summary dismissal may arise.
- In instances where there is sufficient reason to consider that a member of staff might have committed a criminal act, the surgery should offer support by advising them of the possibility as soon as possible, to enable them to source and arrange independent legal advice / representation.

5. Going forward - reduce risk and improve systems

- After an incident has been identified and necessary short-term action taken to rectify the problem, the surgery should invoke its Significant Event Procedure (a problem solving tool that minimises the likelihood of repeat errors occurring, thereby improving patient safety). This will initially examine and facilitate understanding of the issues that caused the incident, then subsequently focus on recommending improving appropriate systems to ensure the risk of the incident recurring is prevented or minimised.

Consider using the support of clinical governance frameworks through which patient safety incidents can be investigated and analysed, including the guidelines suggested in the revised version of the GMC document "Raising and acting on concerns about patient safety", effective 12 March 2012, a copy of which can be downloaded here:

www.gmc-uk.org/Raising_and_acting_on_concerns_about_patient_safety_FINAL.pdf_47223556.pdf

- Record and formalise all necessary procedural changes and ensure relevant staff undergo appropriate training, so that they are competent to implement them.
- When staff training has been completed and the revised system is operational, advise the patient, carers or family.

6. Ensure compliance with privacy and confidentiality regulations

- The Being Open Policy should comply with both the patient's, carer's and their family's rights, and Practice staff rights, to privacy and confidentiality.
- As the details of every patient medical related incident in which a patient suffers harm or dies should be considered as confidential, the consent of the person concerned should be obtained prior to disclosing information to clinician(s) other than those directly involved in treating the patient.
- The Practice Rules for confidentiality of patient data apply.

7. Continuity of care

- If the incident results in a patient expressing a preference for their healthcare need to be managed by a different person within the surgery, or indeed at a completely separate GP practice, the surgery will be responsible for making the appropriate arrangements to facilitate this request and ensure that the patient continues to receive all their usual treatment without interruption.