

Duty of Candour and Being Open Policy

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Duty of Candour and Being Open Policy

1. Introduction

Secondary care providers in England registered with the CQC are now subject to a statutory Duty of Candour. Although clinicians already have an ethical responsibility to be open and honest, the Duty of Candour is an organisational responsibility. This new regulatory requirement was introduced in November 2014 in response to the findings of the Francis Inquiry and the Berwick Review which recommended the enforcement of fundamental standards to prevent problems like those at Mid Staffordshire and Winterbourne.

The Duty of Candour applies when moderate or severe harm occurs as a result of a notifiable safety incident. It also applies to the death of an individual where the death relates to the incident rather than a natural cause or underlying condition. The Trust uses the harm fields on Datix to identify incidents falling within the scope of the Duty of Candour.

The Duty of Candour means we should be open and honest with patients or their representatives when something goes wrong that causes, or has the potential to cause moderate or severe harm, or distress. In your professional capacity you have an important role to play in making sure patients or their relatives receive a full and open explanation, an apology and appropriate support.

The Trust is committed to a culture of openness and communicating honestly with patients, families/carers and people who use our services especially when things go wrong and when harm has occurred.

Being open, honest and compassionate when things go wrong can help patients, families/carers and people understand and manage the distress these events may cause better.

1.1 Being Open Principle

Evidence suggests that openness is welcomed by patients who are more likely to forgive errors when they are discussed fully in a timely and thoughtful manner and that being open can decrease the trauma felt following an incident.

Being open is a process rather than a one off event and is underpinned by 10 principles promoted in "*Saying sorry when things go wrong: Being open: Communicating patient safety incidents with patients, their families and carers*" (NPSA 2009).

The Being Open principles are set out in Appendix 1.

1.3 Duty of candour – an introduction (incidents moderate and above)

This duty applies to all registered providers of both NHS and independent healthcare bodies, as well as providers of social care from 1 April 2015. The duty is overseen by The Care Quality Commission (CQC) and the processes detailed in this policy reflect requirements set out in CQC Regulation 20: Duty of candour. Compliance with the duty is also monitored by CCGs as part of the standard national contract.

1.3.1 What is Duty of Candour?

A legal duty on Trusts to inform and apologise to patients and / or their family if there has been an incident whilst in care that have led to moderate or severe harm, or death

- Having truthful, accurate and open discussions with the patient or their family when things go wrong to help them understand what has happened

- Apologising – verbally as soon as the incident happens and then in writing, clearly stating we are sorry for the suffering and distress caused
- Following up with the patient or their family as investigations evolve
- Documenting those communications

What the Duty of Candour is not

- An apology or explanation is not an admission of liability
- It is not about being defensive
- It is not speculation – Candour is about facts. Never speculate - agree to provide the information later

1.3.2 What is harm?

Medical Harm has been defined as; Any Systemic Failure in the health care system that results in negative psychological, physical or fatal consequences.

For practical examples please visit:

https://www.eforms.nrls.nhs.uk/staffreport/help/AC/Dataset_Question_References/Patient_details/Individual_patient/Impact_on_patient/PD09.htm

Degree of harm (Severity/Actual Impact on patient)

No code	No harm
1	Low (Minimal harm - patient(s) required extra observation or minor treatment)
2	Moderate (Short term harm - patient(s) required further treatment, or procedure including psychological harm of up to 28 days)
3	Severe (Permanent or long term harm – irrecoverable harm)
4	Death (Caused by the Patient Safety Incident)

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

- ✓ Tell the patient or, where appropriate, the patients advocate, carer or family when something has gone wrong.
- ✓ Apologise* to patient or where appropriate, the patients advocate, carer or family.
- ✓ Offer an appropriate remedy or support to put matters right (if possible).
- ✓ Explain fully to the patient or where appropriate, the patients advocate, carer or family the short and long term effects of what has happened.

- ✓ Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations.
- ✓ Take part in reviews and investigations when requested.
- ✓ Must also be open and honest with their regulators, raising concerns where appropriate.
- ✓ They must support and encourage each other to be open and honest, and not stop someone from raising concerns.
- ✓ **Please note that giving an Apology is not an admission of liability.*

Who should say sorry?

- ✓ A senior member of the team where the harm occurred should speak to the patient or their family as soon as possible and follow this up in writing
- ✓ The apology should include a dedicated contact in case patients or their family want to get in touch. If necessary include an explanation about next steps
- ✓ If there is a subsequent serious incident investigation, the lead Serious Incident (SI) reviewer will contact the patient or their family when the investigation commences

Where should you record your apology?

- ✓ Record the dates of your verbal and written apologies in the 'Additional information' box on Datix and on the patient's clinical record (Where access is not immediately available to Datix please make a note of details for later updates to be made to Datix).
- ✓ If it hasn't been possible to give an apology record the reason why in the 'Additional information' box
- ✓ Attach your written apology to Datix and in the patient's clinical record. This should take place within 10 days of the incident occurring.

2. Purpose

The purpose of this policy is to set out the Trust's expectations for all Healthcare Professionals and the contractual, statutory and professional responsibility to be honest with patients in their care if things go wrong. The Trust will support staff by fostering a just culture.

3. Scope

3.1 Who this policy applies to

This policy applies to all Trust staff at all times; we all have a responsibility for being open, honest and transparent with service users, their families and carers.

Duty of candour applies to all patient safety incidents which have an actual impact of moderate harm or where a patient safety incident resulted in severe harm, prolonged psychological harm or prolonged pain or death.

4. Explanation of terms and definitions

Openness - Enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Being open - Communicating with patients, their families and carers, staff and visitors in a manner that is clear, honest and effective, including occasions when things go wrong.

Transparency - Allowing information about the trust performance and outcomes to be shared with staff, patients, the public and regulators.

Candour - Any patient harmed by the provision of a healthcare service is informed and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked.

Apology - A sincere expression of sorrow or regret when things go wrong is not an admission of guilt and should be provided by the health professional involved in the error.

Notifiable patient safety incident in respect to CQC Regulation 20: Duty of candour -

Any unintended or unexpected incident that occurred during the provision of a regulated activity that, in the reasonable opinion of a health care professional, did or could result in:

-The death of the service user,

- Where death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or

-Severe harm, moderate harm or prolonged psychological harm to the service user.

Relevant person - CQC Regulation 20: Duty of candour uses the term 'relevant person' when describing the person who will be informed of an incident in the duty of candour process.

Relevant person is the service user or someone acting lawfully on their behalf in the following circumstances:

-On the death of the service user,

-Where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or

-Where the service user is 16 or over and lacks capacity (as determined in accordance with Sections 2 and 3 of the 2005 Mental Capacity Act) in relation to the matter.

5. Roles and responsibilities

This policy informs all Trust staff of their role and responsibility regarding openness, honesty and transparency if something goes wrong with a patient's care or treatment.

Role	Responsibility
Chief Executive and Trust Board	<p>To ensure and demonstrate the Trusts commitment to the Duty of Candour principles and standards.</p> <p>Ensure organisational systems are in place for implementation of the Duty of Candour.</p> <p>To require all staff to meet the Duty of Candour principles.</p>
Clinical Directors, Medical Staff, Heads of Service, Heads of Nursing Locality Managers, Service Managers, Modern Matrons, Ward and Team	<p>To foster a culture of openness and ensure all staff are supported to follow the principles of Duty of Candour in being open, honest and transparent.</p> <p>And as part of that to provide or coordinate an apology and explanation to the service user in person (unless requested not to), their family or carers where appropriate as soon as possible when something has gone wrong.</p>
Managers and all Registered Professionals across Health and Social Care / Senior Responsible Clinician	<p>To promote the Duty of Candour Policy: Being Open, Honest and Transparent.</p> <p>To fulfil their duty to:</p> <ul style="list-style-type: none"> - Be open and honest with the patients in your care and or those close to them if something goes wrong. Saying sorry when it is identified as your role to do so working with the responsible Senior Operational Manager and Head of Nursing - Comply with HCPC standards of conduct, performance and ethics and guidance set out by the GMC and NMC <p>http://www.gmcuk.org/DoC_guidance_englsih.pdf_61618688.pdf</p>
Operational Governance / Performance Teams, Corporate services (including ; Risk and Governance Department, Legal Services Team)	<p>Ensure the Datix reporting system is used to its full potential</p> <p>Ensure all patient safety incidences, complaints and claims are handled in an open and honest way</p> <p>Processing information consistently and precisely and in a meaningful way</p> <p>Corporate departments have a responsibility to ensure that open communication is promoted at all times:</p>
All Trust Employees	<p>To be open and honest with the Trust.</p> <p>To encourage a learning culture by reporting incidents that led to harm as well as near misses.</p>

The Trust requires all employees to be open, honest and candid and that staff who admit to being involved in accidents, incidents, near misses or errors will be supported and treated fairly.

6. Implementation

6.1 Being open / candour is a process NOT an event, it should be on going and is about being open about all aspects of the care a patient has received, including when things go wrong.

When a patient is affected by a patient safety incident, which may include a mistake that has been made or something that has happened that was not meant to happen, the trust, and clinicians delivering care on behalf of the trust, have a duty to:

- Be open and tell patients/ their families/ carers
- Explain what has happened and answer any questions patients or their families/ carers may have
- Say sorry
- Find out why it happened
- Work to make sure it does not happen again.

The principles of being open apply to all incidents and events although the level of response must be proportionate to the level of harm. The '10 Principles of Being Open' are detailed in Appendix 1. The process that must be followed in respect to being open and duty of candour is summarised in the flowchart in Appendix 2.

6.2 Reporting incidents/ notifiable patient safety incidents.

When an incident occurs staff involved must follow direction provided within the Incident Policy including completing an incident report via the Datix incident reporting web-based system As soon as practically possible after the incident has occurred. The incident report requires the reporter to summarise the nature of the incident, identify if the incident is a patient safety incident, the level of harm and impact on the patient.

Occasionally an incident may not be discovered at the time it happens. A delay in discovering an incident does not mean that duty of candour requirements do not apply.

Should an incident be identified that meets the duty of candour requirements, but which relates to care delivered by another provider, that provider is responsible for implementing duty of candour. A Datix incident report should be completed, and the local governance team alerted who will then inform the other provider.

6.3 Being open actions:

For all incidents it must be acknowledged to the service user that an incident has occurred, verbally and face to face where possible, unless the person cannot be contacted or declines notification.

A sincere verbal apology should be made and the service user provided with information about what happened relevant to the incident.

If further actions are indicated the service user must be advised of these and an agreement made regarding if and what further enquiries are appropriate.

Reasonable support must be provided to the patient or service user, their families or carers.

6.4 Duty of candour actions (moderate and above)

Some patient safety incidents trigger the duty of candour statutory requirements.

A notifiable safety incident that will trigger the duty of candour statutory requirements is one which, in the reasonable opinion of a healthcare professional, could result in, or appears to

have resulted in moderate or severe harm or death or prolonged psychological harm. The definitions of moderate and severe harm are consistent with those used within the NHS for reporting under the NRLS and as defined within CQC Regulation 20; Duty of candour, March 2015.

6.5 Grade and definition of patient safety incident.

No harm

Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.

Impact not prevented – any patient safety incident that ran to completion but no harm occurred.

Low harm

Any patient safety incident that required increased observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.

Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned. Nor does it include a return to surgery or re-admission.

Moderate harm

Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident, including prolonged pain and/or prolonged psychological harm which the service user has or is likely to experience for a continuous period of at least 28days.

Severe harm

Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage.

Death

Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.

The death must relate to the incident rather than to the natural course of the patient's illness or underlying condition.

If the perceived actual impact (harm) caused as a result of the patient safety incident is moderate or above, then the incident has triggered the duty of candour requirements and a greater level of involvement and being open is required.

Duty of candour also applies to occasions when a service user has or is likely to experience psychological harm as a result of an incident for a continuous period of at least 28 days. On occasions this may not be recognised at the time of the incident and may not be recognised until after the 28 day period. On these occasions a new

incident report is required that documents the presence of psychological harm and duty of candour actions are required.

7. Specific Guidance

7.1 Giving an apology

Following any patient safety incident, the patient and/or other relevant person should receive a sincere verbal expression of sorrow or regret for any harm as early as possible from the responsible clinician.

An apology is **not** an admission of liability, but acknowledgements of the person's distress at that time which may mitigate the trauma suffered and potentially avoid any complaint or claim being made.

The apology should be made by the member of staff involved in the error, but may be made by another member of staff if it is decided this is more beneficial.

If the duty of candour applies a further apology must be provided as detailed below and within the flow chart in Appendix 2.

An initial verbal apology should be made by the responsible clinician from within the service where the incident occurred, delivered in person, providing all facts known at the time and explaining what actions are being taken and next steps. {This is not relevant for patients in the community}. Patients / Service Users being treated in the community who sustain an incident of moderate harm or above should be contacted either verbally (where possible) or in writing where an apology should be made as described above. All contacts with respect to complying with Duty of Candour should be documented in the patients / service users medical records.

The decision about who is most appropriate to provide the notification and/or apology will take into account seniority, their relationship to the patient / service user and their experience and expertise in the type of notifiable incident that has occurred.

The verbal apology should be followed by written notification (letter). Example letter templates are provided in Appendix 3. The written notification letter should be sent within 10 days of the incident having taken place.

That an apology has been made in line with duty of candour requirements should be recorded in the appropriate section on the Datix incident report and the patients / service user's electronic medical records ideally by the staff member who gave the apology or by a person delegated / nominated by them to update Datix.

Support, in terms of whom can be contacted to provide updates etc. regarding the investigation, should be provided to the patient, their families or carers after the incident, throughout the investigation and on-going as required including providing the patient or their family with the contact details of an identified person who will coordinate communication and be a single point of contact.

7.2 Commence an investigation into the incident.

The patient/family should be informed if the incident meets the notifiable incident criteria and is being investigated as a serious incident. Whilst duty of candour requirements apply to serious incidents, timescales for investigation may vary and the patient /family should be informed of expectations and that investigation may take up to 60 days.

7.3 Within 28 working days of the incident

An investigation into the incident must be progressed to determine why the incident happened, and an explanation of the events and circumstances which resulted in the incident including identifying learning.

During the course of the investigation the patient/relevant person must be kept informed of progress, especially if agreed timescales are likely to slip; written records should be maintained of communication and interactions.

If the incident is not being investigated as a serious incident, investigation should be concluded in line with timescales set out within the Incident Policy and a report provided to the patient/relevant person outlining an explanation of the events and circumstances which resulted in the incident.

7.4 Within 10 days of the investigation report being completed and accepted

Outcomes from the investigation must be shared with the patient/relevant person and a copy sent to them in a manner of their choosing, for example email or printed copy.

Example letter templates are provided in [Appendix 3](#).

The patient/ relevant person must be provided with an opportunity to discuss the Findings and the service must commence actions to implement recommendations identified through investigation.

8. Special considerations

The following gives guidance on how to manage different patient circumstances, it is based on guidance provided within “Being open. Communicating patient safety incidents with patients and their carers” (National Patient Safety Agency, 2009). When managing different patient circumstances, the over-arching principle is that each circumstance is carefully considered, to ensure that appropriate, sensitive and respectful communication occurs.

8.1 When a patient dies

When an incident has resulted in a patient death it is crucial that communication is sensitive, empathic and open and takes into consideration the individual circumstances of the event and the timing when to discuss what has happened with bereaved relatives or carers.

An incident that results in the patient’s death will be reported and investigated as a Serious Incident.

Usually the being open discussion and investigation will occur before a Coroner’s Inquest. Occasionally however, the Trust may consider it appropriate to wait for the outcome of a Coroner’s inquest before holding being open discussions. On these occasions it is important to explain to the relatives that they will be kept informed as information is released from the Coroner’s Office.

The circumstances surrounding the death of a patient may give rise to a police enquiry. This should not prevent a being open meeting taking place with relatives or carers. It is however important to underline the need ensure that only facts known at the time are communicated.

8.2 Patients with cognitive impairment and who may lack capacity

Wherever possible the patient, including a patient with a cognitive impairment, will be involved in communication about what has happened. An advocate with appropriate skills should be available to the person to assist in the communication process. Referrals for an advocate can be made through PoHwer on 0300 1234044.

Some individuals may 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 someone who holds a valid 'Lasting Power of Attorney' or 'Deputy of the Court of Protection'. In these cases steps must be taken to clarify the extent of this authority and the 'being open / duty of candour' discussion would be held with the holder of the power of attorney. This person would be the relevant person with regards the duty of candour requirements. Where there is no such person, the clinicians may act in the patient's best interest in deciding who the most appropriate person to discuss incident information should be with, regarding the welfare of the patient as a whole and not simply their medical interests.

8.3 Safeguarding

Staff must consult the relevant safeguarding policy for guidance on information sharing when there is a patient safety incident involving concerns about a vulnerable child or adult at risk. This does not exclude safeguarding incidents from the requirements of this policy nor working to the principles of being open.

8.4 Children

The legal age of maturity for giving consent to treatment is 16. This is the age at which a young person acquired 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. Notably; Children under 16 who are competent also have a right of confidentiality, unless for example there is reasonable cause to believe that the child or young person is suffering, or is at risk of suffering, significant harm.

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 give consent (Gillick Competence/Fraser guidelines). 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 an 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.

8.5 Patients with different communication needs

Some patients will have particular communication needs including for example patients with hearing impairment or those with learning disability. Plans for meeting with the patient and discussing the incident should fully consider these needs.

For example access needs may need to be taken into account when planning communication with patients and their families to ensure equity of access. This may include making adjustments to allow access to a building, or other premises or particular aids or equipment such as portable induction loop, for people with hearing aids, British sign

Language interpreters, providing information in alternative formats such as Braille or audio CDs. Knowing how to enable or enhance communication with a patient is essential to facilitating an effective being open process as is focusing on the needs of the individuals and their families and being personally thoughtful and respectful.

8.6 Patients with different language or cultural considerations

The need for translation and advocacy services, and consideration of special cultural needs, including for example patients who may prefer discussions with people of the same gender as themselves, must be taken into account when planning to discuss patient safety information. Avoid using 'unofficial translators' and/or patient's family or friends.

8.7 Patients with mental health issues

Being open for patients with mental health issues should follow normal procedures, unless the patient also has a cognitive impairment (see above). 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. However, such circumstances are rare.

Apart from in exceptional circumstances it is never appropriate to discuss patient safety information with a carer or relative without permission of the patient.

9 References

The National Reporting and Learning website provides further information and resources in relation to 'Being open': <http://www.nrls.npsa.nhs.uk/site-map/> This includes:

- National Framework for Reporting and Learning from Serious Incidents Requiring Investigation. (2009)
- National Reporting and Learning Service (NRLS) Data Quality Standards: Guidance for Organisations Reporting to the Reporting and Learning System (RLS)
- Medical Error: What to do if things go wrong: A guide for junior doctors. (2010)
- Patient Safety Alert. Being Open: Communicating with patients, their families and carers following a patient safety incident. (2009)
- Department of Health. (1999). HSC 1999/198. The Public Disclosure Act 1998: Whistle blowing in the NHS. London: Department of Health. Available at: www.dh.gov.uk
- Department of Health. (2009). Listening, Responding, Improving: A guide to better customer care. London: Department of Health. Available at: www.dh.gov.uk
- General Medical Council (GMC). (2009 [1995]). Good Medical Practice. London: GMC. Available at: www.gmc-uk.org
- Nursing & Midwifery Council (NMC). (2009 [2008]). 'The Code: Standards of conduct, performance and ethics for nurses and midwives'. NMC website page. NMC. Available at: www.nmc-uk.org
- Saying sorry when things go wrong: Being Open: Communicating patient safety incidents with patients, their families and carers. NPSA 2009
- Care Quality Commission (CQC) – Regulation 20: Duty of candour (March 2015)

Appendix 1: The Ten Principles of Being Open

“Saying sorry when things go wrong: Being open: Communicating patient safety incidents with patients, their families and carers”, (NPSA 2009).

The National Patient Safety Agency being open framework has 10 guiding principles which the Trust has adopted and will follow to ensure a proactive approach to being open.

1. Principle of acknowledgment

- All patient safety incidents should be acknowledged and reported as soon as they are identified. In cases where the patient and/or their 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 staff.

2. Principle of truthfulness, timeliness and clarity of communication

- Information about a patient safety incident must be given to patients and/or their carers in a truthful and open manner by an appropriately nominated person.
- Communication should also be timely: patients and/or their carers should be provided with information about what happened as soon as practicable.
- Patients should receive clear information and be given a single point of contact for any questions they may have. They should not receive conflicting information from different members of staff, and medical jargon which they may not understand should be avoided.

3. Principle of apology

- Patients and/or their carers should receive a sincere expression of sorrow or regret for 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. Organisations should decide on the most appropriate member of staff to issue these apologies. The decision should consider seniority, relationship to the patient, and 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 that an incident has occurred.
- A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given.

4. Principle of recognising patient and carer expectations

- Patients and/or their carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident in a face-to-face meeting with representatives from the healthcare organisation. They should be treated sympathetically, with respect and consideration.
- Confidentiality must be maintained at all times.
- Patients and/or their carers should also be provided with support in a manner appropriate to their needs including considering special circumstances such as a patient requiring additional support, such as an independent patient advocate or a translator.

5. Principle of professional support for staff

- Staff should feel supported throughout the investigation process through their line managers and accountable / responsible officers. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration. Staff can also seek additional support via the Trust's Employee Support Services; Care First Lifestyle (Click the link below for online access) [http://elftintranet/sites/common/private/search_quick21.aspx?q=Employee%20Assistance%20Programme&orderby=0&url=ObjectInContext.Show\(new%20ObjectInContext.Url\(2%2C60451%2C1%2Cnull%2C970%2Cundefined%2Cundefined%2Cundefined%2Cundefined%2Cundefined\)\)%3B](http://elftintranet/sites/common/private/search_quick21.aspx?q=Employee%20Assistance%20Programme&orderby=0&url=ObjectInContext.Show(new%20ObjectInContext.Url(2%2C60451%2C1%2Cnull%2C970%2Cundefined%2Cundefined%2Cundefined%2Cundefined%2Cundefined))%3B) .
- 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 staff at an early stage to enable them to obtain separate legal advice and/or representation. They should be encouraged to seek support from relevant professional bodies such as the General Medical Council, Royal Colleges, the Medical Protection Society, the Medical Defence Union and the Nursing and Midwifery Council.

6. Principle of risk management and systems improvement.

- Root cause analysis (RCA), significant event audit (SEA) 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. Principle of multidisciplinary responsibility

- Most healthcare provision involves multidisciplinary teams and communication with patients and/or their carers following an incident that led to harm, should reflect this.
- Senior managers and clinicians must participate in incident investigation and clinical risk management and champion the being open process.

8. Principle of clinical governance

- Being open requires the support of patient safety and quality improvement processes through clinical governance frameworks, in which patient safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence.

9. Principle of confidentiality

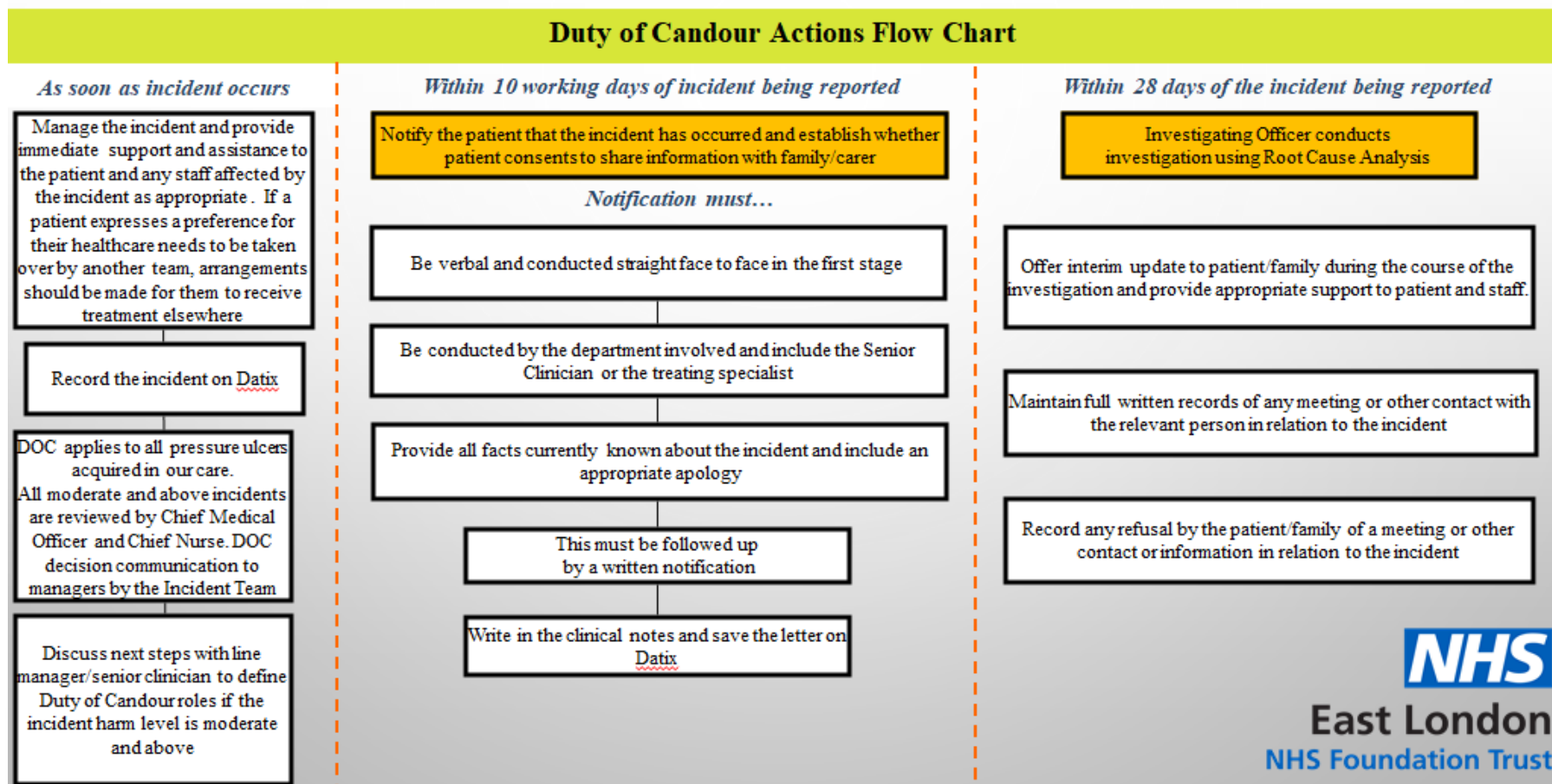
- Policies and procedures for being open should give full consideration of, and respect for, the patient's and/or their carer's and staff privacy and confidentiality.
- Details of a patient safety incident should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient.
- 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.

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.

Appendix 2

DOC PROCESS FLOW CHART



Appendix 3 Letter Templates

Available on Datix for Guidance Purposes