DUTY OF CANDOUR (BEING OPEN) POLICY

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Reference number	WHHT: G003
Version	4
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Division	Corporate
Approved by	Policy & Guideline Review Group (PGRG)
Approved date	18 August 2020
Reviewed by PGRG	18 August 2020
Ratified by QSG	
Issue/Review date	July 2020
Next review date	July 2023
Target audience	All WHHT Staff
Search terms	Being open, duty of candour
Previous Policy name (if different)	n/a

Contribution List

Key individuals involved in developing this version of the policy

Name	Designation
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Change of History

Version	Date	Author	Reason for change
1			New Policy
2	October 2015	Danielle Boyd, SI Investigation Lead	Formal update to reflect change to SI process.
3	October 2017	Eva Ferlez, Serious Incident Investigations Lead Officer	Formal update to ensure the Trust policy is aligned with requirements of the CQC Regulation 20 and effectively described processes for staff.
4	July 2020	Sandra Muffett, Head of Patient Safety	Review and update of the policy to reflect the process required in the event that discharging Duty of Candour is considered inappropriate. Policy reviewed generally and revised where needed.

Abbreviations and Acronyms

Abbreviations and Acronyms	Description
MDT	Multidisciplinary Team
PGRG	Policy & Guideline Review Group
QSG	Quality & Safety Group

Contents

1. Introduction

1.1. West Hertfordshire Hospitals NHS Trust's (The Trust) is committed to open and effective communication with patients, their families and/or carers throughout the time spend under the care of the Trust (Being Open, 2009). When something goes wrong with the clinical care provided and a patient has or could have suffered harm as a result of this, the Trust will ensure full compliance with the principles of being open and duty of candour, as relevant.

1.2. The Being Open framework was originally issued by the National Patient Safety Agency in 2005 and revised in 2008; at its heart are 10 principles:

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 responsibilities
8. clinical governance
9. confidentiality
10. continuity of care (NPSA 2008)

1.3. The publication of the Francis Inquiry report in 2013 instigated, amongst other things, a further drive to improve transparency and openness within the NHS. As a result of the recommendations made in the Francis Inquiry report, duty of candour has been included in NHS Standard Contract issued by the NHS Commissioning Board.

1.4. In October 2014 with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20, the Department of Health introduced the statutory duty of candour, in addition to registration requirements with the Care Quality Commission.

1.5. The professional duty of candour sets out the requirement that every health care 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. The professional duty of candour is recognised by the following regulatory bodies: General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland (Nursing & Midwifery Council and General Medical Council, 2015).

1.6. Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. (CQC, 2015).

1.7. This policy sets out in detail the expectations in relation to being open and duty of candour and the processes in place in the Trust providing assurance that these expectations are met.

2. Definitions

For definitions of key terms please see Appendix 1.

3. Purpose

3.1. When a patient was been harmed in the course of providing care to them, the patient should receive an explanation and an apology as soon as possible after the event occurred and staff should feel able and supported to apologise.

3.2. The purpose of this policy and procedure is to provide guidance to staff with regard to the professional, contractual and statutory requirements in relation to being open and duty of candour and to set out how compliance will be supported and monitored in the Trust.

3.3. This policy sets out the standards for communicating with a patient, family and/or carers following a notifiable safety incident and should be read in conjunction with the Trust's Incident and Serious Incidents Policy.

4. Scope

4.1. This policy applies to all Trust staff and premises where they work and compliments the risk management strategy and incident and serious incidents policy and the management of concerns and complaints and claims handling policies.

4.2. The **statutory** duty of candour (applying to healthcare providers) applies to actual or suspected safety events which occur during provision of care and result in moderate harm, severe harm or death, or prolonged psychological harm, or require treatment in order to prevent moderate harm, severe harm or death, or prolonged psychological harm. (CQC, 2015).

4.3. The **professional** duty of candour (applying to healthcare professionals) extends to all occasions when something goes wrong with treatment or care and the patient suffers harm or distress as a result. It also applies in situations where it is anticipated that the patient will suffer harm or distress as a result of something going wrong with their care. Additionally, it requires that risks are discussed before beginning treatment or providing care, and it requires that healthcare professionals follow the organisational policy for reporting incidents and near misses, and for senior clinicians that they actively foster and contribute to a culture of learning and improvement. (GMC &NMC, 2015).

4.4. The requirements of the professional duty of candour are set out in the joint guidelines by the General Medical Council and Nursing and Midwifery Council *Openness and honesty when things go wrong: the professional duty of candour*; this can be accessed via the Trust's Duty of candour intranet webpage: http://wghintra01/corp_affairs/dutyofcandour.asp.

4.5. The statutory and professional duty of candour **do not** apply to any incidents involving harm to members of staff or visitors (insofar as they are not a patient), however it is recommended that as a matter of good practice the principles of being open and duty of candour are applied also for such incidents.

5. Roles & Responsibilities

Staff designation	Key responsibilities
All staff	If allocated as a duty of candour lead for a particular incident, staff must ensure they are fully compliant with the duty of candour process requirements and timelines as set out in this policy, and that the compliance is fully recorded as described in this policy.
Chief Executive	The chief executive has overall responsibility for governance within the Trust including ensuring that a framework is in place to support openness between healthcare professionals and patients and/or their carers following a patient safety incidents and for championing a culture in accordance with the being open principles.
Trust Board	The Board publically endorse the being open principles and is ultimately responsible for ensuring that the organisation communicates openly and honestly with patients, families and carers when an incident occurs. The Board is also ultimately responsible for ensuring that the culture at the Trust is one that allows the principles of being open to flourish.
Medical Director Chief Nurse Director of Infection, Prevention & Control	The medical director and chief nurse & director of infection, prevention & control have joint executive responsibility for incidents and duty of candour in the Trust.
Quality Committee	The Quality committee has overall responsibility for duty of candour. As a subgroup of the Board of Directors, this committee will be responsible for providing assurance on the implementation and effectiveness of this policy, ensuring the document is updated in accordance with national and local initiatives.
Divisional Directors	Divisional directors must ensure that robust processes are in place in all areas within their divisions to ensure 100% compliance with the requirements of duty of candour process and the timelines as set out in this policy, and that compliance is monitored regularly.

Staff designation	Key responsibilities
Lead Clinicians Heads of Nursing Clinical Divisional Leads Department Leads	Identifying the most appropriate member of staff (usually a consultant, head of nursing, matron or ward sister, but always a person with appropriate seniority and/or experience) to carry out discussions with patient and/or their carer in accordance with duty of candour.
Divisional Quality Governance Facilitators	Advising staff in the divisions on the requirements of duty of candour processes and signposting staff to the Trust resources available on the Duty of candour intranet page. Day to day monitoring to ensure compliance with the duty of candour processes and the timelines as set out in this policy.
Complaints Manager Head of Legal & Clinical Effectiveness	The Complaints Manager and Head of Legal & Clinical Effectiveness are responsible for ensuring that Complaints and Claims processes support a culture of being open.

6. Levels of harm in relation to Duty of Candour (Being Open)

6.1. The table below sets out the thresholds for being open and duty of candour in relation to harm caused to a patient.

Harm assessment	Impact on patient	Communication process
No harm	No impact	**Being Open** Record conversation on patient records
Minor harm	Requires additional monitoring, minor intervention or will require up to a week to heal the injury	**Being Open** Record conversation on patient records
Moderate harm	Harm that requires increase in treatment; prolonged pain or psychological harm.	**Duty of Candour** (see Duty of Candour process in section 7.1)
Severe harm	Permanent	
Death	Death	

6.2. The table below provides detail on the levels of harm moderate and above for which duty of candour is triggered (The Health and Social Care Act 2008).

Includes	
Moderate harm	- harm that requires a moderate increase in treatment (e.g. unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, cancelling of treatment or transfer to another treatment area (e.g. ICU) - significant but not permanent harm

Includes	
Prolonged pain or psychological harm	- pain or psychological harm which a patient has experienced or is likely to experience for a continuous period of at least 28 days
Severe harm	- a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

7. Duty of Candour requirement and process

7.1. A summary of the duty of candour requirements and process is shown in the table below:

Timeline	Actions required * If the patient declines a discuss or written follow-up this is respected, however keep a clear record of the refusal
Within 10 working days of the incident	1. **inform** about the incident **in person**; 2. provide **an account of the facts** known at the time and advise how the incident will be **investigated**; 3. **offer apologies**, 4. provide reasonable **support, and** 5. keep a complete and accurate **record of all discussions** and attempts to contact.
1) a) within 10 working days of the SI Panel discussion; or b) within 10 working days of the discussion with the patient (if the incident was not discussed at the SI Panel); 2) within 10 working days of the completion of the investigation	1) provide a **written confirmation** to the person affected of the above discussion, and 2) provide a written follow-up with **results of the investigation** (sharing the investigation report)

7.2. When a patient has been harmed, the immediate priority is to ensure that prompt and appropriate clinical care is initiated to prevent further harm. For more details of immediate actions to be taken following a safety incident and how to report a safety incident, see Trust *Incident and serious incidents policy* G004.

7.3. As stated in the table above the patient and or the family or carers must be informed about the incident in person. There must be a record of all discussions with the patient and/or the family or carers. The discussions should be recorded in the patient's records **and** in the relevant incident record on Datix. If the patient's records

are not available at the time, staff are to record the conversation separately and upload the record into the relevant incident record on Datix.

7.4. For each incident where the level of harm was moderate or above, there must be a clear record in Datix of:

- whether duty of candour conversation was actioned;
- if no, reason why duty of candour has not been actioned;
- was the duty of candour conversation actioned within 10 working days of the incident being reported on Datix?
- date of the duty of candour conversation
- has this discussion been documented in the clinical records;
- if no, why has the discussion not been documented in clinical records;
- has the duty of candour letter been sent to the patient
- if no, has the patient requested that no duty of candour letter is sent;
- if no, why wasn't a duty of candour letter sent;
- who was contacted regarding duty of candour;
- if anyone other than the patient was contacted, please explain why the patient was not contacted regarding duty of candour;
- the name of the person who was contacted regarding duty of candour
- the name of the member of staff involved in the duty of candour conversation.
- copies of all written correspondence regarding duty of candour must also be uploaded onto the Datix incident records.

7.5. Where there is concern that discharging the duty of candour will have a psychological impact on the patient/carer, advice must be sought from the Assurance department in the first instance. Cases will be discussed on an individual basis with the Executive team, Commissioners and the regulators by the Assurance department. Where agreement is given by the CQC/Commissioners to withhold the duty of candour, evidence of the decision must be attached to the relevant Datix record (see flow chart – appendix 1).

7.6. The Escalation of potential serious incidents (potential SIs) and duty of candour (DoC) process details arrangements for written follow up regarding duty of candour and sign off of the duty of candour letters. This can be found on the Trust's Duty of candour intranet webpage: http://wghintra01/corp_affairs/dutyofcandour.asp.

7.7. The Trust has template duty of candour letters which staff can use when drafting written follow up on duty of candour conversations (the initial apology letter and letter after completion of the investigation) – these can be found on the Trust's Duty of candour intranet webpage (see link above).

7.8. Saying sorry is always the right thing to do, it is not an admission of liability, it acknowledges that something could have gone better, and is the first step to learning from what happened and preventing it recurring. (NHS Resolution, 2017). The NHS Resolution '*Saying Sorry'* leaflet can be accessed online:

http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf. It can also be accessed via the Trust's Duty of candour intranet webpage (see link above).

8. Recommendations for identifying appropriate member of staff to lead on duty of candour

8.1. There are no rules determining which member of staff should lead on duty of candour with respect to a particular incident; this is usually agreed in multidisciplinary discussions including healthcare professionals who were involved with the patient's care at the time of the incident or are involved with the patient's care following the incident. Each case should be considered individually balancing the needs of the patient, their family or carers with those of the healthcare professional concerned. Below are some recommendations and considerations to assist with identifying appropriate duty of candour lead.

8.2. The duty of candour lead is usually the most senior person responsible for the patient's care, i.e. the patient's consultant. They should have expertise in the type of incident that has occurred, knowledge of the facts relevant to the incident and be available for ongoing communication.

8.3. Where the incident relates to non-clinical issues, the senior manager responsible for that area of service should be considered for duty of candour lead with support from the healthcare professional treating the resultant injury.

8.4. Where a member of the healthcare team is directly responsible for the error that resulted in harm, they may or may not wish to participate in the duty of candour or being open discussion. If the healthcare professional wishes to attend in order to offer a personal apology they should attend with support from a senior colleague. If the patient, their family or carer expresses a preference that the healthcare professional should not attend the meeting, this should be respected and a written apology should be offered.

9. How to determine appropriate contact for duty of candour – patient or family and/or carers

a. The patient must be contacted for duty of candour in all circumstances unless;
   - The patient is deceased; in such cases a person acting lawfully on their behalf must be contacted regarding duty of candour; or
   - The patient lacks mental capacity to make a decision regarding their care and treatment[1]; in such cases a person acting lawfully on their behalf must be contacted regarding duty of candour.

[1] This includes:
i) patients who are aged under 16 and lack the mental capacity; and
ii) Patients who are aged 16 or over and lack the mental capacity.

b. For more detail on mental capacity referrals to the Independent Mental Capacity Advocate (IMCA) and Lasting Power of Attorney, see the Trust's 'Mental Capacity Policy' (C255).

c. If the duty of candour discussion is with anyone other than the patient for reasons set out above, the duty of candour lead must record the evidence for the patient's lack of capacity in the patient's records (if they are available, if not, a separate record can be made, which must be uploaded in Datix) and the Datix incident record.

d. Situations where contacting or communicating with the patient is more challenging, such as in case of patients who do not speak English, have conditions which make communication difficult, have moved to another hospital or have been discharged home, etc., are not sufficient justification to have the duty of candour discussion with someone other than the patient, providing that the patient has capacity for such a discussion. In such cases staff must make every reasonable effort to facilitate a discussion with the patient, such as the use of interpreters, the use of specialist staff or tools which can facilitate communication, contact with clinicians whose care the patient is under to facilitate communication, a telephone call or a home visit etc.

e. Where there is concern that discharging the duty of candour will have a psychological impact on the patient/carer, advice must be sought from the Assurance department in the first instance. Cases will be discussed on an individual basis with the Executive team, Commissioners and the regulators by the Assurance department. Where agreement is given by the CQC/Commissioners to withhold the duty of candour, evidence of the decision must be attached to the relevant Datix record (see flow chart – appendix 1).

10. Other considerations and recommendations relating to duty of candour discussions

10.1. For details on how to access interpreting and translation services in the Trust see the Trust Interpreting and translation policy and procedure (G026).

10.2. Duty of candour lead should consider the need for any patient support prior to the initial conversation and make the necessary arrangements.

10.3. When arranging duty of candour meetings, the patient or their family or carer (where relevant) should be informed who will be present and if they prefer to speak to a different healthcare professional, those wishes should be respected.

10.4. When arranging duty of candour meeting s consideration should be given to the patient's, their family's or carer's circumstances including the patient's preference, patient's clinical and emotional condition and availability the patient's family or carer and of key staff such as a translator or advocate.

10.5. It is recommended that, where possible, the meeting is held in a suitable, quiet area away from the place where the incident occurred within the limits of the patient's clinical needs, and there should be no opportunity for interruptions. In some cases it may be appropriate to hold the meeting in the patient's own home.

10.6. Consideration should be given to the number of Trust representatives attending the meeting so as not to overwhelm the patient, their family members or carers.

10.7. Depending on the circumstances of the incident and the timescales identified, there may be more than one follow up meeting however patients, their families and carers must be kept informed of progress in accordance with the arrangements made at the initial meeting.

10.8. For more guidance on facilitating communication in challenging situations see Appendix 2 - Being open: Communicating patient safety incidents with patients, their families and carers (NPSA, 2009).

11. Support for staff involved in the investigation of an incident

11.1. Any member of staff involved in the investigation of an incident should be offered advice and support from their line manager or the corporate governance team. If a member of staff is particularly distressed or requires professional support, this can be obtained via their line manager from the Occupational Health Department. Further details on supporting staff involved in an incident can be found in the 'Serious Incident and Incidents Policy' (G004).

12. Confidentiality

12.1. Wherever staff are carrying out the being open or duty of candour process, full consideration should be given to the patient's and the relevant staff member's privacy and dignity. Identifiable details relating to patients or staff involved in an incident will be considered confidential at all times and shared on a need to know basis only in accordance with the Trust's Data protection and confidentiality policy (G022).

12.2. Where lessons learned are shared for the purpose of improving service provision, the details must be anonymised.

13. Evaluation Measures

13.1. Standards/key performance indicators (KPIs) for all patient incidents with level of harm confirmed (on review by the division) as moderate, severe or death.

KPI	Compliance target
Initial duty of candour discussion took place within 10 days or, if not, valid reasons are recorded to failure to comply.	100%
There is a written record of the initial duty of candour discussion in the following: - patient notes; - electronic incident record (Datix); - included in the investigation report.	100%

KPI	Compliance target
The duty of candour discussion was with the patient, or, if not, there is a clear record confirming that the patient lacks capacity (as set out in section 11 of this policy) and appropriate patient representative was contacted.	100%
There is evidence of written follow up confirming duty of candour discussion sent to the patient or the appropriate patient representative (as set out in section 11 of this policy) within 10 working days of the SI panel discussion; or within 10 working days of the discussion with the patient (if the incident was not discussed at the SI panel).	100%
The initial letter includes - an apology - account of the facts known at the time - how the incident will be investigated - results of any further enquiries.	100%
There is evidence of written follow up after completion of the investigation within 10 working days of the completion of the investigation.	100%
The second letter either: - includes information about the investigation findings - or has a report on the outcome of the investigation appended (evidenced by reference in the letter to appended investigation report).	100%

14. Monitoring & Compliance

Following local and national guidelines and policies, what key elements will require monitoring?	Who will lead on this? – include lead job title (not name) and any MDT/others involved.	Describe which tool will be used to monitor/ observe/ inspect/ evidence that the policy is being implemented and followed?	How frequently will each element be monitored? What are the protocols (if any) for escalation?	Which committee/ panel/ group will reports go to?
Element to be monitored	Lead	Tool	Frequency	Reporting to:
Compliance against the policy requirements to complete all actions	SI Lead	Audit	Annually	QSG

Does this policy have any impact on safeguarding issues for adults and/or children?

15. Equality Impact Assessment

Does the policy affect one group less or more favourably than another on the basis of:			
		Yes/No	Comments
1.	Race	No	
	Ethnic origins (include gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the policy likely to be negative?	No	
5.	If so, can the impact be avoided?	n/a	
6.	What alternatives are there to achieving the policy without the impact?	n/a	
7.	Can we reduce the impact by taking different action?	n/a	

If you have identified a potential discriminatory impact in this policy please refer it to the Head of Patient Safety together with any suggestions about how to possibly avoid/reduce the impact. For advice in respect of answering the above, please contact the Head of Patient Safety.

16. References

- Care Quality Commission*: Guidance for providers on meeting the fundamental standards and on CQC enforcement powers* July 2014 www.legislation.gov.uk/ukdsi/2014/9780111117613/contents Accessed October 2017.

- NPSA Patient Safety Alert *Being Open: communicating with patients, their families and carers following a patient safety incident* NPSA/2009/PSA003 Available at: http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=65170. Accessed October 2017.

- NPSA *Being Open Framework: saying sorry when thing go wrong* Available at: http://www.nrls.npsa.nhs.uk/resources/collections/being-open/?entryid45=65077 Accessed October 2017.

- NPSA *Seven steps to patient safety. The full reference guide*. London 2004.

- General Medical Council and Nursing and Midwifery Council. *Openness and honesty when things go wrong: the professional duty of candour*. 2015.

- The Mental Capacity Act, 2005.

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- NHS Standard Contract 2017/18 and 2018/19 Particulars (Full Length). 2016.

- NHS Resolution, 2017

17. Related Policies and Guidelines

Serious Incident and Incidents Policy (G004)
Data Protection and Confidentiality Policy (G022)

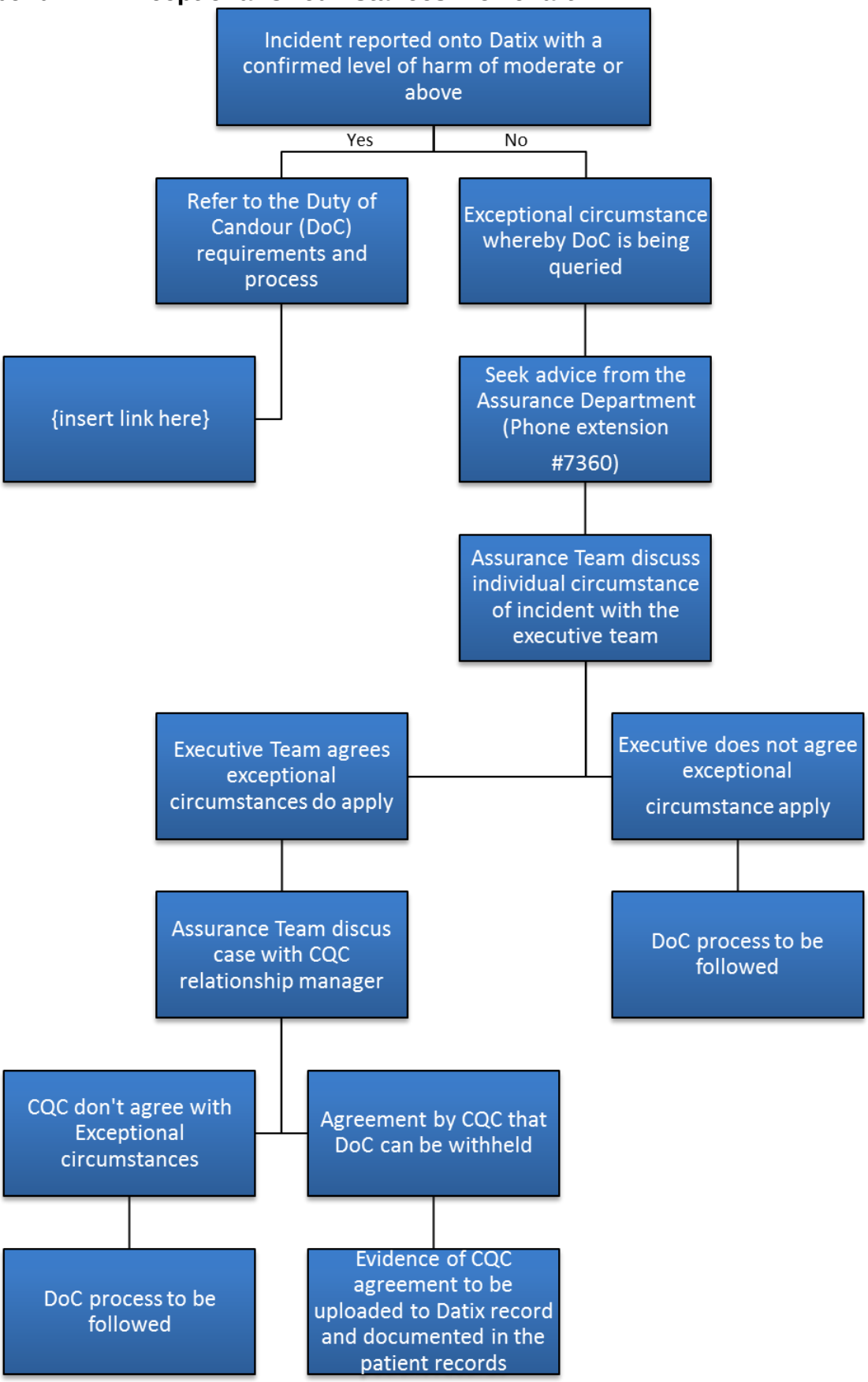
18. Appendices

Appendix 1 – Exceptional Circumstance Flowchart
Appendix 2 – Key definitions (as defined by the CQC, 2015)
Appendix 3 - Communication in particular patient circumstances

19. Policy & Sign-off Sheet

All staff members must sign to confirm they have read and understood this policy			
Policy name and number: Version number: Service and Directorate:			
Name	Signature	Name	Signature

Appendix 1 - Exceptional Circumstances Flowchart



Appendix 2 – Key Definitions
(as defined by the CQC 2015)

- **Apology** – an expression of sorrow or regret in respect of an incident.
- **Compliance** – meeting or conforming with defined requirements.
- **Duty of candour** – The duty of candour required providers to be open with the people who use their service. When a specified incident has occurred in respect of care provided, the regulation sets out a clear set of legal duties on registered providers about how and when to notify people using their service (or their relevant representatives) about those incidents.
- **Harm** - physical or psychological damage or injury.
- **Healthcare professional** – individuals regulated and/or licensed to provide some type of health or social care.
- **Moderate harm** – harm that requires a moderate increase in treatment, and significant, but not permanent harm.
- **Notifiable safety incident** – any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional:
  a. appears to have resulted in;
    i. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,
    ii. an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
    iii. changes to the structure of the service user's body,
    iv. the service user experiencing prolonged pain or prolonged psychological harm,
    v. the shortening of the life expectancy of the service user; or
  b. requires treatment by a health care professional in order to prevent;
    i. the death of the service user, or
    ii. any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned above.
- **Provider –** an individual person, partnership or organisation registered with CQC to carry on one or more regulated activities.
- **Prolonged pain** – pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.
- **Prolonged psychological harm** – psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.
- **Relevant person** (Regulation 20) – the person using the service or, in the following circumstances, a person lawfully acting on their behalf: 1) when the person using the service dies; 2. when the person using a service is under 16 and not competent to make a decision in relation to their care or treatment, or 3. where the person using the service is 16 or over and lacks capacity to make decisions.
- **Treatment** – includes a diagnostic or screening procedure carried out for medical purposes; the ongoing assessment of a person's mental or physical state, nursing, personal and palliative care, and giving vaccinations and immunisations.

Appendix 3 – Communication in particular patient circumstances

NPSA, *Being Open: Communicating patient safety incidents with patients, their families and carers* (2009).

The Trust's approach to Being Open may need to be modified according to the patient's personal circumstances. The following gives guidance on how to manage different categories of patient circumstances.

1. When a patient dies

When a patient safety incident has resulted in a patient's death it is even more crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The patient's family and carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and carers to indicate if they need bereavement counselling or assistance at any stage.

Usually, the *Being Open* discussion and any investigation occur before the coroner's inquest. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of incidents leading up to the patient's death. In any event an apology should be issued as soon as possible after the patient's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and carers will be provided with more information.

2. Children

The legal age of maturity for giving consent to treatment is 16. It is the age at which a young person acquires 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. 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 also give consent. This is sometimes known as Gillick competence or the 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 a patient safety 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.

3. Patients with mental health issues

Being open for patients with mental health issues should follow normal procedures, unless the patient also has cognitive impairment (see below). **The only circumstances in which it is appropriate to withhold patient safety incident information from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient.**

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

4. Patients with cognitive impairment

Some individuals 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 an enduring Power of Attorney. In these cases steps must be taken to ensure this extends to decision making and to the medical care and treatment of the patient.

The *Being Open* discussion would be conducted with the holder of the power of attorney. Where there is no such person, the clinicians may act in the patient's best interest in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened.

An advocate with appropriate skills should be available to the patient to assist in the communication process. See section 5 below

5. Patients with learning disabilities

Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see section 4 above). If the patient is not cognitively impaired they should be supported in the *Being Open* process by alternative communication methods (i.e., given the opportunity to write questions down). An advocate, agreed on in consultation with the patient, should be appointed. Appropriate advocates may include carers, family or friends of the patient. The advocate should assist the patient during the *Being Open* process, focusing on ensuring that the patient's views are considered and discussed.

6. Patients with different language or cultural considerations

The need for translation and advocacy services, and consideration of special cultural needs (such as for patients from cultures that make it difficult for a woman to talk to a male about intimate issues), must be taken into account when planning to discuss patient safety incident information. It would be worthwhile to obtain advice from an advocate or translator before the meeting on the most sensitive way to discuss the information. Avoid using 'unofficial translators' and/or the patient's family or friends as they may distort information by editing what is communicated.

7. Patients with different communication needs

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs. Knowing how to enable or enhance communications with a patient is essential to facilitating an effective *Being Open* process. This involves focusing on the needs of individuals and their families and being personally thoughtful and respectful.

8. Patients who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the *Being Open* process. In this case the following strategies may assist:

- deal with the issue as soon as it emerges;
- where the patient agrees, ensure their carers are involved in discussions from the beginning;
- ensure the patient has access to support services;
- where the senior health professional is not aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team;
- Offer the patient, their family and their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management;
- use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution;
- ensure the patient, their family and their carers are fully aware of the formal complaints procedures;
- Write a comprehensive list of the points that the patient, their family and their carers disagree with and reassure them you will follow up these issues.