One Dental Care are committed to providing a high standard of care to patients.

Introduction

The effects of harming a patient can have devastating emotional and physical consequences for patients, their families and carers. It can also be distressing for the professionals involved. Being open and honest about what happened; discussing the incident/complaint/claim fully, openly and compassionately can help all those involved cope better with the consequences of harm, whether potential or actual, in managing the event and also in coping in the longer term. In addition, being open and candid when things go wrong ensures that the investigation gets to the root cause of the event and promotes organisational testing.

Policy Aim

This policy is designed to improve the experience of patients who are inadvertently harmed during their treatment and to promote better communication between staff and patients. It applies to all team members, who are expected to familiarise themselves with the recommended procedures for being open.

Scope

One Dental Care are committed to “Being Open” and candid; about communicating with patients, their relatives and carers about any failure in care or treatment, whether they be the results via a Patient Safety Incident (PSI) Concern or complaint Claim.
This policy deals with the information and methods of sharing that information with patients, relatives and their carers, staff and other healthcare organisations. The extent to which it is enacted will be determined on the grading of the severity of the event.
Members of the practice are aware of the need for effective communication between patients and/or carers who may be involved in a safety incident and must develop the necessary skills needed for communicating with patients and/or their carers following a patient safety incident. This policy has been developed to help staff communicate to a patient and/or their carer what happened in an incident that led to moderate harm, severe harm or death.

Purpose

The purpose of this policy is to provide a best practice framework, based on the guidance of the National Patient Safety Agency (NPSA), to create an environment where patients, their representatives and staff feel supported, and have the confidence to act appropriately and for ensuring that all communications with relevant people are open, honest and occur as soon as possible after an event.

Definitions

- *Being Open* – The process by which the patient, their family and their carers are informed about a patient safety incident/complain/claim involving them
- *Candour* – An obligation to disclose errors that may not be immediately obvious to the patient. Exercising candour narrows the gap between what the healthcare professional and the patient know about an incident.
- *Claim* – Defined by the Clinical Negligence Scheme for Trust (CNST) as: "any demand, however made, but usually by the patient's legal adviser, for monetary compensation in respect of an adverse clinical incident leading to a personal injury"
- *Complaint* – Any expression of dissatisfaction with care provision, or a perceived grievance or injustice.
- *Event* – Any occurrence that results in a patient safety incident, complaint or claim.
- *Harm* – "No Harm" – No injuries or claim
- *No loss of property* – No significant likelihood of service issues arising from incident.
- *Near Miss/Potential Harm* – Any unexpected or unintended occurrence or incident that did not lead to harm, loss or damage, but had serious potential to do so and was prevented either by intervention or luck.
- *"Low Harm"* – Any incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving care at One Dental Care.
- *"Moderate Harm"* – Any incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving care at One Dental Care.
- *"Severe Harm"* – Any incident that appears to have resulted in permanent harm to one or more persons receiving care at One Dental Care – related directly to the incident and not to the natural course of the patient's illness or underlying condition.
- *"Catastrophic or Death"* – Any incident that directly resulted in the death of one or more persons receiving care at One Dental Care; Death must be related to the incident rather than the underlying condition or illness.
- *"Never Event"* – Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by the healthcare provided. There are currently 25 Never events as determined by the Department of Health.

- *Patient Safety Incident* – Is any unintended or unexpected incident which could have or did lead to harm for one or more of the patients.

Process for acknowledging, apologising and explaining when things go wrong

The first step of the process is the recognition of an incident and when the level of harm dictates that it is appropriate. This can be identified by any of the following mechanisms:

- Via staff at the time of the incident
- Via staff retrospectively
- By the patient/family/carer raising a concern, either at the time or via a complaint or claim in retrospect
- Via the incident reporting system
- Via other sources, such as the incident being highlighted by another patient, visitor or non-clinical staff.

Initial Discussion

Following identification of an incident, a preliminary team discussion should be undertaken to establish as soon as possible to the incident, once the patient is safe:

- Basic clinical facts
- Assessment of the incident and determine level of immediate response required
- Individual responsible for discussing/liaising with the patient/relative/carer
- Whether patient support is required
- Immediate support required for staff involved
- A clear communication plan.

Identifying who should be responsible

In determining who will be responsible for communicating with the patient/family/carers, the individual should:

- Have a good relationship with the patient and/or their carers
- Have a good understanding of the relevant facts
- Be senior enough or have sufficient experience and expertise in relation to the type of incident to be credible to patients, carers and colleagues
- Have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand

- Be willing and able to offer an apology, reassurance and feedback to patients and/or their carers
- Be able to maintain a relationship with the patient and/or their carers and to provide continued support and information
- Be culturally aware and informed about the specific needs of the patients/relatives or their carers

When should the initial discussion be held?

The initial candid "Being Open" discussion with the patient and/or their carers should occur as soon as possible after recognition of the incident. Initially, it is worth noting that something that has gone wrong but that the cause is not yet known.
It must be communicated to the patient and their family/carers that we will be taking the event extremely seriously, that the event will be investigated and that the findings of the investigations will be shared with them.
Through sharing the report and meeting with the patient and their family/carers, the patient will have the opportunity to influence the investigation. Factors to consider when timing this discussion include:

- Clinical condition of the patient. Some patients may require more than one meeting to ensure that all the information has been communicated to and understood by them
- Availability of key staff involved in the incident and in the Being Open process
- Availability of the patient's family and/or carers.
- Availability of support staff, for example a translator or independent advocate, if required Patient preference (in terms of when and where the meeting takes place and who leads the discussion)
- Privacy and comfort of the patient
- Arranging the meeting in a sensitive location

Provision of additional support

Support of the patient, their family/carers

Patients, their family/carers should be provided with support as is necessary during the process of "Being Open". At any face to face meeting, they should be encouraged to be accompanied by another family member/friend/representative. Where appropriate, an independent advocate or interpreter should be offered. The patient is also at liberty to request a second or independent review and this should be facilitated. Information on how patients can access additional support services and other relevant bodies should be offered. External bodies which may be able to produce support for the patient:

- ICAS – Independent Complaints Advocacy Services
- CRUSE (bereavement counselling support

- Relevant charitable organisations

<u>Where the patient is assessed not to have capacity</u>
Where the patient has a formal assessment of lack of capacity, the principles of "Being Open" still apply. In circumstances where the patient has a registered person with lasting power of attorney (LPA), it may be a legal requirement that they are informed. If there is no LPA for the patient, it is best practice that the family and or carers for the patient are informed of the incident. The occurrence of this conversation and grounds for it must be recorded in the patients' medical record.

<u>Department of clinical law</u>
Where the duty to be candid raises specific, ethical or legal considerations, the Department of clinical law can be contacted for advice.

<u>Professional support</u>
It can be very traumatic for healthcare staff to be involved in an event. One Dental Care are committed to ensuring that staff feel supported through the "Being Open" process. Staff are also encouraged to seek advice from their relevant professional body. Staff are encouraged, if appropriate to seek advice from their trade union representative. Staff will not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or threat to their registration. Where there is evidence to believe that punitive disciplinary action may follow or criminal act has occurred. Incidents relating to employee performance or conduct should be referred to Mrs Margaret Valenti and manage in accordance with "Disciplinary Policy"

Risk management and systems improvement
One Dental Care supports the root cause analysis (RCA) approach to looking at the causes of patient safety incidents. The focus is on improving systems of care.

<u>Confidentiality</u>
Details surrounding an event are confidential. Full consideration should be given to maintaining the confidentiality of the patient, carers and staff involved, in line with the "Data protection confidentiality policy"
It is good practice to inform the patient, their family and carers about who will be involved in the investigation, and give them opportunity to raise any objections. Communication outside the clinical team should be strictly on a "need to know" basis. Equally the relatives may need specific questions answered by the investigation process and should be given the opportunity to raise these.

<u>Continuity of care</u>
Patients have the right to expect that their care will continue, and that they will receive all of their usual treatment with the care, respect and dignity that they are entitled to. If the patient has a preference for their care to be delivered by another team, the appropriate arrangements should be made.

<u>Requirements for documenting all communication</u>

All discussions and communication with the patient, their family or carers should be carefully detailed in the patient medical noted. This should include:

- Reviewing the care for that patient
- The interaction with the patient
- Their family or carers should be detailed
- Where the communication happens as part of the complaints or claims process
- Where it occurs as a results of a patient safety incident

Processes for encouraging open communication between organisations, teams, staff, patients/carers.

"Being Open – A duty to be candid" forms part of education programmes. These encourage staff to "be open" with their patients, their relatives and carers, and make explicit their requirement to do so. Where the incident, complaint or claim involves outside agencies (e.g. other healthcare providers, the Commissioners or social services) whether raised by One Dental Care or the other agency, there is an obligation to fully co-operate with them and to communicate collaboratively with them.