NHS trusts’ openness after serious mistakes still leaves much to be desired

Most have formal policies in place, but these are rarely fully enacted, survey shows

Despite widespread recognition in NHS trusts of the importance of being open about mistakes that have been made, the way in which serious patient safety incidents are handled still leaves much to be desired, indicates research published online in BMJ Quality & Safety.

The researchers base their conclusions on the results of an online survey sent to patient safety managers, responsible for the “Being Open” policy, in all 386 NHS trusts in England, between November 2010 and February 2011.

“Being Open,” which was devised by the now defunct National Patient Safety Agency, explains how trusts can best create an open and honest environment for patients, relatives and staff, so that serious incidents are dealt with promptly and comprehensively, and all parties involved are properly supported in the aftermath.

This guidance, which was originally issued in 2005, was reissued in 2009, after it was felt that it had not had much impact.

The survey aimed to find out the extent to which policies were in place and used; what hindered openness; and what types of support for patients, their families, and staff were available.

In all, 209 patient safety managers responded, giving a response rate of 54%.

Virtually all respondents (98%) were familiar with the “Being Open” guidance. But one in 10 trusts had no formal, board approved policy on open disclosure in place.

And less than half the respondents (44%) said the guidance was followed all the time.

Only 38 per cent reported a substantial increase in open discussions about patient safety incidents over the preceding two years; and almost one in five had open discussions with patients and families, half or less than half of the time.

Two thirds of discussions with families took place up to six weeks after the investigation had been completed, suggesting that many patients and their families may be waiting up to a year without any clear explanation of what had gone wrong, say the authors. Managers also tended to outnumber doctors at these discussions.

A policy of openness should apply to all serious incidents, irrespective of the outcome, but the survey responses showed that incidents that led to a full recovery were discussed significantly less often than those leading to death or disability. This is possibly because organisations are more likely to be open when they expect patients to make a formal complaint, suggest the authors.

Managers most frequently cited fear of blame, litigation and the family’s reactions, along with concerns about how doctors would feel about being accused of malpractice as barriers to openness.

But informing patients about what happened, and how, is key to maintaining trust, say the authors.
While managers clearly recognised that support for staff in the wake of an incident was extremely important, it was not always available. Training, in particular, was only available less than half the time.

The authors conclude: Our findings suggest that there is high awareness among patient safety managers of the importance of being more open with patients, but that progress is slow and that some trusts have simply failed to recognise the importance of this issue."

“One of the most striking findings” of the review into Mid Staffordshire NHS Foundation Trust, where poor standards of care provoked a public outcry, was the lack of openness after patients were harmed, they point out.