



COMMUNICATION AND RESOLUTION PROGRAM

Coaching Clinicians to Communicate Effectively with Patients and
Families After Adverse/Harm Events

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LEARNING OBJECTIVES

1. Describe the reasons why effective communication with patient and families after harm events **is a key clinical skill** and articulate the basic elements of harm communication discussions
2. Explain the **fundamental elements** of the harm communication with patients and families
3. Outline **the essential skills** involved when coaching others after adverse/harm events





THE NEED & WHY NOW?

**"MEDICINE USED TO BE
SIMPLE, INEFFECTIVE,
AND RELATIVELY SAFE.**

**IT IS NOW COMPLEX,
EFFECTIVE, AND
POTENTIALLY
DANGEROUS"**

SIR CYRIL CHANTLER





WE ARE NOT PERFECT

A woman with long, wavy brown hair is sitting on a green couch. She is wearing a dark blue short-sleeved top. She is looking down with a sad expression, resting her head on her right hand. The background is a bright, out-of-focus window with sheer curtains. A small potted plant is visible in the background to the left.

PATIENT'S EXPECTATIONS

Each year in the U.S

Nurse Convicted of Neglect and Negligent Homicide for Fatal Drug Error

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mother's breast milk.

It is understood the baby was closely monitored afterwards and

tion to determine how they occurred and takes any action required to minimise the risk of

are secretive, they're not open and transparent," she said. "[They] are notorious for not

Clinical governance departments in hospitals investigated such incidents, he said.



MISINFORMATION



A CASE

You are covering Labor and Delivery, and things have been going well so far....

A Family Medicine colleague asks for consultation for G1P0 at 39w3d that has been pushing for 2 hours. Patient was admitted in spontaneous labor and there had been no concerns up to this point. Prenatal care was uncomplicated and EFW is 3400 grams. Initially patient had made good progress, but she was getting tired and fetal heart rate tracing started to show recurrent variables into the 70's with slow return to baseline. You are asked to assess for possible operative delivery

A CASE

You go in to see the patient with your rock star R4 (about to graduate) and a very experienced Family Medicine colleague. Patient is parting labia and based on your R4's evaluation baby is slightly asynclitic and ROA. Family Medicine Colleague concurs. You decide that it is safe not to check behind them.

Forceps are applied without any difficulty and within two pushes baby's head delivers. To your shock the baby delivers ROT and clearly had forceps placed incorrectly. Baby is born without a heart rate and a neonatal code is called. Baby responds well to CPAP and recovers quickly. Head is misshapen and staff is concerned baby has a genetic condition. Baby is transferred to the NICU

What are you feeling right now?



**Just keep
Swimming.....**

What would you do?

Key Point #1

PATIENT HARM IS FREQUENT AND UPSETTING

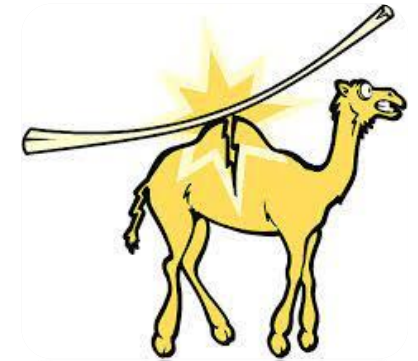
- Nearly 40% of patients think there has been a harmful breakdown in their care
 - Mixture of communication breakdowns and traditional adverse events
- Few share their concerns with the healthcare team or organization
 - But they are happy to talk to friends and neighbors



Key Point #1

PATIENT HARM IS FREQUENT AND UPSETTING

- The emotional impact of harm events on patients and families is **significant**
- Patients and providers rate the level of harm due to a care breakdowns significantly **differently**
 - Series of minor care breakdowns can combine to cause a major loss of confidence among patients and families





There's no easy way I can tell you this
—
so, I'm sending you to somebody who
can...

Key Point #2

HOW WE RESPOND TO HARM EVENTS MATTERS

We all have natural reflexes that can both support **and** inhibit effective responses to patients and families harm

- Helpful: desire to share information, comfort patient/family, apologize, prevent from happening again
- Less helpful: urge to keep information to yourself, rationalize, minimize, blame others, fall on your sword, make assumptions/speculate

Key Point #2

HOW WE RESPOND TO HARM EVENTS MATTERS

- Patients and families also have reflexive reactions
- How we feel and how patients/families feel is **not under our control**
- Harm events often occur **outside of our control**
- How we respond and choices made after a harm event **is under our control**
- It is our fundamental obligation as healthcare workers to respond to harm events in ways that supports patients and families rather than **traumatize further**
- This is why this is an important **clinical skill** to have

PATIENTS/FAMILIES WANT TO KNOW

 Tell us what happened

 Take accountability

 I'm Sorry

 Tell us how you are going to fix the problem

 Let us be a part of the solution (NEW)

CHALLENGES IN RESPONDING TO HARM EVENTS

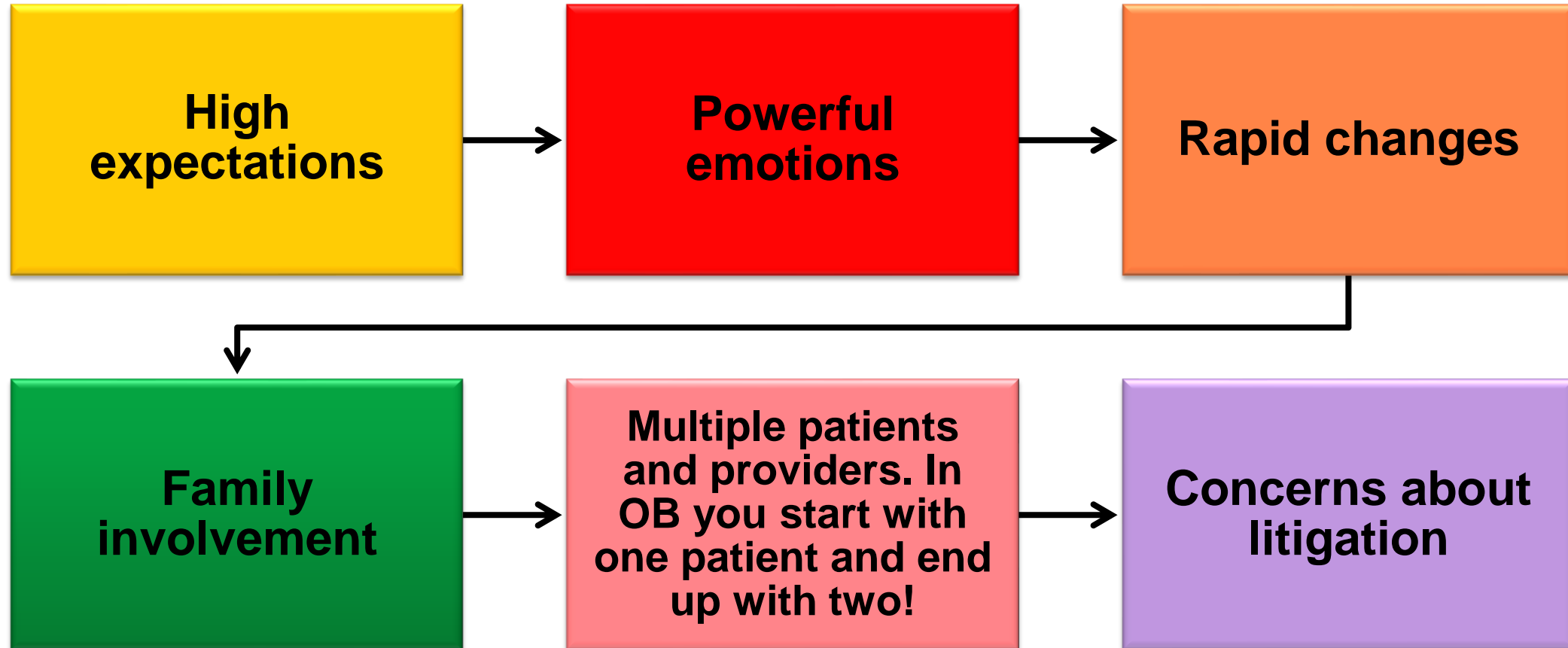
- Uncertainty about what to say and not say to patients
- Status Quo and Inertia (“Don’t Say Anything”)
- Complex cases with grey areas and multiple stakeholders
- Lack of tools, resources, standard work, and measures
 - What exactly am I supposed to do?
 - How well are we currently performing?
 - What can we do to improve it?



**Few clinicians feel
prepared to have
these conversations
with patients and
families**

**And those who say
they are comfortable
often overestimate
their abilities**

SPECIAL CHALLENGES IN OBGYN



CULTURAL CROSSROADS

- Confidence and trust in Science and Medicine is at its lowest
- Labor process not seen as a medical event
- Concern of overmedicalization of pregnancy and childbirth
- Limited and at times conflicting data (restrictions in research in pregnancy and lactation)



DELAYED DIAGNOSIS OF CANCER CASE

Dr. Buckley is seeing Mary McCarthy, who was recently diagnosed with breast cancer and has begun treatment. She had reported a breast lump to her PCP, Dr. Bloom. Dr. Bloom noted a cystic area that was not different from the rest of the breast tissue. Since MM was near the start of her menstrual cycle, Dr. Bloom recommended she be reexamined. Dr. Bloom then went on leave, and Dr. Buckley assumed her care. MM saw Dr. Buckley several times for high blood pressure but did not mention the breast lump and Dr. Buckley did not notice this problem in her chart. Six months later, her blood pressure now under control, MM mentions the breast lump to Dr. Buckley and notes it is getting bigger. Dr. Buckley is surprised and did not know this was an issue. The patient was subsequently diagnosed with metastatic breast cancer and has returned to discuss these events with Dr. Buckley.

DELAYED DIAGNOSIS – BREAST CANCER



WHAT DID YOU LIKE?

**WOULD YOU HAVE MADE DIFFERENT
CHOICES IN THE CONVERSATION?**

LET'S PRACTICE!

- Need three volunteers
 - One person to be the clinician/mentee
 - One person to be the patient
 - One person to be the coach (second opinion)

Communication Tips

Demonstrate	Demonstrate care, build trust
Start	Start the conversation
Discuss	Discuss the facts
Apologize and explore	Apologize and explore emotions
Respond	Respond to common questions
Close	Close the conversation
Document	Document the conversation
Avoid	Avoid pitfalls



The PACT Collaborative

Communication Tip Sheet: *Initial Conversations with Patients and Families about Harm Events*



Overview

This tool provides guidance to a CRP team member on having initial discussions with a patient who has experienced harm during their care and/or their family. It provides suggested language that should be adapted to the individual situation.

Demonstrate Caring, Build Trust

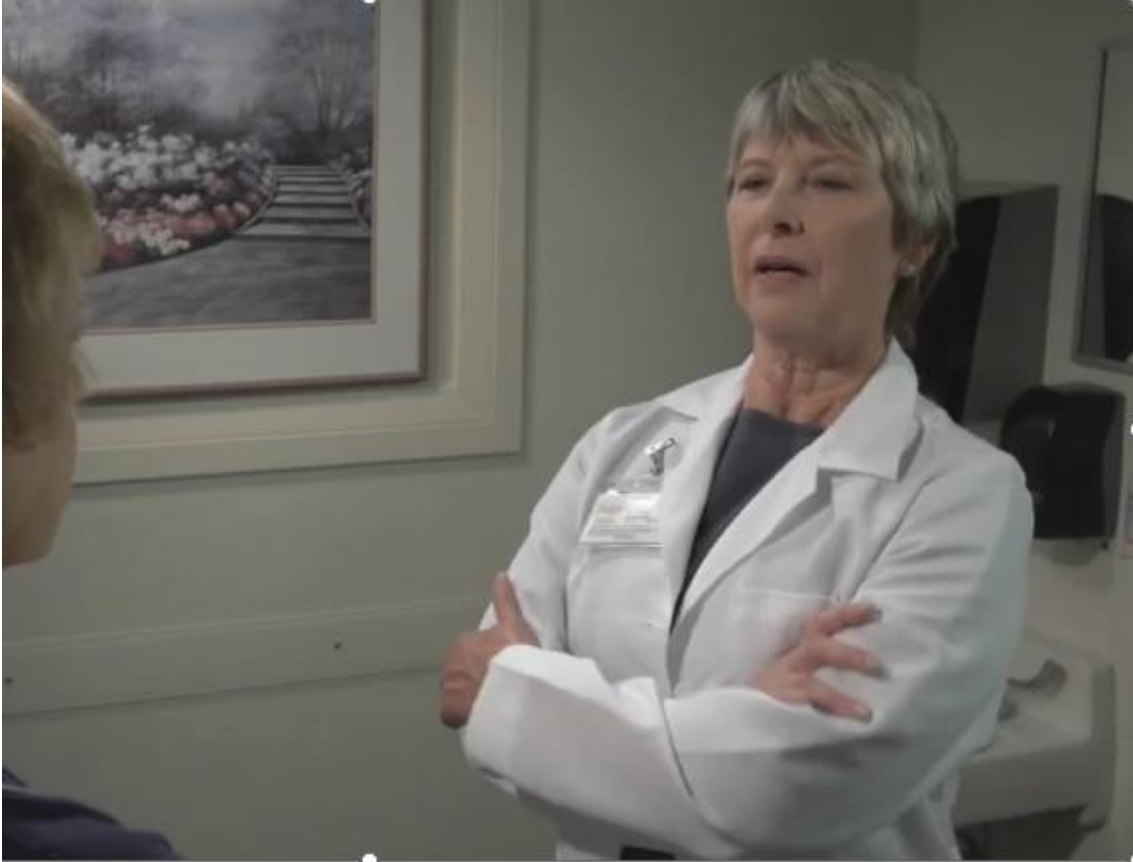
- Reflect on the goals of the conversation. In a successful discussion, trust is maintained because the patient and family:
 - Feel informed promptly that something unexpected has happened, and understand the facts that are clearly known about the event and how we are responding
 - Feel heard
 - Believe that we care about them and have treated them with sincerity, dignity, and respect
 - Are encouraged to ask questions and receive a direct and timely response
 - Know what will happen next and who to contact with questions
- Turn off distractions (phone, pager, TV, etc.)
- Identify who should be a part of the discussion from the clinical team and whether any patient family or other supports should join
- Pay careful attention to your non-verbal communication
 - Remove your white coat if you are wearing one

DEMONSTRATE CARE/BUILD TRUST

In a successful discussion, **trust is maintained** because the patient and family:

- **Feel informed** promptly that something unexpected has happened, and understand the facts that are clearly known about the event and how we are responding
- **Believe that we care** about them and have treated them with sincerity, dignity, and respect
- Are **encouraged to ask questions** and receive a direct and timely response
- Know **what will happen next** and who to contact with questions

DEMONSTRATE CARE/BUILD TRUST



Pay careful attention to your non-verbal communication

- Physicians: Remove your white coat if you are wearing one
- Make eye contact throughout
- Sit down so that you are at the same level as the patient/family
- Ensure your body language is open (no crossed arms)

We have two ears and one mouth
so that we can listen
twice as much
as we speak



EMOTIONAL REGULATION



Absorb

Absorb intense emotion from patients and respond empathically



Sit

Sit despite the impulse to run away



Be

Be silent and let patient/family control conversation



Resist

Resist the urge to just walk in and “get it over with”

DISCUSS THE FACTS (DO NOT SPECULATE)



Developing an accurate understanding of what the harm event was and how it happened takes time

Our first impressions are often incomplete or wrong

Conclusive information about whether the harm event was preventable and if so what caused the event to occur is rarely known until an event analysis is conducted



Sharing information with patients and families that later turns out to be wrong detracts from their understanding and undermines their trust



Therefore, during the initial conversations with the patient and family about the harm event, you should share clinical facts that are clearly known and what we are doing to mitigate the harm



“I wish I could provide more information right now, but getting to the bottom of what happened is going to take time. I don’t want to risk offering my best guess and later learn I caused a lot of confusion because my guess was wrong. I can promise you that soon as we know the facts, we will share them with you.”

WATCH OUT: REFLEXES!



Defensive



It's just a mild hyperinsulism due to islet cell hyperplasia with a touch of hepatic insufficiency and glycogen depletion.

Jargon



Overtalk



Fall on your sword

LOST SURGICAL SPECIMEN

The patient, Olivia Dawson, is a middle-aged woman admitted to the operating room from the emergency department with gynecological bleeding from an unknown cause. She is going to undergo an exam under anesthesia (EUA).

When the surgeon examines her, she finds a large pedunculated mass attached to the cervix. As the surgeon removes the mass, bleeding becomes profuse. The surgeon places the specimen in a surgical towel and tosses it onto the back OR table as he and the nurses become focused on achieving hemostasis. The scrub tech calls for additional supplies and the circulating nurse is also requested by anesthesia to order blood. The surgeon neglects to tell the nurses what s/he did with the specimen.



Once bleeding has been controlled, the circulating nurse is relieved for a break. The circulating nurse reports to the relieving nurse the admitting information, current patient status, occurrence of extensive hemorrhage and order for blood, but does not report to the relieving circulating nurse that the specimen has yet to be received from the scrub tech. The case is completed without further incident, and the room is stripped and prepared for the next case. The relieving circulating nurse takes the formalin-filled specimen container to the specimen room and logs it into the system. By the time the first circulating nurse returns from break the next OR case has started.

Approximately an hour and a half later, the OR nurse manager receives a call from Pathology and is told that the specimen container for the emergency case has arrived empty. The surgical team in the OR is notified and after a quick review, it is determined that the specimen has inadvertently been discarded into the garbage. There is no possibility of retrieval. The surgeon was very concerned as the specimen appeared suspicious and required examination by pathology.



The patient is doing well now, will need to stay overnight for observation, but will need to come back to the OR to obtain additional tissue samples. It is not known if the tissue that will be obtained from the surgical site will contain enough or any actual pathology to make a definitive diagnosis. This will seriously impact upon the surgeon's attempts to devise a treatment/follow-up plan for this patient



LET'S PRACTICE!

- Need three volunteers
 - One person to be the clinician/mentee
 - One person to be the patient
 - One person to be the coach (second opinion)

HARM COMMUNICATION COACHING

Goals of Coaching

- Help clinicians focus **on goals of discussion** and **visualize success**
- Support the clinician's **conflicting reflexes/urges/emotions** and channel that into a productive conversation with patient and family
- Keep the **focus on the patient**
- Identify the situations where clinician **is not likely to succeed**

Coaching Guide

Start	Start Coaching Session
Create	Create a shared mental model
Plan	Plan the initial conversation
Practice	Practice and close the session
Follow-up	Plan the follow-up conversation
Practice	Practice and close the session



The PACT Collaborative

Harm Communication Coaching Guide: *Talking with Patients and their Families about Harm Events*



Overview

This guide helps a communication coach prepare a clinician (coachee) to communicate effectively with a patient who has experienced harm during healthcare and/or their family. Suggested language and prompts are provided but the coach should adapt their language to the situation.

Start the coaching session

- Explain the purpose of the session and describe what the session will look like
 - "We and our organization care about you, we know that harm events are upsetting, and we are here to support you."
 - "The initial interactions with the patient/family after harm are key to maintaining trust"
 - "Planning and practice helps these difficult discussions go better"
- Ask whether the coachee has had this kind of conversation before
- Ask the coachee how they are doing
 - "Have you been connected with the peer support program?"
 - "How does the rest of your day look?"
 - "Do you need to change your schedule?"
- Explore and normalize coachee emotions and distress. Discuss how our emotions can impact the way we communicate with the patient about harm
 - "Some of our emotions in these situations are 'cognitive distortions' (exaggerations such as 'my career is ruined'), while others are natural components of the difficult task we are undertaking"
 - "Talking about how you are feeling can put the situation into perspective and reduce these distortions"
 - "We carry our remaining emotions with us throughout the discussion and they remind us to bring our authentic selves to this critical conversation"



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Plan, Plan, Plan... And Plan

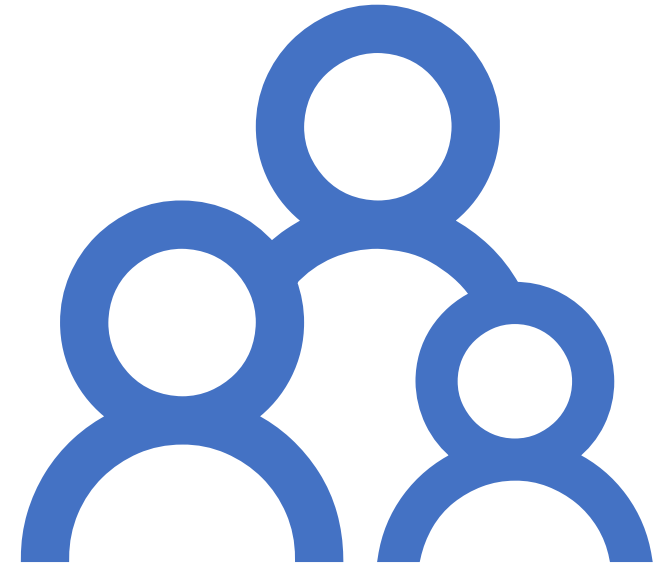
Prepared clinicians can focus on listening to and understanding what patients/families are saying



Being clear on goals of conversation frees up clinicians to allow the patient/family to direct the flow of discussion



More likely to be experienced by patient/family as sincere and authentic



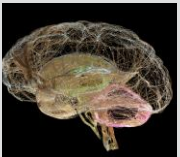
START COACHING SESSION



Ask whether your colleague has had this kind of conversation before



Ask your colleague how they are doing



Explore and normalize emotions and distress. Discuss how our emotions can impact the way we communicate with the patient about harm (Cognitive distortions)

HOW ARE YOU DOING?

#ACSM2023

Ask:



“Have you been connected with the peer support program?” (National resources available)

“How does the rest of your day look?”

“Do you need to change your schedule?”

COGNITIVE DISTORTIONS

American Psychological Association defines Cognitive distortions as faulty or inaccurate thinking, perception or belief.

They are an exaggerated pattern of thought that's not based on facts. Negativity is often the defining characteristic. It leads you to view things more negatively than they really are.

Fortune Telling Assuming something bad will always happen. "I'm a black cloud" 	Minimizing Downplaying the importance of any successes. "I just got lucky" 	Catastrophizing Thinking the worst situation will happen. "I'm definitely going to fail" 	Self-Blaming Blaming yourself if anything goes wrong. "It's all my fault" 
Mind Reading Assuming you know what someone else is thinking. "My boss does not like me for sure" 	Mental Filtering Hyper-focusing on a negative detail of a situation. "That was a disaster, and I forgot XYZ" 	Should & Must Believing things can only be a certain way. "I should have seen this coming" 	Labeling Applying a negative label to yourself. "I'm sure this would not happen to XYZ" 

STATEMENTS COACH CAN SAY

- *“Some of our emotions in these situations are ‘cognitive distortions’ (exaggerations such as ‘my career is ruined’), while others are natural components of the difficult task we are undertaking”*
- *“Talking about how you are feeling can put the situation into perspective and reduce these distortions”*
- *“We carry our remaining emotions with us throughout the discussion and they remind us to bring our authentic selves to this critical conversation”*

CREATE A SHARED MENTAL MODEL

Review with the coachee what is known about what happened
– focus on FACTS!

Discuss the perspective of the patient/family

- What do they know about the event so far?
- What insights do we have regarding patient/family emotions?
- Who from the family is involved? Are any family members especially challenging? Do you anticipate conflict among family members?

Develop an agenda for clarity and set goals for the interaction
with the patient/family

- What 3-4 things do you want to accomplish during the discussion?
- Expect the patient/family to **continue to be upset** or angry even after this conversation
- Do not **seek to move past the emotion too quickly** or try to problem solve the situation in hopes the emotion will go away. Allow the patient and family to dictate the flow of this conversation

PRACTICE, PRACTICE, PRACTICE

Practice allows clinicians to hear and experience the language they will use and the emotions they may experience

- Naturally leads to self-coaching (“Wait-let me try that again...”)
- Some clinicians will resist practice; **the coach must kindly persist!**



APOLOGIZE AND EXPLORE EMOTIONS

Regret

Express regret about what happened: *"I am so sorry you are going through this. This is not at all what we hoped would happen."*

Fault

Fault admitting apologies (*"I am sorry you were harmed by this error"*) are only appropriate if a full investigation concludes that the harm was caused by an error or system failure

Listen

Listen carefully for clues as to how the patient/family is feeling about what happened. If you are unsure how they are feeling, ask directly: *"What has this been like for you?"*

Name and validate

Name and validate emotions as they arise: *"I can see you are very upset about what happened- it is natural and understandable to feel that way."*

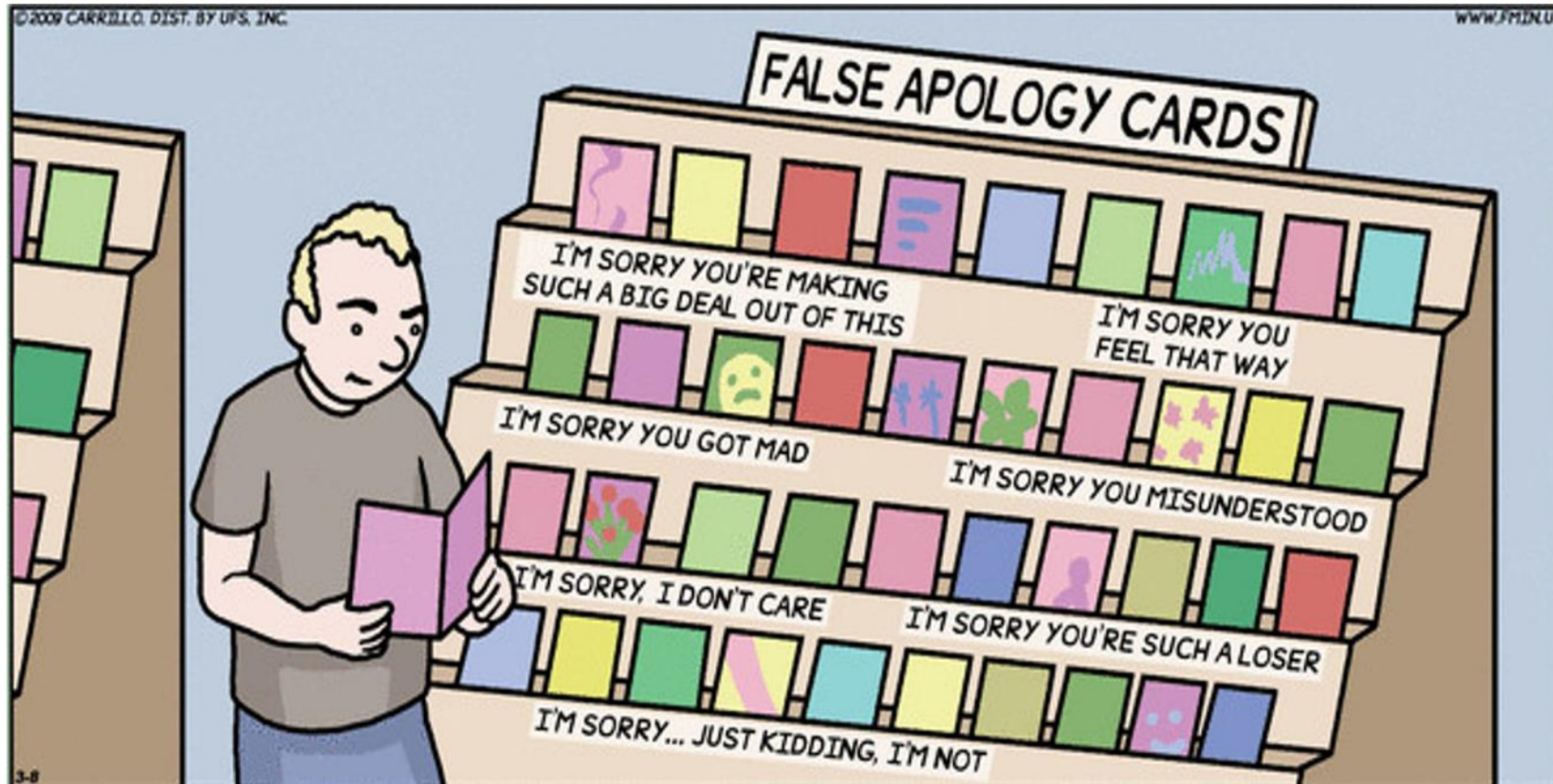
Explore

Explore the emotions further: *"What about this is feeling most upsetting right now?"*

Silence

Allow for silence

Avoid this Type of Apology



COMMON DIFFICULT QUESTIONS AFTER AN ERROR



How could this have happened? (or ...have happened at such a highly regarded institution?)

Who is to blame for this?

Has this happened before?

Is the (nurse/doctor/tech) going to get fired?

Maybe it's time for me to call my lawyer!

**It's not always about WHAT you say, but
HOW you say it**



How could this have happened?



“Our goal is to provide to best care possible, unfortunately despite our best-efforts, errors still occur. We try to learn from them and continuously work on improving care”

Who is to blame for this? Will They get fired?



“We have found that focusing on blame and shaming the people that work in healthcare does not foster a learning environment, we try to focus on systems solutions that support the human beings that work here”

Has this happened before?



*“We take what happened extremely seriously and the event was reviewed carefully to understand what happened. May I share what we have learned and how we are working on how to prevent this from happening again?”**

*Legal consultation prior to sharing event review findings

Maybe it's time for me to call my lawyer!



“You have every right to seek legal counsel as a patient. We are hoping we can continue discussing with you what we have learned from your case/event”

“We are very sorry that this happened. You have our sincerest apologies, although we understand if you are not able to accept it at this point”

HOSTILE NON-PRODUCTIVE CONVERSATIONS

Here is **language** to assist with redirecting or stopping the conversation if no longer productive or if the conversation becomes hostile or excessively aggressive

- **Transitions/Refocusing Conversation**

- *“Would it be helpful to revisit _____ at another time?”*
- *“Can you clarify what you mean by _____?”*
- *“We understand your concern and will look into _____”*
- *“Can we move the discussion to...?”*



- **Non-productive/hostile/threatening**

- *“We had hoped to have a discussion that helped us understand your concerns. Unfortunately, it does not appear that our conversation is productive. I’m sorry to say that we will have to end today’s meeting. We can try to meet again at another time”*



COMMUNICATION PITFALLS

NOT TO PREPARE OR PRACTICE



- Preparation allows clinicians to keep patient/family at the center of the interaction
- Runs counter to clinician reflex of wanting to just go into room and get discussion “**over with**”

SPECULATE ON CAUSE



- Our first impressions are often incomplete or wrong
- Share clinical facts that are clearly known
- This is not the time to start talking about differential diagnosis

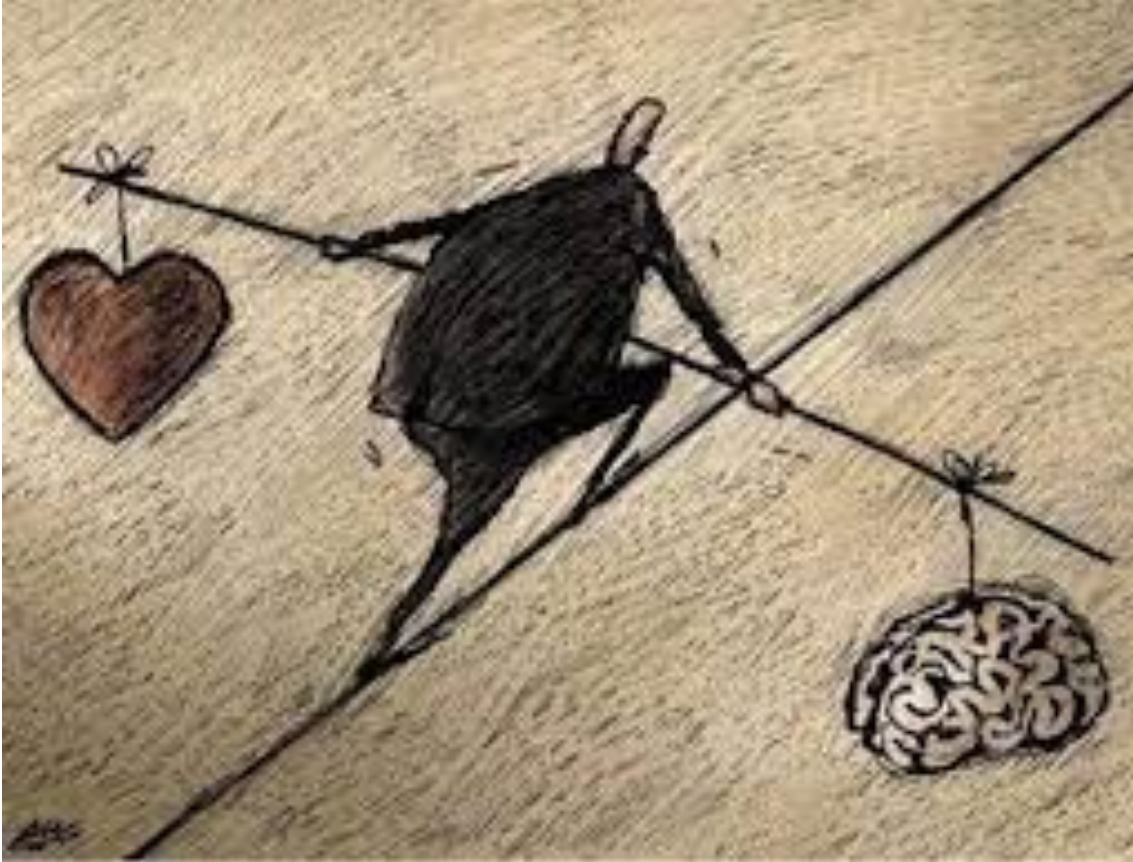
DON'T CARE OR “JUST A MINOR EVENT”



Be mindful of **inadvertently** conveying that we:

- Don't really care about what happened or what the patient/family are going through
- Don't take the event seriously (even when the harm to us appears minor)
- Are mostly focused on how the event affects us or the organization
- Encouraging patient/family to move past what happened

IGNORE EMOTIONS: YOURS AND PATIENT



- Do not ignore your own emotions and reflexes
- Inadvertently ignore or invalidate the patient and/or families' emotions

AND FINALLY

- Do not blame others
- Do not discuss financial resolution or make commitments regarding payment issues
 - If this issue arises, validate the question and let them know you will make sure the right person discusses this with them



QUESTIONS