Frequently Asked Questions (FAQs) about Best Practices for Responding to Harm Events

What healthcare professionals should expect and how they can best respond when patients are harmed by their care.

What are "communication and resolution programs" (CRPs)?
Communication and resolution programs (CRPs) are structured approaches healthcare organizations use to respond when patients are harmed by their care. They focus on early communication, supporting patients and clinicians, reviewing what happened, and learning how to prevent recurrence. CRPs are centered around the principles of accountability, compassion, and transparency. They are the modern, ethical paradigm for responding to harm, and are designed to support healing, rebuild trust, and improve care. CRPs go by a variety of names, and the language of CRPs may evolve over time – for instance to communication and reconciliation programs.

How are CRPs different from historical responses when patients are harmed by their care?
Historically, many organizations responded to harm using a reactive "deny and defend" approach: avoiding open discussion with patients and families out of concern that doing so might increase legal risk. Research has shown that CRPs are associated with *fewer* claims and *lower* defense costs.

How big a problem is harm from healthcare?
Research shows that a significant number of patients and families continue to experience harm despite years of best efforts by healthcare professionals and organizations. Many factors contribute to this problem, including the complexity of modern healthcare, difficult-to-diagnose and difficult-to-treat diseases, and persistent opportunities to improve the systems and processes of care. To learn more, read about Harm from Healthcare – Facts and Common Misunderstandings.

What does the CRP process involve?
CRPs involve:

- Identifying events that should be managed using the CRP
- Supporting the patient/family and communicating with them soon after events
- Supporting clinicians and coaching them about how to talk with patients/families
- Reviewing the event to learn what happened and why, focusing on system factors and opportunities to improve care rather than assigning individual blame
- Closing the loop with the patient/family by sharing what was learned and what's being done
- *Subset of events where an error caused serious harm:* Proactively offering compensation to the patient/family

Learn more by reviewing a process map, or reading a literature review about CRPs.

Which events should be managed using a CRP?
While the principles of CRPs – accountability, compassion, and transparency – should be used to respond to any situation where a patient has been harmed by their healthcare, we recommend that events involving **moderate harm or worse** be managed using a CRP. What constitutes "moderate harm" may vary depending on your organization's harm scale. It is important not to delay the response to harm to determine whether it crossed the threshold of moderate harm; in part because of this, some organizations apply their CRPs to "unexpected outcomes" (as defined from the patient/family perspective), rather than anchoring on the severity of harm. **Tip:** If addressing a patient's care needs after an event requires an unplanned escalation in the level of care, an unplanned procedure, prolonging the length of stay in a healthcare facility, or multiple unplanned ambulatory visits, the event usually involved at least moderate harm.

What if an event did not involve an error, or it's unclear whether it did or not?
Regardless of whether a harm event involves an error, patients and families have important information and support needs. Many harm events are an unintended consequence of appropriate care (for example, medication side effects or

known complications of procedures). It is important to respond to harm events in a timely fashion, regardless of whether they involved an error.

Why should I (a healthcare professional) want my organization to have a CRP?
Responding well after harm is a core part of the clinical mission. Healthcare professionals commit to the principle of "do no harm," but despite their best intentions, sometimes harm happens. When it does, the way in which they and the healthcare organization respond has important implications for the patient, family, and clinicians.

CRPs are designed to help patients and their families recover from the event, and to help clinicians navigate the aftermath. CRPs help clinicians rebuild trust with harmed patients and their families, cope through the difficult experience, avoid devastating professional outcomes, and even experience positive growth (read more here). Many clinicians find that participating in a CRP allows them to respond in a way that aligns with their professional values of honesty, responsibility, and commitment to patient well-being.

Is my organization required to have a CRP?
The Centers for Medicare and Medicaid (CMS) Patient Safety and Structural Measure (PSSM) asks acute care hospitals in the United States to attest whether or not they have a CRP, and whether they measure it and report the results to their board. CRPs are also recommended in the National Action Plan to Advance Patient Safety, and they are aligned with recommendations from Leapfrog and the WHO Global Patient Safety Action Plan.

As a clinician, what is my role in a CRP?
Clinicians play critical roles in CRPs:

- Identifying harm events
- Talking with harmed patients and families, explaining what happened clinically (sharing facts, avoiding speculation) and what it means for them, and in some cases, describing the efforts being taken to prevent recurrence
- Helping meet patient/family support needs
- Incorporating their insights and lived experience into the event review

How do I know whether my organization has a CRP?
Ask your supervisor or director, risk manager, patient safety professional, and/or a representative from your insurer about whether they use a CRP to respond after serious harm events. Note that CRPs can go by a variety of names; your organization may use a different phrase or acronym.

How should I (a clinician) prepare in case one of my patients suffers harm from their healthcare?
Talk with your supervisor or director, chief of service, risk manager, patient safety professional, or insurance representative.

- Ask what you should do and who you should contact for support if you are involved in a serious harm event.
- Ask whether you can tell patients/families involved in harm events that your organization will close the loop with them after the event review is completed.
- Ask about harm-response-related education or training, guidelines, and policies at your organization.

As a physician or advanced practice professional (APP), what should I do if one of my patients suffers a harm event?

- **Report the event to your organization's patient safety team**. Many organizations have electronic systems for doing so. Learn about your organization's process.
- **Get support if you need it**. Many clinicians find being involved in a serious harm event emotionally challenging, especially if a claim or lawsuit is filed. Talking with a colleague or professional who has experience supporting clinicians can be helpful.
- **Get just-in-time coaching**, especially if you're unsure how to talk with patients and families after harm events.
- **Talk with the patient/family about the event**. Check out our Initial Communication Tip Sheet. This early conversation focuses on sharing the facts about what is known, expressing empathy, avoiding speculation or a premature admission of fault, and ensuring patient/family needs are being addressed.

    - **If your organization has a CRP** – During the conversation, explain that someone from your organization (try to have their name and contact information) will be following up with the patient/family as the event review unfolds to share what is learned and what's being done to try to prevent recurrence.
    - **If your organization does not have a CRP** – During the conversation, be careful to not promise something your organization will not do. Often *without* a CRP, organizations do *not* have a mechanism for closing the loop with the patient/family after the event review. Refer the patient/family to Patient Relations (or similar function in your organization) for any questions that arise.
- **Participate in the event review process**. Your expertise and perspective are important. Help your organization learn and improve.

As a nurse, pharmacist, or other healthcare professional, what should I do if one of my patients suffers a harm event?

- **Report the event to your organization's patient safety team**. Many organizations have electronic systems for doing so. Learn about your organization's process.
- **Get support if you need it**. Many clinicians find being involved in a serious harm event emotionally challenging, especially if a claim or lawsuit is filed. Talking with a colleague or professional who has experience supporting clinicians can be helpful.
- **You may have a role in talking with the patient/family** to explain what has happened and the next steps. This will depend on the nature of the event and your organization's systems and processes. Consider just-in-time coaching from a qualified professional if you're uncertain about how best to speak with the patient/family.
- **Continue supporting your patients and their families**
    - **Know what they should expect in terms of communication:** Check out our Initial Communication Tip Sheet to see how that conversation should proceed.
    - **Know how to respond if the patient/family have questions or concerns.** Often Patient Relations (or similar function in your organization) is a good resource.
- **Participate in the event review process**. Your expertise and perspective are important. Help your organization learn and improve.

Am I allowed to apologize after a harm event?

There is a difference between acknowledging an event with an expression of empathy or regret (e.g. *"I'm sorry this happened to you"* or *"I'm sorry you're going through this"*) and a fault-admitting apology (e.g. *"I'm sorry we made an error and caused you harm."*) Regardless of whether your state has an "apology law" that protects certain expressions of sympathy from being used in litigation, it is always appropriate for clinicians to express concern, compassion, and empathy. Fault-admitting apologies are appropriate only if an event review has determined that an error occurred and it caused harm, and for this reason they're rarely part of the initial conversations after harm events. If you are uncertain or concerned about how or whether to apologize, speak with your organization's risk management or patient safety team.

What does being involved in a CRP mean for my malpractice risk or experience?

Overall, CRPs are designed to reduce clinicians' malpractice risk and improve their experience:

- Strong CRPs include proactive support for clinicians.
- When the care provided to a patient was appropriate, if a claim or lawsuit is filed, CRPs involve robustly defending the clinicians.
- For events where the care did *not* meet an acceptable standard, and that lapse caused serious harm, CRPs involve a proactive offer of compensation (aka a settlement).
- While CRPs can lead to claims or payments that would not otherwise have happened, the data suggest there is a concurrent decrease in other claims and costs that would have occurred had there not been a CRP; the evidence shows that overall, in the aggregate, organizations that implement CRPs do *not* experience increased claims or costs, and they may experience *decreases* in claims and costs. The mechanism for this finding is likely CRPs' proactive patient/family-centered approach, which better meets patient/family information and support needs, thereby reducing a driver of claim and lawsuits.
- Most CRP events do not involve a payment made on behalf of a clinician in response to a written demand from a patient or family, so most CRP events do not result in NPDB reports.

- *For the subset of events where a payment is made by an insurer on behalf of a clinician in response to a written demand*, the National Practitioner Data Bank (NPDB) requires a report. Insurers typically submit these reports. The NPDB form allows the submitter to indicate that the payment occurred in the context of a CRP. When organizations' credentialing professionals review a report with such a notation, it can signal the clinician's commitment to their professional obligations, ethics, and best practices.

How can I learn more about responding after one of my patients experiences harm?

- Review our Initial Communication Tip Sheet.
- Read a case-based paper about how to respond.
- Encourage your organization's leaders, and/or your insurer to implement a CRP and provide you with training and support. Share this link with your organization's healthcare leaders: harmresponse.org/who-we-serve/healthcare-leaders

What if I need support after an event?

It is okay and normal to experience challenges after being involved in a harm event. It is important to seek out the support and help you need. These are some options:

- Reach out to your family or friends.
- Access your organization's support resources, such as a trusted colleague, a "peer supporter" or "care for the caregiver" program, or an Employee Assistance Program.
- If you are struggling emotionally, get free confidential support 24/7 through the 988 Lifeline (call or text 988).

What if I know a colleague who needs support?

It is normal for clinicians to experience challenges after being involved in a harm event. A number of factors can make it difficult for them to seek out the support and help they need. We encourage you to **proactively reach out to colleagues involved in harm events**. These resources may be helpful:

- Review the Healthcare Professional Support Tip Sheet.
- Access your local support resources, such as a "peer supporter" or "care for the caregiver" program, or an Employee Assistance Program.
- If a colleague is struggling emotionally, they can get free confidential support 24/7 through the 988 Lifeline (call or text 988).

As a clinician, what should I expect when I report an event I was involved in?

Reporting harm events is essential for learning and improving care. Clinicians' experiences may vary depending on their organization's systems, processes, and culture. We recommend organizations create environments with psychological safety, where clinicians who report events can trust they will be treated fairly, with respect, and support. Best practice is that event reviews focus on understanding what happened and why, identifying contributing system factors and opportunities to improve care, rather than assigning blame for unintentional mistakes that do not reflect a pattern of concerning behavior.

How should I as a clinician expect to be treated by my peers and organization if I'm involved in a harm event?

Clinicians' experiences may vary depending on their organization's systems, processes, and culture. We hope that you will be treated with fairness, respect, and support. Healthcare is complex, and most harm events involve multiple contributing factors, not intentional wrongdoing. We recommend your organization use a **just culture** approach:

- **Access to support**, recognizing that being involved in a harm event can be emotionally difficult
- **An environment where clinicians can speak openly and learn**, known as psychological safety
- **A thoughtful, objective review** focused on understanding what happened, why it happened, and how to improve care for future patients
- **Fair and transparent accountability** that considers the context of your actions and the conditions in which you were working, with a clear explanation of how the review was conducted and why any actions were taken

How can I best advocate for my organization or insurer to implement a CRP?

Share this link with your organization's healthcare leaders: harmresponse.org/who-we-serve/healthcare-leaders