

# Initial Communication with Patients & Families after Harm

**CONTEXT:** For healthcare professionals preparing to talk with a patient/family soon after harm is recognized.

*The phrases in this document are examples. Do not use this as a script; use your own words to ensure authenticity.*

## BEFORE EVENTS OCCUR – Prepare Yourself

- Learn about your organization’s patient safety systems and processes for responding after harm, including whether it has a communication and reconciliation program (aka CRP).
- Familiarize yourself with the supports available to patients, families, you, and your colleagues.
- Practice your communication skills.

## AS SOON AS POSSIBLE AFTER AN EVENT OCCURS – Prepare for the Conversation

- **Care for the patient/family:** ensure immediate care needs are being met.
- **Report the event, get support and coaching if needed:** even if you’re confident, consider communication coaching, especially with high harm events.
- **Plan the conversation**
  - **Goal:** proactively and respectfully talk with the patient & family as soon as feasible (same or next day). Delay is warranted only if there is high patient & family distress (e.g. actively grieving a death or serious injury) or if the patient & family are unreachable.
  - **Gather key information**, e.g. status of the patient and family, basic facts about what happened, etc. – but don’t delay. Do not wait to figure out whether an error happened.
  - **Identify who should attend:** consider the clinical team, family, and other relevant supports.
  - **Anticipate cultural factors, challenges, and questions. Consider the setting and timing.**

## THE CONVERSATION – Demonstrate Caring, Build Trust

Use **CARES** to remember the key elements

*Key elements follow. Their order may vary. Adapt to the situation and patient/family needs.*

**Connect:** “How are you doing?” If the patient/family are aware of the event, invite their perspective and concerns: “What questions or concerns are on your mind?” If they are not aware of the event: “I’d like to talk with you about something important that happened during your care. Here’s what we know so far...[see below re: not speculating]”

**Acknowledge: express empathy for the experience:** “I’m so sorry this happened to you.” Do not share a fault-admitting apology (“I’m sorry that our mistake caused you harm”) unless an organizational event review has concluded an error caused harm. If you’re unsure, talk with your patient safety team or risk manager.

**Respond: to emotions, questions, and support needs.** Pause, listen, observe non-verbal cues carefully. Consider asking if there is silence, e.g. “I’ve just shared some difficult information, how are you feeling? What questions do you have? How can we best support you right now?”

**Explain: Succinctly share the facts about what is known, do not speculate.** Well intentioned efforts to fill in the gaps for patients/families can lead to distrust if initial assumptions are proven incorrect.

**Share next steps:** “We will review this event to understand what happened.” Note: review can take time.

**Support: provide contact info** for questions, concerns, or support needs.

- **If the organization has a CRP:** Note that a representative will follow-up with the patient/family.
- **If the organization does not have a CRP:** “I’m going to give you the name of [a patient safety/relations professional]. Please ask them for updates as the event review progresses.”

## AFTER THE CONVERSATION – Learn and coordinate

- Debrief with the involved professionals: what went well, what didn’t, what might be done differently next time
- Document as you would any important clinical conversation (using an organizational note template, if available) to promote a shared mental model for the team and patient/family.

