Please share your top 2-3 suggestions for getting leadership on board with a solid CRP? There is some fear among leadership about having these conversations.

To help get leadership on board with a solid CRP provide them with a clear ROI. The data now demonstrates there are multiple components to the ROI that include:

1.) Improved patient safety with fewer harm events
2.) Increased staff retention and less turnover
3.) Decreased litigation

In addition, it can be helpful to connect the “heart with the head” through resident or family stories. Many acute care organizations have launched their CRPs after an unfortunate, tragic event that prompts the leadership to realize that this approach is the right thing to do and consistent with the organization’s vision, mission, and values.

Communication and resolution programs advocate early and open dialogue with residents/patients and their families after medical errors and adverse events occur. These programs also aid efforts to prevent harm to future residents/patients by allowing staff to learn from mistakes and implement necessary change. The bottom line is instituting a Just Culture and CRP results in fewer errors, fewer claims, and lower costs.

CRPs are most successful when quality and safety are prioritized within an organization, and leadership and staff work to align internal processes and incentives with those priorities. Organizations that communicate this, and set clear expectations that management and staff actions should consistently reflect these priorities, are best prepared to implement CRPs. CRPs, in turn, can reinforce a culture that is just and accountable and values honesty and transparency.

Finally, it can be helpful for members of leadership to speak to those who have implemented a robust CRP. Our team has worked with more than 500 organizations on CRP implementation, so we often are asked to provide the ROI information we have learned thus far and facilitate
conversations between those who are curious about implementation and those who have embarked on their CRP journey.

I think that a care manager or a case manager should have been in the room. Or perhaps a clinician?
These are good suggestions. The most important factor is that the person who attends should have knowledge of the resident’s clinical course.

In the video, could staff members have provided the resident’s son with some information to ease his anxiety prior to having him come in to the facility?
Yes, there should have been more planning and preparation, including the provision of some information.

Depending on the cultural background of the resident, it could be important to consider the gender, age, and communication style of staff participating.
This is a helpful resident-centered approach to difficult conversations. It is also important to be mindful of language barriers or the presence of hearing impairment.

Why isn’t the patient part of the conversation, even by tele-video? He needs to hear this from the patient.
In this case, the resident requested they not be part of this conversation, but, if the resident wishes to participate that should factor in to your approach.

Feel like there should be end-of-life exceptions and concessions made for family to say "goodbyes".
Some organizations report that they are providing for some of these exceptions.

What support system does he have? Is there a social worker or a spiritual support person for him?
Such support should be provided prior to or after the conversation.

I’m glad they are not using a conference room. I always recommend removing physical barriers or these conversations when possible. It is good to have 24-hour contact phone number because lack of that communication tool has been a huge source of dissatisfaction during the past couple of months without visitation.
Agree – this is a “best practice” that many organizations have developed.

It is interesting to think about the effect of offering a tissue—the son reacted to it! It can be a confusing because some people will interpret it to mean that you want the person to stop crying, but your true intent is to acknowledge his distress!
There has been quite a bit of controversy around the “tissue issue.” Video viewers seem split at around 50/50 on the opinion as to whether offering tissues is a message to stop crying or an empathic gesture. Most have concluded that it will be “context specific” and case-by-case as to appropriateness, but tissues should always be available during “difficult” conversations.
I still do not understand why if someone has COVID-19 and the family wants to be there, even one person, why this cannot be allowed if they are willing to take the risk? From the public policy perspective, the concern relates, in part, to the spread of the virus beyond the visitor to others they may come in contact with after leaving the aging services organization.

What advice can you give to staff members who get choked up or emotional when relaying difficult news? Should they avoid that? Or let it happen? It is okay to become emotional when sharing difficult news. I have always recommended to “let it happen.” But if you cannot stay composed enough to share the important information then reconsider being the primary communicator.

How do you determine the number of staff members so that you have enough staff to provide support, but not so many that family members feel overwhelmed? It seems like it would be a tough balance. Social worker, Chaplain...
There are a couple of useful approaches. Often it is recommended to keep the number of “communicators” or “supporters” to no more than one in excess of the number of family members. You also can ask the family or family member who they would like to be present. It is important to remember that there can be multiple conversations and others with whom the family wants to meet can be present at a later meeting.

Touching an individual is only appropriate if you know it does not violate the person’s cultural preference.
Completely agree and, sometimes, just asking permission is recommended. “Can I give you a hug?” or “I wish I could give you a hug.”

How do organizations handle resistance to vulnerability that arises from a stoic coping strategy that’s common in health care?
There is a lot of work being done in this area by the Institute for Empathy and Compassion at UCSD and their Mindfulness Institute. They are producing an abundance of data demonstrating the power of empathy and compassion. They are in the process of incorporating these concepts into undergraduate and graduate health sciences education. There is a big need to “educate the young” to change the culture.

Can we get certification of attendance for continuing Education documentation?
Yes, attendees of the webinar will receive an email with the issued certificate.