Time-critical telephone conversations in the emergency department: lessons learnt from a pilot educational project to improve communication skills over the telephone in response to the COVID-19 global pandemic

Sarah Edwards, Lisa Keillor, Lorna Sandison, Abigail Millett, Ffion Davies

ABSTRACT
In many countries, the COVID-19 pandemic resulted in restricted hospital visiting by relatives. Staff have been forced to deliver unwelcome and bad news over the telephone. There are few training resources around how to do this. We created a bespoke training package consisting of a 15 min eLearning session and a 1-hour facilitated role-play session. Two simulated telephone calls to a professional actor posing as the relative were undertaken on a speakerphone. Following each simulated call, the actor gave feedback to the caller, focusing on the likely experience of a relative during these conversations. Elements specific to telephone conversations included ensuring the safety of the recipient to take the call (eg, not driving a car), ensuring they had adequate local support, and allowing a deliberate silence after delivering the bad news. Silence has a powerful impact, despite being uncomfortable. The opportunity to have written notes before calling and to offer a return call was seen as an opportunity for improving communication. We collated these experiences into a series of phrases found most useful and empathic by the actor and participants. A practical aide-memoir was created from this learning that could be used to help deliver bad news quickly in the emergency department.

INTRODUCTION AND BACKGROUND
The global COVID-19 pandemic has brought about many challenges to the emergency medicine (EM) community around the world. To reduce the spread of COVID-19, many hospitals restricted visiting.1–3 Difficult conversations over the telephone in time-critical situations has been an unexpected consequence and a challenge of the pandemic.3 Staff in emergency departments (EDs) may have to gather information from relatives, if the patient is unable to give the full information, while breaking difficult news of their current (critically ill) condition. Breaking bad news (BBN) is traditionally encouraged as an in-person conversation to optimise communication (such as body language, eye contact and touch).1,4–6 However, during COVID-19, this has had to be modified. BBN in person, let alone via telephone, is a challenging task. Within the ED, there is the added pressure of doing this with patients and their relatives when the physician has only known the patient for a short period of time or not at all. The Royal College of Emergency Medicine in the UK acknowledges and states that BBN is an important skill for healthcare professionals who work in the ED.5

There is limited research in delivering bad news from the ED over the telephone. Models such as SPIKES,6 BREAKS7 and Kayes8 (figure 1) are rooted in the oncology or palliative care setting.6 Here there is often time to build rapport (through regular clinic visits) and deliver bad news in a quiet, unhurried setting. SPIKES is a six-step approach first described in 2000, having been created to assist oncologists with a structure for BBN.6 In 2010, the BREAKS protocol for generic BBN was developed9 with the Kayes 10-step model being developed in palliative care in 1996.5 These models offer a reminder of important concepts that need to be considered for BBN, but these are focused on the face-to-face setting. Undoubtedly, these core concepts apply to everyday EM practice in relation to BBN. However, these models were not set up for the acute setting. Evidence does suggest that BBN is challenging in the ED, with physicians and those they speak to not always understanding or agreeing on what was said.9

Existing training resources usually recommend delivering unwelcome news face-to-face in a planned environment. Reisman and Brown10 offered scenarios around how a telephone barrier can make communication difficult and miscommunication more likely. Their case-based paper does highlight that telephone conversations are challenging and require a different set of skills. Collini et al recognised that training for difficult conversations and BBN is an important skill needed in the ED3 and describe their telephone simulation project. This concept paper will share how our telephone simulation training project has helped us understand best practices for delivering these challenging conversations in the ED and allowed us to form an aide-memoir for practical use.

INTERVENTION DEVELOPMENT
We developed a bespoke training package aiming to provide practice for staff on having difficult conversations over the telephone. This pilot project was set in Leicester Royal Infirmary, ED in the UK, a tertiary university teaching hospital serving a population of 1.1 million people, with approximately

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240,000 annual patient attendances. The project was advertised to doctors and nurses working in the ED through departmental email and social media. For this pilot, we aimed for approximately 10% of staff to attend in the first instance.

The training package comprised two elements: a presession eLearning package followed by a 1-hour facilitated role-play session using trained actors for two simulated calls. The eLearning package (on Google Forms LLC) was created using information from existing ‘delivering bad news’ resources, experiences of senior ED staff and with advice for obtaining information in stressful circumstances from a Leicestershire Police call-handling trainer. The eLearning was reviewed and revised by three experienced EM consultants with input from specialist palliative care nurses.

The role-play session (online supplemental material 1) involved creating a typical COVID-19 scenario (Box 1) based on the types of cases we were seeing in early to mid-2020. Using a small group of senior ED clinicians, we iteratively tested the scenario over one afternoon session with a small group of senior ED clinicians and actors who provided feedback about the scenario to ensure it was realistic from the perspectives of both the clinician and the relative. Following this feedback, the scenario was modified; evaluation and reflection forms were changed; and the session running times were adjusted. We sought to minimise patient-facing time away from the ED to maximise attendance. This resulted in a 1-hour training session with staff allocated to attend in advance of their shift.

Following this, the pilot programme was rolled out over a 6-week period. Learners were initially invited to attend sessions through advertising via email and local social media groups. If there were spaces left on the day, learners were then allocated to sessions. Each group included one actor via telephone, with typically eight learners, two of whom would act as call-makers, with the remainder as active observers. Active observers were encouraged during the calls to reflect on phraseology, tone of voice, pacing and structure that they might use in their future practice, and to share this learning in a group discussion after the call. The script required critical information to be exchanged: scenario 1 conveying grave and uncertain prognosis and scenario 2 delivering news of the patient’s death (online supplemental material 1). The actor gave feedback to the call-maker, reflecting on their experience as a ‘relative’ during these conversations. The actor’s feedback was unscripted and did not follow a set pattern; it primarily covered positive aspects, with suggestions for improvement and any points of clarification. The facilitator used the actor’s feedback to encourage discussion and learning among the group. Feedback was written down and available for participants to take away and reflect on. All forms including actor’s feedback, participant’s reflections and evaluation forms were collected (examples in online supplemental material 1). The data were reviewed looking for useful phrases and structures that could be used in clinical practice.

A total of 61 members of staff (10% of the total ED staff) were trained between May and June 2020, with slightly more doctors (35) than nurses (25) and a medical secretary. We analysed the data from these initial pilot sessions to help understand what learning there was and what could potentially be used in clinical practice. Two of the authors (SE and LK) reviewed observers’ written reflections and suggestions for improvement, actor’s feedback and the evaluation forms.

### WHAT DID WE LEARN?

Preparations for these conversations is crucial. Like face-to-face conversations, the physician should be sure to have the correct patient notes and find a quiet, private space in which to make the phone call. Mental rehearsal for the call ahead is a useful practice. An advantage of the telephone calls over a face-to-face conversation, participants noted, is the ability for the physician to write down a plan for the key points to cover within the call.

One essential aspect of telephone calls the actors emphasised is the need to check if it is a safe time to talk. With most people using mobiles, there are many anecdotal stories of patients having bad news being broken while driving, shopping and at the gym. All BBN teaching emphasises the need for language and tone to be sympathetic and empathetic.1,6,7,10,11 In face-to-face conversations, the physician can use body language or offer tissues or a cup of tea, but with telephone calls, tone and language are the only thing one has.

Understanding what relatives know of the patient’s situation can help to sign post how you approach the next aspect of the call. The actors found it useful for helping to build rapport with someone they had not met as it felt as if the clinician was really trying to understand what was going on. These questions can also provide insight into the relative’s emotional state.10,11

BBN recommendations all suggest that the physician deliver a ‘warning shot’, which allows the receiver of the news to be prepared.4,6,7,10–11 The ‘relatives’ found this even more important over the telephone. They recommended keeping it simple and not going into too much detail at first. For example, after introductions and checking that the person is in a safe place to talk, the person delivering the news should say something like ‘I’m really sorry but the news I have for you is bad. Sadly, a short time ago Jamie died’. Surprisingly, repeated feedback from the relatives was the need to get to the point of death quickly, after an appropriate warning shot. Going into details of what happened, and then finally saying the person died made the relatives feel as if they were being given false hope.

### Box 1 General scenario

A 42-year-old patient, Jamie Smith, is critically unwell and has been ‘red called’ into the emergency room. Paramedics handover that he has asthma. There are no relatives with the patient. There is no information on the hospital system as they don’t live locally and are visiting family. The man looks severely breathless. Prehospital oxygen saturations were 80% on air. It is suspected he has COVID-19. Non-invasive ventilation (CPAP (Continuous Positive Airway Pressure) is commenced. There is no improvement.

One hour later, Jamie has a cardiac arrest and dies.

<table>
<thead>
<tr>
<th>SPKES</th>
<th>BREAKS</th>
<th>Kayes Model – 10 Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>Background</td>
<td>Preparation</td>
</tr>
<tr>
<td>Perception</td>
<td>Rapport</td>
<td>What Does the Patient Know?</td>
</tr>
<tr>
<td>Invitation</td>
<td>Exploring</td>
<td>Is More Information Wanted?</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Announce</td>
<td>Give a Warning Shot</td>
</tr>
<tr>
<td>Empathy</td>
<td>Kindling</td>
<td>Allow Denial</td>
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<tr>
<td>Summary</td>
<td>Summarise</td>
<td>Explain If Requested</td>
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<tr>
<td></td>
<td></td>
<td>Listen to Concerns</td>
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<td>Encourage Ventilation of Feelings</td>
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<tr>
<td></td>
<td></td>
<td>Summarise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Offer Further</td>
</tr>
</tbody>
</table>

**Figure 1** Comparison of some common breaking bad news models.
Box 2 An example of a structure to approach delivering news that a relative has died/is critically unwell over the telephone in the emergency department

**Set-up**
- Gather notes, review previous conversations.
- Rehearse explanations and language.
- For telephone conversations, you can keep notes in front of you.
- Your language and tone are all that is available on the telephone—plan ahead to get them right.
- Tell the team what you are doing.
- Consider taking someone with you.

**Safety**
- Are you in a quiet place where there is minimal chance of being disturbed?
- Is the person on the end of the phone safe to talk? (not driving, at the gym, etc)
- Are you speaking to the person you think you are, and is that the right person to talk to about this patient?
- Are you the right person to have this conversation?

**Situation**
- Check knowledge of events.
- Try not to draw out delivery of unwelcome news.
- Use unambiguous language that is less likely to be misinterpreted.

**Space and silence**
- Allow some silence, with time and space for questions and emotions.
- Remember it is much more difficult to take in information over the telephone, and you only have your voice and words to get your message across, so take your time!
- Consider offering a call back if the person is unable to take things in.

**Suggest**
- Explain what will happen next.
- Avoid too much detail if you have passed on news of death or other unwelcome news—no one is able to take in lots of information when they have received bad news.
- Provide important numbers/information.
- Plan a second conversation (potentially with a different person) if required.

**Sum up**
- Reiterate important information and the plan.
- Provide contact details for further discussions.

**Stop!** These conversations can sometimes be stressful and emotional for you and the other person. Do not be afraid to ask for a few moments to find the right words or even to arrange for someone else to call back if it is not proceeding as you planned.

Are YOU ok?
Do YOU need some time out or an opportunity to debrief?

Giving space and silence after delivering the initial information to the relative gives them time to take it in and digest it. Silence is known to be crucial when news such as this is given.1 6-8 10 11

While on the telephone, everyone making the call found the silence uncomfortable. However, from the ‘relative’s perspective’, it was felt to be a great comfort.

Not all information needs to be given on the first call. As in the face-to-face setting, information such as bereavement services can be discussed later. Offering to call back and check in or call another family member was found to be a useful tool to ensure the well-being of the relative receiving news of a death over the phone. One key point is to ensure that if you say you are going to ring back, this needs to happen.

BBN, especially saying someone has died, be it on the phone or in person, is undeniably an emotionally challenging situation.14 13 14

Allowing the person who has made the call to have time to reflect after may reduce the risk of them overwhelmed by the task. Telling someone that their relative has died is probably one of the most difficult tasks healthcare professionals undertake.6 7 10 11

Additional points from the actor feedback included avoiding medical jargon, speaking slowly and using unambiguous terminology, avoiding over optimism.

**MOVING FORWARD AND CONCLUSION**

Some of the themes that emerged from these trainings are similar to those raised in face-to-face conversations. Elements specific to telephone conversations included ensuring the safety of the recipient to take the call, that is, not driving a car, and ensuring they had adequate local support. Then after delivering the news, allowing a deliberate silence. This has a powerful impact, despite being uncomfortable. Not everything has to happen in one conversation. While it may seem more imperative to do everything in a single phone call, it may be preferable to handle the situation in the same way as when a relative is present in the ED.

The recipient of bad news can be allowed time to digest a small amount of information, and then spoken to again after a short period, when they may have some questions and be ready to take on board the next steps (eg, hospital processes post death).

Our aide memoir (box 2 and online supplemental material 1) could help any caller think about what they need to do for a BBN. This training is now incorporated as a standard part of our induction period for new doctors to our ED.15 To help staff even further, we have combined this learning into a flash card to carry around (online supplemental material 1). Some of the key empathetic phrases from both observers and actors that could be used are in Box 3. Further work is being undertaken to look at the longer-term impact of this...
training. Anecdotally and from feedback received, overall confidence has improved.

Delivering unwelcome news over the telephone has been a consequence and challenge of the COVID-19 global pandemic. Moving into the future, it is likely this form of BBN will need to continue. The skill of communicating over the telephone is useful to staff working in EM and can be enhanced by focused training.

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REFERENCES
5 RCEM. End of life care for adults in the emergency department, 2015.
Example of Session Plan for a Time Critical Telephone Conversations session

**Time Critical Telephone Conversations**

**Preparation**

**Example Session Plan**

**Total time = 60 mins**

**Introduction & Pre-brief**

**Setup:** Show Clinician Prompt Card to Call Maker

- **Room 1**
  - 1x Call maker
  - 1x Facilitator

- **Room 2**
  - 7x Observers
  - 1x Facilitator

**Phone Call 1**

- Time critical telephone Conversation 1
- Feedback from actor to call maker
- Group discussion about what was learnt from call

**Phone Call 2**

- Time critical telephone Conversation 2
- Feedback from actor to call maker
- Group discussion about what was learnt from call

**Session Closure**

- Closing remarks and summary by facilitators.
- Ensure attendance record is completed.
- Ensure actor feedback forms, reflection forms and completed evaluation forms are collected at the end of each session.
- Learners can photograph or photocopy their forms.

Secondary evaluation form distributed via email in 4-6 weeks
The scenario used in a Time Critical Telephone Conversations session

**Time Critical Telephone Conversations**

**Scenario**

**Part 1**

“You are the Emergency Department clinician working in Emergency Room. Within 5 minutes of arrival it is clear that the patient is critically ill, hypoxic, and Non-Invasive Ventilation (CPAP) is being started. It is suspected he has COVID-19”

**Phone call 1:** You are tasked with calling the next of kin (sibling). You need to rapidly obtain their medical history and explain that the are critically unwell.

**Phone call #1** (5 minutes after arrival)

You need to:

1. Establish Jamie’s recent symptoms and medical baseline.
2. Convey how critical the situation is.

**Part 2**

“After an hour, there is no improvement. Jamie goes into cardiac arrest. Despite full advanced life support he dies.”

**Phone call 2:** You are tasked with updating Jamie’s sibling, who you’ve already spoken to. You need to inform them he has died. You can assume you are the same clinician as earlier.

**Phone call #2** (60 minutes later)

You need to:

1. Inform his brother/sister that he has died.
2. Communicate as if you are the same person as in phone call #1.
An Actor Feedback Form

Conversations in the ED  Actor Feedback

Date:  Session Time:  Call 1 / 2 (please circle)

Using the feedback from the actor. Facilitator to fill this in.

Examples of good practice:

Ideas for improvement:

Any other comments:

Use your phone take a photo for use in your appraisal!
An Observer Reflection form

<table>
<thead>
<tr>
<th>Conversations in the ED</th>
<th>Observer Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date:</strong></td>
<td><strong>Session Time:</strong></td>
</tr>
</tbody>
</table>

Here are some helpful areas to consider reflecting on...

<table>
<thead>
<tr>
<th>Introduction and setting the scene</th>
<th>Tone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>Fact finding - Questions asked?</td>
</tr>
<tr>
<td>Effective communication of information</td>
<td>Pace</td>
</tr>
</tbody>
</table>

**Phrases I might use in my clinical practice:**

**Other ideas for my clinical area:**

**Other reflections:**

Use your phone take a photo for use in your appraisal!
The Evaluation for used

Conversations in the ED Evaluation

Date: Session Time: Call 1 / 2 (please circle)

Please circle your answers

<table>
<thead>
<tr>
<th>FY1</th>
<th>FY2</th>
<th>C1-CT3</th>
<th>ST4-ST4+</th>
<th>What Speciality?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Grade SHO</td>
<td>Trust Grade Registrar</td>
<td>Consultant</td>
<td>Nurse (Band 5)</td>
<td></td>
</tr>
<tr>
<td>Nurse (Band 6)</td>
<td>Nurse (Band 7)</td>
<td>Nurse (Band 8+/)</td>
<td>Advanced Nurse Practitioner</td>
<td></td>
</tr>
<tr>
<td>Advanced Clinical Practitioner</td>
<td>Physician Associate</td>
<td>Nursing Student</td>
<td>Medical Student</td>
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</tr>
</tbody>
</table>

Where did you undertake your primary health care degree?

UK European Union Non European Union

Were you the observer or the telephone call maker?

Call maker Observer

With regards to today’s topic on Time Critical Telephone Conversations:

Prior to this course, have you had any FORMAL training (e.g. organised teaching, simulation training, or courses) in this?

Yes No

Have you had previous clinical experience of this?

Yes No

If you’ve had previous experience what was it?

Before completing today’s topic on Time Critical Telephone Conversations how confident did you feel about this?

Not at all confident Lacking Confidence Neutral Fairly Confident Confident

After completing today’s topic on Time Critical Telephone Conversations how confident did you feel about this?

Not at all confident Lacking Confidence Neutral Fairly Confident Confident
Conversations in the ED Evaluation

To what extent do you agree or disagree that your **knowledge has increased**?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

How useful have you found this teaching to meet your training needs?

<table>
<thead>
<tr>
<th>Not at all useful</th>
<th>Not useful</th>
<th>Neutral</th>
<th>Useful</th>
<th>Very Useful</th>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>

Before you came today what were you expecting to learn?

What were you main learning points?

What did you find the most useful?

Any areas for improvement?

Any other comments?

What is your overall rating of the session?

<table>
<thead>
<tr>
<th>Very Poor</th>
<th>Poor</th>
<th>Neutral</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>

Page 2 of 2
A flashcard summarising the aide-memoir

<table>
<thead>
<tr>
<th>Setup</th>
<th>Helpful Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Gather notes, review previous conversations.</td>
<td>● Doctor/Nurseault 112 or Bond 6</td>
</tr>
<tr>
<td>● Rehearse explanations and language.</td>
<td>● “The lines of the department where we look after our most unwell patients.”</td>
</tr>
<tr>
<td>● For telephone conversations you can keep notes in front of you.</td>
<td>● CPR: “When the heart stops, we sometimes press on the chest and use electricity to try to restart it.”</td>
</tr>
<tr>
<td>● Your language and tone are all that is available on the telephone - plan ahead to get things right.</td>
<td>● Ventilation: “Sedative medication and a machine that breathes for them.”</td>
</tr>
<tr>
<td>● Tell the team what you are doing.</td>
<td>● IV: “A right fitting mask that supports the breathing.”</td>
</tr>
<tr>
<td>● Consider taking someone with you.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Safety</th>
<th>Helpful Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Are you in a quiet place where there is minimal chance of being disturbed?</td>
<td>● “Hello, my name is …… I’m a doctor/nurse from Leicester Royal Infirmary Emergency Department. I need to speak about …… Would you be the best person?”</td>
</tr>
<tr>
<td>● Is the person on the end of the phone apt to talk? (not driving, at the gym etc)</td>
<td>● “Are you ready to talk or would you like me to call back in a few minutes?”</td>
</tr>
<tr>
<td>● Are you talking to the person you were about to talk to before you started this conversation?</td>
<td>● “I need to give you some difficult news, would you like to call someone to be with you?”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Situation</th>
<th>Helpful Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Check knowledge of events.</td>
<td>● “This currently unwell, I’m worried that this could be life threatening.”</td>
</tr>
<tr>
<td>● Try not to draw out delivery of unwelcome news.</td>
<td>● “This is unwell enough that he could die!”</td>
</tr>
<tr>
<td>● Use unambiguous language that is less likely to be misinterpreted.</td>
<td>● “I’m so sorry but unfortunately … died a few minutes ago.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Space and Silence</th>
<th>Helpful Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Allow some silence with time and space for questions and emotions.</td>
<td>● “I gave you some time to take this all in, I’ll be right here on the end of the phone with you.”</td>
</tr>
<tr>
<td>● Remember it’s much more difficult to take in information over the telephone, and you only have your voice and words to get your message across so TAKE YOUR TIME!</td>
<td>● “Do you have anyone you can call to support you?”</td>
</tr>
<tr>
<td>● Consider offering a call back if the person is unable to take things in.</td>
<td>● “I’m sorry we had to do this over the telephone.”</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Suggest</th>
<th>Helpful Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Explain what will happen next.</td>
<td>● “You don’t need to do anything right away.”</td>
</tr>
<tr>
<td>● Avoid too much detail if you’ve passed on news of death or other unwelcome news - no one is able to take in lots of information when they have received bad news.</td>
<td>● “We’ll take you through what happens next.”</td>
</tr>
<tr>
<td>● Provide important numbers/information.</td>
<td>● “Is there anyone else you’d like me to call?”</td>
</tr>
<tr>
<td>● Plan a second conversation (potentially with a different person) if required.</td>
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<table>
<thead>
<tr>
<th>Sum Up</th>
<th>Helpful Phrases</th>
</tr>
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<tbody>
<tr>
<td>● Reiterate important information and the plan.</td>
<td>● “I’ll call again in 30 minutes to give you a bit of time to let all this sink in.”</td>
</tr>
<tr>
<td>● Provide contact details for further discussions.</td>
<td>● “Our direct number is …….”</td>
</tr>
<tr>
<td>● “If you call the bereavement team in the morning then they’ll take you through what happens from here”</td>
<td></td>
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<table>
<thead>
<tr>
<th>STOP!</th>
<th></th>
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<tbody>
<tr>
<td>These conversations can sometimes be stressful and emotional for you and the other person. Don’t be afraid to ask for a few moments to find the right words or even to arrange for someone else to call back if it isn’t proceeding as you planned.</td>
<td>Do YOU need some time out or an opportunity to debrief?</td>
</tr>
</tbody>
</table>