


Coversheet for Network Site Specific Group Agreed Documentation

This sheet is to accompany all documentation agreed by Pan Birmingham Cancer Network Site Specific Groups. This will assist the Network Governance Committee to endorse the documentation and request implementation.

Document Title	Guidelines for Communication of Significant News
Document Date	December 2009
Document Purpose	To provide Network-wide guidelines on the communication of significant news to patients and carers.
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References	1. National Manual of Cancer Services (2004). 2. NICE Guidance on Cancer Services, Improving Supportive and Palliative Care for Adults with Cancer (2004).
Consultation Process	1. Network Specialist Palliative Care Audit and Guidelines Sub Group 2. Supportive and Palliative Care Network Site Specific Group. 3. Network Site Specific Groups 4. Network User Partnership Group
Review Date (must be within three years)	December 2012
Approval Signatures: Network Site Specific Group Clinical Chair	
Date Approved by Network Governance Committee 07 /12 / 2009	

Guidelines for Communication of Significant News

Version History

Version	Date	Summary of change/ process
0.1	18.03.09	Developed by Zoeta Brown, Service Improvement Facilitator/Project Lead, Pan Birmingham Cancer Network. Circulated for comments to Dr John Speakman and Dr Jackie Dominey
0.2	20.04.09	Comments from Dr John Speakman and Dr Jackie Dominey included
0.3	20.05.09	Circulated to Lynn Field and Lara Barnish and comments included
0.3	09.06.09	Draft document circulated for initial consultation to the Network Specialist Palliative Care Audit and Guidelines Sub Group (SPAGG)
0.4	23.07.09	Comments included from Psychology NSSG
0.5	07.08.09	Revised document sent to SPAGG and comments included.
0.6	11.09.09	Document sent to Psychology NSSG for comments.
0.6	1.9.09	Sent to all Site Specific NSSGs
0.6	21.11.09	Discussed at the UPG (and posted out 2 weeks prior)
0.7	17.11.09	Following consultation. Prepared for the Guidelines Sub Group
1.0	07.12.09	Approved following discussion and amendments.

1. Scope of the Guideline

This guidance has been produced to support the following:

- 1.1 The communication of significant news to patients and carers within Pan Birmingham Cancer Network.
- 1.2 The peer review measures 1E-114 and 1E-117 (National Manual of Cancer Services 2004).

2. Guideline Background

- 2.1 NICE Guidance on Cancer Services, Improving Supportive and Palliative Care for Adults with Cancer (2004), makes several key recommendations regarding communication.
- 2.2 In summary, only senior clinicians with training should deliver significant news (Recommendation 5), patients should be offered a permanent (usually written) record of the consultation (Recommendation 6), and organisations should commit to ensuring that their staff are trained (Recommendation 20).

- 2.3 This guidance has been developed to support the planned communication of significant news to patients. 'Significant' news refers to information in relation to the illness, treatment or prognosis that will seriously affect the individual concerned. This will have an even greater impact where the news is bad or unexpected.

3. Guideline Statements

- 3.1 The following cancer standards describe good practice for sensitive and effective communication by healthcare teams who work within cancer services or palliative care (National Manual of Cancer Services 2004).
- 3.2 *The staff groups who should give news:* Breaking bad news should be undertaken by a senior professional who is able to deal with questions and discussion around the plan of care that is to be agreed.
- 3.3 *The staff groups who should refer the giving of news to those staff groups in 3.1:* Any health professional who does not have the necessary skills/experience or confidence to deal with a given situation concerning the communication of significant news, must refer to an appropriately trained professional. In the longer term, appropriate professional development should be sought, if applicable.
- 3.4 *Those who should be present when news is given:* Wherever possible the patient should have the opportunity to have a family member/friend with them during significant consultations. The patient also has the right to be alone if that is their wish.
- 3.5 In addition to the consultant, the key worker or clinical nurse specialist should be present or accessible within 2 working days to support the patient (and family if present), to answer questions and to reinforce information. In the community setting this would be the GP, key worker or clinical nurse specialist.
- 3.6 *The setting:* The consultation should take place in a quiet private environment and every effort should be made to minimise interruptions. Inpatients who are not in a single room should be invited, whenever possible, to a private room for the consultation. In a multi-bedded location the curtains should be drawn.
- 3.7 *Ongoing support available in the patient's environment:* The clinician communicating the significant news should ask about the patient's sources of support.
- 3.8 *Breaking bad news:* The technique taught as part of the Advanced Communications Skills Training should be used in the process of breaking bad news, and should include:
- a) Evaluating the patient's understanding.
 - b) Checking the patient wants the information.

- c) Giving the information in small chunks, using suitable language, checking the patient's understanding after each new fact and responding to the patient's reaction.
- d) Observe and respond to signs of emotions/patient concerns.
- e) Summarise the main points and agree a plan based on the patient's response and expectation.
- f) Offer written information to support the verbal information and give appropriate contact numbers.

(See Appendix 1 for more information on the process.)

- 3.9 If the patient's first language is not English, prior arrangements should be made for an interpreter to attend. Except in an emergency, delegation of this to a relative should be avoided, in particular, children should not be translating. In the event that a family member does translate, an interpreter should be provided at a later point to ensure that the patient accurately receives all the information that they need.
- 3.10 Healthcare professionals should share information with the primary healthcare team within 24 hours if significant information has been shared with the patient/family.
- 3.11 *Strategies for dealing with unplanned requests for significant news:* Every effort should be made to ensure that the communication of significant news is undertaken in a planned way, in order to avoid becoming pressured into giving information inappropriately, for example, corridors and other places where privacy cannot be achieved. When such requests are made professionals should try as far as practicable to follow the earlier guidance for breaking bad news.
- 3.12 Information should not be given to others (family and friends) without the permission of the patient. In this situation, the patient will be consulted for their consent and the guidance above should be implemented. Exceptions to this could include unconscious and confused patients, unless it is reasonably thought that these states are temporary or if the patient at an earlier time (when they had capacity) stated they did not want significant others to know. Staff should refer to, and comply with, those parts of the Mental Capacity Act (2005) which relate to advance decisions (sometimes known as 'advance statements').
- 3.13 Giving significant news over the telephone should be avoided unless the patient/carer has specifically negotiated this beforehand or if there is no alternative. If this is to happen it is important to offer a face to face follow-up consultation at the earliest opportunity.
- 3.14 The patient should be offered a permanent record (usually written and individualised for the patient) of important points relating to the consultation.
- 3.15 Once information is given to the patient an important responsibility of the person breaking bad news is to document and ensure other MDT members have information to work with the managed realisation.

- 3.16 Patients and relatives may seek reassurance from other members of the team and tend to do so with non-clinical staff (e.g porters while waiting for a scan). All members of the team should be able to respond sensitively and when necessary refer the issue to another member of the team.

4. Training and Ongoing Development

- 4.1 Core members of cancer multidisciplinary teams, especially consultants and clinical nurse specialists who deal with communicating significant news, should have attended Advanced Communications Skills Training (*Connected*). At least one core member of each Network Site Specific Group should be accredited to level 2 Communication Skills (peer review measure).

5. Patient Information and Counselling

- 5.1 All patients, and (with their consent) their partners/carers, will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the key worker/palliative care team at all times.
- 5.2 Access to specialist psychological support will be available if required.

Monitoring of the Guideline

Implementation of the guidance will be considered as a topic for audit by the Supportive and Palliative Care Network Site Specific Group in 2012.

Authors

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References

1. National Manual of Cancer Services (2004).
2. NICE Guidance on Cancer Services, Improving Supportive and Palliative Care for Adults with Cancer (2004).

Approval Date of Network Site Specific Group

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Approval Date of the Governance Committee

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Approval Signatures

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Name: Diana Webb

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Date: 07/12/2009

Clinicians Guide for Breaking Bad News

Guidelines for Specific Conversations

1. **Breaking Bad News**

Bad News is bad news. You cannot soften the impact, but you can help the patient's adjustment by the way you deliver it. The key is to slow down the speed of transition from perception of wellness to the realisation of life-threatening disease.

2. **Preparation**

- ◆ Make preparations as full as possible, have all information you require, test results, know what key facts you need to provide if the patient wants them.
- ◆ Plan the time (make sure there is enough time) and prepare a place with privacy,
- ◆ Involve a friend or relative if appropriate.

3. **Delivering Bad News**

- ◆ Find out what the patient already knows.
- ◆ Find out how much the patient wants to know.
- ◆ Give a warning signal, e.g. *'I am sorry the news isn't what we hoped for'*.
- ◆ Break the news using simple but clear language
- ◆ Pause: wait for a response.
- ◆ Assess and focus the patient's feelings.
- ◆ Encourage the patient to express his/her concerns.
- ◆ Check the patient understands.
- ◆ Make a plan of action, including as much positive, practical support as possible, but not false reassurance.
- ◆ Ensure a follow-up appointment is available.
- ◆ Check your own state of mind, before seeing the next patient.

4. **Handling difficult questions**

E.g. Is it Cancer? Am I dying? What is going to happen to me?

4.1 **Key points**

- ◆ Find out the patient's perceptions - *'what makes you feel it may be cancer or what makes you feel that you are dying?'*
- ◆ After obtaining a response, repeat the question by asking if there are any other reasons for the patient feeling this way.
- ◆ **If the patient gives no other reason or changes the subject:**
You might say 'you asked about the diagnosis – is that something you would like to talk about? If the patient says no, leave it there – they are probably not ready to have the truth confirmed.
- ◆ **If the patient gives other reasons:**
- ◆ Confirm the patient's thoughts if correct. Invite the patient to express their emotions and provide support if appropriate.

- ◆ Pause to see if the patient spontaneously raises any concerns. If not, invite the patient to voice their concerns: *“Can I ask you what your main concerns are?”*
- ◆ Address realistically, avoid rushing in with premature false reassurances.
- ◆ Invite further questions.
- ◆ Offer to provide information that may be relevant.
- ◆ Ensure continuity of care.

5. Collusion

For example, when a relative puts pressure on a health professional to withhold medical information from the patient.

5.1 Key points

Focus on:

- ◆ Relatives' feelings.
- ◆ Relatives' reasons for not wanting to be truthful.
- ◆ Acknowledging relatives' motives, e.g. protecting the patient from distress.
- ◆ The strain placed on the patient/relative relationship by not being truthful.
- ◆ The relatives' perception of the patient's understanding. Identify any evidence that the patient may already suspect the truth.

Then:

- ◆ Offer to assess the patient's understanding of his/her illness directly.
- ◆ Reassure the relative that information will not be forced onto the patient if he/she does not want to know.

6. Dealing with angry patients/relatives

6.1 Key points

The following strategies can help to defuse the anger:

- ◆ Acknowledge the anger – ‘You seem to be very angry.’
- ◆ Invite the relatives/patient to explain the cause of the anger – *‘Can you help me understand what is making you so angry?’*
- ◆ Listen to their story to get as much information as possible. Focus on the individual's stress/feelings.
- ◆ Apologise if appropriate.
- ◆ Clarify the situation if appropriate – *‘It must be very difficult to see your husband in pain, but we are working very hard to find the appropriate level of pain relief.’*
- ◆ If possible, negotiate a mutually acceptable solution.

7. Exploration of feelings (e.g. anxiety)

7.1 Key points

- ◆ Recognition – non verbal/verbal evidence.
- ◆ Acknowledgement – ‘I can see you are anxious.’
- ◆ Permission – ‘It's OK to be anxious.’
- ◆ Understanding – ‘I want to find out what is making you anxious.’

- ◆ Empathic acceptance – ‘You are anxious because...’
- ◆ Assessment – severity and effects of anxiety.
- ◆ Alteration (if appropriate) – removal of stress, cognitive challenge, boosting coping with strategies, medication.

8. Patients who do not want to talk

The key task here is to assess what is making the patient reluctant to talk.

8.1 This can include:

- ◆ Denial – fact/feeling
- ◆ Lack of knowledge/understanding - low IQ/incorrect information
- ◆ Depression
- ◆ Dementia
- ◆ Disengagement
- ◆ Talking to someone else
- ◆ Previously dealt with ‘wanting to forget’.

9. Handling denial

Denial is when a patient maintains a positive outlook on their illness/prognosis in spite of medical information given to the contrary.

Denial is a coping mechanism. Its function is to protect against distress or other feelings that could be intolerable. Health professionals may explore the denial to determine if it is an absolute barrier to understanding, but forcing through it could lead to severe psychological problems.

9.1 Key points in exploring denial

- ◆ Look for evidence that denial is not absolute (a window), e.g.
 - ‘How do you feel things are going at the moment?’*
 - ‘Has there ever been a moment when you thought things weren’t going to work out?’*
 - ‘How do you see your illness affecting you in the future?’*
- ◆ No evidence of any awareness – leave the situation as it is.
- ◆ Ensure regular follow-up to reassess the denial.

10. Anxiety

The signs and symptoms of anxiety include:

- ◆ Impaired concentration
- ◆ Sleep disturbances
- ◆ Lack of energy
- ◆ Feelings of panic
- ◆ Irritability
- ◆ Tension

References

NHS Cancer Plan (Department of Health, 2000)

Manual of Cancer Services Measures (Department of Health, 2004)

NICE Supportive and Palliative Care Guidance (NICE 2004)