

BREAKING BAD NEWS	Type: Clinical Guidelines Register No: 07064 Status: Public
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Developed in response to:	Improving Supportive and Palliative Care for Adults with Cancer (NICE 2004) Patient complaints and Chelmsford Cancer Services User Group
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Consulted With:	Post/Committee/Group:	Date:
Lyn Hinton	Director of Nursing	May 2018
Angela Wade, Hilary, Bowring, Ali Cuthbertson, Jo Myers	Associate Directors of Nursing	May 2018
Tim Blake	Chaplaincy team lead	May 2018
Dr Nancy Cohn	Psychological Therapies Service	May 2018
Charlotte Hoctor	End of Life Care Facilitator	May 2018

Professionally Approved By:		
Dr Rupa Gupta	Palliative Care Lead Clinician	May 2018

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Author/Contact for Information	Matt Riddleston, Macmillan Lead Cancer Nurse
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1.0 Purpose

- 1.1 The objective of this document is to provide an accessible and practical set of guidelines for all healthcare professionals involved in giving 'bad news' or in other challenging and difficult consultations with patients, relatives and others.
- 1.2 Each of these situations will have its own particular characteristics and individuality. Guidelines are not rigid constraints upon decision-making and do not stop health care professionals using clinical judgement.

2.0 Scope

- 2.1 These guidelines are applicable to all clinical conditions (malignant and non-malignant) in adults. Whilst many of the issues identified here will be applicable to sick children and their families, when working in a child health setting, healthcare professionals will need additional guidance within a developmentally appropriate framework.
- 2.2 Advice and guidelines for the breaking of bad news to children and their parents/carers are available at: www.rcn.org.uk
- 2.3 As any healthcare professional may have to deal with challenging and difficult consultations, these guidelines have wide applicability and should not be seen as profession-specific. It is important to note however, that those using these guidelines must be aware of the limits of their own competence and skills and always work within the governance of their own profession.

3.0 Background

- 3.1 Breaking bad news is one element of patient-professional communication. As a general rule all communications with patients (and their relatives/carers) should be delivered sensitively and in a manner and at a time that fits with their needs and circumstances. The aim should be to establish a dialogue between the professional and the patient (and relatives/carers). The following statements reflect the particular issues that need to be incorporated into a 'bad news' or "significant news" interview. For the purpose of this document the term "bad news" will be employed.
- 3.2 Breaking bad news is one of the more difficult tasks that healthcare professionals have to undertake. However well it is done, there is no getting away from the fact that bad news is bad news. What is clear, however, is the manner in which bad news is broken can have a profound effect on both the recipient and the giver. To do it badly may affect all of a patient's (and their relatives') future contact with the health care professionals involved in their treatment and may impair their quality of life and well-being. It may also result in a formal complaint. If done well, it can form the basis for a helpful and constructive partnership between patients, relatives and the team caring for them.

4.0 Staff using this Guideline

- 4.1 All healthcare professionals may have to deal with challenging and difficult consultations, and these guidelines reflect the multi-professional approach of the teams caring for the patient.

- 4.2 Staff using these guidelines must be aware of the limits of their own competence and skills and always work within the governance of their own profession.
- 4.3 All staff breaking bad news must have the following competencies:
- Ability to elicit the patient's main problems, the perception of these and the emotional, social and physical impact on the patient and their family
 - Ability to tailor information to the patient's needs
 - Ability to check the patient's understanding
 - Ability to elicit the patient's reactions to the information given
 - Ability to determine how much the patient wants to participate in decision-making
 - Ability to discuss treatment options so that the patient understands the implications
 - Ability to maximise the chance that the patient will follow agreed decisions about treatment.
- 4.4 For guidance on the ethical issues around breaking bad news, each practitioner should refer to their professional Code of Conduct.

5.0 Patient Support Pre Interview

- 5.1 An assessment of the patient's communication needs should be undertaken prior to the breaking of bad news by an appropriate health care professional. Where necessary, arrangements, such as the provision of an interpreter booked via the interpreting service, should be made well in advance (The Big word-details can be found on the Trust intranet).
- 5.2 It is important to ensure patients with special needs are accommodated. When patients have special needs such as sensory impairment, learning or physical disabilities staff should ensure that the appropriate support mechanisms are available. This includes an assessment of Mental Capacity. It may be necessary to contact the CNS for Learning Disabilities or the Safe guarding team for advice and support in the delivery of bad news.
- 5.3 It is important to take into account the patient's religious, cultural and ethnic background when conducting this assessment. The on call chaplain would be able to contact a member of the patient's faith community if that would offer the patient the most appropriate support.
- 5.4 It may be helpful for a relative/significant other and/or another member of the team to be present. It should always be checked with the patient who they might want to have with them.
- 5.5 Check who the accompanying person is and what their relationship is to the patient. Treat them politely and respectfully in the same way as you do the patient. Include them in the interview as they may remember more than the patient and check whether they have any questions.

6.0 Communicating with Families/Carers

- 6.1 Working with families/carers can add a layer of complexity to an already difficult situation. It is important to try to ensure that they are involved as far as they can be

without compromising the patient's care or interfering unduly with the patient's autonomy and right to confidentiality.

- 6.2 In general, collusive arrangements with families about 'not telling' should not be entered into. Patients have a right to know and have a right to expect not to be lied to. However, the fears of families need to be addressed sympathetically and their knowledge of the patient can be helpful in guiding your approach. Listen to the family's views (and these themselves may be contradictory) and explain the position and responsibilities of the healthcare professional in this situation. Try, as far as possible, to attain a sensible balance of views about what information should be given to whom and when. Ultimately the lead should be taken from the patient.

7.0 The Setting

- 7.1 When breaking bad news it is particularly important to maximise privacy. Use a private and quiet room whenever possible. The healthcare professional should take appropriate actions to prevent interruptions, for example diverting mobile phones, delegating bleep devices to a colleague and informing other members of staff that you are not to be interrupted. Allow enough time for the interview so neither you nor the patient feel rushed or pressured. Do not try to 'fit it in' at the end of a busy clinic.
- 7.2 Sit at the same level as the patient where possible. This avoids literally 'talking down' to them. Minimise the distance between you and the patient; so for example do not talk from the end of the bed or with one hand on the door handle.
- 7.3 Every effort should be made to ensure the privacy of the patient receiving the "bad news" This might include having to move a patient to a quiet room on the ward if possible.
- 7.4 If possible an alternative exit should be available for patients to use following a consultation where they have received "bad news".
- 7.5 Not all "bad news" is delivered face to face e.g. informing the next of kin of a patient's death by telephone in which case please refer to Care of the dying person and the handling of the deceased guidelines (No. 06059)

8.0 Language

- 8.1 When breaking bad news it is best to keep it simple by using words and language that are appropriate for people without complex technical clinical knowledge. Do not be concerned about making it too basic. A patient's emotional state will limit the complexity of the information that they can take in and remember, particularly in a 'bad news' consultation.
- 8.2 Non-verbal communication can be as influential as verbal communication. Posture, style and manner will affect the progress and outcome of the interview.
- 8.3 Do not use euphemisms that are misleading or ambiguous, for example, use the word cancer rather than growth, tumour or lump.
- 8.4 Always check that the patient and carer/relative have understood what you have told them. Give them time and a chance to ask any questions.

9.0 The Scope of the Interview

- 9.1 Always attempt to give information that is appropriate for the individual patient's needs at that particular point in time. There is no hard-and-fast rule about how much to tell. It is not good practice to have inflexible rules about 'telling', such as 'Everybody must be told everything at once' or 'nobody must be told anything'.
- 9.2 If there is a lot of information to give it may be better to cover it in a number of short conversations rather than one long one. Do not overload patients and carers/relatives with too much information at any one time.
- 9.3 The vast majority of patients want to know the truth and welcome honesty from someone whom they are trusting with their care. Never tell lies or actively hide the truth, as this will lead to a breakdown of trust later on.
- 9.4 The truth can be presented gently and humanely. It does not have to be the 'bitter truth' or presented with bluntness and inhumanity.

10.0 Managing the Interview

- 10.1 The person leading the interview should always introduce themselves and any other member of the team who is present. It is not good practice to break bad news with too many other people in the room or bedside.
- 10.2 Listen to what the patient is saying or asking, so that you can find out the patient's view of the problem and how much she/he already knows. Watch for non-verbal behaviours that may act as pointers for concerns or worries that the patient may have.
- 10.3 Expect to have to repeat some information both in this interview and in subsequent ones. The initial shock of hearing bad news tends to block out the processing of further information. A patient's awareness of the full implications of the news may come gradually rather than all at once.
- 10.4 Do not assume that a patient who does not want to know things is 'in denial'. Patients will deal with as much information as they can at the time, which means that they may seem to be listening selectively. People will often need to come back to things at some time in the future.
- 10.5 Pace the interview and follow the patient's lead, as they will have to take in and digest a great deal of information and handle some powerful emotions. Never give the impression of being in a hurry. Not all direct questions have to be answered with a direct answer. While this is often appropriate there will be occasions that you will need to ask 'I wonder why you are asking that question?' as it may uncover some other concerns which you need to know about.
- 10.6 Patients and/or carers can be very upset and distressed on hearing bad news. This is to be expected and may not be anything to do with the way you have told them. It is important to acknowledge and accept their reactions and allow them to happen. Avoid premature reassurance in an attempt to comfort.

(Refer to appendix 2 for useful tips)

11.0 Closing the Interview

- 11.1 Check whether the patient or carer/relative has any unanswered questions.
- 11.2 Let the patient know whom to contact for further information or clarification. Give written information about local and national information and support services, if available. Let the patient know that it is very common to ask for further clarification, support and advice.
- 11.3 Ask if the patient would like any further support (e.g. specialist nurse or specialist spiritual/religious support) and arrange for this to be set up. In doing this make sure that the patient has the name of the person whom they can contact and how (and when) this contact can be made. It is good practice to let that person know what you have told the patient.
- 11.4 When considering further support this may include the patient's emotional, psychosocial and spiritual needs. Once assessed it maybe required for you or a member of the MDT to refer onto one or other agencies following your assessment of the patient's and carers needs. This may be the MEHT Psychological Therapies Service or the Chaplaincy team.
- 11.5 Allow the patient time and privacy to assimilate the news and to collect their thoughts and feelings. Give the patient and/or relative time to compose themselves (as far as they can) before they leave the room. It can be additionally distressing for them to emerge from a difficult consultation into a crowd of people whilst they are visibly upset. Ideally, there should be a way for them to leave without passing through a busy waiting room.
- 11.6 Check whether the patient can get home safely.
- 11.7 It may be helpful for someone from the team to follow the patient up after a 'bad news' interview to check how he or she is feeling. Where possible, arrange for the patient to have a follow-up visit or telephone call. Patients do not always feel able to call if they have further questions. This should be done within about a week or so from the interview.

12.0 Documenting and Recording the Interview for the Patient.

- 12.1 A written summary, either done then and there or in the form of follow-up letter to the patient may be effective if audio recording facilities are not available. There is no one correct way of doing this. Always ask the patient what they would like and then try to achieve this within the particular context of your service.
(Suggested proforma in Appendix 3)

13.0 Documentation and Communication with the Multi Professional Team

- 13.1 Always document exactly what you have said to the patient in their notes and record their reactions. The following may be used as a minimum:
 - Person(s) present;
 - Actual diagnostic words used;
 - Actual prognostic words used;
 - Treatment intent (curative or palliative);

- Response of patient and supporter;
- Understanding by patient;
- Treatment plan.

13.2 Inform staff on duty and members of the team what has been said and how the patient reacted.

13.3 Inform the patient's GP of the diagnosis, what the patient has been told and their reaction as soon as possible. Clarify within the team who will do this task and record when it has been done. This maybe delegated to the named key worker in the setting of cancer and palliative care.

13.4 Always tell the patient who else you are communicating with and check out any concerns the patient may have regarding confidentiality.

14.0 Post Interview

14.1 It is good practice to review difficult interviews soon after you have done them to allow yourself the opportunity to reflect on your performance.

14.2 Be prepared to ask any staff present to give you feedback on how well you handled the interview. They will have had a chance to observe with less emotional involvement than you. Ask for both positive and negative comments. This can be a reassurance as you may not be aware of how well you have done it!

14.3 The breaking of bad news may occasionally be particularly difficult. It is recommended that initially you seek the support of a trusted friend or colleague to talk over your feelings in this case. Further support can be arranged via your line manager, occupational health or clinical supervision if available.

14.4 Clinicians involved in the delivery of "bad news" may find clinical supervision of benefit and should discuss this with their line manager on how to access this.

15.0 Audit

15.1 The monitoring of these guidelines in practice; both good and bad often only comes to light through informal feedback or via a formal complaint following the death of a patient. It is important that complaints are dealt with promptly and sensitively in line with Trust policy and that feedback and support is offered to both complainant and clinical team involved.

When site specific tumour groups and services conduct a review of their service it is proposed that they are asked what was their experience when being delivered bad news. This could be done via questionnaire similar to Patient experience surveys that are conducted annually in the cancer setting.

15.2 Results of surveys that take into account patient and carer experience of receiving "bad news" for example the national cancer patient experience survey and National Survey of Bereaved People (VOICES) survey should be circulated and action plans developed where indicated.

15.3 The Trust has introduced a Bereaved Carers Feedback survey, the results are fed back to individual clinical teams and a report highlighting themes is presented quarterly to the Trust Patient experience group.

16.0 Training

16.1 It is expected that all senior clinicians who are involved in “breaking bad news” should attend an Advanced communications skills course. This is considered best practice for senior clinicians who deliver direct patient care to patients with cancer.

16.2 Clinicians who work in the non-cancer setting should also have the opportunity to attend an Advanced communications skills course as it is not disease specific and should be agreed with their line manager through the appraisal process.

17.0 References

The Trust is grateful to the Yorkshire Cancer Network whose Guidelines are reflected in this document

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Recording of minimum data set

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Useful web-site

<http://www.breakingbadnews.co.uk>.

www.skillscascade.com/badnews.htm

<https://www.dyingmatters.org/page/TalkingAboutDeathDying>

<https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/individual-needs/talking-recently-diagnosed>

1. SUMMARY

Breaking Bad News Flowchart

(adapted from Kaye 1996)

Step 1. Do I have the facts?

Ensure privacy and set the scene
Find out whom the patient wants present
Ensure a nurse is in attendance



Step 2. What does the patient know?

'What do you understand so far?'



Step 3. Is more information wanted?

'Would you like me to tell you the full details of the diagnosis?'



Step 4. Give a warning shot

'I'm afraid the results are not good'



Step 5. Allowing denial

'It must be very hard to accept this'



Step 6 Explanation/Information giving

Give information in small chunks
Check out understanding



Step 7 Listen to concerns

Allow time for expression of worries and acknowledge their importance.



Step 8 Encourage ventilation of feelings

'How are you feeling now?'
Be aware of common reactions (see appendix No 2)



Step 9 Summarise and plan

Outline the plan of care and explain it
Offer permanent record of important points discussed



Step 10 Offer further discussion

Follow-up appointment, contact from specialist nurse.



Step 11 Communicate with the 'Team'

Inform patient's GP.

Document in notes (see suggested proforma – appendix 3) and initiate appropriate referrals

General Tips for Responding to the Patient's Reactions to Bad News

Whatever the news that has been imparted, the patient and their family may respond in a wide variety of ways. These may include crying, sobbing, ambivalence, anger or silence. Patients may be disorientated and unable to concentrate. It is likely that this experience will remain in the person's memory for a long while and the action taken by professionals can help or hinder their adjustment to the news.

If possible acknowledge the patients feelings and help the patient name them if they can. This is what helps the patient feel listened to and conveys empathy. It is important for the professionals to manage their own discomfort so that they do not block the patient being able to have some space to acknowledge how the news is impacting them.

Professionals must be able to assess and respond to patients and their families appropriately and helpfully when bad news is imparted. Empathy, time and a willingness to listen will all help the distressed patient.

Disbelief

This is a common reaction if the recipient of the bad news had no warning of the situation. It is a normal and understandable reaction to bad news. It takes time, empathy and acceptance to help the person take in the news.

Shock

This response to bad news is apparent when the person is unable to function as before owing to the overwhelming nature of the news. A person's ability to make decisions is significantly reduced and in this situation it may be necessary to curtail the detail of the interview, for example explaining specific treatment options. It may be preferable to arrange another meeting. Be led by the patient as to what are the most important areas to be covered at any one time.

A common shock reaction is silence. The person is unable to respond at all to the information. Some ways of approaching silence are:

- Simply wait until the patient says something
- After a period of silence, ask the patient if they are able to tell you how they are feeling
- Avoid filling the silence with more information

Denial

By giving news at the patient's pace, you are also giving the patient the opportunity to block any more unpleasant news. This apparent inability or unwillingness to accept bad news is known as "denial". This mechanism is generally a transient reaction and a way of coping with life's difficulties.

In responding to denial, it is important to respect the protective nature of it and appreciate that it is a normal response to an overwhelming threat.

Breaking Bad News Record Template (suggested)

Please attach patient identification sticker

Date and time of interview:

Location: Ward/Outpatients

Names of those present:

Name:

Position/Relationship:

Clinical Diagnosis:

Clinical Options for future management and immediate plan discussed:

Detail of the words used when breaking the bad news:

Copy to General Practitioner: Yes/No

Referral to Palliative Care: Yes/No

Referral to District Nurse: Yes/No

Filed in Patients Notes:

Referral to Others (Please Specify) e.g counselling, chaplaincy services

Signature of the Clinician:

Date:

Equality Impact Assessment (EIA)

Title of document being impact-assessed: Breaking Bad News Guidelines

Equality or human rights concern. (see <i>guidance notes below</i>)	Does this item have any differential impact on the equality groups listed? Brief description of impact.	How is this impact being addressed?
Gender	n/a	
Race and ethnicity	It is important to consider the patients preferred language when delivering bad news and assessing whether the patient and carer require an interpreter.	All clinicians to take into account preferred language of their patient and offer interpreter if indicated
Disability	It is important to assess and recognize if the patient has a learning disability or cognitive impairment that may affect their ability to process the "bad news" being delivered	All clinicians to take into account known learning disability or cognitive impairment and act accordingly and refer to relevant Trust policy where indicated
Religion, faith and belief	n/a	
Sexual orientation	n/a	
Age	n/a	
Transgender people	n/a	
Social class	n/a	
Carers	n/a	

Date of assessment: May 2018

Names of Assessor (s): Matt Riddleston, Macmillan Lead Cancer Nurse