**Purpose of this document**

**Aim**

To identify guidance for best practice to ensure that the breaking of bad news, or giving of significant information to patients is in an appropriate environment, with good communication skills, appropriate support and in a sensitive manner.

**Contents**

1. **Introduction**

   Breaking bad news occurs throughout all clinical areas in the Trust. How this news is broken can affect a patient’s understanding of their situation, satisfaction with care and psychological adjustment to their illness.

   The term ‘bad news’ should be taken to mean any information about the patient’s condition/diagnosis, prognosis or treatment which is assumed to be previously unknown to them and or their carers and relatives and which is likely to cause anxiety or distress. This also includes information previously given that has not been fully understood. The patient’s consent must be obtained prior to discussions taking place with a carer or relative.

   The NICE Guidance for Supportive and Palliative Care for Adults with Cancer states:
Key Recommendation 5: Communicating significant news should normally be undertaken by a Senior Clinician who has received advanced level training and is an effective communicator. As this is not always practical, all staff should be able to respond appropriately to patients in the first instance before referring to a Senior Colleague.

Key Recommendation 6: The outcome of consultations in which key information should be recorded in patient’s notes and communication to others professionals involved in their care. Patients should be offered a permanent record of important points relating to the consultation.

Objectives:

- Patients and carers are able throughout the patient pathway to discuss problems concerning the disease, treatments and impact with professionals who are knowledgeable and skilled communicators.
- Health and Social Care professionals listen and respond to patients and carers in a manner that enables decisions to be made in an atmosphere of genuine partnership.
- Patients are given the opportunity to participate in decision making about their treatment and care.

Staff Groups Involved

Ideally bad news or significant information should be given by a senior doctor or nurse who has received communication skills training.

Best Practice Guidance for Breaking Bad News

Planning

The giver of bad news should:

- Confirm the medical facts of the case
- Create an environment in which the patient is comfortable, both seated and considering privacy where possible.
- Allow adequate time and plan not to be interrupted (ie away from phones/bleeps)
- Ask the patient if they would like anyone with them (entirely the patient’s choice e.g. next of kin, friend, confidant, clinical nurse specialist)
- If the patient is a child under 16, information about disease, prognosis and treatment belongs to the parents. Negotiate with the parents to allow the child to be present, as this will encourage openness and avoid later collusion.

2 What does the patient know/suspect?

It is important to establish what the patient knows or suspects before giving further information. This will give the opportunity for clarification of previous misunderstandings, establish the patient’s expectations and give an indication of the sort of language that may be useful. Questions might include:

What do you understand about your condition?
What tests have you had?
How would you describe your illness?
Have you been worried about your illness?

3. **Is the timing right for the patient?**

Useful questions are likely to be:

*Are you ready for us to discuss your test results?*
*We need to talk about your results, do you want me to go over your test results now and explain what I think is going on?* (This gives the patient opportunity to arrange another time or place).

4. **Gentle warning**

Indicate that the situation is serious and that you have some serious news to give. This gives the patient some time to prepare but also to block any further disclosure by changing the subject or asking more questions. The patient may not be ready to hear the information. For example:

*I am afraid your condition looks/is/appears more serious than we thought.*
*I mean, the news is not as good as we had hoped.*
*I mean, the results of your scan/tests are not good.*

5. **Sharing the information**

Give the information clearly, in manageable pieces and in response to the patient’s questions and prior knowledge.

Observe the patients reactions, both verbal and non verbal. If the patient indicates that they have heard enough, stop, give time for the patient to assimilate each piece of information, use simple language and avoid euphemisms such as “little wart” or “shadow” when you mean cancer.

Check the patient understands the information you are giving at frequent intervals during the discussion.
For example:

*I know patients sometimes worry about how they’ll explain all this to their relatives and friends. Would it be helpful for you to go over what you understand from our discussion today?*

Even when bad news is expected there is an element of shock which may last only a minute or two but may also last for a considerable time depending on the seriousness of the news and the impact on the recipient. During this time the patient is unlikely to retain any further information. Allow the patient to be still and silent. If this silence goes on for long, check if the patient needs more time or more information and if they would prefer the consultation to be continued at a later time.

Give the patient time to ask questions and express their worries and concerns. Address further investigations, treatment options and support. It is important to be honest during these discussions rather than over optimistic.
6. **Follow up**

What next? Make sure the patient knows when they will next be seen and by whom so they can prepare further questions.

Offer written information of the consultation, including main points of diagnosis, treatment options.

Document the consultation with the patient in the patient records and inform healthcare professionals as appropriate i.e. ward team, GP.

7. **Housekeeping**

Nobody likes breaking bad news and causing patients to be upset. It is important the healthcare professional recognises this, recognise their own emotional response and take account of their own needs to ensure their care of this and other patients is not affected.

**When a family member asks you not to tell (collusion)**

Information regarding a patient’s diagnosis and treatment belongs to the patient but occasionally a family member, in order to protect the patient from pain and worry, will ask you not to disclose diagnosis and prognosis. Legally the family have no right to make such a request. In this situation the aim is to break the collusion whilst retaining honesty with the patient and not alienating the family.

Try to establish why the family member wants you to collude and discover from the patient what they know or suspect.

Arrange to see both patient and relative together.

Consider referral to Clinical Nurse Specialist or Palliative Care Team.

**Telephone Communications**

Bad news should not normally be given by telephone but there may be circumstances where this is necessary e.g. information regarding sudden deterioration in a patient’s condition. In such circumstances:

- The call should be made in private so that background noise is kept to a minimum and interruptions avoided.
- Identify the person receiving the news.
- Identify what the person receiving the news already knows.
- The recipient must be given the opportunity to attend the hospital (transport may need to be arranged).
- Messages should not be left on answer machines or the equivalent.
- Bad news should not be given over the telephone if there is any risk to safety i.e. if the recipient is driving.

**Translators**

Family members should not be asked to translate in a situation of breaking bad news – see Provision of Interpreting Service to Patients PP219.
Audit/Standards


All senior clinicians giving patients the diagnosis of cancer should have received advanced communication skills training.

Evidence/references

NICE Guidance for Supportive and Palliative Care of Adults with Cancer June 2004

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<th>Dr R Wade and Foundation Year 2 2008/2009</th>
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