

Title: **BREAKING BAD NEWS**

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Classification: Guideline

Directorate: Trustwide

Due for Review:  
10/11/20

Responsible Hospital Palliative Care Nursing Team Leader  
for review: Consultant in Palliative Care  
Associate Director of Nursing for Community Services  
Delivery Unit

[Document Control](#)

Ratified by: Clinical Director of Palliative Medicine

Applicability: All Staff

## **Breaking of Bad News Guidance for Staff to Patients and their Relatives**

### **Introduction**

These guidelines have been devised in line with National directives on the Breaking of Bad News.

- The breaking of bad news suggests that someone has been given a terminal or very serious diagnosis e.g. cancer or that someone is dying or has died. Bad news for patients frequently implies drastic changes in the quality of their life or the ending of their hope for improvement in their condition in the future.

Breaking bad news to patients or their relatives is never easy; it can be daunting and demanding for the health care professional but it is a skill that can be learnt and it is an essential part of the treatment and care which clinical staff offers to patients and their relatives.

Breaking bad news cannot be a one off intervention. It should be viewed as a process, which accommodates the understanding of patients and their relatives and is conducted in a way that allows them to absorb and deal with the news being given to them.

The communication of bad news may involve a number of clinical staff across different teams and across different organisations. It is important that all staff who care for the patient are aware of the information that has been given to a patient and that channels of communication facilitate staff to offer support to them and their relatives.

These guidelines are written to help staff when they have to deliver bad news to patients in order that patients and their families will receive information from staff in a skilled, compassionate, sensitive and professional manner. This applies to all potentially life threatening/life shortening diagnoses whether due to malignant or non-malignant processes.

### **Overall Practice Statement**

Patients and carers will experience effective communication sensitive to their individual needs and preferences such that high quality care is promoted. Staff are supported and educated in best practice for breaking news.

### **Training**

Staff will be offered training via the Breaking Bad News Working Party. This training will be accessible through the Education and Training Directorate. The training will be based on Peter Kaye's 10 approaches to breaking bad news. (See [Appendix 1](#))

**Preparation** (See [Appendix 1](#) and [2](#))

- The sharing of bad news must be a planned and organised arrangement rather than delivered ad hoc. The structure of the delivery must be thought through beforehand.
- The environment should be planned so that: -
  - The patient feels they have the sole attention of the health care professional and that their needs take primacy over other aspects of work for the duration of the session e.g. telephones/ bleeps switched off.
  - The interview is conducted with the maximum privacy available.
  - Clinical areas should have a designated private room which can be isolated from the normal activity of the area.
  - A box of tissues is available.
  - The 'do not disturb' sign is placed on the door (Trust Breaking Bad News Sign).
- All bad news should be given to the patient/family by a healthcare professional with the appropriate training in clinical and communication skills. Ideally this is a member of the multi-disciplinary team involved, supported by other skilled professionals such as a trained nurse or a clinical nurse specialist. Where effectiveness of an individual is questionable the ward or department culture supports remedial action and substitution.
- The process of breaking bad news is shared by ensuring that another member of staff is included when talking to the patient.
- The patient, whenever possible, should be given the opportunity to have someone of their choosing present at the time.
- The communication needs of the patient/ relatives are assessed. If advice needed consider referral or discussion with speech and language therapists.

**The delivery**

- The professional imparting the information needs to be sensitive to the patient's understanding and their needs when delivering life-changing news.
  - If the patient wishes s/he is given the opportunity to receive the information prior to relatives.
  - Collusion with relatives is avoided as this can erode the professional/patient relationship and trust e.g. families asking not to inform patients regarding their diagnosis without offering the patient opportunity to consider if they would wish to be informed.
  - Pay attention to the rate of delivery and the understanding of the patient. The use of pauses during a conversation and checking of understanding can facilitate this. Patients or relatives may decline or deny all or some of the information offered; it is important to support this decision. Further opportunities for discussion should however be offered. The decision is documented.
  - The approach to breaking bad news needs to be adapted to be sensitive to cultural and language differences to the psychological state and the experience of the patient and or carer. Consideration should be given to:

- Using interpreters where needed.
  - Individual developmental needs and disabilities.
  - Using aids, appliances.
  - Speech and language therapists.
- Warning shots e.g. “I’m afraid it looks rather serious” – then allow a pause for the patient to respond. Allow the patient time to consider their own reactions and whether they wish for further information. Even if the patient asks for full information, it is best to disclose this in a gradual step-by-step way such that the patient or relative can let you know if they do not wish to go further.
  - Time is given to allow the patient to understand and accept the information being given to them at their own speed.
  - The patient or family is given the opportunity to ask questions and for information to be delivered on more than one occasion.
  - The bad news is balanced by an explanation of what services are available and how they can access them e.g. contact details for appropriate professionals, support and information access, plans for follow up.
    - Where possible the patient is given written information about their condition / treatment to which they can refer later.
    - A record of the dialogue and the people involved in the interview is written in the medical notes, or in clinic letter. Annotation of exact terminology used is considered good practice.
    - The relevant professionals are contacted regarding the information that has been given to the patient and family, e.g. GP, DN, Rowcroft, Health and Social Care team, Specialist Palliative Care nurse, site-specific nurse, ward team etc.

[Appendix 1 - Peter Kaye: A 10-step approach to breaking bad news](#)

[Appendix 2 - Breaking Bad News Check List](#)

### Peter Kaye: A 10-step approach to breaking bad news

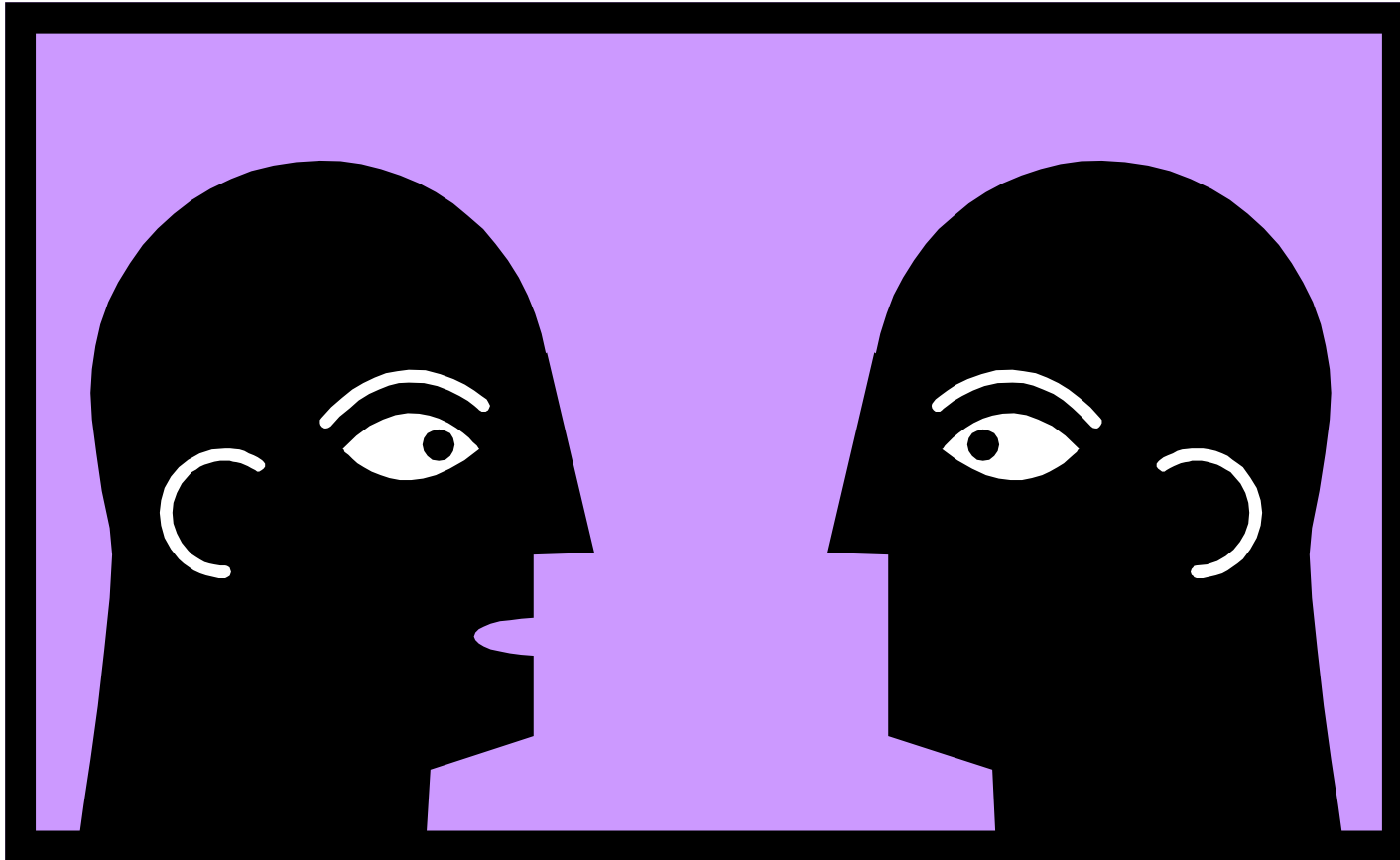
- Preparation  
Know all the facts before the meeting, find out whom the patient wants present, and ensure privacy and chairs to sit on.
- What does the patient know?  
Ask for a narrative of events by the patient (e.g. “How did it all start?”).
- Is more information wanted?  
Test the waters, but be aware that it can be very frightening to ask for more information (e.g. “Would you like me to explain a bit more?”)
- Give a warning shot  
E.g. “I’m afraid it looks rather serious” – then allow a pause for the patient to respond.
- Allow denial  
Denial is a defence, and a way of coping. Allow the patient to control the amount of information.
- Explain (if requested)  
Narrow the information gap, step by step. Detail will not be remembered, but the way you explain will be.
- Listen to concerns  
Ask “What are your main concerns at the moment?” and then allow space for expression of feelings.
- Encourage ventilation of feelings  
This is the KEY phase in terms of patient satisfaction with the interview, because it conveys empathy.
- Summary-and-plan  
Summarise concerns, plan treatment, and foster hope.
- Offer availability  
Most patients need further explanation (the details will not have been remembered) and support (adjustment takes weeks or months) and benefit greatly from a family meeting.

## BREAKING BAD NEWS CHECK LIST

Hospital number  
 Patients Name

ITEM	TICK	SIGN/DATE/COMMENTS
Arrange person to break news.		
Arrange when to hold meeting		
Arrange who to be present Staff/patient/relatives		
Inform all of date/time/place		
Book a room/office for meeting		
Prepare room - Chairs/water/tissues/tea/coffee etc		
Ensure notes/information/results Ready		
Divert phone / put sign on door		
Inform all staff/personnel meeting Taking place		
Give bleep/mobile phone to someone else to answer		
Prepare written information leaflets ready for patient to take away		
Arrange follow up meeting and appointments		
Document meeting in notes		
Remove sign from door /switch phone on /get bleep back		
Inform staff/personnel meeting ended		

# QUIET PLEASE



CONSULTATION IN PROGRESS

Date.....

Time.....

## Protocols & Guidelines – Document Control

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Ref: 0213	Title: Breaking Bad News		
Date of Issue:	10 November 2017	Next Review Date:	10 November 2020
Version:	7		
Author:	Breaking Bad News Working Party		
Index:	Trustwide		
Classification:	Guideline		
Applicability:	All staff		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief.		
Evidence based:	Yes		
References:	Kaye P, Breaking Bad News, EPL Publications (1996) NICE Supportive Guidelines		
Produced following audit:	No		
Audited:	No		
Approval Route:	See ratification	Date Approved:	3 November 2017
Approved By:	Clinical Director of Palliative Care Medicine		
Links or overlaps with other policies:			
All TSDFT Trust strategies, policies and procedure documents.			

### PUBLICATION HISTORY:

Issue	Date	Status	Authorised
1	1 May 1999	New	Medical Director, Director of Nursing & Quality
2	1 September 2001	Revised	Medical Director, Director of Nursing & Quality
3	1 July 2002	Revised	Medical Director, Director of Nursing & Quality
4	1 July 2005	Revised	Director of Nursing & Quality
4	19 July 2007	Revised	Director of Nursing & Quality
4	28 May 2009	Date Change	Lead Cancer Nurse
4	4 September 2009	Publication History Added	
5	2 June 2011	Revised	Lead Cancer Nurse
5	6 March 2013	Date Change	Lead Cancer Nurse
6	24 April 2015	Amended	Consultant in Palliative Medicine Specialist Palliative Care Nurse Team Leader
6	8 September 2017	Date change	Consultant in Palliative Medicine
7	10 November 2017	Revised	Clinical Director of Palliative Care Medicine
7	26 January 2018	Review Date Extended – 2 Years to 3 Years	

## The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

**“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)**

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

[http://icare/Operations/mental\\_capacity\\_act/Pages/default.aspx](http://icare/Operations/mental_capacity_act/Pages/default.aspx)

## Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.



**Rapid (E)quality Impact Assessment (EqIA)** (for use when writing policies)

<b>Policy Title</b> (and number)		<b>Version and Date</b>	
<b>Policy Author</b>			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
<b>Who may be affected by this document?</b>			
Patients/ Service Users <input type="checkbox"/> Staff <input type="checkbox"/> Other, please state... <input type="checkbox"/>			
<b>Could the policy treat people from protected groups less favorably than the general population?</b> <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>			
Age	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender Reassignment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gender	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pregnancy/Maternity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexual Orientation			Yes <input type="checkbox"/> No <input type="checkbox"/>
Religion/Belief (non)			Yes <input type="checkbox"/> No <input type="checkbox"/>
Marriage/ Civil Partnership			Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population?</b> (substance misuse; teenage mums; carers <sup>1</sup> ; travellers <sup>2</sup> ; homeless <sup>3</sup> ; convictions; social isolation <sup>4</sup> ; refugees)			Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Please provide details for each protected group where you have indicated 'Yes'.</b>			
<b>VISION AND VALUES:</b> Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language <sup>5</sup> used throughout?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Are the services outlined in the policy fully accessible <sup>6</sup> ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Does the policy encourage individualised and person-centred care?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy <sup>7</sup> ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
<b>EXTERNAL FACTORS</b>			
Is the policy a result of national legislation which cannot be modified in any way?			Yes <input type="checkbox"/> No <input type="checkbox"/>
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			
<b>Who was consulted when drafting this policy?</b>			
Patients/ Service Users <input type="checkbox"/>	Trade Unions <input type="checkbox"/>	Protected Groups (including Trust Equality Groups)	<input type="checkbox"/>
Staff <input type="checkbox"/>	General Public <input type="checkbox"/>	Other, please state...	<input type="checkbox"/>
<b>What were the recommendations/suggestions?</b>			
Does this document require a service redesign or substantial amendments to an existing process? <i>PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>ACTION PLAN:</b> Please list all actions identified to address any impacts			
<b>Action</b>	<b>Person responsible</b>	<b>Completion date</b>	
<b>AUTHORISATION:</b>			
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
<b>Name of person completing the form</b>		<b>Signature</b>	
<b>Validated by (line manager)</b>		<b>Signature</b>	

**Please contact the Equalities team for guidance:**

For South Devon & Torbay CCG, please call 01803 652476 or email [marisa.cockfield@nhs.net](mailto:marisa.cockfield@nhs.net)

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email [pfd.sdhct@nhs.net](mailto:pfd.sdhct@nhs.net)

**This form should be published with the policy and a signed copy sent to your relevant organisation.**

## Clinical and Non-Clinical Policies – New Data Protection Regulation (NDPR)

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU New Data Protection Regulation (NDPR) in mind and therefore provides the reader with assurance of effective information governance practice.

NDPR intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy.

Furthermore, NDPR requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data. The most effective way of being open is through data mapping. Data mapping for NDPR was initially undertaken in November 2017 and must be completed on a triannual (every 3 years) basis to maintain compliance. This policy supports the data mapping requirement of the NDPR.

For more information:

- Contact the Data Access and Disclosure Office on [dataprotection.tsdf@nhs.net](mailto:dataprotection.tsdf@nhs.net),
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [GDPR](#) page on ICON.