Good communication is essential for safe patient care. Bad communication can have serious consequences. Without a framework the communication of important clinical information may be forgotten or missed. The ISBAR (Identify-Situation-Background-Assessment-Recommendation) technique is a simple way to plan and structure communication. It allows staff an easy and focused way to set expectations for what will be communicated and to ensure they get a timely and appropriate response.

It helps to prevent vital information being missed, provides a recognised framework within which to organise what you want to say and give the opportunity for you to state what outcome you desire from the conversation.

**Identify** – It identifies those to whom the call relates. Verify that you are speaking to the person you are seeking to communicate, state your name, grade and the location you are calling from and identify the name of the patient you are communicating about.

**Situation** - It identifies why you are calling and allows you to state the problem.

**Background** – It gives a summary of information relevant to the current problem this may include medications, laboratory results, diagnostic tests or surgical procedures.

**Assessment** – Summarise relevant information gathered, what has changed, what is your interpretation of this? It describes what you found on examination of the patient, charts and results. It may include an ABC assessment or an Early Warning Score.

**Recommendation** – It allows you to ask for what you would like to happen without hinting or hoping for the right action. It may be that your recommendation is simply to ask for advice. An action plan should be agreed between you.
ISBAR
Communication Tool

<table>
<thead>
<tr>
<th>I</th>
<th>Identify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify: You, Doctor, Patient</td>
<td></td>
</tr>
<tr>
<td>Is this Dr. ______________?</td>
<td></td>
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<tr>
<td>This is _______________</td>
<td></td>
</tr>
<tr>
<td>(e.g. Mary, I am team leader on 7A)</td>
<td></td>
</tr>
<tr>
<td>I am calling about _______________</td>
<td></td>
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<tr>
<td>(e.g. Mr David Jones)</td>
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<table>
<thead>
<tr>
<th>S</th>
<th>Situation</th>
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</thead>
<tbody>
<tr>
<td>Situation: Why are you calling?</td>
<td></td>
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<tr>
<td>I am calling because _______________</td>
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<tr>
<td>(e.g. Total EWS of 6 or 3 in a single parameter)</td>
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</tr>
<tr>
<td>Resp Rate ______ Sats ______</td>
<td></td>
</tr>
<tr>
<td>O2 Delivery ______ Temp ______</td>
<td></td>
</tr>
<tr>
<td>Heart Rate _____ BP _____ Urinary Output _____</td>
<td></td>
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<tr>
<td>LOC _____ (only use abnormal reading initially)</td>
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</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Background</th>
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<tbody>
<tr>
<td>Background: What is relevant background?</td>
<td></td>
</tr>
<tr>
<td>They are ______ years old</td>
<td></td>
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<tr>
<td>Admitted for _______________</td>
<td></td>
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<tr>
<td>Recent surgery or procedures _______________</td>
<td></td>
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<tr>
<td>Relevant past medical/surgical history _______________</td>
<td></td>
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<tr>
<td>They currently have _______________</td>
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<tr>
<td>(e.g. IV fluids, Urinary Catheter, PCA)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>Assessment</th>
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</thead>
<tbody>
<tr>
<td>Assessment: What do you think is the problem?</td>
<td></td>
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<tr>
<td>I think _______________</td>
<td></td>
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<tr>
<td>(e.g. they are hypovolaemic)</td>
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<tr>
<td>(you can skip this if they don’t know what is wrong)</td>
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</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation: What do you want them to do?</td>
<td></td>
</tr>
<tr>
<td>I would like you to _______________</td>
<td></td>
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<tr>
<td>(e.g. come and review him please)</td>
<td></td>
</tr>
<tr>
<td>Is there anything you would like me to do before you</td>
<td></td>
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</tbody>
</table>

Acknowledgement: The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA.
Patient safety and quality are central to the delivery of health care in Ireland. Numerous international studies have identified patients in acute hospitals, whose condition deteriorated unexpectedly, leading to cardiac arrest or even death, may have received suboptimal care. Early changes in patient observations in the 24 hours preceding cardiac arrest or death was evident, but was not detected, or communicated to the appropriate personnel in many cases, leading to a delay in medical intervention.

Early Warning Scores have been developed to assist with early detection of patient deterioration, using a standardised approach to assess acute illness severity and escalate care to a higher level in a timely matter, the focus being on preventing adverse incidents rather than dealing with the consequences.

The National Early Warning Score (NEWS) for non-pregnant adult patients is an aggregate Weighted scoring system, validated for both medical and surgical patients. Six physiological parameters are used as indicators of early deterioration (respiratory rate, heart rate, systolic blood pressure, temperature, neurological status and oxygen saturations). A score of 3 is also assigned if any supplementary O₂ is administered. The parameters are scored between 0 (best) and 3 (worst). These scores are added together and a total score is recorded which is the National Early Warning Score (NEWS). A trend can be seen as to whether the patient’s condition is improving, with a lowering NEWS or dis-improving, with an increase NEWS. If the NEWS is \( \geq 4 \) or 5 on supplementary O₂, and infection is suspected then Screening for Sepsis is triggered.

The NEWS is used for patients who are admitted to medical and surgical wards or on discharge back to the wards from ICU, CCU, Endoscopy suite and Operating Theatre Recovery Rooms. It is also used for all patients, when a decision is made to admit in the Emergency Department.

**Key points about the National Early Warning Score**

- **Action taken early can save lives!!!**
- The NEWS does not replace clinical judgement - if you are concerned about a patient escalate care regardless of the score.
- The NEWS tracks the patient’s condition throughout their hospital stay.
- Abnormal respiratory rate is one of the earliest signs of patient deterioration.
- When certain scores are reached staff must follow the agreed escalation protocol to trigger swift action and bring help to the bedside. A score of 3 in any single parameter must be acted upon immediately.
- The NEWS triggers screening for Sepsis when there is a NEWS of \( \geq 4 \) or 5 if a patient is on supplementary oxygen and if infection is suspected.
- In a small percentage of patients the NEWS does not identify deterioration.
- Always inform the Clinical Nurse Manager if concerned about a patient.
• Where help does not arrive within a certain timeframe the nurse must escalate the care of the patient to a higher level e.g. if the Senior House Officer does not arrive within the timeframe identified for a particular score, or the nurse is not happy with the progress of the patient then the Registrar must be called, or where appropriate the Emergency Response System must be activated.

• Use the ISBAR (Identify, Situation, Background, Assessment, and Recommendation) structured communication tool to relate messages about deteriorating patients (please refer to the ISBAR tool box talk for more information).

• Refer any issues to your hospital implementation governance group/committee.

NEWS - National Clinical Guideline and COMPASS© Education Programme

• The National Early Warning Score – National Clinical Guideline No. 1 was quality assured by the National Clinical Effectiveness Committee, DOH and endorsed by the Minister for Health in November 2014. This National Clinical Guideline can be accessed at: http://health.gov.ie/patient-safety/ncce/national-clinical-guidelines-2/c-d/

• The multidisciplinary education programme, recommended by the National Early Warning Score – National Clinical Guideline No. 1, to support the NEWS is the COMPASS© education programme. The COMPASS© E-Learning programme is now available on HSELand at the following link: https://www.hseland.ie/tohm/portal/. It has been approved by the Royal College of Physicians of Ireland (RCPI) for 8 External CPDs (Continuing Professional Development Credits). This CPD Recognition is accepted by all Irish Medical Postgraduate Training Bodies. The COMPASS© Classroom and E-Learning programmes have both received Category 1 approval by the Nursing and Midwifery Board of Ireland (NMBI) with 8 CEUs (Continuing Education Units) awarded.

More information is available on the website, fast access address as follows: www.hse.ie/go/nationalearlywarningscore/

The motto of the Irish Hospice Foundation is “Living to the End”.

Good end of life care must be about quality of days, enabling each person to live each day until they die. This set of resources is an introduction and does not deal with the specific clinical aspects of care; it gives pointers to where you may be able to locate more information. It may also draw your attention to areas where further training may be required.

It acknowledges that the provision of good end of life care presents many challenges for staff at what is a sad and difficult time for a person and their families. These Tool boxes aim to support staff and provide guidance in looking after a person and their family as they approach the end of their life. How we care for a person at the end of their life absolutely impacts on them but it also has an impact on the family at that time and in their bereavement after that person has died. A whole person approach demands a whole team approach and we believe good end of life care is everybody’s job.

These toolbox talks draw on the belief that end of life care is everybody’s job. HSE Domains of Competence for Palliative Care now exist for most healthcare professions.

1. The Principles of palliative care
2. Communication
3. Optimizing comfort and quality of life
4. Care planning and collaborative practice
5. Loss, grief and bereavement
6. Professional and ethical practice in the context of palliative care
Useful websites

www.irishhospicefoundation.ie

www.hospicefriendlyhospitals.net

All Ireland Institute for Palliative Care Email: info@aiihpc.org, www.dyingmatters.org.uk

Final Journeys staff development programme

Resources

HFH Competence and Compassion – End of Life Care Map
HFH End of Life Resource Folder
HFH/HSE Hospice Friendly Quality Standards for End of Life
HSE/AIIHPC/IHF/IAPC Palliative Care Competence Framework
HSE Inter- Cultural Guide
How can we care for someone as he/she approaches the end of their life... and in the days afterwards

**KEY MESSAGES**

- Keep the person at the centre of all conversations
- Acknowledge and address the family's concerns
- Good end of life care is everybody's job, and continues after death

*To cure sometimes, to relieve often, to comfort always*.
Anonymous physician, 16th century

*If patients couldn't control getting cancer or ultimately dying from it, they wanted power over such issues as treatment decisions, family issues, final days of life and control of arrangements after death.*
- Dr. Debbie Volker

**CARE AFTER DEATH-WHAT HAPPENS NEXT?**

1. Acknowledge loss
   - Family given refreshments and privacy, and information about what happens next.

2. End-of-Life
   - Symbol placed on view
   - Personal belongings placed in Handover Bag

3. Doctor
   - Pronounces death
   - Signs Death Notification Form

4. Inform Nursing Admin/Household/Reception/Mortuary/Porter
   - Complete Care after Death checklist

5. Last Offices*
   - Person's body prepared, ensuring dignity at all times.
   - Appropriate bed drape used

6. Pastoral/Spirtual Care informed, if appropriate
   - Rituals/Prayers

*Last Offices (known as Laying out of the deceased person) refers to the care of a person's body after they have died. Last offices occur when the doctor has certified the person dead and the family have had time to view their deceased loved one.

"If patients couldn't control getting cancer or ultimately dying from it, they wanted power over such issues as treatment decisions, family issues, final days of life and control of arrangements after death."
- Dr. Debbie Volker

"To cure sometimes, to relieve often, to comfort always."
Anonymous physician, 16th century
CONTINUING TO CARE FOR THE PERSON AFTER DEATH

- Ensure dignity, respect and privacy for the person.
- Always refer to the deceased person by name. Leave the person’s body undisturbed for an appropriate time.
- Establish the person’s preferences — check any documented notes of their advance care wishes.
- Gather necessary information and contact numbers for family.
- Last Offices, as per policy — invite the family to play a part (e.g. fixing the person’s hair).
- Prepare the room — use the HFH bed drape and ward altar. (For other cultures, refer to the HSE Multi Cultural Guide for End of Life).
- Place patient’s personal belongings (but not food), in the designated Handover bag.

SUPPORT FOR FAMILY / RELATIVES / FRIENDS

Make sure Next of Kin / Significant Other (s) are informed. Once the person has died, confirm the death to the relatives. Acknowledge the loss. Remember, even though the death may have been expected, it can still come as a shock. Stay with the family until they settle. Then, take your leave, assuring them that you are nearby if they need you. Ensure privacy. Invite people, especially partners/family members, to take five minutes each alone with the person if they want. Inform Pastoral Care, if appropriate. Reassure them that there is no need to rush. Provide refreshments and phone access, if needed, and information on what will happen next. When the family are almost ready to leave, return the person’s belongings in the handover bag and give contact numbers and information on mortuary opening hours, how to collect the Death Notification Form, bereavement support, remembrance services, etc.

Acknowledgements: Irish Hospice Foundation
This tool box talk is based on the National Consent Policy (HSE, 2013) and on the Irish Hospice Foundation’s End of Life Care Map: http://hospicefoundation.ie/what-we-do/hospice-friendly-hospitals/resources-publications/

LEGAL PERSPECTIVE ON ADVANCE CARE PLANS
THE FREEDOM TO DECIDE ONE’S OWN DESTINY IS THE RIGHT OF EVERY COMPETENT PERSON. THIS INCLUDES THE RIGHT TO ACCEPT OR REFUSE MEDICAL TREATMENTS.

BUT IF WE BECOME CRITICALLY ILL, WE MAY NOT BE ABLE TO MAKE THESE DECISIONS. MANY PEOPLE ARE TAKING THE OPPORTUNITY TO PREPARE ADVANCE CARE DIRECTIVES.

ALTHOUGH THESE DIRECTIVES ARE NOT YET UNDERPINNED BY IRISH LEGISLATION, THE LAW REFORM COMMISSION HAS RECOMMENDED THAT ACPs SHOULD BE FOLLOWED “… IF THE TREATMENT IS SPECIFIED, ALL CIRCUMSTANCES OUTLINED ARE PRESENT AND THERE IS NO EVIDENCE THAT AUTHOR HAS CHANGED HIS/HER MIND.”

30% of Irish adults claim that they are comfortable discussing death. 67% believe that it is important to record their preferences for end-of-life care. 70% acknowledge the importance of discussing end-of-life care with those close to them.

Yet, less than 1-in-10 have actually written down or recorded their preferences for care, treatment or their funeral wishes.

Source: Nationally Representative

We all have an idea of how we want our end of life care to be

ADVANCE CARE PLANNING AND DISCUSSION

An advance care planning discussion with a person includes:

- The persons and/or family’s concerns or worries about any aspect of end-of-life
- their values and personal goals for care at this time
- their understanding about their illness and prognosis
- Their preferences for types of care/treatment that may be beneficial in the future. True per son-centered care means taking the time to find out what the person (patient) wants to know and what are their preferences are regarding their end of life care.

These discussions should, ideally, be happening even before the person is admitted to hospital but, all too often, they are not. So, hospital and nursing home staff often have an important role to play too, especially broaching the subject may fall to them and it can be a really important part of person-centered care. The discussion is probably even more important in the following circumstances:

- When it is clear the patient has a life-limiting advanced progressive illness
- When you can answer ‘yes’ to the following question - “would you be at all surprised if this patient was alive in 12 months’ time?”
- If the patient/family have expectations which are inconsistent with clinical judgment (for example, the person thinks that they will be able to live independently again)
- When there is a significant deterioration in the patient’s condition
- When a treatment decision needs to be made
- If disease-specific treatment is not working
- At the time of referring the patient to specialist palliative care services.

It’s really important to us that you are happy here. We want to get to know you and want you to feel comfortable talking to us about your wishes or any worries you might have...

Do you have any worries or wishes about your future care?

We always want to know that we’re doing what you want in relation to your care... We want you to be able to tell us what matters to you.

Have you ever thought about what you might want if you became very unwell...?

Is there anything that you’d like to tell us about looking after you in the future?
Respecting patient’s preferences and choices
Discussing our end-of-life wishes and preferences in good time

RECOMMENDED PRACTICE & SAMPLE PHRASES

The following are some prompts to help you to have conversations with people to help to clarify and capture what they would like for themselves in terms of their future care. (See also the separate Toolbox page on DEALING WITH BAD NEWS for more communication guidance.)

- Start the conversation by finding out from the patient what their level of understanding is of their current condition and prognosis – this helps to establish a common ground. If the patient doesn’t seem to know, it may be worth summarising for him/her what has happened in the patient’s illness to date and then beginning to talk about the current situation.
- Always give the patient the option not to discuss these topics or to defer the discussion to another time. Sample Phrase: “I am very happy to talk to you about any concerns or questions you have about this now or later... Is there anything you would like to ask me about now?”
- Do not make assumptions about the information needs of the patient or of his/her family. Clarify what the patient wants to know and the level of detail they’d like before giving new information. Sample Phrase: “Often people with conditions like yours have a lot of questions that are sometimes frightening or sometimes they’re not certain if they want to know the answer. So if there’s anything you’d like to know, feel free to ask me and I’ll answer as best I can.”
- Explore the patient’s concerns, expectations and fears about the future. Sample Phrase: “What is your biggest concern at the moment?”
- Encourage the patient to ask questions and express their wishes. Sample Phrases: “Is there anything else you’d like to discuss?” “Have you ever thought about where you would like to be cared for in the future?”
- Offer to support the family (as long as the patient has given consent). Sample Phrase: “Would you like me to tell...what we’ve discussed?”
- Consider joint as well as separate discussions with the patient and family (once the patient has given consent) so as to explore and address different people’s information needs.
- Once a terminal diagnosis is made, patients can often feel abandoned. It is important to reassure the patient that you/the team will be there for them throughout their illness. If this is not possible, it is vital that alternative arrangements are spelled out and are reliable. Sample Phrases: “We will do what we can to manage your symptoms and link you in with the services that will support you and your family. You will not be alone in this.”
- Emphasize the available support, such as the palliative care team. Sample Phrase: “We have different ways to relieve (pain/nausea/breathlessness) and other symptoms.”
- It is important to enable the patient to feel control over their illness. Help the patient to identify where control can be fostered, e.g. tidying up unfinished business, arranging to attend a particular event. Encourage patients to share in decision making according to their desired level of involvement. Sample Phrase: “People vary in how they want to make medical decisions. Some people want to make decisions themselves, some want to share decision making with the doctor. What would you like?”

More help on this topic is available from the Irish Hospice Foundation’s Think Ahead website which includes a Conversation Starter kit to help people to think and talk more easily with family and with carers about their end of life care wishes.


Acknowledgement: Irish Hospice Foundation
Key Messages

The survival rate after CPR is only about 13-20% in hospital and even lower if the arrest happened out of hospital.

When a patient is in the final stages of an incurable illness and death is expected within a few days, the success rate of CPR is very low (various studies have suggested it is less than 5%).

A decision not to attempt CPR (DNAR) does not apply to any other treatment and care e.g. IV antibiotics, oxygen therapy, dialysis. There should always be a Care Plan in place which has been developed and reviewed in discussion with the patient.

A person is not obliged to put a DNAR order in place to gain admission to a long-term care setting e.g. nursing home

CPR decisions must always be made on the basis of an individual assessment

When making a decision regarding DNAR, clinicians need to consider:

1. the likelihood of CPR being successful
2. the balance of benefits and risks
3. the individual's goals and preferences

CPR decisions must always be made in the context of advanced care planning. Advanced care discussions could include:

- the patient's concerns
- their values and expectations of care
- their understanding of their illness and prognosis
- their preferences for the future including wishes regarding treatments and place of care

There will be some individuals for whom no formal DNAR decision has been made but where attempting CPR is clearly inappropriate, for example in the final stages of a terminal illness. In these circumstances it is reasonable for healthcare professionals not to commence CPR.

Unethical and inappropriate practices such as "slow coding" and "sham resuscitations" where a full resuscitation is deliberately not attempted must not be performed.

A DNAR order for those close to death does not equate to “doing nothing”. All care provided should follow a palliative approach and focus on easing the patient’s suffering & making him/her as comfortable as possible.
Talking to patients and families about resuscitation

WHAT IS CPR?
CARDIOPULMONARY RESUSCITATION (CPR) including chest compressions, defibrillation (with electric shocks), the injection of drugs, ventilation of the lungs, is an important and potential life saving intervention for victims of cardio-respiratory arrest.

The following outlines some recommendations for clinicians to consider:

It is not necessary to initiate a discussion about CPR with an individual if there is no reason to believe that he/she is likely to suffer a cardio-respiratory arrest.

If a patient has capacity and wishes to participate in decision-making about CPR and DNAR decisions, their input is important.

A patient who has capacity has the right to refuse medical treatment.

When the wishes of a patient who lacks capacity are not known, decisions about CPR must be based on judgment about its benefits and risks for this patient in this particular condition.

For patients who lack capacity, the nature, benefits and risks of CPR as they apply to the patient’s situation should be explained to the family and the CPR decision should be conveyed to them. There is no need to seek permission from the family not to perform CPR however, it is good practice to inform those close to the patient.

When a patient is in the final stages of an incurable illness and death is expected within a few days, the success rate of CPR is very low (various studies have suggested it is less than 5%).

Any decision that CPR will not be attempted should be documented on the patient’s record and details given of the factors that led to that decision. It may also be necessary to consider if/when this decision should be reviewed.

Patients and families should be reassured that a DNAR order does not result in the denial or withdrawal of other treatments that might be thought helpful (for example, radiotherapy or antibiotics). There should always be a care plan in place which has been developed and reviewed in discussion with the patient. Families can also be involved as long as the patient has given consent.

Acknowledgement: Irish Hospice Foundation
Receiving bad news can be traumatic. Don’t make it worse by the way you give the news.

What is Bad News?

This might seem like obvious question, but the answer depends on the recipient of the news: what is bad news to one person (for example, a diagnosis of a life-limiting condition like diabetes) might be perceived as good news to another (‘thank God it’s not worse!’). Bad News is “any information which adversely and seriously affects an individual’s view of his or her future.” Robert Buckman

Five Steps to Breaking Bad News

1. Prepare yourself
   - Set time aside (avoid the "on-the-fly" conversation)
   - Find a quiet private room where you can avoid interruptions (from people as well as from phones or bleeps).
   - Never give information in inappropriate places such as corridors
   - Know all the facts: make sure you have the right patient, confirm test results
   - Have options or treatment plans prepared to discuss with the patient as appropriate
   - Have tissues handy (discreetly)
   - If you can only set aside a few minutes, make sure there are other staff with you who can stay longer with the patient
   - If an interpreter is required, organise in advance and avoid delegating interpretation to a relative

2. Prepare the Patient
   - Find out what the patient knows and wants. Do they want all the details? Would they like their family/friends present? Do they have any particular cultural/religious beliefs/needs?
   - Sit down at the patient’s level (at a 45 degree angle) and introduce yourself and your colleagues

3. Breaking the News
   - Give a “warning shot” and pause
   - Sample phrase: “your test results are back and, unfortunately, the news isn’t as good as we’d like” or “it looks like your disease might have moved to another stage…”
   - Carefully break the news gently, slowly and clearly
   - Avoid jargon and euphemisms - use simple language
   - Chunk: Acknowledge the patient’s emotional reactions
   - Don’t overload the patient with information
   - If necessary, repeat the information
   - Before closing, ask the person to tell you what they have understood about what you are saying-you can correct any misunderstanding, and check-break news into chunks and check understanding of each chunk
"Break bad news well, and you will never be forgotten. Break it badly and you will always be remembered."

4. Supporting the Patient

- Deal with concerns before details; facts may not be remembered but the way they were communicated will be. Allow for silence and tears and avoid false reassurances.
- The person might not be able to take everything in; be prepared to repeat as necessary using supportive written information/diagrams if appropriate.
- Find out if they would like more information.

5. Plan and Follow up

- Give the patient/family (with permission) a clear plan as to what will happen next.
- Have options or treatment plans prepared to discuss with the patient as appropriate and based on patient’s response to the news.
- Avoid phrases like “there’s nothing we can do”. Sample phrase: “There isn’t any specific treatment to make your illness go away, but there is a lot we can offer to help you cope.”
- Offer to meet relatives and/or other staff with the patient.
- Seek the patient’s permission before giving information to others.
- Provide a contact name and number to the patient if they have further questions or require support.
- Find out if there is anyone in particular the patient would like to talk to (e.g., pastoral care).
- Share information with the healthcare team including the GP/PHN and document: a) details of the discussion (using the same language you used with the patient) and b) follow up plan in the patient’s notes.
- Check back with the patient later in the day when they have had a chance to process the news.

BREAKING BAD NEWS OVER THE PHONE

1. Find a quiet room and mentally prepare before you start dialling.
2. Confirm the relative’s identity and their relationship to the patient. Tell them who you are and what your role is.
3. Suggest that the relative sits down.
4. Give a warning shot and pause before breaking the news gently, using simple language. Sample phrase: “I’m afraid I’m calling with bad news.”
5. If there is someone with them, offer to speak to this other person too and/or offer to telephone another family member or friend. When speaking to the next person repeat exactly what you said to the first person to confirm the message.
6. Stay on the phone until the relative indicates that they are ready to end the conversation.
7. Ensure the relative has a contact name and direct line number for you or for one of your colleagues.
8. Contact the hospital reception/security desk and inform them that family members will be arriving. If possible, make it easier for the family by arranging for parking near the entrance to the hospital. Consider sending a taxi to collect the relative if appropriate.
9. Ensure a member of staff greets the family on arrival at the hospital and ward. Document and liaise with the multidisciplinary team.

Ref: HFH Competence and Compassion End of Life Care Map

Acknowledgement: Irish Hospice Foundation
END OF LIFE CARE: ANSWERING DIFFICULT QUESTIONS

“Am I dying?”, “I am not getting better, am I?”, “Can I go home?”, “How long have it got?”...

Being around people at end of life or people who are upset challenges all of us on many levels. There is a focus on keeping patients happy and comfortable. This is not always possible and patients will flag their concerns, sometimes when it is least expected. For example, you may be doing a person’s dressings, giving out medication “these tablets are not really working anymore are they?” While helping a person to wash “I think I am finished”, “I think I am dying”. Such statements are often met with “Not on our shift”, “You’re grand” or “don’t worry” but they really demand more attention from you as a healthcare provider.

It is normal to feel uncomfortable when difficult questions are asked but it’s important not to panic and to find out what lies behind the question.

Conversation triggers

The triggers for 155 conversations with patients, family members and carers when GPs discussed end of life

- Diagnosis (26%)
- Prognosis (14%)
- Deterioration in condition (16%)
- Patient question about future, death or dying (15%)
- Carer question about future, death or dying (10%)
- Patient in pain, distressed, anxious (8%)
- Death, bereavement (3%)
- Ageing (3%)
- Other (3%)
- Not recorded (2%)

There may be an issue for non-clinical staff about how much they might be ‘allowed’ to say (how much clinical information they’re allowed to provide), but the key is that conversations are allowed to happen, that the person is allowed to ask for information, and is not shut down. Keep the communication open.

CAN WE TALK HERE?

When a patient is concerned about something, he/she will carefully chose who to ask or speak to, and this choice will be based on the patient having some sense of who they thought might be the best person for whatever reason.

If the patient is asking you, it is because they believe you will help. Your job is to hold that trust and explore their concerns.

“Research has found that end of life care decisions made too close to death cause unnecessary stress for both patient and families” (C. Grbich et al., 2006)

Lack of discussion can lead to decisions made in crisis, e.g. unnecessary hospital admissions, lack of necessary support being available, family wanting ‘everything’ done because they haven’t had time to process.

A simple response might be:

“Do you feel that bad today?”; “Are you worried about something?”;
“Are you worried about anything in particular?”;
“How can I help?”
Evidence shows that when a person is approaching the end of their lives, he/she can be excluded from all meaningful discussion about what matters to them.

In my role, can I make sure this does not happen to those in my care?

Always remember

1. Deal with concerns before details
2. What is this person most worried about at the moment?
3. I may not have the answer but I can listen and link the person with someone who can

Difficult Questions

The difficulty in responding to difficult questions can often be my own anxiety about having the right answer for the person and wanting to make it better. It is not about having the right answer rather allowing the person to express what it is he/she is worried about and accessing support.

National Audit on End of Life revealed that staff are more comfortable discussing the person’s needs with the family rather than with the person.

Remember !!!!

- Don’t panic!
- Don’t avoid the question
- Don’t rush a response based on your own discomfort
- Keep communication open
- Gently probe to find out what’s behind the question: “What makes you ask that?” or “How are you feeling?” or “What is your biggest worry at the moment?”, “Are you feeling worried/afraid?” or “What do you understand by what the doctor said?” or, simply “How can I help?”
- It’s also okay to say “I don’t know” if you don’t. It might be appropriate to say you cannot answer the question but you will try to find someone that can help.

Be an Active listener:

- Be aware of your body language
- Maintain good eye contact
- If possible sit down with the person.

Key points in listening well

- Don’t interrupt
- Do paraphrase, “What I hear you say is”
- Do clarify, but keep questions until there is a natural pause
- Do give your full attention
- Do not pretend to understand if you do not
- Don’t think of your own input “What will I say next” instead of listening to what the person is saying
- Acknowledge the persons concerns

What Makes Up What We Hear

- Words: 75%
- Tone of Voice: 38%
- Body Language: 45%
Family is who the patient says it is

Key points to remember in supporting families:

- Family can be defined as ‘those closest to the patient in knowledge, care and affection’. This includes the biological family, the family of acquisition (related by marriage, civil, same sex and de facto partners or adoption), and family of choice and friends.
- Communication is key.
- Families need time, space privacy and compassion.
- Families need support with both the practical and emotional aspects of the anticipated loss of someone close and when the person has died.
- It is important to be mindful of the issues that may arise within different death scenarios – expected, sudden, the death of a child, miscarriage, intra-uterine death, stillbirth, neonatal death.

What can I do?

1. Involve family members at the level of involvement they want to have.
2. Provide information and enable family involvement in care.
3. Recognise and allow for different coping styles between family members.

Fundamental to good end of life care is the support we give to the family of the patient we are caring for before, during and after death. While we always need to keep the patient at the centre of care, patient care includes family care. Family- inclusive end of life care should aim to identify the unique needs and abilities of families and to open the lines of communication between family members. We can enhance family support by good communication. Families usually provide the primary support for the person and may also act as mutual support for each other. Support given to families should encompass the domains of care depicted below while recognising social and cultural difference, and diverse family situations and make-up. What do we as a team need to do to meet these needs?

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**Key points for supporting families:**

- **Kindness**
- **Compassion**
- **Preparation**
- **Emotional/Practical**
- **Spiritual**
- **Privacy**
- **Social/Cultural**
- **Information**
- **Respect**
- **Physical/Environmental**
- **Inclusion**
- **Financial**
- **Continuity of Care**

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**Patient Safety Tool Box Talks**

**Effective Care & Support**

**End of Life Care**

**Supporting Families**

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How can we support family members?

Communication

- All communication between healthcare staff and family should be governed by the expressed wishes of the patient and where these are not known, by the best interest of the patient.
- Clear decision making processes should be in place and adopted by all staff, including situations where medical decisions must be made and the patient does not have capacity (see Adv Care disc and CPR/DNAR?).
- Information should be given sensitively in a planned way to ensure time and privacy. Language should be clear and understandable, avoiding jargon (see Dealing with Bad News). Written information may be given to family to take away.
- Support individual family members in their communication with their relative. Each person may need time on his/her own but may not feel they can ask for this.
- Communicate regularly with family members about the care being provided, changes in condition of the patient and about the dying process.
- Prepare families. If families are not aware of what is happening they may miss the chance to say what they need.

Involvement in Care

- With the consent of the patient, families should be offered the choice to be involved in all aspects of care. Involve families at the level of involvement they wish to have.
- Family should be acknowledged as advocates for the patient.
- Families should be encouraged to voice any worries or concerns they may have.
- Family should be seen as playing an important role in assisting with communication with the patient and assisting with their personal care needs if they wish.
- In keeping with the patients wishes flexible visiting arrangements should be in place. While it may be difficult for families they may wish to be there as much as possible, including overnight.

Facilitating family meetings

Family meetings can provide the opportunity to

- Create a partnership / shared care approach
- Listen to family members and clarify their understanding of their relative’s prognosis
- Anticipate their needs in terms of supports. What are they struggling with most at the moment?
- Enable their involvement in care. Including symptom management, communication and assisting with the physical care needs of the patient if they wish
- Explore how the death of the patient may impact upon the physical and emotional health of family members
- Be aware of the fact that each family member is an individual with his/her own coping skills and needs
- Be aware of the possibility of family conflicts and ensure a safe place for people to express concerns.

For further information:

- Quality Standards for End of Life Care
- National Consent Policy
- www.irishhospicefoundation.ie/education/information/training

Acknowledgement: Irish Hospice Foundation
Children experience similar feelings to adults following the death of a significant person in their lives. These include shock, denial, anger, guilt, sadness and fear. However, they often express their feelings differently to adults and can move in and out of grief quite quickly.

**Children’s understanding of death at different ages**

A child’s understanding of death and bereavement will be different at different stages of their development. Although a child’s grief is individual, their understanding of the loss of a loved one progresses as they mature.

- **0-2 Years**: It is common for a baby to become withdrawn or display outbursts of loud crying and angry tears. Maintaining the child’s routine is important.

- **2-5 Years**: Children still do not understand the finality and universal nature of death. They need to know the dead can not come back. They worry they may have caused the death and need reassurance to know that they are not responsible. Their questions should be answered openly and simply.

- **5-8 Years**: Children accept that death is final and universal. This understanding can increase a child’s anxiety regarding the imminent death of other people they are close to. Sometimes they can feel that they need permission to talk about their feelings.

- **8-12 Years**: They understand that death is irreversible, universal and has a cause. Grief can express itself through physical aches and pains and challenging behaviour. Reassurances about changes in lifestyle such as money and whether they can remain in the family home, should be given.

- **13-16 Years**: Teenagers are particularly vulnerable to grief and try to solve everything on their own. They understand the concept of death but do not have the emotional maturity to deal with it. They should not be burdened with adult responsibilities.

**Preparing children for death**

Children need everyone to be open, truthful and honest with them and to give them an opportunity to ask questions.

They must be prepared for what is inevitable to help them to handle it better when the time comes.

Use clear language like “death” and “dead” instead of “lost”, “gone away” or “sleeping”.

Children need to hear that nothing they say or do can cause a death. Often children blame themselves when someone special dies. It is important to reassure them that it is not their fault.

**Should children attend the funeral?**

Children should be given the choice to choose if they want to see the dead body. To make their choice, they should be told clearly what is involved and receive detailed information about each part of it. It should be made clear that they can change their mind if they want to, at any stage.

Children and young people often appreciate taking something of meaning to leave with the body e.g. a card they have made. Give assurance that they can still say good bye even if they don’t attend the funeral.

**Traumatic deaths**

When someone dies in traumatic circumstances there is no time to say good bye. Children can sometimes witness such traumatic deaths and it is important that they receive specialist help in dealing with their grief. These include 1-6 NSS.

**National Support Services**

Barnardos: Tel. 01-4732110, www.icbn.ie
Rainbows: Tel. 01-4734375, www.rainbowsireland.com
ISIDA: Tel. 1850 392391, www.isida.ie
Console: Tel. 01-8574300, www.console.ie
Family Support Agency: Tel. 01-6114100, www.fsa.ie
ICBN: Tel. 01-6793288, www. To be confirmed

**References**

www.winstonswish.org
www.barnardos.org.uk
www.cruse.org.uk
**Level 3**

**Supports Psychotherapeutic Services**

Required by a small number of children. May include psychology, mental health, specialist bereavement counsellors, social work.

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**Level 2**

**Supports**

Listening services: May include Voluntary Bereavement services, Self-help groups (e.g. Rainbows), Bethany Groups.

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**Level 1**

**Supports**

Natural Support Networks: family, friends, school, workplace and community.

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**When does a child need Level 3 support?**

- Persistent anxiety;
- Persistent aggression;
- Social withdrawal, lack of interest in friends and activities;
- Self-blame or guilt about the death, believing they were at fault through something they said, have done or thought;
- Self-destructive behaviour, hurting themselves or expressing a desire to die or to be with the person who has died.

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_Acknowledgement: Irish Hospice Foundation_
This patient safety tool box talk is based on the NICE\(^1\) Guidelines and Quality Standards for End of Life Care in Hospitals (Irish Hospice Foundation)

### Tips for a person who is Bereaved:

If you have experienced a loss, there are a number of things which will help you as you grieve:

1. **Allow yourself to experience the feelings** which come with bereavement even if, at times, they are difficult.

2. **Be gentle with yourself.** Your energy may be low for a while so do not place too many demands on yourself.

3. **Don’t rush things.** You are trying to come to terms with a major upheaval in your life so give yourself permission to take things a bit easier. In general, it is best to put off making major decisions such as moving home or changing jobs for at least six months to a year.

4. **Look after your physical health.** You may find that you have lost your appetite. However, it is important that you eat healthily. Many people find that eating little and often helpful.

5. **Try and get some exercise.** Even a small walk each day can be beneficial.

6. **Make sure you get enough rest and sleep.** This will help you to avoid becoming run down and more likely to pick up infections.

7. **Seek out support from others who are willing to listen.** Talking is important as it helps you express what you are feeling. Try to find one or two people with whom you can simply be yourself and who will allow you to talk when you need to.

### How do I support someone who is experiencing a bereavement?

1. Communicate with people affected by death in a sensitive way
2. Offer support immediately that is appropriate to their needs and preferences
3. Staff are affected by bereavement too—be aware of your own needs and seek support

### What is bereavement?

Bereavement is when we lose something or someone that is important to us. This experience can be especially difficult when someone close to us dies. Making sense of the loss and learning to live without that person is the work of grieving. Grieving is a process rather than an event.

Everyone’s loss is different, therefore, everyone’s grief is different. Grief can be hard at times and it is completely normal to experience a wide range of feelings which can include shock, disbelief, confusion, sadness, loneliness and anger.

### Level 3 Therapy Support

Level 3 Therapy Support is specialised support provided by professionals (psychologists, psychotherapists, counsellors and doctors) and is appropriate for people who develop complications or become stuck in their grieving process (approximately 10-15%)

### Level 2 Extra Support

Level 2 Extra Support is a service usually delivered by trained volunteers who have themselves been bereaved. It may also be provided through a hospital or hospice. (Approximately 25% of people who are bereaved require Level 2 support)

### Level 1 General Support

Level 1 General Support applies to the majority of people who are grieving and involves providing information on the grieving process, practical help with tasks and social support. Family, friends and colleagues will provide much of this support. (Approximately 65% of people who are bereaved require Level 1 support)

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Talking to people who are bereaved is not always easy, but if done with compassion it can make a big difference. Remember:

**What to say**

Don’t worry about trying to find the perfect thing to say - keep it simple e. g.:

- “I’m sorry to hear bout Mary” or
- “Tom, I can’t find the words to tell you how sorry I am”

More important than the words is your compassion

**What not to say**

It is important not to say anything which minimises the loss for the person. E. g.:

- “I heard your father died - we all have to go sometime, or he was very old”

Remember the person who is grieving is the expert on their grief

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**Where can I get more information?**

1. **Bereavement information leaflets:**
   Family Grief - Understanding Grief - Death of a partner etc. Contact: Irish Hospice Foundation (01) 6793188 or www.hospicefoundation.ie

2. **Bereavement booklet:**
   [www.citizensinformationboard.ie](http://www.citizensinformationboard.ie) (search under bereavement)

3. **Quality Standards of End of Life Care:**
   Hospice Friendly Hospitals Program: [www.hospicefoundation.ie](http://www.hospicefoundation.ie) — Ph. 01 6793188

4. **Websites:**
   1. [www.bereaved.ie](http://www.bereaved.ie) - provides advice and information for bereaved people, those supporting them and professionals working with them.
   2. [www.icbn.ie](http://www.icbn.ie) - Irish Childhood Bereavement Network—provides information on supporting children who are bereaved

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*Acknowledgement: Irish Hospice Foundation*
Applying the palliative approach to dementia care can assist in the appropriate identification of the unmet needs of people with dementia, whilst also promoting a continuum of care that focuses on quality of life and values the individuality of the person.

Core Values for Good End of Life Care

1. OPEN THE DIALOGUE ON END OF LIFE CARE.
   Initiating discussions on end of life care allows the person to take a lead role in determining his/her wishes. Family can also provide valuable information in helping to determine the person’s preferences on their future care.

2. DETERMINE THE PERSON’S PREFERENCES.
   Enquire if the person has completed an Advanced Care Plan or if the nursing home has recorded the person’s preferences. Explore the person’s previously expressed wishes on their future care with family and friends.

3. CREATIVE WAYS TO COMMUNICATE.
   People with dementia can struggle to verbally communicate so it is important to closely observe their behaviour and remain vigilant for lucid moments when the person can communicate their needs and preferences.

4. GOOD SYMPTOMS MANAGEMENT.
   People with advanced dementia may be unable to verbally communicate their pain and discomfort so symptom assessments should involve close observations. Referral to specialist teams could be sought if there is difficulty in effectively alleviating the person’s symptoms.

ROLE OF MULTIDISCIPLINARY TEAM IN MEETING THE PALLIATIVE NEEDS OF PEOPLE WITH DEMENTIA

- CARE FOCUSES ON QUALITY OF LIFE
- AVOID UNNECESSARY HOSPITAL ADMISSIONS
- CONTINUUM OF END OF LIFE CARE
- PROVIDE DIGNITY OF CARE

Routine tests and burdensome interventions should only be completed if they aim to benefit the person’s overall wellbeing.

People with dementia can decline when moving to an unfamiliar environment. This admissions can be avoided through advanced care planning & liaison with the medical team.

Ensure documentation clearly explains the person’s end of life preferences and is moved with the person as they transition between care settings.

A range of different mediums can be used to meet the often unmet needs of people with dementia (i.e. touch, smell, meaningful music, photos).
Acknowledgement: Irish Hospice Foundation

References


Key documents & resources


Quotes from Marie Curie Cancer Care (2009).
1. **Definition**: A leg ulcer is a break in the skin of the lower leg which takes more than 4-6 weeks to heal (HSE, 2009)

2. **Causes**:
   - Venous Disease 70%
   - Arterial Disease 15-20%
   - Rheumatoid Arthritis (Less Common)
   - Vasculitis (Less Common)
   - Malignancy (Less Common)

   It is important to know the underlying cause of the ulcer as treatment varies according to the disease process:
   - **Venous Ulceration**: Chronic venous hypertension is the main underlying cause of venous leg ulceration
   - **Arterial Ulceration**: Caused by ischaemia, usually as a result of atherosclerosis.
   - **Mixed Aetiology Ulcers**: Mixed arterial and venous disease (approx 20% of patients with leg ulcers)

3. **Assessment**: should be carried out by a practitioner experienced and knowledgeable in leg ulcer care. A structured **leg ulcer assessment form** should be used and include details about:
   a. **Patient**: the general health of the patient, screening for diabetes, patient and family history of venous or arterial disease.
   b. **Leg**: signs of venous or arterial disease.
   c. **Vascular assessment**: measurement of the Ankle Brachial Pressure Index with a hand held doppler, together with the overall assessment is used to confirm or exclude the presence of arterial disease.
   d. **Ulcer**: site, dimensions, appearance of the wound bed, wound edge, level and type of exudate, the surrounding skin.

**Remember**:
- Leg ulcers of any aetiology can be extremely **painful**.
- Patients with non-healing or atypical leg ulcer should be considered for biopsy to out rule malignancy.
- Bacteriology **swabs** should only be taken where there is clinical evidence of infection.
4. Management: Management of a leg ulcer will depend on the underlying cause of the ulcer e.g. venous or arterial disease.

1. Venous Ulcer Management

- **Compression therapy**: aims to improve venous return and reduce venous hypertension.
  - Multi-layer elastic or inelastic bandages
  - Compression hosiery
  - Intermittent pneumatic therapy

High compression is more effective than lower levels, the general consensus is that pressures in the region of 40mmHg are required at the ankle to reduce venous hypertension. **Compression bandaging should be applied by trained practitioners and in accordance with manufacturers instructions.**

- **Wound Cleansing**: leg ulcers can be cleansed by bathing the leg in warm tap water, irrigation with potable tap water or saline, strict asepsis is unnecessary.

- **Dressings**: simple non-adherent dressings are recommended in the management of venous leg ulcers. Dressing choice depends upon wound circumstances. Routine long term use of topical antiseptics, antimicrobials is not recommended. The peri ulcer skin should be treated with a bland emollient.

- **Systemic Antibiotics**: in patients with chronic venous leg ulcers, systemic antibiotics should not be used unless there is evidence of clinical infection.

- **Exercise and Elevation** should be balanced so that the patient gets adequate rest, but increases muscle activity in the leg.

Management of a patient with a healed Venous Ulcer:

- **Hosiery**: below the knee compression hosiery is advised

- **Surgery**: patients with chronic venous leg ulcer and superficial venous reflux should be considered for superficial venous surgery to help prevent recurrence.

- **Advice**: skin care education and advice regarding continued care.

2. Arterial Ulcer Management

- **Vascular Referral**: refer to vascular specialist for revascularization to restore normal blood flow if possible.

- **Wound care**: keep ischaemic wound as dry as possible to reduce risk of infection.

- **Patient Education**: advice re: stop smoking, control Diabetes, hypertension and hyperlipidaemia. Also give advice regarding foot and leg care, walking...

- **Compression therapy**: is not appropriate for arterial leg ulcers.

3. Mixed Aetiology Ulcers are managed and treated using a combination of both approaches above.

**References:**

- HSE (2009) National best practice and evidence based guidelines for wound management, HSE, Dr Steeven’s Hospital, Dublin 8
- Royal College of Nursing, UK 1998

**Acknowledgements:** Gerardine Craig, CNS Tissue Viability OLOL Drogheda and Maeve Hyland, CNS Tissue Viability, Cavan General Hospital
**Definition:** A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. (NPUAP – EPUAP 2009)

**PREVENTION OF PRESSURE ULCERS**

Each healthcare setting should have a risk assessment policy in place
- A structured risk assessment tool e.g.: Waterlow / Braden should be used which is refined by clinical judgment of risk factors.
- Main risk factors include: Reduced mobility & sensation, poor nutrition & hydration, underlying disease affecting perfusion & oxygenation, unrelied pressure, moisture, friction & shear.
- Repeat and record risk assessment as frequently as required by patient acuity

Inspect skin especially at bony prominences
- Record whether the skin is moist, dry, indurated, unusually warm or cool, broken or discoloured. In dark skin look for purplish / bluish oedema.
- If skin is red note whether the redness is blanching or non blanching on touch (this indicates if capillaries are damaged.
- The European Pressure Ulcer Advisory Panel (EPUAP) Classification system should be used to grade pressure ulcers (see overleaf)
- Assess continence management

**Support surface**
- All foam mattresses on beds and trolleys should be of good quality high density foam with pressure redistribution properties
- Decisions about using a pressure relieving mattresses (dynamic/ electric) should be based on holistic assessment of the individual which includes risk score, skin assessment, general health status, critical care needs and acceptability to the patient.
- Ensure heels are free of bed surface
- For individuals at ‘high’ or ‘very high’ risk of pressure damage restrict the seating to short intervals using a chair / cushion with redistribution properties
- Consult with an Occupational Therapist for advice on specialized seating for individuals with pressure damage.
- Examine the functionality & appropriateness of support surfaces at each encounter

**Plan care in order to minimise risk factors**

**Provide Patient Information**

Repositioning frequency should be determined by the individual’s tissue tolerance, their level of dependency, their general medical condition, service user’s preferences, the overall treatment objective and assessment of the individual’s skin.
- Instigate a written repositioning schedule for individuals who cannot reposition themselves
- Take a 24 hour approach to repositioning which include periods of seating
- Use a 30 degree tilt to increase the range of positions available.
- Keep the elevation of the head of the bed as low as possible in keeping with the individual’s condition
- Do not position the individual directly on a pressure ulcers

**Reference:** HSE (2009) Nat. Best Practice and evidence based guidelines for wound management, HSE, Dr. Steevens’ Hospital, D.8
PRESSURE ULCER MANAGEMENT

It advised that pressure ulcer management strategies should be in line with the European Pressure Ulcer Advisory / National Pressure Ulcer Advisory Panel Guidelines (EPUAP /NPUAP) 2009 Guidelines. The following are highlights of that document only.

- Seat spinal – cord injured individuals with ischial (buttock) ulcers on a seating support surface that provides contour, uniform pressure redistribution and high immersion or off-loading.
- Ideally, ischial ulcers should heal in an environment where ulcers are free of pressure, however this approach should be balanced with physical, social and psychological needs of the individual.
- Limit sitting time for spinal injured individuals with ischial ulcers according to skin tolerance and pressure ulcer response.


**Acknowledgements:** Gerardine Craig , CNS Tissue Viability OLOL Drogheda and Maeve Hyland, CNS Tissue Viability, Cavan General Hospital
WOUND ASSESSMENT

Why carry out a wound assessment?

- To collect information relating to the patient and the wound in order to identify factors which may delay healing
- To plan the management objectives
- To record changes in the wound status
- To evaluate effectiveness of products/interventions
- To communicate with other clinicians
- To improve morale of patient and staff

Assessment Processes

1. Assess the patient’s health and wellbeing:
   a. General health,
   b. Underlying medical conditions,
   c. Medications,
   d. Allergies,
   e. Nutritional status,
   f. Mobility,
   g. Social factors e.g. alcohol/tobacco abuse, and
   h. Quality of life.

2. Assess the wound and document the following:
   a. Location of the wound (may indicate aetiology),
   b. Size: i.e. length x width x depth, undermining, sinuses (measure in cm),
   c. Wound bed - tissue type: i.e. healthy granulation (pink), unhealthy granulation (dark often bleeds on contact), over-granulation, slough (Yellow), necrotic (black, non-viable)
   d. Wound edge (inside perimeter rim): rolled, undermined, callus
   e. Exudate: quality and amount.
   f. Odour: Yes/No.
   g. Surrounding skin: colour, maceration, erythema, induration, eczema.
   h. Infection: document heat, redness, swelling, pain, if clinical signs of infection send swab for culture and sensitivity.
   i. Pain: identify nature and type of pain, use pain assessment tool.
   j. Determine underlying cause of the wound: e.g. pressure damage, trauma, venous or arterial disease, post operative wound infection.
   k. Decide on objectives of wound management

3. Assess the environment where the patient lives/is being cared for: Provision of resources may be limited e.g. access to equipment and constraints of availability of products will influence the management plan.

The purpose of Follow up Assessments is to monitor wound progress, the frequency of follow up will depend on the patient’s condition, severity of the wound and the environment where the patient is being cared for.

Note: Aseptic principles and standard precautions must be applied at all stages of assessment and treatment of wounds.

Tools - the used of standardised tools benefit patient outcomes these include: wound assessment/leg ulcer assessment chart, wound measuring ruler, acetate tracing and photography.

WOUND HEALING PROCESSES

Wound healing is a complex series of events that are interlinked and dependant on one another. Acute wound management usually follow a well defined process described as:
- Coagulation
- Inflammation
- Cell proliferation and matrix repair
- Epithelialisation and remodelling of scar tissue (Dealey 2005)

Chronic wounds however may get ‘stuck’ in the inflammatory and proliferative phase (Ennis & Menses 2000) which may delay healing.

WOUND HEALING OBJECTIVES

The concept of wound bed preparation using the TIME acronym (Schultz et al 2003) allows the clinician to focus systematically on 4 main critical components of non healing and thus establish the objectives of wound treatment. The following is a summary only:

**T**issue non-viable or deficient
Where tissue is non-viable or deficient, wound healing is delayed. Main clinical action is to debride the wound bed by removing devitalised tissue (necrosis / slough). Where debridement is an option the following methods may be used: Sharp (by a trained practitioner), Autolytic (enhanced by dressings), Enzymatic, Larval Therapy & Mechanical.

*Patients with ischemic wounds on their lower extremities, should not be treated with autolytic debriding agents. THESE WOUND SHOULD BE KEPT DRY and patients referred to the Vascular / Surgical team.*

**I**nfection or Inflammation
Host resistance is lowered by poor tissue perfusion, poor nutrition, local oedema and other systemic factors including co-morbidities, medications (eg steroid therapy & immunosuppressive drugs). Main clinical action is to remove infected foci, use of appropriate antimicrobial therapy and antimicrobial dressings.

**M**oisture imbalance
To optimise wound healing, in the majority of wounds, a moist wound environment is desirable. While moisture encourages the breakdown of fibrin and dead tissue, excess moisture can damage the surrounding skin and lead to further skin breakdown. Wounds that get ‘stuck’ in the inflammatory phase have increased exudate production and the wound fluid of these wounds may contain high levels of proteases which have an adverse effect on wound healing.

**E**dge of wound – non advancing or undermining
If wounds fail to epithelialise it is advised to reassess the wound or consider corrective therapies. There are many reasons why the epidermal margins fail to migrate including hypoxia, infection, dessication, dressing trauma, hyperkeratosis and callus at the wound margin (Moffat et al 2004). Undermining or rolling of a wound edge can also influence the ability of the wound to heal. An ulcer with a rolling edge should be considered for a biopsy to out-rule malignancy.

Necrotic Tissue = Black Colour; Slough Tissue = Yellow Colour
Granulation Tissue = Red Colour; Epithelialising Tissue = Pink Colour

References:

Acknowledgements: Gerardine Craig , CNS Tissue Viability OLOL Drogheda and Maeve Hyland, CNS Tissue Viability, Cavan General Hospital
ASEPTIC NON-TOUCH TECHNIQUE (ANTT)

ANTT refers to the infection control methods and precautions necessary during invasive clinical procedures to prevent the transfer of microorganisms from health professionals, procedure equipment or the immediate environment, to the patient.

Principles of ANTT PROCEDURE are:

- Always decontaminate hands
- Never contaminate key parts of sterile materials/equipment or key site
- Touch non-key parts with confidence
- Take appropriate infective precautions e.g. PPE, waste disposal

Asepsis is an accurate and achievable quality standard relating to “the absence of pathogenic microorganisms”.

Key Considerations for Wound Cleansing

The objective of wound cleansing is to remove loosely adherent debris and necrotic tissue from the wound surface to reduce the bioburden on the wound.

Points to consider:

- Does the wound really need cleaning?
- What is the safest method that causes no ill effects?
- What is acceptable to the patient?

Traumatic Wounds: Cleansing bacteria, soil and other debris from traumatic wounds, as well as surgical debridement cannot be overemphasised. Aseptic non-touch technique is not crucial here as tap water in a shower is often used in this situation.

Irrigation is the preferred method for wound cleansing, to minimise trauma and optimise healing of tissue. The solutions used for irrigation are:

- Normal saline: safe for use on all wound types.
- Potable tap water: in contaminated skin lacerations, chronic wounds. The following needs to be considered:
  1. the quality of the water
  2. the nature of the wound, and
  3. the patients’ general condition.

Sterile water: if normal saline is contra-indicated.

Antiseptics: are not generally used for wound cleansing, please seek medical advice.

The classic local signs of infection in acute wounds include:

- Pain
- Erythema (redness)
- Oedema
- Purulent discharge
- Increased heat.

For Chronic wounds it has been suggested that other signs should be added:

- Delayed healing
- Increased exudate
- Friable and exuberant tissue
- New areas of slough
- Undermining
- Malodour and wound breakdown

(Cutting & Harding 1994)

### WOUND PRODUCT CATEGORIES

#### Alginates
They absorb exudate as they change from a fibrous structure to a gel. Suitable for bleeding wounds.

#### Impregnated gauze
Made from open weave gauze or rayon material impregnated with a non medicated hydroactive substance. For minor wounds.

#### Hydrogels
Made from insoluble polymers and have a high water content. Helps to loosen devitalised tissue

#### Hydrofibre
Made from hydrocolloid fibres that gel in the presence of exudate hence can absorb moderate to high levels of exudate

#### Foam
Help to maintain a moist environment at wound surface and are non adherent.

#### Low Adherent
Very little absorbent capacity best on wound with little exudate

#### Non Adherent
Silicone or Paraffin viscoso dressing which is non adherent. For dry, lightly exuding wounds

#### Films
A semi permeable polyurethane film with adhesive. Mostly suitable as a secondary dressing

#### Hydrocolloid
Made from cellulose, gelatins & pectins with a backing of film or foam. Can enhance autolytic debridement

#### Protease Modulator
A range of modern dressings which interact with the wound and modulate enzymatic activity. Some products have high absorbency properties.

#### Antimicrobials
Antimicrobials are impregnated into a variety of dressing types. Indiscriminate use of antimicrobials should be discouraged because of concerns over bacterial resistance and toxicity.

Commonly used antimicrobials in wound care are:

- Iodine
- Silver
- Polyhexamethylene biguanide (PHMB)
- Honey
- Dialklicarbamoyl Chloride (DACC)

(Dealey 2005, Cowen 2011)

### DRESSING TYPE

<table>
<thead>
<tr>
<th>TISSUE TYPE</th>
<th>None to low exudate</th>
<th>Moderate to High exudate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necrotic</td>
<td>Hydrogel</td>
<td>Alginate Hydrofibre</td>
</tr>
<tr>
<td>Infected</td>
<td>Iodine Silver Honey</td>
<td>Silver DACC PHMB Protease Modulator</td>
</tr>
<tr>
<td>Sloughy</td>
<td>Hydrogel Iodoform Iodine Silver Honey</td>
<td>Alginate Hydrofibre Protease Modulator</td>
</tr>
<tr>
<td>Granulating</td>
<td>Low/Non Adherent Hydrocolloid Film</td>
<td>Low/Non Adherent low/Non Adherent Hydrocolloid Film Low/Non Adherent Hydrofibre Alginate</td>
</tr>
<tr>
<td>Epithelialising</td>
<td>Low/Non Adherent Hydrocolloid Film</td>
<td>Low/Non Adherent low/Non Adherent Hydrocolloid Film Low/Non Adherent Hydrofibre Alginate</td>
</tr>
<tr>
<td>Cavity</td>
<td>Hydrogel Impregnated Hydrofibre</td>
<td>Alginate rope Hydrofibre rope DACC rope</td>
</tr>
</tbody>
</table>

Use an outer absorbent dressing as required. Compression Bandaging should be considered for Venous Leg Ulceration

### Acknowledgements

Gerardine Craig, CNS Tissue Viability OLOL Drogheda and Maeve Hyland, CNS Tissue Viability, Cavan General Hospital

Malnutrition is often under-recognised and under-treated. It is mostly preventable and cost effective to treat.

**Key Learning Points:**
1. How common is malnutrition?
2. How are the effects of malnutrition?
3. How to identify malnutrition?
4. How to manage malnutrition?

**Discussion Point:** What goals to set in your ward/unit/centre to improve nutrition care?

1. **How common is Malnutrition? The Facts.**

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>27%</td>
</tr>
<tr>
<td>Care homes</td>
<td>21%</td>
</tr>
<tr>
<td>Mental health units</td>
<td>19%</td>
</tr>
<tr>
<td>Hospital out-patients</td>
<td>16-20%</td>
</tr>
<tr>
<td>GP practices</td>
<td>10%</td>
</tr>
</tbody>
</table>

Malnutrition is common across all care sites. The associated Irish healthcare costs are enormous, estimated at €1.42 billion (11% of total annual healthcare budget), exceeding that of obesity.

2. **How are the effects of Malnutrition?**

- Psychology—depression, apathy
- Ventilation—loss of muscle & hypoxic responses
- Anorexia
- Increased risk of infection
- Liver fatty change
- Decreased cardiac output
- Impaired wound healing
- Loss of strength
- Impaired gut integrity and immunity
- Hypothermia
- Renal function—loss of ability to excrete Na & H₂O

**Inadequately nourished patients have more complications and poorer outcomes**

3. **How to identify Malnutrition?**

Malnutrition is common in certain conditions, for example, cancer, Inflammatory Bowel Disease (IBD), COPD and neurological conditions. Older people are at highest risk, particularly those living alone or with poor social circumstances. Malnutrition can be identified using a validated screening tool such as the "Malnutrition Universal Screening Tool" (MUST) (see overleaf for example). Screening must be linked to an action plan.

**Do not just rely on observation. Obesity and overweight can mask malnutrition. Consider also unintentional weight loss, disease effect and social issues.**
4. How to manage Malnutrition?

The “MUST” Screening Tool (further explanatory notes on www.bapen.org.uk)

Management options can include:

- protected mealtimes, assistance with eating, improving catering options, addressing social issues, and ensuring an individual’s ability to shop.

- adopting a ‘FOOD FIRST’ approach: little and often; frequent snacks; offer milk and milky drinks; choose protein rich foods at each meal (e.g. eggs, meat, chicken, fish)

- oral nutritional supplements may be advised in addition to diet.

- set realistic goals to assess the effectiveness of your management plan: e.g. prevent further weight loss, maintain nutritional status, healing of wounds, improved mobility and improved mood.

- revise the nutrition care plan and adjust accordingly within agreed time frames.

√ record risk √ agree goals of intervention √ monitor and revise

Discussion Point: Reflect on your own practice to identify potential improvements in nutrition care with your patients.

Developed and approved by the Dietitian Managers from Connolly Hospital Blanchardstown; Cavan/Monaghan Hospital; Beaumont Hospital; Our Lady of Lourdes Drogheda and Primary Care Dublin North East.
Some Exceptions to Refusal of Treatment

Obtaining Consent

Next of Kin/Role of the Family

Emergency Situations

“\text{No}” to procedure/Refusal of Treatment

Timely Communication Process

Service User

Informed Consent

Lack of Capacity

Delegation

Voluntary

Age

Capacity

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Please refer to the main HSE Consent Policy for further detailed information

Adapted from Activate Consent Tool by the Rotunda Hospital.
Voluntary
- For consent to be valid the service user must not be acting under duress and their agreement should be given freely, they must understand they have a choice
- Staff should take care to facilitate private discussions with the patient so that ultimately he or she makes their own decision
- Escalate any concerns you may have regarding the voluntariness of consent

Age
- 16+ years for medical, dental and surgical procedures, Non-Fatal Offences Against the Person Act (1997)
- 18+ years for mental health interventions under the Mental Health Act 2001

Lack of Capacity
- If the service user lacks capacity and no other person has legal decision-making authority for her/him, then the health and social care professional should make the decision in their best interests, based on the person’s values and preferences if known.

Informed Consent
- Sufficient information should be provided about the nature, purpose, benefits and risks of a proposed intervention/service.
- The amount of information given will depend on the urgency, complexity, nature and level of risk involved.
- Service users should be asked if they understand the information they have been given, and whether or not they would like more information before making a decision.
- Answer questions honestly and, as far as practical, as fully as the service user wishes.
- Consent should be clearly and accurately documented in the service user’s records

Delegation
- It is the responsibility of the person providing the treatment/service to ensure that informed consent has been given.
- Delegation to another professional is only appropriate where (s) he is sufficiently qualified and trained to be able to accurately communicate the required information to the service user.

Capacity
- Every adult is presumed to have the capacity to give consent to or refuse treatment.
- If the service user is clearly unable to understand the information or communicate a decision, a capacity assessment should be undertaken.
- The test of capacity involves assessing: Does (s) he understand the reason, risks, benefits and alternate options? Does (s) he understand the relevance of their decision? Is (s) he able to retain the information long enough to make and communicate a voluntary choice?

Obtaining Consent
- Consent is a process not a once-off event.
- The validity of consent does not depend on the form in which it is given. Service users may indicate consent orally, in writing or in certain limited circumstances by implication (such as where a service user holds out their arm for a blood pressure reading).
- In all situations, courtesy and respect for the service user is required.
- It is essential to document clearly both the service user’s agreement to the intervention and the discussions that led up to that agreement.

“Next of kin”/Role of the Family
- No other person such as a family member, friend or carer and no organisation can give or refuse consent to a health or social care service on behalf of an adult service user who lacks capacity to consent unless they have specific legal authority to do so.

Some exceptions to refusal of treatment
Although a refusal of treatment by an adult with capacity should be respected, there are some circumstances in which legal advice should be sought: (i) refusal of treatment in pregnancy, (ii) refusal of treatment for isolation of infectious disease, (iii) refusal of treatment by a service user involuntarily admitted under the Mental Health Act 2001, and (iv) refusal to allow blood/urine samples to be taken for Garda investigations.

Emergency Situations
- Treatment may be given without consent in an emergency where the service user lacks the capacity to make a decision or time does not allow the service user to sufficiently understand and appreciate what treatment is required.
- This exception is limited to situations where the treatment is immediately necessary to save the life or preserve the health of the service user.

“No” to procedure/Refusal of Treatment
- Where an adult with capacity to make an informed decision has decided to refuse a treatment or service; this decision/refusal must be respected, even where the service user’s decision may result in his or her own death.
- The discussion of the implications of the decision with the service user and the refusal should be accurately documented.

Timely Communication Process
- Seek consent at a time that is appropriate to the service user and their condition, e.g. if it is an elective procedure, the relevant discussion could take place at an outpatient’s clinic prior to hospital admission.
- Give the service user time to consider their options and ask questions.
- Provide information in a way that facilitates the service users understanding e.g. use simple, clear plain English, avoid medical terminology.
- Use an interpreter, sign language interpretation, visual graphs as appropriate.
- Check the service user’s level of understanding.
Introduction
Healthcare records are legal documents and are designed to provide an overview of the service user’s state of health before, during, and after a particular therapy. The healthcare record should contain sufficient information to identify the service user, support the diagnosis, justify treatment, document the treatment course and results and facilitate continuity of care among healthcare providers.

General Principles
Correct identification of service user- every page should have the forename and surname, identifiable number (MRN) and date of birth. Service user identification should be on every sheet including reverse of double sided sheets and should be verified with the service user on each entry.

Chronological, accurate and complete records- records should be accurate and recorded so as the meaning is clear and intelligible. Records must not be falsified. They must be factual and should not include unnecessary abbreviations, jargon, irrelevant speculation, coded expressions, sarcasm or meaningless phrases to describe service users or care providers. Opinions should be noted as opinions.

Communication with service users and families – the date, time and detail of all communication i.e. face to face meetings, letters and phone-calls must be documented in the service user’s healthcare record.

Specific Requirements

Out-patient/Service user consultations
Entries must be made in the history sheet stating at least any procedures undertaken and the outcome of the consultation (including referrals).

In-patient care
• The admission must be clearly documented both in terms of the requirements of the service user registration, the referral, past medical history, social circumstances, current drug prescriptions, known allergies, physical examination, details of tests ordered and information provided to service users or their carers.
• A working diagnosis and care / treatment plan which should be signed by the appropriate clinician/care professional.
• Any risks or problems that have arisen should be identified and the action taken to deal with them documented.

For nursing records
• Appropriate risk assessments carried out at pre defined intervals post admission and recorded in the nursing care documentation. Care plans, which are prescriptions of care, and evaluation sheets plus any additional documentation
General requirements in relation to making an entry into a Health/Social Care Record

Registration - all aspects of this record must be completely filled in and rechecked on each admission/referral

Legibility - writing is legible, signed by entry maker and using **permanent black ink**

Date and Time– every entry must be dated & timed using 24hr clock

Author Identification- all entries **must** clearly signed with a PRINTED NAME, job title & bleep number and in the cases of doctors and nurses their registered identification number (IMC or N&MBOI). Where students make entries, they must be countersigned by the supervising healthcare professional.

 Corrections, deletions or alterations of contents should be crossed through with a single line, signed, plus name in capitals, dated and time of correct entry and reason for amendment. Entries other than in exceptional circumstances, should be made contemporaneously and before the relevant staff member goes off duty.

Documenting evidence of care - Records should provide information regarding service user’s holistic wellbeing, including any observations or information noted. All entries must be attributable to a healthcare professional. Entries relating to a clinical ward round must identify the most senior doctor present. Where multidisciplinary meetings or assessment forms are documented all members of the MDT present should be identified, since responsibility is shared.

Transfer of responsibility – when the care of a service user is transferred to another consultant the named consultant responsible, time and date of transfer of care must be recorded.

Frequency of records- an entry should be made each time a service user is seen by a clinician. Where there is a time lapse of entries (due to weekend or holiday periods) the next entry should give a reason as to the lapse.

Retrospective entries – these must be dated, timed (24 hr) and signed and also contain a printed name. Reasons for retrospective entry must be clearly stated.

Abbreviations – should not be used on documents for communications, medications sheets, consent forms, death certificates or transfer letters.

Verbal instructions via telephone - should be documented, dated, timed and signed. (Where appropriate counter-signed by colleague within an agreed timeframe).

Test results- should not be filed before they are signed and dated. Results should be signed within twenty four hours of their availability to the clinician. Where abnormal results are evident, it must be documented who was informed and what actions were taken or planned in the health care record.

Medication Prescription and Administration Record – this should comply with clear unambiguous documentation regarding medication management and in keeping with the medication policy.

Language- all records must be written in English, clearly phrased and respectful.

Advice - all advice given by any healthcare professional to service users, including leaflets and education should be documented.

Referral letters- only opened by authorised staff, immediately stamped on receipt, triaged and date recorded and returned to relevant staff within five working days.

Consent – this should be clearly documented in accordance with hospital policy.

Advance Decisions and DNARs - these should be recorded and be in keeping with the service users wishes.

Definition

Healthcare records are legal documents and are designed to provide an overview of the service user’s state of health before, during, and after a particular therapy. The healthcare record should contain sufficient information to identify the service user, support the diagnosis, justify treatment, document the treatment course and results and facilitate continuity of care among healthcare providers.

Role of Healthcare Records

The content of the healthcare record provides an accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The content of each record complies with clinical guidance provided by professional bodies and legal guidance provided by the Clinical Indemnity Scheme. This standard applies to both hardcopy and electronic documentation. Good record keeping, whether at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses such as:

- Helping to improve accountability
- Showing how decisions related to patient care were made
- Supporting the delivery of services
- Supporting effective clinical judgements and decisions
- Making continuity of care easier
- Providing documentary evidence of services delivered
- Promoting better communication and sharing of information between members of the multi-professional healthcare team
- Helping to identify risks, and enabling early detection of complications
- Supporting clinical audit, research, allocation of resources and performance planning helping to address complaints or legal processes.

Key Standards & Practices to be included in the contents of Healthcare Records Management regarding the documentation of the death of a person.

Death entry to be included in the content:

- Date and time of confirmed death, details of what examinations were undertaken to confirm death.
- Events leading to the person’s death and the cause of death.
- Clear signature, PRINTED NAME, job title, bleep number and registered identification number of the medical practitioner confirming death.
- Final diagnosis, to include principal diagnosis and all procedures.
Death notification contents include - information to be entered on the healthcare record of the deceased:

- If family members or others were present at the time of death
- In the absence of family in attendance at time of death, if, how and by whom were the family informed about the death
- Has or will be GP be informed
- Has or will other care services be notified of the death

Care and Documentation after death must include:

- Who provided last offices to the deceased person?
- List of valuables or property within the healthcare setting
- Mortuary transfer documentation
- Part 1 of the Death Notification Form Booklet to be completed
- Cremation medical form if required
- Documentation associated with Hospital Post Mortem Examination or Coroners Post Mortem if required

If the death is reportable to the Coroner, the following information is recorded in the healthcare record:

- The reason why the death is being reported to the coroner
- The name of the person who made the decision to notify the coroner
- The date and time of the notification
- The name of the person who was notified in the coroner’s office
- The decision taken by the coroner’s office regarding post mortem.