Meeting - Saint James's Hospital December 2nd 1999
Notes

Chairs: DD and M F

P Be - Catering Manager
Catering assistant can have between 15-18 contacts with patient/ family per day (check survey)
Staff aren't trained in dealing with families, nor in how to cope themselves
Many have long term relationships with families, are emotionally involved yet this is not formally recognised
There is a need for dedicated space where people can go having received bad news

S D - A&E
Acknowledges difficulties in A&E
They experience sudden and traumatic deaths, can have up to three deaths a day
As a result of the research they intend to facilitate direct admission for palliative care and terminally ill patients who had previously been admitted

E H - Nursing Administration
Acknowledges the centrality of communication
That while palliative care is not available for all the principles should guide action
Difficulties in symptom control to be addressed by increased ownership of the issue by nurses
When is the right time to die?
Support needed for family and for staff

K O'D - General Practitioner
The illness continues into the community as does the need for care
Suggests the need for a community liaison nurse operating out of A&E
Care continues after the death of the patient

M K - Social Worker
Difficulties around bad news and the situation where the question is 'who knows what'
Acknowledges staff upset and the stress they carry in coping with illness and death
Highlighted the resource booklet - 'When someone close dies'
Re-emphasises that death and bereavement are whole hospital issues, not solely palliative care

R S - Medical board
Relatives can be a problem - particularly cross questions during a conversation breaking bad news and a family's own history
A close relationship between one or two relatives and patient best
Difficult to/ not appropriate to build protocols around communication - go with individual circumstances

I C - Deputy CEO
Meets relatives with positive and negative feedback
Negative - Being told about likelihood of death 'Why wasn't I told - in general' 'Why wasn't I told - specific time'
Practical queries about what to do next, about death certificates, funerals

Positive - Feedback about a named member of staff - their kindness/ actions

From the floor

- Death is a part of what we deal with in hospital
- Receiving belongings in a plastic bag - giving them in a plastic bag has effect on staff also
- Medication around the time of death can take the person away in another way, leave regrets about what was not said - communication around medication and its potential effects. Speaker learned through being there 'these are things you know for the second time around'
- Communication to be balanced to the individual patients needs
- Recognising when a patient is beginning to die - care needs to be tailored accordingly - but who is responsible for this? Team communication - listening to each other. Patient communication - hearing the patient. Allowing for the fact that decision can be reversed
- "It's very hard to die in an acute hospital" ; the cure ethos, 'terriers'
- Care assistants provide long term care and get to know families - there is no follow up 'you don't forget, you look at the bed where they used to be' there is no follow up 'you cope as best you can'
- "Doctors don't listen to nurses, we're not part of the team" vs. They listen if time is spent building a relationship
- The patient base is changing, more cultural differences; different religions, different languages

Families fear about patients being discharged centres on whether they can provide the care needed at home and if they'll be able to be readmitted to hospital

Specific examples of good practice from elsewhere

- Bereavement follow-up - After a death in ***** Hospital A&E an invitation was received by relative to attend a memorial service and reception. A lighted candle represented each patient, around 500 people attended and the scheme was over subscribed

- Staff support - How can staff support be organised in a non-stigmatised way? Example from New Zealand where emotional support was merged with career and practical advice service provided by an agency outside of the hospital. An informal counselling approach, occupational health model

- Family support - a dedicated bereavement officer who handles practical information about funeral arrangements, death certificates but also able to understand and facilitate different cultural and religious practices in the face of death.

- Religious contacts - book/ resource compiling different religious contacts in Ireland

- Transporting bodies - a special trolley for transporting a body which the body fits into, is disguised but dignified.

- Returning belongings - what about using a box? some hospitals use paper bags which are deemed more dignified than plastic bags - black or green!

- Policies on death in SJH are being reviewed, at present there are separate policies (e.g. death in A&E, death in theatre) which overlap

DD's summary

Support for staff
Relatives - what is the health service's obligation to relatives, how is this served?
Skills - for coping, for communicating, for treating
Patients and families need to be remembered
Balance - between intervening and letting go, supporting and intruding, patient and relative and carer agenda
Plastic bags

Outcome
Small working group - interested parties to contact LS and M H

Orla Keegan Dec 3rd 1999