COMMUNICATING UNCERTAINTY

Dr Brenda Ward / Sam White

Dealing with Uncertainty: Introduction to ‘The Last Dance’ video

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Introduction

- The Last Dance film was commissioned by Gloucestershire Integrated Care Board (ICB).
- Although the characters are fictional, the writing was informed by real people, situations and experiences.

- The film and accompanying resource guide are designed to help practitioners, reflect on their own experiences and build their knowledge through self-direct study or supported group learning.

Learning Outcomes

- Improve confidence in person-centred conversations.
- Identify opportunities for end-of-life planning.
- Increase awareness of indicators of the last phase of life.
- Increase awareness of communication barriers and how to mitigate these.
- Identify ways to improve communication and support.
- Awareness of resources for further development.

Video

- Last Dance NHS - YouTube

Questions

What did you observe?

What emotions did you experience watching the film? Why do you think you felt that way?

Is there a particular moment from the film that resonated with you? Either from your professional or personal experience.

Did any part of the film remind you of a patient or family you have supported? How did it make you feel?

Reflection Scene 1 - July Trish in ED meets Dr Tim for the first time

What did you observe in this scene?

What were the opportunities in this scene?

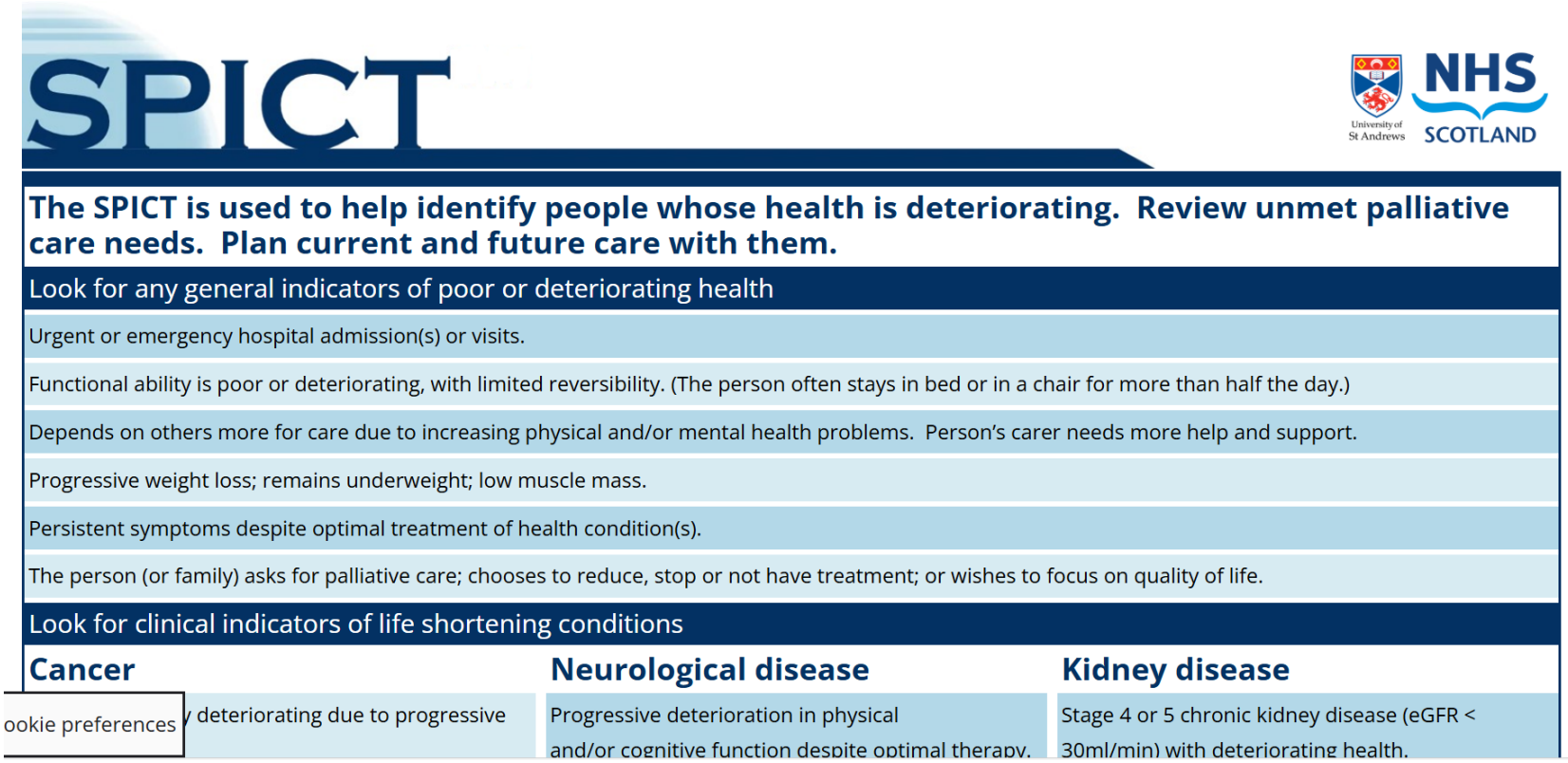
How might you have started a discussion in this context?- what strategies/approaches might you use to create a space for sensitive conversations?

How could this conversation be improved?

What signs or prompts (that someone might be in their last year of life) might you see in your own practice?

SPICT tool

- [e-SPICT | Supportive and Palliative Care Tool]



SPICT

University of St Andrews

NHS SCOTLAND

The SPICT is used to help identify people whose health is deteriorating. Review unmet palliative care needs. Plan current and future care with them.

Look for any general indicators of poor or deteriorating health
Urgent or emergency hospital admission(s) or visits.
Functional ability is poor or deteriorating, with limited reversibility. (The person often stays in bed or in a chair for more than half the day.)
Depends on others more for care due to increasing physical and/or mental health problems. Person's carer needs more help and support.
Progressive weight loss; remains underweight; low muscle mass.
Persistent symptoms despite optimal treatment of health condition(s).
The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of life shortening conditions		
Cancer	**Neurological disease**	**Kidney disease**
ookie preferences / deteriorating due to progressive	Progressive deterioration in physical and/or cognitive function despite optimal therapy.	Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Reflection Scene 2 - September Trish and the Community Nurse at home, talking about the future – daughter arrives.

What did you observe in this scene?

What were the opportunities in this scene?

How might you have managed starting a discussion in this situation?

How might you have managed starting a discussion in this situation?

Reflection Scene 3 - October – Trish back in hospital, Dr Tim talks about planning for the future.

What did you observe in this scene?

What were the opportunities in this scene?

How might you have started the discussion?

How could this conversation be improved?

Reflection Scene 4 – November Community Nurse visit. Dan mentioned family wedding. Community Nurse returns to the house to talk about the future.

What did you observe?

What were the opportunities in this scene initially and what do you think made the nurse return?

Think about the conversation that then happens through the window. What would you say? What topics would you cover?

Last year of life discussions: **General principles**

Build trust and rapport: start with open-ended questions about the person's life, values and what matters most to them

Assess understanding: gently gauge what the person already knows or suspects about their condition.

Use clear, non-technical language: avoid jargon and choose words that are honest but not alarming.

Offer support: reassure the person that you are there to support them, and that their wishes and needs remain paramount.

Be present and listen: allow time for silence, questions and emotional reactions. Minimise distractions and interruptions.

Revisit conversations: take time and introduce end of life and future care planning. Be prepared to start and revisit these conversations, working at the individual's their family pace.

Document conversations: record outline conversations so the colleagues (*or others involved in providing support)* are aware and may pick up cues if they are visiting or engaging with the individual subsequently.

Examples of approaches and phrases : Exploring understanding and values:

"I would like to talk with you about how things have been going and what's most important to you as we look ahead. Would that be OK?"

"Can you share with me what you understand about your health at the moment?"

"As we are thinking about your care, it helps me to know what matters most to you - what brings you comfort or joy day today come on what does a good day look like for you?"

Introducing the possibility of change

"Sometimes, as conditions change, it helps us to talk about what we might expect and how we might make sure that your care reflects your wishes and preferences."

"I wonder if we could talk about what might happen if your health were to change, and how you would like us to support you in those situations?"

"Many people find it helpful to discuss what's important to them, in case there are decisions to be made in the future."

Discussing future planning

"Have you ever thought about the kind of care you would want if things became more difficult or you were less well?"

"If your health were to get worse, are there things that you would want us to prioritise in your care?"

"It is normal for people to hope for the best, and at the same time, we also should plan for any possibility. Would you be open to talking about both?"

"Would you like anyone else close to you to be part of these conversations, so your wishes are understood and supported?"

"I know things have been a bit uncertain lately. Sometimes it helps to talk about what's important do you if your health were to change, so we can make sure your care always reflects what matters to you both. Would you be comfortable about talking about that today?"

Follow-on phrases

These can be used to continue the conversation once the initial question has been acknowledged:

- “What would help you feel more supported right now?”
- “Would you like someone close to you to join us for this conversation?”
- “We can take this at your pace. You don’t need to decide everything today.”
- “Let’s talk about what’s most important to you so your care reflects your wishes.”

REFLECTION WORKSHOP

Dr Tanya de Weymarn

FUTURE TANYA TALKS

To sign up to Tanya's **mailing list** to receive links to future talks, email sofia.smith@nhs.net

To be sent the **invite link** to the following talks, email glicb.ageingwell@nhs.net

Diagnosing Dying – 16/04/26 – 2000 - 2100

ReSPECT – 23/04/26 – 1000 – 1130