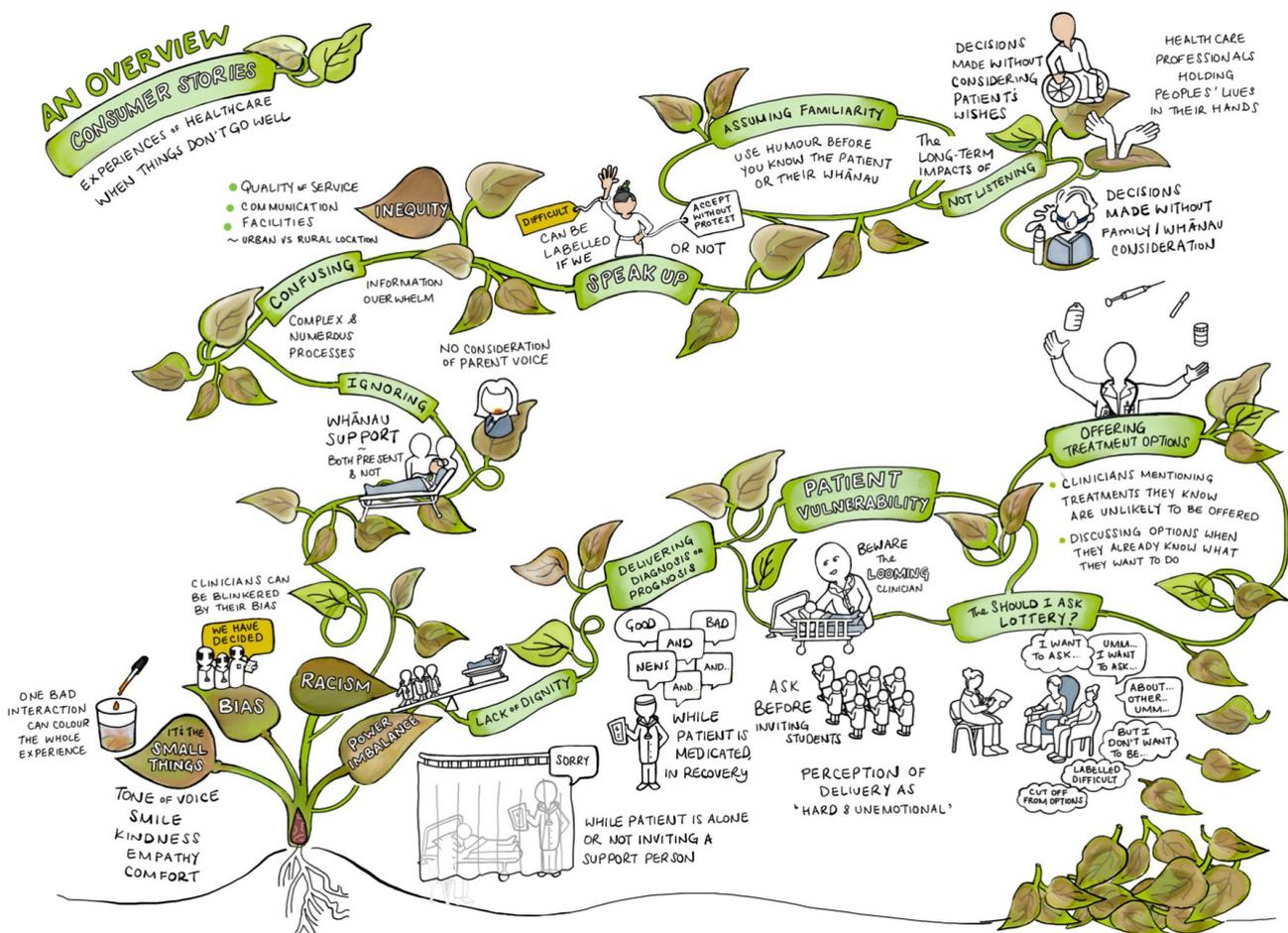


# The case for change

Acute deterioration can happen at any point during a patient's hospital admission. If acute deterioration is recognised early and responded to appropriately, patient outcomes can be improved. Internationally, more than 20 percent of rapid response team reviews are associated with end-of-life decision-making.<sup>1</sup> This suggests that end-of-life decision-making is often delayed until a crisis occurs.

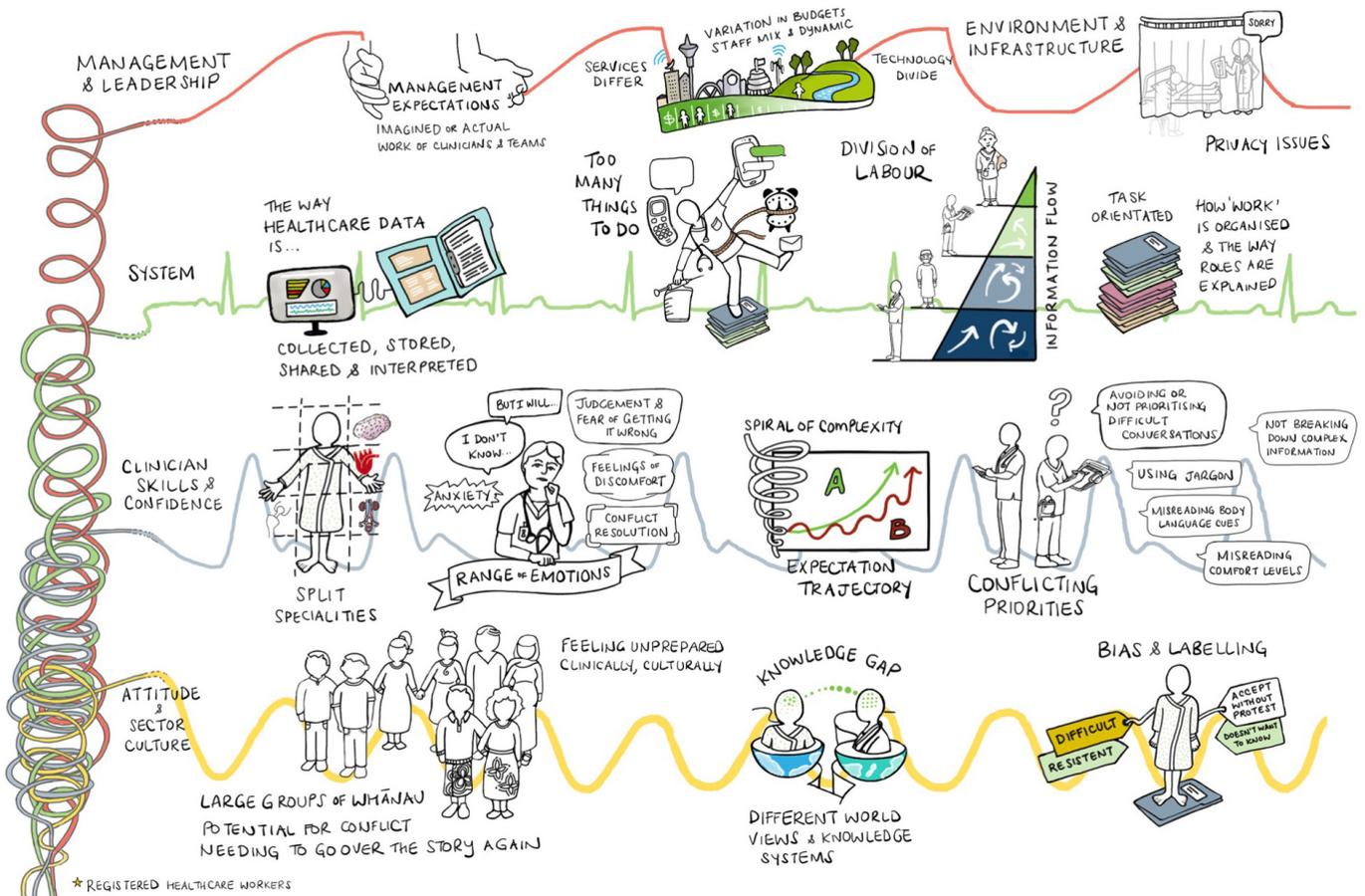
There are significant opportunities to work with patients to identify, discuss and document their care preferences and goals earlier in an episode of hospital care. Earlier discussion and documentation of patients' goals of care will enable the response to be aligned with their wishes if they deteriorate. Ideally, such conversations occur prior to episodes of acute deterioration so patients, whānau and clinicians can participate fully in developing shared goals of care without the pressures of an evolving clinical crisis.<sup>2</sup>

Early conversations about what matters most to a patient and how we can work together to incorporate the patients' values and goals into the care and treatment offered has been associated with better outcomes for patients and their families and whānau.<sup>3, 4, 5</sup>



- 1 Psirides A, Hill J, Jones D. 2016. Rapid Response Team activation in New Zealand hospitals: A multicentre prospective observational study. *Anaesthesia & Intensive Care* 44(3) (in press).
- 2 Stockdale C, Trivedi B, Jerome E, et al. 2013. Implementation of a combined Cardiopulmonary Resuscitation and Treatment Escalation Plan document in a District General Hospital. *BMJ Quality Improvement Reports* 2.
- 3 Wright AA, Mack JW, Kritek PA, et al. 2010. Influence of patients' preferences and treatment site on cancer patients' end-of-life care. *Cancer* 116: 4656-63.
- 4 Detering KM, Hancock AD, Reade MC, et al. 2010. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ* 340:c1345.
- 5 Temel JS, Greer JA, Muzikansky A, et al. 2010. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Eng J Med* 363: 733-42.

# CLINICIANS' EXPERIENCES EXPERIENCES OF HEALTHCARE WHEN THINGS DON'T GO WELL



At times clinicians avoid discussing prognosis, what really matters to the patient, and end-of-life issues with patients because they feel uncomfortable having these discussions. Their discomfort comes from:

- a perceived lack of training
- stress
- not enough time to attend to what might come up for the patient
- a fear of upsetting the patient
- a feeling of inadequacy or hopelessness regarding availability of further curative treatment.<sup>6</sup>

Avoiding these conversations or only initiating them late can lead to:

- anxiety and poorer patient quality of life
- patient and whānau distress
- prolonging the dying process
- unwanted and unwarranted treatments and their complications
- patient mistrust of the health system
- clinician distress
- low value care in which seriously ill patients do not receive the kind of care they desire.<sup>7</sup>

It is in the patient's best interests to offer prognosis information rather than withhold it to protect the patient from losing hope or being upset. Patients and whānau want open and honest information and a balance between realistic information and appropriate hope. Evidence suggests that patients can engage in such discussions with minimal stress and maintain a sense of hope even when the prognosis is poor. Recent feedback from clinicians and consumers reinforced this as outlined in the above infographics.

6 Clayton JM, Hancock KM, Butow PN, et al. 2007. Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in advanced stages of a life-limiting illness, and their caregivers. *MJA Supplement* 186: 12.

7 Bernacki RE, Block SD. 2014. Communication about serious illness care goals – a review and synthesis of best practices. *JAMA Intern Med* Doi:10:1001.