

# **THE NATIONAL CONSENSUS STATEMENT: ESSENTIAL ELEMENTS FOR RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION**

## **Consultation Report**

**July 2010**

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# 1. Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) was formed in 2006 to lead and coordinate improvements in safety and quality. The focus of the Commission's work is on areas of the health system where current and complex problems or community concerns could benefit from urgent national consideration and action.

Ensuring that patients who deteriorate receive appropriate and timely care is a key safety and quality challenge for health care providers. Research has consistently shown that there are observable physiological abnormalities prior to adverse events such as cardiac arrest, unanticipated admissions to intensive care and unexpected death. Abnormalities in vital signs such as blood pressure, consciousness, respiratory rate, heart rate, and oxygen saturation are common prior to the occurrence of these serious adverse events. However, there is consistent evidence that these warning signs are not always identified; and if they are, they may not be acted on.

Increased awareness of this issue has resulted in a significant number of initiatives being undertaken throughout Australia and internationally to enhance the recognition of patients who suffer deterioration while in hospital and to improve the response provided by healthcare staff.

The Recognising and Responding to Clinical Deterioration program is the Commission's response to ensuring that patients who suffer deterioration are recognised and responded to appropriately.

The initial priorities of this program are the development of:

1. a nationally agreed Consensus Statement setting out the essential elements for recognising and responding to patients who deteriorate
2. an implementation and action guide to support the Consensus Statement and provide information about how the elements within it can be put into practice for all patients across all acute settings
3. an evidence-based adult general observation chart that supports recognition of deterioration and prompts action.

The *Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration* (the Consensus Statement) is the first output of the program and provides the platform for future national work in this area.

The Consensus Statement is based on current evidence and effective practice and has been developed to inform and support clinical, organisational and strategic efforts to improve the recognition and response to clinical deterioration in acute care facilities.

Development of the Consensus Statement has involved the following steps:

- ▶ review of existing Australian and international guidelines and evidence and development of an initial working draft

- ▶ initial consultation with a multi-disciplinary Advisory Committee established for the program
- ▶ revision of the initial working draft based on feedback from the Advisory Committee
- ▶ preparation of a consultation paper that contained background information regarding the development of a National Consensus Statement, discussion of how the Statement might be used, and the draft Statement
- ▶ wide consultation with stakeholders about the Consensus Statement between July and September 2009
- ▶ review of consultation feedback and revision of the Statement by the Advisory Committee, internal Commission committees and Commissioners.

On 22 April 2010, Australian Health Ministers endorsed the *National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*, as the national approach for recognising and responding to clinical deterioration in Australian acute care facilities.

This document is a report of the consultation process conducted as part of this initiative. The report contains summaries of the processes used for the consultation, the feedback received and the Commission's response to this feedback.

## 2. Consultation Process

The draft Consensus Statement was circulated widely for consultation in early July 2009. Key stakeholder groups including jurisdictional health departments, health services, peak professional bodies, medical and nursing colleges, associations and societies were all invited to comment on the draft Statement. In addition, there was an invitation for written submissions via the Commission’s website and the program’s mailing database, which consists primarily of researchers, clinicians and policy makers.

The specific points the Commission sought feedback on in the consultation paper were:

- ▶ comment on the draft Statement
- ▶ elements included in the draft Statement
- ▶ proposed use of the Statement
- ▶ application of the Statement in different settings.

The Commission received 43 written submissions regarding the draft Consensus Statement. A list of organisations and individuals who provided submissions is included at [Appendix 1](#) and these submissions are available on the Commission’s website.

The below table provides a summary of the origin of the submissions received.

Type of organisation	Number of written responses
Clinician or health service worker or individual not representing an organisation	17
Health service, hospital or community health facility	8
Professional or member organisation	8
Government department	8
Researcher or university	2

## 3. Consultation Feedback

The response to the draft Consensus Statement was very positive, and there was strong support for the initiative and a nationally consistent approach to the identification and management of patients who are deteriorating. There were many comments made on the content of the Statement and a number of changes to the text were proposed. There was also a general consensus that additional detail would be useful to support the identification of deterioration for specific patient groups and in specific settings.

The National Consensus Statement has been revised based on the feedback received from the consultation process.

### 3.1 Draft Consensus Statement

#### Introduction

The draft Consensus Statement described the elements that are essential for properly recognising and responding to patients who deteriorate in health care facilities in Australia.

The Commission sought feedback on:

- ▶ Whether the existence of such a statement is useful
- ▶ Suitability of the Statement for use by clinicians, health service managers and possibly consumers
- ▶ Whether the language used in the Statement is appropriate
- ▶ Whether the level of detail in the Statement is appropriate, and provides sufficient flexibility for local implementation
- ▶ Preferred options (including structure, style and presentation) for describing the elements in the Statement.

#### Main Issues

Forty respondents commented on the structure and nature of the Consensus Statement. The feedback was overwhelmingly supportive of the need for such a statement with a number of submissions noting that it was timely, in keeping with the developing health environment, useful as an enabling document for further, more detailed procedures and broad enough to provide worthwhile direction without being too prescriptive.

*“The development of the Consensus Statement is a positive development... Realistically, a national body can only provide general guidance in this area due to the variation of organisational sizes and structures.” (submission 36)*

*“The Statement is useful, broad enough to allow local flexibility yet specific enough to provide direction and a framework. The very fact that it exists brings this issue to the fore and forces recognition and debate.”* (submission 8)

Although a couple of responses were concerned about the suitability of the Statement, most respondents were positive about it and its likely impact. One respondent considered that the Statement, on its own, would not be sufficient in solving the inherent problems in this area and questioned whether staff members, currently overlooking clinical deterioration, would utilise such documents. Another respondent was concerned that only a few aspects of the Statement would be useful to clinicians and considered it to be aimed at ‘health care bureaucrats’.

Seven respondents felt that the Statement was likely to be less accessible to consumers and that a more focussed, brief document on what consumers might expect would be needed. Similarly, two respondents noted that while the Statement would be suitable for acute settings, other areas such as maternity, mental health and sub-acute care were not necessarily supported by the Statement, and that further specific documentation would be needed.

*“Most respondents acknowledged that the Statement was flexible for use across a range of acute settings. However... the diversity of acute settings, emergency departments, oncology and many sub-acute and non-acute settings (maternity wards, mental health facilities, rehabilitation, residential aged care and community settings) were not adequately addressed.”* (submission 28)

The language used in the Statement received wide-spread support with several respondents indicating that they considered the language simple and effective. Three respondents commented that more prescriptive statements were required.

It was generally considered that the Statement would be used primarily by healthcare providers and that the document was therefore pitched appropriately. However, eight respondents indicated that a glossary or list of definitions would be useful.

There were differing views on the level of detail. One respondent considered that in attempting to accommodate the variety of clinical scenarios, the Statement was less than specific on detail and another suggested that more detail may be needed as health providers and consumers may be looking for specific references. One respondent, on the other hand, felt that some details of the Statement were overly prescriptive and that this could constrain effective implementation.

The remaining 20 respondents to this question, however, considered that the level of detail was appropriate with several indicating that the broad approach enabled more specific, detailed documents to be developed to suit specific circumstances. The size of the healthcare facility was considered an issue which could be addressed with focused supporting material.

*“The level of detail in the Statement provides a broad framework for implementation and smaller health care organisations may benefit from the inclusion of examples.”* (submission 38)

Respondents generally considered the structure and presentation of the Statement to be effective and user-friendly. Six respondents suggested various formats in which further information could be presented in the Statement including case studies and examples of initiatives in place in Australia, templates, figures and tables.

## Response

The scope of the Consensus Statement has been revised and is now clearly outlined at the beginning of the document. In response to consultation feedback, the Statement will apply to all patients in all types of acute care facilities, including adults, adolescents, children and babies, in situations where a patient's condition is deteriorating. Within the context of physiological deterioration, the Statement will also apply to all types of patients, including medical, surgical, maternity and mental health patients.

The general provision of care in a hospital or other facility is considered out of scope. Specific clinical treatments or interventions that may be needed to stabilise a patient is also considered out of scope.

A glossary has also been added to the document to define common terms.

The National Consensus Statement is the first output of the Recognising and Responding to Clinical Deterioration program and provides the platform for future national work in this area. To support the use of the Consensus Statement an Implementation and Action Guide will be developed to provide further information to assist acute care facilities tailor systems that utilise the elements of the Consensus Statement for recognising and responding to clinical deterioration and that best fit their setting and capacity.

The Implementation and Action Guide will provide information on the elements by way of guidance, tools, templates, worked best practice examples and case studies and will be designed to allow users to interact with material and easily obtain specific details relevant to the setting in which they work.

The Implementation and Action Guide will be aimed at clinicians and managers responsible for the development, implementation and review of systems for recognising and responding to clinical deterioration. The Commission will also look at developing an additional focused guide for consumers, patients and their families and carers.

These documents will address concerns about the level of detail that is required and was not appropriate for the Consensus Statement, as well as ensuring relevant information for specific settings and patient groups is available and accessible to everyone who participates in the healthcare system.

## 3.2 Elements in the Statement Feedback

### Introduction

The draft Consensus Statement was based on eight elements and a number of guiding principles. The elements included:

1. Measurement and recording of observations
2. Escalation protocols
3. Rapid response systems
4. Communication processes
5. Organisational supports
6. Education
7. Evaluation and monitoring
8. Use of new technology

The Commission sought feedback on:

- ▶ Whether the elements included in the Statement are sufficient to cover the range of clinical processes and organisational prerequisites that are necessary to properly recognise and respond to clinical deterioration
- ▶ Whether there are additional elements or points that need to be included in the Statement
- ▶ Whether some of the elements or points in the Statement are unnecessary.

### Main Issues

The responses to this question were generally positive and supportive. Some respondents were critical that the Statement did not specify mandatory requirements. Other respondents felt that additional explanation and/or coverage could be added. There were a large number of suggestions for further detail to strengthen the elements and guiding principles and many respondents also recommended variations to the wording of the draft Statement.

There were eight comments specifically on the guiding principles. Issues that were mentioned included:

- ▶ that early recognition can also prevent cardiac arrest
- ▶ the problem with assuming that staff in attendance will know what to do either by treating the patient or calling for emergency assistance
- ▶ the requirement of minimum standards, otherwise sites may simply ignore the recommendations
- ▶ the need for audit and review for unplanned ICU admissions, cardiac arrests and unexpected deaths as an additional principle.

Most respondents considered that the nominated eight elements were sufficient to cover the range of clinical processes and organisational prerequisites. There were no suggestions that any of the elements were unnecessary.

One respondent recommended an additional clinical process element to cover 'Physical assessment and development of plan of care on admission and review' and another suggested re-ordering the clinical elements as follows:

1. Measurement and recording of observations
2. Recognition of aberration
3. Communication processes
4. Escalation protocols
5. Rapid response systems

Other suggestions related to specific guidelines for specific facilities and diverse acute settings. Paediatric, mental health and maternity settings were seen as areas requiring particular guidelines on timeliness, parameters and types of observations and one respondent suggested adding elements to cater for specific clinical scenarios and chronic disease measurements. Another suggestion was that an element be introduced to cover data definitions to allow for clear definitions for indicators and current evaluation and monitoring systems.

Suggestions for additional information included:

- ▶ projected costs and savings from successful examples of implemented programs
- ▶ implications of patient deterioration for how and when communication occurs with patients/families
- ▶ identification of patients who are at increased risk of deterioration
- ▶ why there is reluctance to initiate a medical emergency team call
- ▶ advanced care planning
- ▶ disease trajectories and clinical pathways.

The following section contains specific comments that were made about each of the elements.

### **1. Measurement and recording of observations**

Nineteen respondents raised issues about the measurement and recording of observations. Six respondents questioned the statement that observations should be taken at least twelve hourly, but modified as necessary. Some suggested daily observations for certain patients requiring less monitoring, i.e. palliative care and rehabilitation patients, may be sufficient. Two respondents noted that given the duration of a standard nursing shift, twelve hourly observations would mean that some staff will not take observations on their patients and will be unaware of their condition.

Six respondents made suggestions about the minimum observations and additions included:

- ▶ pain
- ▶ both systolic and diastolic blood pressure
- ▶ urine output
- ▶ specifying Glasgow Coma Scale to measure consciousness.

It was also queried whether oxygen saturation should be included as a minimum observation when it is not always required.

There were several suggestions about what the other observations and assessments should be. These included:

- ▶ blood sugar level
- ▶ fluid balance
- ▶ chest pain
- ▶ breathing difficulty
- ▶ pupil size and reactivity
- ▶ diaphoresis/sweating
- ▶ nausea and vomiting.

There was some comment that documenting concerns raised by staff, the patient, family or carers on an observation chart would make the chart too cluttered and it was suggested that this instead could be recorded in the progress notes as these are filed in the medical records. Other features considered essential to include on an observation chart were having the capacity to:

- ▶ document escalation when triggering criteria are met, including the associated response and intervention
- ▶ display core observations graphically
- ▶ capturing age related observations
- ▶ allow for the altered physiology that occurs during pregnancy.

## 2. Escalation protocols

Eleven respondents raised issues about escalation protocols and having procedures in place for effective management of clinical deterioration.

Issues that were mentioned included:

- ▶ escalation protocol should also specify acceptable timeframes
- ▶ consider a minimum standard to set staffing and resources, otherwise becomes a resource driven system
- ▶ earlier escalation is required when resources are less likely to be available
- ▶ consultant should be contacted in the early stages of deterioration

- ▶ nurse determined interventions need to be defined, removed or supported with education due to legal issues
- ▶ have a clearly defined process of communication within the escalation process
- ▶ note that the escalation protocol may specify different actions depending on public holidays and the day of week
- ▶ the escalation protocol should allow for staff member ‘worried criterion’
- ▶ provide advice regarding resolution processes where there may be dissension between medical and nursing staff about escalating a patients condition
- ▶ clarify the role of clinicians, patients and carers and whether patients or carers are able to request an urgent escalation of care
- ▶ escalation protocol should be developed cognisant of the context of the service.

### 3. Rapid response systems

Twelve respondents raised issues about rapid response systems. Four respondents commented about implementing this section in smaller rural facilities and there was some concern with respect to not having sufficient staff with the necessary competencies.

*“[at least one clinician who can practise advanced resuscitation on site or in close proximity] is not going to be true of regional centres where (1) the team leader is a nurse (2) the only doctor in the hospital is relatively junior.” (submission 23)*

Other issues that were mentioned included:

- ▶ consider the requirement of a response within 30 minutes (which could be a telephone triage in rural sites)
- ▶ the rapid response team needs to be supportive of the decision to escalate
- ▶ ensure that appropriate medical staff and the patient or their representative are included in this process
- ▶ the level of care during transport needs to be of the same level or higher
- ▶ it is crucial that the home care team be in attendance and are not deskilled
- ▶ training should also be provided to ward staff in a simulated setting.

### 4. Communication processes

Eighteen respondents raised issues about communication processes. There was some concern about documenting transfer of patients at night as an incident and that at times this would be unavoidable due to capacity and bed availability. Conducting a joint clinical review by discharging and receiving

teams was also considered to be problematic, particularly in circumstances where patients were being transferred from a rural facility.

Other issues that were mentioned included:

- ▶ whether innovative communications and the communication processes at handover had received sufficient attention or prominence
- ▶ the importance of communicating deterioration to the patient and relevant family members in a timely and ongoing manner
- ▶ adherence to informed consent policies and involvement of families in decisions
- ▶ training will be required to achieve competence in communication
- ▶ introduce protocols for discussion about death and treatment options with patients and families
- ▶ integration of imaging staff into the treating team will assist coordination and improve team work and oversight
- ▶ importance of clinical reasoning, inter-professional communication and learning has been overlooked.

## 5. Organisational supports

Ten respondents raised issues about organisational supports. Management processes were commented on by several respondents with adequate planning, communication processes and the need for careful planning being the prime issues.

The role of a formal committee was also commented on by five respondents, three of which considered the establishment of a specific committee was too prescriptive. One respondent suggested membership of the nominated committee should include allied health or ancillary staff and another queried the role of a consumer representative.

Other issues that were mentioned included:

- ▶ the need to understand the management culture and governance issues applicable to the facility
- ▶ policy should contain clauses about how the relationship with the patient and family is conducted when deterioration occurs
- ▶ to determine organisation readiness include guidance on self assessment
- ▶ reference to equipment should include emergency drugs
- ▶ the section was too vague.

## 6. Education

Education and training aspects drew nineteen comments from respondents. Many commented on the problems associated with the focus on competencies in this section, specifically that it would be difficult to assess.

Respondents considered it important that education on the recognition and response to clinical deterioration be provided at undergraduate and postgraduate levels and continue into the workplace, especially about understanding the meaning of observations, trends and clinical judgement.

Effective teamwork, communication, graded assertiveness and escalation were other essential areas where education and training were also required.

Regarding communication, respondents considered making reference to communication with patients, families and carers important, including discussing death and treatment options.

Other issues that were mentioned included:

- ▶ education being consistent with the needs and resources of the organisation, within a minimum set standard
- ▶ training and maintenance of skill is essential so staff are not deskilled by medical emergency teams
- ▶ it may not be feasible (especially in small to medium sized facilities) to have all members of the rapid response system trained in advance life support
- ▶ educational modalities should provide both the technical knowledge and essential non-technical skills such as communication and teamwork.

## 7. Evaluation and monitoring

Seventeen respondents raised issues about evaluation and monitoring. One of the main issues that emerged was the difficulty of measuring the proposed indicator 7.3 (from the consultation paper), with the general view that some would be cumbersome and difficult to interpret. One respondent was concerned that the proposed indicators would not be sustainable without the use of an electronic health record. Another commented:

*“Evaluation in terms of patient outcomes is complex, particularly in comparison with other facilities. Variability in case mix and staffing has a significant impacts as do other factors including the definition of ‘cardiac arrest’ and ‘unexpected death’.” (submission 29)*

It was also mentioned that the proposed indicators fail to capture events in emergency departments. Another respondent was concerned that this section did not have enough ‘teeth’.

Eight respondents suggested additional measures which included:

- ▶ number of escalations and evaluation of code blue events
- ▶ potential cost savings in patient outcomes
- ▶ that a data system exists in a hospital
- ▶ process measures e.g. number of clinical and non clinical staff who have received mandatory education and completion rates of basic cardiopulmonary resuscitation or advanced life support training

- ▶ Extent to which clinical incident disclosures were rendered problematic or unsuccessful due to a lack of involvement on the part of the family and/or patient in explanations regarding the deterioration.

Respondents also considered it was important to have the opportunity to provide feedback about areas for improvement and that staff on the front line received feedback on performance.

## 8. New technology

Seven respondents raised issues about new technology. Three respondents expressed concern about the reliance on technology and that it should be used as a support, not a replacement for clinical decision making in recognising deterioration.

One respondent suggested technologies could facilitate alert escalation when principles of the Consensus Statement are not followed and another suggested expanding this element to include other factors, such as specific technologies and ethical issues surrounding the introduction of new technologies.

## Response

There was extensive commentary on this section. Many important and useful suggestions were made and were incorporated into the revised Consensus Statement. There were also some suggestions that the Commission did not accept and other comments that did not require changes to the text. Other suggestions would have required a level of detail that the Commission considered was not appropriate for the Statement and will be addressed in the Implementation and Action Guide.

Specific changes to the Consensus Statement in response to feedback received on the elements include:

- ▶ revision of the guiding principles
- ▶ revised titles of some elements, but no additional elements
- ▶ responsibility for managing the care of patients has been clarified so that it remains with the attending medical officer or team
- ▶ the minimum frequency of observations has been specified as being at least once per shift
- ▶ the list of minimum physiological observations remains the same but has been re-ordered and requires documentation of both blood pressure components, rather than only systolic blood pressure
- ▶ specifying that the escalation protocol should authorise and support staff to escalate care until they are satisfied with the response
- ▶ the role of the rapid response system has been clarified so that it is clear that is in addition to the care provided by the attending medical officer or team
- ▶ transfer to lower care areas, and transfers at night are not within scope of the revised Statement and have been deleted

- ▶ revision of the governance process has been broadened to oversee the development, implementation and ongoing review of recognition and response systems
- ▶ The focus on education and training in communication and teamwork has been strengthened

The focus on competencies has been largely removed, however the Statement requires that clinicians should be able to undertake a range of tasks that are necessary for caring for patients whose condition is deteriorating. The requirement remains that at least some of the individuals providing emergency assistance as part of the rapid response system be competent in advance life support.

Specific key performance indicators have been removed. The Statement now provides general guidance about the need for evaluation processes and what could be evaluated. Information about indicators will be included in the implementation guide.

### 3.3 Use of the Statement Feedback

#### Introduction

The Consensus Statement has been developed to reinforce the importance of properly recognising and responding to patients who deteriorate in hospitals, and to be used by health services to guide their own work in developing systems for recognising and responding to clinical deterioration.

The Commission sought feedback on:

- ▶ The potential for the Statement to be used at a strategic level to guide policy development
- ▶ The potential for the Statement to be used at a local level to guide the development of systems for recognising and responding to clinical deterioration
- ▶ What materials, supports or resources may be needed to use the Statement in practice
- ▶ What barriers there may be to the introduction of systems to improve the recognition of and response to clinical deterioration locally.

#### Main Issues

The feedback was overwhelmingly supportive of the intended use of the Statement although there were a number of suggestions for further enhancement and a number of concerns expressed particularly in regard to resourcing.

Five respondents considered that more attention needed to be paid to scope including a suggestion that the Statement contain a section defining the scope and the intended audience. Another felt that the Commission will need to undertake an advocacy role in respect of implementing the Statement.

Seventeen respondents commented that the Statement could be used to provide policy development guidance. Thirteen respondents considered that the Statement provides sufficient guidance such that local levels should be able to develop the procedures that were required for specific settings.

*“...the Statement would be use at the strategic level to reinforce the value of this [ACT Health Early Recognition of the Deteriorating Patient Project] project.” (submission 28)*

*“An organisation will need to take the Statement and develop it into an implementation plan to make it practical. The Statement will be useful once supported by organisational policy, processes and tools to recognise and respond to the deteriorating patient.” (submission 26)*

One respondent considered that the Statement may be more limited for use at the local level and that there would need to be a more supportive and comprehensive program to encourage its use.

Other comments about how the Statement could be used included:

- ▶ provide an overarching strategic direction and assist smaller organisations in policy development
- ▶ provide a good reference for benchmarking existing models
- ▶ may play a role in the accreditation process where hospitals will need to have systematic plans in place for responding to deteriorating patients
- ▶ assist in developing systems at the local level and identify where improvements can be made to existing systems.

Suggested supports or resources needed to use the Statement received the most response and a significant portion of it was cautionary. Fifteen respondents considered that careful attention would need to be paid to resourcing if the Statement was to have any effect and a number were concerned that not enough dedicated resources would be available to implement the Statement.

*“The Statement is sufficiently flexible to guide policy and procedure in a range of acute care facilities. However the resources required to ensure the sustainability are often underestimated. There needs to be a dedicated clinical/project position in place (hours variable depending on the size/acuity of the facility) to ensure that ongoing education, monitoring and evaluation is maintained.” (submission 29)*

Several respondents considered that specific reference to resources would be an advantage and assist with driving recruitment and planning at the local level. Resource requirements were identified in the following areas:

- ▶ dedicated project management and implementation
- ▶ education

- ▶ equipment
- ▶ evaluation and monitoring
- ▶ support roles, including clinical supervision
- ▶ settings where routine observations are not generally taken.

Fifteen respondents commented on the specific actions or items to support the implementation of the Statement and suggestions included:

- ▶ regulation and development of a national registry of outcomes
- ▶ effective communication systems and teamwork from all areas of hospital
- ▶ visible senior medical and nursing support and champions at executive level
- ▶ access to telehealth along with timely and integrated patient transfer teams
- ▶ training programs and education that begins at university level
- ▶ allocated and protected time for education and data collection
- ▶ standardised tools and documents for measuring changes in patient condition
- ▶ standardised tools and documents for data collection, data entry, analysis, feedback strategies
- ▶ systems that ensure known knowledge deficits are covered by clinicians with experience in areas
- ▶ a formalised adverse event screening program in hospital for assessing clinician performance.

Twenty three respondents considered that there were significant barriers to the introduction of the Statement although many of these related to resourcing, particularly for smaller and/or specialist facilities. A number of respondents considered that management support would be crucial to overcoming barriers.

Thirteen respondents considered that cultural issues will have an impact. These included resistance to change and work practice changes would need to be identified and adequately addressed.

Other barriers noted by respondents included

- ▶ financial resources, particularly for smaller services that might find it difficult to adapt to new systems that required additional education and support
- ▶ staffing levels, especially overnight, after-hours and weekends and the patterns of work of medical consultants, particularly in the private sector
- ▶ lack of appropriate knowledge and skills of staff and having access and protected time to undertake appropriate education and training

## Response

The overwhelming response to this question was welcoming and positive. Comments indicated a need to be clearer in the document about the scope and intended audience and this has been incorporated in the revised version. Further detail about the significance of the Consensus Statement and that it represents guidance rather than mandatory practice has also been included.

The most significant issue remains adequate resourcing and how these are going to be provided. It is not feasible to specify in the Statement what the minimum staff and resource requirements should be. A clear statement at the beginning of the document has been made about the need to implement systems to address all elements and in the near future the Commission will develop an accreditation standard for recognising and responding to deterioration based on the Consensus Statement. The Implementation and Action Guide will also provide an opportunity for organisations to assess existing or proposed systems to recognise and respond to clinical deterioration and see how they can align with the Consensus Statement. Management support and, to a certain extent, drive will be needed to ensure success of the Statement.

Small, remote and rural facilities were identified by respondents as requiring particular assistance to implement the Statement and develop local protocols and procedures to suit their particular setting. The proposed Implementation and Action Guide will provide evidence-based solutions and guidance on how the eight elements should be achieved whilst maintaining flexibility for different contexts and addressing the needs of specific settings and patient groups. This will incorporate the number of suggested implementation supports and tools received in the consultation feedback.

Implementation of programs and systems to improve recognition and response to clinical deterioration will also be addressed throughout the guide in the form of case studies and best practice examples.

### 3.5 Application of the Statement in different settings

The draft Consensus Statement was developed as a generic document that applies to all patients in all acute care facilities in Australia. As part of its work in this program, the Commission is planning to develop a more detailed guide to support effective implementation and use of the Consensus Statement. The guide will provide guidance to suit characteristics of health care facilities and the range of settings in which acute care is provided.

The Commission is also exploring issues concerning the recognition of and response to psychiatric deterioration in patients with mental health conditions.

The Commission sought feedback on:

- ▶ Whether the Statement can be applied in all acute care facilities in Australia
- ▶ Which elements or points in the Statement do not apply in specific settings, and whether and how they could be modified to do so
- ▶ What the specific issues are that will need to be considered in applying the Statement in different settings.

## Main Issues

The responses to this question were generally very positive for the implementation of the Statement. Most considered that the Statement was an excellent outcome:

*"[The elements] can apply to all hospitals. A hospital that does not adhere to this Statement and does not have a planned and systematic approach to clinical deterioration should not be allowed to operate."*  
(submission 1)

Several were concerned that the focus of the Statement was too narrow and respondents wanted additional guidance for specific settings or a statement that additional guidance is planned for these settings.

*"It is a pity that the document has been limited to patients in the acute sector only. Patients in institutional care in sub-acute care settings should also be able to have precise and timely information handed over to relevant people, themselves and their families if their condition deteriorates..."* (submission 17)

Twenty five respondents commented on applying the Statement across acute care facilities and most found the Statement provided a foundation, that with minor modification, could be used as a basis for site specific documents.

*"...this Statement could be applied to all acute care settings. The elements would be the same. The responses and escalation will be what is different amongst the variety of levels within health care establishments, i.e. tertiary, regional, rural, remote etc".* (submission 19)

Fourteen respondents, however also noted that the focus of the document needed to reflect the range of settings in which acute care is provided and would need to be extended to care in other areas including:

- ▶ sub-acute
- ▶ midwifery
- ▶ neonates
- ▶ aged care
- ▶ paediatrics
- ▶ home situations
- ▶ mental health, and
- ▶ smaller / rural facilities.

Eleven respondents, while generally being positive about the Statement, considered that the size or remote location of a facility may mitigate against some or all is being implemented. One mentioned such a circumstance would be where the facility did not have a medical emergency team.

Escalation procedures was identified as an area where some work would be needed to meet the Statement's requirements and that specific procedures and/or protocols would need to be developed in small facilities.

*“... it is likely this Statement could be applied to all acute care facilities in Australia. For rural/remote facilities the required response may need to be flexible to include telephone triage by medical practitioner, review by a nurse practitioner and the use of state ambulance service. When considering local flexibility, clinical excellence and safe practices should be paramount, as opposed to diluting this system into the facility’s current practice which may highlight substandard practices.” (submission 13)*

There was substantial comment relating to specific issues that would need to be considered in applying the Statement in different settings including:

- ▶ agreed time to respond
- ▶ type of response
- ▶ location
- ▶ resources generally in respect of personnel and equipment
- ▶ distances especially between the facility and specialist resources
- ▶ local knowledge and skills
- ▶ access to higher level advice and support
- ▶ IT limitations including the development of data sets
- ▶ lack of readily available specialist services.
- ▶ number of patients requiring transfer and transport resources in general.

Education and training were mentioned as areas that also would need to be addressed. One respondent considered that a self assessment would be desirable and many of the specific issues could be addressed through this process.

## Response

The Consensus Statement will apply in all types of acute health care facilities, from large tertiary referral centres, to small district and community hospitals. Some elements of the Consensus Statement may be used by services delivered by acute health care facilities in the community (such as hospital in the home programs). Within the context of the focus on physiological deterioration, the Consensus Statement will apply to all types of patients, including medical, surgical, maternity and mental health patients.

Different approaches and activities will be required to embed the Consensus Statement in these different settings. The proposed Implementation and Action Guide will provide guidance for tailoring particular systems for recognising and responding to clinical deterioration to suit characteristics of health care facilities such as:

- ▶ location, size, role, skill mix or resources,
- ▶ patient groups such as maternity and paediatric patients, and
- ▶ specific settings, such as smaller facilities.

This guide will provide the opportunity to address the concerns raised regarding applying the Statement in different settings.

The recognition that small, remote and rural facilities will have specific challenges in implementing the Statement is clearly understood. In developing the Implementation and Action Guide, input will be sought from stakeholders who have experience in implementing systems and programs for recognising and responding to clinical deterioration including in specific settings and with various clinical experience.

## Appendix

The following written submissions were provided in the consultation.

1. Professor Rinaldo Bellomo
2. Bruce Kynaston
3. Simone Hazelman
4. Medical Emergency and Response Training Working Group, Royal Brisbane and Women's Hospital)
5. John Fullagar
6. Simon Cooper
7. Centre for Health Communication, University of Technology Sydney
8. Cathy Andrews
9. Greater Southern Area Health Service Critical Care Unit
10. Nursing and Midwifery Office Department of Health, WA
11. Royal Australian College of General Practitioners
12. John Santamaria
13. SESIAHS PACE
14. David Dean
15. Ian Matthews
16. The Royal Children's Hospital Melbourne
17. Australian and New Zealand Society of Palliative Medicine
18. Mary Lou Morritt
19. Lyn Tutt
20. National Patient Safety Agency
21. Tracy Levett-Jones
22. Royal College of Nursing Australia
23. Daryl Jones
24. SESIAHS Nursing and Midwifery Team
25. NSW Health
26. The Victorian Quality Council
27. Stephen Simon

28. ACT Health
29. St Vincent's Hospital PACE Steering Committee
30. Justice Health
31. Australian and New Zealand College of Anaesthetists
32. Michael Buist
33. Melbourne Health Resuscitation Committee
34. Royal Australian and New Zealand College of Radiologists
35. Alfred Health
36. Royal Australasian College of Physicians
37. Gary Lane
38. Emma Matthew
39. Centre for Healthcare Improvement Queensland Health
40. The Council of Deans of Nursing and Midwifery (Australia and New Zealand)
41. Commonwealth Department of Health and Ageing
42. Department of Health and Human Services, Tasmania
43. SA Health