

DRAFT CONSENSUS STATEMENT: ESSENTIAL ELEMENTS FOR RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION

Consultation Paper

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The Commission will be accepting written submissions up to **25 September 2009**. Submissions marked "Recognising and Responding to Clinical Deterioration: Draft Consensus Statement" should be either:

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Please be aware that in order to ensure transparency and promote a robust discussion, all submission will be published on the Commission's website, including the names of individuals and/or organisations making the submission. The Commission will consider requests to withhold the contents of any submissions made in whole or part.

This document is part of a priority program initiated by the Australian Commission on Safety and Quality in Health Care in its 2009-2010 work plan. The content of the document has not been endorsed by Commission members, Health Ministers or State and Territory Health Departments.

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1. INTRODUCTION

The characteristics of patients in Australia and internationally are changing. Acute care hospitals now have an increasing proportion of patients with complex problems who are more likely to be or become seriously ill during their hospital stay (1, 2). Warning signs often precede serious adverse events such as unexpected death, cardiac arrest and unplanned admission to intensive care units (3, 4). However, there is consistent evidence that these warning signs are not always identified; and if they are, they may not be acted on (5).

Ensuring that patients who deteriorate receive appropriate and timely care is a key safety and quality challenge. These patients should receive the required care irrespective of their location in the hospital or the time of day. However survival rates from cardiac arrest are lower on weekends and at night, and mortality rates of patients admitted to intensive care from general wards are higher than those admitted from emergency departments or operating theatres, suggesting that these patients are not receiving optimal care prior to their admission (6, 7).

This situation has been known for some time, and there has been considerable work done over almost 20 years to improve the care that patients who deteriorate in hospital receive. Nonetheless, problems remain. These problems can be seen in the media reports that appear when individuals die unexpectedly in hospitals, reports of serious and sentinel events, and research showing the continuing occurrence of avoidable cardiac arrests (Box 1) (8-11). Although systems have been introduced to better manage these patients, this area needs to remain a priority while patients continue to experience preventable adverse events because their deterioration is not identified or managed properly.

The factors that contribute to a failure to recognise and respond appropriately to deterioration are complex and overlapping. They include issues regarding knowledge and skills of staff, the way in which care is delivered, organisational systems, attitudes and communication of information (12). All of these factors need to be addressed for patients who deteriorate to consistently receive safe and high quality care.

The Australian Commission on Safety and Quality in Health Care (the Commission) was established in 2006 to lead and coordinate improvements in safety and quality nationally. The focus of Commission work is on areas of the health system where current and complex problems or community concerns could benefit from urgent national consideration and action by governments and other stakeholders, including consumers.

Box 1: Examples of sentinel events involving patients at risk of acute deterioration reported by New Zealand District Health Boards

- Patient admitted with pneumonia. Became short of breath and had low oxygen levels. Staff did not call for assistance in a timely way. The patient died.
- Patient admitted from nursing home with blood clot on the brain. Hourly neurological observations ordered but not done. Patient was found dead three hours after last observation.
- Nurse tried for one a half hours to get patient reviewed by surgical team. Patient transferred to ICU and subsequently died. Seriousness of patient's condition not communicated to team.

This program is the Commission's response to the problem of ensuring that patients who deteriorate are recognised and responded to appropriately. The Commission is not in a position to address all of the factors that contribute to failures in this area, and the initiatives included here have been identified as areas where the Commission can use its position as a national leader in safety in quality in Australia to advance this area of work. The main initiatives in this program are the development of:

1. a consensus statement setting out the essential elements for recognising and responding to patients who deteriorate
2. guidelines applying the essential elements in specific settings, namely paediatrics and smaller facilities with no intensive care or limited medical cover
3. a guide to implementation of programs to improve the recognition of and response to clinical deterioration
4. an evidence-based adult general observation chart that supports recognition of deterioration and prompts action.

This consultation paper concerns the first initiative in the program, the development of a consensus statement. This is the first initiative to be developed as part of this program, and will provide the platform for the development of additional guidelines and other supporting materials by the Commission.

A draft consensus statement has been developed by the Commission based on existing evidence and reviewed by an Advisory Committee established to provide input to the program. The purpose of this consultation paper is to present the draft statement for wider review and comment. As well as seeking general comments on the draft statement, there are a number of specific questions that are of particular interest to the Commission. These are summarised on pages 16-17. Feedback on the draft consensus statement should be provided to the Commission by 25 September 2009.

2. THIS INITIATIVE

Much of the development of recognition and response systems to support the care of patients who deteriorate has come from bottom up processes, and a range of different systems have evolved to meet the specific needs of individual hospitals. The use of systems to respond to the needs of patients who are deteriorating is increasing, and in 2005 approximately 60% of hospitals in Australia and New Zealand with an intensive care unit reported having a medical emergency team (13). However the use of a medical emergency team is only one aspect of the recognition, response and organisational supports that are required to provide effective care to patients who deteriorate, and the limited anecdotal information that is available about the wider use of these systems suggests that their implementation and effective use is variable.

The challenge of effectively caring for patients who deteriorate is well recognised internationally, and there is an increasing move towards the systematic promotion and implementation of recognition and response systems by health departments and other organisations that support safety and quality. Both the United Kingdom and the United States have national programs that focus on this issue (14, 15). The only national initiative in Australia has been to promote the use of rapid response systems as part of the Safer Systems – Saving Lives (SSSL) program coordinated by the Victorian Department of Human Services and funded by the former Australian Council on Safety and Quality in Health Care (16). This project did not continue past the end of its funding in 2007, and the sustainability of the initiatives was limited. Several jurisdictions are now developing and implementing programs in this area (17, 18).

There is now scope to build on this work, and also draw on international programs and evidence to maximise and optimise the use of systems to support the recognition of and response to patients who deteriorate. A national approach will support a consistent and coordinated response to the management of clinical deterioration, and also communicate the importance of this as a key safety and quality issue.

The aim of this initiative is to develop a national, evidence-based consensus statement about the:

- importance of providing safe and high quality care to patients who deteriorate in acute care facilities
- systems and processes that are required to recognise these patients, and respond to them appropriately
- organisational systems that are required to ensure that patients who deteriorate are recognised and responded to.

There has already been considerable work describing the systems that are needed to effectively care for patients who deteriorate, and evaluating their effectiveness. This work has been used to inform the draft statement.

The statement has been developed to be applicable for all types of acute care settings, and for all types of patients. This statement focuses on the broad elements

of care required to recognise and respond to patients who deteriorate, and does not specify how they should be achieved. The broad nature of the statement supports the flexibility required for different contexts, but also the standardisation that is an important aspect of the delivery of safe and high quality care.

Health services will be able to use the consensus statement to guide their own work in developing systems for recognising and responding to clinical deterioration. The statement will also be the platform on which the other initiatives in this program are based. The statement could also form the basis of the development of future standards in this area*.

The draft consensus statement has been reviewed by an Advisory Committee convened by the Commission to inform the program. The draft statement is now being circulated for wider comment and review to consumers, clinicians, policy makers, researchers and other stakeholders. The consultation period for the statement closes on 25 September 2009. Once comments have been received the consensus statement will be revised, and presented to the Advisory Committee for a final review in October 2009. The final draft specifications will be submitted to Health Ministers for endorsement in early 2010.

* The Commission is currently developing a number of preliminary safety and quality standards as part of the National Accreditation Reform Program. The preliminary safety and quality standards are in the areas of patient identification, medication safety and infection control.

3. CONSENSUS STATEMENT: ESSENTIAL ELEMENTS FOR RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION

Introduction

The purpose of this statement is to describe the elements that are essential for properly recognising and responding to patients who deteriorate in acute health care facilities in Australia. It should guide health services in developing their own systems for recognising and responding to clinical deterioration.

The statement applies to the recognition of and response to clinical deterioration for all types of patients including babies, children, adolescents and adults; and for all types of conditions, including medical, surgical and mental health conditions. It also applies to the recognition of and response to deterioration in all types of acute health care facilities, from large tertiary referral centres, to small district and community hospitals.

There are a number of existing published guidelines and documents have informed this statement. These are listed at the end of the statement.

Guiding Principles

A number of principles underpin this statement. These are as follows:

- Recognising patients who are deteriorating, and responding to their needs in an appropriate and timely way are essential components of safe and high quality care.
- Systems for recognising and responding to deterioration must apply to all patients, in all patient care areas, at all times.
- Early recognition of deterioration can prevent the occurrence of adverse events, and require a lower level of intervention to stabilise the patient.
- Because the characteristics of acute health care facilities in Australia vary considerably, the way in which facilities recognise and respond to patients who are deteriorating will depend on their context and environment.
- Effectively recognising and responding to deterioration requires appropriate documentation in the patient's notes of diagnosis, and plans for monitoring of observations and ongoing management of the patient.
- Recognition of and response to deterioration requires appropriately qualified, skilled and experienced staff.

- Systems for recognising and responding to deterioration should promote appropriate intervention, either by staff already in attendance, or by calling for emergency assistance.
- Systems for recognising and responding to deterioration must encourage a positive, supportive response to escalation of care, irrespective of circumstances or outcome.
- Care should be patient focussed and appropriate to the needs and wishes of the individual and their family or carer. In some circumstances (for example where there is an advance care directive or at end-stage palliative care) this may include not applying some or all of the actions included in this statement.

Essential Elements

These elements describe the essential features of the systems of care for recognising and responding to clinical deterioration. The elements do not prescribe how this care should be delivered. The application of these elements to the systems for recognising and responding to clinical deterioration in an individual acute health care facility will need to be done in a way that is relevant to the specific circumstances of that facility.

Eight elements are included in this statement. Four elements relate to clinical processes that need to be locally delivered based on the circumstances of the facility in which care is provided. Four elements relate to the structural and organisational prerequisites that are essential for systems to recognise and respond to clinical deterioration to operate effectively.

A. Clinical processes

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

B. Organisational prerequisites

5. Organisational supports
6. Education
7. Evaluation and monitoring
8. Use of new technology

A. Clinical Processes

1. *Measurement and recording of observations*

Measurable physiological abnormalities occur prior to adverse events such as cardiac arrest, unanticipated admission to intensive care and unexpected death (3, 4, 19). Regular measurement and recording of physiological observations is an essential requirement for recognising clinical deterioration.

- 1.1 For every patient, a clear, personalised monitoring plan should be developed that specifies the physiological observations to be recorded and the frequency of observation, taking into account the patient's diagnosis and treatment.
- 1.2 Observations should be taken on all patients in acute care settings.
- 1.3 Observations should be taken on patients at the time of admission or initial assessment.
- 1.4 The frequency of observations should be consistent with the clinical situation of the patient. They should be taken at least every 12 hours, but modified according to changes in clinical circumstances. In some circumstances, some observations will need to be measured more frequently than others. For example, during treatment for acute coronary syndrome, heart rate, respiratory rate and systolic blood pressure will require more frequent measurement than temperature.
- 1.5 If abnormal physiological measurements occur the frequency of observations should be increased in accordance with the escalation protocol.
- 1.6 Minimum physiological observations should be:
 - heart rate
 - respiratory rate
 - systolic blood pressure
 - oxygen saturation
 - temperature
 - level of consciousness.
- 1.7 Clinicians may choose to add other parameters for periodic observation. Examples of additional observations and assessments that may be required include urine output, biochemical and haematological analyses, occurrence of seizures, pain, respiratory distress, pallor, capillary refills and pupils.
- 1.8 All measurements should be recorded in a structured tool such as an observation chart.
- 1.9 Observation charts should include:
 - a system for tracking changes in physiological parameters over time
 - thresholds for each physiological parameter or combination of parameters that indicate abnormality
 - information about the response required when thresholds for abnormality are reached

- the opportunity to document other concerns raised by staff, the patient or their family or carer
- the potential to document the normal physiological range for the patient.

2. Escalation protocols

An escalation protocol sets out the clinical and organisational response required for different levels of abnormal physiological measurements. This may include appropriate modifications to nursing care, increased monitoring, calling the clinician or team with primary responsibility for the patient or calling for a rapid response from intensive care or other specialist team. The escalation protocol describes the basic safety net that must exist for all patients.

- 2.1 A formal documented escalation protocol is required that applies to the care of all patients at all times.
- 2.2 The escalation protocol should be tailored to the characteristics of the acute care facility, including consideration of issues such as:
 - size and role (such as tertiary referral centre, multipurpose service)
 - location
 - available resources (such as staffing mix and skills, equipment, remote telemedicine systems, external resources such as ambulances)
 - potential need for transfer to another facility.
- 2.3 The escalation protocol should allow for a graded response dependent on the level of abnormal physiological measurements, changes in physiological measurements or other identified deterioration. The graded response should incorporate options such as:
 - increasing the frequency of observations
 - nurse-determined interventions such as commencement of oxygen or administration of analgesia
 - calling the team or clinician with primary responsibility for the patient
 - calling the rapid response system for emergency assistance or advice.
- 2.4 The escalation protocol should specify:
 - the levels of physiological abnormality at which patient care is escalated
 - the response that is required for a particular level of physiological abnormality
 - how care of the patient is escalated
 - who care of the patient is escalated to
 - who else is contacted when care of the patient is escalated
 - the timeframe in which a response should be provided at each escalation point
 - alternative or back up options for obtaining a response.

- 2.5 The way in which the escalation protocol is applied should take into account the clinical circumstances of the patient, including both the absolute change in physiological measurements as well as the rate of change over time for an individual patient.
- 2.6 The escalation protocol may specify different actions depending on the time of day or for other circumstances.
- 2.7 The escalation protocol should reinforce the clinical responsibilities of the clinician or team with primary responsibility for the patient.
- 2.8 The escalation protocol should allow for the capacity to escalate care based only on the concern of the clinician in the absence of other documented abnormal physiological measurements.
- 2.9 The escalation protocol should include the potential to escalate care based only on concerns of the patient, family or carer.
- 2.10 The escalation protocol should include consideration of the needs and wishes of patients with a not for resuscitation or similar order or an advance care directive.
- 2.11 The escalation protocol should be promulgated widely and included in education programs.

3. Rapid response systems

Where acute deterioration occurs it is important that there be the capacity to obtain appropriate emergency assistance or advice in a timely way. Different models that have been used to provide this assistance include medical emergency teams, critical care outreach and intensive care liaison nurses. The generic name for this type of emergency assistance is a “rapid response system”, and it should form part of an organisation’s escalation protocol.

- 3.1 Some form of rapid response system should exist to ensure that specialised and timely care is available to patients who are deteriorating.
- 3.2 Criteria for triggering the rapid response system should be included in the escalation protocol.
- 3.3 The nature of the rapid response system needs to be appropriate to the size, role, resources and staffing mix of the acute health care facility, and to the time of day when the rapid response system is called.
- 3.4 The team or individuals providing the rapid response should:
 - be available to respond within appropriate timeframes
 - be able to assess the patient and provide a provisional diagnosis
 - be able to undertake appropriate initial therapeutic intervention
 - be able to stabilise and maintain the patient pending definitive disposition
 - have authority to make transfer decisions and access other care providers to deliver definitive care.

- 3.5 As part of the rapid response system there should be on site or in close proximity at least one clinician who can practise advanced resuscitation.
- 3.6 The rapid response team should have access to a staff member of sufficient seniority to make decisions regarding non-resuscitation, or cessation of resuscitative efforts.
- 3.7 In cases where patients need to be transferred to another site to receive emergency assistance, appropriate care will need to be provided to maintain their condition until such assistance is available.
- 3.8 When a call is made to the rapid response system the team or clinician with primary responsibility for caring for the patient should be notified as soon as practicable that the call has been made, and where possible should attend to support and learn from the rapid response.
- 3.9 Where possible, the team or individuals providing the emergency assistance should use the call to the rapid response system as an educational opportunity for ward staff.
- 3.10 The team or individuals providing the emergency assistance should communicate in an appropriate, detailed and structured way with the team or clinician with primary responsibility for caring for the patient about the consequences of the call.
- 3.11 Events surrounding the call for the rapid response system, and actions resulting from the call should be documented in the patient's record and considered as part of ongoing quality improvement processes.

4. Communication processes

Poor communication at handover and in other situations has been identified as a contributing factor to incidents where clinical deterioration is not identified or properly managed (20, 21). A number of structured communication protocols exist that can be used for handover and as part of ongoing patient management (22).

- 4.1 Standardised handover processes should be used for all patients.
- 4.2 The handover protocol used should include information about the most recent observations and clinical assessment.
- 4.3 Handover procedures should include the identification of patients who are deteriorating and communication of information that is relevant to their management.
- 4.4 The value of information about possible deterioration from the patient, family or care should be recognised.
- 4.5 A clinical review of each patient should be conducted immediately prior to transfer to a lower level of care to ensure that the transfer is safe. This review should be conducted jointly with both discharging and receiving teams, and there should be clear agreement about the ongoing management plan for the patient.
- 4.6 Where patients are being transferred from a critical care area (such as intensive care, coronary care or a high dependency unit) to a general ward,

this transfer should occur as early as possible during the day. Transfer from critical care areas to the general ward during the night shift should be avoided where possible and documented as an incident if it occurs.

- 4.7 All clinical staff should be competent in communicating information about clinical deterioration in a structured way and using appropriate techniques.

B. Organisational Prerequisites

5. Organisational supports

Proper systems for recognising and responding to patients who are deteriorating should be part of standard clinical practice. Nonetheless, the introduction of new systems to optimise this care requires organisational support and executive and clinical leadership for success and sustainability.

- 5.1 A formal policy framework should exist regarding the recognition and response to clinical deterioration that includes issues such as:
 - governance arrangements
 - roles and responsibilities
 - resource allocation, including staffing arrangements
 - training requirements
 - evaluation and monitoring processes.
- 5.2 This policy framework should apply across the acute health care facility, and identify the planned variations in the escalation protocol and responses that might exist in different circumstances (such as for different times of day).
- 5.3 Any new procedures that are established to support the recognition of and response to clinical deterioration should be integrated into existing organisational and safety and quality systems to support their sustainability and organisational learning.
- 5.4 The policy framework and systems for recognising and responding to clinical deterioration should encourage a positive response to escalation of care, irrespective of circumstances or outcome.
- 5.5 Appropriate policies and documentation regarding advance care directives and end of life decision-making are critical in ensuring that the care delivered in response to deterioration is consistent with appropriate clinical practice and the patient's expressed wishes.
- 5.6 Establishment of a formal committee to oversee the development, implementation and ongoing review of systems for recognising and responding to clinical deterioration should be considered. Any committee of this type should:
 - have appropriate responsibilities delegated to it, and be accountable for its decisions and actions

- monitor the effectiveness of interventions and education
 - have a role in reviewing performance data
 - provide advice about the allocation of resources
 - include consumers, medical and nursing clinicians, managers and executives.
- 5.7 There should be systems in place within the organisation to ensure that the equipment required to provide emergency assistance is always operational.

6. Education

Having an educated and suitably skilled and qualified workforce is essential to provide appropriate care to patients who deteriorate. Education should cover knowledge of vital signs and identification of clinical deterioration, as well as critical care skills. Facilities should ensure that staff have the required competencies to provide appropriate care. The education programs provided by an individual facility should be consistent with the needs and resources of the organisation.

- 6.1 All clinical and non-clinical staff should receive education about the local escalation protocol, how to call for emergency assistance, and know that they can request the rapid response system if they have any concerns about a patient. This information should be provided at the commencement of employment and as part of regular refresher training.
- 6.2 All doctors and nurses should be competent in:
- systematic patient assessment
 - recognition of clinical deterioration including understanding and interpretation of abnormal vital signs
 - how to communicate information about clinical deterioration in a structured way
 - early management of patients who are deteriorating, including basic life support.
- 6.3 Clinical staff who are part of the team with primary responsibility for the patient should be competent in:
- formulating a diagnosis (or provisional and differential diagnoses) for the underlying causes of deterioration
 - developing a clinical management plan and writing it in the notes
 - implementing the clinical management plan in a timeframe that reduces the risk of further deterioration
 - responding with life-sustaining measures in the event of acute and rapid deterioration, pending the arrival of emergency assistance
 - consideration and discussion of end of life choices.
- 6.4 Clinical staff providing the rapid response should be competent in advanced resuscitation.

- 6.5 A range of methods should be used to provide the required information and competencies to staff. These may include provision of information at orientation and regular refreshers using face to face and online techniques, as well as simulation centre and scenario based training.
- 6.6 Systems should be established to allow regular and ongoing assessment of competencies.

7. Evaluation and monitoring

Evaluation of the introduction of new systems is important to establish their efficacy and determine what changes might be needed to optimise performance. Ongoing monitoring is necessary to track changes in outcomes over time and ensure that these systems keep operating as planned.

- 7.1 Data should be collected and reviewed locally and over time regarding the use and effectiveness of systems to support the recognition of and response to clinical deterioration.
- 7.2 The following data should be collected for each call to the rapid response system that is made:
 - patient demographics
 - date and time of call, response and stand down
 - the reason for the call
 - the treatment or intervention provided
 - outcomes of the call, including disposition of the patient.
- 7.3 Key performance indicators that should be measured include:
 - number of calls to the rapid response system per 1000 admissions
 - number of unexpected deaths (excluding patients with a not for resuscitation or similar order) where there were abnormal physiological measurements sufficient to meet criteria for calling the rapid response system that were not acted on in the 24 hours prior to death per 1000 admissions
- 7.4 Other indicators that can provide information about the impact of the systems to improve the recognition of and response to clinical deterioration include the number of unexpected cardiac arrests per 1000 admissions, number of admissions to intensive care per 1000 admissions and length of time of instability prior to transfer to intensive care, cardiac arrest or death. When data about hospital standardised mortality ratios (HSMRs) become routinely available they may also provide a useful way of reviewing the impact of new systems.
- 7.5 Regular audits of patient outcomes should be conducted for patients who are the subject of calls to the rapid response system. Where these data are available, this could include longer term outcomes for patients (such as 30 and 60 day mortality).
- 7.6 Regular audits of the completion of observation charts should be conducted.

- 7.7 Measurement of the cost of establishing and maintaining the rapid response system, as well as potential cost savings could also be considered.
- 7.8 Other information should be reviewed regarding the effectiveness of systems for recognition of and response to clinical deterioration, including incident reports, root cause analyses and death reviews. For every death review it would be useful to examine whether the escalation criteria for the rapid response system had been met and acted on.
- 7.9 Information collected as part of ongoing monitoring processes should be:
- fed back to local teams regarding their own calls for a rapid response
 - fed back to the teams and individuals providing the rapid response
 - reviewed to identify lessons that can improve clinical and organisational systems
 - used in education and training programs
 - used to track outcomes and changes in performance over time.

8. *New technology*

In health care new technologies are constantly being developed that have the potential to improve the safety and quality of care. Some of these are relevant to recognising and responding to clinical deterioration, including the use of hand held computers to collect observations, automatic monitoring of observations and automatic alerts where clinical trigger points are reached. Technology needs to be introduced in such a way that it supports the work of clinicians providing care to patients. The potential fallibility of technological systems also needs to be understood when they are used to support the recognition of clinical deterioration.

- 8.1 Systems for recognising and responding to clinical deterioration should consider the inclusion of technological solutions based on evidence of efficacy and cost, as well as consideration of possible additional safety and quality risks. Unintended adverse effects should be sought by explicit study during implementation.
- 8.2 Where technological solutions are introduced the systems for recognising and responding to clinical deterioration should still conform to the elements specified in this statement.

Contributing Documents

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4. CONSULTATION QUESTIONS

The Commission has used existing evidence and consulted with a number of individuals in preparing the draft consensus statement. The Commission is now circulating the draft consensus statement to a wider range of individuals and groups to gain additional input about the statement.

The Commission is interested in receiving feedback on the draft consensus statement to ensure it is adequate and able to be implemented. The Commission would like to receive general comments about the draft consensus statement, as well as responses related to any or all of the points listed below.

1. *Draft consensus statement*

The draft consensus statement describes the elements that are essential for properly recognising and responding to patients who deteriorate in health care facilities in Australia.

The Commission is seeking 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

2. *Elements included in the statement*

The draft consensus statement is based on eight elements. These are:

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 is seeking 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

3. Use of the statement

The 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 is seeking 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

4. Application of the statement in different settings

The draft consensus statement has been 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 more detailed guidelines about recognising and responding to clinical deterioration in paediatric settings and in smaller facilities where there may be no intensive care or limited medical coverage. The Commission is also exploring issues concerning the recognition of and response to psychiatric deterioration in patients with mental health conditions.

The Commission is seeking 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

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