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To <nicola.dunbar@safetyandquality.gov.au>
cc "Jennifer Faulkner" <Jennifer.Faulkner@racgp.org.au>, <mail@safetyandquality.gov.au>
Subject ACSQHC clinical deterioration document. [No Protective Marking]

Good afternoon Nicola,

As per our conversation, the RACGP has circulated the clinical deterioration document to our National Standing Committee for Quality Care and received response from A/Prof Rohan Vora, a GP and physician interested in oncology and palliative care.

In response, Rohan thought that this was an excellent document, but somewhat focused on the acute sector. From his experience he noted that patients in institutional care in sub-acute settings would also benefit from such a statement. He noted that this group (sub-acute) should also be able to have precise and timely information handed over to relevant people, themselves and their families if their condition deteriorates, dependant on their clinical condition and care goals. The response employed within this setting, however, may differ to the acute sector depending on the goals of their treatment. However, to delay their treatments until they are obviously moribund will mean that their treatment options are greatly limited and, if in end-stage care, they may well be denied a significant period of quality life that they and their families may value in spending together to say their good-byes.

Patients in the terminal phase or just pre-terminal may have different observation schedules put in place (eg. Liverpool Care of the Dying Pathway). Patients who have advanced care directives in place with the import being to 'allow for a natural death' and 'not to do anything to extend life' still need to have their symptoms managed in a timely manner and their families need to be informed so they can respond to and plan how they want to be available for supporting their loved one in their terminal phase, when it occurs.

In summary, timely clinical handover of physiological and other information is also vital for the sub-acute care patient group. Rohan noted that it would be concerning if this group received inferior quality of care and if those in end-stage care were left to die with inadequate or delayed response to their condition and symptom load (physical, psychosocial and spiritual).

I hope that this is helpful in further developing the consensus statement. Should you require any further information, please let me know.

Thank you,
Jane.

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