

# AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE



## national consensus statement:

essential elements for  
recognising & responding to  
acute physiological deterioration  
Second Edition

January 2017

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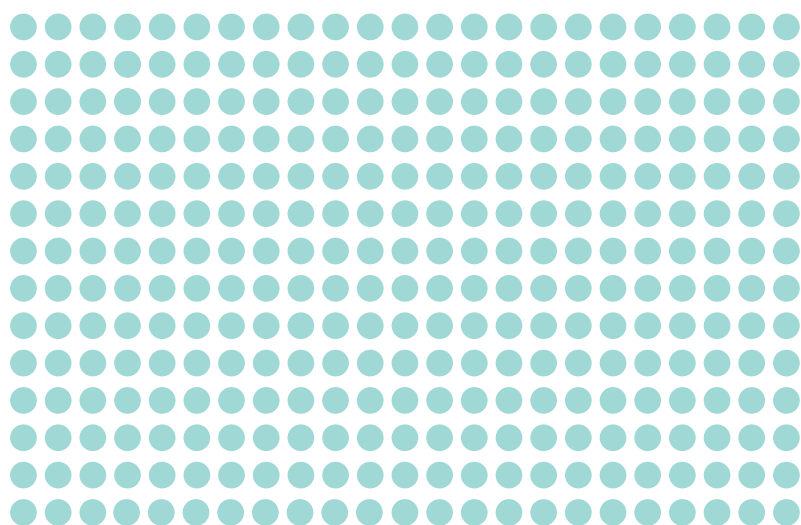
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# introduction

Early recognition of clinical deterioration, followed by prompt and effective action, may mean that a lower level of intervention is required to stabilise a patient. Early intervention also can minimise the occurrence of adverse events such as cardiac arrest, and reduce mortality. In April 2010, Health Ministers endorsed the *National consensus statement: essential elements for recognising and responding to clinical deterioration* (Consensus Statement) as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia.

The Consensus Statement informed the development of the National Safety and Quality Health Service (NSQHS) Standard for recognising and responding to acute deterioration, and can be used to support health services to meet the requirements of the NSQHS Standards.

The evidence base regarding recognition and response systems for clinical deterioration has matured since the Consensus Statement was originally released in 2010. This revision reflects the agreed views of experts in the field and the Australian Commission on Safety and Quality in Health Care, and the findings of a rapid review of the literature from 2010-2016.

The purpose of the Consensus Statement is to describe the elements that are essential for prompt and reliable recognition of, and response to, physiological deterioration of patients in acute healthcare facilities in Australia. The Consensus Statement sets out agreed practice for recognising and responding to acute physiological deterioration.

A glossary of terms used in this Consensus Statement appears on page 19.

The Consensus Statement has been developed for:

- clinicians involved in the provision of acute health care
- clinicians, managers and executives responsible for developing, implementing and reviewing recognition and response systems in individual health services or groups of health services
- planners, program managers and policy makers responsible for the development of jurisdictional or other strategic programs dealing with recognition and response to clinical deterioration
- providers of clinical education and training, including hospitals, universities, professional colleges and societies
- health professional registration, regulation and accreditation agencies.

## scope

This Consensus Statement relates to situations where a patient's physiological condition is acutely deteriorating. The general provision of care in a hospital or other facility is outside the scope of this document.

The Consensus Statement focuses on ensuring that a clinical safety net is in place for patients whose condition is acutely deteriorating, and outlines the organisational supports that are needed to provide this safety net. It does not cover the specific clinical treatments or interventions that may be needed to stabilise a patient.

The Consensus Statement applies to all patients in all settings where acute health care is provided.

Within the context of its focus on acute physiological deterioration, the Consensus Statement applies to all types of patients, including adults, adolescents, children and babies and to medical, surgical, maternity and mental health patients.

Similarly, the Consensus Statement applies in all types of acute healthcare 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 healthcare facilities in the community (such as hospital in the home programs).

## application

The National Safety and Quality Health Service (NSQHS) Standards require that organisations put systems in place that are consistent with the guidance provided in this Consensus Statement.

This Consensus Statement also aligns with the *National consensus statement: essential elements for safe and high-quality end-of-life care* and the *National consensus statement: essential elements for recognising and responding to deterioration in mental state*. It is intended that these three documents be applied together.

Health services will need to develop their own systems to address the principles and elements in the Consensus Statement. These systems will need to be tailored to the setting, the risks and needs of the population, and available resources and personnel, while being in line with relevant state, territory or other programs.

# guiding principles

A number of principles underpin this Consensus Statement.

- 1 Recognising patients whose physiological condition is acutely deteriorating and responding to their needs in an appropriate and timely way is essential for safe and high-quality care.
- 2 Recognition and response systems must apply to all patients, in all patient care areas, at all times.
- 3 Overall accountability for a patient's care rests with the attending medical officer or team, along with treating nurses and allied health. Recognition and response systems should therefore promote effective action by clinicians working in the wards, and the attending medical officer or team. This includes calling for emergency assistance when required.
- 4 Effectively recognising and responding to acute physiological deterioration requires appropriate communication of diagnosis and overall goals of care. This involves documentation within the health care record, as well as communicating information at clinical handover and during routine clinical rounds.
- 5 Effectively recognising and responding to acute physiological deterioration requires development and communication of plans for monitoring vital sign observations and ongoing management of the patient.
- 6 Recognition of, and response to, acute physiological deterioration requires access to appropriately qualified, skilled and experienced staff.
- 7 Recognition and response systems should encourage a positive, supportive response to escalation of care, irrespective of circumstances or outcome. No one should be criticised for escalating the care of a deteriorating patient.
- 8 Care should align with the needs and expressed preferences of the patient, including previously documented advanced care plans and goals of care.
- 9 If a patient lacks capacity to participate in decision making about their care then, when possible, the views of a substitute decision maker should be sought.
- 10 Organisations should regularly review the effectiveness of the recognition and response systems they have in place, including key performance and outcome indicators. This information should be provided to clinicians and relevant wards.



# essential elements

These elements describe the essential features of the systems of care for recognising and responding to acute physiological deterioration. The elements do not prescribe how this care should be delivered. Health services need to have systems in place to address all elements in the Consensus Statement; however, individual health services need to apply the elements in a way that is relevant to local circumstances.

This Consensus Statement includes eight essential elements. Four relate to clinical processes that need to be locally delivered, and are based on the circumstances of the health service in which care is provided. Four relate to the structural and organisational prerequisites that are essential for recognition and response systems to operate effectively.

## a Clinical processes

1. Measurement and documentation of vital signs and other observations
2. Escalation of care
3. Rapid response systems
4. Communicating for safety

## b Organisational prerequisites

5. Leadership and governance
6. Education and training
7. Evaluation, audit and feedback
8. Systems to support high-quality care





## a

# clinical processes

## 1 Measurement & documentation of vital signs and other observations

Measurable physiological abnormalities occur prior to adverse events such as cardiac arrest, unplanned admission to intensive care and unexpected death.

These signs can occur both early and late in the deterioration process. Regular measurement and documentation of vital signs and other physiological observations is an essential requirement for recognising clinical deterioration.

- 1.1** Vital signs should be monitored as part of a systematic physical assessment of all patients in healthcare settings.
- 1.2** Patients' vital signs should be measured at the time of admission or initial assessment, and when a patient transitions between areas within a hospital.
- 1.3** For every patient, a clear monitoring plan should then be developed that specifies the vital signs and other relevant physiological observations to be recorded and the frequency of observation, taking into account the patient's diagnosis and proposed treatment.
- 1.4** The frequency of observation should be consistent with the clinical situation of the patient. For the majority of patients in a health service, vital signs should be measured at least once per eight-hour shift. In some clinical circumstances more frequent or less frequent observation will be appropriate and this should be documented in the monitoring plan.
- 1.5** The frequency of observation should be reconsidered and possibly modified according to changes in clinical circumstances. The clinician who documents any modifications should also verbally communicate the changes to the bedside nurse and/or nurse in charge. The presence of modifications to the usual frequency of vital sign monitoring must be included in handovers between clinicians.



**1.6** At a minimum, monitoring plans should include measurement of:

- respiratory rate
- oxygen saturation
- heart rate
- blood pressure
- temperature
- level of consciousness.

In some circumstances, and for some groups of patients, some vital signs or other physiological observations will need to be measured more or less frequently than others, and this should be specified in the monitoring plan.

**1.7** Vital signs should be documented in a structured tool such as a paper observation and response chart or electronic tool.

**1.8** Vital sign observation charts and electronic tools should be designed and tested with consideration of human factors principles to improve their utility and reduce the risk of human error.

**1.9** A vital sign observation and response chart or electronic tools should include:

- a graphical information display so that vital sign trends can be tracked over time
- thresholds for each physiological parameter or combination of parameters that indicate abnormality
- information about the response or action required when thresholds for abnormality are reached or deterioration identified
- the potential to document the normal physiological range for the patient.

**1.10** Clinicians may choose to document other physiological observations and assessments to support timely recognition of deterioration. Examples include fluid balance, occurrence of seizures, pain, chest pain, respiratory distress, pallor, capillary refill, pupil size and reactivity, sweating, nausea and vomiting, as well as additional biochemical and haematological analyses.

## 2 Escalation of care

An escalation protocol sets out the organisational response required in dealing with different levels of abnormal vital signs and other abnormal physiological observations and assessments. This response may include appropriate modifications to nursing care, increased monitoring, notification of a nurse in charge, review by the attending medical officer or team, or calling for emergency assistance from the rapid response team.

Primary accountability for caring for the patient rests with the attending medical officer or team. In this context, the escalation protocol describes the additional safety net that must exist for all patients. Although this safety net should be tailored to the circumstances of the health service, it should include some form of emergency assistance where advanced life support can be provided to patients in a timely way. A protocol regarding escalation of care is an essential requirement for responding appropriately to clinical deterioration.

**2.1** A formal, documented escalation protocol is required. It must specify how care is escalated for all patients at all times.

**2.2** The escalation protocol should be developed in consultation with clinicians. It should authorise and support the clinician at the bedside to escalate care until they are satisfied that an effective response has been made.

**2.3** The escalation protocol should be tailored to the characteristics of the health service, including consideration of issues such as:

- size and role (such as tertiary referral centre or small community hospital)
- location (such as metropolitan or remote)
- available resources (such as skill mix, equipment, remote telemedicine systems, external resources such as ambulances)
- potential need for transfer to another health service.

**2.4** The escalation protocol should allow for a graded response commensurate with the degree of abnormality in vital sign observations, changes

in physiological measurements or assessments, or other identified deterioration. The graded response should incorporate options such as:

- increasing the frequency of vital sign observations
- appropriate interventions from the nursing and medical staff on the ward
- notifying the nurse in charge of the shift about the deterioration
- review by the attending medical officer or team (or the covering doctor if out of hours)
- obtaining emergency assistance or advice
- transferring the patient to a higher level of care locally, or to another health service.

**2.5** The escalation protocol should specify:

- the levels of physiological abnormality of vital sign or other observations triggering escalation of care for each tier of escalation
- the response that is required for a particular level of physiological or observed abnormality
- how the care of the patient is escalated
- the personnel to whom the care of the patient is escalated, noting the responsibility of the attending medical officer or team
- who else is to be contacted when care of the patient is escalated
- the timeframe in which a requested response should be provided
- alternative or back up options for obtaining a response.

**2.6** The way in which the escalation protocol is applied should take into account the clinical circumstances of the patient, including the absolute change in vital sign or other observations, as well as the rate of change over time for an individual patient.

**2.7** The escalation protocol may specify different actions depending on the time of day or day of the week, or for other circumstances.

**2.8** The escalation protocol must allow clinicians to escalate care based only subjective concern in the absence of other escalation criteria ('worried' criterion).

**2.9** The escalation protocol should allow the concerns of the patient, family or carer to trigger an escalation of care.

**2.10** Modifications to the usual escalation protocol may need to be documented for patients with an advance care plans or other limitations of treatment.

**2.11** The escalation protocol should be promulgated widely and included in orientation and education programs.

### 3 Rapid response systems

Where severe deterioration occurs, it is important to ensure that appropriate emergency assistance or advice can be obtained before the occurrence of an adverse event such as a cardiac arrest. The generic name for this type of emergency assistance is a 'rapid response system'. The emergency assistance provided as part of a rapid response system is additional to the care provided by the attending medical officer or team.

For most health services, the rapid response system will include clinicians or teams located within the hospital that provides emergency assistance. Examples of rapid response providers include medical emergency teams (METs) or nurse-led rapid response teams. This may be in conjunction with earlier or pre-emptive intervention such as critical care outreach services, and intensive care liaison nurses. In some facilities rapid response providers may include a combination of on-site and off-site clinicians or resources (such as an emergency nurse and the local ambulance service or general practitioner). However comprised, and however named, a rapid response system should form part of an organisation's escalation protocol.

**3.1** A rapid response system should ensure that specialised and timely care is available to patients whose condition is 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 and the skill set of the responding team needs to be appropriate to the size, role, resources and patient mix of the health service.
- 3.4** Rapid response providers should:
- be available to respond reliably within agreed 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 to access other care providers to provide definitive care.
- 3.5** As part of the rapid response system there should be access, at all times, to at least one clinician, either on-site or in close proximity, who can practise advanced life support.
- 3.6** Rapid response providers should have access to a clinician of sufficient seniority to make decisions regarding limitations of medical treatment. Where possible, these decisions should be made with input from the patient, family and the attending medical officer or team, and align with the patient's expressed preferences for care.
- 3.7** In cases where patients need to be transferred to another site to receive emergency assistance, appropriate care needs to be provided to support them until such assistance is available.
- 3.8** When a call is made for emergency assistance, the attending medical officer or team should be notified as soon as practicable that the call has been made, and where possible the attending medical officer or team should attend to support and learn from the clinicians providing assistance.



**3.9** All opportunities should be taken by the clinicians providing emergency assistance to use the call as an educational opportunity for ward-based clinicians and students.

**3.10** Rapid response providers should communicate with the attending medical officer or team about the consequences of the call, in an appropriate, detailed and structured way. The patient's family or substitute decision maker should also be informed about the occurrence and consequences of the call.

**3.11** Events surrounding the call for emergency assistance and actions resulting from the call should be documented in the healthcare record and considered as part of ongoing quality improvement processes. Documentation in the healthcare record should include:

- the reason the call was made
- the rapid response providers' impression of the problem, including a differential diagnosis
- clinical assessment findings
- details of interventions provided
- the results and plan for follow-up of any tests and investigations completed as part of the rapid response call
- the immediate plan of care and any changes to the overall plan of care, including updating the monitoring plan as required
- details of any communication with the attending medical officer or team, the patient, family and carers
- identification of who is responsible for further review and follow-up of the patient
- the conditions under which further review should occur.

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. This is particularly problematic when patients transition between different areas of care. A number of structured communication protocols exist that can be used for handover and as part of ongoing patient management. Systems for clinical communication should meet the requirements of the NSQHS Standards.

**4.1** Formal clinical communication protocols should be used to improve the functioning of teams when caring for a patient whose condition is deteriorating.

**4.2** Information about possible deterioration should be sought from the patient, family or carer when possible.

**4.3** Information about deterioration should be communicated to the patient, family or carer in a timely and ongoing way.

**4.4** There should be adequate communication and discussion about the patient's preferences for care. Where advance care plans and limitations of medical treatment are already documented, these should be taken into account if the patient no longer has capacity to participate in decision making.

**4.5** Structured handover processes should be used for all patients. These processes should meet the requirements of the NSQHS Standards.

**4.6** The handover protocol used should include information about the most recent observations and clinical assessment.

**4.7** Handover procedures should include the identification of patients who are deteriorating, and communication and documentation of information that is relevant to their management. This includes the specifics of the plan for management of acute physiological deterioration, any changes to the overall goals of care, and any limitations of medical treatment that have been agreed.

## 4 Communicating for safety

Effective communication and teamwork among clinicians is an essential requirement for recognising and responding to clinical deterioration. Poor



## b

# organisational prerequisites

## 5 Leadership and governance

For success and sustainability, recognition and response systems require executive and clinical leadership and structured organisational governance. Governance structures and processes should align with the NSQHS Standards.

- 5.1 Appoint a clinical leader and an executive sponsor with overall accountability for the ongoing performance and improvement of the recognition and response system.
- 5.2 A formal governance process (such as a committee) should oversee the ongoing performance and improvement of the recognition and response system. If a committee has this role, it should:
  - have appropriate responsibilities delegated to it, and be accountable for its decisions and actions
  - monitor the effectiveness of interventions, education and training
  - have a role in reviewing and feeding back performance data
  - provide advice about the allocation of resources
  - include consumers, clinicians, managers and executives.
- 5.3 A formal policy framework regarding recognition and response systems should exist and should address issues such as:
  - governance arrangements including reporting requirements
  - roles, responsibilities and accountabilities related to governance of the recognition and response system
  - vital sign and other physiological observation requirements, processes and tools





- escalation processes and tools
- roles, responsibilities and accountabilities of rapid response providers
- communication processes and tools
- resources for the rapid response system to ensure that there can be a reliable response from appropriately skilled clinicians who have the necessary equipment
- education and training requirements for all clinical staff and rapid response providers
- evaluation, audit and feedback processes
- arrangements with external organisations that may be part of the rapid response system.

**5.4** This policy framework should apply across the health service, and identify the planned variations in the escalation protocol and responses that might exist in different circumstances (such as for different times of day).

**5.5** Recognition and response systems or procedures should be integrated into existing organisational and safety and quality systems to support their sustainability and opportunities for organisational learning.

**5.6** Clinical and non-clinical members of the workforce should be encouraged to use escalation protocols and responders should react positively to escalation of care, irrespective of circumstances or outcome.

**5.7** Appropriate policies and documentation regarding advance care plans, limitations of medical treatment 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. Relevant policies, protocols and tools should correspond with the requirements of the NSQHS Standards and with the *National consensus statement: Essential elements for safe and high-quality end-of-life care*.

**5.8** Organisations should have systems in place to ensure that the resources required to provide emergency assistance (such as equipment and



pharmaceuticals) are always operational and available.

## 6 Education

Having an educated and suitably skilled and qualified workforce is essential to providing appropriate care to patients whose condition is deteriorating. Education should cover knowledge of measuring and interpreting vital signs and other observations as part of a systematic physical assessment in order to identify physiological deterioration, as well as appropriate clinical management skills. Skills in communication and effective teamwork are needed to provide appropriate care to a patient whose condition is deteriorating, and should also be part of professional development. The education programs provided by an individual health service should be consistent with the needs and resources of the organisation, and could be standardised within areas, regions or jurisdictions.

**6.1** All clinical and non-clinical members of the workforce should receive education about the local escalation protocol relevant to their position. They should know how to call for emergency assistance if they have any concerns about a patient, and know that they *should* call under these circumstances. 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 able to:

- systematically assess a patient
- understand and interpret abnormal vital signs, observations and other abnormal physiological parameters
- initiate appropriate early interventions for patients who are deteriorating
- respond with life-sustaining measures in the event of severe or rapid deterioration, pending the arrival of emergency assistance
- communicate information about clinical deterioration in a structured and effective way to the attending medical officer or team, to clinicians providing emergency assistance and to patients, families and carers

- understand the importance of, and discuss, the role of substitute decision makers when providing care to patients who are unable to make decisions for themselves and use shared decision making strategies
- access a senior clinician who is capable of discussing end-of-life care planning with the patient, family and/or carer
- undertake tasks required to properly care for patients who are deteriorating, such as developing and communicating a goal-directed comprehensive care plan, documenting interventions and other care in the healthcare record, and organising appropriate follow-up.

**6.3** As part of the rapid response system, competency in advanced life support should be ensured for sufficient clinicians who provide emergency assistance to guarantee access to these skills according to local protocols.

**6.4** A range of methods should be used to provide the required knowledge and skills to clinicians. 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.

## 7 Evaluation, audit & feedback

Evaluation, audit and feedback are important to establish the efficacy and ongoing performance of recognition and response systems. Data derived from evaluation processes can be used to determine what changes might be needed to optimise performance of the system. Ongoing monitoring is necessary to track changes in outcomes over time and to check that these systems are operating as planned.

**7.1** Data from evaluation of recognition and response systems should be collected, reviewed and fed back locally and over time.

**7.2** Recognition and response systems should be evaluated to determine whether they are operating as planned. Evaluation may include checking the existence of required documentation, policies and

protocols (such as the escalation protocol) and compliance with policy (such as documentation of vital signs or the proportion of clinicians who have received mandatory training).

**7.3** Systems should be evaluated to determine whether they are improving the recognition of and response to acute physiological deterioration. Evaluation may include collecting and reviewing data about calls for emergency assistance, unplanned transfers to a higher-level health service or higher-acuity care environment, and adverse events such as cardiac arrests and unexpected deaths.

**7.4** The following data should be collected for each call for emergency assistance that is made to the rapid response system:

- patient demographics
- date and time of call, response time and 'stand-down' time
- the reason for the call
- the treatment or intervention provided
- any changes to calling criteria or new limitations of medical treatment documented as a result of the call
- outcomes of the call, including disposition of the patient.

This information, as well as information about reviews conducted by the attending medical officer or team, should be included in the health care record.

**7.5** Regular audits of triggers and outcomes should be conducted for patients who are the subject of calls for emergency assistance. Where these data are available, this could include longer-term outcomes for patients (such as 30 and 60-day mortality).

**7.6** Evaluation of the costs and potential savings associated with recognition and response systems could also be considered.

**7.7** Information about the effectiveness of the recognition and response systems may also come from other clinical information such as incident reports, root cause analyses, cardiac arrest calls and mortality and morbidity reviews. A core question for every death review should be whether the escalation criteria for the rapid response system were met, and whether care was escalated in line with local protocol; that is, was there an adverse event where there was a failure to escalate to the rapid response team.

**7.8** Feedback should be obtained from frontline clinicians about the barriers and enablers to use of the recognition and response system. This information should be used to identify areas for improvement of the recognition and response systems across the organisation and locally in different settings.

**7.9** Information collected as part of ongoing evaluation, audit and feedback processes should be:

- fed back to clinical areas and teams regarding local calls for emergency assistance
- fed back to the clinicians providing emergency assistance
- reviewed to identify lessons that can improve clinical and organisational systems
- used in education and training programs
- used to track patient outcomes and changes in performance of the system over time.

**7.10** Indicators of the effectiveness of recognition and response systems should be monitored by senior clinical and organisational leaders responsible for governance within the organisation (such as senior executives and relevant quality committees).

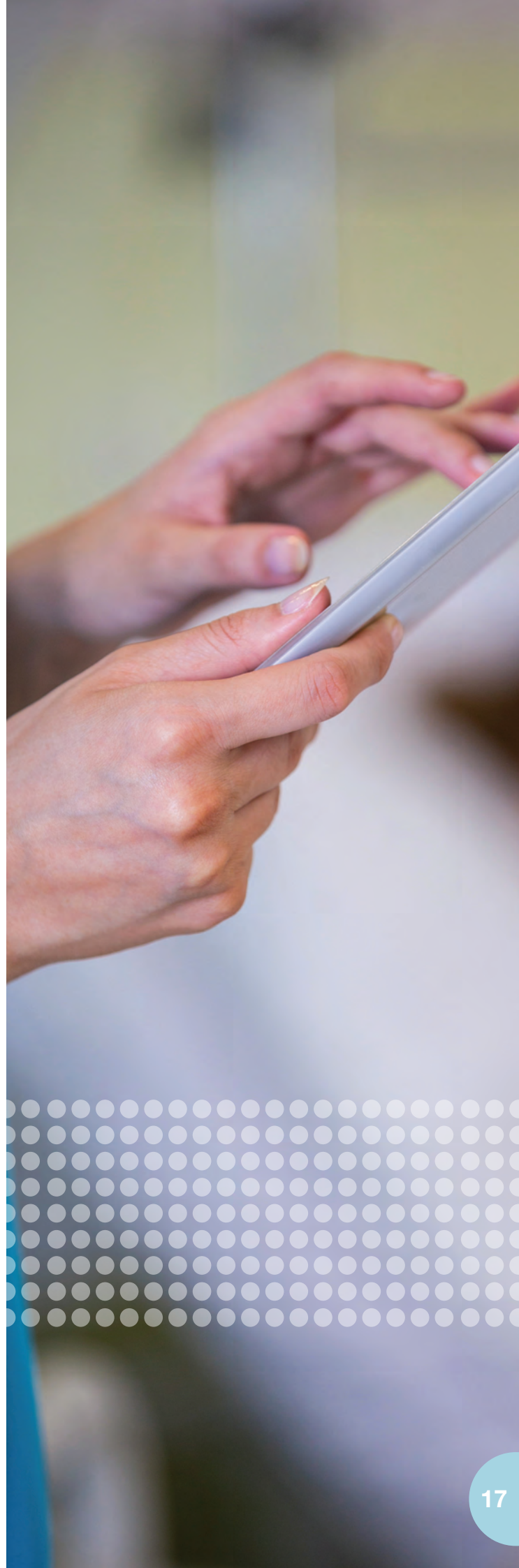
## 8 Systems to support high-quality care

Health service organisations should seek opportunities to align their systems to support best practice and maximise patient safety. For example, aligning systems for end-of-life care with systems for recognising and responding to clinical deterioration will help to ensure coordinated and effective care for patients whose condition is irreversibly deteriorating.

Technological systems can also provide benefit to patients, for example by improving detection of deterioration and automating escalation of care. Technology needs to be introduced in such a way that it supports the work of clinicians providing care to patients. The potential risks of technological systems also need to be understood and managed.

Systems to support high-quality care for patients who physiologically deteriorate should align with the requirements of the NSQHS Standards.

- 8.1** Recognition and response systems should align with the requirements of the NSQHS Standards, the *National consensus statement: essential elements for safe and high-quality end-of-life care*, and the *National consensus statement: essential elements for recognising and responding to deterioration in mental state*.
- 8.2** Technological systems to support recognition and response to acute physiological deterioration should be considered based on evidence of efficacy, cost, and possible additional safety and quality risks. Unintended adverse effects, including human factors considerations, should be considered by explicit evaluation during implementation.
- 8.3** Technological systems should not place a barrier between the clinician and the patient. They should enhance the care process and interaction rather than diminish use of the bedside clinician's clinical skills and judgement.
- 8.4** Where technological solutions are introduced, recognition and response systems should still conform to the elements specified in this Consensus Statement.









# glossary

**Acute health service:** A hospital or other health service providing health care to patients for short periods of acute illness, injury or recovery.

**Advance care plan:** A plan that states preferences about health and personal care, and preferred health outcomes. An advance care planning discussion will often result in an advance care plan. Plans should be made on the person's behalf and prepared from the person's perspective to guide decisions about care.

**Advanced life support:** The preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.

**Assessment:** A clinician's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.

**Attending medical officer or team:** The treating doctor or team with primary responsibility for caring for the patient.

**Definitive disposition:** The location, such as a ward or hospital, to which the patient will be transferred after initial stabilisation.

**Definitive care:** The clinical care required to maintain the stabilisation achieved and, where possible, to restore the patient to health.

**Emergency assistance:** Clinical advice or assistance provided when the patient's condition has deteriorated severely. This assistance is provided as part of the rapid response system, and is additional to the care provided by the attending medical officer or team.

**End of life:** The period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.

**Escalation protocol:** The protocol that sets out the organisational response required for different levels of abnormal physiological measurements or other observed deterioration. The protocol applies to the care of all patients at all times.

**Goals of care:** Clinical and other goals for a patient's episode of care that are determined in the context of a shared decision-making process.

**Monitoring plan:** A written plan that documents the type and frequency of observations to be recorded.

**Rapid response system:** The system for providing emergency assistance to patients whose condition is deteriorating. The system will include the clinical team or individual providing emergency assistance, and may include on-site and off-site personnel.

**Recognition and response systems:** Formal systems to support staff to promptly and reliably recognise patients who are clinically deteriorating, and to respond appropriately to stabilise the patient.

**Substitute decision maker:** A person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision-making capacity is impaired. A substitute decision maker may be appointed by the patient, appointed for (on behalf of) the person, or identified as the default decision maker by legislation, which varies by jurisdiction.

**Treatment-limiting decisions:** Decisions that involve the reduction, withdrawal or withholding of life-sustaining treatment. These may include no 'cardiopulmonary resuscitation' (CPR), 'not for resuscitation' and 'do not resuscitate' orders.

# contributing documents

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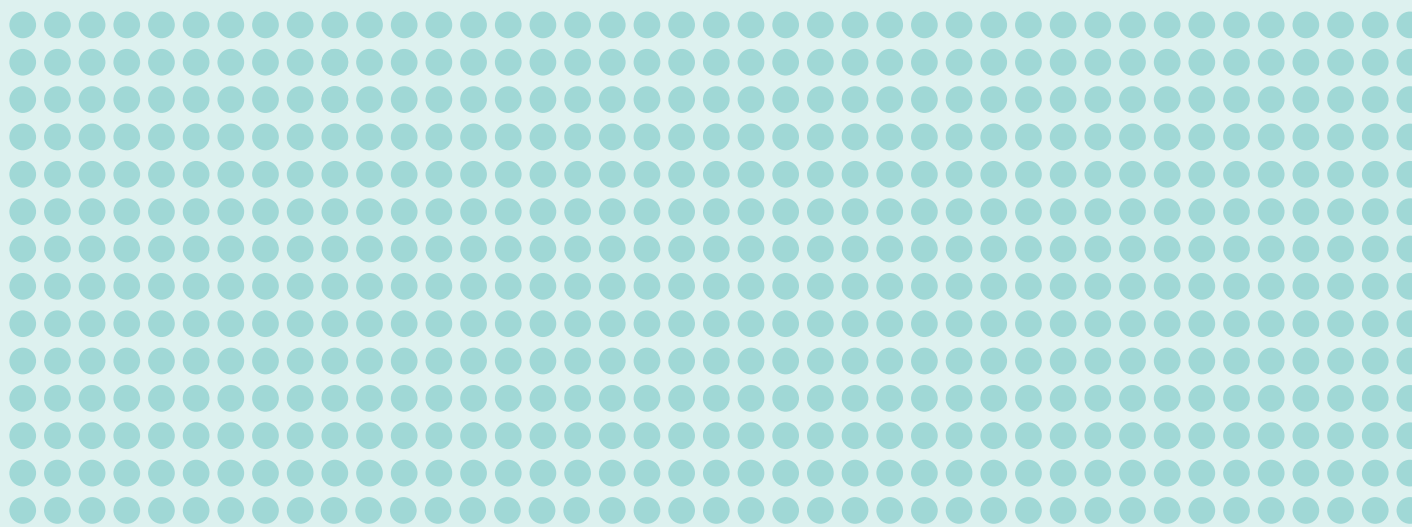
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