Tool 1

Clinical Communication and Teamwork

Tool 1 of the Clinical Communication and Patient Identification Clinical Directive Toolkit

Government of South Australia
SA Health

Contents

This Tool must be read in conjunction with the SA Health Clinical Communication and Patient Identification Clinical Directive and the accompanying toolkit;

Tool 1 – Clinical communication and teamwork
Tool 2 – Using My Health Record in clinical communication
Tool 3 – Patient identification and matching to intended care

Purpose of Tool 1

This tool provides additional information to support health services to ensure excellence in the governance, practices and systems of clinical communication so that;

- patient confidentiality and privacy requirements are respected
- patients' rights to be informed about their healthcare are met
- patients' and carers' experience of care is enhanced through staff engaging with them using kind and respectful communication, and providing person-centred care with the, opportunity to ask questions and provide feedback
- the requirements of National Safety and Quality Health Service Standards (NSQHSS) second edition are met (Appendix 1 of the Clinical Directive – *Actions that support effective clinical communication and safe patient care across the NSQHS Standards*, Australian Commission on Safety and Quality in Healthcare, ACSQHC).
- the requirements of health practitioner's professional codes of practice, conduct and legislative requirements are met
- staff experience, and contribute towards, a respectful workplace culture that values individual and team enabling shared learning, quality improvement and positive patient and carer outcomes.
- throughout all health care and transfers of care, staff handing over and also receiving responsibility for the ongoing care of a patient;
    - use robust verbal, written and electronic systems to provide comprehensive, timely, safe and effective communication that ensures the continuity, safety and quality of the patient's care is maintained
    - use effective systems to communicate critical information, risks and alerts
- accurate, contemporaneous and comprehensive information is legibly documented in the healthcare record.

Patient safety will be improved by:

- providing a structured framework that supports a consistent best practice approach to all clinical communication and patient identification within SA Health services, and between SA Health services and other health providers such as community services and residential care services.
- reducing risks that arise from inaccuracies, errors, delays, omissions or failures in the systems of exchange and documentation of clinical information, including verification of the patients identity and matching them with their intended care and integration of information from multiple systems.

Clinical Communication

Clinical communication is a foundation of person-centred care. It occurs between patients, their family and carers all members of the healthcare team at;

- registration and admission
- prior to and during the planning and provision of care, therapy, medication, diagnostic services or interventional procedures
- when there is possible acute deterioration or critical information emerges or changes
- at transitions of care
- at discharge
- follow-up communication when patient returns to their home/community/other service.

Clinical communication can vary in;

- its purpose and content, for example clinical documentation of care provided, letters of referral, discharge summaries, laboratory request forms and transfer of responsibility for the care provision.
- how it occurs, for example verbal, written or electronic
- who is involved, for example, the multidisciplinary team, between same disciplines, laboratory staff
- where it takes place, for example at the bedside, in a staff area, via telehealth
- when it takes place, for example at shift change, during patient admission, transfer, discharge or referral and prior to surgical and diagnostic procedures.

Clinical Communication with the patient, their family and carers

SA Health staff must develop and maintain skills in clinical communication relevant to their role so that they are able to receive and convey information in a manner that is respectful (Respectful Behaviour Policy Directive), sensitive and responsive to the patients' needs and level of health literacy. Assessment of these skills can be monitored by the TeamSTEPPS® 2.0AU Shared Decision Making tools.

Further information is provided in the section Discharge information for patients and their care / family. Available resources include;

- the Partnering with Consumers and Community e-Learning course
- Resources for improving patient-clinician communication (ACSQHC)

Clinical communication with the patient

Clinical Communication with the patient must:

- support the development of the patient's health literacy and their ability to partner in the management of their condition (NSQHSS action 2.4 and 2.5, ACSQHC resources on health literacy)
- support active participation in care planning, goal-setting and shared decision making by providing relevant and clear information about treatment options, and the potential benefits, risks, and uncertainties of each (NSQHS Standards 2.6 and 2.7);
    - ACSQHC resources on shared decision making , including Helping Patients Make Informed Decisions: Communicating benefits and risks videos and module
- respond to questions and concerns raised, especially if these relate to unexpected deterioration, or failure to improve or recover as expected (NSQHSS action 8.7);
    - SA Health resources on Recognising and Responding to Clinical Deterioration
- take into account, and respect, the patient's expressed wishes, values, needs and culture;
    - Aboriginal Cultural Learning Framework
    - Guide for engaging with Aboriginal people
    - Advance Care Directive Policy Directive
- uphold the patient's healthcare rights including the right to be treated with courtesy, dignity and respect; to participate actively in their healthcare; and to be informed, that is, to receive open and timely communication about services, treatment, options and costs in a way that they can understand (NSQHSS action 2.3 and the SA Charter of Healthcare Rights
- uphold the patient's right to privacy and confidentiality

- ensure that it is clear to the patient, family and carer, and Substitute Decision Maker (SDM) which health practitioner has ultimate responsibility for coordinating the care of the patient, and who the key members of their multidisciplinary care team are at any time
- ensure that patients and SDM's are fully informed about the implications of any health problem(s), their treatment options, likely outcomes and the consequences of any health care that might be provided (this is the basis of informed consent)
- meet requirements for NSQHSS standards (Appendix 1), including;
    - Standard 2: Partnering with Consumers
    - Standard 5.3: Comprehensive Care
    - Standard 6.3, 6.8 and 6.9 Communicating for Safety
- meet relevant health care providers professional standards, for example;
    - Section 3.3 Effective Communication, of Good Medical Practice: A Code of Conduct for Doctors in Australia (Medical Board of Australia 2014)
    - Principle 3 Cultural practice and respectful relationships Code of conduct for nurses.

Engagement with Patients' family and/or carers/SDMs

Engagement with patients' family and /or carers is an important component of safe, high quality, person-centred healthcare and the experience of health care. It can;

- provide a valuable source of relevant clinical information
- promote teamwork between the clinical team and each patient's SDM or support person(people)
- build health literacy, skills and knowledge so that family/ carers are best able to support each patient's recovery, rehabilitation, self-care preventative care and any ongoing treatment plan after discharge
- improve each patient's and carer's experience and perceptions of the outcomes of care.

The TOP 5 tool and other equivalent tools can be used by clinicians to record non-clinical information provided by carers, in order to personalize care for patients.

Clinicians must;

- respect the role of appointed Substitute Decision-Makers (SDM) under the *Advance Care Directive Act*
- engage with carers in accordance with the Partnering with Carers Policy Directive and *Carer Recognition Act.*

The extent of information-sharing with patients' families and /or carers requires consideration of each patients age, ability to consent, decision-making capacity, confidentiality and privacy, and safety of themselves and others. The Information Sharing Guidelines provide further information.

Using interpreters and translators

Clinical communication with the patient and their family/ carer must adequately provide for patients who have limited English proficiency; or who are deaf or hearing impaired; or who have a speech impairment and communicate through sign language such as Auslan or using assistive technology, so that they are enabled to;

- convey and receive information about their health during an episode of care
- participate in shared decision-making and goal-setting
- provide informed consent

- comply with and understand the information and instructions provided at discharge, and
- engage in rehabilitation, prevention or other public health initiatives.

The SA Health Language Services Provision: Operational Guidelines for Health Units applies to people from culturally and linguistically diverse (CALD) backgrounds, including;

- people who are deaf or hearing impaired and communicate through sign language such as Auslan
- Aboriginal people. The South Australian Policy Framework: Aboriginal Languages Interpreters and Translators and the associated Guide offer further detail.

The South Australian Interpreting and Translating Policy for Migrant and Non-Verbal (Sign) Languages applies to all South Australian Government agencies and contracted services. It specifies that;

- credentialed translating services (used to assist with written documentation) must be engaged to provide written documents to patient/client groups where practicable. This is particularly important where informed consent is required and/or where there is potential for a decision or action to impact upon a person's life.
- credentialed interpreting services (used to assist with oral communication) must be provided when requested by a patient/client, and must be offered to a patient/client when it is suspected that proficiency in English language is a barrier to effective communication between a member of the public and South Australian Government staff.

Indicators that a credentialed interpreter is required include if;

- requested by the client
- the client cannot comprehend or respond to basic questions in English
- understanding and responding between you and the client is difficult or limited
- the client relies on family members, friends or carers to communicate (to ensure the view of the patient is being communicated)
- the client prefers to speak in his/her own language, or
- English is the client's second language, and the situation is stressful or complex.

A simple assessment of proficiency in English language is required through asking "what language do you speak most at home?" and "Will anyone in the family need an interpreter?" Yes/no questions in general conversation must not be relied on to decide whether to engage an interpreter.

Clinical Teamwork

There is evidence that effective and collaborative teamwork;

- increases patient safety through minimising any patient incidents and avoidable complications of care that are caused by miscommunication, and/or misunderstandings of team roles and responsibilities
- increases patients' and their family's confidence and satisfaction with their care if they observe, or participate in, collaborative teamwork and clinical communication
- benefits health workers through shared responsibility; reduced hierarchy; use of, and respect for, the varied skills and knowledge of team members; encouraging a culture of shared learning and problem solving; and increased job satisfaction
- addresses the challenges in providing coordinated care that arise from the decentralisation, increasing complexity, specialisation of care; and increasing chronic disease and co-morbidities.

SA Health staff must;

- develop skills and knowledge to participate as team members and leaders, relevant to their role through active participation in available training such as TeamSTEPPS®2.0AU that improves the effectiveness and reliability of teamwork, and through use of tools and techniques such as huddles and structured handover
- demonstrate teamwork and care coordination with other practitioners in accordance with professional Codes of Conduct including;
    - active participation in relevant clinical team activities
    - communication of all the relevant sufficient information, in a timely way, about the patient or client and the treatment needed to enable the continuing care of the patient or client
    - demonstration of appropriate delegation, supervision and mentoring, referral and handover to other practitioners
    - demonstration of respectful communication and interdisciplinary practice that supports shared learning and best practice care. This includes responding to questions, queries and concerns from team members about planned care or possible deterioration in the patient's status or unexpectedly poor progress or recovery.

Clinical Handover

Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

Clinical handover occurs at, but is not limited to, shift-to-shift handover, escalation of the care of a deteriorating patient (ACSQHC Standard 8), team rounds, handover to diagnostic services, transfer between wards, transfer to and from emergency services and patient transport, discharge and referral.

The aims of any clinical handover process are;

- to achieve the timely, efficient and effective communication of accurate clinical information, that is sufficient to enable safe continuity of appropriate care
- to review the care plan with the patient, the clinicians handing over, and the clinicians who are taking over care
- to reduce avoidable delays, gaps, duplications or incorrect treatment
- to communicate critical information (risks and flags)
- to reduce known risks such as falls, pressure injury or self-harm
- to achieve the timely, efficient and effective communication of accurate clinical information, that is sufficient to respond to acute, physical and/or mental deterioration, and to reduce the risk that clinical deterioration is not recognized early.
- to provide an opportunity for shared learning and interdisciplinary teamwork.

Methods of clinical handover

Highly recommended;

- The use of a combination of face to face and written information, and, whenever practical, done in the presence of the patient, family and/or carer, is highly recommended for all clinical handover.

Recommended;

- Use of a combination of telephone/telehealth and written handover is recommended when transferring care for the purpose of tests and appointments; or transfers to another ward, site and to and from services other than SA Health services.
- Consider telehealth may enhance visual handover between sites/caregivers

Adequate;

- Use of a combination of face to face and telehealth/video conference is adequate for all clinical handover.
- Use of a combination of telephone and written handover is adequate for shift to shift handover, team handover and escalating care of the acutely deteriorating patient.
- Electronic applications such as electronic whiteboards can be adequate in combination with telephone for patient transfers for tests/appointments.

Not recommended;

- The use of a single method of communication for clinical handover is not recommended. This does not include the notification of routine laboratory or imaging results.

Further information is available WA Health Clinical Handover Matrix.

Evaluation of the safety and effectiveness of clinical handover

Health services must use audit and analysis of patient incidents and handover processes to identify situations of high risk clinical handover, including handover within and between services and settings.

Health services must take action to improve the quality and safety of handover, and evaluate outcomes.

Structured clinical handover

Structured clinical handover processes, and scheduling occasions of handover have been shown to improve accuracy, efficiency and effectiveness of information transfer and, thereby, the safety of patient care and the recognition and management of acute deterioration because;

- standards are met for the key elements to be completed and for minimum information/content to be included (as agreed for the speciality service and /or clinical context)
- appropriate patient information is gathered and staff are prepared. This can support staff to prepare timely discharge summaries, and other referral information (NSQHSS actions 5.13d, 5.13e and Standard 2.10d)
- interruptions are reduced and critical information such as alerts are more likely to be transferred accurately
- changes to the careplan can be implemented in a timely fashion.

The requirements for structured clinical handover processes are described in NSQHSS Standard 6.8.

Preparation for clinical handover

SA Health staff must actively prepare for and participate in clinical handover, and develop skills and knowledge to participate as team members and leaders, relevant to their role.

Processes of clinical handover

Health services must;

- adapt the structured clinical handover process to fit the health service organisation's particular context and clinical setting
- provide training to staff in their role and responsibilities, and in the processes and use of tools (such as TeamSTEPPS®2.0AU),
- provide tools and resources to support clinical handover processes.

Clinical staff must;

- maintain the privacy and confidentiality of patient information that is verbally discussed or displayed during handover
- use structured processes and contemporary handover tools such as those included in TeamSTEPPS®2.0AU, for example the standard mnemonic ISBAR (Identify, Situation, Background, Assessment and Recommendation), or iSoBAR (identification, Situation, observations, Background, Agree to a plan, Responsibility and risk management)
- use the functional capability of electronic health records such as Sunrise EMR (EPAS) to record and display summary information
- use unit or ward based devices such as journey boards.

Content of clinical handover

The clinical handover must include the review of;

- diagnosis(es), clinical assessment(s), relevant test results, and current clinical condition/progress (NSQHSS action 5.11-5.13, 6.8b, 8.5e, 8.9)
- risk assessments, any patient incidents or acquired complications and other clinical concerns (NSQHSS action 5.7b, 5.10, 5.21-36, 8.6e
- agreed care plan and priorities for care; patient's goals and preferences and any changes to the overall goals of care
- any limitations to medical treatment that have been agreed through 7 Step resuscitation planning or expressed in an Advance Care Directive
- discharge planning, referrals and follow-up, and expected date of discharge NSQHSS action 5.13, 5.14)
- medication history and current medicines list, including adverse drug reactions
- emerging or new critical information (flags or alerts), and the currency of any existing critical information
- early signs of possible deterioration in physical or mental state, (NSQHSS action 6.9 and 6.10)

  The identification of patients who are acutely deteriorating, must be included in all clinical handover procedures. This includes the specifics of the plan for management of acute physiological or mental deterioration, any changes to the overall goals of care, and any limitations medical treatment that have been agreed (ACSQHC).
- infectious status and/or transfusion history as relevant
- other clinical information relevant to the patient / family/carer.

Documentation of clinical handover

Documentation of handover must include a record of;

- an acknowledged transfer of clinical accountability and responsibility
- correct patient identification using a minimum of the 3 core patient identifiers
- any participation by patients, family, carers and SDM when appropriate and where practicable (NSQHSS action 2.6)
- the participation by all relevant clinicians, and the actions for which they were responsible for.

Discharge summaries to health professionals

At the completion of any patient episode of care, comprehensive information must be provided within 48 hours to the General Practitioner nominated by the patient, other treating doctor(s) and other health professionals who will be providing care to enable continuity of care. (System Wide Discharge Directive and Transfer of Individuals between Public Health Services and Residential Aged Care Services Policy Guideline).

There are National guidelines for on-screen presentation of discharge summaries.

For discharge of patients with complex needs, the health service must have care planning processes that support participation by the patient's nominated General Practitioner and other treating doctor(s) or health professionals, where practicable.

Discharge summaries for patients who require ongoing care from nursing, allied health or other professions must include discipline to discipline information, for example around wound care or rehabilitation program.

In the event of the death of a patient, a discharge summary must be provided to the referring hospital and to the nominated general practitioner.

The guide 10 Minimum Standards for Communication between Health Services and General Practitioners and Other Treating Doctors (Australian Medical Association 2017) is recommended for SA Health services and medical practitioners.

NSQHSS Standard 6 requires timely communication directly to a patient's General Practitioner and other treating doctor(s);

- after every episode of care
- during a lengthy admission
- in the event of a harmful patient incident
- about outpatient intake, appointment and follow-up arrangements (NSQHS Standards 7 and 8).

Health service must have secure and reliable electronic systems to send and receive information to and from the Health Service and General Practitioners and other treating doctor(s), and other health professionals. Where electronic systems are not available alternative means of secure information exchange should be established.

Discharge information for patients and their carer /family

Prior to discharge, patients and their family/carer must be provided with information that is appropriate to their needs and their health literacy, and in a form (preferably verbal and written) that supports;

- their understanding and compliance with any follow-up treatment or care, including medication and other treatments, therapies or tests

- knowledge of any precautions or other current critical clinical information, including any arising from the admission such as an adverse drug reaction
- their ability to seek help in the event of delay or failure to recover as expected, or any deterioration (and what the signs of deterioration might be).

This information must include how and when to seek;

- additional advice from the treating team, or
- advice from the GP, or
- urgent or out of hours advice (for example from locum or home doctor services, or Health Direct Symptom Checker or other health call services), or
- emergency assistance such as ambulance.

The use of a credentialed interpreter or translator to convey discharge information may be required where there is limited verbal or written English proficiency.

Critical clinical information, risks and alerts

Critical clinical information is information that has, or has the potential to have, a significant impact on a patient's health, wellbeing or ongoing care (physical or psychological), or the health of others, and therefore requires reassessment and possible changes to a patient's plan of care, or to the way care is provided.

Critical information includes;

- information that is provided by patients and their carers/family, including changes in the patient's goals of care
- known risks such as suicide risk, self-harm, falls risk or delirium (NSQHS Standard 5)
- signs of or actual acute physical or mental deterioration (NSQHSS action 8.4 – 8.13)
- new incidents, such as missed results, medication errors, misdiagnosis or missed diagnosis, complications of care, allergies or adverse drug reactions or medical equipment or device issues (NSQHSS action 1.11 and 6.9)
- new urgent or unexpected diagnostic or test results, for example indicating new infectious status (Diagnostic Imaging Accreditation Scheme, Practice Accreditation Standards, Part 4)
- legal information relating to the care of the patient, for example advance care directives, mental health treatment orders, Guardianship or court orders.

Relevant current critical information must be conveyed during all occasions and methods of handover (NSQHSS action 6.8). Communication with the patient and their family/carers and nominated general practitioner about new critical information must occur and be recorded.

The timelines and responsibility for verification and communication of critical information depends on the nature of the information. Time critical information must be communicated immediately to relevant members of the clinical team to avoid patient or staff risk. Examples include significant results from diagnostic tests or procedures, or when there is risk of exposure to infection.

Verification of patient identification in all communication of critical information avoids risk to patient and staff safety.

Documentation of critical clinical information, risks, precautions and alerts

Some critical information is communicated as an alert or flag. Alerts provide a standardised way to indicate that there are risks to the patient, for example allergies, cognitive impairment; risks to other

people such as infectious status or irradiated blood products; and other critical information such as legal orders, including ACD; and resuscitation plans.

A patient's My Health Record may also contain important allergy and healthcare information and can be used as a reference point to identify additional critical information.

Current risks/alerts/flags must be documented in a consistent, readily located at the front of the paper-based health records and electronic medical records (AS 2828.1 and NSQHSS action 5.12 and 5.13a). Sunrise EMR (EPAS) has a prominent header section for displaying patient alerts, and also a standardised set of alerts.

Current Sunrise EMR/PAS (EPAS) alerts include;

- Allergy, intolerances
- Advance Care Directives and other forms of advance care plans
- resuscitation orders (7 Step pathway)
- corrected age (for newborns)
- Guardianship of the Minister / Family Court Order
- active Mental Health treatment orders (ITO or CTO),
- Multi Resistant Organisms
- Isolation orders - Contact, Droplet, Airborne, Non Infectious
- Latex sensitivity
- Pregnancy
- Breastfeeding status

Current precautions listed in Sunrise EMR (EPAS) are;

- Interpreter needed
- Alias
- Restrict Information (do not release data)
- Child Protection Services Client
- Clinical Trial
- Client of Concern
- Management Plan
- Jehovah's Witness
- Blood Group Antibody Specificity
- Irradiated Blood Products
- Biohazard
- Guillain Barre Positive
- Guillain Barre Unknown
- Renal Fistula – Right Arm
- Renal Fistula – Left Arm
- Clozapine prescribed
- Aspiration Risk
- Bariatric Patient
- Falls Alert
- CMV Negative
- Disability (intellectual)
- Disability (Physical)
- Pressure Injury Risk
- Anaesthetic Risk
- Heatwave vulnerability risk
- Absconding Risk
- Risk of abuse
- Risk of Self Harm
- Suicidal
- Washed Red Cells
- Weapon (incl Firearm)
- Potentially dangerous person on premises
- Visitor Restriction / Security Patient
- Prisoner / inmate
- Violent
- Potentially dangerous environment
- Environment hazard
- Warning type – heat emergency
- Warning type – bushfire emergency
- Warning type – flood emergency
- Warning type – other natural disaster

Sharing and security of patient information

All SA Health staff are required by this policy and their Codes of Conduct to abide by privacy legislation and professional guidelines to protect the privacy and confidentiality of people receiving care.

Health services must collect, keep secure, use or disclose personal information within the legislative, statutory and policy requirements applicable to SA Health, such as the Information Privacy Principles Instruction and the Freedom of Information (FOI) Policy Directive.

Sharing patient information without consent

If a patient does not give consent for details of treatment to be disclosed to a third party, including family members, then this must be followed until such time as consent has been gained and documented. In the case of the primary health provider (GP), the discharge summary and other patient information must not be provided, or shared/uploaded to the patient's My Health Record. This includes results not being uploaded from SA Health's enterprise Pathology and Medical Imaging systems.

If a patient is under the age of 18 years or at risk of harm (e.g. domestic violence), health information must not be shared with the patients My Health Record because an address may not be able to be masked/removed. This aims to avoid inadvertently placing party/parties at risk in situations where there is conflict between parents/guardians.

However, SA Health staff may share with another health or service provider without the consent of an individual in some circumstances.

- If it is considered that the disclosure of personal information is reasonably required for the ongoing treatment, care or rehabilitation of the person. There are provisions for this in section 93 of the Health Care Act 2008 and section 106 *Mental Health Act* 2009.
- If the patient is a prisoner, the Prisoners - Care and Treatment in SA Health Services Policy Directive (Protocol for the Exchange of Information between SA Health and The Department for Correctional Services for the Treatment, Care or Rehabilitation of a Prisoner) describes SA Health's obligations under section 85CA of the *Correctional Services Act* 1982, and details those staff who may share personal information which is reasonably required for the treatment, care or rehabilitation of a prisoner and the likely situations where that disclosure will occur. This responsibility will be principally carried out by SA Prison Health Service, but not exclusively
- There are provisions for mandatory reporting of children who may be at risk of harm, and family violence through Multi Agency Protection Service (MAPS).
- In circumstances when it is unreasonable or impracticable to seek consent and sharing the information is reasonably necessary to prevent or lessen a serious threat to the life, health or safety of a person or group of people (SA Health Information Sharing Guidelines for Promoting Safety and Wellbeing: SA Health ISG Appendix Policy Directive).

For these circumstances, any decision, and the rationale for disclosing personal information without the consent of the patient and / or their authorised representative , must be documented in the individual's file, and an entry made in the Safety Learning System (under the classification 'Patient Information / Confidentiality of information / ISG Information Sharing Guidelines). Actions taken must be guided by the relevant legislation. Assistance and advice is available from Clinical Risk Managers.

Documentation in health records

An essential component of effective communication is documentation or record-keeping. Documentation can be paper-based, electronic or a mixture of both.

This includes all information entered into the health record, such as screening, assessment, the patient's goals, critical information, the care plan, treatment or care that has been provided, pathology and imaging results, operation reports and discharge summaries. (Also refer to Documentation of critical information in previous section).

Delays, misdiagnosis, missed diagnosis and harm can occur as a result of undocumented or poorly documented information, such as incomplete, unclear, illegible or unordered information.

Health practitioners are required by this directive and the State Records Act 1997 and their professional Codes of Conduct, for example Good Medical Practice: A Code of Conduct for Doctors in Australia to maintain clear and accurate clinical records that facilitate;

- continuity of care, and
- prompt transfer of health information as part of all transfers, referral, handover, discharge, or when requested by patients.

Information about a patient's care must be documented in a manner that meets the requirements of the;

- Medical Records Document and Data Capture Standards
- South Australian Client Identification Data Standards
- Health Record Management Policy Directive and LHN specific procedures
- NSQHSS Communicating for Safety Standard 6.11, that is:
    - objective, clear, legible, concise, contemporaneous, progressive, complete, relevant, consistent and accurate
    - include information about assessments, action taken and care provided, outcomes, reassessment, risks, complications and changes to the care plan
    - meet all necessary medico-legal requirements for documentation.

Clinicians need quick and reliable access to current and correct information to make safe clinical decisions and to deliver safe, high-quality care. The NSQHSS Standard 1 Clinical Governance Standard (Action 1.16) require organisations to make the healthcare record available to clinicians at the point of care and support the workforce to maintain accurate and complete healthcare records

Digital clinical information systems and technologies play an increasingly important role in documentation in the healthcare system. Any digital health record system that is implemented must meet the elements of best-practice documentation and on-screen display standards and support effective clinical communication. There are resources to support safety in e-Health. SA Health is implementing a combined electronic medical record and patient administration system called Sunrise EMR (EPAS).

Integration of information between multiple information systems

In providing care to one patient, clinicians may need to integrate information from more than one system to make a diagnosis and plan care. Verification of patient identification across and between systems requires use of the national patient identifiers

The NSQHS Standard 1 Clinical Governance Standard require organisations to integrate multiple information systems if they are used (Action 1.16). Safe integration requires procedures that describe responsibilities, skills and knowledge required for matching and verifying patient identification.

Health services must evaluate potential risks such as patient identification and record-matching, currency of information, gaps and duplications in data, and resolution of data discrepancies.

When designing, implementing or integrating digital health solutions health services must use clinical and technical expertise and structured analysis (such as Failure Mode and Effect Analysis) to identify any safety and quality issues that may arise, and take action to mitigate those risks.

Training for clinical documentation and security of clinical documents

Health services must provide training, that develops skills and knowledge including;

- how to gain legitimate access to, and maintain the security of healthcare records
- how to locate and integrate relevant and current information, particularly clinical alerts
- how to locate and use templates, checklists or other tools and resources that support best-practice documentation
- standards for timely, reliable and consistent documentation practices, across and between paper and electronic records
- security, confidentiality and privacy requirements for appropriate information-sharing.

Governance of clinical documentation and security of clinical information

Health services must have systems and processes that describe roles, responsibilities regarding documentation (Health Record Management Policy Directive) including:

- identification of potential risks to patient safety arising from documentation practices and systems, including integration of multiple systems
- monitoring and reporting patient incidents where documentation practices and systems were contributing factors, and take action to reduce risk (Patient Incident Management and Open Disclosure Policy Directive)
- monitoring and reporting inappropriate access and breaches of privacy or confidentiality (Privacy policy).

Monitoring

Health services must establish clinical governance structures and processes and evaluate the safety and effectiveness of clinical communication and patient identification. Evaluation measures require audit of practice and procedures, recording of completed training, and analysis of incident data.

Health services undertake audits and regular monitoring and evaluation to demonstrate that they meet the requirements of the NSQHSS Standard 6 Communicating for Safety. And report clinical communication incidents to the SLS. The SA Consumer Experience Survey also records consumer perceptions of clinical communication and teamwork.

Example measures to indicate safety and quality of clinical communication are as follows.

Measures of the safety and quality of clinical communication		**Data source**
Appropriate governance	Evidence of a committee or workgroup that receives information and data, and plans and implements quality improvement. Appropriate procedures, tools and protocols in place, and evidence of changes to clinical practice. Evidence that the service has met or exceeded requirements for accreditation against NSQHS Standards 5 and 6.	Agendas, minutes, action plans and reports of quality improvement activities Procedures, tools and processes Accreditation status
Consumer experience and feedback	Rates of complaints, feedback, consumer experience reports. Interpreter use	SLS – consumer feedback module South Australian Consumer Experience Survey (SACESS)
Consumer participation	Evidence of participation of consumers in the planning, design and evaluation of quality improvement activities to improve clinical communication. In accordance with SA Health Framework for active partnership with consumers and the community	Committee participation
Clinical communication education, training	The percentage of clinicians completing training required to ensure skills and knowledge for their role. Completed reviews of content and effectiveness of induction and training programs. Clinical teamwork training, for example Team STEPPS 2.0AU.	Workforce training records. Records of completion of relevant online and face-to-face training
Documentation	Audits of adherence to health records standards. Evaluation of alerts/critical information for currency and completion, and evidence of clinical review. Rate, quality and timely completion of discharge summaries. Rate and quality of provision of information as part of referral. Security of health records Maintenance of privacy and confidentiality. Appropriate accessing and sharing of information	Discharge summary data Clinical audits Medical records audits Reported breaches of security of health records Reported breaches of privacy, confidentiality

Measures of the safety and quality of Clinical Handover		
Timely/appropriate use of clinical handover	Percentage of occasions of handover where the structured process for that area was used, including ISBAR.	Clinical audit EPAS
Incidents relating to clinical handover	Numbers and rates of incidents relating to inadequacy of clinical handover, clinical communication, teamwork.	The Safety Learning System – patient incidents module
Participation of patients and carers in clinical handover	Rates of participation in clinical handover.	Clinical audit
Engagement with other service providers	Evidence of participation of other service providers in the quality improvement activities to improve clinical handover and information exchange at patient transition.	Documentation of quality improvement activity
Written handover	Rates of completion and quality of referrals and discharge summaries	Clinical audit
Electronic transfer of information	My Health Record uploads	Available data
Clinical communication and teamwork	Incidents where communication and teamwork was a major contributing factor	The Safety Learning System – patient incidents module

Recording patient incidents relating to poor clinical communication and clinical teamwork

The Safety Learning System records the patient incidents and also consumer (patient) feedback records (complaints) received in relation to clinical communication.

Depending on the nature or circumstance, incidents involving poor clinical communication and/or teamwork can be classified under

- Communication and teamwork
    - Communication between staff
    - Communication with the patient
    - Teamwork

However, it is recommended that incidents are primarily classified by the effect of the incident on the patient, for example a medication error, a fall, an incident during treatment or a procedure, or during the hours after birth, rather than poor clinical communication and/or teamwork. This is because these are better described as contributing factors.

For more information

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