Clinical governance and partnering with consumers

Overarching actions that support integrated clinical governance, quality improvement and organisational systems to support effective clinical communications

- **Clinical Governance Standard:** ● 1.16, 1.17, 1.18 – Healthcare records; and ● 1.12 – Open disclosure
- **Partnering with Consumers Standard:** ● 2.3, 2.4, 2.5 – Healthcare rights and informed consent; ● 2.6, 2.7 – Sharing decisions and planning care; and ● 2.8, 2.9, 2.10 – Communication that supports effective partnerships
- **Communicating for Safety Standard:** ● 6.1, 6.2, 6.3, 6.4 – Clinical governance and quality improvement to support effective communication

Consider documentation requirements at all stages

Relevant, accurate, complete and timely information is documented in the healthcare record to support patient care (●3.7, ●4.5, 4.6, 4.8, 4.10(c), 4.12, ● 5.4(a), 5.9, 5.12, 5.13, 5.17(b), ●6.6, 6.11, 7.5, ●8.4(a), 8.5(e))

Effective communication is critical at all stages of care

Clinicians should have the skills and knowledge to effectively communicate with patients, carers, families and other members of the care team

Patient's journey

A patient enters a health service organisation

FLOW OF INFORMATION – All relevant information should follow the patient

A patient exits a health service organisation

A patient is in their home/community/ other service

Communicating at registration and admission

Actions to gather administrative information; information about a patient's goals and preferences; and information to inform the plan of care

- Correct identification and procedure matching (●6.5, 6.6)
- Sharing decisions and planning care (●2.6, 2.7)
- Communication to support effective partnerships (●2.8, 2.9, 2.10)
- Informed consent and decision-making capacity (●2.4, 2.5)
- Medication history (including adverse drug reactions) and reconciliation (●4.5, 4.6, 4.7, 4.8)
- Routinely asking patients if they identify as Aboriginal or Torres Strait Islander (●5.8)
- Planning for comprehensive care, screening of risk and clinical assessment (●5.7, 5.9, 5.10, 5.11)
- Preventing delirium and managing cognitive impairment (●5.29, 5.30)

Communicating to plan care and when care, therapy or medication is provided

Actions to support effective communication to support decision-making about care, including between clinicians and multidisciplinary teams; and between clinicians and patients, families and carers

- Correct identification and procedure matching (●6.5, 6.6)
- Sharing decisions and planning care (●2.6, 2.7)
- Communication to support effective partnerships (●2.8, 2.9, 2.10)
- Providing information to patients on their medicine needs and risk (●4.11)
- Systems to deliver comprehensive care, developing and using comprehensive care plan (●5.4(a), 5.13, 5.14)
- Identifying at all times the clinician with overall accountability for patient care (●5.4(d))
- Collaboration and teamwork (●5.5, 5.6)
- Comprehensive care planning, including end-of-life care where appropriate (●5.9, 5.13, 5.15, 5.20)
- Preventing delirium and managing cognitive impairment (●5.29, 5.30)

Communicating acute deterioration and escalating care

Actions where acute deterioration occurs and care needs to be escalated

- Clinicians recognise acute deterioration (in physiological and mental state) and escalate care (●8.5(e), 8.6, 8.8, 8.9)
- Escalation by patients, carers or families (●8.7)

Communicating at transitions of care

Actions when all or part of a patient's care is transferred on a temporary or permanent basis

- Correct identification and procedure matching (●6.5, 6.6)
- Structured clinical handover (●6.7, 6.8)
- Sharing decisions and planning care (●2.6, 2.7)
- Communication to support effective partnerships (●2.8, 2.9, 2.10)
- Ensuring timely and appropriate referral (●5.4(c))
- Communicating infectious state (●3.7)
- Reviewing current medicine order, reconciling any discrepancies at transitions of care (●4.6)
- Providing medicines list to receiving clinicians at transitions of care (●4.12(b))

Communicating at discharge

Actions relevant on discharge, noting that discharge is one type of transition of care

- Correct identification and procedure matching (●6.5, 6.6)
- Structured clinical handover (●6.7, 6.8)
- Sharing decisions and planning care (●2.6, 2.7)
- Communication to support effective partnerships (●2.8, 2.9, 2.10)
- Aligns with comprehensive care plan (●5.13)
- Provision of medicines list to receiving clinicians at transitions of care (●4.12(b))

Follow-up communication

Actions that support closed-loop communication

- Communicating critical information to clinicians and patients (●6.9)
- Transfering responsibility and accountability for care (●6.8(f))
- Predicting, preventing and managing self-harm and suicide (●5.31, 5.32)

Communicating when critical information emerges or changes

Critical information may arise throughout the course of care, and may require changes to the plan of care

- Communicate critical information and risks to clinicians and patients (●6.9)
- Patients, carers and families able to communicate critical information (●6.10)
- Review and adapt plan, reassess patients needs (●5.14(c)-(d))
- Communicate adverse drug reactions during an episode of care or ineffective management of medication (●4.8)