essential element 4

CLINICAL COMMUNICATION
Clinical Communication

The Problem

Effective clinical communication about patient deterioration is a complex process. It includes knowing who to contact when a patient’s condition deteriorates, what information is important to convey, and how to convey this information effectively.

Poor written and verbal communication between clinicians is a leading cause of adverse events in health care.

Many hospitals in Australia do not have clear policies related to communication.

Patients can experience delays in receiving the treatment they need if agreed communication processes are not in place.

Patients, families and carers often identify signs of deterioration and report this to clinicians, but little action may be taken.

Goals of this Essential Element

Verbal and written information to support recognition and response to clinical deterioration is comprehensive, timely and accurate.

Patient, family and carer concerns about possible deterioration are valued and acted on by clinicians.

What You Need to Do

Develop agreed communication processes (written and verbal) to support recognition and response systems.

Develop systems for communicating with patients, families and carers about possible deterioration.

Common Terms Used in this Essential Element

Handover: ‘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.’

Mnemonic: memory devices that help recall larger pieces of information, especially in the form of lists such as characteristics, steps, stages, parts or phases. They can include phrases, acronyms, and rhymes.
### essential element 4: clinical communication

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

2. **The value of information about possible deterioration from the patient, family or carer should be recognised.**

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

4. **There should be adequate communication and discussion about the wishes of the patient regarding advanced care planning, resuscitation and other active treatment.**

5. **Structured handover processes, including documentation of handovers, should be used for all patients.**

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

7. **Handover procedures should include the identification of patients who are deteriorating and communication of information that is relevant to their management.**
roles and responsibilities

Who is responsible?
How does this element apply to your role(s)?
What clinical areas does this element apply to?

A variety of health professionals are involved in developing and implementing communication processes to improve recognition and response to clinical deterioration. To change practice and improve clinical communication systems, it is necessary to determine who will be responsible for undertaking the tasks required for this essential element.
### People Involved in Communicating about Clinical Deterioration

<table>
<thead>
<tr>
<th>Clinical areas involved in communicating about clinical deterioration</th>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| All acute care areas in a facility need to have effective clinical communication processes in place to support recognition and response systems. This includes: | Patients, families and carers | • Participate in developing communication processes to support recognition and response to clinical deterioration  
• Participate in agreed communication processes to support recognition and response systems |
| • emergency departments  
• intensive care units/high dependency units  
• general wards and speciality areas  
• maternity units  
• paediatric units  
• mental health units  
• operating theatre recovery units  
• other clinical areas where patients receive acute care treatments | Non-clinical workforce | • Participate in developing communication processes to support recognition and response to clinical deterioration  
• Participate in agreed communication processes to support recognition and response systems |
| | Clinical workforce | • Participate in developing communication processes to support recognition and response to clinical deterioration  
• Follow agreed communication processes and protocols  
• Educate patients, families and carers on agreed communication processes to support recognition and response systems  
• Educate other clinicians, including those who are casual or from an agency, on local communication processes and protocols related to recognition and response systems  
• Respond to concerns from patients, families and carers related to clinical deterioration  
• Participate in education related to communication processes  
• Participate in evaluating communication processes and protocols |
| | Educators | • Educate the clinical and non-clinical workforce on communication processes and protocols related to recognition and response systems  
• Participate in evaluating communication processes and protocols |
| | Health professionals with responsibility for policy or quality improvement | • Decide when and how communication for events related to recognition and response systems should occur  
• Develop minimum standards for the content and methods for communicating key patient events associated with clinical deterioration and recognition and response systems  
• Develop tools to support communication events  
• Identify opportunities for communicating with patients, families and carers about possible deterioration  
• Develop processes for communicating with patients, families and carers about clinical deterioration  
• Evaluate communication related to recognition and response systems |
| | Health service managers | • Provide ongoing access to training for the clinical and non-clinical workforce on communication processes and protocols related to recognition and response systems  
• Evaluate communication related to recognition and response systems |

### Table 5 - Roles and Responsibilities Relating to Clinical Communication
**Table 5 (Continued...)**

<table>
<thead>
<tr>
<th>Clinical areas involved in communicating about clinical deterioration</th>
<th>People involved in communicating about clinical deterioration</th>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health service boards, executives and owners</td>
<td></td>
<td>• Assign responsibility, personnel and resources to support development, implementation and evaluation of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– minimum standards, including roles and responsibilities, for communication associated with clinical deterioration and recognition and response systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– tools for communication (written and verbal) between health professionals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– tools for informing patients, families and carers of agreed communication processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– education and training programs to improve communication related to recognition and response systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Provide managers with support to implement communication processes and protocols in their areas</td>
</tr>
</tbody>
</table>

**Implementation Tip**

- Developing communication processes and protocols

  - Communication processes may need to vary between clinical areas due to differences in staffing composition, environment and resources. It is important that facilities consider different clinical areas such as emergency departments, paediatrics and maternity when identifying and deciding on communication processes. Seek representation from clinicians in these different areas throughout your project.
  
  - A major barrier to implementing changes to communication processes is scepticism about whether there is a problem with the processes already in place. Gather evidence related to processes such as clinical handover to help communicate the need for change. Use information from this guide and collect patient stories and local incidents to help determine the extent of the problem, and to prepare clinicians for change.
  
  - The Australian Commission on Safety and Quality in Health Care has developed the OSSIE Guide to Clinical Handover Improvement and the accompanying Implementation Toolkit for Clinical Handover Improvement to help facilities review and develop effective handover practices. Facilities are encouraged to use these resources in partnership with the recommendations from this implementation guide to help develop effective handover processes that are specific to recognising and responding to clinical deterioration.
  
  - Patients, families and carers should be involved in processes to improve communication about clinical deterioration. They bring insights about their experiences of receiving care and suggestions about how communication may be more effective.

**Step 2: Self-assessment and planning tool**

Use the self-assessment tool to identify gaps in your systems for clinical communication and develop an action plan.

**Prioritise your changes.**

The self-assessment and planning tool has been designed to assess one clinical area, or an entire facility’s current practice, in relation to this essential element. A modifiable electronic version of this tool, and other supporting tools to help answer the self-assessment questions, are available on the Commission’s web site.

The action plan for this essential element begins on page 191. Follow the instructions in the self-assessment and planning tool to complete the action plan.
<table>
<thead>
<tr>
<th>NAME OF WARD OR AREA BEING ASSESSED:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>task 1</strong></td>
</tr>
</tbody>
</table>

**Develop agreed communication processes (written and verbal) to support recognition and response systems**

<table>
<thead>
<tr>
<th>AGREEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there agreement about when verbal and written communication associated with recognition and response systems is required?</td>
</tr>
<tr>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

| Is it clear how this communication should occur (e.g. face-to-face, phone)? |
| **YES**  | Fill in next two columns |
| **NO**  | Tick ‘Lack of agreement’ in your action plan |

<table>
<thead>
<tr>
<th>PROCESS OR POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are roles and responsibilities related to communication available and included in the escalation policy or similar document?</td>
</tr>
<tr>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are tools for communication available (e.g. mnemonics, documentation templates)?</td>
</tr>
<tr>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

| Do these tools include recent observations, assessments and patient wishes? |
| **YES**  | Fill in next two columns |
| **NO**  | Tick ‘Lack of resources’ in your action plan |

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is training available for clinicians on communication processes?</td>
</tr>
<tr>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SYSTEMS TO SUPPORT MONITORING AND EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are communication processes evaluated?</td>
</tr>
<tr>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>
**Essential Element 4**

### Step 2

**Self-Assessment Tool**

- **Name of Ward or Area Being Assessed:**

<table>
<thead>
<tr>
<th>Where Is It Kept?</th>
<th>Are these policies/processes/resources operating as planned?</th>
<th>Does your data demonstrate effective operation at all times?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES ▶ WELL DONE! Continue to monitor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO ▶ Why not? What are the barriers? Add these to your action plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES ▶ WELL DONE! Continue to monitor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO ▶ Why not? What are the barriers? Add these to your action plan</td>
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<td>NO ▶ Why not? What are the barriers? Add these to your action plan</td>
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<td>YES ▶ WELL DONE! Continue to monitor</td>
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<tr>
<td></td>
<td>NO ▶ Why not? What are the barriers? Add these to your action plan</td>
<td></td>
</tr>
</tbody>
</table>

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**Clinical Communication**
### NAME OF WARD OR AREA BEING ASSESSED:

#### task 2
Develop systems for communicating with patients, families and carers about possible deterioration

<table>
<thead>
<tr>
<th>AGREEMENT</th>
<th>Data or documentation that proves the criteria have been met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YES</strong></td>
<td>Fill in next two columns</td>
</tr>
<tr>
<td><strong>NO</strong></td>
<td>Tick ‘Lack of agreement’ in your action plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROCCESS OR POLICY</th>
<th>Type of data or name of document</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YES</strong></td>
<td>Fill in next two columns</td>
</tr>
<tr>
<td><strong>NO</strong></td>
<td>Tick ‘Lack of process/policy’ in your action plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESOURCES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YES</strong></td>
<td>Fill in next two columns</td>
</tr>
<tr>
<td><strong>NO</strong></td>
<td>Tick ‘Lack of resources’ in your action plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YES</strong></td>
<td>Fill in next two columns</td>
</tr>
<tr>
<td><strong>NO</strong></td>
<td>Tick ‘Lack of knowledge’ in your action plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SYSTEMS TO SUPPORT MONITORING AND EVALUATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YES</strong></td>
<td>Fill in next two columns</td>
</tr>
<tr>
<td><strong>NO</strong></td>
<td>Tick ‘Lack of monitoring and evaluation’ in your action plan</td>
</tr>
</tbody>
</table>

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**CLINICAL COMMUNICATION**
<table>
<thead>
<tr>
<th>Essential Element 4</th>
<th>Self-Assessment Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 2:</strong></td>
<td>Are these policies/processes/resources operating as planned? Does your data demonstrate effective operation at all times?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where is it kept?</th>
<th>YES ▶ WELL DONE! Continue to monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO ▶ Why not? What are the barriers? Add these to your action plan</td>
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</tbody>
</table>

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<tr>
<th></th>
<th>YES ▶ WELL DONE! Continue to monitor</th>
</tr>
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<td>NO ▶ Why not? What are the barriers? Add these to your action plan</td>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO ▶ Why not? What are the barriers? Add these to your action plan</td>
</tr>
</tbody>
</table>

**Knowledge**

- Do clinicians receive training on patient, family and carer communication?
  - YES ▶ WELL DONE! Continue to monitor
  - NO ▶ Why not? What are the barriers? Add these to your action plan

**Systems to Support Monitoring and Evaluation**

- Are patient, family and carer experiences evaluated?
  - YES ▶ WELL DONE! Continue to monitor
  - NO ▶ Why not? What are the barriers? Add these to your action plan
### NAME OF WARD OR AREA BEING ASSESSED:

### what do you need to do?

<table>
<thead>
<tr>
<th>Task not yet achieved</th>
<th>Why has this task not been achieved (barriers)?</th>
<th>What actions are needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ <strong>task 1</strong></td>
<td>Develop agreed communication processes (written and verbal) related to recognition and response systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of agreement</td>
<td>DECIDE</td>
</tr>
<tr>
<td></td>
<td>Lack of process/policy</td>
<td>DEVELOP</td>
</tr>
<tr>
<td></td>
<td>Lack of resources</td>
<td>RESOURCE</td>
</tr>
<tr>
<td></td>
<td>Lack of knowledge</td>
<td>EDUCATE</td>
</tr>
<tr>
<td></td>
<td>Lack of monitoring and evaluation</td>
<td>EVALUATE</td>
</tr>
</tbody>
</table>

### OTHER POSSIBLE BARRIERS:

- Lack of agreement  | DECIDE | p211  |
- Lack of process/policy  | DEVELOP | p212  |
- Lack of resources   | RESOURCE | p214  |
- Lack of knowledge   | EDUCATE | p215  |
- Lack of monitoring and evaluation | EVALUATE | p216  |

### OTHER POSSIBLE BARRIERS:

### OTHER COMMENTS AND PLANS:

Go to the recommended sections of this guide for information on tasks and actions. List the tools and resources from the guide to address this gap here. Also consider other resources that may be available to you to address this gap.

**OTHER POSSIBLE BARRIERS:**

**OTHER POSSIBLE BARRIERS:**
Use the information from the self-assessment and planning tool to complete the action plan. The action plan links the barriers identified by the self-assessment and planning tool with specific actions, tools and resources to address them.

<table>
<thead>
<tr>
<th>Who will be responsible?</th>
<th>When will this happen? Consider undertaking actions that are low cost, easy to implement and support meeting the <em>National safety and quality health service standards</em> first</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Use the information and resources in this guide to help implement your action plan.

For each task, the following actions may be required: Decide, Develop, Resource, Educate and Evaluate

Each of the tasks for this essential element is discussed in detail in this section. Each task includes a brief summary of its importance and a series of actions that can be taken to complete it. Links to resources are included in Appendix C and additional tools to support implementation are available on the Commission’s web site.

key tasks for clinical communication

- **task 1**
  Develop agreed communication processes (written and verbal) to support recognition and response systems

- **task 2**
  Develop systems for communicating with patients, families and carers about possible deterioration
**why this task is important**

This task is needed because:

- poor communication is a leading cause of adverse events in health care
- knowing who to contact when a patient’s condition deteriorates, what information is important to convey, and how to convey this information effectively, is a complex process
- patients can experience delays in receiving the treatment they need if agreed communication processes are not in place
- clinical treatment decisions are based on knowledge of a patient’s current condition.

Successful operation of recognition and response systems requires written and verbal communication associated with abnormal physiological observations and assessments, rapid response system calls, advance care directives, patient transfers, treatment-limiting decisions, and information about deterioration from patients, families and carers.

Some of the most important contributing factors to adverse events in health care are lack of handover processes, insufficient or poor communication techniques during handover, and inadequate clinical documentation. Poor communication also poses risks to patient safety when patients are transferred between clinical areas, and during critical events such as rapid response system calls.

Poor verbal and written communication between clinicians can result in discontinuity of care, delays in treatment, adverse events, and increased morbidity and mortality. Practices such as not reading documentation may also contribute to adverse events and clinical deterioration not being recognised and acted on.

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**learning from coronial inquests**

The importance of effective communication when deterioration occurs

Joan Dennison was a 78-year-old woman who died after the diagnosis of her mechanical small bowel obstruction was missed. She presented at the emergency department of a small hospital without on site surgical registrar coverage. Mrs Dennison’s case was discussed by telephone with the on-call registrar at a neighbouring facility and she was discharged home. Mrs Dennison died two days later from sepsis and aspiration. At the inquest, the coroner found that:

‘Serious failings in the level of communication between the doctors occurred. It is irresistibly the case that Mrs Dennison should never have been discharged from hospital...Mrs Dennison’s death was avoidable.’

Important information can be overlooked if clinicians are not aware of their roles and responsibilities related to communication. It is important to develop agreed communication processes to enable clinicians to understand how to communicate information about clinical deterioration, and who to communicate it to.

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**comments from colleagues**

Everybody has a role in communication

‘A lot of times we do get information from families: “You know dad – he’s really confused.” … We’re picking up a lot more information than just going in and saying “Hi, how are you going. Yep; the patient’s fine.” So for us it’s about clearly documenting. It’s about having a process that you know you can go somewhere and there’s clear communication of any issues that have been identified. We have the same issues. We’ve passed things on and we’re not sure it’s passed on and acted on. We’re not seeing the patient for eight hours of a day. We’re seeing them for maybe half an hour or an hour depending on how we’re working with them… so until we come back and see that patient we don’t know what’s been followed up.’

Occupational therapist, focus groups, 2010
Clear agreement on communication practices (written and verbal) and standardised practices such as mnemonics may improve team performance and ensure that the correct information is conveyed at the right time, to the right person, for the right reasons. Information that is important for recognising and responding to clinical deterioration may be overlooked during routine clinical handover.6

**practice point**

**What gets communicated at handover?**

A review of the reliability of information contained in the clinical handover of 246 patients identified that the following issues were communicated in only 17-18% of handovers.6

- investigations that had not been undertaken
- results pending
- ongoing treatment
- complications.

In the past, clinical handover processes have been varied and highly individualised, and until recently there has been no evidence base to determine their optimal content, process and information tools.1 The development of standardised handover communication processes – some of which are included in the OSSIE Guide to Clinical Handover Improvement – has demonstrated significant improvements in the exchange of information between clinicians. The guide is now regarded as a minimum standard for safe practice in Australia.1 Links to resources about clinical handover are available in Appendix C.

**practice point**

**Mnemonics**

Mnemonics are memory devices that help recall of larger pieces of information, especially in the form of lists such as characteristics, steps, stages, parts or phases. They can include phrases, acronyms and rhymes.

Mnemonics use association as a way of remembering, providing a structured process to recall information or data. Many hospitals in Australia use mnemonics to help with the structure and content of clinical handover. Examples of these include:

- **SHARED**
  (Situation, History, Assessment, Risk, Expectation, Documentation)
- **ISOBAR**
  (Identify, Situation, Observation, Background, Agree to a plan, Readback)
- **ISBAR**
  (Identify, Situation, Background, Assessment, Recommendation)
- **SBAR**
  (Situation, Background, Assessment, Request/recommendation)

Agreed processes for communicating clinical deterioration to patients, families and carers are also required. Families and carers want to be informed when clinical deterioration occurs. Failure to do this may cause families to feel they have been denied time together, missing out on precious moments when a patient may still have been able to communicate. Delays in acknowledging clinical deterioration can also lead to a perception that the service may be withholding critical information.7 For hospitals with systems in place that allow patients and families to call a rapid response team or other clinicians directly, communication issues often underlie the escalation of care.5–10

**comments from patients, families and carers**

**Families want to know about clinical deterioration**

‘We wanted to know if [my son] knew….what’s going to happen to him, if [he] knew he was going to surgery, we wanted to know what happened, what happened between those hours that I went – we all had been there on Wednesday evening, they sent us home. What happened between 9 o’clock and 12 o’clock? I want to know.’

100 Patient Stories Project data (from research funded by the Commission)
### Task 1 - Develop Agreed Communication Processes (Written and Verbal) to Support Recognition and Response Systems

<table>
<thead>
<tr>
<th>Decide</th>
<th>Develop</th>
<th>Resource</th>
<th>Educate</th>
<th>Evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decide when and how communication to support recognition and response systems occurs</td>
<td>Develop roles and responsibilities for communication events to support recognition and response systems</td>
<td>Provide tools to support communication associated with recognition and response systems Include information about recent observations, assessments and patient wishes</td>
<td>Educate clinicians on communication associated with recognition and response systems</td>
<td>Evaluate communication processes</td>
</tr>
</tbody>
</table>
Facilities need to work with clinicians to identify when and how communication should occur to support recognition and response systems.

Events where written or verbal communication is required to support recognition and response systems include:

- reporting abnormal observations and assessments
- concern about a patient’s clinical condition
- patient deterioration that requires a rapid response system call
- clinical handover between staff, such as at shift changes and meal breaks
- transfer of a patient who has deteriorated to another clinical area or facility.

Handover procedures should include identifying patients who are deteriorating or are at risk of deterioration. This enables clinicians to prioritise care and review deteriorating patients in a timely manner.

Patients who have had a recent rapid response call should be discussed during shift change handovers. Facilities may develop agreed communication triggers, such as elevated early warning scores or other high risk scenarios, to identify patients whose condition needs further discussion.

Agreement on communication processes for advance care plans and other treatment-limiting decisions is important to ensure patients receive the right care and treatment in accordance with their wishes. Further information on improving these processes is available in Essential element 2: Escalation of care.

It is also important to consider how communication will take place. Face-to-face communication provides more opportunities to clarify information, and can provide education and promote team-building. However, verbal communication alone without supporting documentation relies heavily on memory and is considered high risk. Facilities may need to consider more than one method of communication for each event.
Once facilities have identified when and how communication to support recognition and response systems occurs, agreement must be reached on each clinician’s roles and responsibilities for communicating key information. This information should be included in the escalation policy or similar document.

Clinicians have different roles in patient care, with each role focusing on different patient assessments, treatment and management practices. Roles and responsibilities for communication need to clearly identify:

- which clinicians should communicate information
- what information each clinician is responsible for communicating
- how the communication should occur (e.g. written, face-to-face, phone).

A team-based approach to communication may be appropriate and should be explored. This approach may be useful following rapid response system calls, when a large amount of information is recalled and communicated.

The benefits of brainstorming

An effective method for reaching agreement on roles and responsibilities for communication processes is to undertake a brainstorming exercise with members of the healthcare team. Brainstorming exercises enable teams to generate a high volume of ideas and information in only a few minutes without criticism or judgement. This process encourages participation and teamwork and is an effective method for getting a large group of people to work together.

Information on different clinicians’ roles and responsibilities should be aligned with each communication event identified. Reaching agreement on these communication processes will help reduce the risk of overlooking critical information.
Agreed communication processes may be applicable to an entire facility, for example information for transferring a patient to an external facility may be the same for all acute areas. However, other communication processes may vary between clinical areas due to differences in staffing composition and resources. It is important that facilities consider different clinical areas and departments when identifying and agreeing on roles and responsibilities for communication.

### Communication agreement checklist

Facilities may like to brainstorm using the following checklist to help develop agreed roles and responsibilities related to communication for recognising and responding to clinical deterioration. Consider each event from a different health discipline’s perspective and clinical area, and ask:

- What information should be communicated?
- Who should be informed?
- How should communication occur (verbal or written or both)?
- Who is responsible for the communication?

Communication events to consider include:

- reporting abnormal observations and assessments
- worry or concern about a patient’s clinical condition
- patient deterioration that requires a rapid response system call
- clinical handover during shift changes, meal breaks etc
- clinical deterioration and communication with the patient, family, carer and healthcare team
- transfer of a patient who has deteriorated to another clinical area or facility
- identification of and discussions related to advance care plans and other treatment-limiting decisions.
A large amount of information is communicated to a range of clinicians when clinical deterioration occurs. If the information is not comprehensive, relevant and clearly understood by the receiver, this poses risks to patient safety.

Facilities need to provide clinicians with tools to support effective communication. A large amount of information is communicated to a range of clinicians when clinical deterioration occurs. If the information is not comprehensive, relevant and clearly understood by the receiver, this poses risks to patient safety.

Communication related to clinical deterioration can be greatly improved using a structured protocol or mnemonic. This enables clinicians to recall important information, reduces the likelihood of information being missed, and helps communicate information in a clear, logical and precise manner. Links to resources about communication, including clinical handover, are available in Appendix C.
Case review

Clinical handover in mental health settings

Tasmania’s Mental Health Services North has implemented a handover tool, ISBARR, to improve the handover of information about mental health clients. The tool is used both in community and inpatient settings.

I – Identification
S – Situation
B – Background
A – Assessment
R – Risk assessment
R – Recommendations

Below is a worked example of using the tool in practice.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Claire, 43-year-old divorced female with two adult children</td>
<td></td>
</tr>
</tbody>
</table>
| S | Brought in by daughter (Marlene)  
Recurrence of bipolar affective disorder – mania  
Admitted on 20/10/08 on an involuntary order  
Lives alone in rented accommodation – disability pension  
Collateral history from daughter – ceased sodium valproate approx 6 weeks ago, until then had functioned well in the community  
No history of violence  
Social drinker (1–2 red wines on occasional weekends)  
Denies illicit drug use |
| B | Past history of admissions (X4), last admitted 2008 – similar presentation  
Non insulin dependent diabetic – diet controlled |
| A | Appears stated age, dressed in bright coloured clothing inappropriate for weather  
Intrusive, hyperactive, poor response to direction  
Delusional belief – she is having affair with prime minister  
Orientated to person-time-place  
Poor insight, judgement and non acceptance of illness  
Speech rapid rate, pressured flight of ideas  
Rates mood 20/10 elated  
Affect – inappropriately smiling  
Does not appear to be experiencing perceptual disturbances  
Memory untested  
No current physical issues – blood sugar level diet controlled  
Good family support |
| R | Previously assaulted staff when presented as manic  
Currently no sign of irritability  
Poor food and fluid intake  
Sexual disinhibition  
At risk of exploitation from unknown males  
Over inflated belief of physical ability |
| R | To be nursed in the high dependency unit for her safety  
To be given finger food and fluids encouraged, twice daily blood sugar checks  
Closely monitor medication  
Repeat sodium valproate |

F. Kamphuis, Department of Health and Human Services, Tasmania, personal communication, 2011
Verbal communication only – compared with verbal communication with some form of supporting documentation – relies heavily on memory and is a high risk scenario.\(^1\) The practice point below provides an example of the importance of documenting clinical handover.

**practice point**

The Importance of documenting clinical handover

A study using simulated nursing handover cycles compared the rate of data loss when handing over information in three styles – verbally, with note taking, and with a combination of a typed data sheet and verbal handover.\(^{12}\) The same data points were to be handed over in five handover cycles, each separated by an hour. Data loss was measured by counting the number of data points that were not handed over in each cycle.

When using verbal communication alone, data loss was almost complete after the first handover cycle. With note taking (the traditional handover style), approximately 30% of data were lost at the first handover and nearly 60% were lost by the fifth. When handovers used the combination of a pre-prepared data sheet and verbal handover, data loss was less than 5% throughout all five cycles.

Physiological observations and other clinical assessments provide a clear indication of a patient’s clinical condition and the presence of deterioration. Handover and documentation protocols or mnemonics must therefore include information about the patient’s most recent observations and assessments to ensure clinical deterioration is not missed. This information should include:

- observations and assessments, including details of the patient’s individual monitoring plan and latest measurements or findings (normal and abnormal)
- abnormal diagnostic tests or pathology results
- results pending (e.g. pathology, radiology)
- current treatments
- modifications to usual escalation protocols (if applicable)
- advance care directives and treatment-limiting decisions.

Observations reported in the protocol may vary between clinical areas based on the types of patients and role of the clinical unit (e.g. neonatal intensive care vs. general medical ward). It may be helpful for clinical areas to develop a list of the minimum observations and assessments to be communicated as part of the handover or documentation protocol.
Making communication about observations easy

The LIME (Logical Information Made Easy) communication tool was developed by one hospital using the ISOBAR handover mnemonic. It is used by clinicians who receive information about patients who are deteriorating. The tool was designed to allow reported observations to be graphically documented in the same format as the hospital’s track and trigger system.
Handover and documentation protocols or mnemonics must also include information about the patient’s wishes regarding advance care planning and any other treatment-limiting decisions. This will act as a trigger to discuss the information, ensuring the patient’s wishes are communicated and avoiding confusion about the care required if clinical deterioration occurs. Further information on tools for communicating end-of-life care and advance care directives can be found in Essential element 2: Escalation of care.

Protocols and mnemonics can also be used to improve the quality of clinical documentation. The practice point below demonstrates the positive effect of a structured documentation tool on communication associated with medical emergency team reviews.

**practice point**

**Improving medical documentation with a standardised form to record medical emergency team (MET) reviews**

An Australian hospital introduced a standardised form to document MET reviews, as well as education of the MET’s medical and intensive care clinicians. The intervention significantly improved documentation of MET call details.

<table>
<thead>
<tr>
<th>Documentation about the MET call</th>
<th>Improvement in documentation rate post implementation (only statistically significant results included)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date and time of MET call</td>
<td>24 %</td>
</tr>
<tr>
<td>Staff member making the call</td>
<td>32 %</td>
</tr>
<tr>
<td>Who attended the call</td>
<td>31 %</td>
</tr>
<tr>
<td>Differential diagnosis</td>
<td>16 %</td>
</tr>
<tr>
<td>Investigations performed</td>
<td>19 %</td>
</tr>
<tr>
<td>Discussions and referrals</td>
<td>24 %</td>
</tr>
<tr>
<td>Doctor’s name</td>
<td>13 %</td>
</tr>
</tbody>
</table>
Clinicians need to be aware of their responsibilities for communication practices associated with patients whose clinical condition is deteriorating.

Communication requirements should be incorporated into education programs for escalation protocols and recognition and response systems.

**Comments from colleagues**

The need for education about how to communicate effectively

‘I think we actually get very little education on how, what we should be writing. Honestly, I don’t think I actually knew. On my first few days I had no idea what to write. So I just copied information from other places where it was already documented and tried to pick up a few bits and pieces on the ward round…. And when things are quick as well, you just don’t know. There should be a few standard things that should be documented. I think the nursing notes are actually better than ours. They are more standardised. But we have no standardisation whatsoever. Very important things are said on the ward round which aren’t documented because they are not sort of said formally enough to be documented. It’s hard to stop your registrar and go, the heart rate is 110 should we document that we are happy with that. At the end of the day that would save people a lot of time, the nursing staff time, because they would know what is ok.’

Medical resident, focus groups 2010

Communication requirements should be incorporated into education programs for escalation protocols and recognition and response systems. Health professionals should be informed of requirements regarding communication when they start employment, when changes to agreed practices are made, and if gaps in communication practices are identified. Strategies for improving communication practices include audit and feedback of clinical documentation practices, peer review, observation using video or trained observers, and scenario-based simulation training.14
TeamSTEPPS® is an evidence based teamwork training system developed by the United States Department of Defense Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality (AHRQ). TeamSTEPPS® offers a flexible, evidence based toolkit to improve patient safety through improved communication and other teamwork skills.

TeamSTEPPS® promotes competence in four core areas.15

- **Team leadership** – the ability to direct and coordinate activities of team members, assess team performance, assign tasks, develop team knowledge and skills, motivate team members, plan and organise, and establish a positive team atmosphere.

- **Situation monitoring (or mutual performance monitoring)** – the capacity to develop common understandings of the team environment and apply appropriate strategies to monitor teammate performance accurately.

- **Mutual support (or backup behaviour)** – the ability to anticipate other team members’ needs and to shift workload among members to achieve balance.

- **Communication** – the efficient exchange of information and consultation with other team members, including the patient.

The South Australian Department of Health and the Australian Commission on Safety and Quality in Health Care undertook a pilot study in 2009 examining the content and validity of TeamSTEPPS® in Australia. The program has since been adapted for the Australian context. Further information can be requested from: safetyandqualitysa@health.sa.gov.au

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**Implementation Tip**

**TeamSTEPPS®: Assuring optimal teamwork in clinical settings**

**Practice Point**

**Training in teamwork can improve clinical outcomes**

Education programs can have significant effects on the quality and reliability of health care. The Veterans Health Administration in the United States implemented a national team training program and studied the program’s effect on patient outcomes in a retrospective health services cohort study.16

The training allowed surgical staff (surgeons, anaesthetists, nurse anaesthetists, nurses and technicians) to train as a team using crew resource management theory from aviation, which was adapted for health care. Clinicians were trained to challenge each other when they identified safety risks and conduct checklist guided preoperative briefings and postoperative debriefings. They also implemented communication strategies such as recognising ‘red flags’, developing rules of conduct for communication, stepping back to reassess a situation, and communicating effectively during care transitions.

After controlling for baseline differences, the 74 trained facilities experienced a significant decrease of 18% in observed mortality (RR 0.82; 95% CI 0.76–0.91; P = 0.01) compared with a 7% decrease among the 34 facilities that had not undergone training (RR 0.93; 95% CI 0.80–1.06; P = 0.59). A dose response relationship for completion of additional quarters of the training program was also demonstrated. For every quarter of the training program completed, a reduction of 0.5 deaths per 1000 procedures occurred (95% CI 0.2–1.0; P = 0.001).
Methods for evaluating communication processes include observation, structured interviews or surveys, focus groups, peer review, audit, and review of adverse events, near misses and complaints.

Observation can include using video or simply recording information using a pen and paper. Information and links to resources for collecting observational data can be found in the *Implementation Toolkit for Clinical Handover Improvement*, which is available on the Commission’s website.

Structured interviews may help identify strategies for improvement. Information on this process and links to resources for developing interview questions are also available in the *Implementation Toolkit for Clinical Handover Improvement*.

Audits of clinical documentation by peers and feedback to individuals, or a group of clinicians, can identify deficiencies in clinical documentation and improve practice. A tool that can be used to audit medical documentation is available on the Commission’s web site.

All clinical areas should also review adverse events to identify any communication problems and areas for improvement. Key questions include:

- Was the agreed communication process followed (e.g. did clinical handover occur, was the agreed mnemonic used, did the right people participate)?
- Were there any gaps in the information that was communicated?
- How could communication be improved?

Facilities need to identify any barriers to the use of communication protocols and develop strategies for improvement. Strategies may include process redesign, additional tools to support communication (e.g. mnemonics, scripts, documentation tools), and further education.

Specifications for a quality measure about communication are available in Appendix B.
why this task is important

This task is needed because patients, families and carers may recognise and report signs of deterioration to clinicians without any action being taken.

learning from coronial inquests

The importance of listening to family concerns

Jezelle Gordon was a generally healthy one-year-old girl who presented at a rural health facility with a very fast respiratory rate, a fever and tachycardia. Despite her parents expressing great concern and making repeated requests for further action to be taken, Jezelle was sent home with oral antibiotics to treat a respiratory tract infection. She was brought back to the facility the next day in respiratory distress, with low oxygen saturations and showing clinical signs of a severe bilateral pneumonia. Jezelle was declared dead that evening.

Mrs Yeeda was clearly of the view that there was something wrong with her baby’s chest which warranted investigation…The point of concern is not simply the fact that Dr Besse rejected the request of Mrs Yeeda that her baby’s chest be X-rayed, Mrs Yeeda was asking in effect for further investigations to be conducted as she was very concerned about the health of her baby and no such investigations were conducted.18

Patients, families and carers are ideally placed to identify signs of clinical deterioration. Families and carers know the patient well, and can often identify subtle changes or signs of clinical deterioration before these signs are identified by the healthcare team. Families and carers also spend time with patients, providing additional surveillance to that provided by the healthcare team.

Case review

Outcomes of patient and family escalation calls

The University of Pittsburgh Medical Center has reported that 69% of patient, family and carer escalation calls may have prevented adverse events.19

An example of the impact that a family escalation call can have is as follows:

A referral to the patient and family escalation system was made when a patient’s wife raised concerns about the patient’s restlessness and abnormal breathing.10 The patient’s wife said that the nurses on the ward were not concerned with the patient’s condition, and she felt that they were too busy. An assessment by the critical care outreach team found that the early warning score had been calculated incorrectly and was too low, and the patient was septic and in sputum retention. The patient’s tracheostomy was cleaned and redressed, investigations ordered and antibiotics commenced after consultation with the patient’s healthcare team.

Adverse events internationally and in Australia have demonstrated delays in patients receiving appropriate treatment, despite families identifying and reporting concerns of clinical deterioration to the healthcare team.18,20 Health professionals must value and act on information provided by patients, families and carers to ensure that clinical deterioration is recognised and responded to.
The benefits of partnerships with patients and consumers

Patient-centred care is recognised as an element of high quality health care in its own right, and there is strong evidence that it can lead to improvements in clinical quality and outcomes by increasing safety, cost effectiveness, and patient, family and staff satisfaction.

Studies have demonstrated significant benefits from such partnerships in clinical quality and outcomes, the experience of care, and the business and operations of delivering care.

Clinical benefits associated with better patient experience and patient-centred care include:

- decreased mortality\(^\text{21}\)
- decreased readmission rates\(^\text{22}\)
- decreased rates of healthcare acquired infections\(^\text{23}\)
- reduced length of stay\(^\text{24}\)
- improved adherence to treatment regimens\(^\text{25}\)
- improved functional status.\(^\text{24}\)

Operational benefits include lower costs per case, improved liability claims experiences and increased staff satisfaction and retention rates.\(^\text{26}\)

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**comments from patients, families and carers**

The importance of considering information from patients and families about clinical deterioration

‘With everything that went on I was readmitted another four times after the initial one and I had a lot of run-ins, not run-ins, but words with a few doctors and nurses, because they just – I just felt they weren’t listening. I kept saying, you know, there’s something wrong, there’s something wrong and they just kept feeding me up on painkillers and I kept saying, no, don’t keep giving me these because you’re masking the fact that something’s wrong, you know. I haemorrhaged twice, I had a heart attack, I was rushed in for an emergency operation which was a curette because they’d left so much placenta in there.’

100 Patient Stories Project data (from research funded by the Commission)
### how to complete this task

**Task 2 – develop systems for communicating with patients, families and carers about possible deterioration**

<table>
<thead>
<tr>
<th>DECIDE</th>
<th>DEVELOP</th>
<th>RESOURCE</th>
<th>EDUCATE</th>
<th>EVALUATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decide on opportunities for communicating with patients, families and carers about possible deterioration</td>
<td>Develop agreed processes for this communication</td>
<td>Provide resources to inform patients, families and carers of the communication processes</td>
<td>Educate clinicians on patient, family and carer communication</td>
<td>Evaluate patient, family and carer experiences</td>
</tr>
</tbody>
</table>
Clinical areas should identify opportunities to improve communication between clinical staff and patients, families and carers about possible deterioration. This proactive and patient-centred approach to care may help confirm physical assessment findings or obtain additional information about a patient’s clinical presentation or problem. Opportunities for communication may include:

- on presentation to an acute care area
- at regularly scheduled intervals throughout a patient’s hospital admission
- daily, during healthcare team rounds
- at any time, by establishing agreed communication processes for patients, families or carers to escalate care.

**DECIDE ON OPPORTUNITIES FOR COMMUNICATING WITH PATIENTS, FAMILIES AND CARERS ABOUT POSSIBLE DETERIORATION**

**practice point**

**What does patient and family centred care look like?**

Patient-centred care is ‘an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among healthcare providers, patients and families.’

- The Institute for Patient and Family Centered Care describes four core concepts in patient and family centred care.28

  - **Dignity and respect** – Health professionals listen to and honour patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care
  
  - **Information sharing** – Health professionals communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information so they can effectively participate in care and decision-making
  
  - **Participation** – Patients and families are encouraged and supported in participating in care and decision-making at the level they choose
  
  - **Collaboration** – Patients, families, health professionals and healthcare leaders collaborate in policy and program development, implementation and evaluation; facility design, professional education, and delivery of care.
Clinicians should consider how communication with patients, families and carers will occur (e.g. face-to-face, by phone) and who will participate.

Bedside rounds provide one opportunity for patients, families and carers to discuss concerns about clinical deterioration and management plans. Steps for improving these opportunities include:

- considering privacy and confidentiality, and how this might affect the process of conducting bedside rounds
- agreeing on processes to maintain privacy and confidentiality; this may include obtaining consent to participation in bedside rounds
- developing information for patients, families and carers that outlines the philosophy of care and policy for bedside rounds
- identifying a process for undertaking the round.

Consider including:
- who will lead
- introductions from team members
- purpose of the visit (teaching, care and treatment review, or other purpose)
- asking for insight and observations from patients or family members
- explaining the care plan
- asking for any questions.

Facilities may like to use an existing communication mnemonic and modify it to suit communication during patient, family and carer team rounds. An example of how this might be achieved is provided in the implementation tip overleaf.
Supporting communication with patients, families and carers

The table below provides an example of how an existing mnemonic (ISBAR) can be used to support communication with patients, families and carers during bedside rounds.

| **INTRODUCTION** | Introduce self and explain purpose of visit  
Obtain verbal consent from the patient for participation in bedside rounds  
Introduce patient, family and carer  
Introduce clinical team |
| **SITUATION** | Explain the current situation (e.g. stable, unstable) |
| **BACKGROUND** | Provide summary of background (e.g. presenting problem, current problems, number of days in hospital)  
Ask the patient, family or carer to discuss any concerns about background information or the current problem  
Use this as an opportunity to confirm information and premorbid condition |
| **ASSESSMENT: ASK THE PATIENT, FAMILY AND CARER** | Ask: what has the patient, family or carer identified?  
Are there any changes or concerns?  
What are the current assessment findings?  
Discuss and explain these findings with the patient, family or carer |
| **RECOMMENDATION** | Recommend a plan  
Reach agreement on this plan with the patient, family or carer |

Example of undertaking bedside rounds

The acute stroke team (medical registrar, nursing, occupational therapist, speech pathologist, social worker, dietitian and rehabilitation specialist) hold ‘stroke rounds’ with patients, families and carers twice a week at a set time in addition to the daily ward round. Patients and families receive a brochure on admission that invites them to attend.

The team shares responsibility for leading the round, and rotates this role between the different health professionals. Rounds occur at the bedside, with the patient’s permission. Consent is obtained from the ‘person responsible’ if the patient is unable to provide consent.

The stroke rounds are an opportunity for the team to discuss physical assessment findings and seek clarification from family members or carers about these findings (such as premorbid conditions). The rounds have helped identify subtle physiological changes that the healthcare team may not have identified, and helped with care planning and discharge requirements.
Facilities should develop resources on agreed communication processes and provide them to patients, families and carers. Resources may include brochures and posters, or information broadcast on internal hospital media systems. Links to resources that have been developed to inform patients and families are included in Appendix C.

Information should include:

- the important role that patients, families and carers play in providing information to the healthcare team
- when agreed communication processes occur (times, locations)
- which clinicians participate in these processes
- alternative methods for communicating concerns to the healthcare team
- ways of providing feedback on these communication processes.

Patients, families and carers should be involved in developing information and resources about communication processes.
Educate all clinicians about the skills that patients, families, and carers display in identifying signs of clinical deterioration. Case examples are powerful tools for illustrating this skill and should be used in education programs about recognition and response to clinical deterioration. To support the development of partnerships between patients and clinicians, the Commission also recommends involving patients and families as teachers, rather than solely as cases to be studied.29

Clinicians should receive training and support to continuously improve their communication skills. This may involve role play and modelling of behaviours from peers.

Best buys for improving the experience of patients

The Picker Institute Europe reviewed the body of evidence for strategies to engage patients in their care.30 According to the review, the most effective ways, or ‘best buys’ to improve patient experience are patient centred consultation styles, communication training for clinicians, and patient feedback (e.g. surveys, focus groups, complaints) with public reporting of performance. The review found that communication skills training for clinicians can lead to improved communication, reduced anxiety and greater patient satisfaction.
EVALUATE PATIENT, FAMILY AND CARER EXPERIENCES

Evaluating patient, family and carer experiences will demonstrate the effectiveness of systems for communicating with patients, families and carers. This may be achieved through surveys, semi-structured interviews or focus groups. In the evaluation, include questions that explore the values, attitudes and actions of clinicians in response to information provided by patients, families and carers about possible deterioration.

Monitoring and investigating complaints and adverse events will also highlight any problems in communication between the healthcare team, patients, families and carers.

In the evaluation, include questions that explore the values, attitudes and actions of clinicians in response to information provided by patients, families and carers about possible deterioration.
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<tbody>
<tr>
<td>DECIDE</td>
<td>Develop agreed communication processes (written and verbal) to support recognition and response systems</td>
<td>Patients, families and carers, Health professionals with responsibility for policy or quality improvement, Clinicians, Health service managers</td>
<td>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 wishes of the patient regarding advance care planning, resuscitation and other active treatment.</td>
<td>9.1.2 Policies, procedures and/or protocols for the organisation are implemented in areas such as:  - communication about clinical deterioration</td>
</tr>
<tr>
<td>DEVELOP</td>
<td>Develop roles and responsibilities for communication events to support recognition and response systems</td>
<td>Patients, families and carers, Health professionals with responsibility for policy or quality improvement, Clinicians, Health service managers</td>
<td>4.5 Structured handover processes, including documentation of handovers, should be used for all patients. 5.1 A formal policy framework regarding recognition and response systems should exist and should include issues such as:  - communication processes</td>
<td>1.3.1 Workforce are aware of their delegated safety and quality roles and responsibilities. 9.1.2 Policies, procedures and/or protocols for the organisation are implemented in areas such as:  - communication about clinical deterioration</td>
</tr>
<tr>
<td>RESOURCE</td>
<td>Provide tools to support communication associated with recognition and response systems. Include information about recent observations, assessments and patient wishes</td>
<td>Health service managers, Clinicians, Health professionals with responsibility for policy or quality improvement</td>
<td>4.1 Formal communication protocols should be used to improve the functioning of teams when caring for a patient whose condition is deteriorating. 4.5 Structured handover processes, including documentation of handovers, should be used for all patients. 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 of information that is relevant to their management.</td>
<td>6.1.1 Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored. 6.2.1 The workforce has access to documented structured processes for clinical handover.</td>
</tr>
</tbody>
</table>
### Summary of Tasks and Actions for Essential Element 4

<table>
<thead>
<tr>
<th>Task</th>
<th>What Is Required</th>
<th>Who Is Responsible</th>
<th>Consensus Statement Recommendations</th>
<th>National Safety and Quality Health Service Standards Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>_task 1</strong></td>
<td><strong>EDUCATE</strong> Develop agreed communication processes (written and verbal) to support recognition and response systems</td>
<td>Health service managers Educators Clinicians</td>
<td>6.2 All doctors and nurses should be able to: • 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 • undertake tasks required to properly care for patients who are deteriorating, such as developing a clinical management plan, writing plans and actions in the healthcare record and organising appropriate follow up</td>
<td>1.4.1 Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities 1.4.2 Annual mandatory training programs to meet the requirement of these standards 1.4.3 Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities</td>
</tr>
<tr>
<td><strong>DETERMINE</strong></td>
<td><strong>EVALUATE</strong> Evaluate communication processes</td>
<td>Patients, families and carers Clinicians Health professionals with responsibility for policy or quality improvement Health service managers</td>
<td>7.1 Data should be collected and reviewed locally and over time regarding the implementation and effectiveness of recognition and response systems</td>
<td>6.3.1 Regular evaluation and monitoring processes for clinical handover are in place</td>
</tr>
<tr>
<td><strong>task 2</strong></td>
<td><strong>DECIDE</strong> Decide on opportunities for communicating with patients, families and carers about possible deterioration</td>
<td>Patients, families and carers Clinicians Health professionals with responsibility for policy or quality improvement Health service managers</td>
<td>4.2 The value of information about possible deterioration from the patient, family or carer should be recognised 4.3 Information about deterioration should be communicated to the patient, family or carer in a timely and ongoing way</td>
<td>1.18.1 Patients and carers are partners in the planning for their treatment 1.18.4 Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders</td>
</tr>
</tbody>
</table>
### Summary of Tasks and Actions for Essential Element 4

<table>
<thead>
<tr>
<th>Task</th>
<th>What is Required?</th>
<th>Who is Responsible?</th>
<th>Consensus Statement Recommendations</th>
<th>National Safety and Quality Health Service Standards Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task 2</strong>&lt;br&gt;Develop systems for communicating with patients, families and carers about possible deterioration</td>
<td><strong>Develop</strong>&lt;br&gt;Develop agreed processes for undertaking this communication</td>
<td>Patients, families and carers&lt;br&gt;Health professionals with responsibility for policy or quality improvement&lt;br&gt;Clinicians&lt;br&gt;Health service managers</td>
<td>4.3 Information about deterioration should be communicated to the patient, family or carer in a timely and ongoing way&lt;br&gt;4.4 There should be adequate communication and discussion about the wishes of the patient regarding advance care planning, resuscitation and other active treatment</td>
<td>9.1.2 Policies, procedures and/or protocols for the organisation are implemented in areas such as:&lt;br&gt;• communication about clinical deterioration</td>
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<td><strong>Resource</strong>&lt;br&gt;Provide resources informing patients, families and carers of the communication processes</td>
<td>Health professionals with responsibility for policy or quality improvement&lt;br&gt;Health service managers&lt;br&gt;Clinicians</td>
<td>4.3 Information about deterioration should be communicated to the patient, family or carer in a timely and ongoing way&lt;br&gt;4.4 There should be adequate communication and discussion about the wishes of the patient regarding advance care planning, resuscitation and other active treatment</td>
<td>9.7.1 Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include:&lt;br&gt;• the importance of communicating concerns about signs/symptoms of deterioration, which are relevant to the patient’s condition, to the clinical workforce&lt;br&gt;• local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration</td>
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<td><strong>Educate</strong>&lt;br&gt;Educate clinicians on patient, family and carer communication</td>
<td>Patients, families and carers&lt;br&gt;Clinicians&lt;br&gt;Health service managers&lt;br&gt;Educators</td>
<td>6.2 All doctors and nurses should be able to:&lt;br&gt;• 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&lt;br&gt;• understand the importance of, and discuss, end-of-life care planning with the patient, family and/or carer</td>
<td>1.4.1 Orientation and ongoing training programs provide the workforce with the skills and information needed to fulfil their safety and quality roles and responsibilities&lt;br&gt;1.4.2 Annual mandatory training programs to meet the requirement of these standards&lt;br&gt;1.4.3 Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities</td>
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| EVALUATE                 | Evaluate patient, family and carer experiences                                    | Patients, families and carers  
Clinicians  
Health professionals with responsibility for policy or quality improvement  
Health service managers                                                                 | 7.1 Data should be collected and reviewed locally and over time regarding the implementation and effectiveness of recognition and response systems | 1.20.1 Data collected from patient feedback systems are used to measure and improve health services in the organisation |

**Summary of tasks and actions for essential element 4**