quick-start guide
to the implementation of

essential element 4

CLINICAL COMMUNICATION

national consensus statement:

essential elements for recognising & responding to clinical deterioration

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

recognising + responding TO CLINICAL DETERIORATION

NSQHS STANDARDS

Quick-start Guide to the Implementation of Essential Element 4: Clinical Communication

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introduction

Early recognition of clinical deterioration, followed by prompt and effective action, can minimise adverse outcomes such as cardiac arrest, and decrease the number of interventions required to stabilise patients whose condition deteriorates in hospital.[1]

each essential element describes a number of specific systems and processes of care that need to be in place to successfully recognise and respond to clinical deterioration

The *National Consensus Statement*: *Essential Elements for Recognising and Responding to Clinical Deterioration* (the consensus statement) describes eight elements that are essential for a prompt and reliable response to clinical deterioration. Each essential element describes a number of specific systems and processes of care that need to be in place to successfully recognise and respond to clinical deterioration. In April 2010, all Australian health ministers endorsed the consensus statement as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia.

using the consensus statement

The consensus statement guides facilities in developing and implementing recognition and response systems according to their local circumstances. The focus of these systems is to ensure that all patients who deteriorate receive appropriate and timely treatment. Facilities may need additional resources such as equipment, personnel, education and training to ensure patients receive appropriate and timely care.

quick-start guides to implementation

This series of quick-start guides has been developed to help people to rapidly understand and implement the essential elements. Implementing the tasks in these guides will help to ensure that the essential elements are in operation and working effectively.

A comprehensive implementation guide (available on the Commission's web site: www.safetyandquality.gov.au) provides more detailed information, resources and examples.

using the quick-start guides

The quick-start guides are structured around an action framework which is designed to help you answer the five key questions to complete each task for each element.

- Do health professionals agree on the basis for the task, the best way to perform the task, and who is responsible?
- Are the necessary processes and policies in place to complete the task?
- Does the facility have the necessary resources to complete the task?
- Is the clinical and non-clinical workforce educated about the importance of the task?
- Does the facility conduct audits, reviews or evaluations to ensure the task is performed properly?

introduction

The types of actions included within this framework and the barriers these actions address are summarised below.

action framework used in the implementation guide

DECIDE → DEVELOP → RESOURCE → EDUCATE → EVALUATE

Action framework		The barriers they address
DECIDE	actions address ▶▶▶	Lack of agreement
DEVELOP	actions address ▶▶▶	Lack of process/policy
RESOURCE	actions address ▶▶▶	Lack of resources and tools
EDUCATE	actions address ▶▶▶	Lack of knowledge
EVALUATE	actions address ▶▶▶	Lack of monitoring and evaluation

Use the action framework to help you complete a self-assessment of your clinical area or facility and to develop an action plan for implementation. Self-assessment and action planning tools can be downloaded from:

www.safetyandquality.gov.au

essential element 4

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 healthcare.

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.

tasks

There are two key tasks to complete for this essential element.

1. Develop agreed communication processes (written and verbal) to support recognition and response systems.
2. Develop systems for communicating with patients, families and carers about possible deterioration.

for each task you will need to:

- identify who has a role in developing clinical communication systems, and what that role is
- use the self-assessment and planning tool (on the Commission's web site) to identify gaps in your systems for clinical communication and prioritise your changes
- use the results of your self-assessment to complete an action plan for your ward or facility
- use the five step action framework – **Decide, Develop, Resource, Educate, Evaluate** – to guide you through implementation.

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.'[2]

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

learning from coronial inquests

The importance of effective communication when deterioration occurs

Susannah McLevie was a healthy 38-year-old woman who died in hospital from puerperal sepsis 28 hours after the birth of her fourth child. Following the birth of her baby, Susannah developed fever, tachycardia, hypotension, oliguria and pain. Despite clear indications to commence antibiotics, and meeting the criteria for a medical emergency call on a number of occasions, Susannah's sepsis was left untreated for more than 24 hours. Her blood pressure eventually became unrecordable and she was transferred to the local tertiary intensive care unit. Susannah suffered an asystolic arrest shortly after her transfer and resuscitation efforts failed to revive her. The coroner described a 'litany of errors' that led to her death, including serious failures of both written and verbal communication that involved the full spectrum of nurses and doctors involved in her care.

'This case has highlighted the dangers associated with relying entirely on oral presentations of the history of patients... [and] the importance of staff clearly communicating important information in relation to specific cases to more qualified and experienced staff.'[3]

'I recommend that training for both medical and nursing practitioners should provide greater focus on the importance of accurate and complete communication of significant changes in patients' conditions to senior practitioners. In particular I recommend that the training of resident medical officers should include a component focused on effective communication with registrars and consultants.'[3]

task 1

DEVELOP AGREED COMMUNICATION PROCESSES (WRITTEN AND VERBAL) TO SUPPORT RECOGNITION AND RESPONSE SYSTEMS

why this task is important

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.[2] Information that is important for recognising and responding to clinical deterioration may be overlooked during clinical handover.[4] 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.[5] Poor verbal and written communication between clinicians can result in discontinuity of care, delays in treatment, adverse events, and increased morbidity and mortality.[6] Practices such as not reading documentation may also contribute to adverse events and clinical deterioration not being recognised and acted on.

It is important to develop agreed communication processes (written and verbal) and use standardised practices such as mnemonics to improve team performance and ensure that the correct information is conveyed at the right time, to the right person, for the right reasons.

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.[2] 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.[2]

how to complete task 1

DECIDE

DECIDE WHEN AND HOW COMMUNICATION TO SUPPORT RECOGNITION AND RESPONSE SYSTEMS OCCURS

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, such as shift changes between staff and meal breaks
- transfer of a patient who has deteriorated to another clinical area or facility.

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.[2] However, verbal communication alone, without supporting documentation, relies heavily on memory and is considered high risk.[2] Facilities may need to consider more than one method of communication for each event.

DEVELOP

DEVELOP ROLES AND RESPONSIBILITIES FOR COMMUNICATION EVENTS TO SUPPORT RECOGNITION AND RESPONSE SYSTEMS

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 (medical, nursing/midwifery and allied health) should communicate information
- what information each clinician is responsible for communicating
- how the communication should occur (e.g. written, face-to-face, telephone).

Agreed communication processes may be applicable to an entire facility (e.g. information for transferring a patient to an external facility may be the same for all acute areas). However, 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.

When agreement has been reached on each clinician's roles and responsibilities for communicating, this information should be included in the escalation policy or similar document.

A communication mapping tool is available on the Commision's web site.

RESOURCE

PROVIDE TOOLS TO SUPPORT COMMUNICATION ASSOCIATED WITH RECOGNITION AND RESPONSE SYSTEMS

Facilities need to provide clinicians with tools to support effective communication. A large amount of information needs to be 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.[2]

how to complete task 1

RESOURCE

Verbal communication only—compared with verbal communication supported by documentation—relies heavily on memory and is a high-risk scenario.[2] It is important to document clinical handover. Protocols and mnemonics can also be used to improve the quality of clinical documentation.

INCLUDE INFORMATION ABOUT RECENT OBSERVATIONS, ASSESSMENTS AND PATIENT WISHES

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.

EDUCATE

EDUCATE CLINICIANS ON COMMUNICATION ASSOCIATED WITH RECOGNITION AND RESPONSE SYSTEMS

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. 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.[7]

EVALUATE

EVALUATE COMMUNICATION PROCESSES

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 of routine handovers can identify if clinicians are using agreed communication processes and tools as planned. Structured interviews may help to identify strategies for 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.[8]

Facilities need to identify any barriers to the use of communication protocols and develop strategies for improvement. All clinical areas should routinely review adverse events to identify any communication problems and areas for improvement. Strategies for improvement may include process redesign, additional tools to support communication (e.g. mnemonics, scripts, documentation tools), and further education.

task 2 DEVELOP SYSTEMS FOR COMMUNICATING WITH PATIENTS, FAMILIES AND CARERS ABOUT POSSIBLE DETERIORATION

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. 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.[9-10] Health professionals must value and act on information provided by patients, families and carers to ensure that clinical deterioration is recognised and responded to.

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 more time with patients, providing additional surveillance to that provided by the healthcare team.

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.[11]

how to complete task 2

DECIDE

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

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.

how to complete task 2

DEVELOP

DEVELOP AGREED PROCESSES FOR THIS COMMUNICATION

Clinicians should consider how communication with patients, families and carers will occur and who will participate. Facilities may like to use an existing communication mnemonic and modify it to suit communication with patients, families and carers.

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:[12]
  - 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.

RESOURCE

PROVIDE RESOURCES TO INFORM PATIENTS, FAMILIES AND CARERS OF THE COMMUNICATION PROCESSES

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.

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.

how to complete task 2

EDUCATE	**EDUCATE CLINICIANS ON PATIENT, FAMILY AND CARER COMMUNICATON** Educate all clinicians about the skills that patients, families and carers display in identifying signs of clinical deterioration. Case studies 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.[13] Clinicians should receive training and support to continuously improve their communication skills. This may involve role play and modelling of behaviours from peers. Facilities may consider providing this education when they are developing systems to enable patients, families and carers to escalate care.
EVALUATE	**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.

references

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13. Australian Commission on Safety and Quality in Health Care. Patient centred care: Improving quality and safety through partnerships with patients and consumers. Sydney. ACSQHC, 2011.

what other resources are available to support implementation of this essential element?

Further information, tools and resources can be found in the full implementation guide and on the Commission's web site:

www.safetyandquality.gov.au

Appendix A of the implementation guide matches the actions discussed in this guide to the National Safety and Quality Health Service Standards, and Appendix B provides examples of quality measures that may assist in guiding evaluation of this essential element in your facility.

Links to other resources specific to this essential element include:

CLINICAL HANDOVER

Australian Commission on Safety and Quality in Health Care, resources related to clinical handover:

- OSSIE Guide to Clinical Handover Improvement
- Implementation Toolkit for Clinical Handover Improvement
- Resource Portal for the Implementation Toolkit for Clinical Handover Improvement

Available from:
www.safetyandquality.gov.au

Institute for Healthcare Improvement (IHI), Clinical Handover and Patient Safety Literature Review

Register at **www.ihi.org** (free), then log in so that you can access documents on the IHI web site

New South Wales and South Australian Departments of Health, ISBAR app
itunes.apple.com/au/app/isbar/id465890292?vnt=8

PATIENT-CENTRED COMMUNICATION

Australian Commission on Safety and Quality in Health Care, Patient-centred care: improving quality and safety through partnerships with patients and consumers
www.safetyandquality.gov.au

Clinical Excellence Commission, Partnering with Patients program
www.cec.health.nsw.gov.au/programs/partnering-with-patients#overview

Institute for Healthcare Improvement (IHI), White paper: Achieving an exceptional patient and family experience of inpatient hospital care

Register at **www.ihi.org** (free), then log in so that you can access documents on the IHI web site

Joint Commission, Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care
www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

Joint Commission, resources related to effective communication
http://www.jointcommission.org/assets/1/6/EffectiveCommunicationResourcesorHCOsrevised.pdf

Planetree and Picker Institute, Patient-Centered Care Improvement Guide (United States)
www.patient-centeredcare.org/inside/practical.html#common

TEAMWORK

TeamSTEPPS®, South Australia Health
www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/safety+and+quality/communications+and+teamwork/teamstepps

TeamSTEPPS®, Victorian Quality Council pilot project
www.health.vic.gov.au/qualitycouncil/activities/teamstepps.htm

TOOLS

Communication agreement planning tool
www.safetyandquality.gov.au

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