Communicating for Safety Standard

Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

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Intention of this standard

The Communicating for Safety Standard aims to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

This standard recognises that effective communication is needed throughout patients' care and identifies high-risk times when effective communication is critical. It describes the systems and processes to support effective communication at all transitions of care: when critical information emerges or changes; to ensure correct patient identification and procedure matching; and to ensure essential information is documented in the patient's healthcare record.

Criteria

Clinical governance and quality improvement to support effective communication

Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.

Integrating clinical governance

Action 6.01

Applying quality improvement systems

Action 6.02

Partnering with consumers

Action 6.03

Organisational processes to support effective communication

Action 6.04

Correct identification and procedure matching

Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.

Correct identification and procedure matching

Action 6.05

Action 6.06

Communication at clinical handover

Processes for structured clinical handover are used to effectively communicate about the health care of patients.

Clinical handover

Action 6.07

Action 6.08

Communication of critical information

Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

Communicating critical information

Action 6.09

Action 6.10

Documentation of information

Essential information is documented in the healthcare record to ensure patient safety.

Documentation of information

Action 6.11

Background to this standard

Communication is a key safety and quality issue, and is critical to the delivery of safe patient care. Communication failures, and inadequate or poor documentation of clinical information can result in errors, misdiagnosis, inappropriate treatment and poor care outcomes.[1,2,3,4-7] Communication errors are also a major contributing factor in sentinel events in health service organisations[8], and communication issues are identified as one of the most common underlying factors in complaints about the Australian healthcare system.[9-11]

This standard recognises the importance of effective communication in health care and the essential role that communication plays in ensuring safe, coordinated and continuous care. Actions in this standard focus on three high-risk areas where communication is critical to patient safety:

- When patient identification and procedure matching should occur
- When all or part of a patient's care is transferred within an organisation, between multidisciplinary teams and clinicians, across organisations and on discharge (that is, at transitions of care)
- When critical information or risks emerge or change throughout the course of care.

Contemporaneous documentation and recording of information that supports the provision of health care are also essential.

Communication is inherent to patient care, and informal communications will occur throughout care delivery. This standard is not intended to apply to all communications within the organisation. Rather, it aims to ensure that systems and processes are in place

at key times when effective clinical communication and documentation are critical to patient safety.

This standard specifically outlines the high-risk situations when effective communication is critical to ensure safe, continuous patient care. The standard requires health service organisations to implement systems and processes to support effective clinical communication and documentation.

This standard is informed by research and work undertaken in Australia and internationally, which recognises the importance of effective clinical communication and documentation to the delivery of safe and high-quality health care.[3,6,7] This includes work by the Commission on the Ensuring Correct Patient, Correct Site, Correct Procedure Protocol; the National Clinical Handover Initiative Pilot Program; the OSSIE Guide to Clinical Handover Improvement, and the Implementation Toolkit for Clinical Handover Improvement. The Commission has also supported research on improving transitions of care, patient–clinician communication and documentation.

Links with other standards

Communication is important across all aspects of care. Implementation of this standard will depend on the organisation-wide systems required under the Clinical Governance Standard and the Partnering with Consumers Standard. These two standards set the overarching requirements for effective implementation of actions within this Communicating for Safety Standard. There are also strong links with actions in the Medication Safety Standard, the Comprehensive Care Standard, and the Recognising and Responding to Acute Deterioration Standard. If appropriate, these standards should be applied in conjunction with this standard.

For example, the Clinical Governance Standard requires organisations to integrate multiple information systems, where they are used (Action 1.16e), and have in place a healthcare record system that makes the healthcare record available to clinicians at the point of care (Action 1.16a). By ensuring that clinicians have access to all the relevant information, these actions support clinicians to effectively communicate. In turn, this standard requires organisations to have systems to contemporaneously document relevant information in the healthcare record, ensuring that the most up-to-date information is available to clinicians.

References

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3. Australian Commission on Safety and Quality in Health Care. OSSIE guide to clinical handover improvement. Sydney: ACSQHC; 2010.

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5. Naylor MD. Transitional care of older adults. Ann Rev Nurs Res 2002;20(1):127–47.

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7. Jorm CM, White S, Kaneen T. Clinical handover: critical communications. Med J Aust 2009;190(11):108–9.

8. Office of Quality and Patient Safety (US). Sentinel event data: root causes by event type 2004–2015. Oakbrook Terrace (IL): The Joint Commission; 2016.

9. NSW Health Care Complaints Commission. Annual report 2015–16. Sydney: HCCC; 2016.

10. Office of the Health Services Commissioner. Health Services Commissioner annual report 2016. Melbourne: OHSC; 2016.

11. Office of the Health Ombudsman. Annual report 2015–16. Brisbane: OHO; 2016.

Related links

Communicating for Safety Resource Portal

Implementation Toolkit for Clinical Handover Improvement