STANDARD 6: Communicating for Safety

CRITERION: Clinical governance and quality improvement to support effective communication (Actions 6.1 – 6.4)

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

Provide a summary of the processes that are in place to meet this criterion.

The Communicating for Safety Committee is responsible for reviewing clinical communication practices across Western Health (WH) and facilitating alignment with the provision of Best Care. This Committee reports directly to the Co-ordinated Care Committee, one of the four domains of the WH Best Care framework.

WH's Communicating for Safety Policy defines WH's governance approach supporting patient identification and procedure matching, clinical handover, communicating critical information and documentation of information that supports safe patient care.

Supporting this policy are a number of operational procedures that guide communicating for safety across the organisation. Policies and procedures are accessible to staff through the WH intranet. Development and review of policies and procedures involves key stakeholder consultation, with review occurring at a minimum every three years.

WH's 'Communicating for Safety Patient Journey' diagram draws together systems and processes supporting communication of clinical information and is used to focus monitoring and improvement planning through the Communicating for Safety Committee.

To support these systems, WH maintains an Electronic Medical Record (EMR) and Digital Medical Record (DMR) for all patients which is available at the point of care and accessible through any computer device connected to the WH network.

Principles of Person-Centred Care, shared decision making and health literacy are included in the resources developed to assist staff to communicate effectively.

Education and training on Communicating for Safety are key features of multiple sessions held across WH including organisation wide orientation days, local induction, graduate and intern study days, and departmental study days.

How does the health service monitor the requirements of this criterion are being met?

The Communicating for Safely Committee is responsible for overseeing the multiple processes adopted across the organisation to measure and review WH's strategies for effective communication and ensures robust systems for monitoring are embedded.

WH's MaP (Monitoring and Reporting) system brings together the data from WH's operational systems to support monitoring of communicating for safety.

Incidents and near misses are entered into the Incident Management System (RiskMan), with incident reports developed for reporting at ward level, divisional level, and through the Best Care Committee Structure.

WH has an operational risk register that records risks relating to communicating for safety, with risks monitored through the Communicating for Safety Committee.

Feedback in the form of complaints and compliments is also entered into RiskMan. Complaints are divided into themes, one of which is communication, and reported bi-monthly through the Best Care Steering Committee. The Victorian Health Experience Survey (VHES) reports quarterly on patients' experience communicating with staff and is reported and included for discussion on a quarterly basis at the Best Care Steering Committee.

The WH Patient Story Program has proven an effective mechanism to review and improve the way we communicate with consumers and carers during and beyond an episode of care. Patient Stories serve as a reminder to staff of our 'Patient First' approach and have informed for example the WH 'Call for Help' program.

Have improvements been implemented?

In late 2018, WH implemented an EMR, a significant step in improving the way we communicate and utilise clinical information to provide co-ordinated and safe patient care. Flyers and postcards for patients, families and visitors were widely distributed across the organisation during the implementation period and were available in multiple languages. A video was also recorded to support staff discussions with patients and families regarding the introduction of the EMR.

Implementing an EMR has supported correct patient identification and procedure matching through functionality such as scanning of the patient wristband to ensure Positive Patient Identification (PPID). The EMR has also supported communication of critical information and risks, with an EMR supported Comprehensive Risk Assessment and Inter-disciplinary Plan of Care (IPOC) process in place, as well as prompts when physiological markers are within escalation criteria.

Drawing information from the EMR, real-time dashboards on clinical documentation have been developed within the WH MaP platform and support auditing. One such dashboard focuses on timely and accurate completion of discharge summaries. In support of quality discharge information, a clinical documentation improvement room for junior doctors was launched as a pilot at Footscray Hospital in December 2019.

Engagement in state-wide collaborative project work has also informed improved communication mechanisms such as the Daily Operating System (DOS). The DOS is a series of tiered huddles that support staff to discuss and prioritise daily actions that improve timely, safe patient care.

Provide examples of outcomes since the previous onsite assessment:

The EMR has enhanced the delivery of Best Care for our patients by providing clinicians with a consolidated view of all relevant information about the patient in real time available on all sites. EMR information is up-to-date, easy to read and instantly accessible by a patient's healthcare team or supporting team(s), facilitating provision of a prompt diagnosis, treatment and information.

Monitoring processes indicate that following the introduction of the Comprehensive Care Risk Assessment tools and associated IPOCs, recognition and management of areas including delirium, falls management, and end of life care have improved.

Performance trends such as a decrease in code blue calls and APINCH (high-risk) medication incidents indicate that WH systems support the communication and use of critical care information.

WH has also benefitted from engagement in state-wide collaborative activity and investigation of new technology that supports effective communication.

CRITERION: Correct identification and procedure matching (Actions 6.5 – 6.6)

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

Provide a summary of the processes that are in place across the health service to meet this criterion.

The Communicating for Safety Committee is responsible for reviewing patient identification and procedure matching practices across Western Health (WH) and facilitating alignment with the provision of Best Care.

WH's Communicating for Safety Policy defines WH's governance approach supporting patient identification and procedure matching. Aligned with this policy are a number of operational procedures.

WH's Patient Identification procedure outlines the use of at least three approved patient identifiers when providing care therapy or services and when transferring responsibility for a patient's care. The use of patient identification bands that meet national specifications is also outlined in this document.

Patients attending WH are allocated a unique unit record number (UR) for identification. It is against this number that patient clinical records are generated and all information is referenced. The WH Management of Duplicate Registrations procedure outlines the monitoring, notification and management of duplicate patient registration at WH.

Procedural areas within Western Health utilise the Timeout method to confirm correct patient, correct procedure and correct site identification before the commencement of a procedure. Divisional Directors and WH Managers of theatre, day procedure units, medical imaging and cardiac catheterisation labs have the responsibility to ensure that all relevant staff are informed of and comply with the WH procedure on Correct Patient, Correct Procedure, Correct Site (Time Out).

Policies and procedures are accessible to staff through the WH intranet.

How does the health service monitor the requirements of this criterion are being met and where is the information reported?

The Communicating for Safely Committee is responsible for overseeing the processes adopted across the organisation to measure and review WH's strategies for correct patient identification and procedure matching.

Incidents and near misses are entered into the Incident Management System (RiskMan), with incident reports developed for reporting at ward level, divisional level, and through the Best Care Committee Structure. As indicated, actions arising from incident investigation are identified and implemented.

Incidents trends across the organisation relating to patient identification and procedure matching are monitored and discussed at monthly Communicating for Safety Committee meetings with any recommendations for improvements shared with key stakeholders.

Auditing processes also support the monitoring of correct patient identification and procedure matching. These include time out auditing conducted by procedural services and reported to Divisional Quality and Safety meetings.

Drawing information from the EMR, real-time clinical care dashboards have been developed within the WH MaP platform and support audit activity and incident review.

In addition, Medical Imaging complies with the DIAS (Diagnostic Imaging Accreditation Scheme) which is completed at WH every three years.

Have improvements been implemented?

Implementing an EMR has supported correct patient identification and procedure matching.

WH has implemented the EMR Point of Care Specimen Collection (POCSC) to scan the patient wristband to ensure Positive Patient Identification (PPID) and scan the pathology sample to ensure Positive Accession ID (PAID).

Monitoring of medication safety incidents led to the implementation of the EMR Medication Administration Wizard (MAW). The MAW is now being used to scan the patient wristband to ensure Positive Patient Identification (PPID). The MAW enhances the system to make it safer and more time-efficient thus all nurses and midwives are guided to use the MAW as the 'standard' when administering medications.

Implementation of the EMR has also supported the conversion from paper to electronic record of some elements of the time out procedure eg pre-admission information.

WH was successful in an application for funding from Better Care Victoria (BCV) to participate in a state-wide project to implement Choosing Wisely, a global initiative aimed at reducing unnecessary and potentially harmful tests, procedures or treatments for patients. It is supported by Australian health professional colleges, societies and associations who provide recommendations. The WH Choosing Wisely campaign urged staff to 'Ask Why and Justify' the necessity of certain tests in the area of medical imaging.

Provide examples of outcomes since the previous onsite assessment:

Using PPID and PAID ensures that the correct patient and correct sample are collected, decreasing the risk of unnecessary pathology collection and wrong blood in tube incidents. The POCSC also enhances the system to make it safer and faster, thus all clinicians are guided to use the POCSC as the 'standard' when collecting pathology.

Use of the MAW to support positive patient identification supports patients to receive the right medication at the right time, decreasing the potential rate of medication error and adverse drug events.

Through participation in the state-wide Choosing Wisely project, WH experienced improvements in clinical information provided in requests forms justifying the commissioning of tests eg adult cervical spine trauma (71% to 88%).

CRITERION: Communication at clinical handover (Actions 6.7 – 6.8)

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

Provide a summary of the processes that are in place to meet this criterion.

The Communicating for Safety Committee is responsible for reviewing clinical handover practices across Western Health (WH) and facilitating alignment with Best Care.

WH's Communicating for Safety Policy defines WH's governance approach supporting clinical handover. Aligned with this policy are operational procedures and tools guiding handover practice.

WH's Clinical Handover procedure outlines the organisation's commitment to the delivery of safe and effective patient care by implementing timely, relevant and structured clinical handover throughout the patient's journey, from their first contact with the health service through to discharge.

The ISBAR framework is used for all clinical handovers, verbal and written, in all clinical settings. ISBAR adoption at WH includes:

I = Identify: For verbal handovers, staff are required to introduce themselves and their role and wear ID badges or cards. The patient is identified using three approved identifiers.

S = Situation: The patient's current status e.g. ready for transfer, is assessed to determine suitability with consideration given to any concerns regarding deteriorating.

B = Background: Past medical history, when patient is admitted to WH and summary of relevant treatment to date.

A = Assessment: Relevant assessment of the patient is concise and factual. If medications are included then current medication management plan should also be handed over. Any clinical risks are also handed over.

R = Request: Plan of care, goals to be achieved and time frames, and any pending results to follow up. If the receiving clinician is being asked to complete tasks, these need to be clearly articulated.

The WH orientation program includes a session dedicated to orientating new clinical employees to clinical handover and ISBAR. In addition to the education and training provided at orientation, staff are required to complete a clinical handover WeLearn training package during orientation.

Where practical, the patient (and/or carer as appropriate) are included in clinical handover. They are given the opportunity to contribute and ask questions. If the patient is unable to be included in the handover, they are updated by clinicians in a timely manner. WH aims to ensure communications with CALD patients occur via an interpreter with an organisational procedure outlining specific points of care when interpreters should be used.

How does the health service monitor the requirements of this criterion are being met?

The Communicating for Safely Committee is responsible for overseeing organisation-wide processes to measure and review WH's strategies for clinical handover.

Incidents and near misses are entered into the Incident Management System (RiskMan), with incident reports developed for reporting at ward level, divisional level, and through the Best Care Committee Structure. As indicated, actions arising from incident investigation are identified and implemented.

Drawing information from the EMR, real-time dashboards on clinical care have been developed within the WH MaP platform and support audit activity and incident review.

The Victorian Health Experience Survey (VHES) reports quarterly on patients' experience communicating with staff, with results discussed at the Best Care Steering Committee.

Have improvements been implemented?

Implementing an EMR was a significant step in improving the way staff handover and utilise accurate, complete and timely information about a patient's care to facilitate the provision of Best Care.

Implementation of timely emergency care improvement plans have progressed over the past two years and have been supported by our participation in the Better Care Victoria co-ordinated state-wide Access Improvement Partnership. Project work has included introduction of a DOS. The DOS is a series of tiered huddles that support staff to discuss and prioritise daily actions that improve timely, safe patient care.

In addition, the WH Junior Medical Advisory Council (JMAC) has facilitated the development of resources to assist with medical handover.

WH purchased the MyBeepr mobile application in June 2019. This application provides electronic and secure instant messaging between WH clinical staff to facilitate effective clinical communication and clinical image sharing. This application will integrate with the EMR so that clinical staff will be able to view patients' clinical images through the EMR or through the mobile application. WH will be launching this application in April 2020.

WH has continued to expand the use of its 'Pulse e-Health Gateway' where General Practitioners (GPs) can register to receive electronic messages about the care of their patients while in Western Health.

Provide examples of outcomes since the previous onsite assessment:

The EMR has enhanced our ability to effectively communicate about the health care of patients by providing clinicians with a consolidated view of relevant, up-to-date information. Information technology has also presented new opportunities to enhance communication and handover of clinical information.

Project work to improve timely, co-ordinated patient flow has also provided the opportunity to enhance systems supporting handover of clinical information.

The number of GP practices registered to use WH's 'Pulse e-Health Gateway' is now over 120.

CRITERION: Communication of critical information (6.9 – 6.10)

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

Provide a summary of the processes that are in place to meet this criterion.

WH's Communicating for Safety Policy defines WH's governance approach supporting effective communication of critical information.

WH's 'Communicating for Safety Patient Journey' diagram draws together systems/ processes supporting communicating critical information and is used to focus monitoring and improvement planning through the Communicating for Safety Committee.

Systems/processes supporting communication of critical information are covered by operational procedures and tools covering for example the documentation of patient allergies and alerts, clinical handover and the identification and management of acute deterioration.

WH has a multidisciplinary workforce and for key critical decisions or risks, the medical workforce is the primary clinical group responsible for critical decision making.

Nursing staff complete a comprehensive risk screening assessment on admission and at specified time points in the patient journey, identifying and commencing an individualised IPOC and actively including the patient and/or carer in planning care related to these risks.

Alerts and risks are documented in the EMR which serves as the source of truth at each encounter.

WH aims to ensure communications with CALD patients occur with the use of an interpreter, with an organisational procedure outlining specific points of care when interpreters should be used. The award-winning WH CALD Assist app supports staff when interpreters may not be available.

The Call for HELP program allows patients, family members and carers to directly escalate their concerns regarding patient clinical deterioration via a clearly defined three step process.

How does the health service monitor the requirements of this criterion are being met and where is the information reported?

As communication of critical information crosses a number of clinical committees, there is a shared responsibility for oversight of organisation-wide processes and performance within the WH Best Care Committee structure.

The Communicating for Safety Committee sees the bigger picture where these processes are integrated into patient information systems and documentation practices.

Incidents and near misses relating to communicating of critical information are entered into the Incident Management System (RiskMan).

Monthly incident reports, including specific high risk situations, are developed for reporting at ward level, divisional level, and through the Best Care Committee structure. As indicated, actions arising from incident investigation are identified and implemented.

Drawing information from the EMR, real-time dashboards on clinical care have been developed within the WH MaP platform and support audit activity and incident review relating to the communication of critical information. This includes a dashboard on activation of the 'Call for Help' program.

The VHES reports quarterly on patients' experience communicating with staff, with results discussed at the Best Care Steering Committee.

Have improvements been implemented?

Implementing the EMR was a significant step in improving the way we communicate and utilise critical information to provide co-ordinated and safe patient care.

A new and improved WH clinical risk assessment screening tool became available to staff through the EMR in November 2019. This tool incorporates the clinical risk areas covered by the NSQHS Comprehensive Care Standard and has been informed by researching best practice and benchmarking.

The EMR also provided the opportunity to enhance support for acute deterioration detection, clinical decision making and escalation. The EMR provides prompts when physiological markers are within escalation criteria and alert messaging for MET/Urgent Clinical Review on the EMR is customised to align with WH escalation procedures.

WH will be launching the MyBeepr mobile application in April 2020. This application provides electronic and secure instant messaging between WH clinical staff to facilitate effective clinical communication and clinical image sharing.

Engagement in state-wide collaborative project work has also informed improved communication mechanisms such as the DOS. The DOS is a series of tiered huddles that support staff to discuss and prioritise daily actions that improve timely, safe patient care.

Provide examples of outcomes since the previous onsite assessment:

The EMR has enhanced our ability to effectively communicate and utilise critical care information by providing clinicians with a consolidated view of relevant, up-to-date information and assessment tools to support identification of clinical risk.

Performance trends such as a decrease in code blue calls, APINCH medication incidents and falls in wards piloting delirium management tools indicate that WH systems support the communication and use of critical care information.

WH has also benefitted from engagement in state-wide collaborative activity and investigation of new technology that supports effective communication of critical care information.

CRITERION: Documentation of information (Action 6.11)

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

Provide a summary of the processes that are in place across the health service to meet this criterion.

WH's Communicating for Safety Policy defines WH's governance approach supporting documentation of essential information in the healthcare record.

WH maintains an EMR and DMR for all patients which is available at the point of care and accessible through any computer device connected to the WH network. These systems support the recording and use of critical information, alerts, re-assessment processes and changes to the care plan.

Clinical information is entered into the EMR by direct entry of patient documentation and through interfaces with other clinical systems such as pathology and radiology. Clinical information entered into the DMR is predominantly in the form of paper medical record documents converted to pdf files via a document scanning process.

The WH Procedure for Management of Patient Clinical Records outlines the requirements for managing patient clinical records, covering key aspects such as content, integrity, transportation, storage, retention, disposal and access.

A comprehensive 'What Goes Where' Guide supports staff to appropriately use the medical record systems in place at WH. This is part of a suite of information on WH's 'Live EMR' site that includes quick reference guides, workflow and functionality videos, patient safety tips, and what's new and coming soon.

WH's clinical policies, procedures and guidelines (PPGs) guide appropriate documentation of essential patient information and these are accessible to staff through the WH intranet.

Education and training on the EMR forms a key part of multiple sessions held across WH including organisation wide orientation days, local induction, graduate and intern study days, and departmental study days. In addition to the education and training provided at orientation, staff are required to complete an EMR WeLearn training package during orientation. Staff are also able to access face-to-face training for the EMR.

Ongoing improvement to the contemporaneity of critical information for the provision of safe care is supported by a Clinical Documentation Improvement working group.

How does the health service monitor the requirements of this criterion are being met and where is the information reported?

WH takes multiple approaches to ensure the integrity of the clinical record. These include a continuous document scanning quality assurance audit, an audit of over 20,000 records per year as part of the coding classification audit, compliance with clinical documentation audits and review of discharge summaries in some units such as Intensive Care and ED.

Incidents and near misses are entered into the Incident Management System (RiskMan), with incident reports developed for reporting at ward level, divisional level, and through the Best Care Committee Structure. As indicated, actions arising from incident investigation are identified and implemented.

Drawing information from the EMR, real-time dashboards on clinical documentation support audit activity and incident review.

The VHES reports quarterly on patients' experience communicating with staff, with results discussed at the Best Care Steering Committee.

WH monitors completion of education modules relating to the documentation of information at both an individual and discipline level.

Have improvements been implemented?

Implementing the EMR was a significant step in improving the way we communicate and utilise clinical information to provide co-ordinated and safe patient care. During implementation of the EMR, approximately 1 in 10 staff were clinical champions to assist with staff training requirements.

EMR form development work has led to the inclusion of condition specific prompts within care planning documents to support clinician-to-clinician communication and continuity of care.

The EMR has also supported the redesign of Comprehensive Risk Assessment and IPOC processes that have subsequently been implemented across WH.

Drawing information from the EMR, real-time dashboards on clinical documentation have been developed with the WH MaP platform and are reviewed at operational meetings to identify improvement strategies. One such dashboard focuses on timely and accurate completion of discharge summaries. In support of quality discharge information, a clinical documentation improvement room for junior doctors was launched as a pilot at Footscray Hospital in December 2019.

Aiming to enhance clinical documentation and the provision of safe care, relationships have been established with interested Medical Officers to act as Documentation Mentors within their unit to model, educate and support initiatives for documentation improvement. The Medical Education Unit in conjunction with the EMR Education team, are also trialling the first extensive EMR training for junior doctors over the weekend preceding the start of the clinical year (February 2020).

Provide examples of outcomes since the previous onsite assessment:

The EMR has enhanced the delivery of Best Care for our patients by providing clinicians with a consolidated view of all relevant patient information in real time.

Monitoring processes indicate that following the introduction of the Comprehensive Care risk assessment tools and associated IPOCs, recognition and management of areas including delirium, violence and aggression, restrictive practices and end of life care have improved.

Real-time dashboards on clinical documentation have informed education, mentoring, and environmental activity to support clinicians enhance the quality of essential information recorded on the health record.