Clinical Communication:
Caring for the Deteriorating Patient

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Today’s Agenda

Interface Between Detecting Deterioration and Clinical Communication

Why improving communication means a system-wide strategy

ISBAR Strategy and Project
Detecting the Deteriorating Patient

Garling Report: clinical staff focus groups (NSW Health)

Over-dependence on automatic monitoring

Adequacy of handover

Uncertainty about when to call for help and/or escalate

Adequacy of documentation

Communication between junior and senior staff
Detecting the Deteriorating Patient

Commissioner Garling’s Recommendation

Recommendation 91
Within 12 months, NSW Health is to implement a system in accordance with the recommendations of the Clinical Excellence Commission for the detection of deteriorating patients containing the following elements:

- a system for early identification of an at-risk patient in every hospital in NSW (this system will involve the implementation of a specifically designed vital signs/observation chart);
- escalation protocols to manage deteriorating patients, which would include a rapid response system;
- development and implementation of detailed education and training programs, aimed at recognising and managing the deteriorating patient;
- the ongoing collection and analysis of appropriate data to monitor the implementation and progress of the program;
- a standardised process for the handover of patients which can be utilised on all occasions and can equally be done when all clinicians are not on site together;
- high level support from management and clinicians; and
- ongoing evaluation.
Why improving communication means a system-wide strategy
Practical Context of Clinical Communication

Training in interprofessional communication and teams

Focus on practical skills, but not on communication

Work practices – eg time for handover

Physical space for handover

Standardisation of processes eg handover guidelines

Electronic tools help, but can’t effectively computerise a non-working system
Clinical Communication:

Leads from Incidents and Complaints

Data from calendar year 2006

403 incidents reported to involve clinical communication.

171 complaints involved clinical communication

127 RCAs involved communication
Incidents Reported via IIMS in 2006

- Relaying concerns about a deteriorating condition to a senior clinician (6%)
- Communicating at handover (32%)
- Communication with patients and carers regarding processes (5%)
- Communication with patients and carers regarding clinical information (2%)
- Speaking up for safety regardless of status (7%)
- Timely transfer of investigations to those in charge (3%)
- Policies communicated adequately (8%)
- Formal documentation systems of communication (1%)
- Interpersonal communication principles and processes (2%)
- Communication on transfer between facilities (34%)
- Incidents reported via IIMS in 2006

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Complaints associated with Communication reported through IIMS in 2006

- Interpersonal communication principles and processes: 53%
- Communication with patients and carers regarding clinical information: 17%
- Communication with patients and carers regarding processes: 11%
- Relaying concerns about a deteriorating condition to a senior clinician: 3%
- Communicating at handover: 3%
- Policies communicated adequately: 3%
- Timely transfer of investigations to those in charge: 3%
- Communication on transfer between facilities: 3%
- Formal documentation systems of communication: 4%
- Speaking up for safety regardless of status: 1%

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Conclusions and Outcomes

Analysis of communication factors and setting an evidence-based direction can build an effective focus for endeavours

Incidents and complaints have markedly different communication factor profiles

Evidence-based communication factors strategies require input from both

Initial incident reports alone may underestimate the impact of communication as a root cause of adverse events

Presentations of this data in clinical meetings have led to constructive and open debate, and offers of participation and involvement in future directions
The ISBAR Strategy
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Why ISBAR?

Used internationally

Applied in health, aviation and defence with good results
Simple and easy to implement
Expected high degree of acceptability
Clinically intuitive

Reaction: enthusiasm, engagement, offering of anecdotes, response to a practical innovation, desire to engage in training, applied in reporting and executive communication
ISBAR

Clinical conversations should be clear, focussed and the information relevant.
Poor communication risks patient safety and contributes to adverse outcomes.

I – Identification
“... (name and position)"
“I am calling from ...............”

S – Situation
“I have a patient (age and gender) who is
a) stable but I have concerns
b) unstable with rapid/slow deterioration”
“The presenting symptoms are ...............”

B – Background
“This is on a background of ...............”
(give pertinent information which may include:
Date of admission/ presenting symptoms/ medications/
recent vital signs/test results/status changes)

A – Assessment
“On the basis of the above:
- The patients’ condition is .......... 
- And they are at risk of ...........
- And in need of ...............”

R – Recommendation
Be clear about what you are requesting.
e.g. “This patient needs transfer to/review ........
Under the care of:....
In the following timeframe ............”

ISBAR Interhospital Transfer Project. For more information please contact Prof. Anne Duggan, Clinical Lead on 0418167264 or anne.duggan@nsw.health.nsw.gov.au or Kim Lane, Senior Project Officer on 49855322 or kim.lane@nsw.health.nsw.gov.au
The Strategy

An organisational approach applicable to all settings and interactions, to embed sustainable change

Culturally focussed - a clinical and academic model, aligned with the clinical context and culture, and applicable for all staff

The campaign includes data-driven story-telling of direct relevance to clinicians and managers to promote the change agenda – including own incidents/complaints

An innovative training model: short training sessions (15mins), routinely repeated at regular intervals (eg in routine unit meetings), and delivered locally to around 14,000 geographically-distant staff

Training scenarios and simulation models applied

Visible, interprofessional and collaborative leadership, clinical champions and clear directions
Australian Commission on Safety and Quality in Health Care Communication Project

The ISBAR project was designed to test ISBAR as a communication tool in inter-hospital transfer.

Evaluated how staff training in ISBAR affected the quality of the communication experienced during 77 inter-hospital transfers by patients, carers, clinicians and other staff.

It demonstrated that the ISBAR approach to communication:

- improved the patient experience
- was rapidly learnt by health professionals
- improved the quality of clinical communication, and
- holds great promise in reducing incidents in which poor communication is a root cause.
Informed by input from patients, carers, clinicians, managers and patient transport officers

More than 260 staff trained in ISBAR using a 15-minute training program - achieved statistically significant improvements in self-reported confidence and skill in communicating effectively in clinical handover

More than 300 patients, carers and clinicians were interviewed about the 50 inter-hospital transfers which occurred after staff were trained

Demonstrated improvements in patient and carer perceptions of quality of communication across seven elements, compared to baseline (before staff were trained in ISBAR)
Australian Commission on Safety and Quality in Health Care
Communication Project

Improved quality of documentation which accompanied the patient in key elements such as having a nursing summary, including test reports and documenting carers’ contact numbers for care

Doubled frequency of documenting that the patient had been informed, although still much work to do
Prompt Card
Moving Forward – Finding the Common Ground
Health leaders, clinical and executive, share common concerns about detecting the deteriorating patient and communication

The factors for success are…

Find common vision and direction

Communication is likely to feature in every quality and safety meeting – find the common themes

Everyone will have stories – they can be shared

ISBAR delivery needs to be just as instinctive as taking a clinical history (or writing an email)

Everyone will be looking for a way forward – some will be ideal champions
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Thank you
Information Sheet

Identifying and Solving Barriers to Effective Handover in Interhospital Transfer Project

ISSUED: May 2008

Informed by the experience of clinicians who transfer patients elsewhere we will develop, implement and evaluate a communication tool to assist in clinical handover of patients transferred between the Maitland Hospital and the John Hunter Hospital, Newcastle.

Who is involved in the project?
The Australian Commission on Safety and Quality in Healthcare has funded the 12-month project.
Dr Kim Hill, Director of Clinical Governance, is the HNE Project Sponsor.
A/Prof Anne Duggan, Clinical Lead, Acting Associate Director Clinical Governance.
Dr Margaret Saniora, Director Medical Services, Maitland.
Dr Rosamary Aitch, Associate Director Clinical Governance.
Prof Kiku Nair, Director of Continuing Medical Education.
Kim Laine, Senior Project Officer.

There will be broad consultation with consumers, carers and clinicians across the Maitland and John Hunter sites.

What will this mean for Hunter New England Health?
The results of this project will inform subsequent decisions about the application of the standardised format more broadly, as well as recommendations about the wider transferability of the solution.

For more information on this project please contact:
A/Prof Anne Duggan, Clinical Lead, on 0419167464 (Speed dial 654414)
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What is the Problem?

Interhospital transfer (IHT) is an everyday part of clinical practice where poor communication risks patient safety. A number of patient safety initiatives, including The National Alarming and Incident Information Monitoring System (NIIMS), demonstrate a high incidence of handover errors. An audit of patient handover documentation at the Maitland Hospital identified a high rate of errors including: incorrect times, incorrect sites, and incorrect medications.

What is the project?

A group of Hunter New England clinicians, managers and senior staff in Clinical Governance are seeking to assess whether a standardised format for communication can improve patient outcome and decrease clinician job satisfaction. The project will test the impact of the ISBAR communication format on the transfer of patients from the Maitland Hospital to John Hunter Hospital.

What is ISBAR?

ISBAR is an acronym. It stands for:
I = Introduction
S = Situation
B = Background
A = Assessment
R = Recommendation

ISBAR provides a framework to frame conversation is conveyed between people in a consistent and concise way. Evidence shows that when a standardised approach is implemented, the effectiveness of that approach increases. The listener knows what to expect and becomes more alert and the speaker knowing what is expected, can participate fully to meet the listeners needs. ISBAR has been applied by a number of high risk industries, including health, and so it does have an evidence background.

How will the project be implemented?
The planned project design is a prospective observation and intervention study. There will be four phases to the project:

- an establishment phase to introduce the project;
- a development phase to characterise existing handover practices and ask clinicians their view on how to improve the process;
- an implementation phase to test the subsequently developed standardised format for handover communication, and
- an evaluation phase to evaluate the effectiveness of the implemented solution, disseminate the findings and assess the wider transferability of the solution.

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Hunter New England Health
840,000 population (12%)
130,000 sq kms
49 inpatient facilities
68 locations
3225 beds
55,600 operations annually
14,000 staff