Clinical Communication and Patient Identification Clinical Guideline

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Clinical Communication and Patient Identification Clinical Guideline

1. Clinical Guideline Statement

The aims of this clinical guideline are to;

- improve patient safety by providing a structured framework that supports a consistent, best practice approach and reduces risk associated with clinical communication and patient identification within SA Health services, and between SA Health services and other health providers such as community services and residential care services.
- ensure excellence in governance, practices and systems of clinical communication so that;
  - patient confidentiality and privacy requirements are respected
  - patients' rights to be informed about their healthcare are met
  - patients' and carers' experience of care is enhanced through staff engaging with them, using kind and respectful communication, and providing person-centred care and the opportunity to ask questions and provide feedback
  - patients' identity is systematically verified so that they receive the care that is intended for them, especially interventional invasive procedures
  - the requirements of National Safety and Quality Health Service Standards (NSQHSS) second edition are met
    - Refer to Appendix 1 – Actions that support effective clinical communication and safe patient care across the NSQHS Standards, Australian Commission on Safety and Quality in Healthcare (ACSQHC)
  - the requirements of health practitioners' professional codes of practice, conduct and legislative requirements are met
  - staff experience and contribute towards a respectful workplace culture that values individual and team enabling shared learning, quality improvement and positive patient and carer outcomes
  - throughout all health care and transfers of care, staff handing over and also receiving responsibility for the ongoing care of a patient use;
    - robust verbal, written and electronic systems to provide comprehensive, timely, safe and effective communication that ensures the continuity, safety and quality of the patient's care is maintained
    - effective systems to communicate critical information, risks and alerts
  - accurate, contemporaneous and comprehensive information is legibly documented in the healthcare record.

SA Health's participation in the national, personally controlled My Health Record system will support these objectives.

The term patient is used throughout this document to represent all people in receipt of care and includes people who could be termed consumers or clients.

This Clinical Guideline must be read in conjunction with the accompanying toolkit.

- Tool 1 – Clinical communication and teamwork
- Tool 2 – Using My Health Record in clinical communication
- Tool 3 – Patient identification and matching to intended care

2. Roles and Responsibility

This Clinical Guideline applies to all SA Health hospitals and services including, but not limited to, acute and sub-acute facilities, residential care services, ambulatory/community settings, SA Ambulance Service (SAAS) and Statewide Clinical Support Services (SCSS).

2.1 All SA Health employees

All SA Health employees or persons who provide health services on behalf of SA Health must reasonably comply with this policy as appropriate to their role, that is;

- participate in clinical communication, clinical handover and team-based patient care processes
- ensure their clinical record-keeping meets required standards
- participate in training, and reasonably comply with instructions and training, to ensure they have the required knowledge and skills for their role
- take all reasonable steps to ensure they are providing the correct care including the correct advice / information to the correct patient every time
- patient incidents arising from either miscommunication, or the lack of communication, or issues to do with patient identification and procedure matching, or any other issues relevant to this policy, are reported in the Safety Learning System (SLS) patient incidents module.

2.2 Chief Executive, SA Health

The Chief Executive, SA Health is responsible for;

- providing the capability for systems to be established within SA Health to enable the management of clinical communication and patient identification across in accordance with this Clinical Directive.

2.3 Director Safety and Quality

The Director, Safety and Quality must;

- review this Clinical Guideline and accompanying tools
- monitor and evaluate the implementation of the policy
- review reports, including incident reports provided by the health services about relevant issues, conduct trend analysis and develop state-wide strategies for system improvement
- disseminate lessons learned from the management of clinical communication incidents
- provide advice to health services in response to specific queries about clinical communication.

2.4 Chief Executive Officers

Chief Executive Officers of Local Health Networks, Statewide Clinical Support Services and SA Ambulance Service must ensure the health services within their control;

- have systems and governance in place that clearly articulate organisational and individual accountabilities for clinical communication and patient identification in accordance with this policy and NSQHSS action 6.1, 1.7, 1.10, 1.19, 1.20 and 1.21, so that health services are able to achieve accreditation as required by SA Health Accreditation to Safety and Quality Standards Policy
- have effective and consistent processes for clinical communication and patient identification, and that these are applied and evaluated
- have sufficient resources in place to enable;
    - effective clinical communication including information systems and technology to manage and link patient related data NSQHSS action 1.17 and 1.18

  - staff training in clinical communication, teamwork and patient identification
  - adherence to the SA Health Patient identification bands standard use of the surgical safety checklist for interventional procedures
- report and investigate patient incidents relating to clinical communication and patient identification, and take action in accordance with the SA Health Clinical Incident Management Policy
- support the engagement of consumers/patients and their families/carers in decision-making about their healthcare, and in the planning, design and evaluation of clinical communication processes.
- support staff to ensure patient confidentiality is maintained and appropriate consents to share information are obtained.

2.5 Senior Managers

General Managers, Executive Directors, Directors, Heads of Service/Departments and other Senior Managers must;

- ensure organisational governance and leadership in relation to effective clinical communication, patient identification and procedure matching is in place in accordance with this policy and NSQHSS action 6.2, 1.8, 1.9 and 1.11 for clinical and non-clinical staff
- be able to demonstrate that local processes are developed, implemented and evaluated;
  - to include patients and carers in clinical communication processes related to their care in accordance with this policy and NSQHSS action 6.2 and 2.3 - 2.10
  - for structured clinical communication processes for clinical handover, procedure matching and patient identification in accordance with this policy and NSQHSS action 6.4
  - to support continuity of care and consistent patient identification within and between health services
  - to ensure adequate and reasonable supervision and training in clinical communication and patient identification (such as TeamSTEPPS 2.0 AU) that support staff, and other persons providing health services on behalf of SA Health, to have the skills and knowledge required for their role
  - for the review of incidents relating to clinical communication and patient identification in collaboration with clinicians, patients and carers
  - to ensure the identification of risks in communication processes and have strategies in place to mitigate and review the risk(s).
  - ensure that any learnings gained from a review of clinical communication processes are shared, fully implemented and monitored.

2.6 Health Record Managers and Administrative Managers

Health Record Managers and Administrative Managers must;

- provide expertise and assistance in the development, implementation, monitoring and evaluation of systems and procedures that describe processes, training and responsibilities for clinical and non-clinical staff in accurate and consistent patient identification and procedure matching
- ensure non-clinicians (such as members of the wards, reception and administration workforces) who communicate regularly with patients about appointments, tests, referrals and transfers have knowledge and skills to enable them to perform these roles effectively.

3. Clinical Guideline Requirements

Health services must ensure that all forms of clinical communication, critical information/alerts and health record-keeping processes support health practitioners to meet their ethical and legal obligations.

3.1 Clinical Communication

Further information is available in Tool 1 Clinical Communication.

SA Health staff must actively support participation in clinical communication, shared decision making and patient identification processes by patients and, where appropriate and confidentiality allows, their family and carers and Substitute Decision Makers (SDM). This includes support to provide feedback or make complaints NSQHSS action 1.14) and to receive open disclosure after any incident (NSQHSS action 1.12).

Clinical communication with the patient must;

- respond to questions and concerns raised, especially if these relate to unexpected deterioration, or failure to improve or recover as expected (NSQHSS action 8.7)
- ensure that it is clear to the patient, family and carer, and Substitute Decision Maker (SDM) which health practitioner has ultimate responsibility for coordinating the care of the patient, and who the key members of their multidisciplinary care team are at any time.

Clinicians must;

- respect the role of appointed SDM under the *Advance Care Directive Act*
- engage with carers in accordance with the Partnering with Carers Policy and *Carer Recognition Act 2010 (Commonwealth).*

The extent of information-sharing with patients' family and /or carers requires consideration of the patient's age, ability to consent, decision-making capacity, confidentiality and privacy, and safety of themselves and others. The Privacy Policy provides further information.

3.1.1 Using interpreters and translators

Clinical communication with the patient and their family/ carer must adequately provide for patients who have limited English proficiency; or who are deaf or hearing impaired; or who have speech impairment and communicate through sign language such as Auslan or using assistive technology, in accordance with;

- SA Health Language Services Provision: Operational Guidelines for Health Units applies to people from culturally and linguistically diverse (CALD) backgrounds
- South Australian Policy Framework: Aboriginal Languages Interpreters and Translators and the associated Guide

3.2 Clinical teamwork

SA Health staff must;

- develop skills and knowledge to participate as team members and leaders, relevant to their role through active participation in available training such as TeamSTEPPS®2.0AU that improves the effectiveness and reliability of teamwork and through use of tools and techniques such as huddles and structured handover.
- demonstrate teamwork and care coordination with other practitioners in accordance with professional Codes of Conduct. This includes respectful behaviour and communication, interdisciplinary practice, delegation and supervision.

3.3 Clinical Handover

Clinical handover is 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.

Structured clinical handover processes include review of the care plan, and improve accuracy, efficiency and effectiveness of information transfer and, thereby, the safety of patient care and the recognition and management of acute deterioration.

3.3.1 Processes of clinical handover

Health services must;

- adapt the structured clinical handover process to fit the health service's particular context and clinical setting, and describe in local procedures
- provide training to staff in their role and responsibilities, and in the processes and use of tools (such as TeamSTEPPS®2.0AU)
- provide tools and resources to support clinical handover processes.

Clinical staff must;

- maintain the privacy and confidentiality of patient information that is verbally discussed or displayed during handover
- use structured processes and contemporary handover tools such as those included in TeamSTEPPS®2.0AU, for example the standard mnemonic ISBAR (Identify, Situation, Background, Assessment and Recommendation), or iSoBAR (identification, Situation, observations, Background, Agree to a plan, Responsibility and risk management)
- use the functional capability of electronic health records such as Sunrise EMR (EPAS) to record and display summary information
- use unit or ward based devices such as journey boards.

To prepare for discharge of patients with complex needs, the health service must have care planning and handover processes that support participation by the patient's General Practitioner and other treating doctor(s) or health professionals, where practicable.

3.3.2 Information included in clinical handover

The handover must include the review of;

- diagnosis(es), clinical assessment(s), relevant test results, and current clinical condition/progress (NSQHSS action 5.11-5.13, 6.8b, 8.5e, 8.9)
- risk assessments, any patient incidents or acquired complications and other clinical concerns (NSQHSS action 5.7b, 5.10, 5.21-36, 8.6e)
- agreed care plan and priorities for care; patient's goals and preferences and any changes to their overall goals of care
- any limitations to medical treatment that have been agreed through 7 Step resuscitation planning or expressed in an Advance Care Directive
- discharge planning, referrals and follow-up, and expected date of discharge NSQHSS action 5.13, 5.14)
- medication history and current medicines list, including adverse drug reactions
- emerging or new critical information (flags or alerts), and the currency of any existing critical information
- early signs of possible deterioration in physical or mental state, and the specifics of the plan for management of acute physiological or mental deterioration (NSQHSS action 6.9 and 6.10)
- infectious status and/or transfusion history as relevant
- other clinical information relevant to the patient/family/carer.

3.3.3 Documentation of clinical handover

Documentation of handover must include a record of;

- an acknowledged transfer of clinical accountability and responsibility
- correct patient identification using a minimum of the 3 core patient identifiers (see section 3.8.3)
- any participation by patients, family, carers and SDM when appropriate and where practicable (NSQHSS action 2.6)
- the participation by all relevant clinicians, including GP, specialist(s) and the actions for which they are responsible.

3.3.4 Discharge summaries to health professionals

NSQHSS Standard 6 requires timely communication directly to a patient's General Practitioner and other treating doctor(s).

At the completion of any patient episode of care, comprehensive information sufficient to enable continuity of care must be provided within 48 hours to the General Practitioner nominated by the patient, as well as other treating doctor(s) and other health professionals who will be providing care.

Uploading patient information, such as a Discharge Summary, to the My Health Record on discharge does not relieve SA Health employees of any obligations to communicate information to healthcare professionals responsible for the patient's next episode of care, for example a GP or aged care facility.

In the event of the death of a patient, a discharge summary must be provided to the referring hospital and to the nominated general practitioner.

3.3.5 Discharge information for patients and their carer/family

Prior to discharge, patients and their carer/family must be provided with information that is appropriate to their needs, and in a form (preferably verbal and written) that supports;

- their understanding and compliance with any follow-up treatment or care, including medication and other treatment, therapy or tests
- knowledge of any precautions or other current critical clinical information, including any arising from the admission such as adverse drug reaction
- their ability to seek help in the event of delay or failure to recover as expected, or any deterioration (and what the signs of deterioration might be).

This information must include how and when to seek;

- additional advice from the treating team, or
- advice from the GP, or
- urgent or out of hours advice (for example from locum or home doctor services, or Health Direct Symptom Checker or other health call services), or
- emergency assistance such as ambulance.

3.4 Critical clinical information, risks and alerts

Health services must have documented processes that describe defined criteria for the use of standard alerts or flags, timeframes and responsibility for;

- matching patient identification with critical information
- documenting and verifying new critical information, or an alert, in a timely and consistent manner, with reference to any relevant defined criteria or critical values
- confirming receipt of communication about a new alert or critical information
- reviewing existing critical information and alerts
- removing an out-of-date patient alert or critical information
- when and how patients and their family/carers can communicate critical information, risks and also concerns about deterioration.

Relevant current critical information must be conveyed during all occasions and methods of handover (NSQHSS action 6.8).

Communication with the patient and their family/carers and nominated general practitioner about new critical information must occur and be recorded. Some critical information must be communicated immediately to relevant members of the clinical team to avoid patient or staff risk. Examples include significant results from diagnostic tests or procedures, or when there is risk of exposure.

3.5 Sharing and security of patient information

All SA Health staff are required by this policy and their Codes of Conduct to abide by privacy legislation and professional guidelines to protect the privacy and confidentiality of people receiving care.

Health services must collect, keep secure, use or disclose personal information within the legislative, statutory and policy requirements applicable to SA Health, such as the Privacy Policy and the Freedom of Information Policy.

3.5.1 Sharing patient information without consent

If a patient does not give consent for details of treatment to be disclosed to a third party, including any family members, then this direction must be followed until consent has been gained and documented. This means that the discharge summary or other patient information must not be provided to the primary health provider (GP), or shared/uploaded to the patient's My Health Record. This includes results not being uploaded from SA Health's enterprise Pathology and Medical Imaging systems.

If a patient is at risk of harm (e.g. domestic violence), health information must not be shared with the patient's My Health Record because an address is required. This aims to avoid inadvertently placing party/parties at risk.

However, in some circumstances SA Health staff may share with another health or service provider without the consent of an individual. Refer to the Privacy Policy and/or Tool 1 Clinical Communication.

For these circumstances, any decision, and the rationale for disclosing personal information without the consent of the patient and / or their authorised representative, must be documented in the individual's file, and an entry made in the Safety Learning System (under the classification 'Patient Information / Confidentiality of information / ISG Information Sharing Guidelines). Actions taken must be guided by the relevant legislation. Assistance and advice is available from Clinical Risk Managers.

3.6 Documentation in health records

Health practitioners are required by this guideline and the *State Records Act 1997 (SA)* and their professional Codes of Conduct, for example Good Medical Practice: A Code of Conduct for Doctors in Australia to maintain clear and accurate clinical records that facilitate;

- continuity of care, and
- prompt transfer of health information as part of all transfers, referral, handover, discharge, or when requested by patients.

Health services must have systems and processes that describe roles, responsibilities and training regarding documentation (Health Record Management Policy). Information about a patient's care must be documented in a manner that meets the requirements of the;

- Medical Records Document and Data Capture Standards
- South Australian Client Identification Data Standards

- Health Record Management Policy and LHN specific procedures
- NSQHSS Communicating for Safety Standard 6.11. The NSQHS Standard 1 Clinical Governance Standard requires organisations to integrate multiple information systems if they are used (Action 1.16). Safe integration requires procedures that describe responsibilities, skills and knowledge required for matching and verifying patient identification. Health services must have procedures for;
- evaluating and addressing potential risks such as patient mis-identification and record mis-matching, out of date information, gaps and duplications in data
- resolution of data discrepancies.

Health services must have secure and reliable electronic systems to send and receive information to and from the Health Service and General Practitioners and other treating doctor(s), and other health professionals. Where electronic systems are not available alternative means of secure information exchange should be established.

Any digital health record system that is implemented must meet the elements of best-practice documentation and The National Guidelines for on-screen presentation of discharge summaries and support effective clinical communication. There are resources to support safety in e-Health.

When designing, implementing or integrating digital health solutions health services must use clinical and technical expertise and structured analysis (such as Failure Mode and Effect Analysis) to identify any safety and quality issues that may arise, and take action to mitigate those risks.

3.7 My Health Record (MHR)

Further information is available in Tool 2 My Health Record in Clinical Communication.

SA Health is a registered healthcare provider with the My Health Record system that enables Individual Healthcare Providers and other relevant employees to access the My Health Record system on the organisation’s behalf when there is a clinical need to do so. SA Health, as a registered provider, must comply with a range of obligations set out under the following legislation;

- *My Health Records Act 2012*
- *My Health Records Rule 2016*
- *My Health Record Regulations 2012*

These obligations specify that health services must have written and accessible policies, procedures in regard to training, employee access to personal records, security controls in place and that these are audited for compliance. The access provided by SA Health to the My Health Record system meets these obligations.

3.7.1 Access to the My Health Record system

All access to My Health Record must be by an authorised user only (defined in Tool 2 My Health Record in Clinical Communication.), and in the context of providing an episode of care. Accessing an individual’s My Health Record outside of the context of providing an episode of care constitutes misuse of the My Health Record, and under the *My Health Records Act (2012)* severe penalties, including imprisonment, can be applied for unauthorised use of the MHR.

All data that has been uploaded to a patient’s My Health Record is available to SA Health users, subject to any access restrictions applied by the patient. This includes documents from both private and public sector healthcare providers.

The My Health Record is not an authoritative medical record, and it is safest to assume information contained within a patient's My Health Record is not a complete record of their clinical history and should be verified through other sources. The My Health Record does not replace the clinical systems used by healthcare providers, or make those clinical systems redundant.

The MHR system includes an emergency access function that can be used to override any access restrictions applied to the record by the patient in certain circumstances. Emergency access is only authorised under the *My Health Records Act* if:

- there is a serious threat to the individual's life, health or safety and their consent cannot be obtained (for example, due to being unconscious); or
- there are reasonable grounds to believe that access to the MHR of that patient is necessary to lessen or prevent a serious threat to public health or safety

3.7.2 Adding content to My Health Record

SA Health does not currently provide the capability for users to add content directly to a patient's My Health Record. SA Health will only upload data to the My Health Record from its conformant systems, which are Sunrise EMR (EPAS), OACIS, EPLIS and ESMI.

SA Health sends the following clinical documents to the My Health Record for patients who have one:

- Discharge Summaries from OACIS/Sunrise EMR (EPAS) (inpatient medical) (enabled 2013)
- Pathology Results from EPLIS (enabled 2019)
- Medical Imaging Reports from ESMI (enabled 2019).

3.7.3 Consent and My Health Record

If a patient has a My Health Record, the *My Health Records Act 2012* authorises a health care professional to contribute information to that record without requiring the patient's consent. This is commonly referred to as "implied consent".

The *My Health Records Act 2012* requires that a patient notifies their health care professional if they do not wish to have a particular record sent to their My Health Record. If a patient notifies a health care professional that they do not want a record to be uploaded to their My Health Record, the health care professional is legally obliged under the *My Health Records Act 2012* to take reasonable steps to comply with this request, which is commonly referred to as 'withdrawal of consent'.

There is no obligation under the *My Health Records Act 2012* for a health care professional to upload a record to My Health Record. SA Health recognises and supports that at times a health care professional may consult with the patient and come to a decision that a record should not be uploaded to My Health Record, or that a health care professional may arrive at this decision themselves.

SA Health has implemented features within its systems that enable the following records to be withheld from the My Health Record if a patient withdraws consent;

- Discharge Summary from OACIS/Sunrise EMR (EPAS)
- Pathology Reports from EPLIS
- Medical Imaging Reports from ESMI.

SA Health provides training for health care professionals about how to comply with a patient's withdrawal of consent, and an instruction guide detailing steps to be taken within OACIS, Sunrise EMR (EPAS), EPLIS, ESMI and via paper orders. These training materials are located on SA Health intranet services, including guides, frequently asked questions and short videos providing an overview of MHR access and use. These training guides and videos are also tailored to metropolitan and country users of the MHR.

3.8 Patient identification

Further information is available in Tool 3 Patient identification and matching to intended care

Health services must design and implement robust systems in consultation with stakeholders to support the reliable management and verification of patient identification.

Health services must also;

- identify, through analysis and review of patient incidents, any local risks and barriers to effective patient identification, and act to mitigate risk
- provide training that describes staff roles and responsibilities and ensures that staff have skills and knowledge to fulfil their roles.

3.8.1 Checking the patient's identity at commencement of an episode of care

Health service procedures for the confirmation or establishment of patient identification on registration, admission or point of entry to the service must meet the requirements of the South Australian Client Identification Data Standards.

If a patient is unable to communicate for themselves, as they are too young, confused, unconscious or don't have English as a first language, the patient must be registered with default values as set out by the South Australian Client Identification Data Standards, until identifying details can be verified. When the patient's identity is established health services must ensure that all records are amended.

3.8.2 Checking the patient's identity during an episode of care

Health service procedures to verify patient identification throughout the episode of care must specify;

- when, and how, patient identification is checked, and by whom
- the three patient identifiers that are to be used (see 3.8.3)
- processes to replace the identification band (or equivalent) if it falls off, is removed, lost or becomes illegible during an inpatient episode of care
- processes to amend information that is found to be incorrect
- processes to verify patient identification if the digital IT system is not available or not working
- other patient identification processes
- the skills and knowledge staff require to perform their roles
- processes to monitor and evaluate identification systems.

To improve continuity of care, any patient of a mental health service that uses an electronic health record Sunrise EMR(EPAS) must also be registered on either the Community Based Information System (CBIS) for metropolitan mental health services, or Country Consolidated Client Management Engine (CCCME) for country mental health, and have their alternate identification (Alt-ID) recorded in Sunrise EMR(EPAS).

3.8.3 Approved patient identifiers

Health services are responsible for specifying the identifiers and the physical means of identifying patients that are approved for patient identification and procedure matching, in their clinical context. Identifiers such as room or bed number must not be used.

At least three patient identifiers must be used to verify the identity of the patient. Where practicable, these must be the 3 nationally agreed core patient identifiers that are required for patient identification bands in SA Health. These are

- name (family and given names);
- date of birth; and
- healthcare record number (URN or MRN).

Other approved identifiers are sex, address, Medicare number and individual healthcare identifier (Individual Healthcare Identifier, IHI).

Where the My Health Record system is in use, include the national unique IHI as a patient identifier (NSQHSS action 1.17).

Mechanisms for registration of individuals with aliases/preferred names must be in place within all sites as part of medical record management. South Australian Client Identification Data Standards. Once the aliases are known the generated documents/MRN are merged in accordance with established procedures.

Electronic and manual patient master indexes and medical records must contain at least the three nationally agreed core patient identifiers. Barcoding systems used in the patient identification process must be linked to this information in the electronic patient master index.

3.8.4 Patient identification bands

Unless there is an exemption, patients must wear a patient identification band, this includes;

- all inpatients of SA Health services
- all same day patients, day surgery, haemodialysis patients and others administered a general anaesthetic.

Patient identification bands must be applied on presentation, or as soon as practicable on the admission of a patient or after a baby's birth. They do not have to be worn on the wrist.

All patient identification bands used in SA Health hospitals must comply with the SA Health Patient Identification Band Standard. This standard specifies the information (three core patient identifiers) and format that is to be used. No other information is to be included.

Only patient identification bands of the type authorised by the Department for Health and Wellbeing are to be used. These bands have been specifically selected to meet the specifications for a standard patient identification band that were endorsed by Australian Health Ministers in 2008 to be used in public and private health services in Australia. The specifications set out standards for the useability, content and colour of patient identification bands.

If the patient identification band needs to be removed prior to a therapeutic procedure, supplemental identification and labelling of the patient must be made prior to the ID band being removed. A staff member who removes an ID band is responsible for ensuring another is applied immediately after the procedure.

Staff who find a patient identification band that is illegible, missing or incorrect are responsible for replacing it immediately in accordance with local procedure.

Patient identification bands must be disposed of in a way that maintains the patient's confidentiality and privacy.

3.8.5 Exemptions and alternatives to patient identification bands

If patient identification bands are not practicable or appropriate for a patient, health services may use equivalent means of identification. Any alternatives must contain the three nationally agreed core patient identifiers (name, date of birth and medical record number). Further information is available in Tool 3 Patient identification and matching to intended care.

3.9 Matching patients and procedures

Health services must have processes in place to identify the patient and match them to interventional procedures, prior to commencement or administration of these.

This includes confirmation that consent has been obtained from the correct patient, Substitute Decision Maker or Guardian for the correct procedure, and the use of a credentialed interpreter when required.

Confirmation of pregnancy/absence of pregnancy must occur because of possible effects of some investigations, medications and treatments on the developing foetus.

Relevant interventional procedures include, but are not limited to;

- prescription, supply and administration of medication and intravenous fluids
  - SA Health policy for user-applied labelling of injectable medicines, fluids and lines
  - Standardised Terminology or Abbreviations and Symbols Used in Medication Documentation: “Spell it Out” Policy
- therapy
- planned procedures including surgery
- investigations, including imaging and endoscopy
- transfusion of blood (Australian and New Zealand Society of Blood Transfusion Guidelines).

Health services must clearly document the process for patient identification and pathology/specimen collection, labelling and matching in each specialist area, the responsibility of clinicians involved and what training is required. The correct identification of any samples / specimens requires adherence to standard procedures or protocols at the point of collection; before and during testing; at reporting; and on receipt of results.

3.9.1 Interventional or diagnostic procedures

Health services must clearly document the process for how patient identification and procedure matching is performed in each specialist area where interventional or diagnostic procedures are carried out, the responsibility of clinicians involved and what training is required (NSQHS Standard 6.6).

3.9.2 Surgical Safety Checklist

In 2009 Health Ministers endorsed the World Health Organization Surgical Safety Checklist as the nationally agreed strategy for surgical safety in Australia. This checklist or an SA Health approved equivalent must be used as patient / procedure matching protocol prior to surgery (SA Surgical Safety Checklist). The principles and processes of the surgical team safety checklist must be applied to other procedures.

The operating surgeon, or practitioner carrying out the procedure is responsible for ensuring the Surgical Safety Checklist is completed (MR 87 or SA Health approved equivalent). The entire team must participate. The checklist must be completed during this process, and no other activities must be undertaken during this task.

If a team member, or the checklist, detects a discrepancy in information, doubt in verification of the procedure, or a failure or unreasonable threat to the safety of the patient or other staff associated with the planned procedure, the procedure must be delayed until the issue is resolved.

If the discrepancy or doubt remains, then the justification for proceeding is to be documented in the health record and the event reported into the Safety Learning System.

In an emergency situation the senior person of the team responsible for the patient will make the decision on the most appropriate course of action.

3. Implementation and Monitoring

Health services must establish clinical governance structures and processes and evaluate the safety and effectiveness of clinical communication and patient identification. Evaluation measures require audit of practice and procedures, recording of completed training, and analysis of incident data.

Health services undertake audits and regular monitoring and evaluation to demonstrate that they meet the requirements of the NSQHSS Standard 6 Communicating for Safety.

The Safety Learning System records the number of patient incidents and also consumer (patient) feedback records (complaints) received in relation to clinical communication. The Quality Information and Performance Hub (QIP Hub) is used to display this information. An annual review of this data is published in the SA Health Patient Safety Report.

For more information refer to Tool 1 – Clinical Communication and teamwork, and Tool 3 – Patient Identification and matching to intended care.

4. National Safety and Quality Health Service Standards

For a diagrammatic representation of linkages between the content of this policy, refer to Appendix 1 – Actions that support effective clinical communication and safe patient care across the NSQHS Standards, Australian Commission on Safety and Quality in Healthcare, ACSQHC).

National Standard 1 Clinical Governance	National Standard 2 Partnering with Consumers	National Standard 3 Preventing & Controlling Healthcare-Associated Infection	National Standard 4 Medication Safety	National Standard 5 Comprehensive Care	National Standard 6 Communicating for Safety	National Standard 7 Blood Management	National Standard 8 Recognising & Responding to Acute Deterioration
☒	☒	☒	☒	☒	☒	☒	☒

5. Definitions

In the context of this document:

carer means: a person who provides personal care, support or assistance to another individual who needs it because they have a disability, a medical condition (including a terminal or chronic illness) or a mental illness, or are frail and/or aged.

clinical communication means: the exchange of information in whatever form about a person's care that occurs between treating clinicians, patients, families and carers, and members of a multidisciplinary team, that underpins seamless continuity of healthcare. Effective clinical communication is two-way, coordinated and continuous communication that results in the timely, accurate and appropriate transfer of information so that treatment is based on best information and provided to the correct patient, at the correct time.

clinical governance means: a system through which organisations and individuals are accountable to the community for continually improving the quality of services provided to patients and carers, and safeguarding high standards of care, ensuring that they are patient centred, safe and effective.

clinical handover means: the communication process that enables 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'. This statement is intended to include all verbal and written interactions about the care of an individual patient. For example, shift to shift, transfers between locations and services, referrals and discharge.

clinical team means: the staff whose collective effort ensures that the most appropriate treatments or interventions are provided to the correct patient. Team members have specialized knowledge and skills and are responsible for different tasks.

clinician means: a healthcare provider, trained as a health practitioner, including registered and nonregistered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They may include nurses, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide healthcare, and students who provide healthcare under supervision.

consumer means: a person who has used, or may potentially use, health services. A healthcare consumer may also act as a consumer representative. See also patient.

critical information means: information that has a significant impact on a patient's health, wellbeing or ongoing care (physical or psychological). The availability of critical information may require a clinician to reassess or change a patient's plan of care. Some critical information is conveyed as an **alert or flag** and these serve as warning of a potential risk to a patient or other person.

discharge summary means: "a collection of information about events during care by a provider or organisation" (AS4700.6 (Int) 2007). It comprises of a document produced during a patients stay in hospital as either an admitted or non-admitted patient and issued when or after a patient leaves the care of the hospital.

Failure Mode and Effect Analysis (FMEA) means: a systematic method of identifying and preventing product and process problems before they occur.

Health care record number means: unique identifier of a given patient for a health record within an organisation.

NOTES:

- The term 'health record number' includes the medical record number (MRN), healthcare record number, UR number (URN), clinical record number, client record number and local record number.
- The healthcare record number is typically used to support filing and retrieval of healthcare records within the healthcare organisations record system.

health literacy means**:** how people understand information about health and health care, and how they apply that information to their lives, use it to make decisions and act on it (ACSQHC).

health record means a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care. (Also known as a medical record, healthcare record, patient record or case notes).

health service (also health service organisation or health care facility) means: a separately constituted health service that is responsible for the clinical governance, administration and financial management of a service unit or service units providing healthcare. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

incident (patient incident) means: any event or circumstance which could have (near miss) or did lead to unintended and/or unnecessary mental or physical harm to a person that occurs during an episode of health care. Incident types are harmful incident, cluster incident, near miss, no harm incident and adverse incidents.

Individual healthcare identifier (IHI) means: the national healthcare identifier assigned to an individual eligible to receive healthcare in Australia. This identifier is used by the Australian healthcare system, and is specific to legislative requirements issued by the Australian government.

informed consent means: a process of communication between a patient and a clinician about options for treatment, care processes or potential outcomes. This communication results in the patient’s authorisation or agreement to undergo a specific intervention or participate in planned care. The communication must ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.

interventional procedures means: any procedure used for diagnosis or treatment that involves incision, puncture, entry into a body cavity or the use of ionising or electromagnetic energy.

ISBAR means: a mnemonic aid for structuring clinical communication where:

- **I** is Identify (establish the name and role of each person giving and receiving information and the correct identity of the patients)
- **S** is the clinical Situation
- **B** is the Background
- **A** is the clinical Assessment (including observations)
- **R** is the Recommendation or proposed plan including identification of risks).

medical record means: health record.

multidisciplinary team (or interdisciplinary) means: professionals from a range of clinical disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible. The composition of the team may change to reflect the changing clinical and psychosocial needs of the patient. Health care can be delivered by a range of clinicians functioning as a team within one organisation; or clinicians from a range of organisations, acting together as a team.

patient means: a person receiving healthcare from a health service organisation, or the subject of care. For the purpose of this document it is intended to also include consumers, clients and residents who are receiving healthcare.

patient identifiers means:

- **approved identifiers** means: items of information accepted for use in identification, including name (family and given names), date of birth, sex, address, medical record number and individual healthcare identifier. Health service organisations and clinicians are responsible for specifying the approved items for identification and procedure matching. Identifiers such as room or bed number are not to be used.
- **core patient identifiers** means: the three nationally agreed patient identifiers (name (surname and first name), date of birth and medical record number) that must be used whenever possible for patient identification. These are the only identifiers to be use for patient identification bands in SA.

patient identification means: the active process of correctly matching a patient through the use of three approved patient identifiers (preferably the core patient identifiers), protocols and guidelines to ensure an individual is correctly matched to the intended service, therapy, medication, test/procedure or documentation.

patient master index means: a permanent listing or register of patients on which health information is held by an organisation; that is, patients who have received or are scheduled to receive services.

procedure means: the set of instructions to make policies and protocols operational, which are specific to an organisation. It can also mean an interventional procedure for diagnosis or treatment.

process means: a series of actions or steps taken to achieve a particular objective.

protocol means: an established set of rules used to complete tasks or a set of tasks.

quality improvement means: the combined efforts of the healthcare practitioners and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.

shared decision making means: a consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the patient's values, preferences and circumstances.

standard means: agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.

structured clinical handover means: a structured format used to deliver information (the minimum information content), enabling all participants to know the purpose of the handover, and the information that they are required to know and communicate. This includes that the method and information content of handover be delivered in a structured format.

surgical procedure means: any procedure involving an incision with instruments that is performed to repair damage or arrest disease in a living body

TeamSTEPPS 2.0.AU means: Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®). This is an evidence-based program designed to improve teamwork and communication leading to a culture of continuous improvement and patient safety. TeamSTEPPS 2.0 AU is a version developed by SA Health in 2018.

telehealth means: the use of telecommunications and virtual technology to deliver healthcare outside of traditional health care facilities (WHO).

timely (communication) means: communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.

training means: organized activity aimed at providing information and/or instructions to improve the recipient's knowledge and skills.

transition of care means: a set of actions designed to ensure coordination and continuity of care when patients move or transfer between services. Transitions of care occur when a patient is leaving a health service, or being transferred to a different institution or level of care, and generally consist of one or more clinical handovers.

6. Associated Directives / Guidelines & Resources

Relevant Legislation

- *Advance Care Directives Act*
- *Carer Recognition Act 2005*
- *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*
- *Freedom of Information Act 1991*
- *Health Care Act 2008*
- *Health and Community Services Complaints Act 2004 includes a Charter of Health and Community Services Rights (the HCSCC Charter)*
- *My Health Record Act 2012 (Commonwealth)*
- *My Health Records Rule 2016 (Commonwealth)*
- *My Health Record Regulations 2012 (Commonwealth)*
- *Mental Health Act 2008*
- *Privacy Act 1988 (Commonwealth)*
- *State Records Act 1997*

SA Health Policies

- Accreditation to Safety and Quality Standards
- Advance Care Directives Policy
- Consent to Health Care and Medical Treatment Policy
- Consent (including where consent cannot be obtained) Guideline
- Freedom of Information Policy
- Guide for engaging with Aboriginal people
- Health Record Management Policy
- Partnering with Carers Policy
- Clinical Incident Management Policy
- People in Custody – Care and Treatment in Public Hospitals and Health Services Policy
- Privacy Policy
- Respectful Behaviour (including management of bullying and harassment) Policy
- Resuscitation Planning - 7 Step Pathway Clinical Directive
- Standardised terminology or abbreviations and symbols used in medication documentation: "Spell it Out" Policy
- User-applied labelling of injectable medicines, fluids and lines Policy

SA Health resources

- Continuity in Medication Management - A Handbook for South Australian Hospitals
- Consumer, Carer and Community Feedback and Complaints Management
- Privacy Principles and protecting personal information
- ISBAR iphone app, fact sheet, lanyard card, stickers
- Know the Plan, share the plan, review the risk – videos and tips for using the clinical handover educational training film.

- SA Health Surgical Safety Checklist – Audit and Observation Tool
- TeamSTEPPS 2.0 AU resources

Standards

- 10 Minimum Standards for Communication between Health Services and General Practitioners and Other Treating Doctors (2017, Australian Medical Association)
- Australian Standard 4846:2014 Person and Provider identification in Healthcare
- Australian Standard for Paper-based healthcare records AS2828.1-2012
- Australian Standard Digitized (scanned) health record system requirements AS2828.2
- General Disposal Schedule No28 for SA clinical and client-related records of public health units in South Australia (version1.1)

- Privacy Principles and protecting personal information
- National guidelines for on-screen presentation of discharge summaries
- National Safety and Quality Health Service Standards Second edition. 2018 Australian Commission on Safety and Quality in Health Care (ACSQHC).
- SA Health Patient Identification band Standard
- South Australian Client Identification Data Standards

Australian Commission on Safety and Quality in Health Care resources:

- Communicating for Safety
  - Resource portal
  - Framework for Communicating for Safety
  - National Statement on Health Literacy
- Clinical Handover
  - Guide for hospitals – NSQHS Standards p228 - 266
  - The OSSIE Guide to Clinical Handover Improvement. 2009.
  - Implementation toolkit for clinical handover.
  - Electronic discharge summary systems self-evaluation toolkit
  - Engaging patients in communication at transitions of care
- Patient / procedure matching
  - Ensuring Correct Patient, Correct Site, Correct Procedure Clinical and consumer information - protocols, fact sheets and FAQs to support correct matching of patients and their care in the specific areas of radiology, nuclear medicine, radiation therapy and oral surgery.

Codes of conduct

- Code of conduct for registered health practitioners. Australian Health Practitioner Regulation Agency (AHPRA)
- Code of Ethics for the South Australian Public Sector
- Good medical practice: a code of conduct for doctors in Australia, 2020. Medical Board of Australia.

Additional Resources

- TOP 5 tool (Clinical Excellence Commission, NSW)
- Clinical Handover: system change, leadership and principles. Issues Paper: Australian Healthcare & Hospitals Association 2009
- Health IT Safe Practices: Toolkit for the Safe Use of Health IT for Patient Identification
- Safe Handover: Safe Patients. Guidance on clinical handover for clinicians and managers, 2006. Australian Medical Association.
- World Alliance for Patient Safety ‘Implementation Manual Surgical Checklist’ (first edition) 2008

7. Document Ownership & History

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Policy history: Is this a new policy **No**

Does this policy amend or update an existing policy? **Yes**

If so, which version? Clinical Handover Policy Directive

Does this policy replace another policy with a different title? **Yes**

If so, which policies (titles)? The following will be retired;

- Surgical Team Safety Checklist Policy Directive
- Patient Identification Policy Directive
- Patient Identification policy Guideline
- Clinical Handover Guideline

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Approval Date	Version	Who approved New/Revised Version	Reason for Change
08/10/2024	V5	Clinical Guideline Domain Custodian	Amendment – removal of reference to under 18 years and update to Surgical Safety Checklist reference.
26/02/2019	V4	Safety and Quality Committee	Formally reviewed in line with 1-5 year scheduled timeline for review Expanded to include My Health Record and clinical aspects.
07/06/2013	V3	Safety and Quality	Review and format changes only
17/09/2012	V2	Safety and Quality	Updated to reflect the restructures within the portfolio and are not material in nature
12/10/2010	V1	Portfolio Executive	Original PE approved version.

APPENDIX ONE

Reproduced with permission from National Safety and Quality Health Service Standards Guide for Hospitals, developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC). ASCQHC:Sydney, 2017.

Framework for Communicating for Safety

Clinical governance and partnering with consumers

Overarching actions that support integrated clinical governance, quality improvement and organisational systems to support effective clinical communications

- **Clinical Governance Standard:** ● 1.16, 1.17, 1.18 – Healthcare records; and ● 1.12 – Open disclosure
- **Partnering with Consumers Standard:** ● 2.3, 2.4, 2.5 – Healthcare rights and informed consent; ● 2.6, 2.7 – Sharing decisions and planning care; and ● 2.8, 2.9, 2.10 – Communication that supports effective partnerships
- **Communicating for Safety Standard:** ● 6.1, 6.2, 6.3, 6.4 – Clinical governance and quality improvement to support effective communication

Consider documentation requirements at all stages

Relevant, accurate, complete and timely information is documented in the healthcare record to support patient care (3.7, 4.5, 4.6, 4.8, 4.10(c), 4.12, 5.4(a), 5.9, 5.12, 5.13, 5.17(b), 6.6, 6.11, 7.5, 8.4(a), 8.5(e))

Effective communication is critical at all stages of care

Clinicians should have the skills and knowledge to effectively communicate with patients, carers, families and other members of the care team

Patient's journey

A patient enters a health service organisation

FLOW OF INFORMATION – All relevant information should follow the patient

A patient exits a health service organisation

A patient is in their home/community/ other service

Communicating at registration and admission

Actions to gather administrative information; information about a patient's goals and preferences; and information to inform the plan of care

- Correct identification and procedure matching (6.5, 6.6)
- Sharing decisions and planning care (2.6, 2.7)
- Communication to support effective partnerships (2.8, 2.9, 2.10)
- Informed consent and decision-making capacity (2.4, 2.5)
- Medication history (including adverse drug reactions) and reconciliation (4.5, 4.6, 4.7, 4.8)
- Routinely asking patients if they identify as Aboriginal or Torres Strait Islander (5.8)
- Planning for comprehensive care, screening of risk and clinical assessment (5.7, 5.9, 5.10, 5.11)
- Preventing delirium and managing cognitive impairment (5.29, 5.30)

Communicating to plan care and when care, therapy or medication is provided

Actions to support effective communication to support decision-making about care, including between clinicians and multidisciplinary teams; and between clinicians and patients, families and carers

- Correct identification and procedure matching (6.5, 6.6)
- Sharing decisions and planning care (2.6, 2.7)
- Communication to support effective partnerships (2.8, 2.9, 2.10)
- Providing information to patients on their medicine needs and risk (4.11)
- Systems to deliver comprehensive care, developing and using comprehensive care plan (5.4(a), 5.13, 5.14)
- Identifying at all times the clinician with overall accountability for patient care (5.4(d))
- Collaboration and teamwork (5.5, 5.6)
- Comprehensive care planning, including end-of-life care where appropriate (5.9, 5.13, 5.15, 5.20)
- Preventing delirium and managing cognitive impairment (5.29, 5.30)

Communicating acute deterioration and escalating care

Actions where acute deterioration occurs and care needs to be escalated

- Clinicians recognise acute deterioration (in physiological and mental state) and escalate care (8.5(e), 8.6, 8.8, 8.9)
- Escalation by patients, carers or families (8.7)

Communicating at transitions of care

Actions when all or part of a patient's care is transferred on a temporary or permanent basis

- Correct identification and procedure matching (6.5, 6.6)
- Structured clinical handover (6.7, 6.8)
- Sharing decisions and planning care (2.6, 2.7)
- Communication to support effective partnerships (2.8, 2.9, 2.10)
- Ensuring timely and appropriate referral (5.4(c))
- Communicating infectious state (3.7)
- Reviewing current medicine order, reconciling any discrepancies at transitions of care (4.6)
- Providing medicines list to receiving clinicians at transitions of care (4.12(b))

Communicating at discharge

Actions relevant on discharge, noting that discharge is one type of transition of care

- Correct identification and procedure matching (6.5, 6.6)
- Structured clinical handover (6.7, 6.8)
- Sharing decisions and planning care (2.6, 2.7)
- Communication to support effective partnerships (2.8, 2.9, 2.10)
- Aligns with comprehensive care plan (5.13)
- Provision of medicines list to receiving clinicians at transitions of care (4.12(b))

Follow-up communication

Actions that support closed-loop communication

- Communicating critical information to clinicians and patients (6.9)
- Transfering responsibility and accountability for care (6.8(f))
- Predicting, preventing and managing self-harm and suicide (5.31, 5.32)

Communicating when critical information emerges or changes

Critical information may arise throughout the course of care, and may require changes to the plan of care

- Communicate critical information and risks to clinicians and patients (6.9)
- Patients, carers and families able to communicate critical information (6.10)
- Review and adapt plan, reassess patients needs (5.14(c)-(d))
- Communicate adverse drug reactions during an episode of care or ineffective management of medication (4.8)