

Our vision: Healthier communities, Excellence in healthcare

Our values: Teamwork, Honesty, Respect, Ethics, Excellence, Caring, Commitment, Courage

Enhancing Clinical Communication between Clinicians: One Health Service's Journey

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Enhancing Clinical Communication between Clinicians: One Health Service's Journey

- Defining Clinical Communication
- One Health Service's Experience
- Clinical Communication in Incidents and Complaints
 - Moving Forward

Defining Clinical Communication

Current Situation

Good communication recognised as essential to quality and patient safety

Good communication skills part of health professional expertise

Incidents, complaints and litigation linked to poor communication

Growing interest in training for teamwork and technology support for communication

But increasingly,

Communication sited as a cause in the “too-hard’ basket

Defining Clinical Communication

Clinical Communication in Handover under review

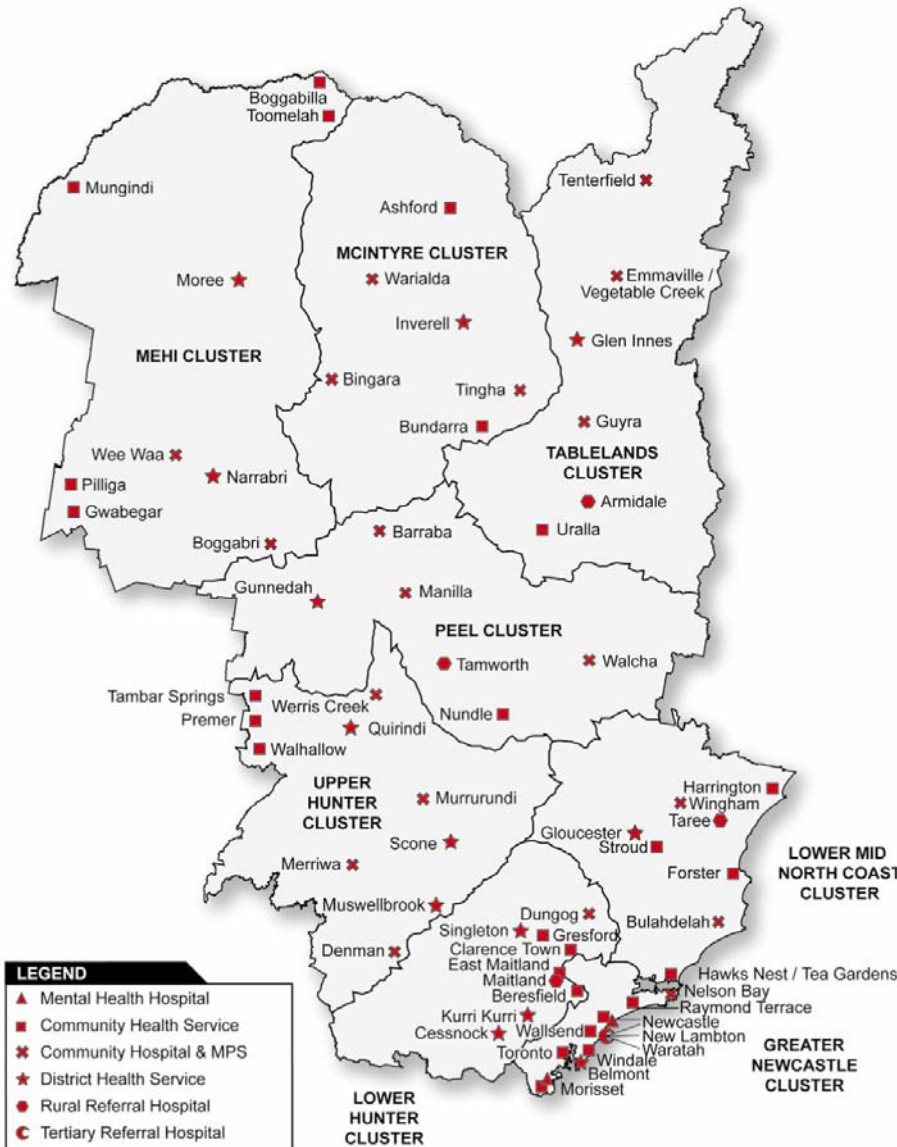
Growing interest in human factors aspects

Recognition of its influence in quality and safety

And

Where to start?

Enhancing Clinical Communication between Clinicians



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

HUNTER NEW ENGLAND
NSW HEALTH

One Health Service's Experience

Human Factors Project - Professor John Fraser, Director, HNEH Rural Training Unit, Tamworth Hospital

Commonwealth Department of Health and Aging funded-initiative

Supported by analysis of incidents relating to human factors and communication with associated literature review

Development of a multi-disciplinary human factors course integrated with existing procedural training courses for General Practice registrars and nurses at two to three rural sites in the Hunter New England Area by July 2007.

One Health Service's Experience

Centre for Medical Professional Development – Professor Kichu Nair

Tailored International Medical Graduates Orientation Program
Supervision skills workshops
Junior Consultants Workshop
Management for Medical Clinicians
Teaching on the Run

One Health Service's Experience

Clinical Handover

Consultant-led and with teaching focus at two sites
Handover registers that form part of Medical Quality Review
Clinical Engagement in Clinical Handover guidelines
Clinical Excellence Commission project on Handover

One Health Service's Experience

Hunter New England Simulation Centre

Focus is on training in teams

Communication focus

Pilot of Medical Emergency Event Course for Career Medical
Officers (Sydney Medical Centre)

Located in northern and southern sectors

Clinical Communication in Incidents and Complaints

Clinical Communication in Incidents and Complaints

Data from calendar year 2006

403 incidents reported to involve clinical communication.

171 complaints involved clinical communication

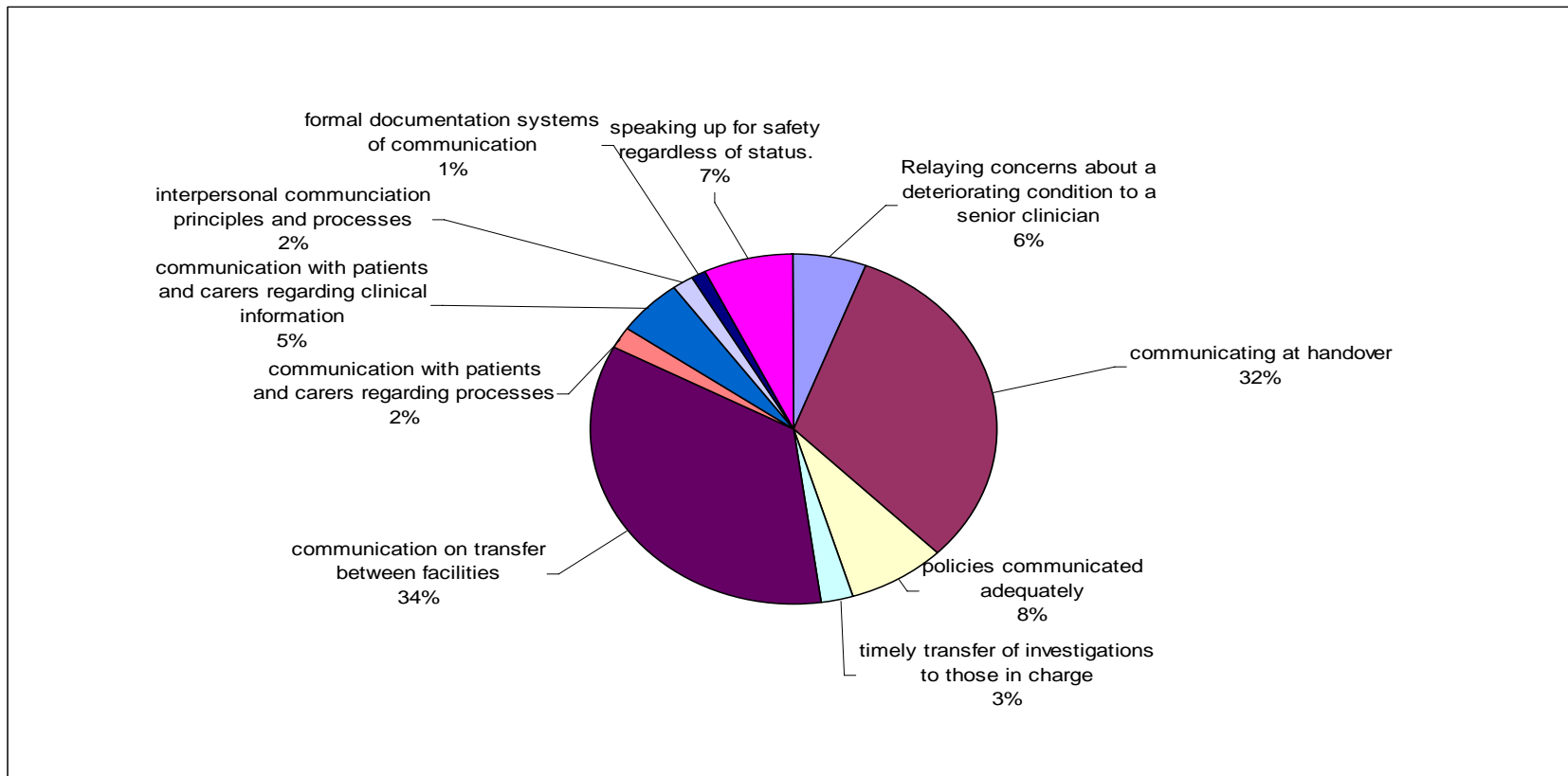
127 RCAs involved communication

Clinical Communication in Incidents and Complaints

Categories for Communication

- Communication at Handover
- Communication on transfer between facilities
- Communication with patients and carers re processes of care
- Communication with patients and carers about clinical care and information
- Interpersonal communication principles and and practices
- Formal documentation
- Relaying concerns about deteriorating clinical condition to senior staff
- Speaking up for safety

Incidents Reported via IIMS in 2006



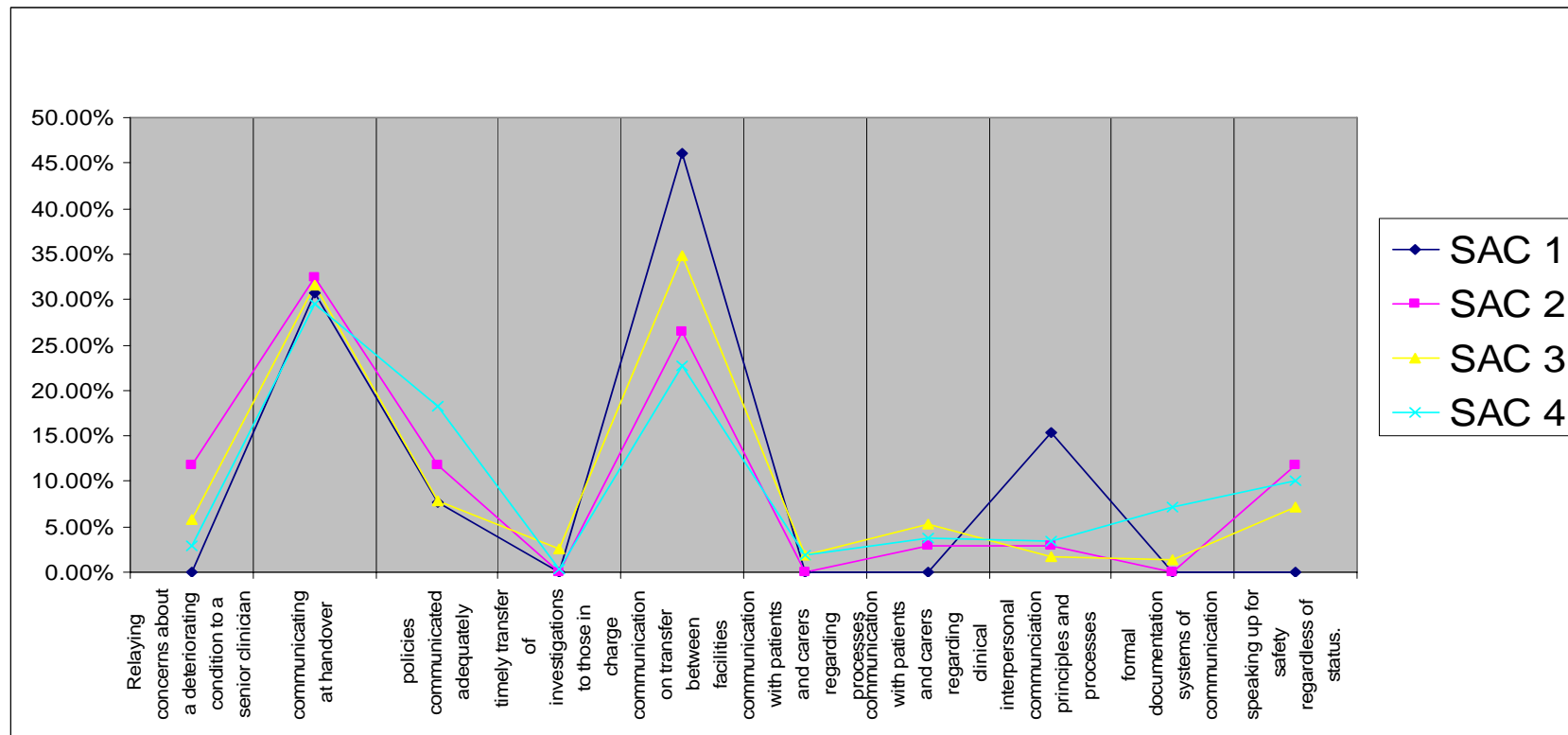
Incidents Reported via IIMS in 2006

Communication around transfer between facilities (34%)

Communication over handover (32%)

Other (34%)

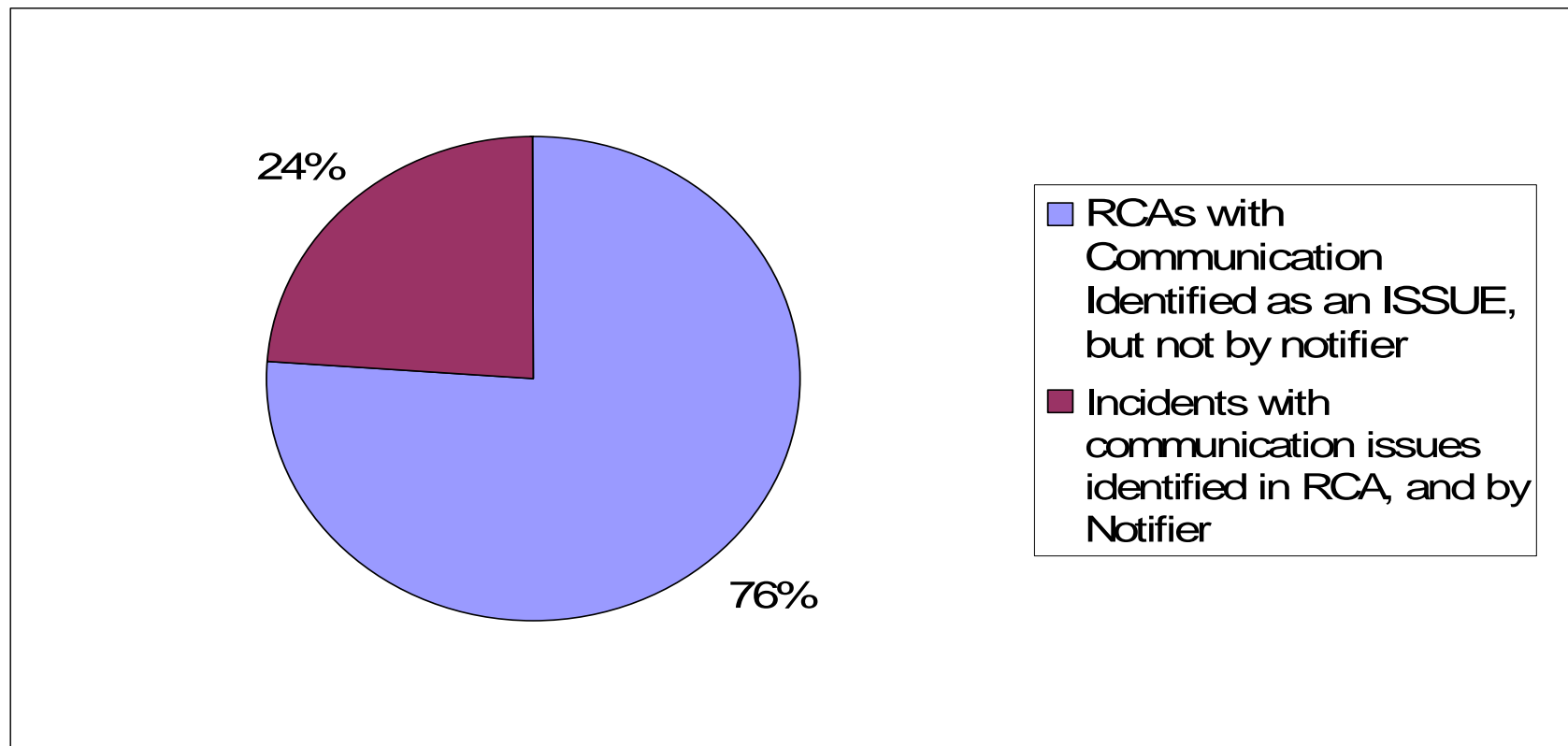
Incidents by Severity Assessment Code (SAC) and reported via IIMS in 2006



Incidents by Severity Assessment Code (SAC) and reported via IIMS in 2006

- Relative frequency for each SAC rating was similar
- No apparent correlation between specific communication categories and incident severity category

Comparison of RCA findings relating to Communication with Initial Incident Report

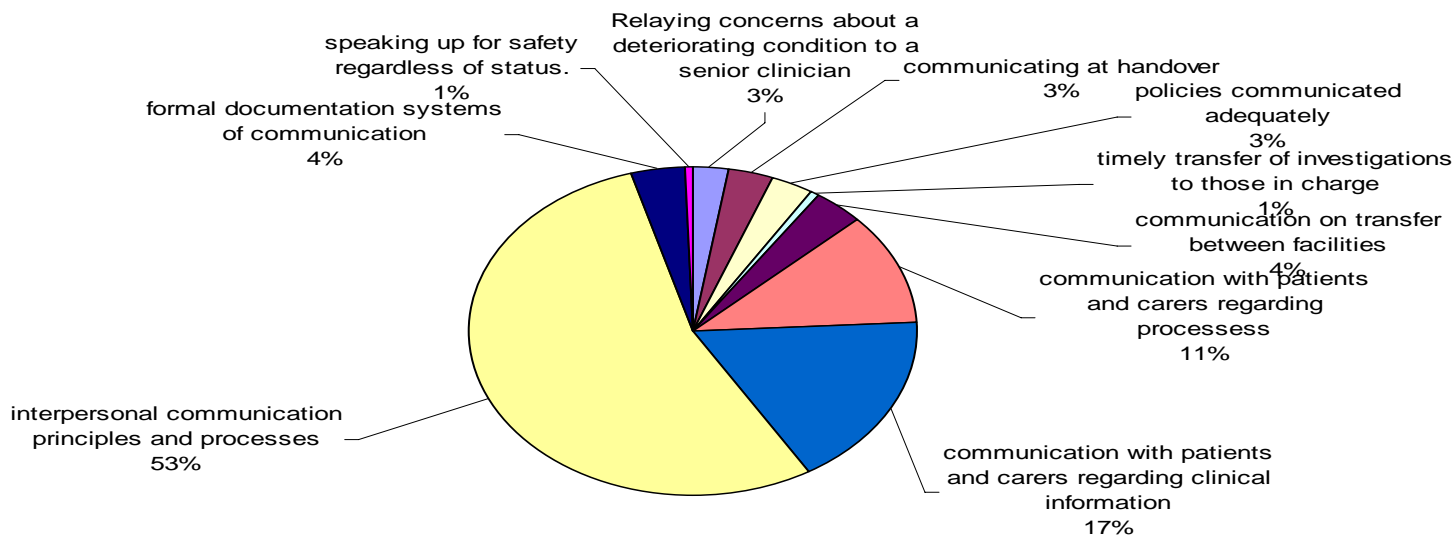


Comparison of RCA Findings relating to Communication with Initial Incident Reports

On review of RCAs in 2006 where the RCA team concluded that communication was a root cause, only 24% of initial incident reports in IIMS cited communication as a component of the incident

This suggests that the actual number of incidents involving communication could be higher than reported, and may be up to four times higher than as reported via initial incident

Complaints associated with Communication reported through IIMS in 2006



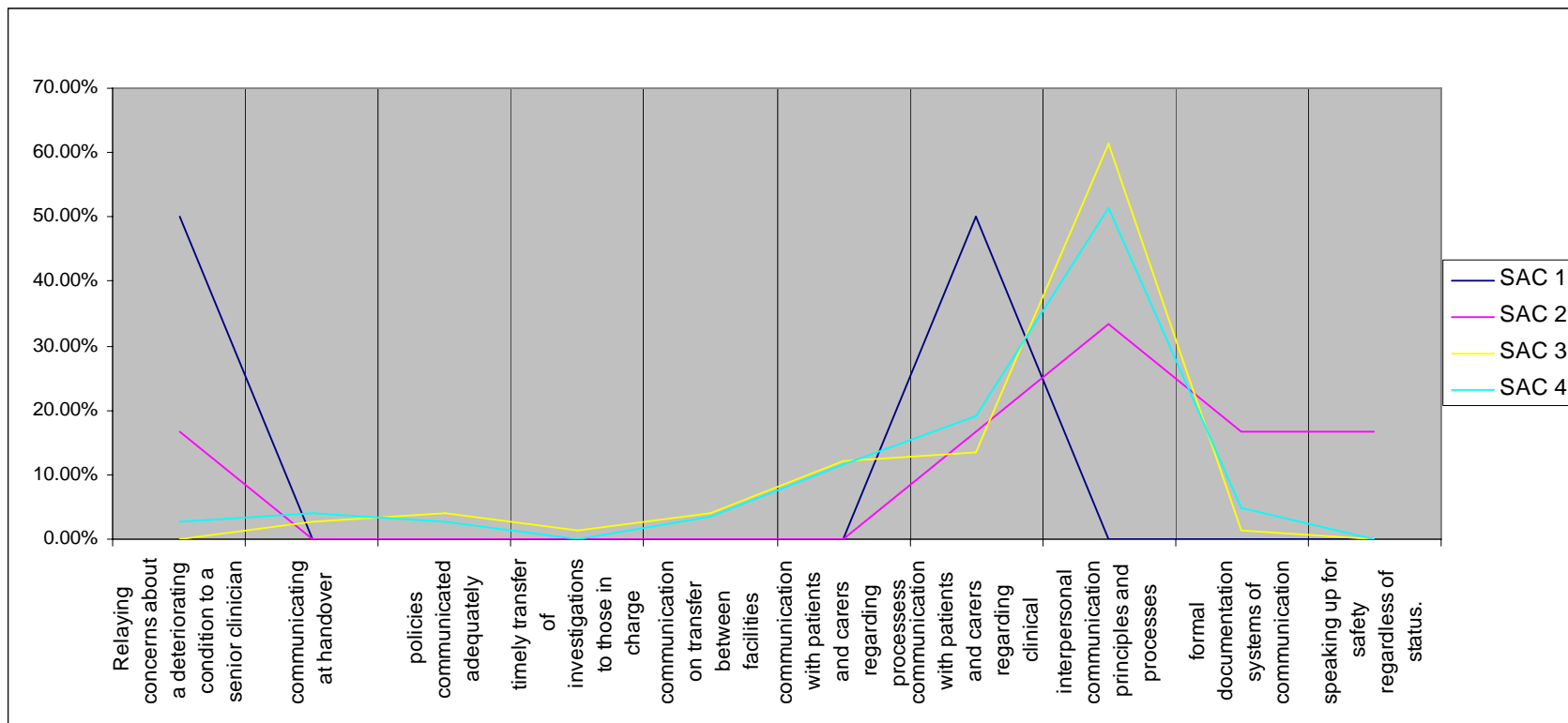
Complaints associated with Communication reported through IIMS in 2006

Interpersonal communication principles and processes (53%)

Communication regarding clinical information (17%)

Other (30%)

Complaints by Severity Assessment Code (SAC) reported through IIMS in 2006



Complaints by Severity Assessment Code (SAC) reported through IIMS in 2006

SAC 1 Complaints more likely to be linked with communication regarding clinical information

Other SAC complaints more likely to be linked with interpersonal communication principles and processes

Summary of Findings

Incidents and complaints have different communication issue profiles

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

There may be a correlation between SAC1 complaints and communication about clinical information

Moving Forward

1. Communication is a Quality and Patient Safety priority
2. Target areas remain clinical handover and inter-facility/department transfers for staff and staff-patient communication for patients and their families
3. Further examination of incident reports and complaints may provide insights
4. Addressing communication in the clinical setting engages clinical staff

Moving Forward

5. Opportunities are in learning from others to leverage greater gains and building organisational capacity (for example, state initiatives and local Clinical Communication Reference Groups)
6. Leadership and role modelling is powerful
 - education and training targeting teamwork, effective supervision,
7. These are systems issues that require systems solutions
 - human factors and training in teams
 - communication technology to support effective communication

THANK YOU