Approved by RHW Safety & Quality Committee April 2022

# Comprehensive Care Plan

This business rule must be read in conjunction with SESLHDGL/088- Standard 5 Comprehensive Care Guideline

Note: A comprehensive care plan is currently in development by NSW eHealth.

**Target Audience**

- All Clinical staff (Nursing, Midwifery, Medical, Allied Health)
- Managers and Heads of Departments

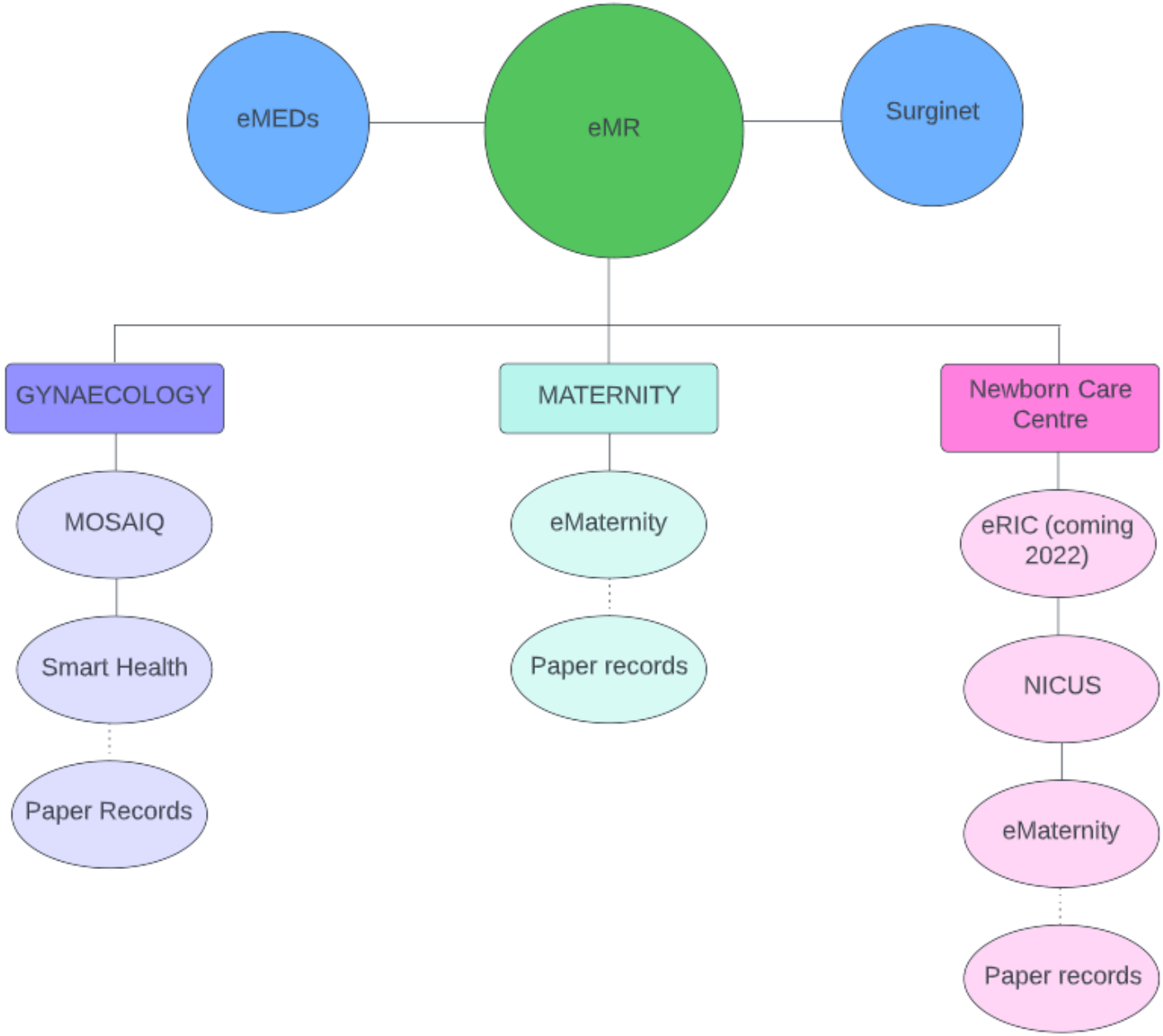
**Purpose and Scope**

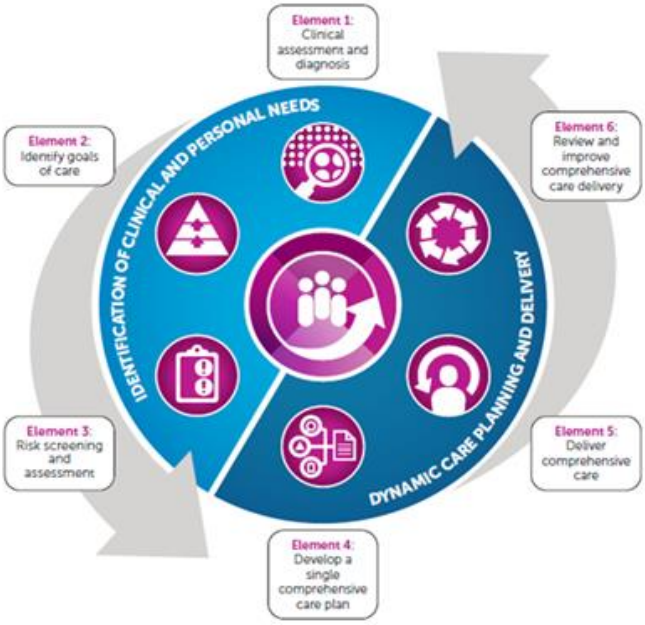
Comprehensive care is defined by the Australian Commission of Safety and Quality in Healthcare, (2021) as care that involves teams of health professionals working together and communicating effectively to plan, manage and coordinate care with the patient, women, neonates and their families/carers/parents. It aims to ensure that our patient cohort are assessed for risk of harm and that these risks are prevented and managed through targeted strategies.

RHW has a hybrid health care record system. There are multiple electronic health record platforms as well as paper based. Some platforms are service specific while others are facility wide. The patient Electronic Health Record (EHR) comprises of multiple platforms that interact to form the patient's comprehensive care plan. In practice, the terms EHR and eMR (an EHR platform) are used interchangeably. eMR is the most commonly used term. Therefore from this point the EHR will be referred to as the eMR. The current platforms that make up the comprehensive care plan and feed into the eMR are outlined in Table 1. Paper based records are used in conjunction with the eMR to communicate the plan.

The patient eMR is the tool for documenting and reviewing the information on care planning for the patient. All clinical staff (nursing, midwifery, medical and allied health) have the ability to access and utilise the patient's eMR. All decision making about care planning must be reflected in the eMR and should be documented at the time of decision making.

*Figure 1: Comprehensive Care Plan (eMR) and healthcare documentation platforms relations*






**The six essential elements for delivering Comprehensive Care Plan**

**Minimising Risk and Harm**

**Risk Screening and assessment**

SESLHDGL/088 Standard 5 Comprehensive Care plan assists clinicians in the identification of the vulnerable person. The training requirements to support clinician education for these assessments can be accessed via HETI.

Identifying patients and risk mitigation strategies are the core part of comprehensive care and involves the patient, families, parents and other carers. These screening processes identify cognitive, behavioural, mental or physical conditions and risks of harm and also identify any social or other circumstances that may increase these risks. Specific risks of harm within this standard are the following;

- Falls Prevention
- Pressure Injuries
- End of Life care
- Nutrition
- Delirium and cognitive impairment
- Self-harm and suicide
- Restrictive Practices
- Violence and Aggression

All incidents of patient harm and near misses are reported via the incident management system (ims+) in accordance with the NSW Health policy, PD 2020_047 Incident Management Policy.

**Developing a single comprehensive care plan**

Comprehensive care plans help healthcare professionals to work with our patient cohort to plan, document and accomplish an individualised care plan, describing agreed goals of care and outlining planned medical, midwifery, nursing and allied health activities. The eMR is regarded as the patient's comprehensive care plan which is easily accessible to all clinicians involved in the persons care.

To aide our clinicians to capture information on the comprehensive care that we deliver for our patients, the RHW use a hybrid medical record/paper record system which includes;

- eMR,
- eMEDS,
- eMaternity,
- Smart health
- MOSAIQ,
- eRIC (will be introduced in Newborn Care Centre proposed end 2022)
- SCHN eMR (NCC only)
- Surginet
- SESLHD Endorsed clinical forms.
- Paper medical records
- NICUS (NCC Only)

**Documentation**

Documentation in health care records must provide an accurate description of each patient/women's episode of care or contact with health care personnel. The NSW Ministry of Health PD2012_069 Health Care Records – Documentation and Management Policy requires that a health care record is available for every patient/woman to assist with assessment and treatment, continuity of care, clinical handover, patient safety and clinical quality improvement, education, research, evaluation, medico-legal, funding and statutory requirements (Documentation in the Health Care Record SESLHDPR/336)

The minimum requirements are listed below;

- Contemporaneous
- Person centred
- Accurate
- Factual
- Readable
- Objective
- Complete
- Avoid judgemental terminology
- Only utilise SESLHD endorsed abbreviation**s**
- Do not 'cut and paste'

**Delivery of Comprehensive Care**

Patients will require different health care depending on their individual needs, preferences and goals. It is important that care is provided continuously and collaboratively in line with their comprehensive care plan. At the RHW, the delivery of the comprehensive care plan will aim to address;

- Identified risks of harm
- Monitor the effectiveness of the comprehensive care plan in meeting the goals of care
- Review and update the care plan when required
- Reassess the patient's needs if there are changes in diagnosis, behaviour, cognition or mental or physical changes that occur.

Examples of evidence of comprehensive care that are used at the RHW may include but not limited to;

- Structured interdisciplinary beside rounding/clinical handover
- Case conferencing
- Family conferencing
- Multidisciplinary team meetings
- MDT Safety huddles
- Electronic journey boards
- Morbidity and Mortality meetings

**Clinician education and training**

**T**he RHW is committed to the education and training for all clinicians. To ensure that clinicians have the necessary education and knowledge to conduct appropriate patient screening and assessments, the following training and education is provided.

- Falls Prevention- Falls and Harm from Falls- Learning Pathway (HETI code 40063943), Post Falls Management for Clinical staff (HETI Code 40101665), Falls Risk Screening Assessment and management plan For Adults (HETI Code 40823720) Learning Path- Maternity Post Falls Management (HETI Code 40101665)
- Pressure Injuries- Pressure Injury Prevention: Risk Assessment HETI Codes 115610702 & 115610919), Wound Assessment (HETI Code 40063891), Wound Management (HETI Code 42833429)
- End of Life care – End of Life Pathway which includes Advanced Care Planning, SHAPE End of Life conversations, End of Life Supportive Care, Person Centred Care (HETI Code 43392513)
- Nutrition- Nutrition Screening for Malnutrition (HETI Code 66794494)
- Delirium and cognitive impairment- Delirium (stage 1, HETI Code 233003664) & Delirium (stage 2, HETI Code 266621954), The Confused patient: Dementia or Delirium? (HETI Code 39966589)
- Self-harm and suicide - NSW Health Gate Keeper Training for Suicide Prevention (HETI Code 208562351)
- Violence and Aggression- Violence and Prevention Management in the Workplace- Awareness (HETI Code 39831935), Violence Prevention and Management in the Workplace- Promoting Acceptable Behaviour in the Workplace (HETI Code 39964553), Violence and Prevention Management- Legal and Ethical issues (HETI Code 39964553), Be aware for Personal Safety (HETI Code 27624273), Security Awareness- All Staff (HETI Code 194502198)
- Violence and Prevention Management for Managers (HETI Code 39990453)
- Restrictive Practices -It must be documented in the patient's notes that restraints are required.

  **PLEASE NOTE: Soft restraints are located in the roster office. They are disposable and ONCE use only.**

  The restraint register is located in the roster office.

**Compliance Monitoring and Evaluation**

RHW collects and interprets multiple forms of data from a range of measures that are co-ordinated and managed to obtain a complete account of patient safety in the facility. These measures use multiple sources of data. Examples of sources are listed in the below table.

| | |
|---|---|
| **Patient Experience** | Patient experience examples<br>Patient stories<br>Compliments<br>Complaints<br>Care Opinion |
| **Systems and Processes** | Incident management<br>Key performance indicators<br>Clinical process audits<br>HAC data<br>QIDS<br>QARS |
| **Facility culture and governance to support a comprehensive care approach** | Recruitment and retention<br>Risk registers<br>Policies and procedures<br>Staff satisfaction |

**Compliance Evaluation**

Evidence of compliance evaluation will be reported and tabled at the Standard 5 Governance Committee meeting.

**References**

SESLHDGL/088- Standard 5 Comprehensive Care Guideline. September 2020

Clinical Care Standard Heavy Menstrual Bleeding 2017

Clinical Care Standard Delirium 2016

Clinical Care Standard Delirium 2021

Clinical Care Standard Third and Fourth Degree Perineal Tears 2021

Clinical Care Standard Venous Thromboembolism Prevention 2020

SESLHDPR/292 Hybrid Health Care record Procedure 2021

SESLHDPR/483 Restrictive Practices with adult patients. July 2021

SESLHDPR/336 Documentation in the Health Care Record. November 2021

MOH PD2012_069 Health Care Records – Documentation and Management Policy

SESLHDPR/282 Clinical Abbreviations. February 2022

REVISION & APPROVAL HISTORY
Developed: Comprehensive Care Committee April 2022