SESLHD GUIDELINE COVER SHEET

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SUMMARY	To ensure that patients accessing SESLHD health services receive care that is coordinated and meets their individual needs. Comprehensive care provided in SESLHD also aims to ensure that risks of harm for patients during health care are identified, prevented, and managed through adequate screening and assessment, followed by implementation of targeted and individualised strategies which are documented in the care plan.

SESLHD GUIDELINE COVER SHEET

Comprehensive Care

Section 1 - Background

Comprehensive care as defined by the Australian Commission of Safety and Quality in Health Care (the Commission) is the delivery of health care that is based on identified goals for the episode of care. These goals are aligned to the patient's expressed preferences and healthcare needs, consider the impact of the patient's health issues on their life and wellbeing, and are clinically appropriate. Comprehensive care aims to ensure that risks of harm for patients during health care are identified through screening and assessment processes and are prevented and managed through targeted strategies. These include strategies related to falls, pressure injuries, nutrition, mental health, cognitive impairment and end-of-life care.

SESLHD aims to provide safe, continuous, and collaborative care to all patients to reduce harm within all patient care settings. Patient harm is minimised through using targeted screening assessments, comprehensive care planning, and delivery of services that are timely, evidenced based, and delivered in partnership with patients, carers, and families. Age and developmentally appropriate care, as well as trauma informed considerations are also fundamental to providing comprehensive care.

This guideline outlines the requirements of SESLHD to demonstrate performance against the National Safety and Quality Health Service Standards (NSQHS) Standard 5 Comprehensive Care.

More information about the Comprehensive Care Standard can be found here.

In developing this guideline, SESLHD has considered existing policies that are specific to areas of clinical care that address assessment and care planning, patient risk, and minimisation of harm. This guideline does not replace any existing policies and should be read as a complementary guideline to existing NSW Health and SESLHD policies and procedures, as well as other accepted documents (e.g. Clinical Care Standards).

Comprehensive Care refers to actions needed within a single episode of patient care, however, it is important that each episode of care is considered as part of a patient's continuum of care. This requires that the systems and processes necessary to meet the requirements of this standard also meet the requirements of the Partnering with Consumers Standard and Communicating for Safety Standard.

Section 2 - Definitions

Definition:

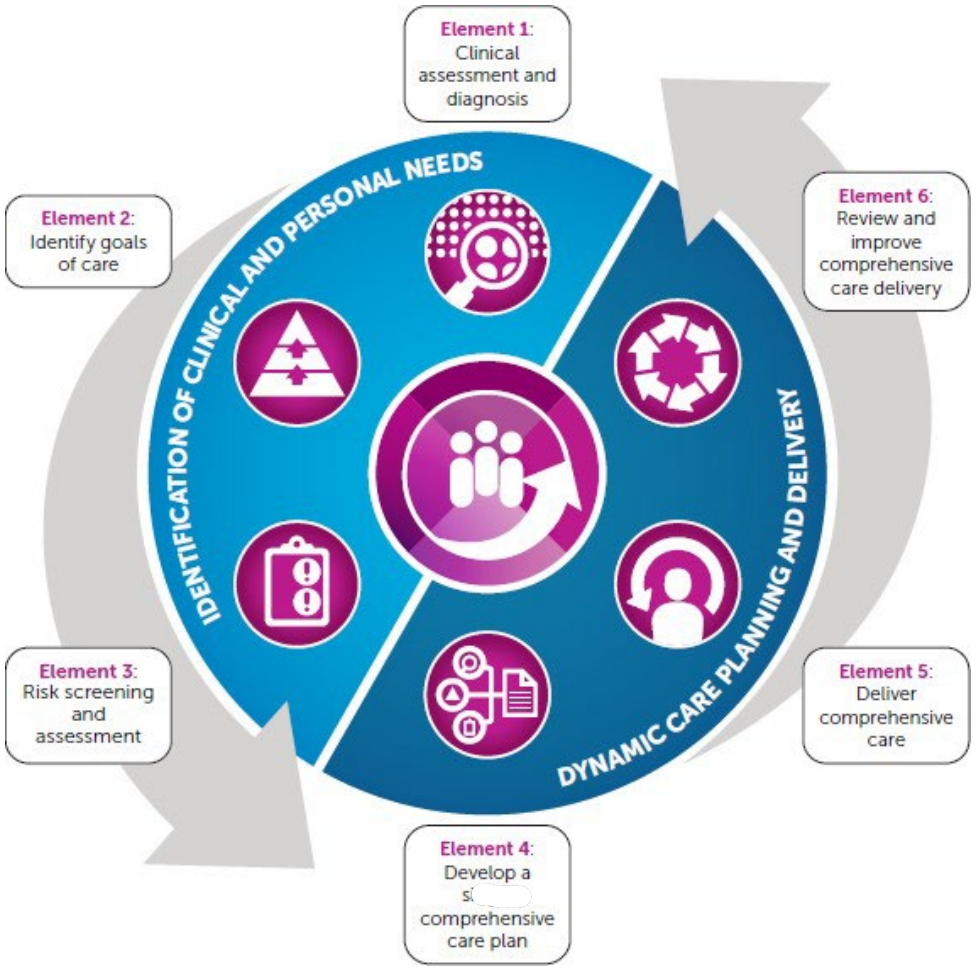
- **Cognitive impairment** – a temporary or permanent loss of mental functions, causing forgetfulness, lack of concentration, learning difficulties, and other reductions in effective thinking.
- **Comprehensive care** – health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the patient's health issues on their life and wellbeing, and are clinically appropriate.
- **Comprehensive care plan** – each patient should have a plan for care developed relevant to their care needs. The plan for care should allow for core information to be easily shared, accessed and acted on by all members of the multidisciplinary team.
- **Delirium** – is an acute change in mental status that can result in disturbance to consciousness, attention, cognition and perception. Patients with delirium may be agitated and restless (hyperactive delirium), quiet and withdrawn (hypoactive delirium), or move between these two subtypes (mixed delirium).
- **End of life care** – processes that aim to assist patients who have a life-limiting or life- threatening illness. The focus of this type of care is managing symptoms and providing comfort, assistance, physical, emotional, and spiritual support.
- **Fall** – an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.
- **Facilities** – all sites and services within SESLHD that provide clinical care.
- **Nutrition and hydration** – malnutrition occurs over time if someone does not meet their nutritional needs. People become malnourished if they don't eat enough, or the right types of food, or if their body can't absorb all the nutrients from food. Dehydration occurs when you don't have enough fluids in your body. Malnutrition and dehydration are both causes and consequences of illness and have significant impacts on health outcomes.
- **Patient safety** – the processes by which hospitals and other health care organisations protect their patients from errors, injuries, accidents, and infections.
- **Pressure Injury** – an area of damage to the skin and the tissues underneath

caused by constant pressure, friction or sheering force and often occur over bony areas such as the sacrum, elbows, heels or hips.

- **Restrictive practices** – restrictive practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person. These primarily include restraint (chemical, mechanical, social or physical) and seclusion (social confinement).
- **Risk factor** – is any attribute, characteristic, or exposure of an individual that increases the likelihood of developing a disease, injury, or other negative outcome**.**
- **Risk screening** – a short process to identify patients who may be at risk of, or already have a disease or injury. It is not a diagnostic exercise, but rather a trigger for further assessment or action. This must be documented.
- **Risk assessment** – assessment, analysis, and management of risks. It involves recognising which events may lead to harm in the future and minimising their likelihood and consequences. This must be documented.
- **Shared decision making** – 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.
- **Unpredictable behaviour** – people in health care settings can exhibit unpredictable behaviours that may lead to harm. Unpredictable behaviours may include self-harm, suicide, aggression, and violence.

Section 3 – Essential Elements for Delivering Comprehensive Care

The Commission has identified six essential elements for the delivery of comprehensive care. These elements represent different stages or processes that a patient may experience when care is delivered. SESLHD has adopted this model of comprehensive care and all SESLHD facilities are to ensure care across all settings aligns with the six essential elements. SESLHD recognises that communication, goal setting, shared decision making, and collaborative care planning with patients/ carers/ families and the multidisciplinary team are essential in comprehensive care and minimising risk of patient harm.



Source: Australian Commission on Safety and Quality in Healthcare (2018). Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care. Retrieved from https://www.safetyandquality.gov.au/our-work/comprehensive-care/essential-elements-comprehensive-care

Element 1: Clinical assessment and diagnosis

The first step in delivering comprehensive care is undertaking a clinical assessment. Clinical assessment should be based on the patient's subjective report of the symptoms and course of the illness or condition, and objective findings from clinical assessment to determine provisional and differential diagnoses.

SESLHD requires each facility to:

- Foster a person centred culture in delivering comprehensive care.
- Specify, communicate and document a clear process and the roles and responsibilities for supervision of clinicians.
- Provide access to training and education to support clinical assessment activities and diagnostic processes.
- Provide systems to capture relevant information for comprehensive care delivery including clinical assessment and diagnosis.

Element 2: Identify goals of care

Goals of care to be identified in collaboration with the patient, rather than focusing on clinical goals alone, to ensure that care is individualised to patient needs and preferences and not only driven by population-based data and outcomes.

SESLHD requires each facility to:

- Foster a person centred culture in delivering comprehensive care, including supporting the identification of personal and clinical priorities to determine the agreed goals of care.
- Establish systems and processes that support eliciting and documenting goals of care.
- Provide access to training and education to support effective communication and person centred approach to care.

Element 3: Risk screening and assessment

Identifying patients who may be at risk of harm, and mitigating risks for those patients is an integral part of comprehensive care planning and treatment.

SESLHD requires each facility to:

- Foster a person centred culture in delivering comprehensive care, including supporting risk screening and assessment processes that are person-centred.
- Identify the risks of harm that are a priority across the organisation, including those specified in the NSQHS Standards.
- Define and communicate organisation-wide processes for risk screening and assessment of those priority risks, and the appropriate models of care that mitigate those risks.
- Establish a list of tools for those risks, ensuring those tools are approved for use within the organisation.
- Describe and communicate the roles and responsibilities for risk screening and assessment in the organisation.
- Identify key points in healthcare episodes when risk screening may be required (which may include pre-admission, admission, transfer, discharge, or if there is a change in the patient's condition).
- Have policies and processes for escalating care of patients who are at high risk of experiencing harm.
- Define and communicate models of care for high-risk population groups.

- Provide access to training and education to support implementation of organisational risk screening and assessment processes, risk mitigation, and escalation of care.
- Provide systems to capture relevant information for comprehensive care delivery, including outcomes and actions from risk screening and assessment processes.
- Develop processes for patients, families, and carers to escalate care and communicate how to activate these processes to patients, families, and carers.

Element 4: Develop a comprehensive care plan

A comprehensive care plan describes the agreed goals of care following consideration of personal and clinical needs and priorities, outlining key aspects of planned medical, nursing, and allied health activities for a patient to achieve those goals. The plan for care should allow for core information to be easily shared, accessed and acted on by all members of the multidisciplinary team.

SESLHD requires each facility to:

- Foster a person centred culture in delivering comprehensive care including supporting collaboration in comprehensive care planning.
- Establish agreed policies, processes, or templates for developing a comprehensive care plan that are appropriate to the care context.
- Determine systems and processes to review patient outcomes against the comprehensive care plan.
- Provide access to training and education to the multidisciplinary team on the use of the organisation's processes for developing a comprehensive care plan.
- Provide systems to capture information on comprehensive care delivery.

Element 5: Deliver 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 diagnoses, agreed goals of care, and the comprehensive care plan. The delivery of comprehensive care should aim to address the health issues the patient was admitted with, the preferences expressed by the patient, and the risks of harm identified, to achieve the agreed goals of care.

SESLHD requires each facility to:

- Foster a person centred culture in delivering comprehensive care, including supporting the delivery of person centred comprehensive care.
- Provide access to training and education to support delivery of care that is person-centred and responsive to changes in the patient's needs.
- Support services to provide models of care that are person-centred and comprehensive.
- Provide systems to capture information on comprehensive care delivery, including patient experience of comprehensive care delivery.

Element 6: Review and improve comprehensive care delivery

Reviewing the delivery of comprehensive care is important for ensuring patients are receiving care that meets their personal and clinical needs; that risks are efficiently and effectively identified and mitigated; that the agreed comprehensive care plan is achieving what it aimed to; and that patient expectations and agreed goals are being met.

SESLHD requires each facility to:

- Establish processes to review whether the care a patient receives aligns with the comprehensive care plan, meets the patient's needs, and mitigates relevant risks.
- Provide access to training and education to the multidisciplinary team on the use of the organisation's processes for reviewing the delivery of comprehensive care.
- Provide systems to capture information on the review of comprehensive care delivery.
- Periodically review processes for the delivery of comprehensive care, including for screening, care planning, and delivery.
- Monitor practice and outcomes for comprehensive care and take action where variation or opportunities to improve exist.

Section 4 – Minimising Harm

The Comprehensive Care Standard identifies specific risks of patient harm that require health services to implement prevention and minimisation strategies. The purpose of risk screening, assessment, and care planning is to minimise the risk(s) associated with the identified potential for harm.

Within SESLHD, risk screening and assessment tools have been adopted to identify patients at high risk of harm to guide care plans and support the implementation of strategies that prevent or minimise these risks. Risk screening and assessment tools are also used when there is a change in a patient's condition. It is important to note that many patients will present with multiple risk factors which may increase their overall risk of harm.

Vulnerable patients may be more susceptible to harm in each of the categories identified within the Comprehensive Care Standard. The categories and details of risk of harm are as follows:

End of Life

Planning care for patients who are approaching end of life will generally involve a shift in the focus of care away from aggressive medical intervention and towards a palliative approach (refer to NSW Health Policy Directive PD2014_030 - Using Resuscitation Plans in End of Life Decisions). End of life decision making involves a process that promotes advanced care planning, collaboration, and clear communication among the treating team and with patients and families (refer to SESLHDPD/308 - Terminal Care / End of Life Care Plan).

Pressure Injuries

Pressure injuries can occur in patients of any age who often have one or more of the following risk factors: immobility, older age, lack of sensory perception, poor nutrition or hydration, excess moisture or dryness, poor skin integrity, reduced blood flow, limited alertness or muscle spasms. Strategies to prevent and manage pressure injuries should be used if screening or clinical judgement identifies that a patient is at risk of developing a pressure injury (refer to SESLHDPD/326 Pressure Injury – screening, preventing and managing).

Falls

Fall-related injury is one of the leading causes of hospital-acquired morbidity and mortality and while most inpatient falls are associated with minor injury, more serious events such as fractures, intracranial injury, and death can also occur. A fall may lead to a fear of falling, a loss of confidence and decline in mobility, and an injurious fall can increase the likelihood of discharge to a residential aged care facility (ACSQHC, 2018). While older people are at highest risk, falls and injury from falls can occur at any age. Risk factors for falls in hospital include cognitive impairment and/ or delirium, balance and mobility limitations, incontinence, visual impairment, orthostatic hypotension, medications, and environmental considerations (ACSQHC, 2009).

Health service organisations are required to establish and maintain systems that are consistent with best-practice guidelines for preventing falls, minimising harm from falls and post-fall

management (refer to SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care and SESLHDGL/042 - Falls Prevention and Management: Guideline for Designated High Risk Observation Rooms (Adult Inpatients). This includes prevention strategies as part of routine care, identifying risk factors for falls and injury, and developing and documenting individualised falls prevention strategies in partnership with patients and carers as part of the comprehensive care plan (refer to SESLHDGL/044 - Falls prevention and management for non-admitted patients, SESLHDGL/099 Falls Prevention and Management: A Best Practice Guide for Allied Health Professionals, and SESLHDPR/421 Bedrails – Adult – for use in Acute and Subacute Care Settings).

Nutrition and hydration

Patients with poor nutrition, malnutrition and dehydration are at greater risk of complications including pressure injuries, healthcare-associated infections, falls with injury, increased length of stay, readmission, and mortality. There are many risk factors for developing malnutrition and dehydration including:

- Reduced food and fluid intake – arising from anorexia, taste changes, dislike of hospital food, depression, poor dentition, pain when eating/ swallowing, dysphagia, cognition changes, an eating disorder, food avoidance linked to mental state and inability to self-feed.
- Increased nutrition requirements – due to infection, wound healing, and trauma.
- Malabsorption and nutrient losses – which can occur with vomiting, diarrhoea, gastrointestinal diseases, and wounds.

When a patient is identified as being at risk then strategies to improve their nutrition should be initiated (refer to NSW Health Policy Directive PD2017_041 - Nutrition Care).

Cognitive Impairment

People over the age of 65, or over 45 years of age for Aboriginal and Torres Strait Islander people and people with disabilities, require screening for risk of cognitive impairment on admission. In addition, patients that fall outside these criteria but demonstrate or report altered neurological state are required to undergo screening.

Management includes strategies around care needs, including assistance with nutrition and hydration, reorientation, safe mobilising, maintaining or restoring function, and providing meaningful activities.

Further assessment and follow up on discharge is paramount, including the recommendation of a referral to a geriatrician for ongoing management. Involve and inform patients and carers about ongoing care decisions.

Delirium

Key risk factors that increase the likelihood delirium are being aged over 65 years, or over 45 years for Aboriginal and Torres Strait Islander people, having a disability, pre-existing dementia

or cognition impairment, severe medical illness (or in cases where there is underlying infection), hip fracture, and surgery.

Delirium screening is recommended on arrival to hospital or when a change in cognition is noted. If delirium is detected, investigate and treat the causes of delirium through taking

a comprehensive history, medical review and physical examination, and support implementation of a non-pharmacological management strategy. Delirium can be prevented and managed by implementing person centred strategies (refer to SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older People, SESLHDGL/092 Evidence-based guide to cognitive screening measures and Delirium Clinical Care Standard).

Self-harm and suicide

A high proportion of people who die by suicide have had contact with a healthcare provider in the months leading up to their death (Stene-Larsen & Reneflot, 2018). However, many people will not disclose suicidal thoughts and plans unless asked directly and even then, it can be difficult for people to disclose. Asking a person directly about suicide is critical for the early identification and appropriate support of people who may be contemplating suicide. The evidence shows asking someone if they feel suicidal will not make the situation worse or increase their likely hood of taking their own life. Early identification is paramount to suicide prevention strategies (Dazzi et al, 2019 & Polihronis et at, 2020).

SESLHD facilities are to comply with expectations outlined in the NSW Health PD2022_043 - Clinical Care of People who may be Suicidal, and should be guided by the Suicide Prevention in NSW – Strategic Framework 2022-2027 and the Zero Suicides in Care initiative.

These policies and frameworks ensure consumers in SESLHD who are experiencing suicidality, suicidal crisis, or self-harm, receive trauma informed care, are appropriately screened, receive timely compassionate engagement, appropriate treatment and brief interventions, with clear escalation pathways, appropriate follow-up and effective transitions of care within the following care settings:

- Emergency Department
- General Hospital Wards
- Community Mental Health
- Community General Health
- Mental Health In-Patient Unit

The Zero Suicides and NSW Strategic Frameworks advocate for the use of universal screening tools such as the Ask Suicide-Screening Questionnaire (ASQ) Toolkit[1]., as an approach to enhance early identification, engagement and appropriate interventions for people who may be experiencing suicidal distress or crisis, in conjunction with effective communication and understanding of the persons unique needs and circumstances.

SESLHD facilities have established business rules for recognising and responding to Deterioration in mental state:

- Mental state change – Recognition and management of, including self harm and suicidal behaviour in general hospital setting – St George Hospital
- Recognition and management of deterioration in a person's mental state including self harming and suicidal behaviour in a general hospital setting – The Sutherland Hospital
- Mental health escalation – Maternity and Gynaecology (Inpatient) – The Royal Hospital for Women
- Mental health escalation – Maternity and Gynaecology (Outpatient) – The Royal Hospital for Women
- Mental Health Acute Patient Management – Sydney/Sydney Eye Hospital
- Management of deteriorating patient – Clinical Emergency Response (CERS) – Prince of Wales Hospital
- Management of patients/persons with possible self-harming / suicidal behaviour in a general hospital setting – Prince of Wales Hospital

[1] National Institute of Mental Health (n.d.). Ask Suicide-Screening Questions (ASQ) Toolkit. U.S. Department of Health and Human Services. Accessed 7/9/2021

Restrictive practices

Minimising, or if possible, eliminating the use of restrictive practices (including restraint and seclusion) is a key requirement of the National Mental Health Policy. Minimising the use of restraint in healthcare settings other than mental health has also been identified as a clinical priority.

Identifying risks relating to unpredictable behaviour early and using tailored response strategies can reduce the use of restrictive practices. Restrictive practices must only be implemented by members of the workforce who have been trained in their safe use. The health service organisation needs processes to benchmark and review the use of restrictive practices (refer to Action 5.35 of the Comprehensive Care Standard).

******Please note this is a guide. Clinical judgement, evidence-based practice, multidisciplinary input, and patient/ carer/ family consultation should also guide decision making when risk screening and assessing to minimise patient harm.***

Section 5 – Comprehensive Care for Aboriginal and Torres Strait Islander People

The six essential elements of comprehensive care provide a model for the delivery of care for all patients. There are additional considerations that are important for ensuring culturally appropriate care for Aboriginal people. This section outlines a holistic approach to comprehensive care in recognition of cultural factors. SESLHD would like to acknowledge Margaret Broadbent (Manager Cultural Capabilities, Aboriginal Health Directorate SESLHD) as the author of this section.

******Please note: Within this document the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of New South Wales. No disrespect is intended to our Torres Strait Islander colleagues and community***

In comparison to non-Aboriginal people, Aboriginal and Torres Strait Islander people experience far worse health for almost every major cause of mortality and morbidity; continue to be hospitalised at much higher rates for most health conditions; have poorer outcomes of care and have lower access to health interventions.

Taking a comprehensive care approach will not only allow patients to be directly involved and empowered in their care but will take into account the patient's cultural and individual needs, preferences, beliefs, values as well as their comfort and surroundings. This approach will improve the patient's experience and health outcomes, and benefit health services clinically and organisationally.

Aboriginal comprehensive care refers to healthcare services that are culturally appropriate, holistic, and tailored to meet the needs of Aboriginal people. This approach focuses not only on physical health but also on emotional, social, and spiritual well-being. It incorporates traditional knowledge and practices alongside Western medicine to provide more inclusive care.

Within this model of care, the role of community and family is often emphasized, as they are central to the health and well-being of individuals. This approach also recognises the importance of cultural sensitivity, ensuring that healthcare providers understand the specific health challenges faced by Aboriginal communities, such as higher rates of chronic illness and access barriers to healthcare.

By recognising the importance of culture and community, Aboriginal comprehensive care aims to reduce health disparities and improve health outcomes for Aboriginal people.

1. **Cultural safety**: Ensuring the environment and practices are respectful of Aboriginal culture and history.
2. **Community-driven health models**: Engaging local communities in the planning and delivery of healthcare.
3. **Holistic care**: Treating the whole person, considering mental, physical, emotional, and spiritual health.
4. **Access and equity**: Addressing the social determinants of health and improving access to services in remote or underserved areas.

Aboriginal and Torres Strait Islander people and culture are diverse and dynamic, representing many nations and language groups. Aboriginal people have different backgrounds, traditions, and life experiences, living in both urban and non-urban regions.
When offering/ delivering comprehensive care to Aboriginal patients, it is important to understand and appreciate the importance of culture, spirit, family and community along with social and historical factors when discussing choices available.

Patients often travel long distances or are transferred to health settings that are off country which are unfamiliar in respect to language and cultural differences. This can be extremely overwhelming for the Aboriginal patient and cause emotional stress that can be further heightened by other stressors, including culture shock, fear of being judged, of the unknown, of procedures and isolation, and disconnection from family and social support networks.

Aboriginal patients and their families may experience the following:

- fear and distrust of the mainstream health services and buildings, which can be threatening and alienating
- feelings of vulnerability, isolation, shame and disempowerment
- cultural misunderstanding, stereotyping and disrespect
- inadequate time for effective healthcare
- financial burden
- accommodation difficulties.

Cultural stressors for Aboriginal people in healthcare are significant and multifaceted, influenced by a complex history of colonisation, systemic discrimination, and the erosion of cultural practices. These stressors can have a profound impact on mental, physical, and emotional health, and they often arise in interactions with the healthcare system. Here are some key cultural stressors that Aboriginal people may face:

1. **Historical Trauma**: Colonisation, forced displacement, and policies like the Stolen Generations (where Indigenous children were taken from their families) creates a deep sense of trauma. This historical context affects trust in healthcare systems, leading to reluctance in seeking care or fear of mistreatment.
2. **Cultural Mismatch**: Western healthcare practices and values may clash with Aboriginal cultural beliefs and practices regarding health, healing, and wellness. Traditional healing methods, spiritual practices, and community-based care are often overlooked or dismissed in clinical settings, leading to a sense of disconnection from the healthcare system.
3. **Racism and Discrimination**: Indigenous people in many regions face racism and discriminatory attitudes from healthcare providers, which can contribute to feelings of alienation and mistrust. These experiences can discourage them from seeking help, leading to poor health outcomes.
4. **Language Barriers**: Many Aboriginal communities speak languages or dialects that are different from those used in healthcare settings. Language barriers can lead to misunderstandings, misdiagnoses, and inadequate care, as well as a general sense of disempowerment in navigating healthcare systems.
5. **Geographical Isolation**: Many Aboriginal communities, particularly in rural or remote areas, face challenges in accessing healthcare due to distance, lack of transportation, or

limited availability of healthcare facilities and professionals. This can lead to delayed care, poor health management, and underutilisation of available services.

6. **Loss of Traditional Knowledge and Practices**: Displacement from land and communities, as well as the impact of policies aimed at assimilation, have led to a loss of traditional health practices, which many Aboriginal people turn to for healing. The absence of these practices in mainstream healthcare settings can lead to feelings of disempowerment and a sense that their health needs are not fully understood or respected.
7. **Mistrust in Healthcare Systems**: Due to historical and ongoing injustices, including the forced removal of children from families, poor treatment in hospitals, and neglect by healthcare professionals, many Aboriginal people may not trust the healthcare system. This mistrust can manifest in avoidance of seeking care until health issues become severe.
8. **Mental Health Stigma**: In some Aboriginal cultures, mental health issues may be viewed through a spiritual or communal lens, which may not align with the individualistic focus of Western psychiatry. This can create barriers to understanding, treatment, and acceptance of mental health care.

Addressing these cultural stressors involves culturally competent care, which includes recognising and respecting the cultural practices, beliefs, and values of Aboriginal communities. In recent years, there has been an increased focus on integrating traditional knowledge and practices with Western medical approaches and improving trust and outcomes to ensure that Aboriginal people have a voice in their own health care decisions.

Creating a welcoming environment for Aboriginal patients is crucial for ensuring they feel respected, understood, and supported. Here are some steps to help achieve inclusiveness and culturally sensitivity.

1. **Cultural Awareness and Education**:
    - Educate yourself and your team about the history, culture, and traditions of Aboriginal peoples. This can help you understand their values, beliefs, and practices.
    - Acknowledge the diversity within Aboriginal communities, as there are many different groups with unique customs and languages.
2. **Respect for Traditional Healing Practices**:
    - Be open to and respectful of Aboriginal patients' use of traditional healing methods alongside Western medicine.
    - Engage in conversations with patients about their preferences and explore ways to incorporate both approaches, ensuring that the patient feels comfortable.
3. **Building Trust and Communication**:
    - Take the time to build trust. Aboriginal patients may have experienced historical trauma or discrimination within the healthcare system, which can create apprehension.
    - Use clear and respectful communication. Avoid medical jargon and ask open-ended questions to better understand their concerns.
    - Active Listening: Give patients the time and space to express themselves. Listen actively, showing respect for their perspective, and allowing them to guide the conversation.

- Allow for Silence: Silence can sometimes be a meaningful part of communication in many Aboriginal cultures, so be patient and avoid rushing patients for responses.

4. **Cultural Safety**:
   - Ensure that your healthcare setting feels culturally safe by promoting an environment where Aboriginal patients feel that their culture and values are respected.
   - This may include incorporating Aboriginal art, signage in their languages, or providing access to support persons such as elders or cultural liaisons.
5. **Understanding Health Disparities**:
   - Be aware of the health disparities that Aboriginal populations may face, including limited access to healthcare services, higher rates of chronic illness, and socio-economic challenges.
   - Take these factors into consideration when assessing the patient's health needs and provide appropriate resources or referrals.
6. **Support for Family and Community**:
   - Recognise the importance of family and community in Aboriginal culture. Include family members in healthcare discussions and decision-making, with the patient's consent.
   - Encourage family involvement and provide space for them in the healthcare environment, if possible.
7. **Use of Culturally Competent Staff**:
   - Involve Aboriginal staff members, cultural liaisons, or interpreters who can bridge any gaps in communication and provide support to Aboriginal patients.
   - If available, seek out culturally competent healthcare professionals who are experienced in providing care to Aboriginal communities.
8. **Flexible Appointment and Service Options**
   - Acknowledge that not all Aboriginal patients reside locally, some may have travelled from rural and remote areas for treatment. Consider offering telehealth options or flexible scheduling to accommodate travel and other challenges.
9. **Being Open to Feedback**:
   - Regularly seek feedback from Aboriginal patients and their families to understand their experiences and identify areas for improvement.
   - Show willingness to adapt and make changes based on their input.

Creating an environment where Aboriginal patients feel safe, respected, and cared for is essential. By integrating cultural awareness, sensitivity, and a commitment to understanding their needs, healthcare providers can make a positive difference in their experiences.

A comprehensive care plan for Aboriginal patients should be holistic, culturally sensitive, and patient centred. These plans are to be developed collaboratively with the patients' medical team, the patient, their family, and Aboriginal health workers, and where possible referral to culturally specific programs and services are strongly encouraged.

1. Cultural Sensitivity and Understanding

- Acknowledging the patient's cultural background and community, ensuring that care is aligned with their values and traditions.

- Incorporating traditional healing practices alongside Western medicine if the patient prefers this approach.
- Respect for family and community roles in decision-making.

2. Holistic Health Focus

- **Physical Health**: Addressing medical issues and ensuring access to necessary healthcare services.
- **Mental and Emotional Health**: Recognising the impact of historical trauma, grief, and loss, and providing access to mental health resources.
- **Spiritual Health**: Supporting spiritual needs, which may include connection to the land, ceremonies, or specific cultural practices.
- **Social Health**: Considering social determinants of health like housing, employment, education, and connection to community and culture.

3. Patient-Centred Goals and Preferences

- Actively involving the patient in their care planning, respecting their preferences and priorities, which may include traditional treatments or ceremonies.
- Ensuring that the care team understands the patient's values around family involvement and decision-making.
- Setting clear, achievable health goals in partnership with the patient, taking into account their lifestyle, family needs, and community ties.

4. Access to Culturally Competent Healthcare Professionals

- Involving Aboriginal healthcare workers, such as Aboriginal liaison officers or Aboriginal health workers, who can bridge the gap between medical professionals and the patient.
- Ensuring that healthcare providers are trained in cultural competency and aware of the specific health disparities faced by Aboriginal communities.

5. Chronic Disease Management

- Aboriginal populations face higher rates of chronic conditions such as diabetes, cardiovascular disease, and respiratory issues. Comprehensive care plans should include long-term management strategies, education, and support for these conditions.
- Regular monitoring and adjustments to the plan based on health changes and patient needs.

6. Health Education and Advocacy

- Providing accessible health education in a culturally respectful manner, using methods that are suited to the learning style and literacy levels of the patient.

7. Continuity of Care and Follow-Up

- Ensuring that the care plan includes regular follow-up, through healthcare providers, to ensure the patient's health is managed effectively over time.
- Supporting the patient's transition between care settings, especially if they need to move from hospital to home or from one community to another.

The care plan should foster trust, respect, and partnership between the patient, healthcare providers, and family and reflect on cultural identity and holistic health.

End of life decision making involves a process that promotes advanced care planning, collaboration, and clear communication among the treating team and with patients and families.

Cultural practices around death and dying are deeply significant, and understanding these practices is essential for providing respectful and culturally safe care. For Aboriginal and Torres

Strait Islander people, death is not just an individual event but a communal experience. The role of family, community, and connection to culture and traditions are vital, so creating an environment that respects these elements can offer comfort and dignity to the patient and their loved ones.

For effective Advance Care Planning with Aboriginal people, it's important to approach the conversation with openness, respect, and an understanding of the community's specific needs and values. This process can help ensure that individuals' wishes are respected and that their care is provided in a way that aligns with their cultural, spiritual, and family values.

When approaching sensitive conversations around death, with Aboriginal patients and their families, engagement with the Aboriginal supportive and community care coordinator, Aboriginal liaison officers, and Aboriginal health workers is essential to guide staff through the culturally appropriate protocols.

Section 6 – Responsibilities

All SESLHD facilities must review the delivery of comprehensive care across all services and ensure alignment of care with the six essential elements and inclusive of:

- A focus on the patient experience.
- Evidence of collaboration in shared decision making, care planning/ goal setting with patients and/ or their substitute decision maker.
- Systems and processes to deliver comprehensive care.
- Organisational governance and support to deliver comprehensive care.
- A multidisciplinary approach to the delivery of comprehensive care.
- Identified training requirements to deliver comprehensive care.

SESLHD is responsible for:

- Providing leadership and governance in the delivery of comprehensive care across the district.
- The delivery of information technology systems that support comprehensive care, including consultation with eHealth on the development of future systems to enhance the delivery of comprehensive care.
- Developing policies and procedures to support a systematic approach to the delivery of comprehensive care that reduces unwanted variation.
- Managing and monitoring risk associated with providing comprehensive care.
- Supporting training requirements in the delivery of comprehensive care.
- Reporting on outcomes of quality improvement projects to the governing body, workforce, and consumers.
- Monitoring trends in incidents of patient harm and near misses as per the NSW Ministry of Health Policy Directive PD2020_047- Incident Management Policy.

SESLHD facilities are responsible for:

- Providing leadership and governance in the delivery of comprehensive care across all services provided by the facility.
- Managing and monitoring risk associated with comprehensive care via reporting systems, for example the Quality Improvement Data System dashboard and the Enterprise Risk Management System.
- Implementing processes to support a systematic approach to the delivery of comprehensive care in alignment with District policies and procedures.
- Supporting multidisciplinary collaboration and teamwork in the delivery of comprehensive care.
- Supporting training requirements in the delivery of comprehensive care and the use of relevant screening processes and tools designed to deliver comprehensive care.
- Establish and improve on systems and processes that support the documentation of comprehensive care.

- Promoting best practice approach and a culture of quality improvement in the delivery of comprehensive care which promote partnerships with patients, carers, and families.
- Supporting the promotion of the use of appropriate resources to meet the patient's information needs.
- Reporting on outcomes of quality improvement projects to the governing body, workforce, and consumers.
- Ensuring that incidents of patient harm and near-misses are reported via the Incident Management System (ims+), and have a system in place to monitor trends and manage incidents in line with the NSW Ministry of Health Policy Directive PD2020_047- Incident Management Policy.

Department managers are responsible for:

- Supporting multidisciplinary collaboration and teamwork.
- Ensuring best practice in the delivery of comprehensive care which promote partnerships with patients, carers, and families.
- Managing and monitoring risk associated with comprehensive care.
- Supporting training requirements for staff in the delivery of comprehensive care and minimisation of patient harm.
- Promoting the use of appropriate resources to meet the patient's information needs.
- Promoting a culture of quality improvement in the delivery of comprehensive care.
- Providing reports on outcomes of quality improvement projects to the governing body, workforce, and consumers.
- Managing incidents of patient harm and near-misses via the Incident Management System (ims+), and escalating serious harm as per the NSW Ministry of Health Policy Directive PD2020_047- Incident Management Policy.

Clinical staff are responsible for:

- Completion of training in the provision of comprehensive care and minimisation of patient harm.
- Using relevant organisationally endorsed risk screening processes.
- Developing a comprehensive care plan in collaboration with the multidisciplinary team with active involvement from patients, carers, and families.
- Documenting findings of screening and assessment and the care plan in the healthcare record.
- Monitoring the effectiveness of the comprehensive care plan with the patient, carer, family, and multidisciplinary team; reassessing if there is a change in diagnosis, behaviour, cognition, or mental or physical condition.
- Documenting and communicating with the patient, carer, family and multidisciplinary team the discharge plan/ transfer of care to reflect the comprehensive care plan.
- Utilisation of appropriate resources to meet the patient's information needs.
- Monitoring and reporting on risk within area of service delivery.
- Identifying and participating in quality improvement activities designed to improve

patient safety and minimise risk of harm to patients.

- Reporting on incidents of patient harm and near-misses via the Incident Incident Management System (ims+) and escalating serious harm to managers as per the NSW Ministry of Health Policy Directive PD2020_047- Incident Management Policy.

Section 7 - Documentation

Documentation of comprehensive care planning, screening and assessment for risk of harm, identifying patient goals, evidence of shared decision making, multidisciplinary care, and delivery of comprehensive care is required to demonstrate performance against the Comprehensive Care Standard.

All SESLHD clinical and other relevant staff receive induction and training in healthcare record systems, including the electronic medical record system (eMR). There are standardised templates that clinicians use to screen for risk, conduct assessments, and document the care provided as well as the ongoing treatment plan for the patient. All SESLHD services document patient clinical information in the healthcare record, which includes eMR and in some cases paper-based forms (where electronic version not available). All forms (electronic and paper) are approved for use by SESLHD Forms Committee.

SESLHD has processes in place to routinely ask patients if they identify as being from Aboriginal and/ or Torres Strait Islander and to record this information in administrative and clinical information systems e.g. iPM and eMR.

SESLHD support patients to document clear advance care plans. The advance care planning process incudes discussion of patient's wishes, preferences, and personal and family circumstances. Outcomes of advance care planning may include nomination of a substitute decision maker, documentation of an advance care plan or directive, or the development of a localised SESLHD procedure to upload advance care planning documents into the electronic medical record.

It is the responsibility of all clinicians to provide clear, accurate, and concise clinical documentation in the patient record. The comprehensive care plan documentation should include evidence of:

- Actively involving patients in their care.
- Meeting the patient's information needs.
- Having evidence of shared decision making.
- Identifying the clinician with overall accountability for the patient's care, e.g. Medical Officer a patient is admitted under.
- Supporting multidisciplinary collaboration and teamwork.
- Integrated and timely screening and assessment.
- Identifying and implementing strategies to reduce the risk of harm.

Screening of risk and clinical assessment

SESLHD supports the use of relevant screening processes on presentation, during clinical examination and history taking and as required during patient care. These screening processes identify cognitive, behavioural, mental, and/ or physical conditions and risks of harm, as well as any social and/ or other circumstances that may compound these risks.

SESLHD supports clinicians to comprehensively assess conditions and risks identified through screening processes to determine healthcare needs and appropriate treatment and management options.

SESLHD endorses the following validated screening tools and/ approaches to support identification, prevention, and management of risk to minimise patient harm:

- Pressure injuries: Waterlow as part of the nursing Adult Admission Assessment (AAA)
- Falls: Ontario Modified Stratify (OMS) as part of the nursing AAA (OMS found in Adhoc forms and ED stethoscope) and Fall Risk Assessment and Management Plan (FRAMP) where indicated (FRAMP paper-based)
- Nutrition and hydration: Malnutrition Screening Tool (MST) as part of the nursing AAA
- Delirium: 4AT and/ or Confusion Assessment Method (CAM)
- Self-harm and suicide: screening of self-harm and suicide risk is required for all patients. The Ask Suicide-Screening Questions (ASQ) tool is recommended, with a project underway across SESLHD to embed use and develop education and training resources. *Note: Where acute deterioration in mental state is identified relevant local processes for recognising and responding to acute deterioration should be followed.*
- Aggression and violence: Behaviour Monitoring Charts and Behaviour Support Plans are implemented where indicated. *Note: Code Black processes should be activated where a person is facing a personal threat or physical attack to prevent or minimise injury or other harm. Refer to SESLHDPR/410 - Escalation Process and Expectations In-Hours and Out-of-Hours (On-call).*

Screening tools should be used to support identification of risks of harm, however clinical judgement may override the result of a screening tool if concerns remain and the patient would benefit from the implementation of prevention and management strategies.

Developing and documenting the comprehensive care plan

SESLHD supports clinicians to use organisational and local processes to accurately and contemporaneously document the findings of screening and assessment processes.

SESLHD supports clinician involvement in evaluating and improving documentation processes.

SESLHD supports clinicians to use processes that promote shared decision making to develop and document individualised care plans that:

- address patients' health issues and risk of harm.
- identify goals and actions for the patient's treatment and care.
- identify support people that may be involved in the patient's care.
- commences discharge planning at the beginning of an episode of care.
- includes plan for referral to follow up services if appropriate.
- are consistent with best practice and evidence.

Delivery of comprehensive care

SESLHD supports the workforce, patient, carers and families to work in partnership to use the comprehensive care plan to deliver care, monitor the effectiveness of comprehensive care, review and update the comprehensive care as required, and reassess patients' needs when a change in diagnosis, behaviour, cognition/ mental, or physical state occurs.

Evidence of comprehensive care may include, but is not limited to:

Patient journey from intake through to discharge, inclusive of completion of relevant risk screening and assessment, goal setting and care planning, shared decision making, and discharge planning. These include but are not limited to:

- structured interdisciplinary bedside rounding/ clinical handover.
- case conferencing.
- family conferencing.
- peer support.
- multidisciplinary team meetings.
- electronic patient journey board.
- multidisciplinary safety and post-incident huddles.
- bedside clinical audits.
- patient stories/ feedback on experience.

Section 8 – Audit, Reporting and Monitoring

Auditing

Each facility will develop an audit schedule to monitor performance against the Comprehensive Care Standard. Facility audit schedules will be designed based on service delivery for that facility and patient cohort.

An audit schedule will include but not be limited to:

- Annual Pressure Injury Point Prevalence Survey.
- Monitoring/ maintenance of equipment for the prevention and management of pressure injuries and falls.
- Completion and documentation of risk screening and assessment, including management plans.
- Completion and documentation of individualised care plans and a Person-Centred Profile / Top 5 (where indicated).
- Implementation of strategies identified as part of risk management and care plans.
- Completion of mandatory training modules relevant to comprehensive care.
- Feedback on patient experience and involvement in the delivery of comprehensive care.
- Completion rates of advance care plans and directives.
- Post incident huddle completion (refer to SESLHDGL/072 Post Incident Bedside Safety Huddles and effective use of the HUDDLE UP tool).
- Monitoring against relevant Clinical Care Standard indicators.

The audit schedule should be based on risk and therefore may change over time and differ depending on context. Sound rationale is required when determining elements for inclusion and exclusion in local audit programs.

Reporting

All patient safety incidents and near-misses are reported in the Incident Management System (ims+) as per the NSW Ministry of Health Policy Directive PD2020_047- Incident Management Policy.

The Clinical Excellence Commission (CEC) Quality Improvement Data System (QIDS) combines data sources so that data can be used to understand incident and complication trends to support identification of quality improvement (QI) opportunities. The CEC Quality and Audit Reporting System (QARS) is a tool that has been designed to conduct audits to evaluate performance, initiate relevant action plans incorporating QI opportunities, and monitor and evaluate the effectiveness of these actions.

Reporting and monitoring of data should be tabled locally within departments or teams and at peak safety and quality committees, with escalation of risks unable to be mitigated locally to the appropriate district committee.

Monitoring

Each facility to monitor the effectiveness of the delivery of comprehensive care through identified local governance structures. Monitoring of comprehensive care includes but is not limited to:

- The completion of risk screening, assessment, and management plans.
- Risk management and incident management systems.
- Audit results of clinical practice in the delivery of comprehensive care.
- Hospital Acquired Complications (HAC) and/ or incidents and near misses of patient harm related to comprehensive care such as but not limited to:
    - Hospital-acquired falls injury rate
    - Hospital-acquired pressure injury rate
    - Hospital-acquired delirium rate
    - Hospital-acquired malnutrition data
    - Self-harm/ suicide incidents
    - Aggression/ violence incidents
    - Use of antipsychotics and other psychoactive medicines
    - Restrictive practices e.g. mental health and Emergency Department seclusion/ restraint data
    - Incidents related to seclusion/ restraint
    - Patient feedback on experience
- Staff training on the delivery of comprehensive care.
- Processes around multidisciplinary collaboration and teamwork to deliver comprehensive care.
- QI activities aimed at improving outcomes from comprehensive care and processes.

Section 9 – Staff Eductaion and Training

The district endorses the following learning modules to support comprehensive care, which are available to all clinicians through My Health Learning:

Learning modules to support Comprehensive Care	
Pressure injuries (5.21-5.23)	• Learning Path - Pressure Injury Prevention: Risk Assessment and Risk Management (117156049, 75-95 minutes, 3 parts)
Falls (5.24-5.26)	• Learning Path - Preventing Falls and Harm from Falls (89640886, 90 minutes, 3 parts)
Poor nutrition and hydration (5.27-5.28)	• Nutrition Screening for Malnutrition (Course Code: 66794494, 20 minutes)
Delirium and cognitive impairment (5.29-5.30)	• The confused patient: Dementia or Delirium? (Course Code: 39966589, 30 minutes) • Delirium Care (Course Code: 266621954, 30 minutes) • Delirium Care 1 (Course Code: 233003664, 25 minutes) • Responding to behaviours and care needs of the person with dementia (Course Code: 426921217, 30 minutes) • Older people with dementia: A person centred approach (Course Code: 331925925, 15-20 minutes) • Younger onset dementia (Course Code: 415490634, 20 minutes) • Culturally Inclusive Care for Aboriginal People Living with Dementia (Course Code: 400643360, 20-25 minutes) • Differentiating dementias (Course Code: 372460168, 25-30 minutes)
Self-harm and suicide (5.31-5.32)	• Core Suicide Prevention Training for NSW Health Staff (Course Code: 208562351, 30-35 minutes) • Using a Zero Suicide Approach (Course Code: 507419227, 20 minutes) • Safety planning and counselling to reduce access to means (Course Code: 520599080, 20-25 minutes)
Aggression and violence (5.33-5.34)	• Learning Path - Violence Prevention and Management (40014032, 30-45 minutes, 2 parts)
End of life (5.15-5.20)	• Learning Path - End of Life Screening and Planning (399129451, 35-40 minutes)
Collaboration and teamwork (5.05-5.06)	• Building Effective Teams (Course Code: 39831483, 20-30 minutes) • CEC Older Persons' Patient Safety Program - Comprehensive Care Minimising Harm video series (Course Code: 543888391, 45 minutes) • Comprehensive Care: Patient Care Journey and Care Scenario Simulation (CSK131258)

Each facility must also undertake a risk assessment of workforce competency and training needs of staff to support them with planning and delivering comprehensive care specific to the context in which they are providing care.

Local staff training on comprehensive care can include but is not limited to:

- Partnering with patients, carers, and families to deliver care.
- Falls prevention and management.
- Pressure injury prevention and management.
- Mental health assessment and management.
- Strategies for minimising risks of harm.
- Support for patients at risk of malnutrition or dehydration.
- Cognitive impairment and delirium prevention and management.
- Shared decision making and goal-setting.
- Risk screening and clinical assessment processes and tools for comprehensive care.
- Multidisciplinary teamwork and collaboration.
- Identifying patients who are at the end of life.
- Planning and delivering comprehensive care, including at the end of life.
- Obtaining information about Aboriginal and Torres Strait Islander patients and providing culturally appropriate care.
- Providing culturally appropriate care to culturally and linguistically diverse (CALD) consumers.
- Documentation related to comprehensive care planning.

- Roles and responsibilities of the multidisciplinary team and their involvement in the delivery of care.
- Training around avoidance and safe use of restrictive practices.

District subject matter experts in the areas related to comprehensive care are able to provide tailored face to face training for clinical teams to support local comprehensive care planning and delivery.

******Please be advised that further staff education and training should be considered at facility or department level. Completion of staff training must be monitored at a department and facility level.***

References

NSQHS Standard 5 – Comprehensive Care

National Safety and Quality Health Service Standard – Comprehensive Care Standard

NSW Health Policy Directives:

GL2005_057 – End-of-Life care and Decision-Making - Guidelines

PD2010_019 - Maternity - Breast Milk: Safe Management

PD2012_042 - Aboriginal and Torres Strait Islander origin – Recording of Information of Patients and Clients

GL2012_005 - Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline Focused Upon Older People

PD2014_030 - Using Resuscitation plans in End of Life Decisions

PD2017_041 - Nutrition Care

PD2017_043 - Violence Prevention and Management Training – Framework for NSW Health Organisations

PD2017_044 - Interpreters – Standard Procedures for Working with Health Care Interpreters

PD2018_043 - Pasteurised Donor Human Milk (PDHM) for Vulnerable Infants

PD2019_057 - Prevention of Venous Thromboembolism

PD2020_001 - Identifying and responding to abuse of older people

PD2020_047- Incident Management Policy

PD2021_023 - Pressure Injury Prevention and Management

PD2022_043 - Clinical Care of People who may be Suicidal

SESLHD: Policies/Procedures/Guidelines:

SESLHDBR/014 - Prone Restraint Restriction for the Mental Health Service (MHS)

SESLHDBR/022 - Emergency Department (ED)/Mental Health (MH) Complex Case Conference (CCC)

SESLHDBR/029 - Referral to the Mental Health Service Complex Care review committee

SESLHDBR/058 - Referral, Prioritisation and Allocation for Non-Acute Community Services

SESLHDBR/071 - Consumers in the Community with Complex Needs (including high risk civil clients)

SESLHDGL/037 – SESLHD Clinical Pathway Guideline

SESLHDGL/042 - Falls Prevention and Management; Guideline for designated high risk observation room

SESLHDGL/044 - Falls prevention and management for non-admitted patients

SESLHDGL/053 - Management of Complex Discharges / Escalation Guidelines

SESLHDGL/054 - Falls Prevention and Management: guideline for the use of bed/chair alarm units

SESLHDGL/057 - Care Champion for falls prevention – key roles and standards

SESLHDGL/072 Post Incident Bedside Safety Huddles and effective use of the HUDDLE UP tool).

SESLHDGL/082 - Clinical Risk Assessment and Management – Mental Health

SESLHDGL/092 Evidence-based guide to cognitive screening measures guideline

SESLHDGL/099 - Falls Prevention and Management: A Best Practice Guide for Allied Health Professionals

SESLHDPD/308 - Terminal Care / End of Life Care Plan

SESLHDPR/205 - Wound – Incontinence Associated Dermatitis (IAD)

SESLHDPR/293 - Consumer Sexual Safety in Mental Health Settings

SESLHDPR/326 – Pressure Injury – screening, preventing and managing

SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older People

SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care

SESLHDPR/410 - Escalation Process and Expectations In-Hours and Out-of-Hours (On-call)

SESLHDPR/421 - Bedrails- Adult – for use in Inpatient and Residential Settings

SESLHDPR/424 - Diet Ordering in eMR

SESLHDPR/483 - Restrictive practices with adult patients

SESLHDPR/511 - Extended Seclusion Events – Governance for

SESLHDPR/643 - Procedure for the Upload of Advance Care Planning Documents into the Patient Electronic Medical Record (eMR)

SESLHD clinical business rules

POWH/SSEH CLIN037 – Comprehensive care

SGH CLIN647 - Mental state change – Recognition and management of, including self harm and suicidal behaviour in general hospital setting – St George Hospital

TSH CLIN661 - Recognition and management of deterioration in a person's mental state including self harming and suicidal behaviour in a general hospital setting – The Sutherland Hospital

SSEH CLIN011 - Mental Health Acute Patient Management – Sydney/Sydney Eye Hospital

POW CLIN005 - Management of deteriorating patient – Clinical Emergency Response (CERS) – Prince of Wales Hospital

Local operating procedure - Mental health escalation – Maternity and Gynaecology (Inpatient) – The Royal Hospital for Women

Local operating procedure - Mental health escalation – Maternity and Gynaecology (Outpatient) – The Royal Hospital for Women

SESLHD Polices and Publications: Functional Groups

Allied Health

Mental Health

References: Other

Australian Commission on Safety and Quality in Health Care (ACSQHC). *Delirium Clinical Care Standard.* Sydney: ACSQHC, 2021.

Australian Commission on Safety and Quality in Health Care (ACSQHC). *Falls resulting in fracture or intracranial injury: Selected best practices and suggestions for improvement for clinicians and health system managers*. Sydney: ACSQHC, 2018.

Australian Commission on Safety and Quality in Healthcare (ACSQHC). *Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care*. Sydney: ACSQHC, 2018.

Australian Commission on Safety and Quality in Health Care (ACSQHC). *National Consensus Statement: essential elements for safe and high-quality end-of-life care*. Sydney: ACSQHC, 2015.

Australian Commission on Safety and Quality in Health Care (ACSQHC). *Preventing Falls and Harm from falls in Older People: Best Practice Guidelines for Australian Hospitals.* Sydney: ACSQHC; 2009

Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? Psychological Medicine, 44(16), 3361-3363.

National Mental Health Policy 2008. Canberra: Commonwealth of Australia, 2008. 16. Council of Australian Governments.

National Pressure Injury Advisory Panel (NPIAP), Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers / Injuries: Clinical Practice Guideline*. 3rd Edition (2019).

Polihronis, C., Cloutier, P., Kaur, J., Skinner, R., & Cappelli, M. (2020). What's the harm in asking? A systematic review and meta-analysis on the risks of asking about suicide-related

behaviors and self-harm with quality appraisal. Archives of Suicide Research, 1-23. doi.org/10.1080/13811118.2020.1793

Stene-Larsen, K., & Reneflot, A. (2019). Contact with primary and mental health care prior to suicide: a systematic review of the literature from 2000 to 2017. Scandinavian Journal of Public Health, 47(1), 9-17

Version and Approval History

Date	Version	Version and approval notes
July 2020	DRAFT	Drafted by Standard 5 Working Group
July 2020	DRAFT	Draft for comment period.
August 2020	DRAFT	Feedback incorporated and final version approved by Executive Sponsor.
August 2020	DRAFT	Executive Services formatted and amended links. Table at September 2020 Clinical and Quality Council for approval.
September 2020	DRAFT	Approved by Clinical and Quality Council Published by Executive Services
December 2021	1	Minor review: New policy links added and updated; Suicide risk assessment resources added
January 2022	1	Approved by Executive Sponsor. Processed and published by SESLHD Policy.
10 March 2025	2.0	Major review following gap analysis and action plan against requirements of Advisory 18/14 and Advisory 18/15 by District Comprehensive Care Working Party and noting updates to AS18/15 in June 2024. Additional section added: Comprehensive Care for Aboriginal and Torres Strait Islander People. Approved at SESLHD Patient Safety and Quality Committee.