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. SESLHD also aims to ensure that risk of harm to patients is identified and managed through targeted strategies which are documented in the care plan.

SESLHD GUIDELINE COVER SHEET

STANDARD 5 – Comprehensive Care Plan Guideline

Section 1 – Background

Comprehensive care as defined by the Australian Commission of Safety and Quality in Health Care is the delivery of coordinated care that is required or requested by a patient to meet their individual healthcare needs. Comprehensive care aims to ensure that patients are assessed for risk of harm and that these risk are managed through targeted strategies.

SESLHD aims to provide safe, continuous and collaborative care to all patients in order to reduce harm within all patient care settings. Patient harm is minimised through the use of targeted screening assessments, comprehensive care planning and delivery of services that are timely, evidenced based and delivered in partnership with patients, carers and families.

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

> *The Comprehensive Care Standard aims to ensure that patients receive comprehensive health care that meets their individual needs, and considers the impact of their health issues on their life and wellbeing. It also aims to ensure that risks of harm for patients during health care are prevented and managed through targeted strategies.*
>
> *Comprehensive care is the coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the impact of the patient's health issues on their life and wellbeing, and is clinically appropriate.*
>
> *The Comprehensive Care Standard integrates patient care processes to identify patient needs and prevent harm. It includes actions related to falls, pressure injuries, nutrition, mental health, cognitive impairment and end-of-life care.*

Standard 5 and the intentions of this Standard can be found here.

In developing this guideline, SESLHD has taken into consideration 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/procedures.

NSQHS Standard 5 – 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 the continuum of care for a patient. This requires that the systems and processes necessary to meet the requirements of this standard also meet the requirements of Standard 2 - Partnering with Consumers and Standard 6 - Communicating for Safety.

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** - a document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for a patient. Comprehensive care plans reflect shared decisions made with patients, families, carers and other support people about the tests, interventions, treatments and other activities needed to achieve the goals of care.
- **Delirium** - is an acute change in mental status that results in disturbance to of 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 aims 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 (WHO).
- **Facilities –** All sites 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.
- **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.
- **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.
- **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. In this standard unpredictable behaviours include self-harm, suicide, aggression and violence (Australian Commission on Safety and Quality in Health Care).

Section 3 - Essential Elements for Delivering Comprehensive Care

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

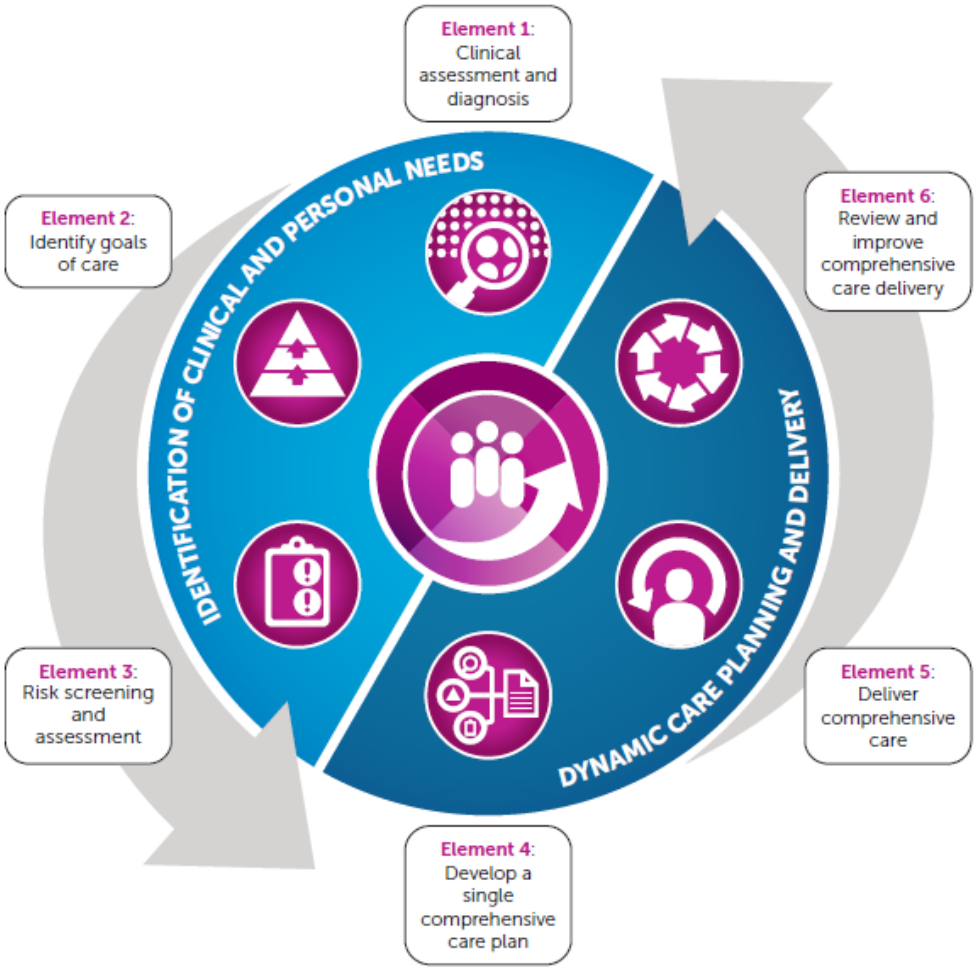

Image taken from: Australian Commission NSQHS - Implementing the Comprehensive Care Standard – essential elements for delivering comprehensive care, August 2018

All SESLHD facilities must review the delivery of comprehensive care across all care settings and ensure alignment of care with the six essential elements.

Element 1: Clinical assessment and diagnosis

Clinical assessment is based on the patient's subjective reports of symptoms and course of the illness or condition. Objective findings from clinical assessment determine provisional and differential diagnosis.

SESLHD requires each facility to:

- Foster a person centred culture in delivering comprehensive care
- Specify and communicate 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, ensures care is individualised 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 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. Risk screening and assessment are a core part of healthcare delivery and comprehensive care.

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, with tools that 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)
- Identify when risk assessment may be required
- 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 populations
- 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 risk screening and assessment processes including outcomes and actions
- 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 single comprehensive care plan

A comprehensive care plan is a single document describing the agreed personal and clinical goals of care, and outlining key aspects of planned medical, nursing and allied health activities for a patient to achieve those goals.

SESLHD requires each facility to:

- Foster a person centred culture in delivering comprehensive care including supporting collaboration in comprehensive care planning
- Establish agreed policies, process or templates for developing a comprehensive care plan
- 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, and the risks of harm identified, to achieve the agreed clinical and personal 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
- Resource 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 clinical and personal 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 goals and expectations are being met.

SESLHD requires each facility to:

- Establish policies and 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 the agreed policies and processes for the delivery of comprehensive care, including for screening, care planning and delivery
- Monitor variation in practice and outcomes for comprehensive care and take action for improvement.

Section 4 - Minimising Harm

Standard 5 Comprehensive Care has identified specific risks of patient harm that require facilities, inclusive of patients', carers and the multidisciplinary team, to implement strategies to prevent and minimise these risks. The purpose of risk assessments and care planning is to minimise the risk/s associated with the identified potential for harm.

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

The purpose of this document is to assist in the identification of vulnerable patients that may be more susceptible to harm in each of the categories identified within Standard 5. The identified 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 (PD2014_030). End of life decision making involves a process that promotes advanced 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 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 identifies that a patient is at risk of developing a pressure injury. (Refer to NSW Ministry of Health Policy Directive PD2014_007 - Pressure Injury Prevention and Management).

Falls

Fall-related injury is one of the leading causes of hospital-acquired morbidity and mortality and while the majority of inpatient falls are associated with minor injury, more serious events such as fractures, intracranial injury and death 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 targeted falls prevention strategies in partnership with patients and carers as a part of a comprehensive plan of care.

Nutrition/Hydration

Patients with poor nutrition and malnutrition are at greater risk of complications including pressure injuries, healthcare-associated infections, falls and injuries, increased length of stay, greater readmissions and mortality.
There are many risk factors for developing malnutrition 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 and inability to self-feed.
- Increased requirements – as a result of 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 used. Refer to NSW Health Policy Directive PD2017_041 - Nutrition Care.

Cognitive Impairment

People over the age of 65, over 45 years of age for Aboriginal and Torres Strait Islander people and people with disabilities require screening for risk of cognitive impairment on arrival to hospital. In addition, patients that fall outside this 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 is required 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 the implementation of non-pharmacological management strategy. Delirium can be prevented by implementing person centred management plans. Refer to SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older People.

Restrictive practices

Minimising or, if possible, eliminating the use of restrictive practices (including restraint and seclusion) is a key part of National Mental Health Policy. Minimising the use of restraint in other 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 Standard.

*****Please note this is a guide. Clinical judgement, evidenced based practice, multidisciplinary consultation and patient/family consultation should also guide decision making when risk assessing against patient harm.**

Section 5 - Responsibilities

All SESLHD facilities must review the delivery of comprehensive care across all care settings 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 in the delivery of comprehensive care across the district
- The delivery of information technology systems that support comprehensive care
- Consultation with eHealth on the development of future systems to support the delivery of comprehensive care
- Developing policies and procedures to support a systematic approach to the delivery of comprehensive care
- 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 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_020 - Incident Management Policy.

SESLHD facilities are responsible for:

- Managing and monitoring risk associated with comprehensive care via reporting systems, for example QIDS dashboard
- Implementing policies and procedures to support a systematic approach to the delivery of comprehensive care
- 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/families and carers

- Supporting the promotion of the use of appropriate resources to meet the patient's information needs
- Report on outcomes of quality improvement projects to governing body, workforce and consumers
- Ensuring that incidents of patient harm and near-misses are reported via the Incident Management System, and have a system in place to monitor trends and manage incidents in line with the NSW Ministry of Health Policy Directive PD2020_020 - Incident Management Policy.

Department managers are responsible for:

- Supporting multidisciplinary collaboration and teamwork
- Promoting best practice in the delivery of comprehensive care which promote partnerships with patients/families and carers.
- Managing and monitor risk associated with comprehensive care
- Support 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 best practice and a culture of quality improvement in the delivery of comprehensive care which promote partnerships with patients/families and carers
- Providing reports on outcomes of quality improvement projects to governing body, workforce and consumers
- Managing incidents of patient harm and near missus via the incident information management system and escalate serious harm as appropriate as per the NSW Ministry of Health Policy Directive PD2020_020 - Incident Management Policy.

Clinical staff are responsible for:

- Completion of training in the provision of comprehensive care and minimisation of patient harm
- Using relevant standardised risk screening processes
- Developing comprehensive care plan in collaboration with the multidisciplinary team with active involvement from patients, families and carers.
- Documenting findings of screening and assessment and the care plan in the healthcare record
- Monitoring the effectiveness of the comprehensive care plan with patient, carer, family, MDT and reassess if there is a change in diagnosis, behaviour, cognition or mental or physical condition.
- Documenting and communicating with the patient, carer, family and MDT 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 Information Management System and escalate serious harm to managers as per the NSW Ministry of Health Policy Directive PD2020_020 - Incident Management Policy.

Section 6 – Documentation

To demonstrate performance against NSQHS Standard 5 – Comprehensive Care, documentation of comprehensive care planning, screening for risk of harm, identifying patient goals, evidence of shared decision making, multidisciplinary care and delivery of comprehensive care are required.

All SESLHD clinical and other relevant staff receive induction and training in the electronic medical record system (eMR). The eMR provides standardised templates that clinicians use to screen for risk, conduct assessments and document the care provided and treatment plan for the patient. All SESLHD facilities document all patient clinical information in the eMR, however there are a small number of paper based forms that are also currently in use. All forms 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 origin 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.

As there is no dedicated comprehensive care plan template or form available in the eMR it is the responsibility of all clinicians to provide clear, accurate and concise clinical documentation. The comprehensive care plan should document:

- Actively involve patients in their care
- Meet the patients information needs
- Have evidence of shared decision making
- Identify all clinicians with overall accountability for patient's care
- Support multidisciplinary, collaboration and teamwork
- Integrated and timely screening and assessment
- Identify strategies to reduce the risk of harm.

*****Please note: A comprehensive care plan is currently in development by NSW eHealth.**

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 or physical conditions and risks of harm; and any identify social and/ or other circumstances that may compound these risks.

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

Refer to relevant Ministry of Health policy directives, SESLHD policies, procedures and guidelines and clinical pathways for specific screening and risk assessments.

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 changes in patients' needs in diagnosis, behaviour, cognition or mental or physical condition occur.

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

- Evidence of patient journey from intake through to discharge, inclusive of completion of relevant risk assessments, care planning and goal setting, shared decision making and discharge planning.
- Structured interdisciplinary bedside rounding/clinical handover
- Case conferencing
- Family conferencing
- Peer Support

- Multidisciplinary team meetings
- Electronic patient journey board
- MDT Safety huddles
- Bedside Clinical Audits

Section 7 - Auditing, Reporting and Monitoring

AUDITING

Each facility will develop an audit schedule that assists in the monitoring of performance against Standard 5. Facility audit schedules will be designed based on service delivery for that facility and patient cohort.

An audit schedule will include but not will not be limited to:

- Annual Pressure Injury Point Prevalence Survey - CEC
- Monitoring/maintenance of equipment for pressure injuries and falls
- Nutrition/Hydration screening and management
- Completion of risk assessment/screening and management plans
- Completion of person centered profile
- Completion of Mandatory training modules relevant to comprehensive care
- Patient experience and involvement in the delivery of comprehensive care
- Advanced directives completion rates.

REPORTING

All incidents relating to patient harm are reported in the incident management system as per the NSW Ministry of Health Policy Directive PD2020_020 - Incident Management Policy.

The CEC Quality Improvement Data System (QIDS) combines data sources so that data can be used to understand incident trends and identify quality improvement opportunities (QI). 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 and QI opportunities and to provide evidence for accreditation processes.

Reporting and monitoring of data should be tabled locally within departments or teams and at peak safety and quality committees, the Board and relevant groups within facilities.

MONITORING

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

- The completion of risk screening, assessment and management tools
- Risk management systems
- Audit results of clinical practice in the delivery of comprehensive care
- Hospital Acquired Complications (HAC) and/or patient harm incidents related to Standard 5 such as:
    - Falls injury rate

  - Pressure injury rate
  - Hospital-acquired Delirium
  - Self-harm incidents
  - Aggression incidents
  - Use of antipsychotics and other psychoactive medicines
  - Restrictive Practice
  - Incidents requiring seclusion
- Staff training on the delivery of comprehensive care
- Processes around interdisciplinary collaboration and teamwork to deliver comprehensive care
- Quality improvements activities that are aimed improve the outcomes from comprehensive care and associated processes. Local QI Managers/facilitators can advise on QI methodology and evaluation measures.

Section 8 - Staff Education and Training

Each Facility must conduct risk assessment of workforce competency and training needs of staff to support them with planning and delivering comprehensive care. Local staff training on comprehensive care can include:

- Partnering with patients, carers and families to deliver care
- Falls prevention and management
- Pressure Injury prevention and management
- Mental health
- Strategies for minimising risks of harm
- Support for patients at risk of malnutrition or dehydration
- Cognitive impairment and delirium
- 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
- Documentation related to comprehensive care planning
- Roles and responsibilities of multidisciplinary team and their involvement in the delivery of care
- Training around avoidance and safe use of restrictive practices.

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

Section 9 - References

NSQHS Standard 5 – Comprehensive Care
https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard

NSW Health Policy Directives:
GL2005_057 – End-of-Life care and Decision-Making - Guidelines

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

PD2010_019 - Maternity - Breast Milk: Safe Management

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

PD2014_007 - Pressure Injury Prevention and Management – under review

PD2014_030 - Using Resuscitation plans in End of Life Decisions

PD2016_007 - Clinical Care of People who may be Suicidal

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_020 - Incident Management Policy

NSW Health – Framework for Suicide Risk Assessment and Management for NSW Health Staff

- Suicide Risk Assessment and Management Protocols: Community Mental Health Service
- Suicide Risk Assessment and Management Protocols: Emergency Department
- Suicide Risk Assessment and Management Protocols: General Community Health Service
- Suicide Risk Assessment and Management Protocols: General Hospital Ward
- Suicide Risk Assessment and Management Protocols: Justice Health Long Bay Hospital
- Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Unit

SESLHD: Policies/Procedures/Guidelines:

SESLHDGL/037 - SESLHD Clinical Pathway Guideline

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

SESLHDGL/053 - Management of Complex Discharges / Escalation Guidelines

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

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

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

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

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

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

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

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

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

SESLHDPR/424 - Diet Ordering in eMR

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

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

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

SESLHDPR/483 - Restrictive practices with adult patients

SESLHDPR/511 - Extended Seclusion Events – Governance for

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

SESLHDPR/293 - Consumer Sexual Safety in Mental Health Settings

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

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

SESLHD Polices and Publications: Functional Groups

Allied Health

Mental Health

References: Other

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

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Section 10 - Revision and Approval History

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