

INFORMATION
for clinicians

Comprehensive Care Standard

Comprehensive care plan

What is a comprehensive care plan?

A comprehensive care plan is 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, carers and families about the tests, interventions, treatments and other activities needed to achieve the goals of care. The content of comprehensive care plans will depend on the setting and the service that is being provided, and may be titled differently in various health service organisations.

Components of a comprehensive care plan

There is a large range of information that could be included in a comprehensive care plan. Determining what should be included in a comprehensive care plan can be complex, as the plan needs to have sufficient information to inform care delivery and decision-making, be relevant and tailored to the patient's circumstances, yet not so cumbersome that it deters use.

The Commission has identified eight key components of a comprehensive care plan. It is recommended that information from each of these components be included in comprehensive care plans. However, the fields within each of these components will vary depending on the patient's circumstances and organisational context.

Component	Examples of potential fields
Personal identifiers and preferences	Patient name; medical record number; date of birth; preferred name; family/carer involvement; substitute decision maker; communication requirements (e.g. need for an interpreter); spiritual, emotional or other support needs; gender; cultural and linguistic background; Aboriginal and Torres Strait Islander background; legal status
Clinical assessment and diagnoses	Provisional diagnosis; differential diagnosis; final diagnosis; comorbidities; reason for admission; allergies; reactions; history of cognitive impairment, mental illness, frailty, falls, bleeding, infection, absconding, pressure injury, medications
Goals of care	Clinical goals; personal goals; when information should be reviewed; short, medium and long term goals; advance care plans; preferences for end-of-life care or treatment limiting orders
Risk screening and assessment	Identified risks and planned mitigation strategies; review timeframe



Component	Examples of potential fields
Planned interventions	Diagnostic tests; surgery; oxygen requirements; VTE prophylaxis; medications, pathology, radiological examinations
Activities of daily living	Functional status including: Assistive devices and processes needed; nutritional needs; hydration and fluid restrictions; elimination including urinary and faecal continence; wounds and dressings; drains; mobility; recreational activities
Monitoring plans	Parameters for monitoring; frequency; escalation plan; review dates; additional specialty or problem specific observations
People involved in care	Identification of patient's family, carers and other nominated support people the patient has indicated to be involved in care decisions and delivery Identification of team members involved in care decisions and delivery which may include: admitting medical officer; lead clinician; treating doctors; nurses; midwives; pharmacist; social worker; physiotherapist; occupational therapist; dietician; speech therapist; care coordinator; other allied health professionals; pastoral/spiritual care advisor; Aboriginal and Torres Strait Islander health worker; general practitioner or others as appropriate
Discharge plan / Transfer of care	Estimated date and location of discharge; final diagnosis; services and resources required post-discharge; referrals; primary care providers including general practitioner; discharge instructions; medication reconciliation

Questions?



For more information, please visit:
safetyandquality.gov.au/comprehensive-care

You can also contact the Comprehensive Care project team at: mail@safetyandquality.gov.au

