Implementing the Comprehensive Care Standard

A conceptual model for supporting comprehensive care delivery

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Contents

Background

This paper is part of a series of resources developed by the Australian Commission on Safety and Quality in Health Care (the Commission) describing the conceptual basis, organisational support and key elements of comprehensive care delivery as described in the National Safety and Quality Health Service (NSQHS) Standards (first and second editions).

The National Safety and Quality Health Service Standards

One of the key drivers for safety and quality improvement in Australia are NSQHS Standards.[1,2] The NSQHS Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of healthcare provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure expected standards of safety and quality are met.

The second edition of the NSQHS Standards includes the following eight standards:

- Clinical Governance Standard
- Partnering with Consumers Standard
- Preventing and Controlling Healthcare-associated Infection Standard
- Medication Safety Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Blood Management Standard
- Recognising and Responding to Acute Deterioration Standard.

One of these standards, the Comprehensive Care Standard, relates to the delivery of comprehensive care for patients within a health service organisation. Safety and quality gaps are frequently reported as failures to provide adequate care for specific conditions, or in specific situations or settings, or to achieve expected outcomes in particular populations.

The Comprehensive Care Standard

The intent of the Comprehensive Care Standard is to ensure that patients receive comprehensive care – that is, 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. In addition, the Comprehensive Care Standard aims to ensure that risks of harm for patients during health care are prevented and managed. Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

There are four criteria in the Comprehensive Care Standard:

1. **Clinical governance and quality improvement to support comprehensive care**: Systems are in place to support clinicians to deliver comprehensive care.
2. **Developing the comprehensive care plan**: Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.

3. **Delivering comprehensive care**: Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and family. Comprehensive care is delivered to patients at the end of life.

4. **Minimising patient harm**: Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.

Systems for delivering comprehensive care will vary, even within the same health service organisation. A flexible approach to standardisation supports local implementation and innovation in organisational systems. Screening, assessment, comprehensive care planning, and delivery processes need to be targeted to improve the safety and quality of care delivered to the population that is served.

Although the Comprehensive Care Standard refers to actions needed within a single episode of patient care, it is fundamental that each single episode or period of care is part of the continuum of care for a patient. Meaningful implementation of the Comprehensive Care Standard requires attention to the processes for partnering with patients in their own care, and for safely managing transitions between episodes 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 and Communicating for Safety standards.

This paper

This paper is the first in a series of resources to support implementation of the Comprehensive Care Standard. It presents a conceptual model to support the delivery of comprehensive care as described in the NSQHS Standards.

Part 1 outlines the processes undertaken by the Commission to inform the development of the model.

Part 2 outlines the model and the elements that are important for health service organisations to consider when implementing the Comprehensive Care Standard. The model can also be used to identify gaps where quality improvement activities are needed to support the provision of comprehensive care.

This paper has been developed for:

- Clinicians, managers and executives responsible for developing, implementing and reviewing comprehensive care delivery
- Planners, program managers and policymakers responsible for developing jurisdictional or other strategic programs dealing with the processes associated with providing comprehensive care.

It may also be relevant for clinicians involved in the delivery of care, providers of clinical education and training, research organisations and other health bodies.

The Commission will use this model to identify practical tools and resources to assist health service organisations to meet the requirements of the NSQHS Standards.

PART 1:

Informing a model for comprehensive care

The Commission undertook a number of processes to inform the development of a conceptual model for the delivery of comprehensive care, including: a rapid review of the literature; scoping interviews with representatives from health service organisations around Australia; and the establishment of a Comprehensive Care Committee. This section briefly describes the key issues identified during these processes.

Rapid literature review findings

In 2015, the University of Adelaide undertook a rapid review of the evidence on the impact of comprehensive care on patient outcomes for the Commission.[3] The review used a standard literature search methodology, including peer reviewed and grey literature. For the purposes of the literature review, the researchers defined 'comprehensive care' as including at least two of the following elements:

- Screening and assessment for common clinical risks associated with cognitive, behavioural, mental and/or physical conditions
- Integrated multidisciplinary care planning
- The delivery of integrated, multidisciplinary care and/or team work and collaboration across specialties and disciplines.

Additionally, the intervention has to involve patient-centred care and goal-directed care, where the goals of care have been defined by a shared decision-making process that explicitly included patient preferences in goal setting and development of a care plan.[3]

Limits were applied to the search terms used and the years of publication searched. The combined search yielded 272 articles for full text review with most of these subsequently excluded. A significant number of exclusions related to how 'comprehensive care' was defined for the review.

The final review included 16 articles, of which 12 were considered to have moderate to high methodological quality.[3] The 16 articles were mapped against the following three questions:

1. Does comprehensive care lead to improved patient outcomes in acute care settings?
2. For those comprehensive care interventions that have been evaluated and have some evidence of improving outcomes as defined in question 1, what are the system-level, organisational-level and unit-level (team, people) factors that have been associated with effective implementation?
3. For those comprehensive care interventions identified in question 1 that included in the intervention screening and assessment for risks associated with cognitive, behavioural, mental and/or physical conditions:
   a) How has integrated screening for multiple, common clinical risks been conducted (for example, pressure injury, falls, malnutrition and dehydration, frailty, and cognitive impairment in older, frail populations)?
   b) Which screening tools have been used and is there evidence that these are validated tools?

Most of the 16 articles related to patients aged 55 years and older and all were considered relevant to the Australian population. No articles discussed individual factors associated with effective implementation of comprehensive care.

The articles usually described an intervention and one or more patient-centred, healthcare system or clinical outcomes. Implementation processes and outcome measures were reported

in all articles. None of the articles discussed factors at the level of the healthcare system. Five articles included a screening tool as part of the comprehensive care intervention and only one of these included a validated tool. This is a relevant finding as risk screening is ubiquitous in health service organisations[4] and has not always accurately predicted or prevented adverse events, such as in-hospital falls.[5]

At least one measure relevant to comprehensive care was reported in each article, although not all articles reported a significant improvement. Key findings included:

- Patient-reported experience, including patient satisfaction, improved in six of the 10 articles in which it was reported
- Frequency of patient involvement in shared decision making and goals of care discussions increased significantly in three articles
- Other outcome measures included: length of stay, which improved in four of the five articles that had it as an outcome measure; costs of care, which improved in five of seven articles; and acute care readmissions, which improved in two of four articles.

Initiating a comprehensive care program has the potential to lead to improved health care and patient and clinical outcomes in acute care settings. Processes to implement comprehensive care at an organisational level included upskilling the workforce, embedding comprehensive care into ongoing quality improvement initiatives and updating hospital policies and procedures to reflect best practice. To enable this at a team level, it was suggested that appropriate team structures and the method for delivery of care required local consideration and adaptation.

Many of the findings in the rapid review were also reflected in the Commission's scoping interviews, which are described in the following sections.

Scoping interview findings

'… With five minutes good care, patients will never forget us. With five minutes poor quality care, patients will never forgive us.'

The Commission held 26 semi-structured interviews and focus groups with the aim of exploring the types of tools and resources that could be useful to clinicians, managers and health service organisations in supporting implementation of the Comprehensive Care Standard.

The interviews were conducted from September to November 2015, and involved tertiary, metropolitan and day facilities from four Australian states and territories. There were 14 sites, 26 sessions and more than 60 individuals involved. A number of sites contributed to multiple interviews across disciplines and corporate structural levels. Different clinical disciplines and hospital executives were represented in the interviews. A list of participating facilities appears in the Appendix.

The sessions were audiotaped and subsequently transcribed. Answers to the question set were extrapolated from transcripts as not all questions were asked, or not always asked, in the same way. Content areas were defined by text scrutiny to identify themes related to the provision of comprehensive care. De-identified representative interview quotations are included in the text. The interviews covered wide-ranging topics and not all of them are reflected in the discussion. The relevant components have been selected and these have shaped the development of this conceptual model for comprehensive care.

The themes generally fit within two broad categories: cultural conditions, and systems and processes to support the delivery of comprehensive care.

Cultural conditions

'I think culture's very much driven around, I guess, a vision, everybody having clarity of the vision, and their role within that vision.'

The culture of the organisation was repeatedly reported to be important to the provision of comprehensive care. Participants believed that when leaders at all levels promoted the values of the organisation, clinicians understood how to contribute to the team and provide comprehensive care to patients.

Interview participants discussed the need for inclusion of multiple disciplines in care decisions, as well as the value of implementing structured and inclusive communication strategies supported by education programs.

Participants reported that when the team structures were disconnected there was greater confusion about the goals of care and planned interventions. Disconnection was more evident when there were multiple medical teams involved in patient care, and the accountability for decision making was unclear.

When clinicians worked together, comprehensive care was perceived to be more achievable.

> 'You get a lovely dynamism going there where you are all in together.'

Interview participants believed that when there were established systems and processes to support team communication and collaboration, there was a shared understanding about the provision of comprehensive care across the different organisational layers of the hospital.

> 'It is about everybody in the organisation being a leader and taking that responsibility and accountability for care, contribution to the organisation.'

Leadership and accountability

> '… It's about seeing your leadership team and that level of integrity and respect that is held within that leadership team.'

Strong executive and clinical leadership was seen as important for facilitating the right cultural conditions needed to deliver comprehensive care. There were defined hierarchies in the hospital, and while decision making about patient care was mostly seen as a medical domain, hospital outcomes and processes were viewed as the responsibility of the executive. Sometimes these two roles were seen as being in conflict.

> 'This is where you are, constantly running into barriers that are about anything other than the patient.'

> 'The institutional demands always outweigh what you're actually trying to do for the patient.'

> 'The public health system rewards you for getting people in and out of hospital.'

The competing priorities of hospital, clinician and individual patient goals were identified as a hindrance to comprehensive care and played a role in affecting clarity of accountability for the patient care plan.

> 'So, you've got to have what you said about the supports in the system. That's got to come right from the top.'

Accountability was mostly discussed in relation to identifying the clinical decision maker for the patient's care. Usually the doctor listed on the patient record was seen as the decision maker and therefore accountable. The team was considered integral to provision of comprehensive care and

communication was the key process to ensure everyone was working towards the same plan.

> '… The AMO [attending medical officer] is the final decision maker. But it's communication within that team that it's tilted that way.'

Care was seen to be negatively affected when there was a lack of clarity about who the medical decision maker was, or when the decision maker was unavailable. This was seen as a particular problem when there were multiple teams involved in a patient's care. This is becoming more common as patients increasingly experience multiple co-morbidities and require more complex and multi-disciplinary care.

> '…who's the primary doctor on the sticker? We've got lack of clarity about that, let alone who's the primary decision maker.'

> 'Delayed decision making from treatment planning as well as a discharge planning perspective, prolonged length of stay, increased risk of complications of duplication for the patient, because all of a sudden nobody else knows that plan, so you have everybody else asking the exact same questions of this poor patient.'

Communication

> 'It is people feeling heard.'

Communication is fundamental for reliable and robust comprehensive care, and was an independent and inter-dependent theme of the interviews. Many interview participants emphasised good communication as a key component of comprehensive care, but also described missed opportunities for optimal communication. The context in which communication issues were described included information technology and the various system limitations related to access and sharing of patient information, as well as peer-to-peer and multi-disciplinary interactions.

> '… there's nothing in the admission paperwork that says how I'll be treating this patient, have we discussed this, or whatever else. It's just not there …'

Many facilities reported using mixed modes (electronic and paper-based) for patient record-keeping. This appeared to lead to an inability to compile a complete patient story, with no one person able to access and interpret all the necessary information.

'... It's quite profound how nobody gets all of the information, including the family.'

'The challenge is that information doesn't talk to each other. There is no system in place for it to be – every individual thing is put onto the system.'

Clarifying terminology and the ability to provide clear, relevant and contemporaneous team communication was considered either a limitation or asset to providing comprehensive care depending on the strength of the system in place. Ensuring the space and capacity for the team to meet and discuss patient progress produced a more cohesive working environment. Meetings were considered an opportunity to add clinical input and ensure clarity around patient care goals.

'... integrated meetings and case coordination meetings I think are so vital because it's probably the only time that the team actually gets in together to say "Are we actually working on the same path?"'

Improving multi-disciplinary team (MDT) input to care planning, with clear patient goals specified in the treatment plan, was important. The term 'multi-disciplinary' was particularly contentious and was defined differently by different disciplines and specialist groups.

'... doctor plus doctor does not equal multi-disciplinary.'

Communication as a theme was not always distinct from leadership, team composition, role clarification and goal-setting conversations with patients.

Table 1: Strategies to support comprehensive care*

Human resources	Systems/processes	Screening and risk stratification tools
• Allocated team nurses • Care coordinators • Case managers • Clinical nurse consultants • Dedicated rostered teams, e.g. medical officer for specific types of patients • Special teams • Volunteer programs	• Automatic flagging • Bedside handover/communication tools • Case conferences • Checklists • Decision support tools • Information portals • Journey boards • Magnet program® • MDT meetings • Plan, do, study, act (PDSA) • Pre-admission clinics • Queuing process • Rapid rounding • Situation, background, assessment, and recommendation (SBAR) • Six sigma methodology • Specialised workforce training- facilitation, difficult conversations, mindfulness, resilience • Teach back, graded assertion, chunk and check, other specific communication processes • Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS)® • Track and trigger charts	• Abbreviated Mental Test • Alcohol Smoking and Substance Involvement Screening • Braden Risk Assessment Tool • Confusion Assessment Method • Falls Risk Assessment Tool • Malnutrition Universal Screening Tool • Resource Utilisation Group – Activities of Daily Living • Smoking Nutrition Alcohol Physical Activity • Supportive and Palliative Care Indicators Tool • Other hospital/jurisdiction specific tools

*Strategies were extracted from interview transcripts.

Systems and processes

'There are some things that need to be standardised and the organisation needs to have the system …'

'You have to understand the system to be able to navigate it.'

A range of processes and structures were identified by participants as contributors to the successful delivery of comprehensive care. These included initiatives that improved service reliability, comprehensive care planning, and integrated service delivery. **Table 1** (see previous page) outlines examples of some of the processes and structures identified by participants. These have been grouped into human resources, systems and risk stratification through screening.

Team processes

Interview participants indicated that when processes were supported by clear policies and procedures, engaged and active leaders, and clear accountability, teams were more cohesive, communicated more effectively and had a more structured and consistent approach to care planning and provision.

'The hospital has very clear processes and structures in place that really enable the collaborative approach.'

'There's a system that we need to address. We've got to break down these craft group silos if we are going to really look at the patient as a whole because we're never going to shift the culture.'

Many of the participants from facilities that had successful collaborative and cohesive teams had implemented clinician education programs. These focused on the use of specific communication techniques such as situation, background, assessment, and recommendation (SBAR) and service development using specified improvement methodologies such as Six Sigma and plan, do, study, act (PDSA) cycles.

The interview participants suggested that comprehensive care provided by a MDT was more likely to be achieved when there were processes for team information sharing and planning, such as case conferences, team meetings and regular rounding.

'The nurses are there you see and the allied health's there and the registrars are there, and one or two consultants are there and so you get that multi-headed multi-disciplinary look and work out what's the best way to get the person to where we think the person needs to go.'

In some of the interviews, this included discussion of identified patient health issues, patient goals and identified risks. The consideration of these domains with a MDT allowed for an integrated approach to care, with each member of the care team contributing with their disciplinary expertise.

'So, each patient comes in and the care that we provide for them is individualised to each of their specific needs. There is involvement by all members of the multi-disciplinary team and key things, like that which you've already identified, are what are their risks, have we identified them, can we look at them as a whole, how does that affect the patient, not just the ability to fill out the forms?'

Interview participants most often reported this working well when there was a nominated person who was responsible for coordination and accountability. This 'coordinator' role was adopted in various formats but was often a nurse. Individual clinicians also reported needing to use 'work arounds' for some patients based on their own corporate knowledge and clinical positions across multiple facilities when there were gaps in services. An example of this was the description of an admitted patient requiring an intervention that was not available in the facility. A rapid intervention was arranged at an alternate facility using a clinician's network connections rather than established transfer channels.

'We've got the tool that delivers the outcomes when it's used, but it's still not often used. Because there's all these work arounds … The culture around it is so much more important.'

Goal setting

'I'd like to know if people walking out the door felt that they were adequately listened to and their goals were being met.'

Interview participants saw determining goals of care as important for care planning, although how goals were derived was not always clear. Goals were sometimes described as either clinicians telling the patient the goals of care, or the goals being reached after discussion with the patient.

'… the first thing is to have a clear and coordinated communication of what the actual goal of care is and then they're actually communicating that with the patient.'

No specific goal-setting instrument or tool was described by participants, and it was not clear if goals were documented in an accessible format. Some clinicians, particularly visiting medical officers, stated that for many conversations where goals of care may have been discussed with the patient in private consulting rooms, the goals were not documented, and relevant information not centrally compiled. This meant it was not accessible to the MDT or the patient.

'I think the big thing is, yes, we ask the patient, what do you want to do in this scenario? What is your goal? Have that clearly stated and we go from that.'

Goal setting and risk screening were not always specifically part of the care planning process, or at least were not always documented or accessible to clinical team members or patients. Interview participants reported that screening was completed, but it often related to compliance with policies, protocols and standards, rather than being a signal to modify care plans when risks were identified. This contributed to the perceived tension between performance-based hospital targets and person-centred care. It also highlighted the perceived competing priorities within organisations that were noted earlier.

For example, interview participants described how mandated audits often related to completion of the screening tool in accordance with policy, rather than taking action to address any risks for the patient identified during the screening. This is not aligned with the intent of screening. A better indicator of comprehensive care would be to monitor how often mitigation strategies were implemented for risks that were identified in screening processes. Shifting the focus of screening, from the process of screening to whether action is taken, would increase the relevance and utility of screening.

Care planning

Care plans were discussed as a by-product of other processes such as MDT meetings, or were reported as being subsumed by risk screening processes rather than considered as an important component of ensuring comprehensive care. Care plans were overtaken by the busy-work of task management, checklists and risk management.

'… there are so many risk assessments that there was so much paperwork that people then – what can we get rid of? So I think they tended to get rid of the care plans.'

'… so, it's all great that you might have done your risk assessments but what's actually come out of them or where have they been documented?'

It was apparent that the process of risk screening was disconnected from the care planning process, and that the clinical workforce viewed risk screening as a checklist exercise that added little value to the care plan and took up time. There appeared to be an inability to connect risk screening to the safe provision of care and incorporate findings into documented care plans.

'We don't find our staff necessarily value that assessment because it doesn't connect necessarily into the care, the planning and the outcomes.'

'While we're documenting the risk, we're not really fully comprehending and translating that into the care that we're giving the patient.'

In the few cases where specific care plans were discussed, they were usually specialty – or disease-specific. Risk screening was also linked to specific disciplines – usually nursing or allied health. Integration of services identified through risk screening and care planning processes was best achieved when there was a distinct care coordinator assigned to support the patient care journey.

'… From the beginning of the person's journey, everyone gets together, finds out what the patient's goals are and then every single intervention is targeted against those goals … with an identified link person who is kind of the go-to person around anything to do with that person's care.'

PART 2:
Creating the conditions for comprehensive care delivery

Creating conditions for comprehensive care, as described in the NSQHS Standards, is about ensuring that health care delivered to a patient is informed by their needs and preferences, is shaped by their decisions, and is planned and delivered in partnership with the patient and their support people. It involves having teams of health professionals working together, and communicating effectively to plan, manage and coordinate care for the patient. It requires health service organisations to have systems and processes in place to support this, and to foster a collaborative and person-centred culture.

While the actions in the Comprehensive Care Standard relate to basic processes of health care, this is the first time they have been brought together in a mandatory set of standards. All health service organisations already provide care that meets many of the requirements of the Comprehensive Care Standard; the challenge now is to integrate these elements in a way that wraps around the patient.

The Commission proposes using the following model as a way of thinking about the systems and processes required to support the delivery of comprehensive care. This model will also inform the development of a set of practical tools and resources to support health service organisations to meet the requirements of this standard.

There are a range of cultural conditions, and key systems and processes needed to support the delivery of comprehensive care. Many of these cultural conditions, and systems and processes are similar to the characteristics of high-performing person-centred healthcare organisations,[6] high-reliability organisations and those with a strong safety culture.[7, 8]

The cultural conditions, and systems and processes for comprehensive care fall into three groups:

- A focus on patient experience – having an organisation-wide commitment to the delivery of care that is person-centred and working to improve the patient experience.
- Systems, processes and protocols to deliver comprehensive care – having systems, processes and protocols to guide and support healthcare providers to deliver comprehensive care consistently and effectively (such as screening protocols and communication tools)
- Organisational culture and governance that supports a comprehensive care approach – having organisation-wide governance, leadership and systems that embed the delivery of high-quality person-centred comprehensive care as the organisational standard

These groups are illustrated in **Figure 1** (see next page) and are described in more detail in the following sections.

Figure 1: Supporting the delivery of comprehensive care

Organisational culture and governance to support a comprehensive care approach

Organisational culture is a shared set of assumptions taught to new members of an organisation's 'tribes'.[9] Organisational culture affects how the workforce operates, what they do, and how they interact with others – it shapes attitudes, practice and perceptions. Culture contributes to how care is delivered, how teams interact, and a patient's experience of care. Culture can also potentially influence clinical outcomes and hospital performance.

Defining 'culture' is complex and there are many factors that contribute to the creation of a particular culture. However, there are a number of ways that culture can be influenced, so that it better supports the delivery of safe, high-quality person-centred comprehensive care.

Leadership across the organisation

There is considerable research about the importance of effective leadership in ensuring high quality healthcare systems – in shaping organisational culture, setting expectations, modelling behaviours and influencing attitudes and practice.

Recent inquiries and reports have also promoted clinician engagement and clinical leadership as critical to achieving and sustaining improvements to care quality and patient safety.[10]

Leadership involves having a vision of what can be achieved, communicating this vision to others, and then evolving strategies for realising this vision. Leaders motivate people and can negotiate for resources and other support to achieve organisational goals.

Leadership needs to be demonstrated across the organisation and is not strictly tied to management responsibility or traditional medical and hospital hierarchies. A health service organisation should have a range of leaders with shared vision and goals within and across professions, teams and support networks.

Leaders can be found in all services and can include clinicians, managers, consumers, volunteers, executives, board members, support staff or others working within the organisation to drive improvement in care and practice.

Different leadership styles and approaches may be needed within an organisation to address differing needs. Regardless of the style of leader, or where they sit within an organisation, the health service organisation should clearly define and communicate the roles and accountabilities of leaders, and members of the workforce in supporting the delivery of safe and high-quality comprehensive care.

Considerations

Focusing on leadership development and defining and communicating accountability for leadership behaviours across the organisation can help foster a person-centred culture. This is critical in ensuring members of the workforce and consumers understand their role and responsibilities in supporting the delivery of comprehensive care.

Health service organisations should seek out, foster and strengthen leadership across the organisation, and support the shared values, vision, culture and capability needed for the delivery of comprehensive care.

Effective clinical governance systems

Fostering leadership and ensuring clear accountability across an organisation are critical in shaping the organisational culture. An effective and strong clinical governance framework provides a structure for describing the organisation's vision, expectations and philosophy, as well as allowing for clarity regarding roles, responsibilities and accountability.

The National Model Clinical Governance Framework[11] provides a national approach for clinical governance that is based on the NSQHS Standards and supports a shared understanding of clinical governance amongst everyone working in health service organisations. It identifies factors that contribute to sustaining a culture that supports safe and high-quality care including:[11]

- Leaders articulating a vision for high-quality, compassionate and safe care, and acting on this vision through the organisation
- Translating the vision into clear objectives for safety and quality at all levels of the organisation, and establishing measures to assess progress
- Providing a supportive and positive environment for the members of the workforce
- Ensuring that the workforce are engaged in their work
- Having an organisation that is transparent about performance, open to learning and continuously improving
- Supporting multi-disciplinary teams to work together effectively.

Effective clinical governance should also include systems for quality improvement that use data to understand practice, and to identify opportunities to improve the delivery of care.

Supporting these types of factors through a clinical governance framework provides a foundation for a health service organisation to create a positive organisational culture that permeates all levels of an organisation, from front-line workers to executive management.

Considerations

A structured governance model should be based on shared values and clear objectives, and be focused on fostering a positive collaborative working environment grounded in learning organisation principles. This allows leaders to articulate expectations and responsibilities and embed systems that support consistency and reliability in healthcare delivery.

Health service organisations could consider using this type of model as a means of supporting the delivery of comprehensive care. This type of approach balances personal responsibility and the introduction of systems by providing a workplace environment where performance expectations are clearly defined at every level.

Implementing a robust and structured governance model also meets actions in the Clinical Governance Standard. The National Model Clinical Governance Framework[11] can be used for this purpose.

Supporting the workforce through education and training

Education, training and other development support is necessary for the members of the workforce to understand the principles of comprehensive care, and how to effectively deliver comprehensive care within their own health care context.

Clinicians currently receive a range of education and training opportunities, and many may already have been trained in different aspects of comprehensive care (such as communication, risk screening and multidisciplinary teamwork). However, some members of the workforce may not have considered how different components of care contribute to the delivery of comprehensive care and may require support to understand and adopt new approaches or policies. For example, if a health service organisation instigates a new process for improving screening and assessment, members of the workforce may require training to become familiar with the approach and tools used.

Education and training may be required for organisation-wide processes and policies, as well as more specific processes for use at the ward, unit or service level. This could include orientation, and education and training for clinicians and other members of the workforce to understand their individual roles, responsibilities and accountabilities in delivering care in accordance with the comprehensive care plan.

In addition to providing training to doctors, nurses, midwives and allied health clinicians, training is also needed for auxiliary members of the workforce involved in delivering patient care. For example, members of the food service workforce may need training about their role in managing risks associated with malnutrition and dehydration, and ward clerks may need training to ensure that substitute decision makers are identified, and carers are able to be with patients outside of usual visiting hours.

Education and training can be provided in a variety of formal and informal formats. This can include structured programs, online learning, attendance at relevant external seminars and conferences, self-directed learning, education placements, mentoring and buddying.

Considerations

Education and training is an important component of supporting members of the workforce to understand and implement changes in policy and processes, and to facilitate the consistent delivery of high-quality comprehensive care.

Health service organisations should consider the workforce within their organisation, and undertake an assessment to identify where there is a need to deliver education and training to support the understanding and delivery of comprehensive care.

The Commission will be developing a set of tools and resources that can be used by health service organisations to inform their education and training programs and strategies.

Systems, processes and protocols to deliver comprehensive care

To achieve the consistent delivery of comprehensive care, a health service organisation needs to consider the variety of systems, processes and protocols that operate within its organisation and contribute to the patient's experience of comprehensive care.

A number of core systems, processes and protocols are influential. These can include risk screening, goal identification, care coordination and care planning. Understanding these systems, processes and protocols and aligning them with the overall aim of delivering comprehensive care can support greater consistency of approach.

Teams work collaboratively and communicate effectively

To deliver comprehensive care that is safe and continuous, effective communication and teamwork are critical.

Comprehensive care relies on effective communication between healthcare teams, within healthcare teams and between clinicians and consumers. Communication failures and inadequate or poor documentation of clinical information result in errors, misdiagnosis, inappropriate treatment and poor care outcomes.[12–17]

Health care in general is reliant on teamwork: no single clinician can deliver all aspects of the care that a patient requires. Different clinical and non-clinical members of the workforce bring specific skills and expertise, and must work together to provide the complete health care that a patient requires.

The scoping interviews identified that when team structures were disconnected there was greater confusion about the goals of care and planned interventions. Disconnection was more evident when there were multiple medical teams involved in patient care. However, when clinicians worked together, comprehensive care was seen to be more achievable.

Considerations

Teamwork is critical to safe and high-quality care, yet the scoping interviews identified that clinicians often still work in silos.

Health service organisations should explore how well teams work together and communicate within the organisation. This may involve observing teams, examining patient and workforce experience data, undertaking audits of medical records, or talking with members of the workforce and consumers about their experiences. Improvement strategies could be implemented in areas where specific teamwork issues have been identified.

The Commission will be providing information for health service organisations on a range of approaches that could be used to support improved teamwork and communication at various levels within health service organisations.

Improving teamwork and communication between teams, and with consumers, also meets actions within the Partnering with Consumers Standard and Communicating for Safety Standard.

Tools and processes for risk identification and mitigation

Risk identification for common adverse events is an important process in determining care priorities and identifying where specific resources or interventions may be required for a patient.

Screening for risk is often performed using checklists or tools, which are a simple assessment of risk factors. There are many screening and assessment tools currently in use; however, very few are validated and many have been developed in an ad hoc way for specific purposes.

The interviews highlighted a disconnect between clinicians' use of screening tools, their perception of the value of screening, their awareness of the implications of identifying a risk, and the level of action taken to mitigate risks identified during the care episode. This is consistent with comments suggesting that risk screening in some cases (and in some services) can be more focused on minimising organisational liability, rather than improving patient safety.[18]

Clinicians' views of risk identification and screening processes are coloured by the quantity and quality of tools available; the proliferation of screening requirements being imposed on clinicians; the lack of training and support in undertaking effective screening; and the perceived lack of value when risks that are identified are not addressed in care delivery.

Considerations

Screening and risk identification is an important part of delivering comprehensive care. Health service organisations need to consider how effective, consistent and coordinated their current screening processes might be, and whether the identification of risk using these processes contributes to comprehensive care planning and delivery.

According to the interviews and the literature on screening, current screening processes in Australia may not be working as intended. Consequently, one of the initial areas the Commission will focus on is to provide guidance and support on how health service organisations can improve the quality and effectiveness of screening processes within their service.

Goal setting

The identification and attainment of goals in health care can be a complicated process. It is reliant on effective communication between healthcare providers and consumers, and a shared understanding of feasible and achievable options and outcomes. Goal attainment requires effort, persistence and concentration, and there are many factors that have an impact on any goal set for an indivdual.[19]

Many goal setting instruments have been described in the literature with each instrument having strengths and weaknesses; no tool has been specifically recommended for use in acute care.[20] However, goal setting tools have been reported to be useful in tailoring and monitoring treatment, improving team communication and clarifying team roles.[20]

Considerations

The Comprehensive Care Standard requires that care planning and delivery is aligned with the patient's expressed goals, but guidance may be required on different approaches to goal setting, negotiation and communication to support health service organisations to embed goal setting as a key process of comprehensive care.

Health service organisations can examine the current tools and processes used within their service to support the identification of goals, and integration of those goals into care planning.

In addition, the Commission may undertake a broader review to identify tools and processes that can assist in goal setting in different types of services and with different types of patients.

Care planning and review

Models for developing care plans can be disconnected and discipline-specific, mostly relying on a biomedical model and patient contribution from a passive position. This is not consistent with current person-centred approaches to care, which promote shared decision making and collaboration with patients. Also, it does not address the inclusion of patient-specific goals of care.

Many countries and regions, including some Australian states and territories, have adopted integrated models of care planning. The core components of care planning involve more than a treatment plan for a specific condition devised by a single clinician.

Comprehensive care plans integrate multiple components of health for the patient by including agreed goals linked specifically to desired outcomes, and they ensure inclusion of appropriate MDT members. Care plans should be action focused and include agreed goals and interventions that are in place to manage diagnoses and identified patient risks.

Consideration should be given to improving the communication and inclusion of the primary health team members across the boundaries of the acute service. This supports the ideal of wrapping care around the person rather than the facility.

Considerations

Health service organisations should consider the type of care plans that are currently in use within their service. This may involve a review of the different approaches used, and discussion with clinicians, patients and families about whether this approach meets their needs and addresses the requirements of the Comprehensive Care Standard.

The Commission will be developing guidance and support for health service organisations describing different types of approaches, processes and protocols that can be used for care planning. This includes models that can be used in different types of health service organisations.

Coordinating care

The care coordinator model has been implemented in specialty areas and chronic disease management for some time as a means of improving patient satisfaction and some quality of life measures.[21]

Care coordination can contribute to meeting patient needs and preferences by providing more tailored and personalised care. This is particularly important for patients at high risk of harm, complex patients, or patients that do not fit speciality models. In a small study, these types of high-risk patients were identified and provided with specialised care plans; this was associated with a decrease in adverse events and readmissions.[22]

While allocating an official care coordinator for every patient may not be feasible, some participants in the interviews described approaches to providing differing levels of care coordination, based on patient need and complexity. For example, in one facility the nurse unit manager acted as a surrogate coordinator for low-risk or uncomplicated patients.

Considerations

Care coordination is a part of delivering safe and high-quality comprehensive care. When patients have multiple morbidities, complex health problems and multiple specialities involved in their care, the risk of errors or failures increase. Having a centralised person who has responsibility and accountability for coordinating care (administratively and/or clinically) can help reduce risk and provide a more tailored care experience.

Health service organisations should consider their current approach to care coordination, identifying the types of patients within their service that would most benefit from this approach and the different types of strategies that could be used to better coordinate care.

A focus on the patient experience

The delivery of comprehensive care requires a focus on the patient experience. Ensuring that consumers are engaged, communication is effective, decisions are shared, and consumers and their support people are treated as part of the care team is critical to the delivery of comprehensive care. It is also core to ensuring care is person-centred.

Person-centred principles

Person-centred care is care that is respectful of and responsive to the preferences, needs and values of the consumer,[23] and considers care and treatment in the context of their life and what is important to them. The delivery of comprehensive care is reliant on the core principles of person-centred care: dignity and respect, sharing information, participation and collaboration.[24]

For care to be comprehensive and address the holistic needs of the patient, the health service organisation, the care team, clinicians, consumers and their support people need to work together to understand and address the needs and preferences of the patient, and to plan care and to share decisions, including those about future care in the context of their clinical needs.

Considerations

To support the delivery of comprehensive care, person-centred principles should be embedded in the policies, processes and governance of the organisation. Commitment to person-centred principles and the delivery of comprehensive person-centred care should be visible and demonstrated throughout the organisation.

The Commission has developed resources describing the principles of person-centred care, and the attributes of organisations that excel in their commitment to person-centred care. The Commission will be developing further materials to help health service organisations integrate person-centred care principles and approaches into organisational systems.

Health service organisations should embed the principles of person-centred care into their organisation's systems and governance so that there is a shared understanding of the organisation's values and focus on the person.

Consumers engaged in partnership in their own care

Partnering with consumers in their own care is an important pillar of comprehensive care. It focuses on the relationship between a consumer and a clinician, and recognises that trust, mutual respect and sharing of knowledge are needed for optimal health outcomes.[25]

Partnerships with patients comprise many different, interrelated practices – from communication and structured listening, through to shared decision making, self-management support and care planning.

Comprehensive care requires the engagement of consumers (as a patient, support person or substitute decision maker) in the processes of care planning and delivery. It involves partnering with consumers from the start of the epsiode of care by collaboratively discussing patient preferences, care options, potential risks and benefits, care processes, expectations, possible outcomes, and what happens after discharge.

Consumers are considered part of the care team and are engaged throughout the journey to ensure that needs and preferences are met, and that the patient experience is positive.

There is growing acceptance that involving consumers as partners in their own care can improve the safety and quality of health care, improve patient outcomes and experience, and improve the performance of health service organisations.[26]

Considerations

When delivering comprehensive care, consumers should be engaged in partnerships with clinicians and others who deliver care.

Health service organisations can support this to occur in their services by fostering a person-centred organisational culture, by supporting the communication skills of members of the workforce, and by establishing systems and processes that facilitate engagement of consumers in their own care.

The Commission has developed a range of resources describing how consumers can be engaged in partnerships in their own care. Additional resources will be developed based on evidence-based models for partnering with consumers.

Engaging and partnering with consumers in their own care is also a key feature of the Partnering with Consumers Standard.

Decision making is shared

Shared decision making is a critical strategy for effectively partnering with consumers in their own care. It is a structured process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, their risks and benefits, and considering the patient's values, preferences and circumstances.[27]

Shared decision making offers a framework for working jointly with patients (and carers and families, if the patient chooses to have them involved) to make decisions about the comprehensive care plan. This should be based on a shared understanding of the patient's goals of care, and the risks and benefits of clinically appropriate options for diagnostic tests, treatments, interventions and care.[28]

Shared decision making may involve the use of decision support tools, which support the communication of information in a clear and simple way, and help confirm consumers' understanding of the options, risks and benefits of different approaches to care.

Considerations

Shared decision making is a process and a tool for partnering with consumers to make a joint decision about the most appropriate care option for the patient. Using shared decision-making processes also supports effective informed consent processes, as risks and benefits are explained in a way that meets the needs of the consumer.

The Commission is developing tools and resources to improve understanding of shared decision making, and risk communication and to support discussions between consumers and clinicians about healthcare options.

Conclusion

Based on the review and scoping interviews undertaken, in order to support the delivery of comprehensive care, health service organisations could focus on three main areas:

- A focus on patient experience – having an organisation-wide commitment to the delivery of care that is person-centred, and working to improve the patient experience.

- Systems, processes and protocols to deliver comprehensive care – having systems, processes and protocols to guide and support healthcare providers to deliver comprehensive care consistently and effectively (such as screening protocols to minimise the risk of harm, communication tools and good care-planning processes)

- Organisational culture and governance to support comprehensive care approach – having organisation-wide governance, leadership and systems that embed the delivery of high-quality person-centred comprehensive care as the organisational standard

This may require health service organisations to examine: the way they currently shape care delivery; how their culture affects practice; and how their systems influence patient experience.

The model for comprehensive care that is proposed in this paper provides a starting point for health service organisations, and the Commission, to consider the elements that influence how comprehensive care is delivered and where change may lead to improvements that align with the intent of the NSQHS Standards (2nd ed.)

The Commission aims to support health service organisations to make improvements in these areas, and to work towards meeting the requirements of the Comprehensive Care Standard.

Next steps

This conceptual model for delivering comprehensive care will be used by the Commission to inform the development of tools and resources, including education materials, for health service organisations to help meet the requirements of the Comprehensive Care Standard. The model can also be used by health service organisations as a way of structuring an examination of how comprehensive care is being delivered within their service, and exploring areas where improvements can be made.

The Commission's next step will be to provide guidance on some of the key practical elements required for comprehensive care delivery such as eliciting goals; planning care with consumers; identifying and mitigating risks of harm through screening; working in a team collaboratively; and reviewing and improving the care plan.

This will be followed by the development of more detailed information about the specific elements identified, starting with an exploration of options for improving approaches to person-centred screening and risk identification. The Commission has commenced a project that involves examining the different types of screening tools currently available, the extent of validation of these tools, and how screening is working in practice within Australian health service organisations. This work will lead to guidance for health service organisations on alternate models for screening so that risks for patients are identified and mitigated effectively.

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Appendix: Interview participants by organisation

State	Organisation	Type
NSW	John Hunter Hospital (adult)	Tertiary metropolitan public teaching hospital in Newcastle
	John Hunter Hospital (children's)	Public metropolitan paediatric hospital in in Newcastle
	Royal Prince Alfred Hospital	Tertiary metropolitan public hospital in Sydney
QLD	St Vincent's Private Hospital Brisbane	Metropolitan private hospital in Brisbane
	Princess Alexandra Hospital	Tertiary metropolitan public hospital in Brisbane
	Private Hospital Association Queensland	Hospital association with representation of private day surgeries
SA	Flinders Medical Centre	Tertiary metropolitan public hospital in Bedford Park
	Lyell McEwin Hospital	Tertiary metropolitan public hospital in North Adelaide
	Queen Elizabeth Hospital	Metropolitan public hospital in South West Adelaide
VIC	Brighton Plastic Surgery	Small metropolitan private day surgery facility in Melbourne area
	Cabrini Health	Metropolitan facility group including three private medium-sized acute facilities in Melbourne area and two aged care homes
	Peter MacCallum Cancer Centre	Medium metropolitan public cancer centre in Melbourne with four smaller outer services. Inpatient and outpatient services
	Western Health	Public metropolitan and regional facility group including three medium-to-large acute hospitals, one day surgery and one transition program in Victoria
	Royal Children's Hospital Melbourne	Public metropolitan paediatric hospital in Melbourne

Glossary

carer: a person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail and aged.

An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation or caring as part of a training or education program.[29]

clinical governance: an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services. Clinical governance systems provide confidence to the community and healthcare organisation that systems are in place to deliver safe and high-quality care.

clinician: a healthcare provider, trained as a health professional, including registered and nonregistered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.

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, 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 called different things in different health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.

consumer: a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.[30]

goals of care: clinical and other goals for a patient's episode of care that are determined in the context of a shared decision-making process.

governance: the set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including patients and consumers). Governance incorporates the processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure for setting the corporate objectives (social, fiscal, legal, human resources) of the organisation and the means to achieve the objectives. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives. In the NSQHS Standards, governance includes both corporate and clinical governance.

health care: the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.[31]

health service organisation: a separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a group of

clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

leadership: having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals.[32]

multi-disciplinary team (MDT): a team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.[33] Multi-disciplinary care includes inter-disciplinary care. (A discipline is a branch of knowledge within the health system.[34])

patient: a person who is receiving care in a health service organisation.

patient or person centred care: an approach to the planning, delivery and evaluation of health care that is founded in mutually beneficial partnerships among clinicians and patients.[35] Patient-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of patient-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care.[26]

policy: a set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.

procedure: the set of instructions to make policies and protocols operational, which are specific to an organisation.

process: a series of actions or steps taken to achieve a particular goal.[36]

protocol: an established set of rules used to complete tasks or a set of tasks.

quality improvement: the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.[37] Quality improvement activities may be undertaken in sequence, intermittently or on a continuous basis.

responsibility and accountability for care: accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgement that a person has to take action that is appropriate to a patient's care needs and the health service organisation.[38]

risk: the chance of something happening that will have a negative impact. Risk is measured by the consequences of an event and its likelihood.

risk assessment: the chance of something happening that will have a negative impact. Risk is measured by the consequences of an event and its likelihood[39]

risk management: the design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.

safety culture: a commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management. Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.[40]

screening: a process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.

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.[27]

training: the development of knowledge and skills.
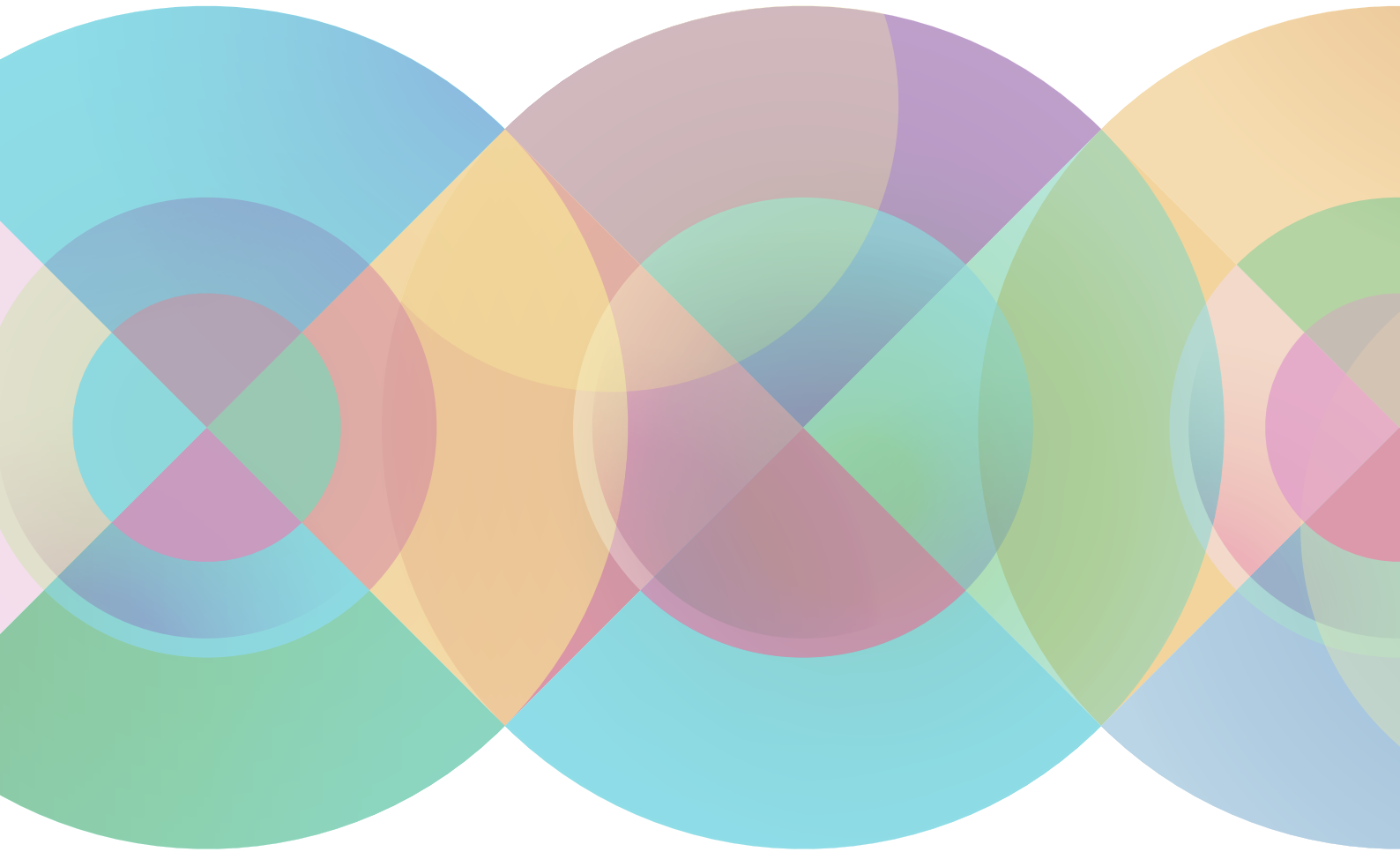
workforce: all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation. See also *clinician*.

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