



Implementing the Comprehensive Care Standard

Develop a single comprehensive care plan

June 2019



Published by the Australian Commission on Safety and Quality in Health Care

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Website: www.safetyandquality.gov.au

ISBN:

Print: 978-1-925948-21-9

Electronic: 978-1-925948-20-2

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Australian Commission on Safety and Quality in Health Care. Implementing the Comprehensive Care Standard: Develop a single comprehensive care plan. Sydney: ACSQHC; 2019.

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Introduction

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (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 health service 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 aims to address some of the causes of these safety and quality gaps.

The second criterion of the Comprehensive Care Standard focuses on developing the comprehensive care plan. In addition, there are a number of other actions across the NSQHS Standards that should be considered during the process of developing a comprehensive care plan (see **Appendix 1**).

Comprehensive care plans integrate multiple components of health care for the patient by linking agreed goals to desired outcomes. Having a single clear comprehensive care plan for the patient that is shared by the multidisciplinary team can contribute to improved communication, collaboration and coordination of care.

The length, format and content of a comprehensive care plan will vary depending on clinical complexity, goals and circumstances of the patient. However, there are a number of key components that should be included in comprehensive care plans for most patients to ensure that the health care delivered aligns with the goals of care.

This paper

This paper provides practical advice for clinicians and health service organisations about developing comprehensive care plans, as required for the Comprehensive Care Standard Criterion 2: Developing the comprehensive care plan.

The paper also provides further information about Element 4 of the essential elements of comprehensive care. It is part of a series of resources supporting implementation of comprehensive care that are based on six essential elements:

- Element 1: Clinical assessment and diagnosis
- Element 2: Identify goals of care
- Element 3: Risk screening and assessment
- Element 4: Develop a single comprehensive care plan
- Element 5: Deliver comprehensive care
- Element 6: Review and improve comprehensive care delivery.

There are also separate short tip sheets that summarise options for minimum components of a comprehensive care plan.

The elements were developed to support practical implementation of the Comprehensive Care Standard and more information about all of the essentials elements is available from: [Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care.](#)

This paper has been developed for:

- Clinicians involved in the delivery of care, providers of clinical education and training, research organisations and other health bodies
- Managers and executives responsible for developing, implementing and reviewing processes to support identification of goals
- Planners, program managers and policymakers responsible for the development of state and territory governments or other strategic programs dealing with the processes associated with providing comprehensive care.



Element 4: Develop a single comprehensive care plan

Purpose

- To develop a single, clear and holistic plan that addresses the diagnoses, goals of care, identified risks, action taken and key treatment information for the episode of care
- Provide an accessible resource that can be shared, used and updated by the multidisciplinary team.

Principles

- Communication and comprehensive care planning is person-centred and tailored to meet health literacy needs of the recipient
- Comprehensive care planning and delivery should be multidisciplinary and include patients, family, carers and other support people
- Information about the patient's personal and clinical goals, along with diagnoses, drives the comprehensive care planning process
- Information about the risks identified and action taken, including mitigation strategies commenced or proposed for a patient, are integrated into the comprehensive care plan
- The focus of comprehensive care planning is on improving outcomes for the patient and delivering care that is person-centred
- Comprehensive care plans should be contemporaneous, accurate and relevant
- Comprehensive care plans should be succinct but also include all critical information for the patient.

Consumer actions

- Patients engage as partners in healthcare discussions and planning, to the extent that they wish to and as appropriate
- Families, carers and other support people participate in and engage with care planning processes, in alignment with the wishes of the patient.

Clinician actions

- Clinicians focus on including interventions and risk mitigation strategies in comprehensive care planning that are likely to improve patient outcomes
- Clinicians use multidisciplinary processes, engage with the multidisciplinary care team and communicate effectively with team members to plan the patient's care
- Clinicians include patients, family, carers and other support people in comprehensive care planning, in alignment with the wishes of the patient
- Clinicians ensure information in the comprehensive care plan is current and updated, accurate, relevant and succinct.

Organisational actions

- Health service organisations foster a person-centred culture in delivering comprehensive care including supporting collaboration in comprehensive care planning
- Health service organisations establish agreed policies, process or templates for developing a comprehensive care plan
- Health service organisations determine systems and processes to review patient outcomes against the comprehensive care plan
- Health service organisations provide access to training and education to the multidisciplinary team on the use of the organisation's processes for developing a comprehensive care plan
- Health service organisations provide systems to capture information on comprehensive care delivery, including planning processes.



What is a comprehensive care plan?

A comprehensive care plan is a document describing agreed goals of care, and outlining planned medical, nursing, midwifery 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.¹

A single comprehensive care plan should be prepared for a patient so that core information can be shared, accessed and acted on by all members of the multidisciplinary team.



Developing a comprehensive care plan

Developing a comprehensive care plan should be a person-centred process that includes principles of good communication, and involves multidisciplinary team members, family, carer and other support people as appropriate.

The comprehensive care plan should include information about goals, any identified risks and be aimed at improving patient outcomes. The content of comprehensive care plans will depend on the setting and the service that is being provided in, and may be titled differently in various health service organisations. Examples of a comprehensive care plan may be a care pathway for a specific intervention, a nursing care plan that is shared across disciplines, or a document within the electronic medical record that includes core multidisciplinary information.

Documentation is a critical part of healthcare communication. Given the complexity of health care and the fluidity of clinical teams, healthcare records are one of the most important information sources available to clinicians. The comprehensive care plan should be provided in an accessible format with consideration of the principles of good documentation. See **Appendix 2 for the principles of good documentation.**



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 or creates a barrier to timely access to sentinel information.

The Commission undertook a survey to identify and prioritise the key components and fields that could be included within a comprehensive care plan. There were 1300 responses received to the survey, with overall feedback indicating that almost all of the identified components and fields were considered a high priority. Respondents also indicated that those fields that are included in a comprehensive care plan need to be tailored to reflect the individual patient's needs. Results of the survey can be found in the factsheet: *Survey findings: Components of a comprehensive care plan*.²

The fields identified as of greatest importance have been grouped into nine 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.

The nine components and examples of fields can be found in **Table 1**.

Table 1: Components of a comprehensive care plan and examples of potential fields

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
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	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

Personal identifiers and preferences

Personal identifiers and preferences help ensure the correct identification of the patient, as well as ensure that core needs and preferences are understood and communicated to the care team.

Personal identifiers can be personal information such as name, date of birth and reference numbers such as Medicare numbers, health insurance numbers or medical reference numbers.

Information about personal preferences include preferred names, and the details of people the patient would like involved in their care decisions, such as family, carers and other support people. It may also include information about the characteristics of the patient and their specific needs such as their level of health literacy, cultural background and language preferences, and the need for psychosocial or spiritual support. These factors may have an impact on the way in which patients, families and carers are involved in the planning process and the delivery of comprehensive care.

Clinical assessment and diagnoses

Clinical assessment is the process of identifying a condition, disease, injury or needs of a patient which is based on the clinical information obtained through examination and application of clinical reasoning. The patient's subjective report of the symptoms and course of the illness or condition, and objective findings from clinical assessment are used to determine provisional and differential diagnoses.³

Information about clinical assessment and diagnosis can include provisional and differential diagnoses, as well as factors that have informed the diagnosis including symptoms, presentation, comorbidities and reason for admission. It may also include relevant information about the patient's history such as allergies and reactions, history of cognitive impairment, mental illness, frailty, falls, bleeding, infection, absconding, pressure injury and current medications which may also inform the risk screening and assessment process.

Goals of care

Identifying the patient's goals of care and regularly checking they are current helps to organise and prioritise care activities and contributes to improved satisfaction, quality of life and self-efficacy for patients.⁴⁻⁶

Information about goals of care can be clinical, personal, or combination of goals as discussed and agreed between the patient and the care team. Goals can be short-, medium- or long-term, and can include key milestones and timeframes.

In addition, goals can be articulated in advance care plans, particularly for patients with chronic and complex conditions or patients at the end of life. Advance care plans should be available and used to inform the comprehensive care plan. For more information about goals of care see *Implementing the Comprehensive Care Standard: Identifying goals of care*.⁷

Risk screening and assessment

Risk screening and assessment are a core part of healthcare delivery and comprehensive care. As well as identifying clinical issues, they also identify the likelihood of harm, and support decision making about treatment and risk mitigation.

Information about risks identified and mitigation strategies should be included in the comprehensive care plan. For more information about risk screening and assessment see *Implementing the Comprehensive Care Standard: Risk screening and assessment*.⁸

Planned interventions

Evidence based interventions are associated with improved outcomes and increased cost-effectiveness of care but need to be implemented so that care is provided consistently and unwarranted clinical variation is minimised.⁹ Planned interventions should be recorded reliably on the comprehensive care plan to support effective care and communication between team members.

Planned interventions could include any tests to confirm or rule out provisional and differential diagnoses, procedures including planned surgery, medications including oxygen requirements and VTE prophylaxis, and any standard clinical pathways, x-rays, pathology and therapeutic monitoring.

Activities of daily living

Activities of daily living are essential and routine activities needed for functioning and self-care, and will vary depending on the complexity of needs of the patient. Activities relate to mobility, dressing, personal hygiene, nutrition and elimination.¹⁰ Recreational activities may also be a relevant aspect to include in the comprehensive care plan.

Information about activities of daily living that could be included in a comprehensive care plan could be information on assistive devices and processes needed, special nutrition and hydration needs or restrictions, toileting and personal hygiene needs, wound management including dressings, drains, mobility needs and any planned recreational activities.

Monitoring plans

Monitoring the patient's condition and the impact of interventions is an important part of delivering comprehensive care. The comprehensive care plan should include information about how the patient's care and condition is being monitored and include dimensions for recognising and responding to deterioration in physical or mental state.

Information about monitoring could include specific parameters for ongoing monitoring, the frequency with which they will be monitored and action that will be taken if escalation is required. It also could include specified timeframes for review of progress, additional specialty specific observations, or change of emphasis to end-of-life care and any limitations to medical treatment.

People involved in care

Depending on the complexity of the clinical situation, there may be a large number of people involved in the care of a patient. To work effectively as a multidisciplinary team it is important to know who is involved in the patient's care, and what action has been taken by different members of the multidisciplinary team.

Information about people involved in the patients care may include details of the patient's family, carers and other nominated support people the patient has indicated to be involved in care decisions and delivery. It also should involve identification of clinical team members involved in care decisions and delivery such as admitting medical officer, lead clinician, treating doctors, nurses, midwives, pharmacists, social workers, physiotherapists, occupational therapists, dieticians, speech therapists, care coordinators, other allied health professionals, pastoral/spiritual care advisors, Aboriginal and Torres Strait Islander health workers, general practitioners, or others as appropriate.

Discharge planning/transfer of care

Discharge planning is a process of preparing for an individual patient to have a smooth transition out of the facility and begins when a person is admitted. Discharge planning should include the patient, family, carers and other support people contributing to the planned decisions, as equal partners. It should be coordinated, systematic, comprehensive and part of a multidisciplinary approach.¹¹

Information about discharge planning and transition arrangements including estimated date and location of discharge, final diagnosis, services and resources required post-discharge, referrals including to primary care providers, discharge instructions and final medication reconciliation should be included in the comprehensive care plan.

Patients with complex healthcare needs

Good documentation of healthcare decisions, planning and delivery are particularly important for patients with more complex healthcare needs. People can be at greater risk of harm and poor health outcomes and include:

- Older patients
- Children
- People with mental illness
- Patients with multiple comorbidities
- Patients admitted to intensive care
- Aboriginal and Torres Strait Islander patients
- Patients moving along a perioperative pathway
- Palliative care patients or patients at the end of life.

The complexity and fluidity of information generated for patients means that documenting up to date, accurate and complete information can be challenging. It is important to consider if there is any additional information that needs to be documented and communicated to ensure that information is tailored to a patient's specific care needs.



Conclusion

A comprehensive care plan is a document describing agreed goals of care, and outlining planned medical, nursing, midwifery 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.¹¹

Comprehensive care plans will differ depending on the complexity and needs of the patient, and may also be titled differently in various health service organisations. The content of a comprehensive care plan should be tailored to the patient's needs, with consideration to the setting and the service that is being provided.

There is a substantial amount of information that could be included within a comprehensive care plan; however, if all relevant information were included the plan could become unwieldy and may deter use. Information that should be included within a comprehensive care plan can be grouped into nine components including:

- Personal identifiers and preferences
- Clinical assessment and diagnosis
- Goals of care
- Risk screening and assessment
- Planned interventions
- Activities of daily living
- Monitoring plans
- People involved in care
- Discharge planning.

There are a variety of fields within each of these components that could be included within a comprehensive care plan.

Health service organisations should aim to include information from each of these components within a comprehensive care plan. However, when identifying specific fields for inclusion health service organisations should consider what is most appropriate, meaningful and useful for their patients and the context in which they operate.

Appendix 1: NSQHS Standard actions to consider when developing a comprehensive care plan

Standard	Consideration	Action
Clinical Governance	Diversity and high-risk groups	1.15, 1.21
	Healthcare records	1.16
	Evidence-based care	1.27
Partnering with Consumers	Healthcare rights and informed consent	2.4, 2.5
	Sharing decisions and planning care	2.6, 2.7
	Communication that supports effective partnerships	2.8–2.10
Preventing and Controlling Healthcare-Associated Infections	Standard and transmission-based precautions	3.6, 3.7
	Invasive medical devices	3.10
Medication Safety	Medication reconciliation	4.5, 4.6
	Adverse drug reactions	4.7, 4.8
	Medication review	4.10
Comprehensive Care	Criterion for developing the comprehensive care plan	5.7–5.13
Communicating for Safety	Organisational processes to support effective communication	6.4
	Correct identification and procedure matching	6.5
	Clinical handover	6.7, 6.8
	Communicating critical information	6.9, 6.10
Blood Management	Documentation	7.5
Recognising and Responding to Acute Deterioration	Recognising acute deterioration	8.4, 8.5
	Escalating care	8.6



Appendix 2: Principles of good documentation

Good documentation contributes to better patient outcomes by enabling information exchange and continuity of care by all members of the healthcare team. Some of the principles of good document include the following:¹²

Person-centred

The care plan needs to reflect the goals of care and tailored to the specific needs of the patient. Information documented should take into consideration what practical information is needed to support safe high-quality care.

Contemporaneous

Information from all relevant sources that changes the way care is delivered is integrated at the time or as close to the time it is discovered or determined. This includes information from multidisciplinary team members, the patient and their family or carer. Information is up to date (e.g. new or emerging information is recorded on the care plan).

Accurate and relevant

All relevant information is captured. Recorded information correctly reflects the events being documented and pertains to the issues that have been identified by the patient, family, carers and other support people (as appropriate) and the multidisciplinary team.

Reliable

Legislative requirements are met (e.g. privacy and confidentiality) Standards, policies and procedures set by relevant federal, state and territory governments, health services and professional bodies are adhered to, including rules relating to both clinician and patient identification. Standardised language, terminology, symbols and approved abbreviations are used (medications and describing general health terms). Aligned with guidance on structured formats and on-screen presentation. Clinicians complete the comprehensive care plan and use them in the ways mandated.

Accessible

The comprehensive care plan needs to be available to clinicians who need them, when they need them, and in language that is easily understood by the intended readership. This means that the information needs to be up-to-date, easy to locate or searchable. The needs and the capabilities of those who will use the information are considered, and language does not exclude the people who will be using the information. This may include the patient, families, carers and other clinicians across disciplines (deferred accessibility).

Readable

The comprehensive care plan is legible and able to be understood. Whether in electronic or paper, forms and checklists must provide enough space for accurate and legible completion and must include clear instructions about how they should be completed. Acronyms and abbreviations are avoided in both design and completion if there is any potential for ambiguity. Be as specific as possible, such as when delegating actions to be taken by specific clinicians.

Enduring

The comprehensive care plan should be materially durable (not loose paper that is likely to be lost or on thermal paper that can fade). The meaning should be maintained, and written to be interpretable by a person who is not present at the time of the recording (self-explanatory).

There should be evidence of critical thinking. For example, information should not just simply list tasks but provide enough information and justification to explain recommendations and instructions (actions to be taken and why), and details of the impact and outcome for the particular patient and family involved. An example would be the level of intervention required to mitigate for specific risks or the reason a person has been placed on a specific care pathway.

Format

The comprehensive care plan may be paper-based or electronic. It is preferable that the care plan is available in one format only and is not spread across both media in health service organisations where both paper and electronic records are used. It is acceptable for a comprehensive care plan to be printed from an electronic system, however the date of the latest update must be conspicuous as a means of version control to prevent old plans from being enacted.



Glossary

carer: a person who provides personal care, support and assistance to another individual who needs it because the individual has 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.¹³

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 non-registered 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, families, carers and other support people 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.¹⁴

diagnosis: The identification of a condition, disease, or injury made by evaluating the symptoms and signs presented by a patient.¹⁵

goals of care: clinical and personal 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.¹⁶

health literacy: the Commission separates health literacy into two components – individual health literacy and the health literacy environment.

Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action.

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the health system, and it affects the ways in which consumers access, understand, appraise and apply health-related information and services.¹⁷

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.

higher risk (patients at higher risk of harm): a patient with multiple factors or a few specific factors that result in their being more vulnerable to harm from health care or the healthcare system. Risk factors may include having chronic clinical conditions; having language barriers; being of Aboriginal or Torres Strait Islander background; having low health literacy; being homeless; or being of diverse gender identities and experiences, bodies, relationships and sexualities (currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

multidisciplinary team: 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.¹⁸ Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.¹⁹)

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

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.²⁰ Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-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.²¹ Also known as patient-centred care or consumer-centred care.

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.²²

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.²³ 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.²⁴

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

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.

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.²⁵

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.²⁶

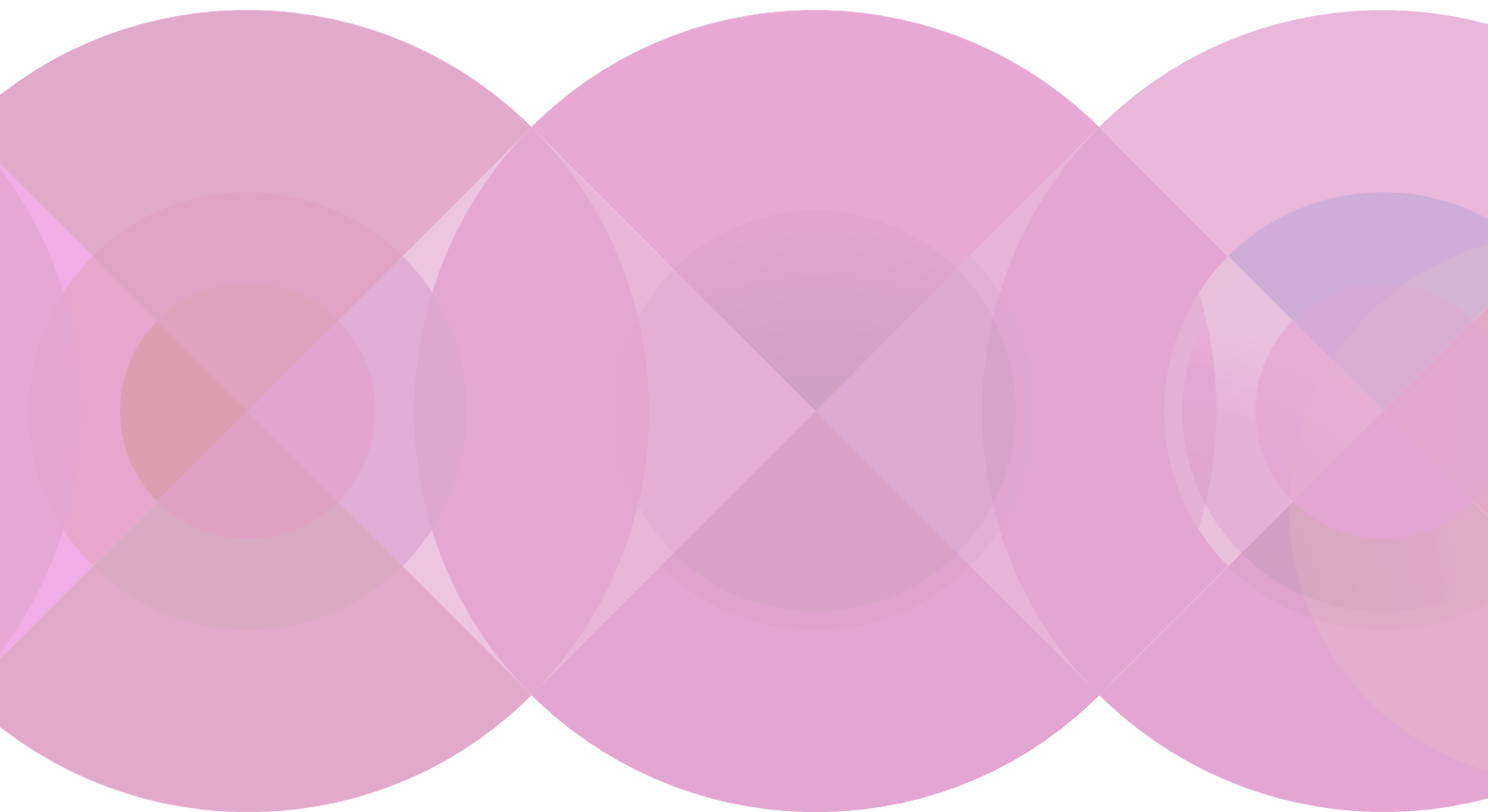
training: the development of knowledge and skills.

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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