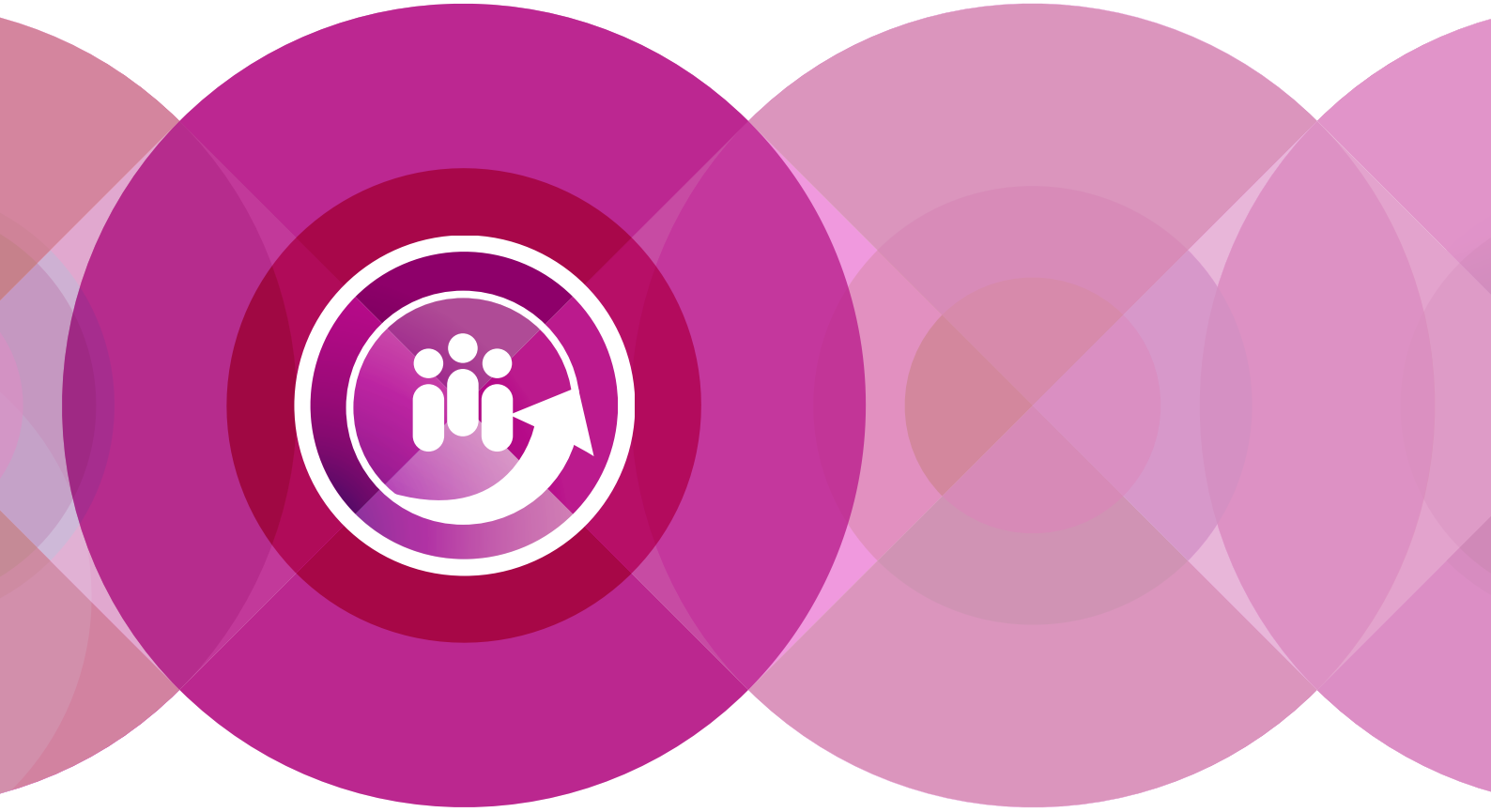
AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS
STANDARDS



Implementing the Comprehensive Care Standard

Essential elements for delivering comprehensive care

August 2018

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

Level 5, 255 Elizabeth Street, Sydney NSW 2000
Phone: (02) 9126 3600
Fax: (02) 9126 3613

Email: mail@safetyandquality.gov.au
Website: www.safetyandquality.gov.au

ISBN
Print: 978-1-925665-52-9
Electronic: 978-1-925665-53-6

The Commission's preference is that you attribute this publication (and any material sourced from it) using the following citation:

> Australian Commission on Safety and Quality in Health Care. Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care. Sydney: ACSQHC; 2018.

Disclaimer

The content of this document is published in good faith by the Commission for information purposes. The document is not intended to provide guidance on particular healthcare choices. You should contact your health care provider for information or advice on particular healthcare choices.

The Commission does not accept any legal liability for any injury, loss or damage incurred by the use of, or reliance on, this document.

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 in the context of the National Safety and Quality Health Service (NSQHS) Standards (second edition).[1]

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, state 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 care 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, families, carers and other support people 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 second in a series of resources to support implementation of the Comprehensive Care Standard. It moves from a conceptual model describing the culture, systems and the philosophy within an organisation that supports comprehensive care, to a set of practical elements for comprehensive care delivery.

The paper identifies some of the key actions and processes required for comprehensive care delivery, such as clinical assessment and diagnosis, goal setting, risk screening and assessment, care planning, care delivery and review. These elements are relevant in all settings where the NSQHS Standards apply, including acute, subacute and community health service organisations. However, the way in which specific elements are operationalised will differ depending on the context of the health service organisation, its size, the location, the demographics of the patient population and the type of care delivered.

This paper focuses primarily on the second and third criteria of the Comprehensive Care Standard, which address developing a comprehensive care plan, and delivering comprehensive care. However, the elements described in the paper are also relevant to the actions in the first criterion focused on designing systems for comprehensive care, and supporting processes for teamwork and collaboration.

The elements are also integral to effectively identifying and minimising the specific risks of harm included in the fourth criterion.

This paper has been developed for:

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

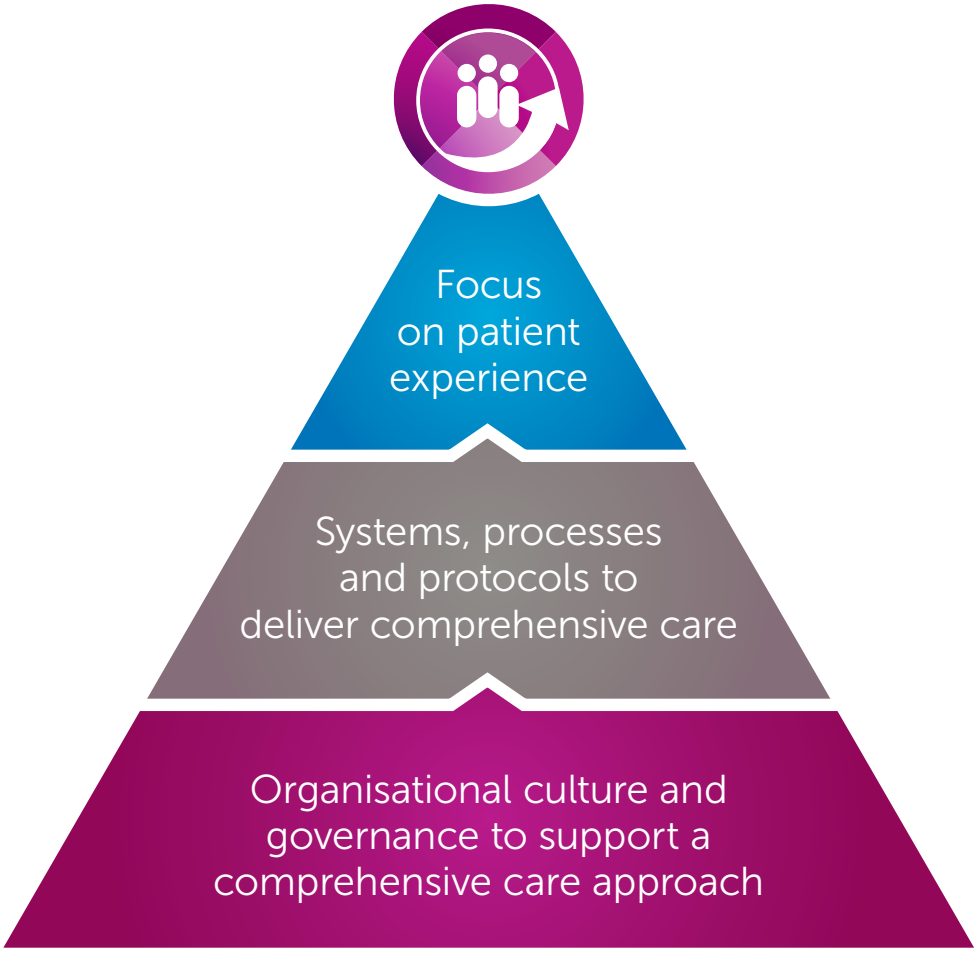
It may also be relevant for clinicians involved in the delivery of care, providers of clinical education and training, research organisations and other health bodies.

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

Conceptual model for supporting the delivery of comprehensive care

To support a shared understanding of the Comprehensive Care Standard, the Commission has developed a conceptual model describing the key organisational requirements for supporting the delivery of comprehensive care in health services. The organisational requirements in this conceptual model are grouped into three domains[3], as illustrated in **Figure 1.**

Figure 1: Conceptual model for supporting the delivery of comprehensive care[3]



1. **A focus on patient experience**: having an organisation-wide commitment to the delivery of care that is person-centred, and working to improve the experience of patients by engaging them in their own care and sharing decisions.
2. **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, in the areas of teamwork, collaboration, risk identification and mitigation, goal setting, care planning and review, and care coordination.
3. **Organisational culture and governance to support 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.

The conceptual model provides a basis for creating the organisational conditions to plan and deliver comprehensive care. It also provides a starting point for health service organisations and the Commission to consider the existing organisational culture, systems and processes that influence how comprehensive care is delivered, and where potential change may lead to improvement.

More information on this model can be found in *Implementing the Comprehensive Care Standard: A conceptual model for delivering comprehensive care*.[3]

Introduction to the essential elements

To help identify where practical improvements can be made in comprehensive care delivery, it is important to understand how the conceptual model of comprehensive care applies to the day-to-day business of delivering health care.

The Commission has identified a set of six essential elements for comprehensive care delivery, which represent different stages or processes that a patient may experience when clinical care is delivered. Where the conceptual model provides an organisational perspective of comprehensive care, the essential elements for comprehensive care delivery integrate these organisational pre-requisites with the clinical processes required to care for individual patients.

Each element contributes to the delivery of comprehensive care that is coordinated and 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. These elements provide a practical lens for considering where improvement can be made throughout the patient journey and how care can best be provided to patients. The essential elements are:

- 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.

The first three elements focus on gathering information to identify the patient's personal and clinical needs, including gaining an understanding of the type of treatment they require, the personal needs and preferences they may have, what the provisional diagnosis may be, and the risk of harm they might experience. These three elements are about collecting information to use as a basis for discussion and shared decision making with the patient, so that options can be explored and treatment planned that aligns with personal and clinical needs.

The last three elements focus on dynamic care planning and delivery that includes documenting and implementing the shared decisions that are made about the patient's care. It involves ensuring that there is a contemporaneous and centrally accessible plan that is used by the multidisciplinary team to guide the delivery of collaborative and coordinated care. It also involves reviewing what was agreed, planned and implemented in the comprehensive care plan should the patient's circumstances change.

Figure 2 provides an illustration of how these six elements interact. The figure describes where the patient is likely to come into contact with the elements along their healthcare journey.

These elements are described and presented in a linear way, but health care is complex and people present to health service organisations with multiple and diverse health issues. Implementation of the actions outlined in the Comprehensive Care Standard is an iterative process; changes in a patient's condition, their diagnosis, their location, their goals, as well as other clinical and personal decisions often require revisiting some of these elements along the patient's care journey.

Table 1 provides a summary of the six essential elements of comprehensive care delivery, including the purpose of the element and where this element might relate to actions in the NSQHS Standard actions.

Figure 2: Essential elements of comprehensive care delivery

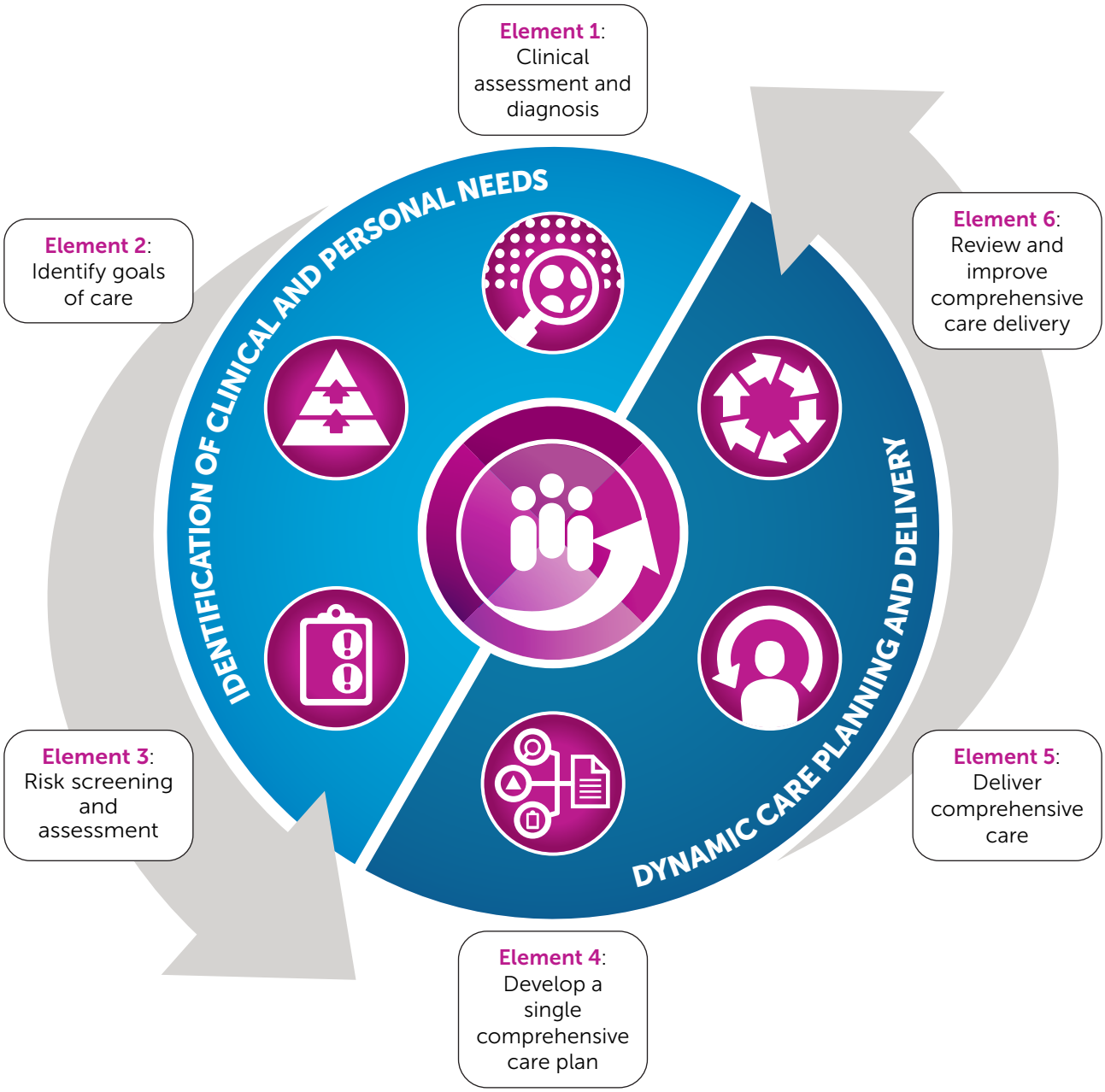


Table 1: Essential elements of comprehensive care delivery

Element	Purpose of the element	Related NSQHS actions
Element 1: Clinical assessment and diagnosis	• To evaluate the clinical information and make a provisional, and possible differential diagnoses • To determine appropriate investigations and actions required by the healthcare team • To prioritise and delegate interventions, timeframes and appropriate escalation processes • To commence the development of an appropriate and effective comprehensive care plan with the patient, families, carers and other support people and the multidisciplinary team	1.1, 1.6, 1.23, 1.24, 1.27 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.10 5.3, 5.4, 5.5, 5.11, 5.12, 5.13, 6.9, 6.10, 6.11 8.6–8.9
Element 2: Identify goals of care	Develop a shared understanding of: • The patient's goals for their health care in the short, medium and long term • The clinical situation, including diagnoses, treatment options and clinical goals • The patient's values, needs and preferences about their health and care • The patient's expectations about the care episode and treatment outcomes	1.16 2.6, 2.7, 2.8, 2.10 5.3, 5.9, 5.13 6.1, 6.3, 6.11
Element 3: Risk screening and assessment	• To gain an understanding of the degree to which a patient might be at risk of harm, or poorer outcomes • To inform decisions about action the healthcare team needs to take immediately to address identified risks such as specific assessment processes, implementation of risk mitigation strategies, and escalation of care where needed • To inform the development of a comprehensive care plan with the patient	1.15, 1.16 2.2, 2.7 3.6 5.7, 5.10–5.12, 5.21–5.34 6.3, 6.4, 6.7, 6.9–6.11 8.9, 8.10, 8.13
Element 4: Develop a single comprehensive care plan	• To develop a single, clear and holistic plan that includes the 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	1.16 2.6, 2.10, 2.7 4.3 5.3–5.6, 5.12, 5.13 6.3, 6.4, 6.7–6.11
Element 5: Deliver comprehensive care	• To ensure patients receive coordinated delivery of the total health care required or requested • To ensure the care provided meets the agreed clinical and personal goals of care as described in the care plan	1.16 2.7 5.6, 5.14 6.3–6.11
Element 6: Review and improve comprehensive care delivery	• To confirm the care delivered aligns with the comprehensive care plan • To allow for the revision or modification of the comprehensive care plan and delivery, in response to changes in patient health and circumstances • To review the delivery of comprehensive care and support ongoing quality improvement	1.16, 1.28 2.10 3.6 4.3, 4.10 5.14, 5.19 6.3, 6.7–6.11

Essential elements of comprehensive care delivery

This section defines each element and sets out the underlying principles and actions that consumers, clinicians and organisations can take to contribute to effective comprehensive care delivery.

Element 1: Clinical assessment and diagnosis

The first step in delivering comprehensive care is undertaking a clinical assessment. Clinical assessment should be based on the patient's subjective report of the symptoms and course of the illness or condition, and objective findings from clinical assessment to determine provisional and differential diagnoses.[4]

Diagnostic error has been reported frequently in different types of investigations and research[5], and contributes patient harm.[6] Accurate clinical assessment and diagnosis is crucial to developing a comprehensive care plan that is appropriate, effective and aligned with a patient's lifestyle and wellbeing. Comprehensive care requires clinicians to use thorough clinical reasoning and therefore improve diagnostic accuracy[4], so that the underlying clinical issues are identified and treated and the best possible outcome is achieved.

Purpose

- To evaluate the clinical information and make provisional and possible differential diagnoses
- To determine appropriate investigations and actions required based on the provisional diagnosis
- To prioritise and delegate interventions, timeframes and appropriate escalation processes
- To commence development of an appropriate and effective comprehensive care plan with the patient, families, carers and other support people and the multidisciplinary team.

Principles

- Communication during clinical assessment and investigations is person-centred and tailored to the recipient
- Patients, families and other support people, as identified by the patient, are involved in clinical assessment processes where appropriate
- Clinicians have the skills and capacity to communicate effectively and discuss patient symptoms and conditions
- Evaluation of a disease or condition incorporates the objective clinical findings and the impact of patient's experience of symptoms on their lifestyle to inform comprehensive care planning and delivery
- Clinicians, patients, families and other support people have a shared understanding of provisional, differential and final diagnoses and that it drives comprehensive care planning
- Awareness of the changing information is maintained so that diagnoses are reviewed as appropriate.

Consumer actions

- Patients communicate openly and honestly with their clinician to discuss symptoms and clinical conditions and diseases
- Families, carers and other support people participate in clinical assessment and diagnosis, including discussion of symptoms, when requested by the patient.

Clinician actions

- Clinicians use person-centred approaches to discuss diseases and conditions
- Clinicians consider the patient's level of health literacy, and tailor communication styles accordingly
- Clinicians apply processes of clinical reasoning to reach valid, reasoned conclusions about medical treatment
- Clinicians identify who the patient wants involved in discussions about diagnoses, interventions and care planning
- Clinicians use the information about the provisional diagnoses to inform and drive the comprehensive care plan
- Clinicians document and communicate the outcomes of clinical assessment including provisional, differential and final diagnoses, investigations and the comprehensive care plan
- Clinicians review information as it becomes available, revise diagnoses and incorporate relevant changes to interventions into the comprehensive care plan.

Organisational actions

- Health service organisations foster a person-centred culture in delivering comprehensive care
- Health service organisations specify and communicate a clear process and the roles and responsibilities for supervision of clinicians
- Health service organisations provide access to training and education to support clinical assessment activities and diagnostic processes
- Health service organisations provide systems to capture relevant information for comprehensive care delivery including clinical assessment and diagnosis.

Element 2: Identify goals of care

A focus on patient experience is critical to the delivery of comprehensive care. Talking with patients about their needs and preferences helps clarify what is important to them as an individual. Developing a shared understanding of these things can provide a foundation for trust, and a basis for discussion about healthcare options. Understanding a patient's values and their expectations and aspirations for their health and wellbeing helps to establish their goals for care, and contributes to understanding the actions to be taken.

Identifying and setting goals of care in collaboration with the patient, rather than focusing on clinical goals alone, ensures care is individualised and not only driven by population-based data and outcomes. Nonetheless, clinical issues such as diagnosis, prognosis and risks of harm are also essential to the establishment of effective goals of care. Having a clear, shared understanding of goals of care becomes increasingly important when a patient has complex healthcare issues, such as multiple comorbidities or a life-limiting illness.

Characteristics of the patient, such as their level of health literacy, values, expectations and cultural background can have an impact on the goals of care that people set, and the way in which this occurs. Clinicians and health service organisations need to support patients, families and carers to participate in these discussions and enable them to make effective shared decisions about goals of care.

The process of goal setting involves a number of stages including goal negotiation, goal setting and evaluation. Goal setting tools have been reported to be useful in tailoring and monitoring treatment, improving team communication and clarifying team roles.[7] There are some goal setting tools available; however each instrument has a range of strengths and weaknesses, and no tool has been specifically recommended for use in acute care.[7]

Purpose

To develop a shared understanding of:

- The patient's goals for their health care in the short, medium and long term
- The clinical situation, including diagnoses, treatment options and clinical goals
- The patient's values, needs and preferences about their health and care
- The patient's expectations about the care episode and treatment outcomes.

Principles

- Communication about goals is person-centred and tailored to meet health literacy needs of the patient
- Patients, families, carers and other support people, as identified by the patient, are involved in discussions about goals
- Clinicians have the skills and capacity to communicate effectively to discuss patient goals and preferences
- A shared understanding of the patient's clinical and personal goals drives comprehensive care planning.

Consumer actions

- Patients engage with clinicians and talk about what they want to achieve, and what is important to them
- Families, carers and other support people participate in discussions, including goal setting conversations, when requested by the patient.

Clinician actions

- Clinicians use person-centred approaches to discuss the patient's wishes and expectations
- Clinicians consider the patient's level of health literacy, and tailor communication styles accordingly
- Clinicians identify who the patient wants involved in discussions about goals and planning
- Clinicians use the information about the patient's goals to inform and drive the comprehensive care plan and immediate action that may be needed
- Clinicians document and communicate the outcomes of goal setting discussions.

Organisational actions

- Health service organisations foster a person-centred culture in delivering comprehensive care, including supporting the identification of personal and clinical goals of care
- Health service organisations establish systems and processes that support eliciting and documenting goals of care
- Health service organisations provide access to training and education to support effective communication and person-centred approach to care.

Element 3: Risk screening and assessment

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

The Comprehensive Care Standard requires the use of screening and assessment processes with patients, carers and families. In addition to these general screening and assessment processes, the Standard highlights the need to identify specific risks of harm in the areas of falls, pressure injuries, cognitive impairment, malnutrition, self-harm and suicide, violence and aggression, and seclusion and restraint.

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. While there is considerable variability in how the terms are used, the Commission uses the following terminology:

- **Risk screening**: a short process to identify patients who may be at risk of, or already have a disease or injury. It is not a diagnostic exercise, but rather a trigger for further assessment or action.
- **Risk assessment**: a more complex and in-depth measurement process designed to be completed when required after screening to quantify risks of harm and identify potential mitigation strategies.

The way in which risk screening and assessment processes are used varies within health service organisations, depending on a range of factors, including:

- The hospital context, such as the size, location, type of hospital and patient population
- The available clinical workforce
- The way in which an individual patient has presented, such as through the emergency department, as an elective admission, or as a referral from outpatients, or a doctor's rooms
- The characteristics of the patient, such as their presenting problem, age, comorbidities and social circumstances
- Where they are admitted to, and their treatment pathway, including whether they are a surgical, medical or subacute patient, and the particular specialty they may be under.

The specific processes for risk screening and assessment will vary depending on the combination of these factors. The overall focus is on evaluating conditions and illnesses while also implementing processes to identify and mitigate risks.

Health service organisations can implement different strategies to screen, risk assess and mitigate potential risks of harm to patients. These strategies include using local data to understand and mitigate common risks, developing models of care that mitigate risks to patients in particular wards, using screening conversations to triage patients who may need further risk assessment, and using validated tools to quantify risk.

Purpose

- To gain an understanding of the degree to which a patient might be at risk of harm, or poorer outcomes
- To inform decisions about action the healthcare team needs to take immediately to address identified risks such as specific assessment processes, implementation of risk mitigation strategies, and escalation of care where needed
- To inform the development of a comprehensive care plan with the patient.

Principles

- Communication during risk screening and assessment processes is person-centred, and tailored to meet the health literacy needs of the patient
- Risk screening and assessment policy and processes value the use of clinical judgement
- Organisation-wide risk screening and assessment policies and processes are defined and consistently applied across a health service organisation
- Risk screening and assessment approaches used within a health service organisation consider the patient in a holistic way to understand the personal and clinical factors that affect their risk of experiencing harm
- Risk screening processes are short, dynamic and able to be adapted based on the patient's responses
- Risk screening processes are focused on action and closely link to comprehensive care planning and delivery
- Risk assessment processes are used to quantify risks of harm and identify and implement mitigation strategies that are incorporated into planning and delivery of care.

Consumer actions

- Patients communicate openly and honestly with their clinician about their health and wellbeing, conditions, diseases and the factors in their life that influence their potential risk of experiencing harm, to the extent that they wish
- Families, carers and other support people communicate to clinicians any concerns they may have about the patient's health and care, particularly any recent changes that may increase risk of harm
- Patients, families, carers and other support people use established patient, family and carer escalation processes.

Clinician actions

- Clinicians use person-centred approaches to communication, and consider the patient in a holistic way to understand the personal factors that might put them at risk of harm
- Clinicians use risk screening and assessment processes as a mechanism to take action to tailor care, mitigate risks and improve patient care and outcomes
- Clinicians use the risk screening and assessment approaches and processes that are agreed consistently in their health service organisation
- Clinicians use their clinical judgement to inform decisions about potential risks of harm, and need for action to mitigate risk
- Clinicians take action immediately if there is a high risk to the patient, or their care needs to be escalated
- Clinicians use organisational processes to document and communicate the findings of risk screening and assessment processes and include actions in the comprehensive care plan.

Organisational actions

- Health service organisations foster a person-centred culture in delivering comprehensive care, including supporting risk screening and assessment processes that are person-centred
- Health service organisations identify the risks of harm that are a priority across the organisation, including those specified in the NSQHS Standards
- Health service organisations define and communicate organisation-wide processes for risk screening and assessment of those priority risks, and the appropriate models of care that mitigate those risks
- Health service organisations establish a list of tools for those risks, with tools that are approved for use within the organisation
- Health service organisations describe and communicate the roles and responsibilities for risk screening and assessment in the organisation
- Health service organisations identify key points in healthcare episodes when risk screening may be required (which may include pre-admission, admission, transfer, discharge or if there is a change in the patient's condition)
- Health service organisations identify when risk assessment may be required
- Health service organisations have policies and processes for escalating care of patients who are at high risk of experiencing harm
- Health service organisations define and communicate models of care for high-risk populations
- Health service organisations provide access to training and education to support implementation of organisational risk screening and assessment processes, risk mitigation and escalation of care
- Health service organisations provide systems to capture relevant information for comprehensive care delivery including risk screening and assessment processes including outcomes and actions
- Health service organisations develop processes for patients, families and carers to escalate care and communicate how to activate these processes to patients, families and carers.

Element 4: Develop a single comprehensive care plan

A comprehensive care plan is a single document describing the agreed personal and clinical goals of care, and outlining key aspects of planned medical, nursing and allied health activities for a patient to achieve those goals. Patients only need to have one comprehensive care plan; separate plans are not needed for different parts of health care.

Comprehensive care plans integrate multiple components of health care for the patient by linking agreed goals to desired outcomes. There are a number of key components that should be included to ensure there is a documented comprehensive care plan that addresses the requirements for delivering care to the patient. Information should be together in an accessible format. A comprehensive care plan can also act as a tool to support multidisciplinary communication and prompt the inclusion of appropriate team members in the care of the patient.

When preparing the comprehensive care plan, clinicians need take into account the characteristics of the patient, such as their level of health literacy and cultural background. These factors may have an impact on the way in which patients, families and carers are involved in the planning process and the content of the comprehensive care plan.

The specific content of comprehensive care plans will depend on the setting and the service that is being provided, and the comprehensive care plan may be called different things in different 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 an electronic health record that includes core multidisciplinary information. The type of plan used, what is includes and how it is used will vary depending on the type of service, context and patient cohort.

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.

Element 5: Deliver comprehensive care

Patients will require different health care depending on their individual needs, preferences and goals. It is important that care is provided continuously and collaboratively in line with their diagnoses, agreed goals of care and the comprehensive care plan.

The delivery of comprehensive care should aim to address the health issues the patient was admitted with, and the risks of harm identified, to achieve the agreed clinical and personal goals of care. The process of delivering comprehensive care should include relevant clinical disciplines working together in a multidisciplinary team to achieve this outcome. Patients, families, carers and other support people are also essential for the delivery of comprehensive care, and strategies need to be in place to ensure they are supported to be effectively involved.

The processes to deliver comprehensive care will vary depending on the type of health service organisation and the population served.

Purpose

- To ensure patients receive coordinated delivery of the total health care required or requested
- To ensure the care provided meets the agreed clinical and personal goals of care as described in the care plan.

Principles

- Communication and delivery of the comprehensive care plan is person-centred and tailored to meet health literacy needs of the recipient
- Delivery of care should align with the comprehensive care plan and address the identified clinical and personal goals of care, diagnoses and risks
- Comprehensive care delivery should be multidisciplinary and involve collaboration and effective teamwork
- Comprehensive care delivery needs to be dynamic and responsive to changes in the patient's needs, diagnoses, risks or condition
- Comprehensive care delivery needs to involve patients, family, carers and other support people in alignment with the wishes of the patient.

Consumer actions

- Patients engage as partners in comprehensive care delivery, to the extent that they wish to and as appropriate
- Families, carers and other support people assist in the care of the patient if they choose to and if it aligns with the wishes of the patient.

Clinician actions

- Clinicians deliver care that is person-centred and appropriate to changes in the patient's diagnoses, condition, experience or expectations
- Clinicians work collaboratively in a multidisciplinary team to achieve the patient's goals of care
- Clinicians care for the patient in a dynamic and individualised way, being responsive and alert to changes in circumstances that require modification to the comprehensive care plan and delivery
- Clinicians involve family, carers and other support people in comprehensive care delivery in alignment with the wishes of the patient.

Organisational actions

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

Element 6: Review and improve comprehensive care delivery

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

The way that comprehensive care is delivered should be reviewed at the end of the care episode but it also may need to be reviewed during the episode of care if there are changes in the patient's condition, expectations, needs, diagnoses or prognosis, or if the care plan is ineffective.

The way comprehensive care is delivered needs to align with the comprehensive care plan, acknowledging that health care is an iterative process. The workforce needs to be agile and responsive to changes in the patient's needs and context, and modify and adapt the comprehensive care plan and the way that care delivered to meet those changing needs.

It is also important for the health service organisation to review the delivery of comprehensive care across the organisation and examine variation in practice and outcomes. Understanding variation in comprehensive care can help to target improvement efforts.

Purpose

- To confirm that the health care delivered aligns with the comprehensive care plan
- To allow for the revision or modification of the comprehensive care plan and delivery, in response to changes in patient health and circumstances
- To review the delivery of comprehensive care and support ongoing quality improvement.

Principles

- Delivery of comprehensive care takes a quality improvement approach, and is dynamic and responsive to changes in the patient's health and circumstances
- Review of the delivery of comprehensive care is person-centred, involving the patient, their family, carers and other support people
- Review of the delivery of comprehensive care involves collaboration from the multidisciplinary team
- Review of comprehensive care plans and delivery are timely
- Review of comprehensive care delivery involves revisiting diagnoses, clinical and personal goals of care
- Multiple avenues are available and used to prompt review of the delivery of comprehensive care.

Consumer actions

- Patients communicate and work with the multidisciplinary team to review and revise goals and comprehensive care plans as needed
- Families, carers and other support people participate in and engage with review processes as aligned with the patient's wishes.

Clinician actions

- Clinicians deliver care that is person-centred and appropriate to changes in the patient's diagnoses, condition, experience or expectations
- Clinicians work collaboratively in a multidisciplinary team to achieve the patient's goals of care and communicate changes in the patient's circumstance
- Clinicians care for the patient in a dynamic and individualised way, being responsive and alert to changes in circumstances
- Clinicians involve family, carers and other support people in alignment with the patient's wishes
- Clinicians use multiple avenues to prompt review of comprehensive care delivery.

Organisational actions

- Health service organisations establish policies and processes to review whether the care a patient receives aligns with the comprehensive care plan, meets the patient's needs, and mitigates relevant risks
- Health service organisations provide access to training and education to the multidisciplinary team on the use of the organisation's processes for reviewing the delivery of comprehensive care
- Health service organisations provide systems to capture information on the review of comprehensive care delivery
- Health service organisations periodically review the agreed policies and processes for the delivery of comprehensive care, including for screening, care planning and delivery
- Health service organisations monitor variation in practice and outcomes for comprehensive care and take action for improvement.

Conclusion

The Commission has described a set of six essential elements that are practical components for comprehensive care delivery. These include:

- 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.

Each of these elements contributes to the efficient and effective delivery of comprehensive care. The elements establish the requirements for effective care for a patient. These include engaging and supporting multidisciplinary communication and collaboration; developing agreed pathways for the patient through a shared plan of care; and engaging the patient and their support people in partnerships with the healthcare team to achieve the agreed goals of care.

The elements are closely linked, and follow the trajectory of care planning and review. However, in practice the patient and their care team may need to work in an iterative way, revisiting different elements as their care evolves and their clinical and personal needs and goals change.

Thinking about the planning and delivery of comprehensive care in this way provides a framework for assessing how care is currently being delivered, whether it aligns with the principles and approaches described here and whether there are specific areas where improvements could be made.

The Commission will next develop a set of short guides describing each of the elements in detail, including providing different strategies and approaches that could be used by health service organisations to plan and deliver comprehensive care in this way.

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.[8]

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.[9]

diagnosis: The identification by a medical provider of a condition, disease, or injury made by evaluating the symptoms and signs presented by a patient.[10]

differential diagnosis: a process of weighing the probability of one disease or condition versus that of others accounting for a patient's clinical features. A prioritised list of potential alternate diagnoses

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.[11]

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.[12]

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).

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.[13]

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.[14] Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.[15])

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.[16] 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.[17] 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.[18]

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

provisional diagnosis: a temporary diagnosis which requires further information to confirm or rule out a particular disease or condition. It is the highest prioritised differential diagnosis.

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.[19] 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.[20]

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.[21]

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.[22]

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.

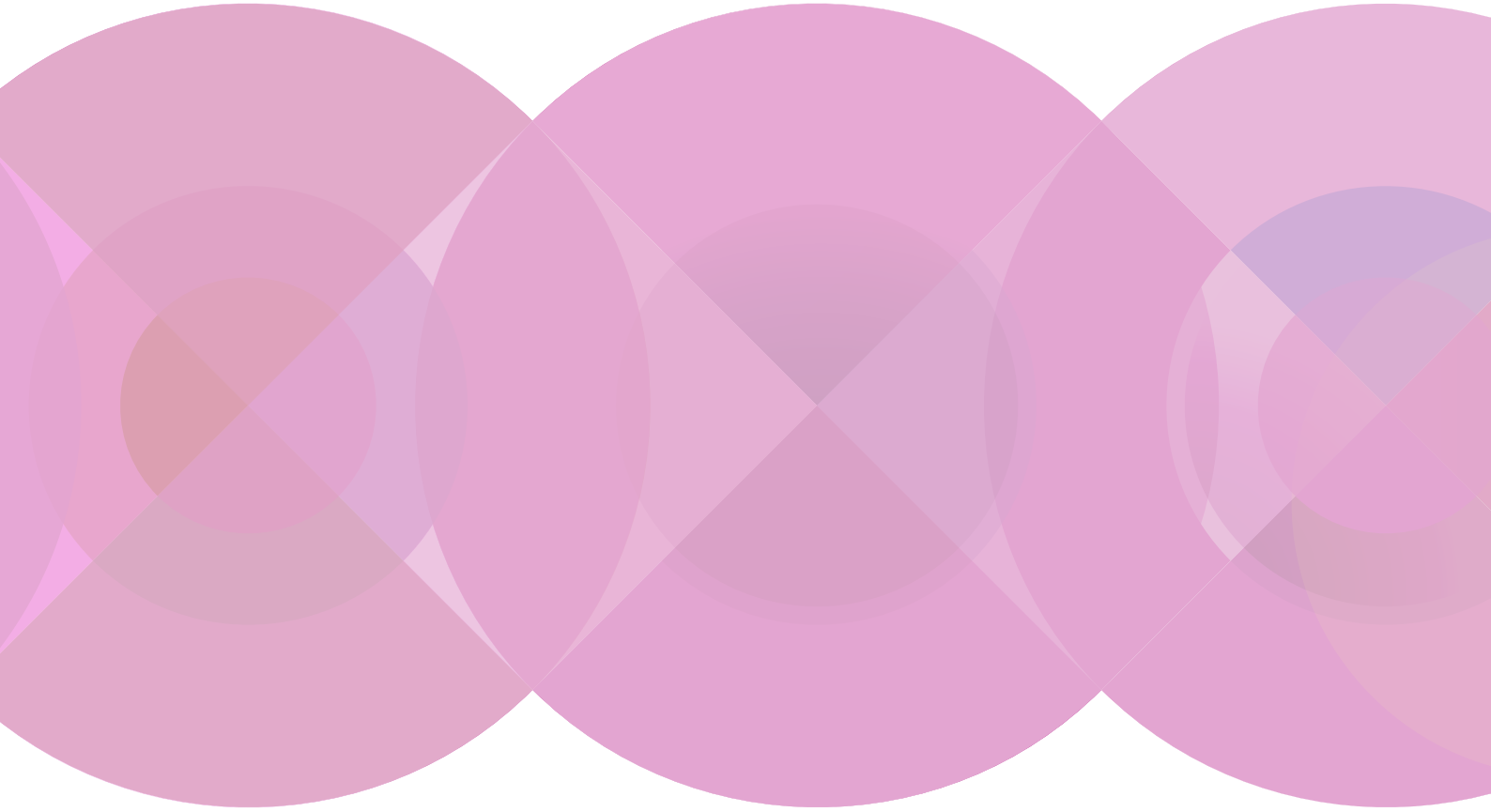
shared decision making: a consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.[23]

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*.

References

1. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney: ACSQHC; 2017.
2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards Sydney: ACSQHC; 2012.
3. Australian Commission on Safety and Quality in Health Care. Implementing the Comprehensive Care Standard: A conceptual model for supporting comprehensive care delivery. Sydney: ACSQHC; 2018.
4. Rajkomar A, Dhaliwal G. Improving diagnostic reasoning to improve patient safety. The Permanente journal. 2011 Summer; 15(3): 68–73.
5. Graber ML. The incidence of diagnostic error in medicine. BMJ quality & safety. 2013 Oct; 22 Suppl 2: ii21–ii7.
6. Singh H, Sittig DF. Advancing the science of measurement of diagnostic errors in healthcare: the Safer Dx framework. BMJ quality & safety. 2015 Feb; 24(2): 103–10.
7. Stevens A, Beurskens A, Koke A, van der Weijden T. The use of patient-specific measurement instruments in the process of goal-setting: a systematic review of available instruments and their feasibility. Clinical rehabilitation. 2013 Nov; 27(11): 1005–19.
8. Carer Recognition Act (No. 123), (2010).
9. Consumer Health Forum of Australia. About consumer representation [Internet]. Canberra: CHF; 2016 [cited 20 April 2016]; Available from: https://chf.org.au/representation.
10. The American Heritage Science Dictionary. Dc. diagnosis. Houghton Mifflin Company; 2018; Available from: https://www.dictionary.com/browse/diagnosis.
11. Australian Commission on Safety and Quality in Health Care. Australian Open Disclosure Framework. Sydney: ACSQHC; 2013.
12. Australian Commission on Safety and Quality in Health Care. Health literacy: Taking action to improve safety and quality. Sydney: ACSQHC; 2014.
13. World Health Organization. Leadership and management. In: Operations manual for delivery of HIV prevention, care and treatment at primary health centres in high-prevalence, resource constrained settings. Geneva: WHO; 2008. p. 264–81.
14. Mitchell GK, Tieman JJ, Shelby-James TM. Multidisciplinary care planning and teamwork in primary care. The Medical journal of Australia. 2008 Apr 21; 188(8 Suppl): S61–4.
15. Discipline. English Oxford living dictionaries [Internet]. Oxford: Oxford University Press; 2015 [11 April 2011]; Available from: https:///en.oxforddictionaries.com/definition/discipline.
16. Institute for Patient- and Family-Centred Care (US). FAQ [Internet]. Bethesda (MD): IPFCC; 2016 [19 April 2016]; Available from: www.ipfcc.org/about/pfcc.html.
17. Australian Commission on Safety and Quality in Health Care. Patient-centred care: Improving quality and safety through partnerships with patients and consumers. Sydney: ACSQHC; 2011.
18. Process. English Oxford living dictionaries [Internet]. Oxford: Oxford University Press; 2015 [11 April 2017]; Available from: https://en.oxforddictionaries.com/definition/process.
19. Batalden PB, Davidoff F. What is "quality improvement" and how can it transform healthcare? Quality & safety in health care. 2007 Feb; 16(1): 2–3.
20. Manias E, Jorm C, White S, Kaneen T. Handover: How is patient care transferred safely? Windows into Safety and Quality in Health Care In: Australian Commission on Safety and Quality in Health Care, editor. Sydney: ACSQHC; 2008. p. 37–48.
21. National Patient Safety Agency (UK). Healthcare risk assessment made easy London: NHS; 2007.
22. Institute for Health Care Improvement. Quality Improvement and Patient Safety Glossary [Internet] Cambridge: IHI; 2015 [9 July 2015]; Available from: http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Tools/QualityImprovementAndPatientSafetyGlossary.aspx.
23. Hoffmann TC, Legare F, Simmons MB, McNamara K, McCaffery K, Trevena LJ, et al. Shared decision making: what do clinicians need to know and why should they bother? The Medical journal of Australia. 2014 Jul 7; 201(1): 35–9.



AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Level 5, 255 Elizabeth Street
Sydney NSW 2000

GPO Box 5480
Sydney NSW 2001

Telephone: (02) 9126 3600
Fax: (02) 9126 3613
NSQHSStandards@safetyandquality.gov.au

www.safetyandquality.gov.au