The Provision of Comprehensive Assessment and Care Planning in the Hospital Setting

Principles Document

1. Purpose and aims

The *Provision of Comprehensive Assessment and Care Planning in the Hospital Setting: Principles Document* (Comprehensive Care Principles Document) has been developed to provide guidance, principles and recommendations for decision-makers and hospital healthcare workers. The purpose of the document is to provide guidance on the expectations of comprehensive care provision in Queensland Health facilities which supports patient's involvement in their care, minimises common complications associated with hospitalisation and ensures that care is person-centred, coordinated and delivered in a holistic manner by the healthcare team as stated in the National Safety and Quality Health Service (NSQHS) Standards - Comprehensive Care Standard. This document will be used to improve and streamline the application of comprehensive care across Queensland Health facilities.

Comprehensive Care is the coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the impact of the patient's health issues on their life and wellbeing, and is clinically appropriate.
(Australian Commission on Safety and Quality in Healthcare, 2017)

The document aims to:

- Highlight the importance of risk screening and assessment processes in identifying potential risks of harm for patients during healthcare provision
- Promote the importance of practical, evidence-based care planning strategies to mitigate the risks of harm identified at admission and arising during the provision of health care
- Emphasise the importance of developing goals of care with patients and care partners through shared decision making processes at initial presentation and throughout the admission
- Promote the importance of providing evidence-based care interventions which are contextualised to the patient's risks, needs, goals, routines and preferences. This will include activities which preserve patient autonomy, dignity and promote patient independence (i.e. fundamentals of care), while reducing risk of harm from complications of hospitalisation
- Reinforce understanding that risk screening/ assessment should not be considered in isolation to care planning and the screens/assessments should lead

to individualised interventions and actions which are integrated within the patient's comprehensive care plan
- Recognise the importance of efficient risk screening and assessment incorporating the use of good clinical judgement rather than reliance on exhaustive screening/assessment tools which are burdensome to the clinician and patient
- Emphasise that interdisciplinary risk screening/assessment processes should be integrated to reduce duplication and fragmentation. These should be completed in a timely fashion and clearly identifiable in the clinical record which is routinely accessed by the healthcare team
- Promote compassionate and coordinated person-centred care for patients, particularly those with complex care requirements

These Principles have been developed in consultation with the Comprehensive Assessment and Care Planning (CACP) Reference Group. The CACP Reference Group represents a broad range of clinicians (including medical, nursing and allied health), quality and safety leads and subject matter experts across the state. The Reference Group met twice in 2021 to discuss the CACP Project and associated Principles.

The CACP Reference Group members represent the following groups:

- Aboriginal and Torres Strait Islander Leadership Team
- Australian Commission on Safety and Quality in Health Care
- Consumers
- Dietetic Nutritionist Strategic Coalition
- Eat Walk Engage Program
- End of Life Project, Healthcare Improvement Unit
- NSQHS Standards Falls Reference Group
- Healthcare Improvement Unit, Clinical Excellence Queensland
- Mental Health, Alcohol and Other Drugs Branch
- Patient Safety and Quality Improvement Service, Clinical Excellence Queensland
- Pressure Injury Prevention Collaborative Strategic Advisory Panel (PIPCSAP)
- Office of the Chief Clinical Information Officer (OCCIO)
- Statewide Dementia Clinical Network
- Statewide Nurse Navigator Network
- Statewide Older Persons Health Clinical Network

This group also has representation from across the following Hospital and Health Services (HHSs):

- Cairns and Hinterland Hospital and Health Service
- Darling Downs Hospital and Health Service
- Gold Coast Hospital and Health Service
- Metro North Hospital and Health Service
- Metro South Hospital and Health Service
- North West Hospital and Health Service
- South West Hospital and Health Service

- Sunshine Coast Hospital and Health Service
- Townsville Hospital and Health Service

These Principles have also been developed through consultation with the following groups:

- Directors of Clinical Governance Group
- NSQHS Standards Falls Reference Group
- Pressure Injury Prevention Collaborative Strategic Advisory Panel (PIPCSAP)
- Statewide Cancer Care Clinical Network
- Statewide Dementia Clinical Network
- Statewide General Medicine Clinical Network
- Statewide Older Persons Health Clinical Network
- Statewide Rehabilitation Clinical Network
- Statewide Stroke Clinical Network

The Principles were endorsed by the Comprehensive Assessment and Care Planning Steering Committee.

2. Scope

The guidance applies to all inpatient services of Queensland Health hospitals. It is designed to inform and support local HHS and hospital policies and has been developed in partnership with consumers. It is not a mandate and does not replace individual HHS/facility decisions and clinical judgement related to specific circumstances or patient groups. **These principles do not address every component of the Comprehensive Care Standard and the National Safety and Quality Health Standards (NSQHS) should be used as the primary resource.**

3. Background

The second edition of the NSQHS Standards includes the Comprehensive Care Standard. This standard requires hospitals to provide person-centred, coordinated, and comprehensive health care that meets patient's individual needs and reduces the risks of harm associated with healthcare. These harms, known as hospital acquired complications, include delirium, falls, pressure injuries, malnutrition and incontinence. It is well-recognised that these complications significantly impact patients through increased mortality and morbidity, reduced quality of life, reduced function, longer length of stays and distress to patients and care partners. In addition, these complications place significant burden on the healthcare system through increased costs of admission, increased medical complexity, increased post-acute healthcare utilisation and considerable financial penalties.

There is good evidence that many complications can be prevented and managed through the identification of risk, and subsequent employment of targeted strategies to mitigate risk which are coordinated by the healthcare team. The risks and targeted interventions have mutual benefit across multiple preventable hospital acquired complications (e.g. encouraging mobility and changing position is important for delirium, pressure injury, incontinence and falls prevention) and therefore it is important to view the patient's care holistically and provide consistent and comprehensive person-centred care.

Work processes around the application of patient assessments to meet all the requirements of the Comprehensive Care Standard are poorly integrated within many parts of Queensland Health. Issues include variations in risk screening/assessment tools used across digital and non-digital facilities, ambiguity in requirements for various clinical areas, differing workflows across the patient journey and transitions of care. There is also a lack of patient and care partner engagment and input into their goals of care and care plans. This results in care plans which may not be aligned to patient priorities and at its worst, failure to incorporate patient decisions including acceptance of risk.

Furthermore, patient risk assessments and plans of care currently available in the integrated electronic Medical Records (ieMR) are numerous and fragmented and do not allow for risk screening/assessments and associated care planning as a combined process. There is also disjointed visibility of clinical information across disciplines resulting in a duplication of documentation and inconsistencies in coordinating a comprehensive approach to care. For example, a patient may be asked the same screening and assessment questions by multiple different clinicians within the first day of admission due to the system mandating repeated screening at each care transition, rather than when clinically necessary or based on clinical judgement. This leads to inefficiencies and burden for both patients, care partners and clinicians and reduces time to provide care to mitigiate the identified risks. Risk assessment and care planning currently relies heavily on the nursing workforce (without other healthcare team member input). There is a perceived low-value on risk assessments by clinicians due to the considerable time taken to perform, overlap of screening tools and lack of action to improve patient outcomes.

The Statewide Comprehensive Assessment and Care Planning (CACP) project was commissioned by the Frail Older Persons Collaborative to perform an in-depth analysis of the current state and problems within digital and non-digital Queensland Health facilities, to identify opportunities for improved workflows and to provide a plan for future Queensland Health work to support facilities in the streamlined provision of comprehensive assessment and care planning.

The CACP project has prioritised the development of the following Principles to ensure consistency in approach and overarching high level expectations of the provision of comprehensive care at a Statewide level. To achieve these ambitious agreed Principles within Queensland Health facilities, considerable work will be required to ensure flexible

standardisation of practices, continuous updates in line with evidence and practice improvement, ongoing stakeholder engagement (including consumer representatives), implementation and change management for clinicians to improve patient experience and outcomes, and better provision of person-centred care.

4. Guiding Principles

The Principles that form the foundation for this document are as follows:

- Comprehensive assessment and care planning is the foundation for the provision of timely, quality, person-centred care
- What matters most to the patient and their care partners' must be identified as essential information by clinicians in the process of developing individualised care plans and should be accurately recorded for future reference within the patient's medical record. This should include but not be limited to their personal history, background, cultural preferences, social context, usual routines, likes and dislikes
- Understanding patient and care partner's goals in care and encouraging their engagement in shared decision making in care planning is fundamental to the provision of comprehensive care. Patients should be provided with the best available evidence about treatment options and care planning strategies appropriate to their health and social needs through understandable communication and are supported to consider and express their goals of care
- Comprehensive assessment and care planning is essential for the care of all patients but should be especially prioritised for those with complex needs. This includes, but is not limited to, those with cognitive impairment, intellectual disabilities, people with frailty and with multimorbidity
- Awareness and understanding of the cultural identity and considerations of all individuals is essential to provide truly person-centred and comprehensive care. This is especially important for Aboriginal and Torres Strait Islander peoples. Additional or specialised risk screening/assessment to inform care planning should be undertaken to ensure that this meets the needs of First Nations peoples. This will be achieved through shared decision making, coordinated and holistic care and works towards achieving health equity
- Processes for assessment and care planning must be efficient. They must free up time for clinicians to provide care at the bedside and minimise duplication, which wastes time and leads to patient and care partner burden
- It is recognised that the cycle of comprehensive care includes screening and assessment, care planning, care delivery, monitoring of care and re-assessment as clinically indicated (e.g. as condition changes or on transitions of care). Monitoring is critical to ensure that the care plan continues to be appropriate for the patient and addresses their current goals and risks of harm

- Screening, assessment, and associated care planning should start at the earliest time available, including in pre-admission assessments or at Emergency Department triage, and updated as clinically required during the care episode
- System level training and audits should focus on implementation and monitoring of care planning strategies rather than completion of risk screens/assessments as it is recognised that assessment without actions does not improve patient care
- Clinicians require better access to previously documented information, to trust the quality of that information and where appropriate validate, update and clarify information rather than frequently repeating questions that may lead to patient and care partner burden

Risk Screening and Assessment:

- An integrated risk screening/assessment tool should be used which prioritises the patient's risks of harm during the delivery of care, but does not view the risks in segregation/isolation
- Risk screening/assessment should directly engage the patient (and/or care partners). Where appropriate, screening/assessment tools may be completed directly by the patient or care partner
- Integrated risk screening/assessment tools should be standardised and endorsed at a Statewide level to inform consistent care across QH facilities, but must remain adaptable to specific patient or contextual needs and responsive to changing evidence
- Screening and assessment should be evidence-based and time efficient, and support use of clinical judgement as a validated method to identify risks
- In certain clinical locations or patient groups, it may be appropriate to consider all patients to be at risk and detailed screening/assessment is not required however care planning must include relevant interventions to address these risks
- Screening/assessment tools must support clinical reasoning and have face validity that they contribute to better patient care

Comprehensive Care Plan:

- Care planning should be individualised to each patient, incorporating their goals/requirements and the context or place of care. Comprehensive care plans include relevant information about the patient and their values, goals and preferences to support care provision and decisions
- Care planning should directly engage the patient, care partners and multidisciplinary clinicians, including those providing longitudinal care (e.g. general practitioner or community services) if appropriate
- As long as patients have capacity to understand the implications of their decisions, they have the right to refuse aspects of the recommended care plan and to determine what risk mitigation actions are accepted. These decisions should be respected and

complied with except where there are clear contraindications to an intervention. This is consistent with the concept of dignity of risk

- Care planning should be informed by and performed at the time of risk screening/assessment. The plan should be monitored and updated as necessary, based on change in clinical condition or the context of care. Care plans form a key part of clinical handover (intra and inter-facility)
- The actions arising from the care plan will usually focus on consistent delivery of the fundamentals of care (e.g. encouraging mobilisation, promoting independence with activities of daily living, support for oral intake and meaningful cognitive engagement), with these being prioritised by the entire healthcare team in line with the patient's routines and preferences
- The care plan must be easily accessible for the entire healthcare team. It must contain key clinical information documented in language understood by all team members, and available in a single view which can be rapidly interpreted to inform care decisions and guide day-to-day care activities. Where practicable, the care plan should be discussed and accessible in plain language format for patients and their care partner
- Care strategies should be evidence-based, sustainable on transfer of care and adaptable to specific patient or contextual needs. Documentation of care plans should be time-efficient and standardised where possible, while supporting clinical reasoning

5. Related Documents, References & Resources

5.1. Standards, procedures and guidelines

- National Safety and Quality Health Service (NSQHS) Standards: https://www.safetyandquality.gov.au/standards/nsqhs-standards
    - National Safety and Quality Health Service Standards, Second Edition
    - Comprehensive Care Standard | Australian Commission on Safety and Quality in Health Care
    - Essential element 2: Identifying goals of care | Australian Commission on Safety and Quality in Health Care
    - Essential element 4: Develop a single comprehensive care plan
    - Action 6.3 | Australian Commission on Safety and Quality in Health Care
    - Shared decision making | Australian Commission on Safety and Quality in Health Care
- Aboriginal and Torres Strait Islander Health Equity Discussion Paper Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples: working together to achieve life expectancy parity by 2031

5.2. Further Reading

- Bennett, P.N., Wang, W., Moore, M., Nagle, C. (2017). Care partner: A concept analysis. *Nursing Outlook*, 65 (2), 184-194.
- Ibrahim, J., Davis, M. (2013). Impediments to applying the 'dignity of risk' principle in residential aged care services. *Australasian Journal of Ageing*, 32 (3), 188-193.
- Kitson, A.L. (2018). The Fundamentals of Care Framework as a Point-of-Care Nursing Theory. *Nursing Research*, 67 (2), 99-107.
- Peel, N., Bell, RAR., Smith, K. (2008). *Queensland Stay On Your Feet® Community Good Practice Guidelines* – preventing falls, harm from falls and promoting healthy active ageing in older Queenslanders. Queensland Health, Brisbane.

6. Definitions

Term	Definition
Patient	A person receiving care or continuing care in Queensland Health hospitals
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 screening	A screen is the minimum process to determine which people are at greatest risk of a condition. Typically, the screen consists of a small number of items (up to five) based on presence or absence of a risk factor
Risk assessment	Assessment is a more detailed and systematic process than screening. It is used to identify modifiable factors that contribute to a person's increased risk of a condition and to develop an individualised plan focused on prevention of the condition. The implicit assumption underlying the concept of assessment of risk is that early detection and intervention (that occurs before overt development of the disorder or adverse event) will lead to a more favourable prognosis or outcome
Care partner	A care partner is an individual who is an important stakeholder in the care of the patient and may assist with decision making or in providing care. This could be a family member, care support worker, neighbour, friend or other support person
Shared decision making	Involves discussion and collaboration between a consumer and their healthcare provider. It is about bringing together the consumer's values, goals and preferences with the best available evidence about

Term	Definition
	benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person
Person-centred care	A person-centred approach is where the person is placed at the centre of the service and treated as a person first. It is care that is respectful of, and responsive to, the preferences, needs and values of the individual patient
Fundamentals of care	These are cares which meet basic human needs such as eating and drinking, personal hygiene, toileting, sleep, mobility and support a person's dignity
Inpatient	A person who lives in hospital to receive care
Dignity of Risk	Dignity of risk is the principle of allowing an individual the dignity afforded by risk-taking, with subsequent enhancement of personal growth and quality of life

7. Version Control

Version	Date	Comments
0.1	05/05/2021	Initial draft
0.2	06/05/2021	Final draft by the CACP Project Team
0.3	01/06/2021	Comments and feedback from the CACP Reference Group were considered by the CACP project team and additional changes were made
0.4	16/6/21	Broader feedback was considered by multiple stakeholder groups and additional changes were made

If you have any questions or feedback regarding this document, please contact the Healthcare Improvement Unit, Clinical Excellence Queensland.