Coordinated Care Planning and Clinical Pathways for Patients/Consumers

Contents

1 Definitions....2
Risk Screening....2
Assessment....2
Approved Clinical Pathway....2
Plan of Care....2
Continuum of Service/Care....2
Needs....2
2 Clinical Pathways....3
3 Plans of care....3
3.1 Contents....3
3.2 Continuum of Care....4
3.3 Processes for evaluation of outcomes....4
Measurement/Evaluation....5
References....5

Policy

Within 24 hours of admission to a service/unit, every patient/consumer will have an individualised care plan developed. A care plan will be used in conjunction with clinical pathways where applicable.

An area/speciality specific risk screen/Initial Assessment must be completed within 6 hours of presentation to a facility

Purpose

This policy ensures a risk screening/assessment is undertaken and plan of care is developed for each patient/consumer to meet his or her individual needs, with agreed outcomes, and ensuring continuity of service across services, service providers, and service levels within the CDHB.

Scope/Audience

All CDHB services admitting patients/consumer (including day patients) as inpatients/consumers.

Associated documents

- CDHB Manual, Volume 2 Legal and Quality - Tikanga Policy
- CDHB Manual, Volume 11 Clinical, Clinical Records Management Policy
- Level 2 and 3 line manuals

1 Definitions

Risk Screening

Risk screening is a process that primarily aims to identify people at increase risk.

Assessment

Assessment aims to identify factors that increase the risk that can be dealt with by subsequent intervention.

Approved Clinical Pathway

A pre-determined plan of care that outlines the standards of care for a particular diagnosis or patient group.

Plan of Care

A planned way to treat and care for a patient/consumer.

Continuum of Service/Care

Provision of co-ordinated service, including treatment and care, across sectors, e.g. community to acute care, rehabilitation to long-term care, acute care to home care.

Needs

Includes physical, mental, emotional, cultural, social and spiritual needs of the population or patient/consumer group served.

2 Clinical Pathways

Clinical pathways must be:

- Authorised by the medical, allied health and nursing managers of the service prior to their development to enable multidisciplinary use and must be time orientated
- Used for all patients/consumer for whom the pathways have been developed
- Multidisciplinary
- Developed in consultation with patient/ their whanau and community agencies
- Reflective of recommended best practice and evidence-based practice where possible
- Able to be overridden if clinicians (medical, nursing, or allied health) deem this necessary for clinical reasons
- Standardised to reduce variation in care
- Used correctly by all staff
- Analysed for unintended, unwanted, or unnecessary variation in care and patient/consumer, system outcomes by the service
- Developed with identified:
  - Variance codes that the service will evaluate
  - Methods to measure those variances
  - Person responsible to undertake the evaluation
  - Frequency of evaluation
  - Key stakeholders to be involved in the analysis
  - Person responsible for Coordinating the action planning arising from the evaluation

3 Plans of care

Plans of care must be:

- Individualised to meet the assessed physical, mental, emotional, nutritional, dietary, spiritual, social and cultural needs of the patient/consumer
- Reviewed and updated to reflect the patients' current condition/circumstances according to service requirements
- Multidisciplinary
- Developed in consultation with the patient/consumer (and where possible the family)
- Reflective of evidence-based practice

3.1 Contents

Plans of care must include:

- Name and designation of multidisciplinary team members principally involved in the plan of care for the patient/consumer
- Details of other service providers and family involved
- Goals, expected outcomes, progress, and outcomes achieved for services and interventions in consultation with patient/consumer and family
- Encompass risk screening management
- Where appropriate, strategies for prevention and health promotion assistance and education
- Expected date of discharge and arrangements to be made for discharge

3.2 Continuum of Care

Provision of service is co-ordinated across the full spectrum of care. Care and service delivery is developed and managed to meet needs

Services/Units will ensure:

- Care is planned and provided in a co-ordinated way to meet the needs of patients and their whanau, using the principles that underpin continuity of care
- Care is planned and provided in partnership with patient/consumer and family, using a multidisciplinary care model
- All relevant information is communicated to providers and other services and organisations in a timely, effective, and confidential manner
- All patient/consumers have documented clinical care plans and/or pathways
- Any changes to service provision are undertaken in consultation with patient/consumer group representatives
- Discharge, transition, and end of service planning is undertaken in collaboration with patient/consumers. This commences as early as possible to ensure a well-planned discharge that will result in an optimal patient/consumer outcome

3.3 Processes for evaluation of outcomes

The CDHB expects that:

- The goals and expected results for patient/consumers are monitored and either achieved or variances are recorded
- Services monitor and evaluate the progress of individual patient/consumers
- Services monitor and continuously improve the outcomes of their services

Measurement/Evaluation

The process will be evaluated through service audit.

References

Close, J. & Lord, S., 2011; Fall Assessment in older people, British Medical Journal retrieved online, April 2012 http://www.bmj.com/content/343/bmj.d5153

New Zealand Public Health and Disability Act 2000

Health and Disability Commissioner Act 1994

Human Rights Act 1993

Privacy Act 1993

NZS 8134:2008 Health and Disability Sector Standards

Policy Owner	CDHB Quality Managers
Policy Authoriser	Chief Medical Officer, Executive Director of Nursing
Date of Authorisation	October 2013