Clinical Care
Policy, Guidelines & Framework

Current Version

Service Area	Disability, Aged, Community	**Version**	1.0
Process Owner	Governance Lead | CEO | COO	**Date of Issue**	May 2023
Approved by	Chief Executive Officer	**Review**	May 2025

Modification History

Version	Date	Author	Approved by	Description of change
1.0	5/2020	Tahla Small	CEO	New policy
1.1				

In conjunction with:

- All National Policies

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Care Planning Policy 2

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Care Planning Policy

POLICY STATEMENT
National Community Care are committed to ensuring all client/participant's and or participant is receiving 'SIL' Supported independent living and/or identified complex clinical care have an individualised relevant care plan within their home. The care plan will include identifying all aspects of required supports by provider, information on the delivery process of the identified supports, medical and health risks identified and information on how these risks are managed.

SCOPE
All employees of National Community Care

POLICY

All SIL/clinical participants will have an individualised, relevant comprehensive holistic care plan developed through reviewing all supporting documentation received by National Community Care through support coordinators, allied health, subjective and objective information, and observations to ensure all supports implemented are meeting the current needs/requirements of the participant.

All care plans will be reviewed 3rd monthly, and/or unless amendments are required before this time. Care plan to be documented on the contents page in between reviews. Information within the care plan remain private and confidential, the care plan is to be stored in a folder and kept within a cupboard or filing cabinet (depending on client/participant accommodation situation), when not in use to maintain privacy and confidentiality.
Participants and their representatives will be invited to attend a six-monthly care planning meeting, this can be held onsite, via telephone, via email, via zoom or skype.

All employees are to adhere to directives within the care plan, unless otherwise advised through informal / formal notification by either a National director or the clinical coordinator.
Emergency management is to be specified within the care plan tailored to the participants health requirements.
All identified risks, hazards identified when developing a participants care plan are to be documented on the client/participants NCC *Risk Profile* and the 'ALL Risk register' (excel) additions are to be notified to National Directors via email correspondence.

Care Planning Procedure

DEFINITION

A care plan outlines the participants care needs, the types of services they will receive to meet those needs, who will provide the services and when. It will be developed by the service provider in consultation with the participant.

PURPOSE

All SIL/Clinical participants will have an individualised, relevant comprehensive holistic care plan developed through reviewing all supporting documentation received by National Community Care through support coordinators, allied health, subjective and objective information, and observations to ensure all supports implemented are meeting the current needs/requirements of the participant.

SCOPE

All employees of National Community Care

PROCEDURE

- Service Agreement is signed by participant providing consent to private and confidential information, prior to initial draft commencing and client/participant risk assessment is implemented with client/participant and support network input.
- Initial draft is to be developed using the National Community Care Template facilitating feedback on any changes / amendments required.
- All care plans are to be developed in partnership with either the participant and or the nominated representatives.
- An initial draft is to be provided via email or print out to ensure all feedback from participant / representative is sought, all feedback and changes are made, and final draft is sent for approval and implementation.
- A care plan folder will be implemented within each participant home, this folder is to be kept onsite, preferably within a cupboard – discussion between participant and National to identify where the participant would like the folder kept.
- Reviewed Care Plans are amended and reviewed and signed off by a senior registered nurse. A comprehensive review of the participant is undertaken, this includes reviewing all incident forms, clinical documentation, feedback from participant or representative, preferences in delivery of services, social participation, a review of the emergency management plans and general service guides.
- Care Planning meetings to be documented in the participant's profile and any action items and outcomes are to be emailed to participant and representatives.
- All items raised are to be reviewed by clinical team, if risks or hazards identified they are to be placed on the 'ALL risk register' and actioned in a timely manner.
- Care Plan review time frames have generalised time frames unless stipulated otherwise. These are as followed:

Community Care Plans

- Care Plans are to be drafted upon commencement of service and reviewed 1 month after.
- Care Plans are then to be reviewed annually, every 12 months OR
- After a hospital admission, or clinically indicated, and/or significant care changes required.

CARE PLANNING	DEVELOPMENT	PRACTICALITY REVIEW	ANNUAL REVIEW	HOSPITALISATION	CLINICAL CARE CHANGES
UPON COMMENCEMENT	✓				
1 MONTH		✓			
12 MONTH			✓		
UPON CHANGE			✓	✓	✓

SIL Complex Clinical Participant Care Plans

- To be reviewed 3rd monthly unless amendments are required prior in which review will be done at this time.
- A six-monthly care planning meeting is to be organised by the SIL Clinical Team and/or Clinical Lead. An invitation is to be sent via email to participant / representatives providing minimum two weeks' notice of intention for a meeting.

COMPLEX SIL CARE PLANNING	DEVELOPMENT	PRACTICALITY REVIEW	CARE PLAN REVIEW	HOSPITALISATION	CLINICAL CARE CHANGES
UPON COMMENCEMENT	✓				
1 MONTH		✓			
3-6 MONTHLY			✓		
UPON CHANGE			✓	✓	✓