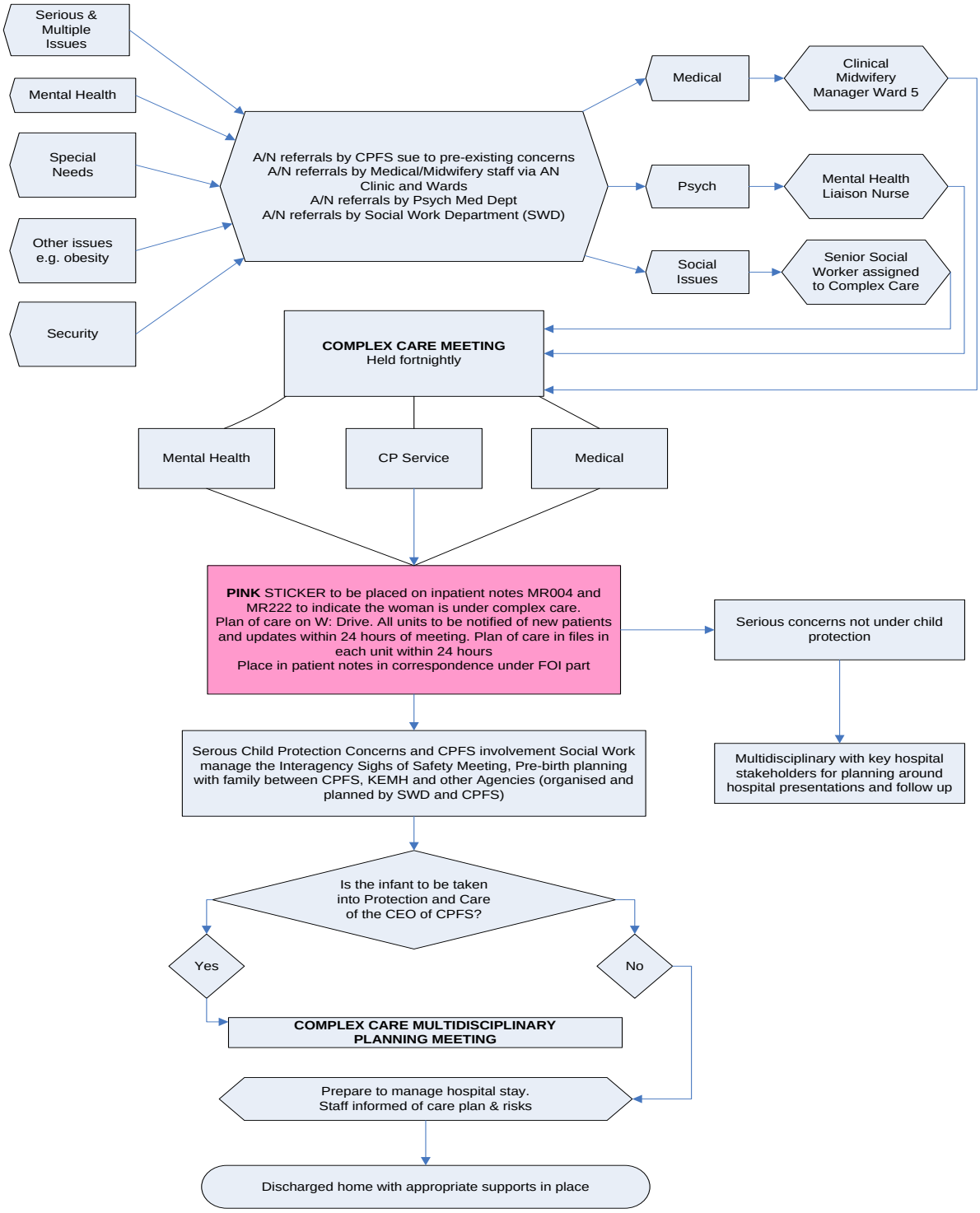
COMPLEX CARE

PLANNING FOR A COMPLEX CARE NEEDS PATIENT AT KEMH



Keywords: Complex care, high risk social work, department for child protection, psychological medicine, referral

PURPOSE

To ensure that the plan for the management of the woman's admission to hospital, including the discharge plan is available to relevant staff when the woman is admitted for care.

BACKGROUND

The purpose of Complex Care planning is to identify and alert staff to the management plan for any woman identified as requiring complex care. The management of the clinical needs of the woman and her unborn child remain the responsibility of the clinical team. When serious child protection concerns are identified, pre birth planning is the responsibility of the Social Work Department. In these cases hospital policy W151 and the Reciprocal Child Protection Procedures which form the basis of the agreement between King Edward Memorial Hospital (KEMH) and the Department for Child Protection and Family Support (CPFS) shall be followed.

THE COMPLEX CARE TEAM

This multidisciplinary team consists of:

- A representative from the Obstetrics and Gynaecology Clinical Care Unit – a Clinical Midwifery Manager.
- A representative from the Department of Psychological Medicine
- A representative from the Social Work Department.

The complex care team meets fortnightly, where referrals of these cases are discussed and the need for enhanced multidisciplinary care or staff awareness is considered.

FUNCTIONS OF THE COMPLEX CARE TEAM

- To identify and alert the relevant hospital staff of high risk and complex patients who are likely to birth at King Edward Memorial Hospital.
- To optimise the management of women with special needs through an efficient and collaborative multi disciplinary team approach.
- To identify those women and / or their family members who may pose management difficulties while in KEMH.
- To identify women whose management may require an interagency planning meeting because of child protection / statutory action by the Department of Child Protection and Family Support when the baby is born.
- To ensure that the plan for the management of the woman, including the discharge plan is available to the relevant staff when the woman is admitted for care.

CRITERIA FOR REFERRALS

- Serious or multiple issues such as
  - Mental health problems
  - Special needs
  - Child Protection
  - Security implications
  - Significant medical problems

REFERRAL PROCESS

Referrals to the Complex Care Team can be made in the following way:

- Psych Liaison- all psychological issues from the Department of Psychological Medicine
- Clinical Midwifery Manager of Ward 5- Medical issues by midwifery/medical staff via antenatal clinics and wards.
- Social Worker- Social issues and when the Social Work Department is alerted by the Department for Child Protection and Family Support because of pre existing concerns.
- Security – issues of security are reported to and noted by the Social Worker.

IDENTIFICATION, REGISTRATION AND DISCHARGE OF COMPLEX CARE PATIENTS

- Those women who are identified as needing complex care planning are entered on to the Complex Care Register (On W drive Obstetrics & Gynaecology folder: Complex Care Planning subfolder) and a brief description of the complex needs and management plan are documented. When women have birthed, their names are removed from the Complex Care Register.

- A pink "Complex Care" sticker is placed in the woman's medical record :

  - the MR 004 (Special Instruction sheet)and
  - on the MR 222 (Antenatal record)

- Following the fortnightly meeting, an email is sent to the Complex Care email list with the updated Register which includes new and updated patients.

- The Hospital Clinical Managers and Clinical Managers/ Clinical Nurse Consultants of each area, including the OSH manager and Head of Security, print out the updated complex care plans for existing and new women from the complex care folder in W.Drive. These updates are to be filed in the Complex Care File of each area.

- The Social Work Representative ensures each social worker receives the relevant updated information according to his/her clinics

- On the woman's admission the shift coordinator shall locate the management plan for the woman (located in the Complex Care file in each area) and follow the plan of care.

REFERENCES (STANDARDS)	
National Standards – 1 Clinical Care is Guided by Best Practice Legislation – Nil Related Policies – Nil Other related documents – Nil	
RESPONSIBILITY	
Policy Sponsor	HoD Social Work
Initial Endorsement	June 2009
Last Reviewed	August 2014
Last Amended	
Review date	August 2017

Do not keep printed versions of guidelines as currency of information cannot be guaranteed.
Access the current version from the WNHS website.