

1.11 COMPLEX CARE

1.11 PLANNING FOR A COMPLEX CARE NEEDS PATIENT AT KEMH

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1.11.1 Planning for a complex care patient at KEMH
Section B
Clinical Guidelines
King Edward Memorial Hospital
Perth Western Australia

1.11 PLANNING FOR A COMPLEX CARE NEEDS PATIENT AT KEMH

AIM

- To ensure that the plan for the management of the woman, 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 shall be followed.

The complex care team is multidisciplinary and 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.

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 patients with special needs through an efficient and collaborative multi disciplinary team approach.
- To identify those patients and / or their family members who may pose management difficulties while in KEMH.
- To identify patients whose management may require an interagency planning meeting because of child protection / statutory action when the baby is born.
- To ensure that the plan for the management of the patient, including the discharge plan is available to the relevant staff when the patient is admitted for care.

REFERRAL PROCESS

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

- When the Social Work Department is alerted by the Department for Child Protection because of pre existing concerns.
- By midwifery staff via antenatal clinics and wards.
- From the Department of Psychological Medicine

- From security.

Criteria for referrals

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

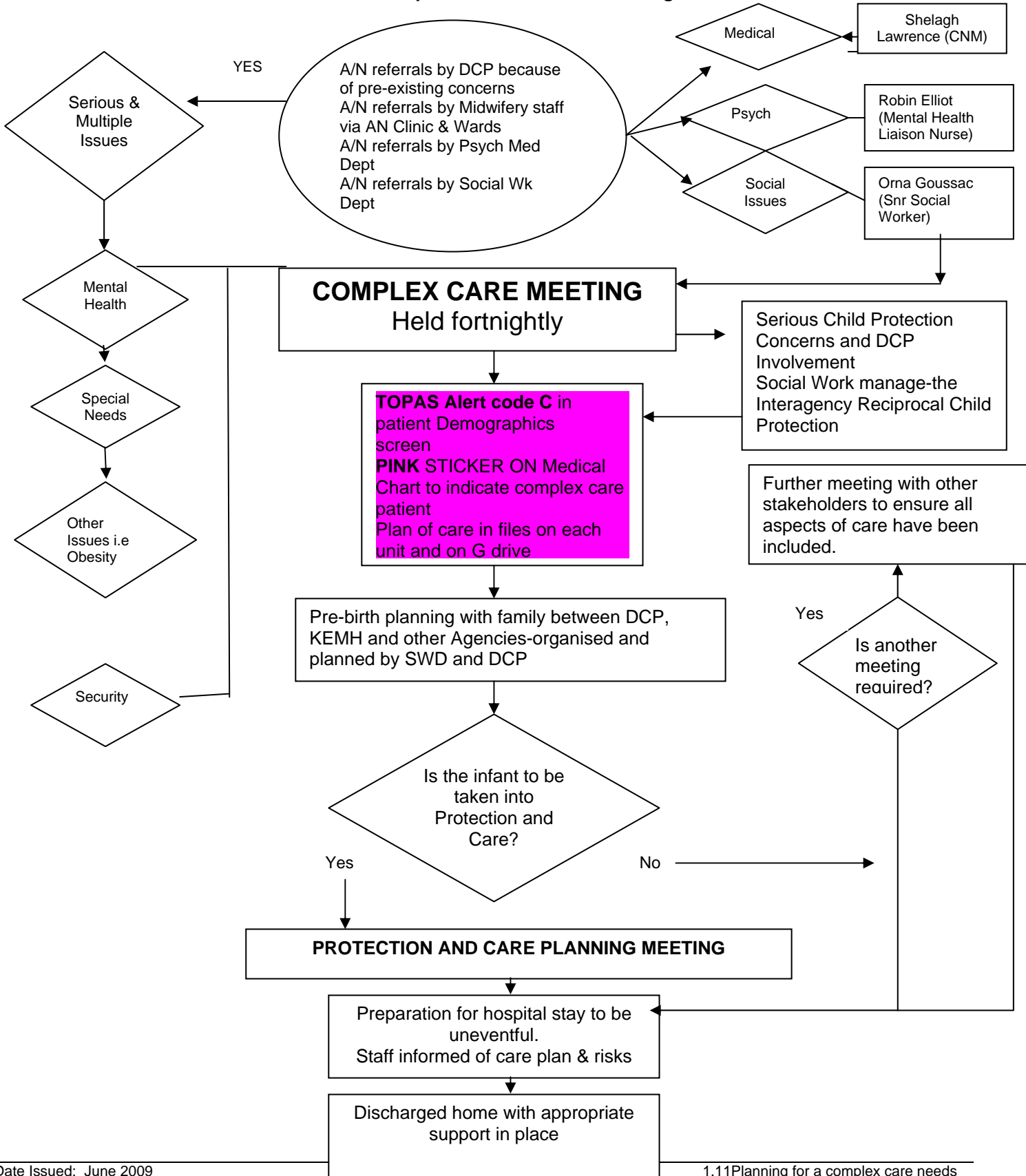
The complex care team meets fortnightly. Referrals of these cases are discussed by the Complex Care Team and the need for enhanced multidisciplinary care or staff awareness considered.

Identification, registration and discharge of Complex Care Patients

- Those women who are identified as complex are entered on to the Complex Care Register (On G drive OBGYN/AE folder: Complex care subfolder) and a brief description of the complex needs and management plan are documented.
- A pink "Complex Care" sticker is placed in the woman's medical record on the MR222 (Antenatal record) and the MR 004 (Special Instruction sheet).
- A complex care alert is entered into TOPAS (code 'c') on the Patient Demographics screen in the Special Indicators field. The clinical midwifery manager representative / team secretary have the responsibility for entering the alert on TOPAS.
- On admission: The admitting clerk must inform the nurse / midwifery manager of the area (in hours), the hospital clinical manager (out of hours) and the shift coordinator of the area that the woman is a complex care patient.
- 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.
- Following discharge the complex care team (at the next meeting) will remove the woman's name from the register and remove the alert from TOPAS

See flow chart on next page

Flow chart for Complex Care Referral and Management



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