CLINICAL PATHWAYS

Therese Oates
Nurse Manager Clinical Redesign

Great State. Great Opportunity
Clinical Pathway - definitions

» Clinical pathways are standardised, evidence-based multidisciplinary management plans, which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for an homogenous patient group (Queensland Health Clinical Pathways Board definition 2002).

» Clinical pathways are associated with reduced in-hospital complications and improved documentation. (Cochrane review 2011)

Primary function - Provide a written document of patient/client goals and outcomes and staff interventions at agreed intervals.
Critical components of CPW

1. Be a structured multi-disciplinary plan of care

2. Be used to translate evidence based guidelines, clinical consensus and patient expectations into local structures

3. Chronological list of activities to be performed by the multidisciplinary team or patients and their families – grouped under headings

4. Include timeframes &/or criteria-based progression - PATIENT OUTCOME FOCUSED

5. Variance recording - to allow deviations to be documented, reported and acted upon when necessary.

6. Facilitate standardised patient care guided by clinical evidence/consensus standards of practice and patient expectations

What is a clinical pathway? Development of a definition to inform the debate Leigh Kinsman†1, Thomas Rotter†2, Erica James†3, Pamela Snow†4 and Jon Willis†5Kinsman et al. BMC Medicine 2010, 8:31 http://www.biomedcentral.com/1741-7015/8/31
Orientating to the Clinical Pathway

- Title & expected length of stay
- Patient details

- Overview of care pathway
- Reference to using organisational guidelines

- Exclusions to the clinical pathway
  - This highlights patients to be excluded

- Date of admission and expected date of discharge
- Accompanying documentation to sit with the pathway at the bedside

- Signature log for all team members to complete

- Highlights routine/mandatory care requirements required for each patient.
- Signature represents routine care provided for each shift, against routine care elements and nursing mandatory requirements.
- Signatures for variances and achievement of expected patient outcomes are recorded separately.
Phase of care – identified along dark blue banner

Represent a breakdown of expected milestones for the patient throughout admission

Care elements mapped within phase of care

Group activities to be performed are under headings

Ensure links to National Standards and local policies/guidelines/procedures

Consider red flags to highlight critical considerations/actions

Discharge planning – considered from admission

Signed off as outcomes within phases or linked to discharge phase at end of document

Expected outcomes of care for that phase – milestones to achieve

Criteria-based progression – patients progress to next phase when outcomes achieved

To be signed when achieved or if not achieved within that phase nominate a 'V' for variance and document on details on the variance page
- Discharge planning requirements criteria outlined either as:
  - outcomes within phases or
  - outcomes on separate discharge planning phases
- Staff to sign off on date completed (as guided within phases) – under

- Post operative education plan (where possible link to established parent education brochures/resources)

- Establish if criteria led or medical led discharged

- Discharge criteria – agreed criteria to be met by patient
- Establish if criteria led or medical led discharged

- Sign and date discharge
What is variance?
A deviation from an expected action of care. Can be classified as…

<table>
<thead>
<tr>
<th>Positive</th>
<th>- where a patient is ahead of the pathway (e.g. recovers more quickly than allocated timeline)</th>
</tr>
</thead>
</table>
| Negative      | – where an expected action in care cannot take place. This may or may not have an impact on patient overall care.  
                NB: sometimes it may be so extreme that it required the patient to be removed from the care pathway (e.g. A medical emergency leading to an intensive care transfer) |
| Avoidable     | – An occurrence that has not affected care with more planning could have been avoided |
| Non avoidable | – Planning could not have prevented and includes those occurrences which are outside immediate control |
What should a variance look like?

- State the description of the variance

<table>
<thead>
<tr>
<th>Description of variance</th>
<th>Action taken</th>
<th>Interventions/outcome required for ongoing care</th>
<th>Date</th>
<th>Time</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient not tolerating fluids</td>
<td>Dr Jones notified and patient reviewed</td>
<td>• NBM- recommence IVT</td>
<td>12/8/2014</td>
<td>1325hrs</td>
<td>OD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Abdo X -Ray booked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• remove NGT tube</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Commence light diet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient tolerating diet day 1 post surgery and has good bowel sounds</td>
<td>Dr Jones notified and patient reviewed</td>
<td></td>
<td>10/7/2014</td>
<td>0900hrs</td>
<td>RLB</td>
</tr>
</tbody>
</table>

Clear actions to:
- escalate concerns
- Or
- Outline progression

Outline of required interventions
Commonly Asked Questions???

1. Do we have to document in the patient medical record as well?
   › No - the clinical care pathways provides written documentation of care

2. When might I need to document in the medical record
   › only where there is a requirement to document more comprehensive notes for specific reasons e.g. social issues, complex variance that requires patient to be removed from the pathway

3. Who can sign the phase outcomes
   › Any member of the multidisciplinary team

4. Who initiates a Clinical Pathway?
   › Anyone of the multidisciplinary team
Tools to support Pathway development

- Clinical Pathway Procedure available
- Blank pathway template & Gantt tool
- Spreadsheet for service division tracking
- Template for individual project plans linked to organisational leadership program
- Links and assistance with literature searching and pathway development (Clinical Redesign team)
- Intranet – Easy access and navigate ‘go to’ site - planned
- ieMR-( alignment) – ongoing
Prepare; Diagnose; Design; Implement; Sustain

**Prepare**
- Identify need for CPW
- Confirm variation in current practice
- Identify gap between evidence and practice
- Gain Divisional Director Sponsorship
- Establish Working Group
- Develop Plan

**Diagnose**
- Divide treatment/recovery into Phases
- Draft CPW of existing care
- Research evidence
- List relevant NSQHS Standards
- Perform Gap Analysis

**Design**
- Schedule meeting and circulate documents
- Hold Working Party meeting
- Submit draft CPW for publication
- Circulate draft to Key Stakeholders
- Collate feedback to create trial version
- Submit for publication
- Gain Divisional Director sign off
- Submit to PSQS with signed PMF 2

**Implement**
- Liaise with NUM's NE's CNC's & CPF's
- Create Education Plan
- Create communication Plan
- Educate Staff
- Implement 3 month trial
- Audit & Collect feedback from users
- Publish final version & gain Director sign off

**Sustain**
- Audit CPW 6 monthly and feedback to users
- Review CPW 2 yearly and when necessary
Clinical Pathway variance analysis

» Variance analysis evaluation –
✓ Family audit (n = 15 in pilot phase)
✓ Staff evaluation tool
✓ Documentation compliance
✓ Information and streamed variances
✓ Achievement of SMART outcomes established in early part of drafting the pathway
✓ Audit responsibility linked to local clinicians with loop to Divisional Directors re ongoing variances
CLINICAL PATHWAYS PILOT LAUNCHED

- PILOT FOR 15 ADMISSIONS
  - Feedback via:
    - NUM -huddles or email
    - Educator –daily round/ or email

A massive thankyou to all the team on launch day and SPECIAL THANKS TO POVSTAR for the awesome T-Shirts……..you rock Pov thanks so much!!
Questions