Clinical Pathways
Frequently asked questions

Clinical Pathways Defined

A clinical pathway is a document outlining a standardised, evidence-based multidisciplinary management plan, which identifies the appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogenous patient group. (Quality Improvement and Enhancement Program, Clinical Pathways Board: 2002).

How do clinical pathways fit into the strategic direction of Queensland Health

Strategic

Implement the HSCID strategic direction by engaging clinical leaders and the clinical workforce through the provision of advice and guidance on clinical improvement models to senior clinicians, Queensland Health Staff and other stakeholders.

Support HHS to comply with the National Safety and Quality Health Service Standards in their drive to implement safety and quality and improve the quality of health care within Queensland.

Tactical

- Forge strong links with clinical networks and local clinicians to encourage and spread innovative models of care
- Collaborate with clinical networks to identify gaps in clinical practice, and develop evidence based tools to guide practice.
- Receive recommendations from root cause analyses, HQCC and Coroner on standardising clinical practice
- Provide advice on and develop tools to assist compliance with national clinical standards.

Operational

- Point of service for the development of state-wide clinical pathways
- Facilitate clinical pathways working groups and promotes standardised care pathways
- Establish expert groups to develop clinical pathways
- Maintain links and liaise with HHS to implement and educate on new pathways;
- Research and seek approval from groups on international/national best practice on which to base pathways
- Horizontal bridging with Queensland Health Divisions and Units and forging strong links between HHS on matters relating to clinical pathway development and implementation
- Maintain current suite of clinical pathways on the Queensland Health internet site

Why have clinical pathways?

Supports the Clinical Excellence Division responsibility to drive quality and clinical improvement agendas through the facilitation and dissemination of best-practice clinical standards and processes that achieve better outcomes for patients.

What is the background to Queensland Health endorsed Clinical Pathways?

Clinical Pathways support the implementation of the HSCID strategic direction by engaging clinical leaders and the clinical workforce through the provision of advice and guidance on clinical improvement models to senior clinicians, Queensland Health Staff and other stakeholders.

Support HHS to comply with the National Safety and Quality Health Service Standards in their drive to implement safety and quality and improve the quality of health care within Queensland.

Historically, since 2004 significant redesign of clinical processes has resulted in a reduction of variation in clinical practice. This has been facilitated by the adoption of a standardised approach to the development and implementation of clinical pathways for selected patient groups. It builds on the work undertaken during various quality, safety and improvement initiatives implemented within Queensland Health.

This approach has seen as an important means of ensuring that best practice processes are incorporated and consolidated into usual daily clinical practice at point of care.

What is the difference in format between other Clinical Pathways and the Queensland Health endorsed Clinical Pathways?

There are critical components included in the format for Queensland Health endorsed clinical pathways that have not always been included in the past. These are:

- Evidence base
- Interdisciplinary approach
- Clinician driven
- Continuum of care context
- Variance analysis
- Review process
- Patient education

A development process includes a process of documentation by exception by removing the need to duplication of effort in repetitive documentation. The format complies with the following Australian Standards:

AS 2828.1 2012 Health Records paper based health records

AS 2828.2 2012 Health Records (digitalized) scanned health record system requirements

Approval of the format was initially approved by the Clinical Pathways Board (2000) and relevant updates and subsequent changes endorsed by the relevant Clinical Network and Patient Safety Sponsors. This demonstrates that the documents are a living document and under constant review as clinician requirements recommend.

What is the definition of a clinical pathway?

A clinical pathway is a document outlining a standardised, evidence-based multidisciplinary management plan, which identifies the appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogenous patient group. (Quality Improvement and Enhancement Program, Clinical Pathways Board: 2002).

What are the aims of clinical pathways?

The aim of the clinical pathway is to:

- support the implementation of evidence-based practice
- improve clinical processes by reducing risk
- reduce duplication through the use of a standardised tool
- reduce variation in health service process delivery

How do I know that clinical pathways are current?

Clinical pathways are reviewed each 24 months or as required when clinical evidence changes or an emergent issue arises that requires a change the clinical pathway content. The review process is managed by the clinical pathways team within the Healthcare Improvement Unit in the Healthcare Innovation and Research Branch within the Clinical Excellence Division.

What supports can the Clinical Pathways Team provide to the HHS?

Monitoring: The CPT is able to assist the HHS with education and support for implementation of clinical pathways.

Variance Management: Development of tools for auditing of clinical pathways and variance management analysis.

Education: An education program has been developed for use within HHS and this is available through the i-learn platform.

How much do clinical pathways cost?

Clinical Pathways are either printed in hard copy and stored at the printer for you to order through your normal procurement processes or directly printed from the website.

Printed pathways are ordered through your normal procurement processes.

How do I order clinical pathways?

Printed pathways are ordered by using the ordering process available at http://qheps.health.qld.gov.au/caru/clinical-pathways/.

Can care be changed or varied during the course of treatment whilst the patient is on a Clinical Pathway?

There are no restrictions of treatment choice for the patient and clinician. It is always important to provide care that is tailored to suit the individual patient based upon the best practice evidence available. The clinician's continuous assessment and review of the patient while the patient is under their care determines whether the care provided needs to be varied. When care needs to be varied, the variance is documented during the course of the clinical pathway.

Each clinical pathway states:

Clinical pathways never replace clinical judgement. Care outlined I this pathway must be altered if it is not clinically appropriate for the individual patient.

Do Clinical Pathways affect Medical Liability?

Clinical Pathways are developed to demonstrate the following:

Documentation that patient education and expectations have been achieved

Variations to care are documented with assessment undertaken and the reasons for variation and outcomes of actions undertaken

Expert panels have assessed the content of the pathway

A full literature review has been undertaken and the process of review has been developed

The document itself provides expert opinion/guidelines for care and patient expectations in a logical, legible presentation. The care outlines in the clinical pathway is based on the best available evidence at the time of development.

If the care processes outlined in the document has not been completed this variation in care should be documented as a variance and backed by sound clinical judgement. Clinical judgement is the responsibility of each individual clinician. If an activity is contraindicated for a particular patient then the pathway would be customised accordingly.

Clinical pathways are a multidisciplinary tool so that all care providers can assess it and encompasses the full continuum of care for that admission episode. The tool itself has been developed with input from the multidisciplinary team.

What are the benefits of using a Clinical Pathway?

- evidenced based care
- standardisation of care
- reduction in documentation (documentation is by exception only)
- patient outcome focused
- standardisation of reporting systems (in the future)
- all documentation in one area in medical record
- easy to identify gaps in care
- multidisciplinary
- tool for further clinical and epidemiological research
- decrease risk of patient complications and readmission

- decreases errors
- enhances patient education
- improves patient experience and satisfaction
- enhanced legal advantage and reduces liability

What are the liabilities of using a Clinical Pathway?

Evicence needs to be reviewed to ensure that it is current. Each Statewide clinical pathway is routinely reviewed each two years as required.

Without adequate clinician education, effective use of the clinical pathway may be at risk. The CPT will provide education workshops at the request of facilities.

Documentation is done now – why change?

Traditionally, patient care is recorded in handwriting in the medical chart as progress notes. Writing descriptions of all care processes carried out in the patient journey can be extensive and time-consuming.

Clinical pathways are based on the best evidence available and are designed to capture all aspects of care. Patient care follows an expected process flow of care throughout the care continuum, eg. frequency of observations, necessity of routine pathology. Clinical pathway documentation and processes provide clinicians with the opportunity to improve patient experience and care provision by reducing the amount of handwriting done by traditionally documenting all components of care as outcome statements.

Further, clinical pathways reduce paper bulk and documentation time (particularly in nursing and allied health). In nursing, for example, there is no need to “write up the charts” for patients on pathways at the end of the shift. Documentation is done simply and quickly, in real time as care is given. Clinical pathways have also proven to be useful guides for clinicians, in particular new graduates who have had limited exposure to particular specialities, and staff who for whatever reason are not working in their usual workplace.

Statewide clinical pathway design and data collection, together with a variance management system lends itself to clinical and epidemiological research and evaluation by providing a baseline of expected care. Variance management measures the exception to that care. By using a quality management methodology, variance from the clinical pathway can be later analysed to examine whether there is a needfor change in practice or whether care delivered is effective, eg. early feeding or mobilisation without adverse events. Accessing clinical process information for study purposes is facilitated and more accessible as all care that is provided is available in one document for study, increasing the possibilities of positive improvements to care.

Storage of information and accessibility to information are important factors in care. Once health care workers are familiar with the design and process of using the clinical pathway document, medical information is easier to find within the medical record.

An outcome-based record of care provides a robust legal defence. Clinical pathways are based on evidence and as such provides expert advice for care. The lack of rigorous documentation may increase the risk of action being brought against a clinician. Another aspect of the clinical pathway is that the treating clinician is the one who actually signs the document. The document itself is clear, legible and simple with a signature log clearly identifying the care provider, all legal requirements of a medical record.

Is technological support required?

The Clinical Pathways Team (CPT) will continue to support the HHS with education, document design, printing arrangements and the supporting evidence base for Statewide endorsed clinical pathways. The CPT is continuing to investigate opportunities for automated processes of variance analysis of clinical pathways and the management of variance reporting.

Is there any evidence of the effectiveness of Statewide Clinical Pathways?

Yes. Numerous studies have been undertaken on the efficacy and use of clinical pathways. For a copy of any evidence, please contact the clinical pathways team. An evidence base will be provided to support each clinical pathway.

How often are Statewide Clinical Pathways updated?

Clinical pathways are reviewed each 24 months or as required when clinical evidence changes or an emergent issue arises that requires a change the clinical pathway content. The review process is managed by the clinical pathways team within the Clinical Access and Redesign Unit.

Is there a Clinical Pathway for all conditions that may present to Queensland Health facilities?

The short answer is no. For those conditions that have a clinical pathway please see the clinical pathways website.

For these patients, it is generally recognised that clinical pathways generally best fit 70% of a particular diagnosis related group. Patients outside this group usually have extensive health issues or co-morbidities to preclude them from having their care documented using a traditional clinical pathway. If the patient does not or cannot move through clearly-defined or expected phases during their continuum of care because of other factors; then other care management plans should be put in place eg generic care plans. Other courses of action can be developed to manage variations to care. These pathways may be depicted as algorithms, protocols and management plans.

Are complimentary pathways available?

Protocols are used to provide decision support for specific presentations to Emergency eg chest pain. Management plans are a brief document that outlines the daily specific management for a condition. Management plans can be used with or without its complementary clinical pathway. For example a management plan can be used for a patient with multiple co-morbidities to guide the care for that particular condition and a generic care plan can be used to document other treatment required.

How do we get further printing done?

All Statewide clinical pathways are available and ordered through Office Max using your local ordering processes. This has been arranged in order to ensure high quality documents are being produced and the latest versions are always available. If you have a special request please contact the CPT.

Do you have clinical pathways for download and print?

Some low use and one page clinical pathways are available for download and print. These are located on the clinical pathways website. **http://qheps.health.qld.gov.au/caru/clinical-pathways/**

Can we change the Statewide Clinical Pathway?

Yes. At the point of care, patients requiring individualised care for issues that are specific to them may require alterations to their care. To alter the Clinical Pathway and record the variance the clinician needs to: write the rationale on the free text/clinical event page cross out the care item that is not applicable • write the appropriate care. Statewide Clinical Pathways are living documents and, as new evidence is published or feedback is received from the user groups and expert panels updates can be incorporated as part of the bi-annual review process. Regular user group forums can inform the review process.

Where can I find out further information on developing pathways?

Go online at: http://www.health.qld.gov.au/caru/pathways/default.asp

What is a variance?

A variance is defined as any difference to the proposed standard of care outlined in the clinical pathway.

What is a variance management system?

For variance management to have an impact in clinical care, it should be managed as a whole system. It is not enough to just collect the data. Information gleaned from this data collection should be fed back to a high level decision making group. This group can then use a systems approach to collect analyse and report on data to measure performance and examine ways of improving that performance. This continuous improvement methodology ensures that the best outcomes for patients can be achieved in a continuous quality cycle.

How do I document a variance?

If a care outcome has not been achieved it is called a variance. This is documented by using the letter **V**. The **V** indicates that a variation from the pathway has occurred on that day. When applicable flag it in the "Variance Column", then document in the free text area as instructed. (The free text area is also known as free text / clinical events/variance page). If this variance occurs more than once daily, document the additional times of the variance in the variance free text area and in the patient's progress notes as applicable. The treating clinician is then expected to go to the variance page to complete the entry.

Document the relevant Code; describe the Variance (V), any Actions (A) taken and Outcomes (O) as they occur.

For example write

- **V** Patient states they are nauseated
- **A** Antiemetic given as ordered, medical officer notified
- **O** Medical officer reviewed patient, medication order changed, patient placed on clear fluids only

What is documentation by exception?

The Clinical Pathway documents the planned process outcomes as described in the evidence. This information covers what clinicians would normally write in the chart. As the normal process of care is documented (typeface) and signed; there is no legal reason for it to be documented in progress notes by hand. That would be duplication. The only documentation requirement then is where the Clinical Pathway doesn't cover that care. This is relevant when patients deviate from the process of care; this is called a variance. Documentation by exception is the process for capturing unprinted data/care.

How do I complete the documentation in a clinical pathway?

An **Initial** indicates that the action or care that has been ordered is administered.

N/A indicates that the preceding care/order/phase is not applicable

Crossing out indicates that there is a change in the care outlined. Where the care is not required or not applicable nearly draw a line through that phase of care.

Need more information:

Please contact the Clinical Pathways Team

Clinical_pathways_program@health.qld.gov.au