Definition of a Queensland Health Clinical Pathway

“A document outlining a standardised, evidence-based, multi-disciplinary management plan, which identifies an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogeneous patient group.” (Quality Improvement and Enhancement Program (QIEP) Clinical Pathways Board 2000)

What is the Background to Queensland Health endorsed Statewide Clinical Pathways

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 statewide approach to the development and implementation of clinical pathways for selected patient groups, and builds on the work undertaken during the Quality improvement and Enhancement Program.

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

A statewide approach ensures that clinicians are supported to improve quality, efficiency and to provide appropriate care in a sustainable way.

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

There are critical components included in the format for Queensland Health Statewide Clinical Pathways that have not been always included in the past. These components include demonstration of the:

- evidence-base
- interdisciplinary approach
- continuum context
- variance analysis
- review process
- and patient education.

The Statewide Clinical Pathway document format was developed to support documentation by exception removing the need for repetitive documentation. The format complies with the Australian Standard for Paper-based health care records (AS2828-1999) and the Queensland Health Clinical Form Design Standard / Guidelines.

Approval of the format has been through a formal signoff process by the Clinical Pathways Program Board (2000). The documents have undergone several reviews,
upgrading them, which demonstrates they are living documents and under constant review.

For more information on how Clinical Pathways were developed please contact us via: http://www.health.qld.gov.au/psq/pathways/

**How are Statewide Clinical Pathways developed?**

The Clinical Pathways and Systems Design Team (PSQ) manages the development and implementation of Statewide Clinical Pathways and the framework for development and implementation.

Clinicians who believe that a need for a Statewide Clinical Pathway exists should approach the relevant Statewide Clinical Network or contact the PSQ Clinical Pathways & System Design Team by e-mail at PSQ@health.qld.gov.au

**Have the Statewide Clinical Pathways been validated?**

Expert panels are sourced via Statewide Clinical Networks and are involved in the signoff of supporting evidence and document format design for Statewide Clinical Pathways. 2008/09 saw the re-establishment of panels of expert clinicians where there is no network to endorse the Statewide Clinical Pathways.

**What are Statewide Clinical Networks?**

Since 2007 Statewide Clinical Networks have been established for a range of areas. Statewide Clinical Networks are a multidisciplinary, statewide collaboration of staff who share the common goal to improve services. They undertake problem definition to identify key priority areas including identification of the need for development of Statewide Clinical Pathways.

**What evidence is used to validate the content of a Statewide Clinical Pathway?**

Full database searches are conducted including but not limited to Medline, Cochrane Library and CINAHL. The search criteria includes conditions; procedures and individual aspects of care related to the targeted DRG’s as well as extended searching on critical / clinical pathways / care-paths.

Articles are graded according to the NHMRC evidence scale. If external Clinical Practice Guidelines exist for the clinical area a check is made to ensure evidence scales have been used eg SIGN, National Heart Foundation and National Stroke Guidelines.

Some well recognised guidelines (NICE, SIGN, NHMRC) have been used to support the pathways without requiring additional rework. The supporting evidence documents will be available to clinicians on the QHEPS Intranet site or on request to the Clinical Pathways & Systems Design Team.

**Who is on the expert panel/Board?**

Where there is no statewide network a clinical expert panel will be established to review evidence and endorse the Clinical Pathway for use statewide. An expert panel consists
of clinicians from all streams involved in the clinical care of the patient, including allied health, consumers, medical officers and nursing officers. The expert panel is listed on each of the supporting evidence documents.

**How are Clinical Pathways sustained in Queensland?**

Since the Queensland Public Hospital Commission of Inquiry (Davies Commission) and the Queensland Health Systems Review (Forster Review), Queensland Health is more strenuously committed to evidence based practice and standardisation of care.

The Clinical Practice Improvement Centre (CPIC) was established in 2005 with the merger of three quality improvement programs undertaken by the Quality Improvement and Enhancement Program (QIEP).

Queensland Health recognises the importance of clinical safety, quality and sustainability.

In 2010, the Clinical Practice Improvement Centre and the Patient Safety Centre realigned to form the new Queensland Health Patient Safety and Quality Improvement Service (PSQ).

Statewide Clinical Pathways are sustained by:

- **Monitoring** - District uptake of Clinical Pathways is done by the Clinical Pathways and Systems Design Team. The team provides educational support and periodic review of the format and evidence embedded in the Statewide Clinical Pathway.

- **Variance Management** is also an important element of that commitment. Periodic survey across the state will help to inform PSQ of District needs and ensures that the goal of PSQ to continue to assist with future spread and sustainability of Statewide Clinical Pathways is achieved contributing to the overall goal to maximise best-practice outcomes and minimise patient harm.

- **Education** the Clinical Pathways and System Design project team developed an on-line learning package that is currently under review. The previous on line learning tools have been well received by clinicians. Clinical Pathway awareness through undergraduate health courses further enhances the smooth transition towards clinical pathway processes and documentation.

**Who pays?**

The Clinical Pathways and Systems Design Team negotiate printing arrangements with a preferred printer for Statewide Clinical Pathways. Selected pathways are listed on FAMMIS and are available from your local supply department.

Within PSQ, the Clinical Pathways and Systems Design team continues to support initiatives for statewide projects e.g. # Neck of Femur, Risk Stratification of Chest Pain, Acute Coronary Syndrome, TIA/Stroke, Surgical, Pregnancy Hand Held Record, Head Injury Management, Maternity suite of Clinical Pathways, Meningococcal, Renal Dialysis Peritonitis, Tonsillectomy and Adenoidectomy (T’s and A’s), Total Hip Arthroplasty and Total Knee Arthroplasty.
The Clinical Pathways & Systems Design Team is investigating new and innovative ways of capturing variances and has funded initiatives in this area. For example, variances were recorded in real time using a Digital Pen to assist staff in capturing the data.

**Can care be changed or varied during the course of 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 clinicians’ 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 Statewide Clinical Pathway must state:

“Clinical Pathways never replace clinical judgement. Care outlined in this pathway must be altered if it is not clinically appropriate for the individual patient”.

Clinical Pathways could potentially be implemented across the state without restrictions as to which hospitals can use them and, in fact, there has been an exceptional cross fertilisation of knowledge across Queensland by Statewide Clinical Pathway users. Statewide Clinical Pathways are not designed to control cost or services. They do not prevent patient access to whichever facility they choose to go to and do not force competitive tendering across public hospitals. Statewide Clinical Pathways use the best evidence, determined by the latest research, guidelines and expert peer groups related to the standard of care for the conditions and procedures targeted.

**Do Clinical Pathways affect medical liability?**

Statewide Clinical Pathways are developed to demonstrate:

- documentation that patient education and expectations have been achieved
- variations to care are documented with assessment undertaken and 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 for review has been developed
- the Clinical Pathways have been altered to represent best practice
- trial friendly – the document itself provides expert opinion / guidelines for care and patient expectations in a logical, legible presentation. The care outlined in the Clinical Pathway is based on the best available evidence at the time of development.

If the care process 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 contra-indicated for a particular patient then the pathway should be customised accordingly.
The tool (document) is multidisciplinary so all care providers can access it and encompasses the full continuum of care for that admission episode. The tool itself has been developed with input from the whole interdisciplinary team.

What are the benefits and liabilities of using a Clinical Pathway?

Benefits

- 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

Liabilities

- If not maintained may be at risk of becoming outdated. Each Statewide Clinical Pathway is routinely reviewed every two years and as required.
- Without adequate clinician education, effective use of the Statewide Clinical Pathway may be at risk. The PSQ Clinical Pathways and Systems Design Team conduct 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.

Statewide Clinical Pathways are based on the best evidence available and are designed to capture all aspects of care. Patient care follows an expected standard of care throughout the whole continuum of care, eg. frequency of observations, necessity of routine pathology. Statewide 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. Statewide 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 Statewide Clinical Pathway can be later analysed to examine whether there is a need for change in practice or whether care delivered is effective, e.g. early feeding or mobilisation without adverse events. Using a Statewide Clinical Pathway information is more accessible as all care is delivered 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 Statewide Clinical Pathway document, medical information is easier to find within the medical record.

An outcome-based record of care provides a robust legal defence. Statewide 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 Statewide 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 Pathway & Systems Design Team will continue to support the districts with education, document design, printing arrangements and the supporting evidence base for Statewide endorsed Clinical Pathways. The Clinical Pathways & Systems Design Team 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. The original list of articles relating to each Statewide Clinical Pathway, including studies using randomised controlled trials, supporting the use and effectiveness of the Clinical Pathway is available by contacting the project team for a copy at PSQ@health.qld.gov.au

How often are Statewide Clinical Pathways updated?

Every two years and when research is available to determine the need for an update or a change in clinical practice, a review process is conducted for Statewide Clinical Pathways.

Is there a Queensland Health policy on the development and use of a Queensland Health endorsed Statewide Clinical Pathway?

An Implementation Standard has been created for reference within all Queensland Health facilities and can be found on the PSQ website:
Do all patients follow a Statewide Clinical Pathway?

In reality, all patients follow a journey of care. It is 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 “FAMMIS”. This has been arranged in order to ensure high quality documents are being produced and the latest versions are always available.

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?

What is a variance?
A variance is defined as any difference to the proposed standard of care outlined in the 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, a flag is noted in the variance column by writing a "v". The treating clinician is then expected to go to the variance page (sometimes known as free text / clinical events 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.

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