# General Pathways Education Workshop

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# Introduction to Workshop/Instructions

- This is a web-based workshop that has been designed to allow you to easily navigate through the slides. Whenever you see words *underlined like this*, you can click on that area to go to another section or to find more information on a topic.

- You can go through as much as or little of the workshop as you like at a time.

- If you have any questions about how to use this workshop or the individual pathways, feel free to ask your **unit/department manager**, **Model of Care Site Lead**, or find answers to your questions at *www.gov.pe.ca/carepathways*.

# Why Care Pathways?

These Care Pathways have been developed as part of the **_One Island Health System Project._** The purpose is to develop Provincial Care Pathways that are standardized across all Island hospitals.

Care Pathways are a leading practice that are used across Canada and have been shown to improve:

• **Continuity of care** through increased collaboration across professions, departments, hospitals, and community partners;

• **Clinical outcomes** through consistent application of best practices and identification of optimum sequence and timing of interventions;

• **Lengths of stay** through incorporation of efficient and timely care; and

• **Patient satisfaction** through clearer expectations, coordinated patient teaching, and improved coordination of care across the continuum.

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# Components of a Pathway Package

All pathways developed for Health PEI have been developed using the same template. Each pathway package contains the following:

- **Clinical Practice Guidelines**

- **Pre-Printed Orders**

- **Clinical Pathway**

- **Patient Pathway**

- **Patient Education Materials**

- **Caregiver Handouts & Caregiver Checklist** (if applicable)

- **Primary Care Clinical Pathway** (if applicable)

# Clinical Practice Guidelines

- The Clinical Practice Guidelines are a collection of the evidence used in the development of each Pathway and the most current clinical research.

- It can be used as a reference if you have any questions about the content of the Pathway.

- All Clinical Practice Guidelines can be found here:
  *http://www.gov.pe.ca/carepathways*

# Order Set

- An order set is to be used by physicians for patients that fit the inclusion criteria for the pathway.

- Pre-printed orders are located in the nursing stations on each unit and can also be found on the **_OSOS website_**.

- Order Sets often include Care Pathways as a mandatory order.  Currently the order sets that have corresponding Care Pathways are:
  - **COPD**
  - **Acute Stroke**
  - **Stroke Rehab**
  - **Heart Failure (in development)**
  - **Community Acquired Pneumonia (in development)**

# Clinical Care Pathway

- This a multi-disciplinary documentation tool used by all health care professionals who care for the patient on the pathway.

- Pre-printed Care Pathways can be found in your unit/department and should be placed in the front of the patient chart and used in addition to electronic charting.

- Beginning in July 2010, all approved Care Pathways will be available online. *http://www.gov.pe.ca/carepathways*

- Each pathway template looks and works the same. The first page contains instructions for use, on transfer of patients, and a master signature sheet for all professionals to sign if they are using the pathway.

# Types of Clinical Care Pathways

- There are two types of pathways – a *day format* and a *phase format*. Each looks similar, but works a little differently.

**Day-Type Pathway**

- The *Acute Stroke Pathway* is formatted as a *day-type pathway*. On the day-type pathway we track "Performance Indicators."

- **Performance Indicators** are goals that we as health care providers hope to achieve on the specified day.

- The additional rows below the indicators are tasks to be done for the day. They have been separated into different types of tasks, i.e. assessments, treatments, etc.

# Types of Care Pathways Cont…

**Phase-Type Pathway**

- The other type of clinical pathway is a *phase-type* pathway (e.g. ***COPD*** & Heart Failure)

- The patient moves from one phase to the next by achieving the **Patient Outcomes** at the top of the page. Once these are achieved, the patient can move to the next phase.

    - If the outcome is NOT achievable due to patient complication or for a reason we are not able to resolve, move the patient to the next phase of the pathway.

    - If the outcome will need more time to achieve, continue in the same phase with a new blank page that can be printed from ***http://www.gov.pe.ca/carepathways***.

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# Types of Care Pathways Cont…

**The following applies to both the phase and day-type pathways:**

- On the right hand side are columns – they correspond to the number of shifts in a day. Each day starts at the beginning of your day shift.

- As each task is completed, initial in the time frame you did it. If a task does not apply to that patient, or has already been done and does not need to be done again that day, indicate "N/A" and initial the box.

- At the end of your shift, no boxes should be left blank.

- At the end of the Clinical Care Pathway you will find a page of **Discharge Criteria**. This page is a list of goals the patient needs to achieve before going home. Thus, if the patient has achieved all of the Discharge Criteria, he/she should be able to be discharged. If not, he/she should stay until the Discharge Criteria has been met.

# Types of Care Pathways Cont…

- Throughout each of the phases, refer to and complete the Discharge Criteria page.

- When the Discharge Criteria has been met, the patient is ready for discharge regardless of which phase they are in.

- If the patient is transferred or discharged with home care supports, refer to the first page of the clinical pathway for information to forward on transfer or discharge.

- If a patient is taken off the Care Pathway for any reason, fill out a *Variance Report* and place it in the patient's chart. The Variance Report will help us to identify areas of the care pathway that might need to be revised and will provide necessary data during a chart audit.

   ….detailed information about how to use and fill out a Care Pathway can be found in the *Care Pathway Simulation* section.

# Patient Pathway

- Each pathway package will include a patient pathway which mirrors the clinical pathway, but is worded in lay terms.

- It is on 8 ½ x 11 paper in 14 font, and covers each phase of the pathway.

- It should be given to the patient or family on admission and referred to throughout the stay to help the patient understand what to expect and what the plan is during this admission.

# Patient Education Materials

- Each pathway will include materials for the patient that include information about his/her condition or procedure. These should be given to the patient or family on admission.

- These can be used as a guide by healthcare professionals when teaching to ensure consistent teaching.

- The patient can take these materials home with him/her to aid in self- care and to be used by any community or outpatient providers in continuing care.

# Teaching Checklist

- The Teaching Checklist is used by the healthcare team to aid in patient teaching. It will provide a guideline for teaching and has references to the patient education materials.

- It should be placed on the chart and referred to when teaching to reduce redundancies and ensure all topics are covered before discharge.

# Primary Care Pathway

- Many times patient care begins in the community, either at a walk-in clinic or in the family physician's office.

- To delay or prevent admission into the hospital, we are developing Primary Care Pathways to help primary care staff care for their patients in the community.

- In many cases, care for a patient after discharge from hospital flows into either outpatient services or home care services. The Primary Care Pathway will aid in continuity of care and ensure transfer of appropriate information.

- Primary Care Pathway is for staff caring for patients in an outpatient or home care setting, and will help provide a guideline for care as well as allow us to evaluate care in those settings.

# Care Pathway Simulation

**We've reviewed the basics of Care Pathways. Now lets put it into practice.**
Make sure you have a copy of the *COPD Care Pathway* in front of you as you go through this exercise.

*Nancy arrives in hospital. She has a history of COPD and the physician determines she should be admitted. She doesn't have any co-morbid conditions, so it is determined that she fits the care pathway criteria and is put on the COPD pathway.*

**NOTE: Inclusion/exclusion criteria is on the first page of the care pathway**.

# Care Pathway Simulation Cont…

- The ***pre-printed orders for COPD*** should be pulled for the physician to use and a Patient Label affixed. If applicable, the pathway will be started in the Emergency Department because this is where care begins. If the patient is admitted directly from the physician's office, the pathway will be started on the unit.

- The assigned staff member (e.g. Ward Clerk) will attach a Patient ID sticker to each page of the Clinical Care Pathway Package where *PATIENT LABEL* is written. This includes the Order Set, Teaching Checklist(s), and where appropriate, the Caregiver Checklist.

- After all Patient ID stickers have been affixed, the Clinical Pathway and ***Teaching Checklist*** is placed on the chart. The ***Patient Pathway*** and patient education materials are given to Nancy (or family member if patient is too tired, confused, etc.).

- Nursing staff review the Order Set once completed by the physician, and cross out and initial corresponding Care Pathway tasks that do not apply to the patient. Add tasks as indicated on the Order Set as appropriate in "Other" boxes.

# Care Pathway Simulation Cont…

- On the front page of the Clinical Pathway are basic instructions on the first page on how to use the pathway. Remember, each page will need a Patient ID sticker.

- The first page of the Clinical Pathway is a **Master Signature Sheet**. Write your name, initial, sign your signature, and write in your title. You only need to do this once for each patient. For the remainder of the care you provide for Nancy, simply initial in the appropriate boxes.

  **NOTE: All health care professionals involved in the clinical care of Nancy must fill in their name and title on the Master Signature Sheet. Non-nursing tasks have been highlighted to improve visibility.**

- Flip to the next page.  This is *Phase 1* of the COPD Clinical Care Pathway.

# Care Pathway Simulation Cont…

- At the top of the first page of each pathway will be a section for co-morbid conditions.  Please list any conditions the patient has other than COPD that may affect the care you are giving. *This will help health records in coding Nancy appropriately*.

- This page starts the first day Nancy is admitted. You will see six columns on the right hand side (one for each shift – if there are only two 12 hour shifts, you will only need two of these).
    - Write in today's date at the top.
    - Below the date, write in the shift you will be caring for Nancy (**D**ay, **E**vening, **N**ight).

- You will then use this column to initial as each task on that page is completed. You can use your *nursing progress notes* if you require further documentation.

# Care Pathway Simulation Cont…

**The first section of Phase 1 lists the Patient Outcomes.**

- Decreased respiratory rate
- Decreased heart rate
- Decreased temperature
- Dyspnea scale score improving
- Saturations achieved with less oxygen (flow or %)

The rest of the page lists the tasks that are to be completed during the first day. For example, under Assessments, vitals should be taken PRN and QID. Initial in the column to the right that corresponds to your shift as each task is completed.

Some tasks are not appropriate for all patients or all time frames. In these cases, you can indicate an N/A and initial to show this. (*See a sample page completed*)

# Care Pathway Simulation Cont…

*By the end of the 2nd day of Nancy's admission she is breathing much easier and she has met all of the patient outcomes for this phase so she can move to Phase 2 for the next shift.*

**Note:**

- **Some patients might meet the patient outcome criteria earlier (or later) than what is in the care pathway. That is ok.  As soon as all of the patient outcome criteria have been met, the patient is ready to be moved to the next phase.**

- **If the patient is taking more time to achieve the patient outcome, print off a blank page and continue care in the same phase.**

- **If the patient is unable to achieve an outcome due to patient complications (i.e. co-morbid condition) or for an issue that we are unable to resolve, make a note on the pathway  with  further details on the electronic chart and move the patient to the next phase of care.**

# Care Pathway Simulation Cont…

- Flip to the next page of the pathway which is used for Phase 2 of Nancy's hospital admission. It works the same as the first page. Be sure to indicate the date and time you are caring for Nancy at the top of each column. The top section entitled **Patient Outcomes** identifies goals for the next timeframe; in this case, it's the remainder of the 2nd day.

- The other sections are tasks that are to be completed for that day. Again, some tasks are not applicable to each patient, or to each shift.
  - For example, if it is night shift you may not be teaching Nancy, so under "Psychosocial Support/Education," you can indicate *N/A* and initial "Review Patient Pathway" and "Start Teaching Checklist."

# Care Pathway Simulation Cont…

On each day of all pathways, you will notice a referral to a Teaching Checklist and a Patient Pathway.

- The *Teaching Checklist* is kept on the chart and filled in as topics are covered with Nancy. This way the next nurse on shift will know what has been covered and can continue down the list.

- The *Patient Pathway* is given to the patient on admission. However if Nancy is not ready for education during your shift, indicate *N/A* and initial these tasks until she is ready for education.

- The education materials are for Nancy and she should take them home once she is discharged, but should also be referenced to aid you in teaching. The Patient Pathway should be referred to on a daily basis to help Nancy understand the plan of care.

- The reference materials for the Teaching Checklist are *Deep Breathing and Coughing Handout*, *Inhaler Checklist*, *The BreathWorks Plan Booklet*, *Living Well with COPD Booklet*, *Living Well with COPD Action Plan*, *Living a Healthy Lifestyle Brochure*, and *Smoking Cessation Brochure*.

# Care Pathway Simulation Cont…

- At the end of each day, in the Discharge Planning section (last section of each Page of the Clinical Pathway), you will notice it says "Assess Discharge Criteria Daily." This means you will need to flip to the last page of the pathway, the Discharge Criteria, on a daily basis and check if any of these goals have been met. If they have, initial and date them. Once all of these criteria have been met, Nancy is ready to go home.

*Lets assume it is admission day 3 and we are into Phase 2 of the pathway. Nancy has achieved all of the Discharge Criteria so she can go home.*

- If Nancy is transferred to another hospital or discharged with home care supports, refer to the first page of the Clinical Pathway under "How to use the Clinical Pathway." There is a list of documents to forward to the receiving hospital / home care so they can continue using the pathway.

# Implementing Care Pathways on Your Unit

**Now that you understand the different components of Care Pathways, and have seen how a real-scenario would work, lets walk through the specifics of implementation….**

- Every unit/department Manager identifies Care Pathway Lead (e.g. Clinical Educator or Clinical Team Lead) and determines an accessible location in your department for storage of printed care pathway package.

- Care Pathway Lead meets with unit/department staff to introduce and explain the purpose and process for using the clinical care pathway, including the new *Care Pathways Website* . It will be the responsibility of the Care Pathway Lead to ensure that all new staff are trained on the use of clinical care pathways.

# Implementing Care Pathways on Your Unit Cont…

- The Care Pathway Lead is responsible for ensuring that all staff (nursing, allied health, ward clerks, etc) in their unit/department understand how to use Care Pathways and have a clear understanding of what each person's role is (RN, allied health, ward clerk).

- There is an online, self-guided education presentation similar to this one that should all staff should complete. It only takes about 10 minutes and will answer many of the questions that staff have. It will also help to make training easier for you.

- Every unit will have a Care Pathways lead, so you're not doing this alone. Cross training, collaboration, coordination and integration are highly encouraged.

# Implementing Care Pathways on Your Unit Cont…

Remember to emphasize these points to staff:

- The final page of the Clinical Care Pathway is Discharge Criteria. Care providers should review this page on a daily basis and when criteria have been met, indicate date completed and initial. When ALL of the discharge criteria have been met, the patient is ready for discharge regardless of which phase of the Care Pathway they are in.

- If a patient needs more time to complete an outcome(s), continue in the phase with a new blank page that can be printed from *http://www.gov.pe.ca/carepathways*

- If a patient is transferred to another facility, agency, or discharged to Home Care, make sure a copy of the pathway and teaching checklist are forwarded to ensure an efficient and effective transition of patients through the continuum of care.

- The **Clinical Care Pathway**, **Teaching Checklist**, and **Caregiver Checklist** are to remain on the chart. Medical records will collect the clinical care pathway.  They will be used to evaluate and monitor care pathway program.

# Feedback

- Staff are encouraged to provide feedback (written or verbal) to their Department/Unit Care Pathway Lead.

- Feedback can also be submitted online *here*.

- A formal review of the Care Pathways will be conducted in October 2010.  All suggested changes will be reviewed at that time and any necessary changes will be incorporated.

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# Frequently Asked Questions

1.  **Where do I find the Clinical Pathway?**

    *The Clinical Care Pathways are located in each unit/department, including the Emergency Department. They are also located on the* **Care Pathway Website** *and as an associated document on the OSOS website.*

2.  **How do I know when to start the Clinical Pathway?**

    *The Clinical Pathway will be ordered as a mandatory part of the physician order set. All Care Pathways should be started upon admission and continued if transferred to an in-patient unit.*

3.  **What do I do when a patient doesn't progress as fast as the pathway phases?**

    *If a patient needs more time to achieve an outcome print off a blank page and continue care in the same phase. However if because of patient complications that we are unable to resolve, move the patient to the next phase of the pathway. Care Pathways are a guide to usual care and can be modified based on patient needs. However, ALL Discharge Criteria must be met before the patient can be discharged from hospital.*

# Frequently Asked Questions Cont…

4. **What do I do if a patient is taken off the pathway?**

   *If a patient is taken off the Clinical Care Pathway for any reason, a **Variance Report** must be filled out. These are located on the nursing unit or available from **http://www.gov.pe.ca/carepathways** The completed Variance Report should be kept in the patient's file and a copy should given to your unit's Care Pathway Lead.*

5. **So does this mean that we'll be doing dual charting?**

   *No. Documentation on the Clinical Care Pathway is not intended to be duplicated. Initials Indicate that a task has been completed during the date and shift specified on the pathway and provides a quick visual for other staff in communicating patient care. All charting is to be completed as per normal processes.*

6. **When a patient is on a Clinical Pathway, do we still have to use CIS?**

   *Yes. We are moving towards an electronic health record and while using Care Pathways in a paper-format may seem like a step backwards, it will help you get used to the new process. We are working on incorporating Care Pathways into CIS, however it will be a few years before this project is completed.*

# Frequently Asked Questions Cont…

7.  **This seems like it is going to create more work for me, do I really have to use the Care Paths?**

    *Clinical Care Pathways have been identified as a leading practice in hospitals across North America and are a valuable tool in improving the flow of patients through the hospital.*
    *While it may seem like more work at first, the care you are already providing to your patients is very similar to the care that is required in the Care Pathways. The only difference is that the Care Pathway will help to ensure that the care we are providing is not only timely and efficient, but also based on current best practice. Care Pathways will become standard practice and will be used in all Island hospitals.*

8.  **Can I use the education materials for patients who aren't on a Care Pathway?**

    *Absolutely. The education materials have been developed to use across the Province and if you have a patient that you think would benefit from the materials, please use them!*

9.  *I've still got more questions.* **Who can I talk to?**

    *Your Model of Care Site Lead should all be able to answer your questions about Care Pathways. If you still have questions, refer to the Provincial Care Pathways website,*
    ***http://www.gov.pe.ca/carepathways***

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