



INTEGRATED CARE PATHWAYS FOR DAY SURGERY PATIENTS



Integrated Care Pathways for Day Surgery Patients

Guidelines for the development, implementation and monitoring of care pathways

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Introduction

This booklet aims to provide a guide on developing, implementing and evaluating care pathways for day surgery patients. It is important to understand that a well developed care pathway is not solely a unitary patient record, but a tool with which to effectively manage patient care from pre-admission assessment through to the post-discharge period. Day surgery patients follow a systematic and logical process of care. This care can be clearly managed and reflected by using a structured casenote such as an Integrated Care Pathway.

Definition of Integrated Care Pathways (ICPs)

The National Pathways Association defines an ICP as a tool which is locally agreed by the multidisciplinary team. It is based on guidelines and evidence, for a specific client group, forming all or part of the clinical record, documenting care given and facilitating the evaluation of outcomes for continuous quality improvement.

Sue Overill, Journal of Integrated Care 1998, 2, 93-98

History of care pathway development

It is generally agreed that the origin of the ICP lies in the American Hospital Insurance system. Structured case-notes to reflect the local degree of 'managed care' were developed to reflect the hospital's need for evidence of care which varied from the standard care reimbursed by the insurance companies.¹ In the early 1990s, the first recognisable ICPs in the UK were introduced as structured case-notes to facilitate clinical effectiveness and quality improvement.²

Benefits of implementing ICPs in the Day Surgery setting

1. Best practice and equity of care is promoted from pre-admission assessment to post-discharge support within the multi-specialty setting
2. Designed, implemented & monitored by a local multidisciplinary day surgery team
3. Provides a framework to support clinical governance, such as, improving risk management, process redesign, promoting clinical effectiveness and continuous quality improvement³
4. Ability to evaluate evidence based care in a more structured way.⁴
5. Minimises repetition and patients not inflicted with same questions
6. Acts as a guide and specific framework for new staff, locums & agency nurses⁵
7. Care pathways can form the basis of Electronic Patient Record
8. Improves communication within the multidisciplinary team, between staff groups and patients.⁶

Development Process

There are 5 main stages⁷

1. Raising awareness and gaining commitment
2. Putting Systems into place (Multi-disciplinary review of current system)
3. Documentation
4. Implementation (including training)
5. Evaluation

1. Raising awareness and gaining commitment

This stage addresses: where to start and what to do initially: how to get organised and who to involve. Choice of a specific patients' pathway may be prompted by variations in practice, documentation and/or outcome.

- Identify the best evidence of care
- Gather support for the project both locally among health care staff (*and possibly nationally through user groups*)
- Divide the tasks into manageable parts: documentation, implementation, evaluation.

At this stage

- Identify a lead person/co-ordinator and required resources: see Appendix 1

Timescale is dependent on commitment of organisation in terms of resources, philosophy of continuous improvement and complexity of care pathway. The first ICP can take up to 12 months to fully implement, with the team meeting on 8-10 occasions. Thereafter the subsequent pathways can roll out within 3-4 months after a few meetings. If a full-time facilitator is employed anywhere between 5 & 12 pathways can be developed within 24 months.⁸

Any systematic approach to developing professional practice requires plans to develop, implement, monitor, evaluate, maintain and reinforce the change. Successful strategies to change practice requires adequate resources in terms of time, finance and appropriately trained persons⁹. It is important to clearly identify the critical success factors at an early stage as indicated in Box 1.

Box 1 Critical Success Factors

The chances of success are greater with:

- management and multi-disciplinary support
- lead consultant
- local co-ordinator to support the development, implementation and review
- local resource for administration, (for example, computing, copying)
- local ownership
- patient-centred rather than procedure-focused

It is vital to complete this step, otherwise there is every chance it will come back to haunt you. It is imperative that a minimal number of clinicians and managers are committed to the development process before starting to look at systems and processes. Good information should lead to good will, poor communication /awareness will lead to suspicion and lack of commitment. It is worth spending time on this phase to ensure effective team-working. (if teamworking is one of the drivers for implementing ICPs in your organisation, you may wish to consider ‘the Leuvan Clinical Pathway Compass’ as developed by the Belgian/Dutch Clinical Pathway Network framework¹⁰). One member of staff (or small group) requires to explore the benefits of developing and implementing pathways and the forces which may assist or challenge progress.

Objections and/or reservations are commonly raised at this stage. Box 2 indicates some of the most common issues raised.

Box 2 Main concerns regarding development of pathways

Restriction of clinical freedom.

This is only to the extent that the reasons for not following agreed best practice need to be explicitly qualified.

Litigation

It is suggested that ICPs reduce litigation, as the system encourages logical and sequential recording of events which have been planned according to agreed best practice.

Inflexibility and not a true reflection on individualised patient care

Deviation from the routine pathway reflects patient individuality, emphasising that guidelines are not rigid: “guidelines, not tramlines”

Multiple pathologies

The patient’s care pathway can be modified using supplementary sheets and/or managed with free text documentation to meet his/her needs or requirements.

Increased documentation

There is less time writing. A pragmatic approach is required when there are patients undergoing similar procedures such as gynaecological patients. Therefore, in place of a multitude of procedure specific ICPs, adopting a ‘generic day surgery’ ICP with, applicable specific procedure sections is more beneficial for these patients.

2. Multi-disciplinary review of current system

- Form a multidisciplinary group to compare current practice with established clinical guidelines.
- Submit a summary report to all members of the local group and senior management
- Review practice, both current and past. This information forms a baseline for future evaluation of ICP impact.
- Identify established guidelines or develop new ones which follow national recommendations¹¹
- Identify key indicators to examine clinical and non-clinical aspects of care

Agree objectives such as;

- reduce number of routine pre-operative tests/investigations by X% for patients scheduled for hernia repair within a specific time frame
- all laparoscopic cholecystectomy patients receive standard thromboembolic prophylaxis within a specific time frame

A multi-disciplinary team review of the ‘map’ of the patient’s pathway; this will vary from situation to situation. Local decisions regarding specific information, assessment tools, charts will be reflected in the process map but will include the following headings: specific phases of care & the aspects of care at each phase / timescale.

This is usually laid out as a matrix, with time/phases of care → and clinical headings ↓ on an A3 sheet: e.g.

Clinical Headings	GP Consultation	Surgical Consultation	Pre-assessment	Pre-operative	Intra-operative	Post-operative	Discharge	Post-Discharge
Medical								
Social								
Obs/Vital Signs								
Test/Investigations								
Information/ Education								
Discharge planning								
Diet								
Output								
Medication								
Fluids/iv therapy								
GOALS								

Headings for the phases should reflect the patient’s journey, rather than the way the clinicians see their input. Clinical headings should be chosen to suit local clinical documentation purposes. It is important to clearly indicate expected outcomes (‘goals’) and not solely list a series of actions.

This is the most useful stage to involve a patient representative as part of the multi-disciplinary group or ensure that all participants try to view the process from the patients’ perspective. It is impractical to write a map for 100% of your patients. Consider how ~80% of the ‘normal’ patient pathway operates, using this as a base from which ‘Variances’ can be identified & recorded. As Day Surgery expands and develops, more day surgery clinicians are caring for patients with more complex needs which need to be reflected in the patient pathway. As an example, specific evidence-based guidelines can be built into the care pathway for patients who are insulin dependent.

Refining this phase of the pathway development will reduce the time required to gain consensus regarding the minutiae of the draft clinical documentation. Experience shows that by the end of the mapping process some changes will already have been made to the current processes. The team needs to plan training and evaluation at this stage of the process.

With reference to the critical success factors, senior management and the care pathway multi-disciplinary team need to ascertain the level of commitment and support before proceeding any further. By this stage, the patient pathway will be refined and evaluation of progress and outcome may already be part of the hospital's clinical improvement programme.

Some teams may halt at this point. It is important to note that guidelines and protocols are more effective if they, not only reflect local circumstances and staff are well-informed and educated, but that they are embedded into routine practice. "It is essential that there are routine mechanisms by which individual and organisational change can occur"¹². By proceeding with the development of the ICP, it is also easier to evaluate the variations from the pathway, rectify care which deviates from the expected more promptly and improve the patients' experience.

3. Documentation

Develop an integrated care pathway which specifies elements of care detailed in local protocol, the sequence of events and expected patient progress over time. Refer to www.bads.co.uk to review examples of ICPs such as 'Generic gynaecological daycase' ICP, laparoscopic cholecystectomy ICP.

The documentation needs to meet legal requirements and standards set by, for example, Clinical Negligence Scheme for Trusts, RCN/UKCC, Royal College of Surgeons and Chartered Society of Physiotherapists.

The main aim is to guide staff. It needs to reflect local needs/circumstances, for example:

More outcome-than task-focused	Short, concise user-friendly
Evidence-based	Variances easily captured
Standardised format ¹³	Colour-coded for each discipline
Date developed/review	Signatories sheet

Although the chosen style and format needs to suit the patients' needs as well as the clinicians', standardising the format for all day surgery patients is more beneficial.

4. Implementation

A baseline record of compliance to specific standards is useful before auditing outcomes identified in the new or revised pathway. This should be conducted to measure performance against the standards which the ICP will be measured against.

Training

Staff will need different levels of training. The main lead clinician may need discussion with experienced staff, while a local co-ordinator may require some more specialised training. The local co-ordinator's role is vital to ensure successful implementation and needs suitable support.

Pilot

Prior to the pilot ensure that there is full consultation with all users. This will include identifying training needs and administration processes. The indicators of success need to be discussed & agreed, and ideally a pre-audit conducted. Identify a sample size, for example, 25 pathways. Key points of the audit include:

- an exhaustive baseline of compliance, measuring each data item to provide 'data in the bank' for future audit use. (a full document compliance audit means training can be targeted to areas of particular concern (signatures, address labels etc) as well as general education about the principles)
- Evaluate staff concerns/comments, which can be invaluable (Appendix 2)
- Feedback results of pilot to staff very quickly
- You may find during the pilot that you require to refine the indicators/objectives for the main phase and ideally these would be incorporated into routine practice as part of a Clinical Improvement project. Basic indicators could be '% receiving appropriate prophylactic antibiotic', 'percentage unplanned overnight admissions'. Better indicators include 3 parts: Verb + Feature of Quality + Subject, such as "Increase Utilisation of Day Case Surgery in patients having Inguinal Hernia Repair". Indicators should be SMART: Specific, Measurable, Achievable, the Right aspect, within a specified Timescale.

Time & energy invested in the pilot phase will pay dividends in the main implementation.

5. Evaluation

Main points in evaluating ICPs are usually summarised under four headings:¹⁴

- Compliance with using the care pathway documentation
- Information on the variations
- Achievement of standards or outcomes monitored within the ICP
- Patient and staff comments/concerns with the care pathway.

Regularly analyse variances from the integrated care pathway. Investigation of the reasons why current practice is different from that recommended in the integrated care pathway can be used to:

- (a) identify common variations from agreed best practice
- (b) alert staff to patients who fail to progress along the care pathway as expected:
 - unavoidable variations might be coexisting disease which complicates care for an individual;

- avoidable variations can be addressed: e.g. a clinician using custom or personal preference instead of the agreed pathway of care.
- (c) Update the integrated care pathway by incorporating agreed changes.
- (d) Identify research issues.
- (e) Note achievement of standards & objectives, possibly benchmarking against local or national standards, and 'Best practice' statements.
- (f) Assess patient and staff comments, sample of questionnaire Appendix 3.

After an agreed number of cases, a sample of 20-25 should be fully audited and this should be done at regular intervals thereafter as a quality measure, taking note of external standards to guide internal data quality requirements.

In all cases feed back the information very quickly to the team involved in development. It is at this stage that the multi-disciplinary team will be rewarded for their planning. This is an iterative rather than a linear process. It is important to review and revisit the various stages to ensure the tool facilitates and reflects best practice.

Challenges to Overcome

This may seem a lot for the multi-disciplinary team to 'take on board' at the start of the process. However working on the 'forewarned is forearmed' principle, ensures that all the groups affected by an ICP have been identified at an early stage.

The obstacles to organisations becoming more evidence based are fairly well known.¹² There is little evidence of written strategies, co-ordinating groups, or training when it comes to implementing clinical effectiveness locally. Similar issues apply when it comes to considering implementing ICPs.

The ways of overcoming barriers (as identified in the CRAG project above on barriers to implementing guidelines) include:

- Need for a champion
- Prioritisation of topics
- Resources identified and allocated
- Structured implementation/dissemination process

Successful strategies will have significant costs, whether financial or as opportunity costs, and will need adequate resources. The roles of the multi-disciplinary team need to be clear and training needs identified. Awareness of the barriers or enabling factors should make the design and content of a dissemination/implementation strategy for introducing an ICP more successful.

Future developments

Electronic Patient Record

Current patient documentation is in a format which is difficult to transfer to a computer system, such as the electronic patient record. The ICP facilitates this transition. The DoH state that all Trusts and PCTs must have "elements" of systems in place by 2005 with full implementation by 2008¹⁵. Electronic booking is to be implemented by 2005. It is envisaged that GP and practice and district nurses will record the patient care within this pathway.

Interface between Primary and Secondary Care

Currently certain practice nurses are involved in pre-admission assessment. Initiating the process at this stage and, where appropriate, following the pathway through to the post-discharge period, is beneficial to the patient, carer and clinician. The Electronic Patient Record (EPR) will enable this continuity of care, ease access to relevant information and monitoring of progress. Patient confidentiality needs to be protected and systems must be secured by varied access codes. Although communication between primary and secondary care can be enhanced with the implementation of the electronic record, day surgery clinicians need to continue promoting care pathway development with the primary care team.

Audit and research

The full impact of care pathways needs to be more fully evaluated in the UK. Despite the lack of robust research, widespread adoption continues with 86% Trusts in UK using care pathways to some degree in delivering care¹⁶. This has been acknowledged from the earliest days, and currently there is only 1 Cochrane Collaboration explicitly involving ICPs: 2002 #2 includes work on ICPs and Stroke. To find 86% of Trusts have ICPs (even though the median number per Trust is 2)¹⁷, suggests many clinicians acknowledge the benefits of embedding protocols within routine practice. We believe that the Modernisation Agency's 'push' for 'Protocol-based care'¹⁸, allied with a developing journal of Integrated Care Pathways will mean that better quality studies will be forthcoming sooner rather than later.

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www.leedsth.nhs.uk/performance_improvement/presentation/

<http://www.icpathways.org.uk/> *

* Website currently on hold

http://www.hsurg.sk.ca/resource_centre/care/GettingStarted.pdf

<http://www.nkp.be/docs/intro/intro.php>

<http://www.smartgroups.com/groups/clinicalpathways>

<http://www.smartgroups.com/groups/carepathways>

Comment

for ICP Users in Scotland - an active website, with new features appearing regularly

National Electronic Library for Health allows you to search an ICP database of known ICP's. From summer 2002 ICP documents are included

Leeds ICP project - website with development frameworks etc (related to project below)

Collaborative Project between the Uni. of Teesside School of Health, York Uni. Dept of Health & Economics & South Tees Acute NHS Trusts

A ICP development manual & while some sections are local to Canada, the principles are the same

Dutch/ Belgium Clinical Pathway Network

These are two discussion groups on the web for folk involved in ICP's. The former is more generic than the latter, which has a Mental Health focus.

Appendix I - Resources

(refer to Kathy de Luc (2000) for good introduction to roles & responsibilities)

Key players

- lead co-ordinator
- surgeon(s)
- nurses
- anaesthetist(s)
- pharmacist
- physiotherapist
- Trust/Directorate CP Facilitator

Requirements

- time out for meetings
- administration & clerical support – both for co-ordination & to resource production of documentation
- training and education – initial & ongoing
- time for continual evaluation – from an early stage

Appendix II - Staff Evaluation Form

3a Staff attitudes to ICP's - being researched in a major study from University of Manchester

i. When did you first hear about Integrated Care Pathways?

..... days/ months/ years ago

ii. In principle they are a good idea

Agree Strongly |-----| Disagree Strongly

iii. In practice they are a bad idea

Agree Strongly |-----| Disagree Strongly

iv. Designation:

Cons Other Doc. Midwife Other Nurse Dietician other AHP

1. "ICP's have helped introduce guidelines and evidence-based practice into care"

Agree Strongly |-----| Disagree Strongly

2. "ICP's are a good educational tool for new staff"

Agree Strongly |-----| Disagree Strongly

3. "ICP's infringe on clinical freedom"

Agree Strongly |-----| Disagree Strongly

4. "I feel that I can make changes to the ICP in my area"

Agree Strongly |-----| Disagree Strongly

5. "ICP's have given patients more information about their care"

Agree Strongly |-----| Disagree Strongly

6. "ICP's have improved communication between staff and patients"

Agree Strongly |-----| Disagree Strongly

7. "ICP's make clinical audit more difficult"

Agree Strongly |-----| Disagree Strongly

8. "ICP's have standardised the care we give to patients"

Agree Strongly |-----| Disagree Strongly

9. "ICP's should not continue to be used or developed in areas in this Trust"

Agree Strongly |-----| Disagree Strongly

10. "This ICP documentation is worse than what we had before"

Agree Strongly |-----| Disagree Strongly

Please add any further comments overleaf.

3b Staff attitudes to a specific set of ICP documentation

Which draft of this ICP have you used?

Original Draft V2 Both

If you have used both which did you find easier to use?

Original Draft V2

Could you say why?

What instruction were you given prior to the introduction of this document?

Please specify who / when / how equipped it left you:

What information do you wish you had been given prior to using this ICP?

Questions about the individual sections within the DOCUMENTATION

Section 1. Useful Contacts & Checklist

Do you find the content easy to follow? Yes No Partly

If 'Yes', please note which areas are best:

If 'No', or 'Partly', which areas are of concern:

Is there anything in this section that you feel is not required? Yes No

If 'Yes', please note which areas:

Is there anything you feel should be in this section and is not? Yes No

If 'Yes', please note which areas:

Questions about the individual sections within the DOCUMENTATION

Continue for Section 2 etc.

Probably finishing with more general questions

In general

Do you have to write anything more than once? Yes No Partly

If 'Yes', please note what and where:

Do you think that once you are more familiar with the document it will save you time? Yes No

This is meant to be a staff-friendly record.

Does it meet that objective? Yes No

If 'Yes', please note what and where:

If 'No', please tell us how it could be improved:

Please note this page is condensed from version of surveys for different questionnaires

Handbook Series

Editor - Dr Anthony Hart

IT for day surgery

Ready to go home?

Skill mix and nursing establishment

Day surgery and the diabetic patient

Spinal anaesthesia - a practical guide

Integrated Care Pathways for Day Surgery Patients

In preparation

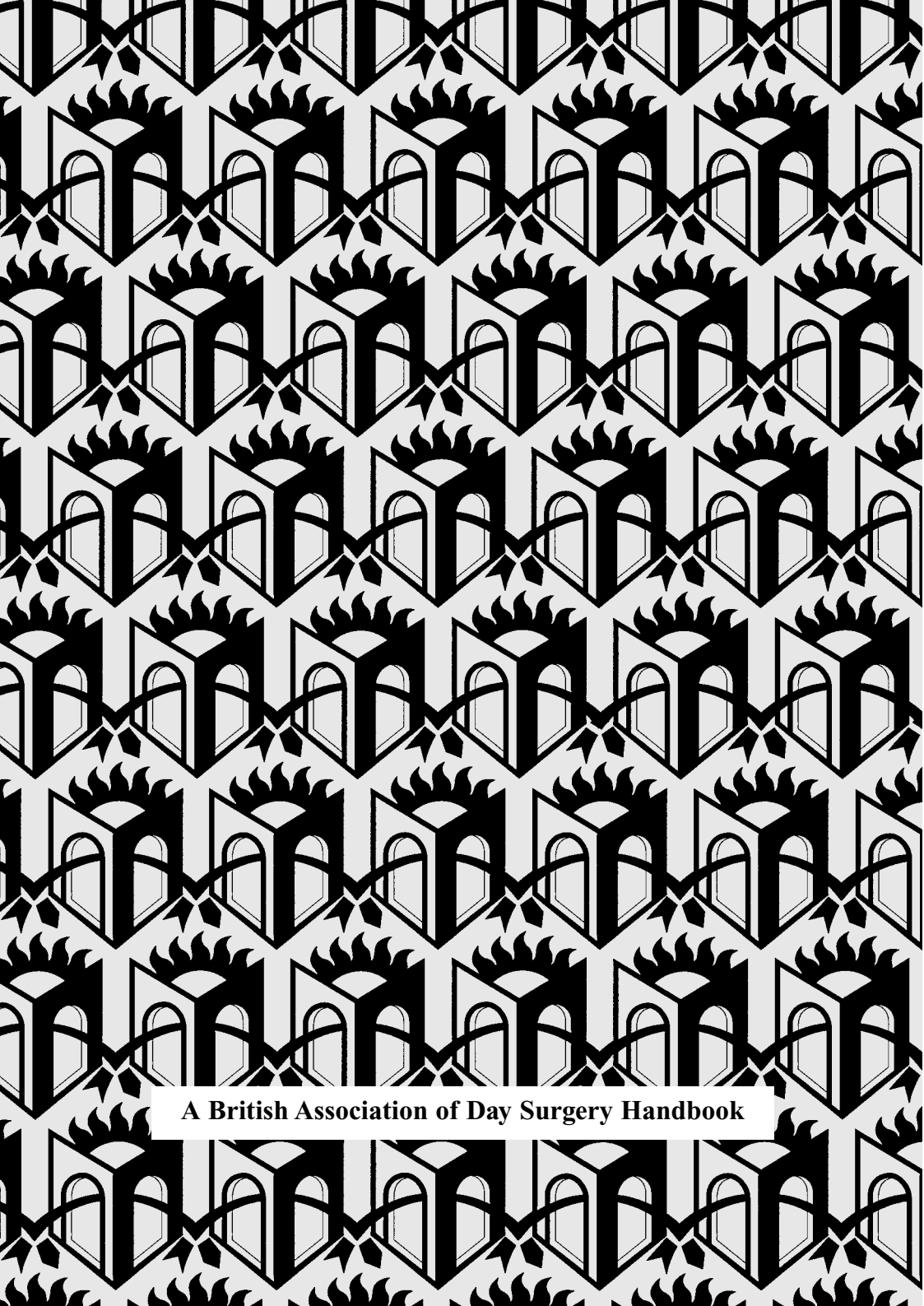
Day case laparoscopic cholecystectomy

Tonsillectomy as a day case

These publications may be obtained from

The British Association of Day Surgery
35 - 43 Lincoln's Inn Fields
London WC2A 3PN

Tel: 020 7973 0308



A British Association of Day Surgery Handbook