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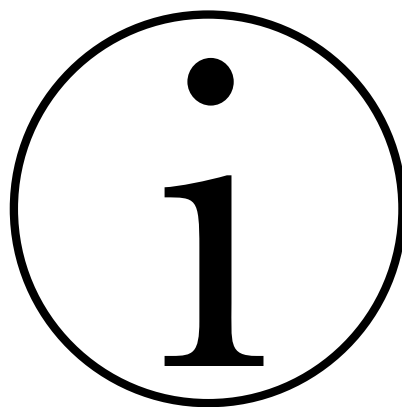
14 BEDFORD ROW, LONDON, WC1R 4ED TEL 020 7306 6666 FAX 020 7306 6611
www.csp.org.uk



Integrated Care Pathways

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1. Introduction

Integrated care pathways are one means for improving the delivery of care to patients. Increasingly, members are becoming involved in their use. This involvement might be:

- in developing a pathway for a specific client group, e.g. total hip replacement,
- reviewing a pathway that has been developed,
- using one in practice,
- assessing the results of an audit of a pathway,
- implementing changes as a result of the audit,
- teaching other staff members in the use of the pathway.

If members understand the theory underpinning integrated care pathways, they are better placed to have a constructive but critical approach to their involvement.

This paper aims to help members understand what integrated care pathways are, what their background is, and how a pathway can be developed. It also provides some resources to access, and gives several practical examples of some frequent problems and possible solutions.

2. Definition

Integrated Care Pathways are also known as care profiles, care protocols, critical care pathways, multi-disciplinary pathways of care. Throughout this document they will be referred to as Integrated Care Pathways (ICPs).

“An integrated care pathway determines locally agreed multidisciplinary practice, based on guidelines and evidence where available for a specific patient/client group. It forms all or part of the clinical record, documents the care given, and facilitates the evaluation of outcomes for continuous quality improvement” (National Pathways Association, 1998).

A second definition helps to further explain a pathway:

“Integrated care pathways are structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem and describe the expected progress of the patient” (Campbell, et al, 1998).

They are **multidisciplinary, locally agreed, evidence-based plans**, describing the **expected progress** of a *specific* patient group. They form **all** or **part** of the **clinical record**. By facilitating the **evaluation of outcome**, they can be a quality improvement tool for use as part of **clinical governance** (see glossary).

3. Background

The concept of integrated care pathways emerged from care management initiatives originally in the USA, and was gradually introduced into the UK in the late 1980s. Developed and used initially for the purpose of cost containment, in the UK the emphasis has been to use integrated care pathways as a quality tool.

Originally used in cold surgery, because the healthcare can be more easily standardised, they are increasingly being developed and used for other patient / treatment categories.

They are *promoted* as a means for:

- Reducing variations in care from case to case (and/or consultant to consultant) in the same department,
- Empowering patients and staff,

- Allowing the patient and commissioner to preview the expected care to be provided,
- Incorporating the clinical research evidence base into practice,
- Facilitating the rehearsal by practitioners of repetitive processes in an effective way (see 7.4),
- Embedding clinical audit into daily practice (see 7.5),
- Streamlining and combining multidisciplinary documentation (see 7.3 and 7.8),
- Reducing duplication among the healthcare team (see 6, 7.4),
- Establishing critical incident reporting in a blame-free way,
- Allowing managers of provider units with a means for assessing human and equipment resources, which could lead to cutting costs,
- Identification of exact costs / levels of expenditure or need for investment.

They are one mechanism proposed for improving the quality of patient care. A pathway should try to ensure everyone who participates in the pathway does so knowing what happens at earlier and later stages of the care the patient will receive. This might include the relationship between primary, secondary and tertiary providers (e.g. GPs, hospitals, specialist centres). Or it might be between two professional colleagues, e.g. medical practitioner and physiotherapist.

A pathway will be different in each place, according to the goals of the team that devise it. They should be realistic, and achievable, not idealistic. They are attempting to improve the quality of care provided in the clinical setting. However they should be developed in conjunction with national and locally agreed standards of practice, making use of good research evidence, clinical practice guidelines, where available.

They are an opportunity to identify good practice, remove bad practice, identify and apply evidence, identify education and training needs, and appreciate the skills and contributions of all professionals and care sectors (Scott, 1999). This can be through analysis of the organisation of the care and not merely the delivery of care (i.e. the diagnosis and treatment).

4. Development of a pathway

The success of a pathway depends on everyone being involved in an active and positive way. For physiotherapists, this means ensuring the format integrates the physiotherapy perspective within the team pathway, using physiotherapy knowledge and experience to make decisions.

4.1 Steps in the development of a pathway

1. Review other pathways on the same topic/ patient group, that have already been developed in other parts of the country (RCN, 1998, NeLH, 2002).
2. Review the current clinical service – consider the types of clinical interventions involved with this patient group: map the process from start to finish by considering the following at each stage of the patient's journey:
 - What is the most appropriate care?
 - When is the most appropriate time?
 - Who is the most appropriate person?
 - Where is the most appropriate location? (Layton, 1999)
3. Test and pilot your pathway; audit and monitor it closely.
4. Evaluate options for further development of it.
5. Implement it.
6. Involve local audit department to analyse early results (e.g. after a few weeks) to look for flaws and provide encouragement for staff.

7. Feed results back to all staff using the pathway so they can see the relevance and use of the pathway, and maintain their interest.
8. Attempt ongoing improvement of the pathway and service according to the results / variances and ongoing audits.
9. Review the ICP regularly in the light of new research / evaluation of results and audit.

4.2 Issues to consider

- Whoever leads the development of a pathway should be experienced in pathway development
- What is the added value of the pathway going to be?
- Remember the development of an ICP has to take place within other organisational changes:
- What are the resource implications?
The time required to develop and implement the ICP
The time required to initially train, and later to update staff.
Don't underestimate the time it will take.
- How will the issue of professional autonomy be tackled?
- How will you make sceptics use them? Watch for "covert resisters" (people who sit quietly in the meeting apparently agreeing, but go away and bad mouth the ideas).
- How will you involve the patient?
- How will you gain and keep the commitment from all in the organisation?
- Who will take responsibility for ensuring the pathway is used and audit results fed back to clinicians?

4.3 Some suggestions

1. Develop standardised documentation – this is not easy! How will the document be laid out (presented), and where will it be kept? Will it be additional to current documentation, or part of the clinical record?
2. Be creative, innovative.
3. Look for a local champion of ICPs within the team to help understanding and drive the ICP.
4. Learn the process of using a pathway with an easy one, e.g. cold surgery, as opposed to selecting a more complex group of patients.
5. Can this be a way for helping clinicians become used to the idea of the Electronic Patient Record?

5. Professional autonomy and discretion

Professional autonomy and discretion should be preserved if members collaborate with their colleagues from the beginning in the development of the pathway. The clinical-analysis and decision-making process will still be integral to patient care. Individualised care will not be lost.

There may be occasions when stages of the pathway are not relevant to a particular patient. There is no requirement for all elements of a pathway to be applied. Indeed, the clinician is still expected to use professional judgement, and treat the patient according to their needs. Any variance from the pathway should be recorded. This variation will form part of the ongoing evaluation process, which will help to ensure the continuing relevance of the pathway.

6. Skill mix

Pathways can help to clearly establish and define the skill mix required for the particular patient group. They can also unearth areas where physiotherapists are undertaking unnecessary tasks, e.g. duplication of tasks, with colleagues.

7. Some lessons learned

7.1 Uni-professional and multi-professional pathways

Uni-professional care pathways have been produced in discreet areas of practice. The validity of uni-professional pathways is questionable, as there are bound to be other professions involved in the care process at some stage.

Scott (1999) identified a pathway as being *integrated* (multi-professional) when it recognises:

- the contribution of all professionals and those who support the professionals,
- all practitioners involved with the delivery of the health care,
- all component parts of the patient's journey.

7.2 Professional image

ICP's can be an opportunity to portray a positive image to other professions in the method and standards the profession has for such issues as documentation, the use of evidence, listening to the views of patients, team working, desire to avoid duplication of tasks.

7.3 Terminology

Some difficulties may arise during discussions on terminology within the ICP and also in the use of multi-disciplinary documentation. An open-minded and flexible approach will help these discussions.

Many of the words healthcare professionals' use, including physiotherapists, have not been carefully defined, disseminated and agreed. They can lead to misinterpretation:

- e.g. within physiotherapy, 'mobilisation' can mean two different things, i.e. walking, spinal treatment technique, or
- e.g. 'manipulation' means one thing to a physiotherapist, and another to a psychologist.

As the pathway is developed, and once it is being used, the team will need to discuss, decide, record, and review the success of language commonly used.

7.4 Challenges

An ICP may well challenge the real daily working practice of the team. A pathway should be seen as an opportunity to improve individuals' understanding of the role played by the different team members, to avoid duplication of work, and provide consistent care for the patient.

All too often routine procedures occur within a team, or on a ward, that have never been discussed and agreed upon as a team, e.g. referral and provision of cervical spine collars in neurosurgery, timing of ward rounds to suit the patients and all team members. An ICP is one means of gaining written team agreement and co-operation on procedures undertaken daily or frequently.

7.5 Results / Variance analysis

The pathway should be written and layout presented so that when patients vary from it, an easy way of writing this variance down is available. The ICP should incorporate the evaluation of care into the process of care delivery. The results of a pathway audit should be analysed and acted upon. This might involve looking at how frequently variances occur.

Analysis of the variance of patients from the pathway may reveal areas that require altering, or changing practice to improve the quality of care provided. Physiotherapists need to analyse the variance scores and consider the underlying reasons to help highlight issues and use as evidence.

7.6 Time

Making explicit the anticipated timing of events throughout the pathway is an integral element of the pathway. This can help both patient and professional to know when something should happen, e.g. "your inpatient stay will be 6 days", or "on the second day after your operation you will see the physiotherapist, who will conduct an assessment of your mobility".

With use, the audit of the pathway (i.e. service delivery) may serve as a means for changing practice and a direction to speed up service delivery, or to slow it down. **ICPs should not be implemented purely as a vehicle for saving time, or money**, but with the intention of improving the effectiveness of clinical practice.

7.7 Education and training

ICPs have resource implications. All new staff working in a unit using pathways, will require induction about the development, implementation, and clinical audit of the pathway. Current staff will require ongoing training. This might well be best provided in an inter-professional way, to assist with the multi-professional working of the team.

7.8 Record Keeping

Traditionally healthcare professionals have recorded their interventions separately. There is a great deal of debate within healthcare as to the pros and cons of different documentation systems. The arrival of computerised systems of recording and communication is set to herald major changes. Members are reminded: if something is not recorded, then, in legal terms, it is deemed not to have taken place.

Physiotherapists should keep records in line with the Standards of Physiotherapy Practice (CSP, 2000). Members do not need to keep separate notes to comply with these standards *per se*, nor, if they maintain intra-professional notes, do they have to keep duplicates of their notes in the physiotherapy department. If they choose to keep inter-disciplinary notes, they must ensure systems are in place to ensure issues of confidentiality, security, and access, comply with the Standards. Members are referred to PA 47 General **Principles of Record Keeping and Access to Health Records** (CSP, 2000).

Members are advised to consider the appropriateness of the records they keep. For example, the necessity to record items already noted by other healthcare professionals: re-recording a patient's past medical history word-for-word is inappropriate.

7.9 Example integrated care pathway

The following is an example of one integrated care pathway, reproduced with permission from Ms M. MacDowell, Head of Therapies & Rehabilitation Services, Central Middlesex Hospital NHS Trust, London.

8. Conclusion

Integrated care pathways are one means for evaluating and improving, if necessary, the quality of the actual service delivered to patients. They are devised locally using nationally developed standards or evidence-based guidelines, and should be audited regularly. The results of the audit should be fed back to the participants to enable modification and change of practice, if required. Physiotherapists are increasingly being encouraged to participate in the development, use and analysis of pathways.

9. Resources

The National Pathways Association

Jan Harvey, 21 Channel Reach, Channel Road, Blundlesands, Liverpool, L23 6TA

Tel: 0151 924 8317

Website: www.the-npa.org.uk

Directory of Integrated Care Pathways

Royal College of Nursing (1998) **Directory of NHS Trusts using Integrated Care Pathways** Royal College of Nursing Institute, Oxford OX2 6HE. Tel: 01865 224 667

The Chartered Society of Physiotherapy

For further physiotherapy-specific queries contact the Professional Affairs department at:

14 Bedford Row, London WC1R 4ED. Tel: 020 7306 6633

Fax: 020 7306 6611

Email: pa@cspphysio.org.uk

Website: www.csp.org.uk

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Field MJ, Lohr KN Eds (1992) **Guidelines for Clinical Practice: From Development to Use** Washington DC: National Academy Press. 1992

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NHS Executive (1996) **Promoting Clinical Effectiveness – framework for action in and through the NHS** Department of Health London

Royal College of Nursing (1989) **A framework for quality – a patient centred approach to quality assurance in healthcare** Scutari Press, London

Royal College of Nursing (1998) **Directory of NHS Trusts using Integrated Care Pathways** Royal College of Nursing Institute, Oxford OX2 6HE. Tel: 01865 224 667

Sackett DL, Rosenburg WMC, et al (1996) **Evidence based medicine: what it is and what it isn't** *British Medical Journal* 312, 71 – 72

Scott I (1999) **Integrated Care Pathways: An Introduction** Talk given at the Royal College of Physicians, England 24 June 1999. Contact: Director of Nursing, Leicester Royal Infirmary NHS Trust.

Secretary of State for Health (1998) **A First Class Service: Quality in the New NHS**, Department of Health.

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Currie L, et al (1998) **Care pathways - development and implementation** *Nursing Standard* 12, 30, 35-8.
Kitchiner D, et al (1996) **Integrated care pathways: effective tools for continuous evaluation of clinical practice** *Journal of Evaluation in Clinical Practice* 2(1), 65-9.

Kitchiner D, et al (1998) **Integrated care pathways increase use of guidelines.** *British Medical Journal* 317, (7151), 147-8.

Layton A, Moss F, Morgan G (1998) **Mapping out the patient's journey: experiences of developing pathways of care** *Quality in Health Care* 7 (Suppl), S30 – S36

Lowe C (1998) **Care pathways: have they a place in 'the new National Health Service?** *Journal of Nursing Management* 6(5), 303-6.

12. Glossary

The plethora of new terms in healthcare can cause confusion. The CSP uses these terms and definitions to avoid misunderstanding.

Clinical effectiveness

Is "the extent to which specific clinical interventions, when deployed in the field for a particular patient or population, do what they are intended to do – i.e. maintain and improve health and secure the greatest possible health gain from the available resources" (NHS Executive, 1996).

Clinical governance

Is 'a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (Secretary of State for Health, 1998). See CSP (1999).

Clinical practice guidelines

These are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances' (Field MJ, Lohr KN 1992). They can form part of the evidence base from which practitioners work. They are written on a carefully defined topic and, after a systematic search, use the best available evidence. They should define the references used, the reasoning for how the recommendation was written, and provide a grading of the strength of the recommendation and the quality of the evidence.

Standards

Standards are 'a professionally agreed level of service or care which encapsulates a definition of good practice. The standard is expressed in the form of a statement, against which current practice can be tested to see whether or not the standard has been achieved' (RCN, 1989).

They should be a statement for use as a basis for measurement, and define a level of established or accepted excellence.

Criterion

Criteria qualify how the achievement of a standard can be measured. Several criteria may be required for a standard.

Evidence based practice

Evidence based practice (or healthcare) is "the conscientious, explicit and judicious use of the current best available evidence in making decisions about the care of individual patients. ...integrating individual clinical expertise with the best available external clinical evidence from systematic research" (Sackett D, 1996).

Ralph Hammond
Research and Clinical Effectiveness Unit
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