QBP Pathway Improvement Program

Frequently Asked Questions For Front Line Staff

1) When is the Clinical Pathway started?

The Clinical Pathway starts as soon as possible after the diagnosis and the decision to admit. The Care Journey documents (Clinical Pathway and Patient Experience Pathway) will come with the Order Set as a package. If the patient is transferred to an inpatient bed within 4 hours after the decision to admit, the Clinical Pathway will be started by the unit staff. Otherwise, the ED staff will start the Clinical Pathway as soon as possible, with the expectation that the Clinical Pathway is initiated within the first 4 hours.

2) Is it an MRP decision to use the Care Journey documents?

The MRP decides the admitting diagnosis in conjunction with the ER physician. The primary diagnosis drives the use of the Order Set and also the Clinical Pathway and Patient Experience Pathway.

3) Who provides the Patient Experience Pathway booklet?

The "My Care Journey" booklet is provided by any member of the care team as soon as possible after the decision to admit. Professional judgement and common sense should be used based on the condition of the patient and caregivers. For example, if the patient is being prepared for an urgent intervention and does not have any family members present, the booklet should be given after the intervention.

4) Where do I keep the Clinical Pathway in the chart?

Keep the Clinical Pathway with the Patient Summary Tool (or Kardex). You will use the Clinical Pathway to address progress and barriers to discharge at Care Rounds and Shift to Shift.

5) How do we handle patients with comorbid conditions?

Based on the primary admitting diagnosis, the Order Set, Clinical Pathway and Patient Experience Pathway documents should be used. The primary condition drives the Order Set selection and documentation and the comorbid conditions are handled with hand-written physician orders.

6) What about dual diagnoses or changing diagnoses?

The MRP with the ED Physician will decide the admitting diagnosis at the point of admission. If the admitting diagnosis is not clear or is a dual diagnosis, the patient is not on a pathway. If the patient presentation is extremely complex, the patient is palliative, or the primary diagnosis changes, the patient would no longer be on the pathway. Discuss the situation at Care Rounds and make a note in the progress notes.

7) What about post-admission conditions, do they start on the pathway? For example, a patient is admitted with a Hip Fracture, but mid way through we begin to treat a new diagnosis of CHF?

Patient will only start on the pathway (Clinical and Patient Experience Pathways) at the point of admission based on the primary diagnosis. Additional pathways are not added for post-admission diagnosis since patient has already been in hospital and physician orders are already standing from prior/current diagnosis. The physician will use hand-written orders or a different Order Set as is the practice today.

8) What if a few of the patient outcomes are not being met? Does patient fall off pathway?

Patient outcomes should continue to be monitored and addressed in consultation with the MRP and entire care team while the patient is on the pathway. The decision to discontinue the pathway should be made during Care Rounds with consultation and information from the MRP. This should be documented in the progress notes. The patient should be taken off the pathway only because the clinical condition has significantly deteriorated or the primary reason for hospitalization has changed.

9) What happens when all discharge criteria are met?

When all the discharge criteria on the last page are met, the patient should be clinically ready for discharge with regards to their condition. The primary nurse should alert the care team at Care Rounds and Shift to Shift, as well as the UM Nurse. At this point, the Clinical Pathway can be discontinued.

10) What happens when a patient has exceeded the expected length of stay (LOS) and still has unmet discharge criteria? For example, a COPD patient with an expected LOS is 6 days, but the patient is still in-hospital on Day 8 and has no planned to be discharged?

The purpose of the pathway is to assess the patient's condition and progress the patient towards discharge. If the patient is still receiving acute care relating to the diagnosis but are "slower" to meet the discharge criteria than the expected LOS, the Clinical Pathway should still be used. A blank sheet can be printed from the Order Set Library with the discharge criteria. Using this document the discharge criteria can continue to be assessed.

The primary nurse should alert the care team at Care Rounds, Shift to Shift, and UM Nurse that the patient has gone beyond their expected LOS but some discharge criteria remain unmet. If the patient would cease to benefit from the Clinical Pathway because of changes to their condition or a change in their care plan, then the pathway can be discontinued after discussion with the multidisciplinary team.

11) Is the Patient Experience Pathway available in other languages?

Yes. Copies of the text in the booklet are available to be printed on your unit in other languages at WRHCareJourney.ca. The hard copy of the booklet itself is only printed in English.

12) Does this integrate with some of the Standard Unit Bundles?

Yes it does. The Clinical Pathways and Patient Experience Pathways are designed to work hand in hand with the Standard Unit Bundles: specifically:

- Care Rounds: The Clinical Pathways will be brought to daily Care Rounds to provide an update on discharge criteria or patient outcomes that are not being met as expected. This provides an opportunity of discussion about next steps or changes to care plans that might be required.
- Shift to Shift: The Clinical Pathways can be used as part of the Shift to Shift report to alert the oncoming nurse of patient outcomes not being met and additional actions that may need to be taken on the following shift.
- In-Room White Boards: The Patient Experience Pathway (my Care Journey booklet) has patient outcomes and expectations that can be selected to use on the In-Room White Boards. Both the white board and booklet work together to explain care plans during the inpatient stay.