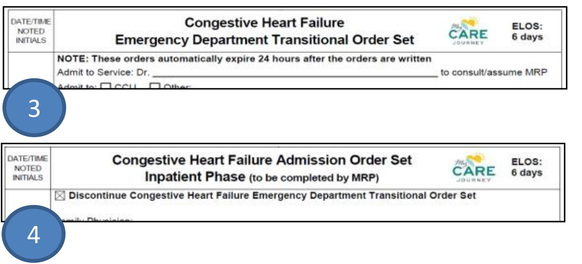
Quality Based Procedures (QBP) Pathway Improvement Program - Standard Work Instructions

Using Inpatient Order Sets, Clinical Pathways & Patient Experience Pathways	**Objective:** To standardize care for patients with similar conditions and improve communication with patients and families	**Date:** 12-Jul-17 **Owner** SOP

Front Line Staff & Physicians

1	Patient is admitted to the hospital
2	ER clerk (or ERP) selects the QBP Pathway Package and adds to the chart
Order Sets:	
3	ERP, in consult with MRP if possible, fills out condition specific QBP "Emergency Department Transitional Order Set" at the time of admission
4a	Within 24 hours, MRP rounds in person and completes the "Inpatient Phase Order Set", which automatically stops the "Emergency Department Transition Order Set"
4b	During TOA, the Inpatient Nurse asks if the patient is on a Pathway and if the Order Set was used as part of the completing the TOA
Clinical Pathway:	
5	Within the first 4 hours post-admission, the Clinical Pathway is initiated as below:
5a	The Admission Date, EDD (Expected Date of Discharge), and Today's Date are written down. The shift is written in the column near the initials section *The EDD is based on the expected length of stay. For example, a Monday admission with an expected length of stay of 5 days would be discharged 5 days after Monday (Saturday)*
5b	The interventions section for that day is to be reviewed as a guide to care and recommendation for consideration
5c	The outcomes section is reviewed and noted with with **initials** for complete and *** + initials for not completed** Any outcomes with a * should be addressed in the nursing/progress notes
6	Each shift, the Clinical Pathway interventions are reviewed, outcomes assessed and noted by the primary nurse
7	Each morning, before Care Rounds, the Discharge Criteria are reviewed and assessed as to whether the Discharge Criteria has been met or not
8	The Clinical Pathway is brought to Care Rounds and the outstanding Discharge Criteria are discussed, as well as any concerns from the Interventions and Outcomes that are preventing the patient from progressing are discussed at Care Rounds
9	If the patient remains on the pathway longer than the expected length of stay, use the "Blank Discharge Criteria" page, found as additonal documents in the Order Set Library or order through Print Shop
Patient Experience Pathway:	
10	As soon as possible after admission, the patient or family member is provided with the My Care Journey Booklet and My Care Journey Mobile App Postcard by the nurse *Note: Use clinical judgement to provide the booklet and postcard at an appropriate time depending on family support and patient acuity*
11	If necessary, print text copies of the Booklet in French, Arabic, Italian or Spanish from the WRHCareJourney.ca website
12	Explain the Booklet and Mobile App to the family; There is valuable information to help in their recovery - See WRHCareJourney.ca for more information
13	Patient and family review the Booklet and App as needed
14	Update the patient's Whiteboard each shift with the goals outlined in the Patient Experience Pathway Booklet; Remind family about the Mobile App daily


Congestive Heart Failure
Emergency Department Transitional Order Set
ELOS: 6 days
NOTE: These orders automatically expire 24 hours after the orders are written
Admit to Service: Dr. ______ to consult/assume MRP

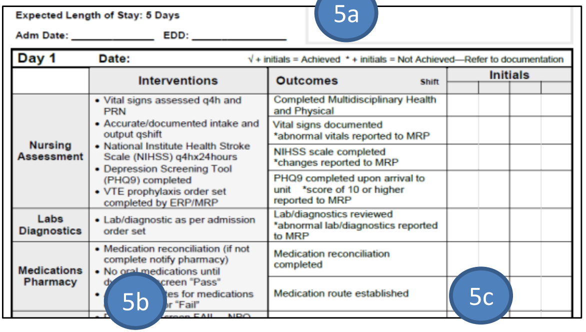
Congestive Heart Failure Admission Order Set
Inpatient Phase (to be completed by MRP)
ELOS: 6 days
☒ Discontinue Congestive Heart Failure Emergency Department Transitional Order Set

CONGESTIVE HEART FAILURE
Clinical Pathway
Expected Length of Stay: Less than 6 days
Adm Date: EDD:

Discharge Criteria

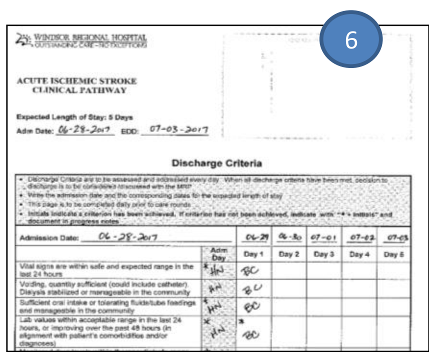
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	D/C Day
No new arrhythmias for 24-48 hours prior to discharge							
Blood pressure controlled or at baseline							
O_2 sats greater than 92% on room air at rest and activity, or at baseline							
Able to lie flat with no dyspnea							
Able to mobilize safely and returned to baseline mobility							
Ideal (dry) weight: ___ kg Daily weight (kg):							

8


Expected Length of Stay: 5 Days
Adm Date: ______ EDD: ______

Day 1 Date: √ + initials = Achieved * + initials = Not Achieved—Refer to documentation

	Interventions	Outcomes	Shift	Initials
Nursing Assessment	• Vital signs assessed q4h and PRN • Accurate/documented intake and output qshift • National Institute Health Stroke Scale (NIHSS) q4hx24hours • Depression Screening Tool (PHQ9) completed • VTE prophylaxis order set completed by ERP/MRP	Completed Multidisciplinary Health and Physical Vital signs documented *abnormal vitals reported to MRP NIHSS scale completed *changes reported to MRP PHQ9 completed upon arrival to unit *score of 10 or higher reported to MRP		
Labs Diagnostics	• Lab/diagnostic as per admission order set	Lab/diagnostics reviewed *abnormal lab/diagnostics reported to MRP		
Medications Pharmacy	• Medication reconciliation (if not complete notify pharmacy) • No oral medications until ...	Medication reconciliation completed Medication route established		


WINDSOR REGIONAL HOSPITAL
ACUTE ISCHEMIC STROKE CLINICAL PATHWAY
Expected Length of Stay: 5 Days
Adm Date: 06-28-2017 EDD: 07-03-2017
Discharge Criteria

11 ...nic Obstructive Pulmonary Disease (COPD)

My Care Journey: A Recovery Guide for You and Your Family

Arabic (عربي) French (français) Italian (italiano) Spanish (Español)

Quality Based Procedures (QBP) Pathway Improvement Program - Standard Work Instructions

Using Inpatient Order Sets, Clinical Pathways & Patient Experience Pathways	**Objective:** To standardize care for patients with similar conditions and improve communication with patients and families	**Date:** 12-Jul-17 **Owner** SOP

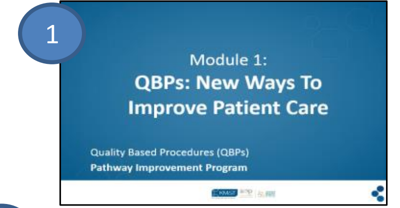
Operations Managers:

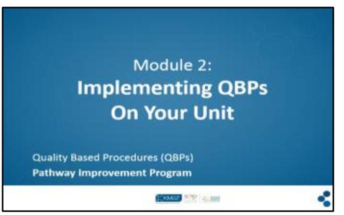
1	Confirm all front-line staff are properly trained on your unit, using the Module 1 and Module 2 training materials available on WRHow.ca
2	Incorporate Pathways into your Care Round discussions using these prompting questions: Day 1: Did the QBP Pathway Package come up from ED? Day 1: Did the MRP use the Order Set? Day 1: Is this patient on a pathway? - If no, should they be on a pathway? Every Day: What day of the pathway are we on? Every Day: Is the Clinical Pathway still in use? If not, why? Every Day: What are the un-met discharge criteria today according to the Clinical Pathway? Every Day: Discuss Plan of Care: Have the outlined tasks been completed specific to the day of the pathway (use Pathway Tip Box on the bottom right corner of the Care Round Boards)? Every Day: Are the patient and family aware of the Booklet and Mobile App?
3	On the electronic Care Round Board, if the pathway bundle is being used, enter the QBP Pathway in the Pathway column and the day of the pathway into the Pathway Day column; If they fall off the pathway, indicate using "Off"
4	Direct UM to escalate barriers to discharge that are not being completed in a timely manner to their Director or to the Command Centre as per Standard Work
5	**Follow-up:** If Order Set is was not used, root cause issue (was document available, indicated, etc.) and follow-up with the MRP if needed, or direct nursing staff to do so
6	**Auditing:** During Leadership Rounds, ensure that the Patient Experience Pathway Booklet and Mobile App have been provided and explained to patients

Clinical Practice Managers:

1	Ensure all front-line staff are properly trained on your unit, using the Module 1 and Module 2 training materials available on WRHow.ca
2	During Care Rounds, identify patients who should be on the Pathway and confirm the staff have the Order Set, Clinical Pathway, and Patient Experience Pathway available
3	Support the Operations Manager and Front-Line Staff in the identification of outstanding discharge barriers during Care Rounds using the Clinical Pathway
4	**Auditing:** Follow-up daily with staff who are not bringing the Clinical Pathway to Care Rounds or who are uncertain about the patient outcomes and discharge criteria
5	**Auditing:** During daily chart audits, confirm that Order Set and Clinical Pathway documents are being used by the care team and that the My Care Journey Booklet is not still in the chart; Verify that the Clinical Pathway is completely filled out including the Discharge Criteria
6	**Auditing:** Determine daily if the patient and family have been provided the My Care Journey Booklet and Mobile App Postcard; Ask if these were explained and used as part of Today's Plan of Care on the In Room Whiteboard
7	**Auditing:** Review patient's In Room Whiteboard daily to ensure it is updated each shift with the goals and expectations outlined in the Patient Experience Pathway
8	**Auditing:** Ensure staff are aware of the new Mobile App and promotional material is available to staff

1





2

5

6

8