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Accountability for What?

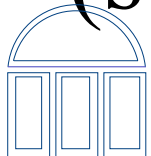
Health Care has many hidden barriers to sound evaluation processes, which pose problems even for those with many years of healthcare experience. One easy assumption is that stakeholder group discussions use terms and descriptors with a common meaning. In a decade of implementation of evidence-based care management tools, the author has found instead two common problems; terms may have different meanings, and descriptive phrases may lack precision. Thus, facilitation processes must include accountability for expressing each professional's perception of ordinary terms like ambulation. Such preparatory work is necessary if data used in quality assurance processes and other cyclical or focused evaluation activities is to have the internal consistency to support reliable evaluation processes.

In this presentation, the author will use examples from various settings illustrating glossaries' role in supporting an accountable evaluation process, by defining terms and activities, which support precisely stated outcome indicators.

<i>Type of Presentation:</i>	<i>Paper</i>
<i>Conference Themes Addressed:</i>	<i>Accountability, Evaluation</i>
<i>Language of Presentation:</i>	<i>English</i>

Multidisciplinary Health Care Teams
in many health care organizations
are producing “Clinical Pathways”

The pathways (see definition) support
tracking of patient clinical progress with
“variance tracking” or “key indicator”
(see definition) of progress tracking.

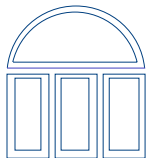


Definition

Pathway:

“A multidisciplinary tool, which makes explicit the usual patient problems and activities that must occur to facilitate the achievement of expected patient outcomes in a defined length of time.”

As adopted by the Durham Region Path Work Group



Definition

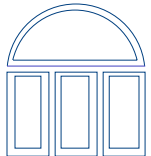
Key Indicators

- Events or outcomes that show patient progress
- Developed systematically by the team (congruence of expert opinion & evidence)
- Used to evaluate patient progress & identify variances



Examples of Key Indicators

- Up in chair
- Pain score 3
- Tolerating clear fluid diet
- Demonstrates ostomy care
- Lung sounds clear



Challenges with Key Indicators

Past experience indicates a lack of intra & inter organization consistency in describing and tracking expected patient progress in activity (e.g. ability to ambulate)

Evidence supports some professional interventions (e.g. physiotherapy)

Since indicators therefore are process based, what is the current status of agreement in describing & tracking activity?

Stakeholder group discussions use terms and descriptors with the expectation of a common meaning. However:

- terms may have different meanings to different professions
- descriptive phrases may lack precision

So, facilitation processes must include accountability for expressing each professional's perception & use of "ordinary" terms like ambulation

Note – such data is often used in:

- quality assurance processes
- cyclical (scorecard) or focused (program) evaluation activities

Information Elicited From Two Online Interest Groups

Tracking progress toward defined patient outcomes (rather than variance from expected care events). In your pathways, do you have a standard approach for:

1. Assessing a patient activity / ambulation level? (e.g. a modified Romberg test for gait/ambulation with geriatric patients)
2. Describing expected patient outcomes in activity / ambulation? (e.g. achievement on a standard test, or stages of activity / ambulation progress as defined at your organization)
3. Charting patient progress in activity / ambulation? (e.g. is this done on a flow chart, on the path, or somewhere with standard language? Does the phrase Activity as Tolerated appear?)

Poor response – SARS! Therefore, ➔

Clinical Pathways Were Examined for Patient Activity Indicators:



PNEUMONIA in the patient with a co-morbid condition, e.g.,
CHF, COPD, asthma or confusion

	EOR/ADMISSION Day 0	Day 1	Day 2-3
Activity	Stage 1-2 Physio consult for ambulation prn	Stage 1-3 Establish individual ambulation plan with pt/family	Stage 3-5 or as per amb. plan Teach energy conservation. Communicate plan to health team
Positioning			

CREDIT VALLEY THE CREDIT VALLEY HOSPITAL

CLINICAL PATHWAYS Elective Colorectal Resection with or without Colostomy

Phase:	OR	PACU	Day of Surgery Postop	Postop Day 1
Activity/ Safety	Cautery safety Teeth inspection Positioning: supine or lithotomy/leg Holders & padding	Assist with repositioning/ turning Foot and ankle exercises	Turn q2-4 hrs Assess skin if patient receiving local anaesthetic in Epidural infusion Post-op bath	AAT with assistance, sit in chair Skin assessment Bedbath,

Standard Assessment Examples Were Identified:

From the LAKERIDGE HEALTH CORPORATION
 MEDICAL DIRECTIVE1.
 GENERAL AMBULATION GUIDELINE

- Stage 1: ABSOLUTE BEDREST: Deep breathing and coughing exercises, active leg and foot/ankle exercises.
 Stage 2: DANGLE: Sit on side of bed. Commode use.
 Stage 3: UP TO CHAIR/COMMUNE as tolerated.
 Stage 4: UP TO BATHROOM and/or WALKING IN ROOM
 Stage 5: WALKING IN HALL as tolerated.
 Stage 6: STAIRS OR BRISK WALKING

From the Grey Bruce Health Network Myocardial Infarction Clinical Pathway

ACTIVITY LEVEL GUIDELINE*			
LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
<ul style="list-style-type: none"> BED REST BED SIDE COMMUNE PRIVILEGE IF STABLE FEED SELF ASSISTED BATH ANKLE AND FOOT EXERCISES DEEP BREATHING/ COUGHING/CALF PUMPING 	<ul style="list-style-type: none"> SIT UP 20 MINUTES (TID/MEALS) BRPs ASSISTED BATH 	<ul style="list-style-type: none"> UP IN ROOM AD LIB BRPs SIT UP FOR MEALS SHOWER WALK IN HALL 	<ul style="list-style-type: none"> ACTIVITY AS TOLERATED STAIRS

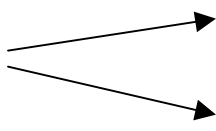
*ADAPTED FROM THE GUELPH GENERAL HOSPITAL AMI ACTIVITY LEVEL GUIDELINE

SUMMARY - Descriptions of Activity Status / Progress

✦ Activity as Tolerated

✦ Specification of one or combinations of the following:

- Distance (day x walks 10 m in hall with walker)
- Weight bearing
- Frequency
- Devices needed (some organizations disagree with this)
- Toleration by measured criteria (breathing, heart rate, etc)
- Ability to transfer (e.g. bed to chair, to toilet, to car)

✦ Stages of Activity  4 Stages
6 Stages

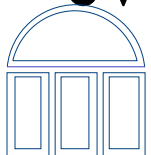
✦ Note - degree of rigour associated with activity measure may vary within an organization by diagnosis and perceived relationship of activity progress to resolution of reason for admission

Realities:

- Online documentation means data is being gathered →
- Agreement in literature only on some indicators (e.g. degree of flexion for safe discharge of Total Knee Replacement)

Concerns:

- Aggregation of this data may already be occurring
- Indicator data aggregation in hospitals a challenge even when data are clearly defined!



Data from online documentation



AGE	PATH	RFU /PRUDx /UPOTDx	LOS	PROG	ATTDr	FAMDr	MOVE	PAIN	DIET/NAU	PERIPH/CNTRAL	DRAINS	C/TUBE	BM	BLADDER	ISOL	REFERRAL
53		DIABETES/CHF/CHRONIC RENAL FA 33	MDIAL				4/ROOM	0	DIABETIC				Y	URETH C		
		Dsc Plan:BB/NEED OP HEMO SPOT					TO BED	NO C/O	0-NONE					CONDOM		
		NsgPlan-DIAB/CHF/CRF					NONE/IND									
58	CUA	(R) CUA	8	MEDG			3/CHAIR	0	0					N		
		Dsc Plan:NG/Somchai to see					TO CHAIR	shoulder	0-NONE							
		NsgPlan-L-SIDED WEAKNESS					1 PERSON							URINAL		
76		CUA/MEDICALLY UNSTABLE	27	ALC			1/BEDRES	0	DENTAL	2/3 & 1/			Y	URETH C	N	
		Dsc Plan:BB/ASSESSMENT IN PROGRESS					TO BED	NO C/O	0-NONE							
		NsgPlan-C-DIFFCUA					2 PERSON							CONDOM		
N 71		ELECTROLYTE IMBALANCE,CA THR 14	MEDG				5/HALL	2	0	05/NS			Y	URETH C		
		Dsc Plan:BB/DR.CHIAO TO SEE					TO BED	THROAT	0-NONE							
		NsgPlan-CA THROAT? DEHYDRATION					NONE/IND							BATHROO		
57	AFTT	CUA	49	ALC			5/HALL	0						N		
		Dsc Plan:BB/J FEEDS/HOME		regulate feeds			IN ROOM	DENIES	0-NONE							
		NsgPlan-CUAPLACEMENT					1 PERSON	SPLINT						BATHROO		
87	COPD	SOB,COPD	10	MPULM			5/HALL	0	0					N		
		Dsc Plan:BB/MRP DR.ROSS					IN ROOM	NO C/O	0-NONE							
		NsgPlan-COPDSOB					1 PERSON							COMMODE		

Next Questions:

- Does there need to be a basic approach across all patient groups?
- If “Stages of Ambulation” support consistent tracking, *how many stages* support needed observations?
- What information is necessary for full information on a patient’s progress: amount of assistance? walking aides (walker, crutches)?
- Does distance count?
- When is additional information necessary
 - Degree of Flexion, Range of Motion
 - Gait, Stance, Turning, etc
- Should “Activity as Tolerated” ever be on a patient’s plan or documentation?

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