PURPOSE

- To ensure the development of care pathways is consistent with organisational policy, complies with any legal requirements and supports sound practice.
- To provide a framework for the development, implementation, management and evaluation of care pathways.

STANDARDS TO BE MET

1. Care pathways are a tool for guiding patient care but are not a substitute for reasoned clinical judgement by health professionals.
2. Care pathways are developed and implemented as health records. The content, format and process are subject to risk management process during development and are consistent with quality standards and conform to any relevant legislation.
3. As a health record care pathways are an integrated multidisciplinary record, should be as brief as is compatible with recording all material information and avoid duplication of other components of the record.
4. Care pathways will be selected for development where the greatest level of process improvement may be made, for the purpose of improving patient outcomes and providing a mechanism of standardising predictable patient care.
5. Patients whose treatment plan is via a care pathway will be informed of this and will be provided with a copy of the relevant patient care pathway.
6. Care pathways should capture and retrieve data required to measure both process and outcome against audit criteria.
7. Care Pathway Development
   New care pathways should be selected for development using the following criteria as a guide:
   - 7.1 High multidisciplinary involvement.
     - a) Crosses the continuum of care.
     - b) High volume and / or high cost.
     - c) Aligns with regional and annual plans
     - d) Provides opportunities for reduction in length of stay at Bay of Plenty District Health Board (BOPDHB).
   - 7.2 Development of care pathways should be based, where possible, on the best available evidence obtained from systematic reviews or well designed randomised controlled trials. Where evidence is weak, a consensus of respected opinion should be sought.
   - 7.3 All new care pathways will be developed and produced using the electronic Trendcare Care Paths module.
   - 7.4 Care pathways should be developed with wide consultation among staff participating in the care of patients with that condition and include consumers as part of the process.
   - 7.5 Once consultation has been undertaken with all key stakeholders and the clinical content endorsed, the draft care pathway is sent by the lead clinical developer to the Trendcare Co-ordinators who will publish on Trendcare for use.
   - 7.6 Education on new care pathways will be provided to staff by the clinical lead with responsibility for developing the pathway.

8. Use of Care Pathway
   - 8.1 Care pathways are initiated as soon as the diagnosis is made or procedure is determined. If for any reason there is delayed initiation, an explanation is documented in the patient's health record.
   - 8.2 As a treatment plan, a care pathway is subject to the requirements of informed consent.
   - 8.3 The patient's name and any other identifying information is provided on all care pathway and supplementary pages.
   - 8.4 All staff to print name / signature / initials and designation on care pathway signature page.
   - 8.5 Each check box / initial space is to be signed by the appropriate member of the patient care team when an action is completed. This is a legal record of care / information provided.
   - 8.6 All variances are accompanied by the relevant variance code, are signed and dated and any explanatory note made in the appropriate place.
   - 8.7 The supervising medical professional may alter the treatments of patients placed on care pathways. These alterations should be documented in the usual manner of prescribing treatment changes. Any additional actions should be recorded on the care pathway in the additional actions box, including the Indicator, Action and details of action.
   - 8.8 Variance reporting for patients on care pathways will report on anything not detailed in the care pathway that has impacted upon patient care.
   - 8.9 If a patient is removed from the care pathway for any reason, this is to be documented including signature, time and date.
   - 8.10 Care pathways will utilise appropriate existing protocols.
   - 8.11 Monitoring and auditing of the care pathways will be the responsibility of the relevant service.
   - 8.12 Auditing will be agreed by the service but should take account of actual patient volumes as well as compliance with use.
   - 8.13 Once care pathways have been implemented, it is the responsibility of the individual departments to define the additional type of information required on audit.

REFERENCES

- Auckland DHB, Clinical Pathway Guide (Clinical Pathways Group, 2002)
- Lowe .C. (2006) Clinical Pathways – Leading to quality care, efficiency and best practice outcomes. (paper presented at Best practice conference)
- Trendcare Clinical Pathway Development and Maintenance version 3.4 Trendcare systems Pty Ltd
- Trendcare Clinical Pathway User guide – 2012 Trendcare Systems Pty Ltd

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 2.5.2 Health Records Management
- Bay of Plenty District Health Board policy 1.4.4 Maori Cultural Safety
- Bay of Plenty District Health Board policy 1.1.1 Informed Consent