Accountability for What?

Tracking Patient Activity

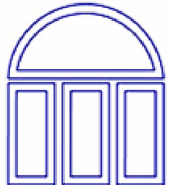
A Poster Presented

at the Conference of the

Canadian Evaluation Society

In the Public's Best Interest: Evaluation, Accountability and Transparency

Vancouver, June, 2003



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Accountability for What? Tracking Patient Activity

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.

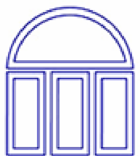
In this presentation, the author will use examples from various settings illustrating glossaries' role in supporting an accountable evaluation process, by defining terms and activities, which support precisely stated outcome indicators.

Type of Presentation: *Paper*
Conference Themes Addressed: *Accountability, Evaluation*
Language of Presentation: *English*

Issue 1

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.

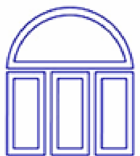


Definition

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



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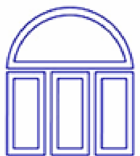
Definition

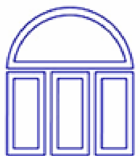
Key Indicators

- 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

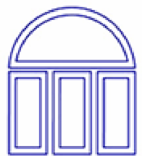


Challenges with Key Indicators

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?



Issue 2

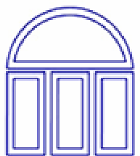
Stakeholder group discussions use terms and descriptors with the expectation of a common meaning. However:

A. terms may have different meanings to different professions
B. 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



Process 1

Information Elicited From Two Online Interest Groups

These questions are about tracking progress toward defined patient outcomes (rather than variance from expected care events).

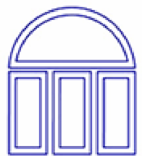
In your pathways, do you have a standard approach for:

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, ➔



Process 2 – What have teams produced?

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

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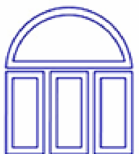
CLINICAL PATHWAYS
Elective Colorectal Resection with or without Colostomy

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,



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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/COMMODE 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
• BED REST • BED SIDE COMMODE PRIVILEGE IF STABLE • FEED SELF • ASSISTED BATH • ANKLE AND FOOT EXERCISES • DEEP BREATHING/ COUGHING/CALF PUMPING	• SIT UP 20 MINUTES (TID/MEALS) • BRPs • ASSISTED BATH	• UP IN ROOM AD LIB • BRPs • SIT UP FOR MEALS • SHOWER • WALK IN HALL	• ACTIVITY AS TOLERATED • STAIRS

*ADAPTED FROM THE GUELPH GENERAL HOSPITAL AMI ACTIVITY LEVEL GUIDELINE

DRAFT

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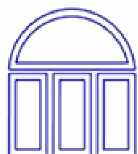
Last Modified May 29, 2003



Process 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:

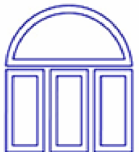
- Online documentation means data is being gathered (see next page), however
- Agreement in literature only on some indicators (e.g. degree of flexion for safe discharge of Total Knee Replacement)

Concerns:

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

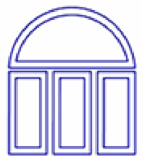
Data from online documentation

AGE PATH	RFV /PRVDx /UPDTDx	LOS	PROG	ATTDr	FAMDr	MOVE	PAIN	DIET/NAU	IVs PERIPH/CNTRAL	DRAINS	C/TUBE	BM	BLADDER	ISOL	REFERRAL
53	DIABETES/CHF/CHRONIC RENAL FA Dsc Plan:BB/NEED OP HEMO SPOT NsgPlan-DIAB/CHF/CRF	33	MDIAL			4/ROOM TO BED NONE/IND	0 NO C/O	DIABETIC 0-NONE				Y CONDOM	URETH C		
58 CVA	(R) CVA Dsc Plan:NG/Somchai to see NsgPlan-L-SIDED WEAKNESS	8	MEDG	SI	E	CHAIR CHAIR PERSON	0 shoulder	0 0-NONE				N URINAL			
76	CVA/MEDICALLY UNSTABLE Dsc Plan:BB/ASSESSMENT IN PROGRESS NsgPlan-C-DIFFCVA	27	ALC			1/BEDRES TO BED 2 PERSON	0 NO C/O	DENTAL 0-NONE	2/3 & 1/			Y CONDOM	URETH C	N	
N 71	ELECTROLYTE IMBALALNCE,CA THR Dsc Plan:BB/DR.CHIAO TO SEE NsgPlan-CA THROAT? DEHYDRATION	14	MEDG			5/HALL TO BED NONE/IND	2 THROAT	0 0-NONE	D5/NS			Y BATHROO	URETH C		
57 AFTT	CVA Dsc Plan:BB/J FEEDS/HOME regulate feeds NsgPlan-CVAPLACEMENT	49	ALC			5/HALL IN ROOM 1 PERSON	0 DENIES SPLINT	0-NONE				N BATHROO			
8	,COPD D RP DR.ROSS SOB	10	MPULM			5/HALL IN ROOM 1 PERSON	0 NO C/O	0 0-NONE				N 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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