

# [A patient pathway can be defined nursing essay](https://assignbuster.com/a-patient-pathway-can-be-defined-nursing-essay/)

A patient I encountered and treated on placement has been selected as the case study for this essay. This patient has been identified as having complex needs. Rankin and Regan described complex needs as impacting beyond the individual challenges faced, describing them as “ interlocking problems where the total represents more than the sum” (2004, p7). The patient presented is a medically complex, older woman with psychosocial issues in addition to her chronic illness of osteoporosis and ankle fracture. This essay will evaluate the role and application of physiotherapy throughout this patient’s pathway. It will focus on the role of health improvement related to the patient and the features for effective team work during the patient’s treatment.

A patient pathway can be defined as

“ A plan of care that aims to promote organised and efficient multidisciplinary patient care based on the best available evidence. Care pathways are complex interventions made up of a number of components, and is often implemented with some form of education and usually form all or part of the patient record.” (Kwan & Sandercock, 2005)

It is important to note that due to the complexity of individual patient cases it is not always possible to follow a pre-determined patient pathway. As in this case, the individual needs of the patient coupled with the clinical autonomy and decision making of the involved professional parties, dictates the patients pathway.

## The Patient

The patient, Mrs W, is a 68 year old woman, who lives at home with her husband (69). Her husband has osteoarthritis and is awaiting total knee replacements in both knees. Mrs W suffered a complex distal tibia fracture of her right ankle, when putting her foot down to stop, while cycling. She has since been diagnosed with osteoporosis. She suffers from emphysema and smokes up to twenty cigarettes a day, although she reports a desire to quit. She has a history of depression, which she is not currently receiving any treatment for.

Prior to the accident, Mrs W was independent and active. She loves gardening, cycling, walks the dogs twice daily and carries out most of the household chores due to Mr W’s painful knees. She lives in a two storey house, with bedroom and bathroom upstairs, in a rural area with limited public transport. They moved here fifteen years ago due to work commitments of Mr W, but he has recently retired due to his osteoarthritis and he has also been forced to quit driving leaving the responsibility of the town commute to Mrs W. The nearest town, with most local services and amenities is a forty minute drive away. There is a local shop and post office which can cater for some services, a twenty minute walk away.

Mrs W’s family remain in England and abroad. They have a small, close but ageing community of neighbours who they would encounter regularly while out and about.

## The Role of Health Improvement

The foundation of health promotion is grounded in the World Health Organization’s first international conference on health promotion in Ottawa in 1986 which defined health promotion as the “ process of enabling people to increase control over, and to improve their health. This perspective is derived from a conception of health as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment” (WHO, pp. 1, 2009). http://www. who. int/healthpromotion/Milestones\_Health\_Promotion\_05022010. pdf

Health promotion targets the strengthening of health by improving conditions of life.

## Health Education

Due to an increasingly ageing population and changing demographics there is more demand for health promotion and patient education by physiotherapists (Davis and Chesbro, 2003). Health promotion and patient education are fundamental skills that fall under the scope of practice for a physiotherapist, but Davis and Chesbro (2003) argue that the effects of the delivery of this skill set is diminished unless models and methods of teaching and interacting with older adults are used. In the case of Mrs W, it was paramount that the health promotion message was being understood and taken on board to ensure adherence to treatment and the overcoming of barriers to treatment. Three areas of health promotion discussed with Mrs W were falls prevention, smoking cessation and depression. Health empowerment was crucial to ensuring adherence of the previously mentioned health promotion areas, and will be discussed under the headings self-efficacy and health literacy in relation to the treatment of Mrs W.

## Falls Prevention

Without adequate care, acute ankle trauma can result in chronic joint instability. Reductions in ankle strength and ROM in older people has been associated with decreased functional mobility and risk of falls (Gras et al, 2004). Therefore in order to get Mrs W back on her feet and restore her independence, ankle mobility and strength exercises were prescribed as well as the participation in a lower limb class once a week with a view to progressing into a falls prevention class. Ankle mobility is an important determinant of balance and functional ability in older people (Menz et al, 2005) while the strengthening of weakened muscles is essential to prompt recovery and important in preventing re-injury (Thacker, 1999).

It was paramount that Mrs W understood the benefits of these exercises and the dangers associated with being a falls risk in her current living environment. Initial barriers to adherence included Mrs W’s denial of being a falls risk and that additional falls prevention measures were needed. There were also practical barriers associated such as depending on others for transport etc. These barriers were overcome by focusing on the wider benefits of additional exercising such as general increased mobility, health, confidence, mood and the social aspect of a group class.

Upon reflection an emphasis could have been placed on more positive terminology such as “ strength and balance training” rather than “ falls prevention” which can be perceived to have negative connotations. Falls prevention is also associated as being an older person’s problem which could result in negative reactions should the patient not like to think of themselves as being old. This is consistent with the results of studies analysing older people’s outlooks on general exercise, which highlights an aversion to health promotion messages specifically targeting older adults, and identifies psychosocial benefits rather than health benefits as a primary motivating factor (Hawkins et al, 2003; Yardley et al, 2006).

## Smoking Cessation

I discussed with Mrs W in our first appointment that if she was to quit smoking it would both improve the level of her physical and mental health as well as improve the quality of her healing. There was an initial reluctance and she reported needing them now more than ever during this stressful time. I gave her some information leaflets on quitting as she left and explained that with the additional exercise she was about to undertake, this would be a great time to consider quitting, with exercise identified as a resource to help achieve smoking cessation (World confederation for Physical Therapy, 2012).

When she returned for her next appointment she had the information leaflets in her hand and explained that she talked it over with her husband and is determined to quit smoking. I referred her to the healthpoint clinic located in the hospital and advised her to contact her GP. Upon reflection I could have followed this up more throughout our treatment. Evidence suggests she could have benefitted from continuous encouragement and motivation from other health professionals, which has been found to influence participation (Yardley et al, 2006).

## Depression

Mrs W has a history of depression. Her injury had temporarily removed her independence and left her requiring help. The injury had removed her ability to drive to the local town for services eg. food, carry out her household chores and care for her husband. How one perceives themselves, self-concept, significantly mediates the relationship between physical injury and depression (Seff et al, 1992; Crichlow et al, 2006). Research establishes the association between declining function and depression (Lynch & George, 2002). Societal level support is important for the psychological well-being of the elderly, especially when they face common, but unexpected loss of functions without support from family or friends (Muramatsu et al, 2010). This is relevant in the case of Mrs W who had found her independence suddenly stripped away following her accident. She was left with limited access to local services, and her immediate family in England or abroad. Contact was made with a local community development officer to arrange alternative transport for Mrs W to and from the town and the benefits of regular aerobic exercise were discussed with Mrs W.

The aims being to help reduce her symptoms of depression and anxiety while maintaining and progressing any level of fitness she had with the view to restoring full independence. The effects of aerobic exercise on depression remission appear to be similar to some antidepressant medication and seem to extend the short-term benefits of exercise and may supplement the benefits of antidepressant use (Hoffman et al, 2011).

## Health Empowerment

## Self-Efficacy

Glanz and Rimer (2005) believe that positive self-efficacy combined with realistic patient goal expectations will result in a more effective treatment experience. A physiotherapist’s treatment goal is to help patients achieve their highest functional ability. Health promotion aims to prevent ill health through the promotion of health allowing people to develop self-control. Self-empowerment is described as the method of allowing individuals to be in control and therefore is fundamental to health promotion. Hammer, Degerfeld and Denison (2007) explain how the likes of physiotherapy can utilize health education and health promotion in practice with the view to improving ones self-empowerment and self-efficacy.

Hammer, Degerfeld and Denison (2007) also look at the correlation between self-efficacy and compliance or adherence to home exercise plans through analysing the social cognitive theory (SCT). The SCT hypothesises that people will comply when they believe certain actions will produce the wanted results and that those certain actions are achievable (Glanz and Rimer, 2005).

Tailoring the message based on her health and functional status is paramount, and counselling should be on-going and included at every visit (Struck, Ross 2006). Different options of chair and bed exercises were discussed and Mrs W and her husband were both involved in the decision process, identifying exercises and building a home exercise programme that suited her and her needs. Empowerment through education and discussions about the benefits of exercise to her health contribute to adherence and participation (Resnick et al, 2007). Involvement in the exercise selection process and knowing her actions made a difference to her health put her in control and increased her self-efficacy. It is the role of the physiotherapist to encourage and work with these feelings of control, self-efficacy and empowerment, working together to implement achievable exercise goals throughout the patient pathway.

Tai Chi classes were also discussed as a future treatment. While Mrs W thought the idea to be daft at a stage when she was still not even mobilising independently, the class had a large waiting list. Also the future planning and belief from the physiotherapy staff that a full recovery would be reached a few months down the road instilled a confidence in the patient. Tai Chi has been found to improve the proprioception in ankle joints, improve balance and reduce falls in older people (Xu 2003). Light exercise and Tai Chi specifically has also been found to reduce depression in the elderly (Lindwall et al, 2007, Lavretsky et al, 2011).

## Health Literacy

Vanderhoff (2005) defines health literacy as “ the degree to which individuals have the capacity to obtain, process and understand basic information and services needed to make appropriate decisions regarding their health” Health literacy is another prominent feature of health promotion, which physiotherapists need to give special attention to in order to deliver successful health education and health empowerment. A contributing factor to poor compliance is that patients do not always fully understand their diagnosis or their treatment plan. This can lead to incomplete home exercise plans, exasperation of symptoms, prolonged or repeated injury.

Research correlates health literacy with successful treatment identifying that the greater the health literacy the greater success with participation and empowerment of patients, holistic approaches, client centred practices, teaching information and methods and access to services and equity issues (Vanderhoff, 2005).

In the case of Mrs W, her husband was present at all appointments and consultations to aid with the retention of information. All information including exercise prescription and follow up appointments were given on a hand-out and thoroughly explained to ensure clarity. A member of the physiotherapy department was always present during the lower limb classes should there be any confusion with her treatment programme and her involvement in the exercise selection process ensured that they were also exercises she was comfortable with and therefore easier to remember.

## Features of effective team working with relation to the Patient

There is a growing importance of effective team working and the role it plays in delivering an effective health and social care service to patients (Forte and Fowler, 2009, p. 58). The general understanding today, throughout the UK and the rest of the developed world, is that treatment will involve the collaborative practice of the necessary health professionals, focusing and supporting patient centred care through their treatment pathway (Suter, Arndt, Arthur, Parboosungh, Taylor and Deutschlander, 2009). The importance of effective team working in a health care environment is further emphasized in the World Health Organisation Annual Report (2008) where there is a call for further collaborative practice/teamwork amongst healthcare professionals. Effective teamwork can be described as multiple healthcare professionals, from various professional backgrounds combining to deliver quality care to patients and their families through, problem solving, sharing experience, and coordinating care (Barr and Ross, 2009).

Many studies have analysed teamwork throughout many different disciplines. Such studies have resulted in the formulation of around 138 different conceptual frameworks over a 20 year period, all identifying and detailing the components and features which both lead to effective teamwork and which act as a barrier to effective teamwork (Burke, Salas & Stagl, 2004). For the sake of discussing the features of teamwork and evaluating the effectiveness with relation to the experience of Mrs W, this essay will adopt the Salas conceptual framework applying it liberally to the healthcare environment in an outpatients setting.

The Salas framework describes five core components for effective teamwork, including, team leadership, collective orientation, mutual performance, backup behaviour and adaptability (Salas et al, 2005). The framework describes these components interaction as follows;

Leadership directly affects collective orientation, performance monitoring and backup behaviour.

Collective orientation and back up behaviour influence performance monitoring.

Performance monitoring and backup behaviour generate adaptability. (Salas et al, 2005).

The Salas framework also identifies three coordinating mechanisms which promote and allow the above interactions to run effectively, shared mental models, closed loop communication and mutual trust. It is the collaboration of the core components with the three coordinating mechanisms which allow for an environment to utilize the team members/ health professional’s specific knowledge, skills and abilities (KSA’s) to promote the desired effective teamwork (Salas et al, 2005 & Baker et al, 2006). It is widely accepted that the components of this framework can be applied for the development and improvement of effective team processes (Lo, 2011, Mickan et al, 2000, West et al, 1994 and McIntyre et al, 1995).

## Team Leadership

Team leadership is described as “ the ability to direct and coordinate activities of other team members, assess team performance, assign tasks, develop KSAs, motivate team members, plan and organize, and establish positive atmosphere” (Lo, 2011, p. 9)

No specific leader is assigned when discussing team work within a health care setting. The specific skill set associated with team leadership are typically adopted by various team members throughout in order to utilise the specific KSA’s available within the team through the various health care professionals (Webber, 2002). This was seen in the case of Mrs W. Initial team leadership came through the orthopaedic surgeon who after completing surgery directed and co-ordinated the involvement of physiotherapy through a referral to the outpatient department where I met and treated Mrs W. While communication opportunities were available at all times between the orthopaedic surgeon and the physiotherapy team, it was limited, with the leadership from this point on in terms of exercise prescription, treatment plans, goal setting and rehabilitation all falling under the scope of the physiotherapist. One week Mrs W reported considerable confusion and upset after visiting the surgeon on a follow up appointment. Decisions had been made by the physiotherapy team in terms of walking aids and exercise progression based on weekly assessments. The surgeon then provided conflicting advice and instructions based on his assessment after 6 or 8 weeks without any involvement in the rehabilitation process in between appointments. All conflicting instructions and patient confusion were later rectified through a series of phone calls however it was an additional burden the patient could have avoided through some more effective team work. Upon reflection better planning, organizing and communication was necessary to ensure a more positive atmosphere for the patient and to demonstrate a more holistic and mutual understanding of the patients goals and targets (Burke, Salas and Sims, 2009).

## Mutual performance

Mutual performance is described as “ the ability to develop common understandings of the team environment and apply appropriate task strategies to accurately monitor teammate performance” (Lo, 2011, p. 9)

During Mrs W’s physiotherapy treatment she reported the development of a rash and redness on her affected leg. After consultation with my clinical educator and further discussion with Mrs W, we agreed to refer her to a dermatologist. After Mrs W’s first appointment with the dermatologist I received a phonecall where the dermatologist outlined her findings and treatment plan. We identified that no adjustments were required in the physiotherapy treatment plan. We developed an understanding of one another’s roles in the treatment of Mrs W allowing me to monitor the skin condition when I met with Mrs W twice a week and should things be getting worse arrange for her follow up appointment with the dermatologist to be moved sooner. This was also a very good example of mutual trust, one of the three key coordinating mechanisms which promote and allow the interactions to run effectively, leading to effective teamwork. Mutual trust is described as “ Shared belief that team members will perform their roles and protect interests of their teammates” (Lo, 2011, p. 9). You could really tell that Mrs W appreciated the high level of communication between team members. It allowed for the development of a mutual understanding of the team environment, apply appropriate multi-disciplinary treatment strategies and to monitor the individual treatment performances more effectively (Barach and Weingart, 2004).

## Backup Behaviour

Backup behaviour is described as “ Ability to anticipate other team member’s needs through accurate knowledge about their responsibilities; ability to shift workload among members to achieve balance during periods of increased workload or pressure” (Lo, 2011, p. 9)

During Mrs W’s treatment she benefitted from a strong working relationship between the physiotherapy team and the occupational therapy team. From early assessment it was very clear that Mrs W would require adjustments made to her living arrangements as well as various aids to allow her to perform certain duties while initially in a wheelchair and whilst depended on walking aids. Mrs W expressed concern about her ability to carry out particular tasks by herself. Through accurate knowledge of the skill base and services available to Mrs W through the occupational department, the physiotherapy team were able to both put Mrs W’s mind at rest while anticipating the occupational team-members needs when retrieving necessary and relevant information for an efficient referral. Support and backup behaviour within a team setting when used correctly like this, instils a confidence and trust amongst team members, allows for the sharing of workloads, reduces stress and pressure and results in more effective teamwork (Ellis et al, 2003). This was a good example of shared mental models, one of the three key coordinating mechanisms which promote and allow the interactions to run effectively. Shared mental models are described as “ The knowledge structure of the relationships between task team is engaged in and how team members will interact” (Lo, 2001, p. 9).

## Adaptability

Adaptability is described as “ Ability to adjust strategies based on information gathered from environment through using compensatory behaviour and reallocation of intra-team resources; Altering course of action or team repertoire in response to changing conditions” (Lo, 2011, p. 9)

Mrs W was using a wheelchair at the beginning of her rehab for mobilising long distances and outdoors. She obtained this wheelchair from the Red Cross who wanted the wheelchair back. At this stage of her treatment she was attending a lower limb class once a week as well as a one on one physiotherapy session in the outpatients department. She found the wheelchair made access to the hospital easier as she may have some distance to travel from the carpark to the hospital. Mrs W at this stage could mobilise short distances with two elbow crutches but would become very fatigued due to a lack of physical strength and respiratory complications. This meant that both the Red Cross and the physiotherapy department, needed to adapt their strategies. After some communication between both parties, changes were put in place to accommodate Mrs W through the reallocation of team resources. A change in plan can often derail a team’s strategy with implications on team motivation, performance and effectiveness (Gully et al, 1999) however good communication and adaptive skills ensured positive outcomes for the patient. This was also a good example of strong communication skills, demonstrating closed loop communication, another one of the three key coordinating mechanisms which promote and allow the interactions to run effectively. Closed loop communication is described as “ Sender initiates communication; receiver confirms that the communication has been heard and repeats the content; sender verifies the accuracy of that content” (Lo, 2011, p. 9)

## Collective Orientation (47-49)

Collective orientation is described as “ Propensity to take other’s behaviour into account during group interaction; belief in importance of team goal’s over individual member’s goals” (Lo, 2011, p. 9).

Teamwork Definition

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