Pathway Analysis

Contents

1.0.Introduction

Nursing care has a direct influence on the well-being of the patient, but this also depends on the decision-making process (Ashworth et al., 2008) in the assessment, planning and intervention stage to ensure the patients' needs are met. This article uses a case study scenario to evaluate the concept of shared decision-making in the context of meeting health and social care need(s) of a young service user. To support shared decision-making process among the nurses with regards to assessing, planning and intervening for clients' needs, relevant theoretical concepts have been utilized. A biopsychosocial perspective has helped in the critical review of the complex needs of the client, and the importance of suitably shared decision-making in preventing a patient crisis, improving recovery and coping, and contribution to the good end of nursing care is emphasized.

The nurse's role in assessing the client's situation to identify risk, changes in dependency levels, and points of care escalation have been expounded comprehensively. Further, an outline of the patient's journey is indicated, and how this has been used to addressing complex health and social care needs. The concept of risk identification and management has been considered with regards to proper assessment skills. Another concept highlighted is cared escalation and dependency levels of patients which are captured in the Kaiser Triangle illustration (McKee and Nolte, 2008). Sound nursing practice, reinforced by evidence-based policies and practice, has greatly improved handling of complex and co-existing health and social care needs at the patients and local community level. Finally, recommendations are proposed in response to key findings and learning points of the study.

2.0.Background

Children and young people undergo rapid biological, psychological and physiological changes in the process of growth (Browne, Cashin, Graham, 2012). Boys and girls experience marked differences while transiting from childhood through their teenage years to young

adulthood and eventually mature adults (Manna, 2014). Each of this stage is characterized by distinct biological, psychological, and social needs. With regards to the same, health and social care needs over this time series are differentiated hence the knowledge of appropriate health care and social services is paramount. Human conditions that do occur over this period are complex and require an appropriate understanding for purposes of bio-medical or bio-psychosocial intervention. Gallop and Reynolds (2004) intuit that, the human condition is incredibly complex, and those psychological, sociological, and psychological theories all contribute to our practice and research, then how we reconcile these notions and advance clinical practice is both intriguing and challenging (p. 359).

The case study scenario shows the transition of a teenage patient from early teen (13) years to around 18 years. As well as the standard biological and psychological developments that occur during this period, the client has been diagnosed with anorexia nervosa. Acknowledged as a serious and distinct mental disorder, anorexia nervosa causes fear of weight gain among individuals especially "adolescent and young adult women" (Zipfel et al., 2015, p. 1). More so, victims view their body image as wanting hence decide to cut on food intake through ways such as purging and increased physical activity. Zipfel et al. (2015) add that "cognitive and emotional functioning is markedly disturbed in people with this disorder. Serious medical morbidity and psychiatry comorbidity is the norm" (p. 1). Generally, comorbidity occurs when physical and mental disorders are present at the same time regardless of which occurred first. In this case, a mental disorder would include a condition such as depression or anxiety disorders (Gruss and Walker, 2011).

Hannah Goldsmith's situation seemed to have reached this extreme manifesting physical and mental illness and care from Child, and Adolescent Mental Health Services (CAMHS) was sought. CAMHS assesses and helps young women like Hannah with behavioral and emotional difficulties. Medical teams working in this agency comprise of therapists, nurses, support

workers, social workers, and psychologists. Problems with eating, depression, anxiety, self-harm and anger/violence are some of the cases dealt with by CAMHS. Having started to experience adolescent changes in her body both internally and externally, the young woman struggled to cope up with emotional and peer pressure. Notably, menstruation commenced, the body weight increased, and her face developed acne. These developments turned out to be of significant concern to her. In response, she decided to deny herself food through purging.

Further, she indulged in intensive exercises and restriction of food intake, something that she thought would help her cope with emotional feelings and weight issues. Unfortunately, adverse effects emerged including low weight, low BMI, dry and flaky skin covered with lanugo, peripheral oedema, heart murmur and low levels of potassium in the blood. The severity of her situation was manifest when she fainted during her mock exams after which she was referred to CAMHs on the advice of a general practitioner. At the moment, there are plans to transfer her to adult services. The patient journey would be handled better by utilizing a concept known as an Integrated Care Pathway, a procedure that is certified by the National Health Services and fundamental for individual and community health (Robertson, 2010).

3.0 Theoretical Concepts

To address the young client's complex health care and social needs, integration between theoretical concepts, national guidelines and policies, and actual clinical practice is appropriate. This means that a practice like sharing decision-making processes was considered as one of the key elements to have been used in addressing Hannah's complex case. Professional and national guidelines and relevant theoretical concepts guide service providers in the assessment, planning, and delivery of proper and relevant intervention measures. The UK has developed "national standards for the organization and delivery of mental health services" under the National Service Framework for Mental Health (Curran and Brooker, 2007 p. 480). According to the Department of Health (2004), mental health practitioners need to have essential skills in

providing and maintaining standardized services. A policy paper authored and published by the Department of Health (2006) states that one of the new expectations during implementation was that nursing care standards would be high and involve both carers and service users, especially in planning and choice. That provision underscores a collaborative way of seeking treatment by the client and delivery of services by the provider. Some theoretical concepts have been explored in the following sections to help the reader(s) understand multi-faceted alternatives that might have been considered in helping the client. There are about five theoretical concepts that have been evaluated thoroughly in the following sections, and they include; Integrated Care Pathway (ICP), collaborative decision making, risk assessment and management, bio-psychosocial model, family systems theory, and social identity theory.

3.1 Integrated Care Pathway/NICE Pathway

An integrated care pathway (ICP) was developed from the National Health Service standards to address mental health challenges and improve the quality of health services (Whittle and Hewison, 2007). Developed by many stakeholders including local authorities, NHS employees, voluntary organizations, service users, cares and independent units, ICP focuses on patients with depression-related problems (Robertson, 2010). Robertson asserts that "the ICP is intended to provide a standard model of good care based on the current evidence base and expert opinion" (p. 6) but should never substitute sound professional advice. The diagram below shows a detailed example of an ICP for patients like Goldsmith.

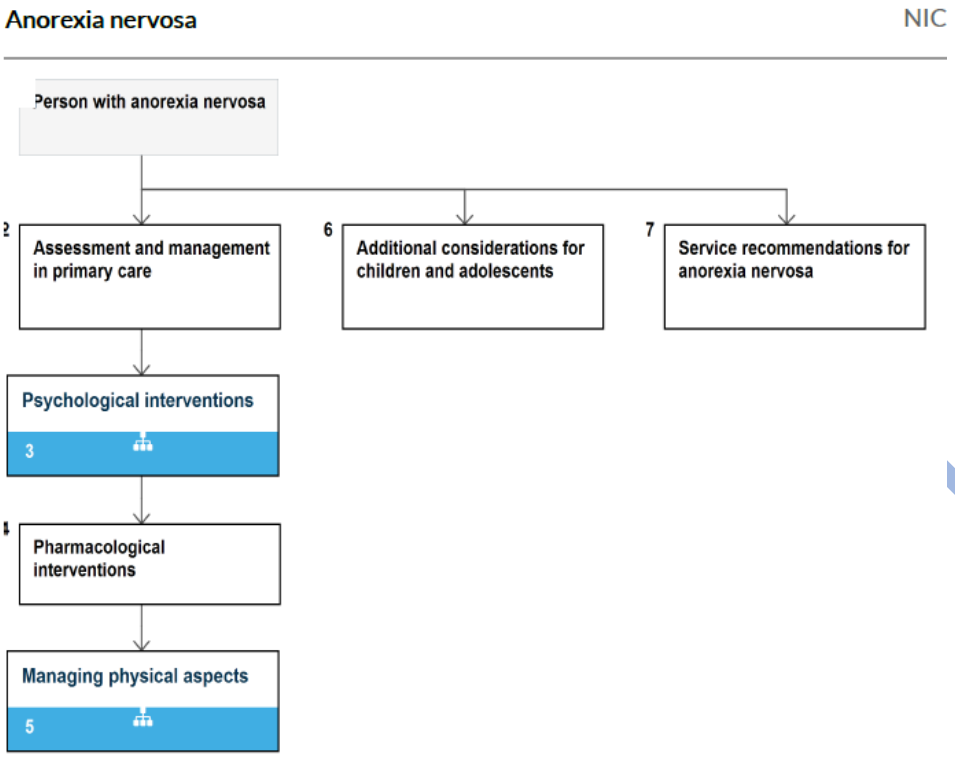

Figure1: a NICE pathway for Anorexia Nervosa

The pathway above shows a flow chart as provided in the National Institute for Health and Care Excellence (NICE) guidelines, quality standards, and any other relevant information. Notably, the guidelines are updated frequently. The diagram is numbered from 1 to 7 where the first stage is identifying the patient with anorexia nervosa symptoms, for example, Hannah Goldsmith's case. This is followed by assessing the status of the client and offering primary care management. It is worth noting that anorexia nervosa patients require detailed assessment other than considering weight and BMI indicators only; an overall clinical assessment is requisite. In case, psychosocial conditions such as those portrayed by Goldsmith persist, psychological intervention is recommended. Issues such as poor perception of body image, low self-esteem, depression, and isolation can be dealt with using psychological intervention. Severe physiological and biological disorders such as fainting, heart murmur, low potassium in the blood, low BMI, underweight, and dry and flaky skin would call for pharmacological treatment. Importantly, pharmacological intervention calls for close collaboration with the patient to ascertain the potential side effects of the drug treatment. For example, patients

diagnosed with anorexia nervosa experience compromised cardiovascular activities which may be vulnerable to antihistamines, tricyclic antidepressants, antipsychotics, and macrolide antibiotics (NICE, 2016). Eventually, the care service provider needs to work closely with the client in managing the physical aspects, for example, body weight, skin condition, and BMI levels. The data already shows that the client is responding well towards that treatment.

3.2 Collaborative Decision Making

It is worth noting that the physician-patient partnership determines the effectiveness of nursing significantly. Grady and Jadad (2010) intuit that,

> "To "collaborate," means to "work together, especially in a joint intellectual effort." Physicians have More expertise in medical issues, whereas patients have expertise about their life issues and experiences. They may also have medical knowledge that should not be discounted. Unlike shared decision making which focuses on an event (the treatment "decision"), collaborative decision making is a process of engagement that seeks to devise an optimal plan of action. Also, unlike shared decision making, which focuses on the "medical" issue, the collaborative model focuses more broadly on the highest priority health-related problems that emerge from the confluence of medical and non-medical issues" (para 6).

Collaborative decision making is within the framework of integrated care (Ashworth et al., 2008). Therefore, Goldsmith must have collaborated with the GP for her to be placed under CAMHS care as a day patient. Anti-depressant medication and physical intervention might prove more effective through such a decision making process. Unless the patient shows severe levels of depression at early stages or the risks associated are very high, secondary care may not be required. Thus, the health complexity of the patient, choice for psychological intervention, and concern about risk are some of the reasons which might have led Hannah to such care levels. With regards to the severity and complexity of the mental health situation, another concept emerges; care escalation and dependency levels. About risk stratification,

Pinto et al. (2015) assert that the system uses a "combination of risk factors to define pre-treatment groups" (p. 3008) hence high, middle, or low-level risk.

3.3 Risk Assessment, Stratification, and Management

Risk stratification uses previous information or data of the patient to get an understanding of how care services need to be provided. For example, understanding the history of the young woman assisted greatly in knowing risk levels associated and intervention measures required on short, intermediate, and long-term basis. Such history would include her age, adolescent experiences, social life in school and at home, fears, psychological attributes, eating habits, cardiac information, weight, blood composition etcetera which would help in placing her in a certain category of risk. The above characteristics are referred to as risk factors (Pinto et al., 2015). On the other hand, dependency levels are closely associated with risk levels implying that high-risk factors call for escalated care and dependency level from service users increases as well. For example, the young woman was taken to hospital under severe conditions that were life threatening; low levels of potassium in the blood, heart murmur, dehydration, and severe depression. Based on these risk factors, the patient had to be placed under pharmacological intervention (shown in the diagram above). An emergency intervention requires that the patient is treated the same day. Similar to assessment procedures at the primary care level, the patient is taken through a repeated risk assessment procedure, measurement of depression (using PHQ9 form), reviewing previous interventions, and a possibility of psychological intervention in agreement with the client).

A crucial model that supports risk assessment and management is the Kaiser Permanente model to chronic care (McKee and Nolte, 2008). In this model, patients are categorized into three major levels commensurate to their risk levels. At level 1, patients require relatively low-level health care need or attention. The primary care team can advise patients to carry on with self-treatment processes even though they are diagnosed with chronic illnesses. However, level

2 patients have an increased risk because of unstable conditions or likelihood of deterioration unless a structure intervention process is in place. Specialized disease management is needed. Lastly, level 3 patients have complex health needs and "high-intensity use of unplanned secondary care (emergency admissions)" (p. 76). Looking at Hannah's case, the fainting episode automatically placed her at level 1 in addition to other severe biological and psychological symptoms. Therefore, a case manager comes in handy to address the highly complex situation before further care services are administered. With time, her risk level reduces hence other forms of treatment can be applied. This model is illustrated by Kaiser Permanente triangle or pyramid of care as shown below.

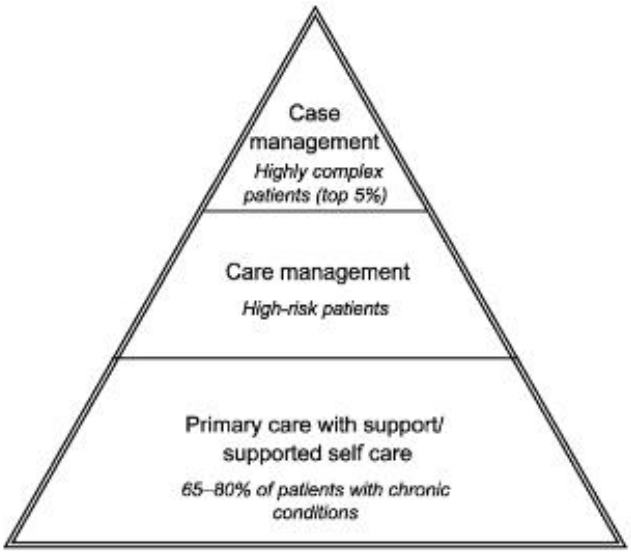

Figure 2 showing the pyramid of care or Kaiser Triangle

The integrated care pathway for the patient has had a positive outcome looking at the biological and physiological data (Schrivjers, Hoorn, and Huiskes, 2012). With the patient's consent, the carer can approach the parents for further intervention which may be more psychologically-oriented. Since anorexia nervosa is a severe mental disorder that has adverse implications, a referral to the next stage is vital. Psychological services/interventions and therapies at this stage are high intensity, and it may require specialists practitioners.

3.4 Community health care and Biopsychosocial model

Involving all stakeholders in addressing a situation such as that of Goldsmith is critical. Kazak et al. 2010argue that, “interventions with children need to take into consideration the family system, the school system, and often the pediatric health care and the mental health systems, as well as child protection systems” (p. 124).

A collaborative model such as the C-STAR model was developed in the U.S consisting of partnerships between children and their families, community-based organizations, schools and universities for the welfare of children. Working with children and young patients with mental health difficulties like needs collaboration with parents or family members besides “traditional medical models.” Ideally, inclusivity in the treatment of mental health disorders is captured well in the biopsychosocial model framework which allows the integration of “biological, psychological, and social domains of human functioning ” (p. 189).

Application of this model has proved important in family therapy when dealing with terminal and chronic illnesses similar to Goldsmith’s case. More so, the biopsychosocial process is an approach envisaged in the medical family therapy field and an application of family systems theory. Other than the biological factors that are associated with the biomedical model, contemporary clinical practice has become conscious of feelings, behaviors, and thoughts that may affect the physical state of an individual. Inerney (2015) claims that psychological and social factors influence biological functioning, and also that health and illness are determined by these factors. This “new theoretical model” (para 4) is offered as an alternative to the disease / medical model often held.

In light of this, nurses can identify major social and psychological issues that affect patients like Hannah. As mentioned above, background on her social life in school and family can provide pertinent information as to what might have caused Hannah’s decision to ‘binge’ and purge her food. For example, a nurse or practitioner handling such a case would make an informed decision based on the evidence that he/she has received from the patient or her family.

Apart from the biomedical treatment that consists of fluoxetine and high-calorie food supplements, an intensive therapeutic session is inevitable to deal with negative social and psychological attributes. Building the internal confidence of such a patient requires a skilled intervention that is not drug-related and probably this might have been the decision to transfer to adult services. A proper psychological and therapeutic intervention process should follow once the biomedical services have begun to prove successful or concurrently in case the medication is long-term. The current assessment data shows that the patient is responding well and the remaining task is to carry her through proper psychotherapy or psychological intervention process. This is conducted at the last stage of the integrated care pathway commonly referred to as tertiary care (Robertson, 2010). In the case of Goldsmith, a specialist service would be appropriate to ensure that the patient begins the process of full recovery steadily and reviewing the progress regularly. Review, which should be performed at every stage, is to ensure smooth discharge or transfer process as in Goldsmith's case or prevention of relapse. It seems that the new doctor handling the young girl has his work cut out because she has not responded positively yet besides her complaints that her mother is fussing around her every time.

4.0 Conclusion

The contemporary clinical practice uses biomedical and biopsychosocial frameworks, and this is a shift from tradition practice. Attending to complex health care needs should involve proper decision-making structures where all stakeholders are informed. A collaborative decision-making model ensures that the patient and practitioner interact freely rather than one person overseeing the treatment process. Complex health and social care needs can be properly handled with the help of an integrated care pathway where patients receive primary to tertiary care depending on the levels of risks such as depression. In addition to that, the Kaiser Triangle within the risk assessment and management framework help in classifying the patient as low,

medium or high risk to make the right decision with regards to the treatment process. Essentially, the family system theory within the biopsychosocial framework emphasizes executing therapeutic services where all stakeholders including the caregiver, patient, and the family are involved. More so, community health care is paramount in ensuring social, health and psychological needs of members in schools, universities, and homes are dealt with accordingly.

Reference

Ashworth et al. (2008). Principles to inform decision making: what do I need to know? Royal College of Nursing, pp. 1-13. Available at: https://www2.rcn.org.uk/__data/assets/pdf_file/0009/78696/003034.pdf

Browne, G., Cashin, A. and Graham, I. (2012). Models of case management for working with young children: Implications for mental health nurses. *International Journal of Mental Health Nursing*, 21(2), pp.123-130. Available at:http://sci-hub.cc/10.1111/j.1447-0349.2011.00782.x

Curran, J. and Brooker, C. (2007). Systematic review of interventions delivered by UK mental health nurses. *International Journal of Nursing Studies*, 44(3), pp.479-509. Available at:http://sci-hub.cc/10.1016/j.ijnurstu.2006.11.005

Druss, B. G. and Walker, E. R. (2011). Mental Disorders and Medical Comorbidity. Robert Wood Johnson Foundation. http://admin.issuelab.org/permalink/resource/10265.

Great Britain. (2006). *From values to action: the Chief Nursing Officer's review of mental health nursing*. London, Dept. of Health. Available at:http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4133840.pdf

Johansen, M. and O'Brien, J. (2015). Decision making in nursing practice: A concept analysis. *Nursing Forum*, 51(1), pp.40-48. Available at: http://sci-hub.cc/10.1111/nuf.12119McInerney, S. J. (2015). Introducing the biopsychosocial model for good medicine and good

doctors. *The British Medical Journal*, n. p. Available at:http://www.bmj.com/rapid-response/2011/10/29/introducing-biopsychosocial-model-good-medicine-and-good-doctors

McKee, M. and Nolte, E. (2008). *Caring for people with chronic conditions*. 1st ed.

Maidenhead, England: Open University Press. Available at: https://books.google.co.ke/books?hl=en&lr=&id=RV3id1wQIcsC&oi=fnd&pg=PA64&dq=Kaiser+triangle+of+care+management&ots=Q-2iw5FYt2&sig=ZeMMJRY1JzudhEdhicwHOMnPlAU&redir_esc=y#v=onepage&q=Kaiser%20triangle%20of%20care%20management&f=false

Miller, C. C., Reardon, M. J., & Safi, H. J. (2010). *Risk stratification: a practical guide for clinicians*. Cambridge Books Online. Cambridge, Cambridge University Press. Available at: http://ebooks.cambridge.org/ebook.jsf?bid=CBO9780511666452

National Institute for Health and Care Excellence, (2016). Anorexia Nervosa. *NICE*, p. 1-6.

O'Grady, L. and Jadad, A. (2010). Shifting from share to collaborative decision making: A change in thinking and doing. *Journal of Participatory Medicine*, n. p. Available at: http://www.jopm.org/evidence/case-studies/2010/11/08/shifting-from-shared-to-collaborative-decision-making-a-change-in-thinking-and-doing-4/

Pinto, N. R. (2015). Advances in risk classification and treatment strategies for Neuroblastoma. *Journal of Clinical Oncology*, 33(27), pp. 3008-3017.

Schrijvers. G., Hoorn, A. and Huiskes, N. (2012). The care pathway: concepts and theories: an introduction. International Journal of Integrated Care, pp. 1-7.

Robertson, K. (2010). Depression: Integrated Care Pathway. National Health Services, pp. 1-24. Available at: http://www.nhslanarkshire.org.uk/Involved/consultation/Documents/Mental%20Health%20ICP/Depression-ICP-Consultation-Draft-August-2010.pdf

Watson, W. (2012). Family Systems. *Encyclopedia of Human Behaviour*, pp.184-193. Available at:http://sci-hub.cc/10.1016/B978-0-12-375000-6.00169-5

Whittle, C. and Hewison, A. (2007). Integrated care pathways: pathways to change in health care? *Journal of Health Organization and Management*, 21(3), pp.297-306.Available

at: https://sci-hub.cc/10.1108/14777260710751753

Zipfel, S., Giel, K., Bulik, C., Hay, P. and Schmidt, U. (2015). Anorexia nervosa: aetiology, assessment, and treatment. *The Lancet Psychiatry*, 2(12), pp.1099-1111. Available at: http://www.wpanet.org/uploads/Sections/Eating_Disorders/Lancet_Psychiatry_AN.pdf

APPENDIX

Table showing Hannah Goldsmith CARE PLAN

Needs Identified	- Poor physical health e.g. underweight, low BMI, heart murmur, low potassium level in the blood, fainting; symptoms of anorexia nervosa - Behavioural/social needs including purging, binging, lack of food intake, and intensive exercises. - Psychological needs including low self-esteem, severe depression, and social
Problem Statement	Hannah Goldsmith's case represents multi-faceted, complex health and social care needs that require adequate attention from various stakeholders by way of systematic review or assessment, planning, and rolling out care services. In this case, an integrated care plan is to be utilised with respect to various theoretical concepts about evidence-based nursing and clinical practice. Further, the concept of collaborative decision making, bio-psychosocial perspective, care escalation and dependency level, risk assessment and management have been utilised in addressing the problem
Objective	- To review the complex health and social care needs of the client and intervene accordingly - To highlight the interconnection between theoretical concepts and evidence-based clinical practice when providing care services - To apply the bio-psychosocial and integrate care plan in handling complex health and social needs - To show the importance of individual and community health care services where all stakeholders are involved
Goal	Utilising theoretical concepts, evidence-based clinical practice, and UK health policies in addressing complex health and

	social care problems both at the individual and community level.
Intervention	-Assessment and primary care management, Physiological intervention, Pharmacological treatment, and managing physical needs -Service recommendations for anorexia nervosa