The research agenda for protocol-based care


Abstract

Background Protocol-based care is increasingly being used to deliver collaborative, integrated and improved patient-centred care, based on the best available evidence. This article provides an overview of key issues arising from protocol-based care literature to illustrate the research agenda for this important care delivery approach.

Conclusion Protocols provide great potential to deliver best practice. However, questions remain about the benefits of protocol-based care.

In response to this changing policy context, health professionals’ roles have been evolving. To deliver patient-centred services based on robust evidence, a more flexible team response is required and traditional professional boundaries should be modified. In 2000, it was anticipated that by 2004 most NHS staff would be working under agreed protocols that identify how common conditions should be managed and which staff would be best placed to handle them (DoH 2000).

Making a Difference (DoH 1999) outlines the contribution that nurses, midwives and health visitors can make to delivering this agenda through, for example, nurse-led clinics, nurse prescribing and nurse-led primary services. More recently, Freedom to Practise: Dispelling the Myths (DoH and Royal College of Nursing (RCN) 2003) considers the potential that nursing has to improve the patient’s journey through new ways of working. Further, the development of roles such as nurse and midwife consultants, and modern matrons, demonstrates that these professional groups, by virtue of their close and continuous contact with patients, are well placed to act as leaders in the development of high quality, responsive services.

A variety of initiatives provide evidence of the policy drive to increase NHS capacity. These include Agenda for Change (DoH 2003b), the NHS Plan, containing ten key roles for nurses (DoH 2000), and the introduction of the skills escalator, where healthcare workers are supported to increase their knowledge, skills and competencies and move along a flexible career pathway in health care (DoH 2000). The implementation of workforce policy initiatives has important implications for the roles that nurses, midwives and health visitors adopt in the healthcare team. It has been

Key words

- Evidence-based practice
- Patient-centred care
- Protocols

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Nurses and midwives are often the co-ordinators of care. Individual studies suggest there may be other benefits associated with the implementation of protocol-based care, including improved patient outcomes, reductions in length of stay, enhanced multidisciplinary working and improved record keeping.

Nurses and midwives are often the co-ordinators and facilitators of protocol-based care activity.

These issues are described more fully in the following text.

Management of clinical care processes, variations and terminology

Protocol-based care is concerned with providing clear statements and standards for the delivery of local care across a range of environments and different professions (NHS Modernisation Agency 2002). However, Currie and Harvey’s review of literature on the management of clinical care processes draws attention to the many terms used to describe these processes. The terms include care pathway, algorithm, clinical indicator, local guideline, protocol, procedures, integrated care pathway, expected recovery path and patient group directive (PGD), to name a few (Currie and Harvey 2000a, 2000b). This finding is reflected in practice by the many terms used in the NHS to guide treatment.

While all these care approaches have the same aim of improving patient care, they present different processes for achieving this. For example, care pathways have been described as both a tool and a process, can be condition- or procedure-specific, as well as symptom-based and generic (Campbell et al 1998, Currie and Scrivener 2002, de Luc and Currie 1999, Morris 2003). In contrast, an algorithm is a specific step-by-step tool to direct practitioners on the absolute course (or rule) of treatment for a particular aspect of care and decision (Hadhorn 1995). This emphasises two issues: first, there are many potential types of protocol-based care that could be the subject of an evaluation; and second, these have not necessarily been well defined. This points to the need to ensure clarity about the different models of protocol-based care being implemented, including how they have been described in the literature, their mechanisms, how they are developed, and whether and how they have been used in practice. For the purposes of this article, ‘protocol’ and ‘protocol-based care’ will be used as umbrella terms for these care processes, and where specific models are referred to, these will be labelled appropriately.

Local implementation of national evidence

In the context of modernising the NHS, protocol-based care offers a mechanism to facilitate the local implementation of evidence-based, patient-centred care (Currie and Harvey 2000a, 2000b, Grubnic 2003, McQueen and Milloy 2001, Morris 2003, NHS Modernisation Agency 2002). Protocols can function as templates to enable clinical staff to incorporate national evidence – clinical guidelines, national service frameworks (NSFs) – and local evidence – local guidelines, regional protocols. For example, the Myocardial Infarction National Audit Project (MINAP) (Birkhead 2003, Royal College of...
The development of ICPs offers staff a way of adapting and owning the evidence through providing a forum for peer review, debate and negotiation that aids consensual decision-making about the content of the pathway (Currie and Harvey 2000a, 2000b). Recent results indicate that more than 75 per cent of patients receive thrombolytic treatment within 30 minutes (RCP 2003). This represents an increase of more than 50 per cent on figures collected a year earlier (RCP 2003). While MINAP provides powerful data to support local implementation of national evidence through protocols, there has been minimal systematic evaluation of how and why this occurs.

A systematic evaluation of protocol-related developments and their role and impact in transferring evidence into local contexts is warranted. Further, a consideration of how different types of protocols have an impact on care outcomes is needed, whether and how they facilitate the implementation of national evidence, and what might mediate this transfer. These questions need to be considered in application to different care settings, for example, acute and primary, and clinical specialties, for example, midwifery, intensive care, cardiac care and nurse-led primary care clinics.

Impact of protocol-based care on outcomes

Empirically, outcomes of protocol-based care have received the most attention. Many individual studies, mainly using an experimental design, report how interventions, primarily care pathways, have helped improve patient outcomes, reduced length of stays, enhanced multidisciplinary working and improved record keeping. This work has been conducted across a variety of clinical areas, including genetics (Campbell et al 2000), vascular surgery (Abu-Ow et al 1999), mechanical ventilation (Ely et al 2001, Grap et al 2003), orthopaedics (Gregor et al 1996), stroke care (Kwan and Sanderson 2003) and postnatal care (MacArthur et al 2002, 2003).

There are some limitations to this body of research. It has focused mainly on ICP activity, limiting potential generalisability to other processes, such as PGDs. Additionally, impact measures have tended to be specific and limited to a few key clinical and organisational indicators, thus neglecting the potential impact on other variables, such as process, economic, workforce and professional aspects. Research has tended to focus on managing predictable, procedural care issues, such as surgery. There is less understanding of the impact protocols could have in more complex conditions, such as mental health (Jones 1999).

Research activity focuses on the impact on specific clinical settings and rarely tracks between care settings; for example, between primary and secondary care. To ensure transferability and obtain a realistic evaluation of protocol-based care, research needs to be conducted that addresses these issues in different clinical settings, and explores a range of care issues and different models of protocol-based care. The research agenda is summarised in Box 1.

Patient and carer involvement

It has been suggested that protocol-based care increases patient and carer involvement through, for example, better sharing of information (McQueen and Milloy 2001, NHS Modernisation Agency 2002). While this assertion makes sense, it has yet to be tested empirically. Findings from a study that explored the experiences and views of a range of professional staff using care pathways in their everyday practice, reported patient benefits including better professional-patient communication (Currie and Harvey 2000a, 2000b). For example, having pathways at the bedside enabled patients to see what was planned for them, and to challenge particular courses of action. However, because this study was reliant on interviews with professionals, it was unable to clarify the mechanisms that aid better communication and whether this is a precursor to improved participation (Rycroft-Malone 2002).

Nemeth et al’s (1998) study tracked the development of a pathway showing that if patients are involved at an early stage, their experience of the patient journey and particular care priorities are more readily incorporated. The belief that development and implementation of protocol-based care provide a mechanism for patient-centred care and participation makes sense, but there is little empirical evidence to support it. This emphasises the need for research into patient and carer issues; more specifically, to ascertain how they have been involved in protocol development and implementation, as well as to determine their perspectives on care being guided by protocols.
a clinical champion, usually a doctor. These findings emphasise two issues. First, while nurses and midwives have taken on these roles, little is known about the specific contribution they make or their perceptions about their involvement. Second, as we move further towards patient pathway approaches to care delivery, it will be necessary to consider the impact on the healthcare team as a whole.

Documents such as *Freedom to Practice: Dispelling the Myths* (DoH and RCN 2003) and initiatives such as *The Changing Workforce Programme* (www.modern.nhs.uk/cwp) and *The Collaboratives* (www.modern.nhs.uk) point towards the reconfiguration of services to ensure an improved patient journey. In this case, it is the contribution that the clinical team as a whole makes, rather than the role each profession takes that is important in the delivery of patient-centred care. As *Freedom to Practice: Dispelling the Myths* (DoH and RCN 2003) outlines, nurses under agreed protocols have expanded their roles in assessment and diagnosis, prescribing and discharging patients. Clearly, this has significance for the autonomy, professional identity and capacity of nurses, midwives and health visitors, the collaboration of the clinical team and the education and training of personnel to meet the new requirements of different roles. In any evaluation of protocol-based care it will be important to incorporate an exploration of these key issues.

**Conclusion**

The literature base of protocol-based care is varied and ill-defined, with most published material focusing on ICP development and activity. There is great potential in protocols as a mechanism to streamline care, reduce variations in practice and galvanise the multidisciplinary team to deliver best practice. However, questions remain about the nature, benefits and impact of protocol-based care on roles, costs and service delivery, about the nursing contribution to its development and delivery, and about workforce and team working issues.

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**Implications for practice**

- Protocols enable the delivery of collaborative, integrated and improved patient-centred care
- Nurses, midwives and health visitors have a central role to play in the delivery of protocol-based care
- The delivery of protocol-based care, has clear implications for the professional identity and autonomy of nurses, midwives and health visitors

**REFERENCES**


