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IMPLEMENTATION OF CONSENSUS-BASED PERIOPERATIVE CARE PATHWAYS TO REDUCE CLINICAL VARIATION IN ELECTIVE SURGERY: A MIXED METHODS PRE-POST STUDY PROTOCOL

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Manuscripts

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3 **IMPLEMENTATION OF CONSENSUS-BASED PERIOPERATIVE CARE**
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5 **PATHWAYS TO REDUCE CLINICAL VARIATION IN ELECTIVE SURGERY: A**
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7 **MIXED METHODS PRE-POST STUDY PROTOCOL**
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ABSTRACT

Introduction: Addressing clinical variation in elective surgery is challenging. A key issue is how to gain consensus between largely autonomous clinicians. Understanding how the consensus process works to develop and implement perioperative pathways and the impact of these pathways on reducing clinical variation can provide important insights into the effectiveness of the consensus process. The primary objective of this study is to understand the implementation of an organisationally supported, consensus approach to implement perioperative care pathways in a private healthcare facility and to determine its impact.

Methods: A mixed-methods Effectiveness-Implementation Hybrid (Type III) pre-post study will be conducted in one Australian private hospital. Five new consensus-based perioperative care pathways will be developed and implemented for specific patient cohorts: spinal surgery, radical prostatectomy, cardiac surgery, bariatric surgery and total hip and knee replacement. The individual components of these pathways will be confirmed as part of a consensus-building approach and will follow a four-stage implementation process using the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework. The process of implementation, as well as barriers and facilitators, will be evaluated through semi-structured interviews and focus groups with key clinical and non-clinical staff, and participant observation. Administrative and clinical end-points will be analysed to assess the effectiveness of the pathways.

Discussion: This project proposes a facility-specific approach to perioperative care pathway development and implementation to reduce variation which could be extended to hospitals across Australia and internationally. The results of this study will contribute to the current

1
2
3 knowledge base about the factors that impact on effective implementation of perioperative
4
5 pathways via a consensus approach.
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9 **Ethics and dissemination:** This study received ethical approval from Macquarie University
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11 Human Research Ethics Medical Sciences Committee (Reference No: 520221219542374).

12
13 The findings of this study will be disseminated through peer-reviewed publications,
14
15 conference presentations, and reports for key stakeholders.
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18
19 **Keywords:** Implementation Science, Clinical variation, Perioperative pathways, Consensus,
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21 Elective surgery, Private providers
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23

24 25 **Strengths and Limitations:**

- 26
27 • This study will provide valuable insights into the effectiveness of the consensus-
28
29 building process to guide the implementation of standardised perioperative pathways
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31 in a real-world setting, potentially enabling generalisability to other contexts.
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35 • Investigation of the consensus-based approach to clinical variation is novel.
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39 • Multiple forms of qualitative data collection will be used to ensure rigour and a
40
41 diverse range of perspectives will be gathered. This will provide a deeper
42
43 understanding of the experiences of implementation at different time periods across
44
45 multiple surgical cohorts, as well as barriers and facilitators to adopting new
46
47 standardised processes of care.
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- 50
51 • The pragmatic nature of the study will deliberately make use of existing practice
52
53 structures and approaches to implement the consensus pathways and to obtain patient-
54
55 related outcomes. This, however, limits pre/post comparison of some clinical
56
57 outcomes to a smaller sample size from one surgical cohort only.
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60 **INTRODUCTION**

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2
3 Addressing clinical variation is a fundamental component of health system improvement.
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5 Whilst in some circumstances variation can be beneficial (e.g., when it represents innovation,
6
7 or responses to individual patient need or preference), variation in healthcare processes that
8
9 are unrelated to patient needs or those that differ from evidence-informed guidelines can
10
11 compromise patient care, create inefficiencies, and contribute to health inequality (1, 2). This
12
13 is a growing problem both in Australia and internationally, where on average, 60% of
14
15 recommended care according to best practice guidelines is delivered to patients (3, 4, 5, 6). In
16
17 addition, 30% of all care provided could be considered “low value” or waste, and 10% results
18
19 in some form of iatrogenic harm (1, 4, 5). For example, care processes and outcomes for
20
21 certain surgical patient cohorts have been found to differ substantially between hospitals in
22
23 both public and private sectors (7). Data from Australia and the United States of America
24
25 (USA) demonstrate a high degree of variation in length of stay (LOS), rates of transfer to
26
27 inpatient rehabilitation following hip and knee arthroplasty (8), and specific to private
28
29 hospitals, higher unplanned stay (>2 hours) in recovery after surgery (7). Considering the
30
31 increasing number of elective surgeries and associated hospitalisations undertaken in private
32
33 hospitals in Australia (9) and elsewhere (10, 11, 12) reducing unwarranted clinical variation
34
35 in these settings is critical to generating higher value care, improving patient outcomes, and
36
37 reducing healthcare expenditure.
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45 A number of studies have examined ways to reduce unwarranted clinical variation, such as
46
47 through the implementation of perioperative care pathways for surgical cohorts (13, 14, 15).
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49 However, despite many studies demonstrating the efficacy of some strategies in reducing
50
51 variation, the optimal methods of developing and implementing such strategies into complex
52
53 healthcare systems remain unclear. More evidence is needed on how best to implement and
54
55 sustain these changes, as well as the barriers and facilitators to different methods of
56
57 implementation to reduce unwarranted variation.
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3 Evidence-informed perioperative care pathways designed to standardise the management of
4 surgical patients to the best evidence-informed practice have been shown to reduce variation
5 and improve patient outcomes (16). Perioperative care refers to the care of patients before,
6 during, and after surgical procedures involving anaesthesia (17). Care leading up to a surgical
7 procedure involves the reduction of modifiable risks, often in a preoperative clinic, through
8 patient education, medication optimisation, and other prophylactic treatments. After surgery,
9 the focus is on expediting recovery and minimising the risk of complications by optimising
10 such things as pain relief, antibiotic regimens to reduce infection risks, anticoagulation
11 protocols to avoid blood clotting, and early mobility to return to normal function. Private
12 hospitals in most countries have historically relied on accredited medical practitioners to
13 individually develop their own perioperative care protocols using a combination of their
14 experience, past practice, and clinical practice guidelines (18). Such protocols, when
15 implemented as frontline care, can create variation in care delivery based on provider
16 preferences.

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36 Implementing changes to patient care is complex and challenging, requiring concerted efforts
37 over time. This challenge is well documented and usually involves the provision of resources
38 to support change efforts, shifting professional roles, and altering cultural norms (5). Rather
39 than a “one size fits all” approach, pathways need to be developed to suit the particular needs
40 of the patient cohort and surgical discipline, as well as local resources available. However,
41 there is no universal approach to implementing these pathways. In many private hospitals,
42 medical practitioners tend to operate with a high degree of professional autonomy, which
43 necessitates a consensus-building approach between providers for any standardisation of care
44 processes.

55 56 57 58 **Objectives** 59 60

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3 The primary objective of this study is to determine successful processes to implementing
4 perioperative care pathways in a private hospital setting using an organisationally supported
5 consensus approach for surgical cohorts, including: i) spinal surgery; ii) radical
6 prostatectomy; iii) cardiac surgery; iv) bariatric surgery and; v) hip and knee replacement
7 surgery. The secondary objective is to assess the impact on administrative and, where
8 possible, clinical and patient-reported outcomes.
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17 **METHODS**

18 **Study design**

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21 A mixed-methods Effectiveness-Implementation Hybrid (Type III) pre-post study will be
22 used to evaluate the implementation of evidence and consensus-based perioperative
23 pathways, prioritising assessment of effectiveness of the implementation strategies. Whilst
24 improving clinical outcomes is an important goal of any change process, standardisation of
25 perioperative pathways has already been demonstrated to confer benefit to clinical outcomes
26 (13, 19, 20, 21, 22). As such, clinical outcomes will be considered secondary in this study.
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28 The perioperative care pathways will be implemented once consensus has been reached and
29 outcomes will be compared to those observed before pathway development and integration
30 into routine care, as a control period.
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47 **Study Setting**

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50 The study will be conducted over a two-year period from October 2022 to December 2024 at
51 Macquarie University Hospital (MUH). MUH is located in Sydney, Australia and is a
52 university-owned, private teaching hospital that focusses on clinical care, teaching and
53 research. MUH comprises 144 beds, 16 operating theatres, and is staffed by over 200
54 surgeons and other health professionals.
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Eligibility criteria

Hospital staff and patients will be considered as study participants for the surgical cohorts: spinal surgery, radical prostatectomy, cardiac surgery, bariatric surgery and hip and knee replacement surgery. Data from hospital staff participants will primarily be used to examine the implementation of perioperative care pathways. Administrative data and data from consenting prostatectomy patients will be used firstly, to conduct a process evaluation and secondly, to evaluate impacts on patient-related outcomes.

Hospital staff: Local hospital staff involved in the delivery of clinical care or development and implementation of care pathways (i.e., both clinicians and non-clinical staff) will be considered eligible to participate in the implementation component of this study.

Patients: Those admitted during the relevant study periods, seeking care for any of the clinical cohorts of interest will be considered eligible for this study.

There are no specific exclusion criteria for this study.

Intervention

Development and implementation of the cohort-specific standardised perioperative pathways will follow a six-step process nested within four implementation stages using the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework (23). The EPIS Framework guides projects through key stages of the implementation process and highlights important factors influencing implementation success within the broader “outer context” (system) and the proximal “inner context” (organisation) across each EPIS stage. The proposed implementation strategies are summarised in Table 1. The general implementation strategies will be tailored to each new patient cohort utilising a consensus-building approach. Our

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2
3 implementation science approach will examine this consensus-building process to support
4
5 successful implementation of the pathways.
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8 9 *Stage 1: Exploration*

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12 The exploration stage will aim to understand the existing and emerging needs of both
13
14 clinicians and patients, and to identify the optimal modifications and supports required for the
15
16 implementation strategy to address those needs. This could include modifications to existing
17
18 information technology (IT) processes or the introduction of organisational support and
19
20 educational resources for staff members to implement the pathways. To achieve this
21
22 objective, a care pathway implementation support team will be established comprising
23
24 members of the research team and key hospital stakeholders. Stakeholders will include a
25
26 coalition of both clinical partners, such as clinical education coordinators, and non-clinical
27
28 partners, such as hospital administrators, to ensure a wide breadth of expertise are included.
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31 The primary goal for the team will be to act as a vehicle for organisational leadership that
32
33 builds capacity in clinical improvement and implementation science methodology. Individual
34
35 roles within the team will be clarified across the project to reduce the risk of any duplicative
36
37 efforts and improve the visibility of activities across different patient cohorts where pathways
38
39 will be implemented. The team will meet monthly for the duration of the study to discuss
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41 goals and action items relating to the project to facilitate implementation of the perioperative
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43 pathways. For example, an important aim for the support team will be to reduce the time-
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45 burden for clinicians during pathway implementation and to establish actions that will
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47 minimise potential time pressures.
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54 55 *Stage 2: Preparation*

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3 The objective of the preparation stage is to use a consensus-building approach to develop and
4
5 standardise perioperative care pathways for each surgical cohort, and to use learnings from
6
7 the hip and knee replacement surgery cohorts retrospectively to facilitate successful
8
9 implementation. During this stage, perioperative pathways will be drafted by a clinician-
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11 researcher in a hospital leadership position (AH) and senior management staff, based on a
12
13 combination of 'current' surgeon clinical guidelines and evidence-based practice. Clinical
14
15 consensus groups will then be established for each cohort by the clinician-researcher. These
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17 groups will include multidisciplinary representation such as surgeons, anaesthetists, nursing
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19 and allied health, and will be led by the discipline heads. Clinical consensus groups will
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21 attend regular meetings facilitated by the clinician-researcher to discuss components of care
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23 to be included in the standardised perioperative pathways, including acceptable bounds of
24
25 variation in practice. The pathways will optimise components of care differently across
26
27 cohorts based on current evidence and joint medical decision making, including, but not
28
29 limited to, preoperative optimisation, postoperative analgesia, surgical antibiotic prophylaxis,
30
31 anticoagulation protocols and mobilisation after surgery. An 'informal' approach will be
32
33 utilised to achieve consensus on the perioperative pathways whereby a set of pre-defined
34
35 components will be discussed at each meeting and agreed upon by group members using both
36
37 evidence and their own perspectives to inform discussion (24). Items will be documented by
38
39 the facilitator and relevant documentation will be sent to each group member for further
40
41 review as required following each meeting. Following this process, pathways will be
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43 circulated by each group member to their individual teams for feedback and critical
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45 modifications will then be made by the consensus groups at additional meetings which will
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47 facilitate implementation during the next two stages.
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57 An additional goal of this phase will be to establish consensus from both the taskforce and
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59 clinical consensus groups on a plan to implement the pathways. A draft implementation plan
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3 will be created by the task force. This plan will be reviewed by the clinical consensus groups
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5 for modifications as required and each member will serve as “champions” to drive
6
7 implementation. Components of the implementation plan may include education and training
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9 sessions for nursing and allied health and establishing audit and feedback processes on the
10
11 wards.
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16 A separate stakeholder engagement group will be formed to represent the views of patient
17
18 representatives, engage frontline clinical staff in implementation, and facilitate rapid
19
20 feedback regarding implementation challenges to the care pathway implementation support
21
22 team. Researchers involved in qualitative data collection will observe this process through
23
24 naturalistic observation however, they will not have a role in determining components of the
25
26 pathways. During this stage, learnings obtained from implementation of pathways for the hip
27
28 and knee replacement cohort will also be analysed by the research team to further understand
29
30 the process of implementation using a consensus approach.
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34 35 *Stage 3: Implementation* 36

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39 In the implementation stage, installation of the care pathways will be guided by the planned
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41 implementation supports formalised in the preparation phase. It will be critical to monitor the
42
43 implementation process during this stage and adjust supports accordingly. Care pathway
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45 toolkits including education and documentation resources will be finalised and disseminated
46
47 to clinical staff and patients at this stage to foster prompt widespread practice change. Further
48
49 monitoring of the degree of engagement and cohesion between clinical leadership and
50
51 frontline clinical staff will be achieved using participant observations. Particular attention
52
53 will be paid to the capacity of frontline clinical staff to absorb and apply new care pathways,
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55 avoiding “bottlenecks” between care pathway development and implementation. This stage
56
57 will also be supported by an iterative audit and feedback process and data analytics to
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3 identify gains made and update external benchmarking comparisons over time. Audit and
4
5 feedback will relate to process (implementation) outcomes, health services outputs, and
6
7 patient-level outcomes.
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10 11 *Stage 4: Sustainment* 12

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14 The sustainment stage involves the continued application of the structures and processes of
15
16 the care pathways to realise tangible improvements in patient outcomes. At this stage, care
17
18 variation reduction becomes a standing item on regular Patient Safety and Quality Committee
19
20 meeting agendas. “Roadshow” presentations to the stakeholder engagement groups, frontline
21
22 clinical staff and hospital leadership groups can continue bi-directional communication and
23
24 feedback loops to identify new areas of care variance prioritised for future care pathways. We
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26 also plan to translate our findings via policy maker round tables and engagement and training
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28 with other private hospitals.
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Table 1 Overview of implementation strategies

Implementation stage	Implementation strategy	Description
<i>Exploration</i>	Build a coalition	Recruit and cultivate relationships with partners in the implementation effort by formally establishing a care pathway support team
<i>Preparation</i>	Conduct local consensus discussions	Establish a structure for local providers and other stakeholders to form cohort-specific clinical consensus groups to discuss the processes of care and standardisation of pathways
	Co-develop a formal implementation blueprint	Co-develop a formal blueprint for iterative care pathway prioritisation and implementation
<i>Implementation</i>	Develop and implement care pathway toolkits	Develop, test, and introduce quality improvement tools and educational materials
	Audit and provide feedback	Embed a comprehensive system audit around care variation, clinical and process outcomes over specified time periods and disseminate to clinicians and administrators to monitor, evaluate, and modify provider behaviour
<i>Sustainment</i>	Facilitate relay of clinical data to providers	Undertake formal monitoring and evaluation and develop a reporting structure and channels of communication for care pathway development, implementation, and outcomes

Recruitment

Semi-structured interviews and focus groups with hospital staff

A purposive sample of staff who have been previously involved in the development of perioperative pathways or provision of care for the hip and knee replacement surgical cohorts, and staff currently involved in the development and implementation of the new pathways for the four new surgical cohorts will be recruited. Staff will be identified by MUH

1
2
3 co-investigators. Research staff not employed by MUH will approach the identified staff
4
5 members either by email invitation or face-to-face to request their participation in the
6
7 interviews, indicating that they have been identified by the research team as a key stakeholder
8
9 in the development and implementation of the pathways. This approach is designed to avoid
10
11 the potential impact of any existing relationships between hospital staff and co-investigators.
12
13 A brief explanation of the study and a written participant information form will be provided
14
15 to the staff members. Staff members will be provided with time to review the information and
16
17 ask any questions of the research staff prior to their decision to consent to participate in the
18
19 interviews and focus groups, or not.
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23 24 25 *Participant observations with hospital staff*

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27 Staff attending relevant meetings will be recruited, such as planned support team project
28
29 meetings, clinical consensus group meetings, stakeholder engagement group meetings,
30
31 patient safety and quality committees, and ward based clinical meetings. Attendance of these
32
33 meetings by external staff will be through invitation from hospital co-investigators. Study
34
35 information and a participant information form will be provided prior to the initial meeting
36
37 where participant observations will take place.
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41 42 **OUTCOMES**

43 44 45 **Primary outcomes**

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48 A summary of the primary outcome measures for this study can be found in Table 2.
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50 Implementation outcomes including acceptability, appropriateness, feasibility, adoption,
51
52 fidelity and sustainment, and penetration, will be used to understand the impact of the
53
54 implementation strategies and implementation using a consensus-building approach on
55
56 secondary outcomes (25).
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Table 2 Summary of primary outcome measures

<i>Acceptability</i>	Provider knowledge and satisfaction with aspects of the perioperative pathways and their implementation will be collected via qualitative interviews and participant observation
<i>Appropriateness</i>	Appropriateness will be assessed both retrospectively based on the experiences piloting the intervention for the hip and knee replacement cohorts using qualitative interviews, as well as for the four prospective cohorts using participant observation
<i>Feasibility</i>	Feasibility will be measured both retrospectively using pilot data from the hip and knee replacement cohorts and prospectively for the four new cohorts of interest using interviews and participant observation
<i>Adoption</i>	Participant observations of the clinical consensus-building process will be used to measure the reasons pertaining to the intention, initial decision, or action to integrate the perioperative care pathways into routine clinical practice
<i>Fidelity and sustainment</i>	Regular audits of adherence to the care pathways will provide an indication of variations to practice over time, including potential modifications and tailoring of the pathways by frontline staff (e.g., nurses) to better fit within their work routines

<i>Penetration</i>	Penetration will be assessed by the number of eligible patients who receive the care pathway as intended according to planned audits
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Secondary outcomes

Secondary outcomes assessed will include both process outcomes and clinical outcomes:

- Hospital or intensive care unit LOS for each cohort will be collected from routine administrative data systems.
- Patient-reported experience measures (PREMs) collected via patient surveys.
- Patient-reported outcome measures (PROMs) collected via patient surveys e.g., health-related quality of life questionnaires.
- Discharge destination collected from routine administrative data systems.
- Hospital-acquired complication rates collected from routine incident reporting systems.
- Hospital readmission rates collected from routine administrative data systems.

Selected PREMs and PROMs for the prostatectomy cohort are currently routinely collected at some site hospitals by specialist nurse practitioners and recorded in the patient's medical records. These include the Prostate Cancer Distress Screen (26), the International Prostate Symptom Score (IPSS) (27) and the Sexual Health Inventory for Men (28). Research staff will assist with sending out surveys prior to the routine six-month follow up assessment for up to 50-100 patients both before and after pathway implementation where patients consent, standardising an existing clinical interaction for comparison. Specific PROMs and PREMs measures for the remaining pathways will be determined during the consensus building

1
2
3 process and if agreed, these measures will only be collected for research purposes where
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5 patients consent, prospectively.
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8 9 **Data collection**

10 11 12 *Qualitative interviews and focus groups*

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14 Semi-structured one-on-one interviews or focus groups will be conducted over a 12-month
15
16 period with key clinical and non-clinical hospital staff and patient/consumer representatives,
17
18 focussing retrospectively on the pilot hip and knee replacement cohorts and prospectively for
19
20 each of the four new cohorts. Interview guides will be piloted prior to data collection and will
21
22 include questions pertaining to participants knowledge and experiences of implementing the
23
24 standardised perioperative pathways, as well as barriers and facilitators to this process.
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27
28 Interviews and focus groups will be conducted by one experienced qualitative researcher (LP)
29
30 via videoconference or face-to-face at participants' preferred time and location, lasting
31
32 between 30-60 minutes. The researcher will conduct all interviews in a private room suited to
33
34 the interviewee, where interviews will be digitally recorded and transcribed verbatim. Field
35
36 notes will also be made by the interviewer including initial thoughts, interpretations and
37
38 analysis of the data collected. Audio and written data will be immediately saved in a
39
40 password protected file on an encrypted password protected computer.
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45 46 *Qualitative participant observation*

47
48 Data collectors will conduct naturalistic participant observations within the planned support
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50 team project meetings, clinical consensus group meetings, stakeholder engagement group
51
52 meetings, patient safety and quality committee, and ward-based clinical meetings (29). Each
53
54 observation session is anticipated to last between one to two hours. Fieldnotes will be taken
55
56 to spatially contextualise events within the study aims (30). These observations will not be
57
58 guided by a pre-determined schedule, but rather, they will inductively evolve in real-world
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3 practice environments. This includes how staff converse with one another, how they plan and
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5 make decisions together about perioperative care (i.e., implementation, communication
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7 pathways, leadership), and how decision-making processes evolve and take shape across
8
9 different meetings with different stakeholders.
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12 13 *Quantitative clinical outcomes data*

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17 Data on clinical outcomes will be collected from administrative databases. These data include
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19 measures such as hospital LOS, discharge destination, acquired complications, and
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21 readmission. Those data not routinely collected within existing administrative databases will
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23 be collected prospectively or via retrospective electronic medical review.
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27 **Sample size**

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30
31 Qualitative data pertaining to the implementation of the perioperative clinical pathways will
32
33 use the concept of theoretical saturation to determine the observation and interview sample
34
35 size (31). Based on prior studies, we anticipate conducting 30 interviews and 15-20 meeting
36
37 observations (32, 33). Staff will be recruited using convenience time-frame sampling which
38
39 removes opportunistic recruitment of staff and patients, and any researcher or hospital
40
41 selection bias.
42
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45
46 For quantitative data, a power calculation was undertaken for each of the four cohorts based
47
48 on the mean and standard deviation of LOS for each at a site hospital in the 2020 and 2021
49
50 financial years, an estimated important reduction in LOS, two sided $\alpha=0.05$ and 80% power.
51
52 For spinal surgery, for example, reduction of mean LOS from 4.28 (SD: 4.66) to 2.78 (the
53
54 peer group average) required 152 patients pre- and post-intervention, which is achievable
55
56 with twelve months' follow-up. Bariatric surgery requires only 6 months', so the latter two
57
58 cohorts will be prioritised for early intervention. Overall, MUH LOS for cardiac surgery is in
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3 line with its peer group, so for this cohort the target is intensive unit LOS, which is higher
4
5 than that of peers. It is important to note that the research team does not view LOS as the
6
7 most important clinical outcome for these four cohorts; it is used for sample size estimation
8
9 because it is an administrative outcome where there is a prospect of measuring relevant
10
11 quantitative change in the time available to the study. Moreover, relevant data on means and
12
13 standard deviations is routinely available, permitting sample size calculation.
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15

16 17 18 **DATA ANALYSIS**

19 20 21 **Qualitative**

22 23 24 *Qualitative interview and observation analysis*

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26
27 Fieldnotes and interview transcripts will be imported into Nvivo20 for data management.

28
29 Data will be analysed thematically (34, 35) by two experienced qualitative analysts (primary
30
31 and secondary) (LP and MS or EFA) working together to ensure the process is rigorous, and
32
33 to enable them to discuss the major and minor themes arising inductively and their
34
35 concomitant categories until consensus agreement can be achieved. The secondary analyst
36
37 will examine a subset of the complete dataset, to ensure methodological veracity during the
38
39 analytic process.
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45 46 **Quantitative**

47 48 49 *Quantitative analysis of clinical endpoints*

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52 Data will be analysed by three researchers (LP, GA and MNS) using SPSS. Descriptive
53
54 statistics will be used to summarise demographic data. For LOS, historical data will be
55
56 sourced from administrative databases to identify any secular trend and take this into account
57
58 in attributing any pre-post change to intervention. For other clinical outcomes, PREMs and
59
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3 PROMs will be descriptive only and restricted to 50-100 patients from the prostatectomy
4 cohort and any other cohort where these outcomes are available, while hospital acquired
5 complications and hospital readmission rates will be compared pre- and post-intervention.
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10 **Patient and Public Involvement**

11 Input and feedback was obtained from the site hospital's Clinical Leadership Committee and
12 the Clinical Disciplines on aspects of the study design, such as the planned implementation
13 strategies and outcome measures. Patients were not involved in the design of this study,
14 however, patient consumer input and feedback will be sought from the site hospital's
15 consumer advisory committee where resources for patients are developed.
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26 **DISCUSSION**

27 Translating standardised clinical consensus pathways into current practice has proven
28 complex and challenging. Whilst the efficacy of such pathways on process outcomes such as
29 LOS and postoperative complications has been well-established, evidence suggests
30 suboptimal implementation into healthcare settings with inconsistent adherence to some
31 recommendations (13, 19, 21, 22, 36). Reported issues with sustainability of new care
32 pathways following implementation further highlight the complexities of this process (37).
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There is no universal way to implement perioperative pathways of proven efficacy into
hospital settings. Studies evaluating the success and effectiveness of care pathways can
provide a basis for service providers however, inconsistent reporting on the methods used for
implementation, as well as barriers and facilitators, make determining the optimal approach
difficult. The focus of this research is to evaluate the process of implementing perioperative
care pathways into a private hospital facility through a consensus-building approach, where
key stakeholders will work together to conduct 'local consensus decisions' (38). The
pragmatic nature of the study will deliberately make use of and augment existing practice

1
2
3 structures, staffing and approaches to implement these consensus pathways. This can provide
4
5 valuable insights into implementation during routine clinical practice and is thus, potentially
6
7 generalisable and transferrable to similar healthcare contexts.
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9

10
11 Successful implementation of perioperative care pathways is dependent upon numerous
12
13 factors due to the multifaceted nature required for change (39, 40, 41, 42). A thorough
14
15 understanding of the social and organisational contexts is required to optimise
16
17 implementation into hospital settings and ensure sustainability (42). It is important to
18
19 ascertain the views of clinicians and patients involved in implementation to gain a deeper
20
21 understanding of the acceptability of the pathway and the use of a consensus-building process
22
23 (43). Previous studies examining provider and patient perceptions of implementing Enhanced
24
25 Recovery After Surgery pathways have reported many barriers to successful implementation
26
27 (44, 45, 46). Ineffective communication between team members, lack of hospital resources,
28
29 increased workload and negative provider attitudes to the proposed interventions have been
30
31 cited as key issues that must be addressed to optimise implementation and sustainability (37,
32
33 40, 45). These themes are not isolated to surgical cohorts alone, with similar themes
34
35 impacting on implementation of standardised pathways reported for other areas, such as
36
37 mental health (40) and asthma (47).
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45 The utilisation of semi-structured interviews with key clinical and non-clinical staff is
46
47 designed to provide insight into the attitudes and experiences of the process of
48
49 implementation. This will enable an exploration of the barriers and facilitators to successfully
50
51 adopting a new standardised process of care. The degree of engagement and cohesion
52
53 between clinical leadership and frontline clinical staff will be monitored using participant
54
55 observations; with particular attention paid to the capacity of staff to absorb and apply new
56
57 care pathways into practice. The inclusion of a variety of staff members from different
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3 disciplines and different surgical cohorts will provide a deeper understanding of the processes
4
5 of implementation for a variety of surgical procedures, where different cohorts may have
6
7 different views and experiences of implementing consensus-based pathways.
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9

10
11 The insights obtained through these methods aim to contribute to the growing knowledge
12
13 base about the factors that impact upon effective implementation of perioperative pathways
14
15 into hospital settings utilising a consensus approach. The application of implementation
16
17 science methods and use of the EPIS framework (23) will enable us to characterise the
18
19 processes of implementation and evaluate factors that may impact upon implementation at
20
21 different phases of the process. This enables forward thinking about sustainability and
22
23 optimising implementation in the future. Other clinical settings may find this knowledge
24
25 useful to inform integration and adaptations of similar pathways into routine care to reduce
26
27 unwarranted variation.
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29
30

31
32
33 **Word count:** 3994 words
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35

36
37 **List of Abbreviations:**
38

39 EPIS Exploration, Preparation, Implementation, and Sustainment Framework;
40
41

42 IT Information Technology;
43
44

45 LOS Length of stay;
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49 MUH Macquarie University Hospital;
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53 PREMs Patient-reported experience measures;
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57 PROMs Patient-reported outcome measures;
58
59

60 SD Standard deviation

1
2
3 USA United States of America
4
5

6
7 **DECLARATIONS:**
8

9
10 **Ethics and dissemination:**
11

12
13 Approval to conduct this study has been obtained from the Macquarie University Human
14 Research Ethics Medical Sciences Committee (Reference No: 520221219542374). Research
15 governance authorisation has been provided by the MQ Health Clinical Research Executive.
16
17 A waiver for consent will be sought from participants for data obtained in this study.
18
19 PROMs/PREMs data being collected for clinical purposes will seek informed patient consent
20 for de-identified data to be used for research purposes. The findings of this study will be
21 disseminated through peer-reviewed publications, conference presentations, and summaries
22 or reports for key stakeholders and partners in the field.
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31
32
33 **Protocol amendments:**
34

35
36 Approval from the study investigators, Human Research Ethics Committee, and research
37 governance will be sought for any protocol amendments. Amendments will be reported in the
38 published manuscript as a deviation from the protocol.
39
40
41
42
43

44
45 **Consent for publication:**
46

47
48 Not applicable.
49

50
51 **Availability of data and materials:**
52

53
54
55 Data sharing is not applicable to this article as no datasets were generated or analysed during
56 the current study.
57
58
59
60

Competing interests:

The authors declare that they have no competing interests.

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Authors' contributions:

The study was conceived by MS, AH, EF-A, GA, JCL, JB, GG, PDH, KC, KH, AP, CH, DG, LAE, LT, and RP and all authors contributed to the study design. LP, CH and MS wrote the initial draft of the manuscript. All authors contributed to and approved the final version of the manuscript.

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For peer review only

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IMPLEMENTATION OF CONSENSUS-BASED PERIOPERATIVE CARE PATHWAYS TO REDUCE CLINICAL VARIATION FOR ELECTIVE SURGERY IN A PRIVATE HOSPITAL: A MIXED METHODS PRE-POST STUDY PROTOCOL

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Complete List of Authors:	<p>Pagano, Lisa; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Hemmert, Cameron; The University of Sydney Faculty of Medicine and Health, School of Health Sciences Hirschhorn, Andrew; Macquarie University Faculty of Medicine Health and Human Sciences, MQ Health Francis-Auton, Emilie; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Arnolda, Gaston; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Long, Janet; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Braithwaite, Jeffrey; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Gumley, Graham; Macquarie University Faculty of Medicine Health and Human Sciences, MQ Health Hibbert, Peter; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation; University of South Australia Allied Health and Human Performance, IIMPACT in Health Churruca, Kate; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Hutchinson, Karen; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Partington, Andrew; Flinders University, Flinders Health and Medical Research Institute; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Hughes, Clifford; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation; Macquarie University Faculty of Medicine Health and Human Sciences, MQ Health Gillatt, David; Macquarie University Faculty of Medicine Health and Human Sciences, MQ Health Ellis, Louise A.; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Testa, Luke; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation Patel, Romika; Macquarie University Faculty of Medicine Health and Human Sciences, Australian Institute of Health Innovation</p>

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SCHOLARONE™
Manuscripts

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3 **IMPLEMENTATION OF CONSENSUS-BASED PERIOPERATIVE CARE**
4
5 **PATHWAYS TO REDUCE CLINICAL VARIATION FOR ELECTIVE SURGERY IN**
6
7 **A PRIVATE HOSPITAL: A MIXED METHODS PRE-POST STUDY PROTOCOL**
8
9

10
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ABSTRACT

Introduction: Addressing clinical variation in elective surgery is challenging. A key issue is how to gain consensus between largely autonomous clinicians. Understanding how the consensus process works to develop and implement perioperative pathways and the impact of these pathways on reducing clinical variation can provide important insights into the effectiveness of the consensus process. The primary objective of this study is to understand the implementation of an organisationally supported, consensus approach to implement perioperative care pathways in a private healthcare facility and to determine its impact.

Methods: A mixed-methods Effectiveness-Implementation Hybrid (Type III) pre-post study will be conducted in one Australian private hospital. Five new consensus-based perioperative care pathways will be developed and implemented for specific patient cohorts: spinal surgery, radical prostatectomy, cardiac surgery, bariatric surgery and total hip and knee replacement. The individual components of these pathways will be confirmed as part of a consensus-building approach and will follow a four-stage implementation process using the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework. The process of implementation, as well as barriers and facilitators, will be evaluated through semi-structured interviews and focus groups with key clinical and non-clinical staff, and participant observation. We anticipate completing 30 interviews and 15-20 meeting observations. Administrative and clinical end-points for at least 152 participants will be analysed to assess the effectiveness of the pathways.

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2
3 **Ethics and dissemination:** This study received ethical approval from Macquarie University
4
5 Human Research Ethics Medical Sciences Committee (Reference No: 520221219542374).
6

7
8 The findings of this study will be disseminated through peer-reviewed publications,
9
10 conference presentations, and reports for key stakeholders.
11
12

13 **Keywords:** Implementation Science, Clinical variation, Perioperative pathways, Consensus,
14
15 Elective surgery, Private providers
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17

18
19 **Strengths and Limitations:**
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- 21
22
- 23 • The pragmatic nature of the study will deliberately make use of existing practice
24 structures and approaches to implement the consensus pathways and to obtain patient-
25 related outcomes.
26
27
 - 28 • Multiple forms of qualitative data collection will be used to ensure rigour and a
29 diverse range of perspectives will be gathered.
30
31
 - 32 • An understanding of the barriers and facilitators to adopting new standardised
33 processes of care will be obtained which will provide a deeper understanding of the
34 experiences of implementation at different time periods across multiple surgical
35 cohorts.
36
37
 - 38 • Due to the pragmatic nature of the study, pre-post comparison of some clinical
39 outcomes will be limited to a smaller sample size from one surgical cohort only.
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INTRODUCTION

Addressing clinical variation is a fundamental component of health system improvement.

Whilst in some circumstances variation can be beneficial (e.g., when it represents innovation, or responses to individual patient need or preference), variation in healthcare processes that are unrelated to patient needs or those that differ from evidence-informed guidelines can compromise patient care, create inefficiencies, and contribute to health inequality (1, 2). This is a growing problem both in Australia and internationally, where on average, 60% of recommended care according to best practice guidelines is delivered to patients (3, 4, 5, 6, 7).

In addition, 30% of all care provided could be considered “low value” or waste, and 10% results in some form of iatrogenic harm (1, 4, 5). For example, care processes and outcomes for certain surgical patient cohorts have been found to differ substantially between hospitals in both public and private sectors (8). Data from Australia and the United States of America (USA) demonstrate a high degree of variation in length of stay (LOS), rates of transfer to inpatient rehabilitation following hip and knee arthroplasty (9), and specific to private hospitals, higher unplanned stay (>2 hours) in recovery after surgery (8). Considering the increasing number of elective surgeries and associated hospitalisations undertaken in private hospitals in Australia (10) and elsewhere (11, 12, 13), reducing unwarranted clinical variation in these settings is critical to generating higher value care, improving patient outcomes, and reducing healthcare expenditure.

A number of studies have examined ways to reduce unwarranted clinical variation, such as through the implementation of evidence-based perioperative care pathways for surgical cohorts (14, 15, 16). Enhanced recovery after surgery (ERAS) models are one such example involving the implementation of multimodal, evidence-based perioperative pathway designed to achieve early recovery and optimal patient outcomes (17). However, despite many studies

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3 demonstrating the efficacy of some strategies in reducing variation, the optimal methods of
4 developing and implementing such strategies into complex healthcare systems remain
5 unclear. More evidence is needed on how best to implement and sustain these changes, as
6 well as the barriers and facilitators to different methods of implementation to reduce
7 unwarranted variation.
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15 Evidence-informed perioperative care pathways designed to standardise the management of
16 surgical patients to the best evidence-informed practice have been shown to reduce variation
17 and improve patient outcomes (18). Perioperative care refers to the care of patients before,
18 during, and after surgical procedures involving anaesthesia (19). Care leading up to a surgical
19 procedure involves the reduction of modifiable risks, often in a preoperative clinic, through
20 patient education, medication optimisation, and other prophylactic treatments. After surgery,
21 the focus is on expediting recovery and minimising the risk of complications by optimising
22 such things as pain relief, antibiotic regimens to reduce infection risks, anticoagulation
23 protocols to avoid blood clotting, and early mobility to return to normal function. Private
24 hospitals in most countries have historically relied on accredited medical practitioners to
25 individually develop their own perioperative care protocols using a combination of their
26 experience, past practice, and clinical practice guidelines (20). Such protocols, when
27 implemented as frontline care, can create variation in care delivery based on provider
28 preferences.
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48 Implementing changes to patient care is complex and challenging, requiring concerted efforts
49 over time. This challenge is well documented and usually involves the provision of resources
50 to support change efforts, shifting professional roles, and altering cultural norms (21, 22).

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53 Rather than a “one size fits all” approach, pathways need to be developed to suit the
54 particular needs of the patient cohort and surgical discipline, as well as local resources
55 available. However, there is no universal approach to implementing these pathways. In many
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3 private hospitals, medical practitioners tend to operate with a high degree of professional
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5 autonomy, which necessitates a consensus-building approach between providers for any
6
7 standardisation of care processes.
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10 11 **Objectives**

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14 The primary objective of this study is to determine successful processes to implementing
15
16 perioperative care pathways in a private hospital setting using an organisationally supported
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18 consensus approach for surgical cohorts, including: i) spinal surgery; ii) radical
19
20 prostatectomy; iii) cardiac surgery; iv) bariatric surgery and; v) hip and knee replacement
21
22 surgery. The secondary objective is to assess the impact on administrative and, where
23
24 possible, clinical and patient-reported outcomes. We hypothesise that a consensus-based
25
26 approach to care pathway development and implementation will lead to high levels of fidelity
27
28 to best practice perioperative care processes and improve patient outcomes.
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34 35 **METHODS**

36 37 38 **Study design**

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41 A mixed-methods Effectiveness-Implementation Hybrid (Type III) pre-post study will be
42
43 used to evaluate the implementation of evidence and consensus-based perioperative
44
45 pathways, prioritising assessment of effectiveness of the implementation strategies. Whilst
46
47 improving clinical outcomes is an important goal of any change process, standardisation of
48
49 perioperative pathways has already been demonstrated to confer benefit to clinical outcomes
50
51 (14, 23, 24, 25, 26). As such, clinical outcomes will be considered secondary in this study.
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54 The perioperative care pathways will be implemented once consensus has been reached and
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56 outcomes will be compared to those observed before pathway development and integration
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58 into routine care, as a control period.
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Study Setting

The study will be conducted over a two-year period from October 2022 to December 2024 at Macquarie University Hospital (MUH). MUH is located in Sydney, Australia and is a university-owned, private teaching hospital that focusses on clinical care, teaching and research. MUH comprises 144 beds, 16 operating theatres, and is staffed by over 200 surgeons and other health professionals.

Eligibility criteria

Hospital staff and patients will be considered as study participants for the surgical cohorts: spinal surgery, radical prostatectomy, cardiac surgery, bariatric surgery and hip and knee replacement surgery. Data from hospital staff participants will primarily be used to examine the implementation of perioperative care pathways. Administrative data and data from consenting prostatectomy patients will be used firstly, to conduct a process evaluation and secondly, to evaluate impacts on patient-related outcomes.

Hospital staff: Local hospital staff involved in the delivery of clinical care or development and implementation of care pathways (i.e., both clinicians and non-clinical staff) will be considered eligible to participate in the implementation component of this study.

Patients: Those admitted during the relevant study periods, seeking care for any of the clinical cohorts of interest will be considered eligible for this study.

There are no specific exclusion criteria for this study.

Intervention

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3 Development and implementation of the cohort-specific standardised perioperative pathways
4 will follow a six-step process nested within four implementation stages using the Exploration,
5 Preparation, Implementation, and Sustainment (EPIS) framework (27). The EPIS Framework
6 guides projects through key stages of the implementation process and highlights important
7 factors influencing implementation success within the broader “outer context” (system) and
8 the proximal “inner context” (organisation) across each EPIS stage. The proposed
9 implementation strategies are summarised in Table 1. The general implementation strategies
10 will be tailored to each new patient cohort utilising a consensus-building approach. Our
11 implementation science approach will examine this consensus-building process to support
12 successful implementation of the pathways.
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27 *Stage 1: Exploration*

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31 The exploration stage will aim to understand the existing and emerging needs of both
32 clinicians and patients, and to identify the optimal modifications and supports required for the
33 implementation strategy to address those needs. This could include modifications to existing
34 information technology (IT) processes or the introduction of organisational support and
35 educational resources for staff members to implement the pathways. To achieve this
36 objective, a care pathway implementation support team will be established comprising
37 members of the research team and key hospital stakeholders. Stakeholders will include a
38 coalition of both clinical partners, such as clinical education coordinators, and non-clinical
39 partners, such as hospital administrators, to ensure a wide breadth of expertise are included.
40
41 The primary goal for the team will be to act as a vehicle for organisational leadership that
42 builds capacity in clinical improvement and implementation science methodology. Individual
43 roles within the team will be clarified across the project to reduce the risk of any duplicative
44 efforts and improve the visibility of activities across different patient cohorts where pathways
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3 will be implemented. The team will meet monthly for the duration of the study to discuss
4 goals and action items relating to the project to facilitate implementation of the perioperative
5 pathways. For example, an important aim for the support team will be to reduce the time-
6 burden for clinicians during pathway implementation and to establish actions that will
7 minimise potential time pressures.
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16 *Stage 2: Preparation*

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19 The objective of the preparation stage is to use a consensus-building approach to develop and
20 standardise perioperative care pathways for each surgical cohort, and to use learnings from
21 the hip and knee replacement surgery cohorts retrospectively to facilitate successful
22 implementation. During this stage, perioperative pathways will be drafted by a clinician-
23 researcher in a hospital leadership position (AH) and senior management staff, based on a
24 combination of 'current' surgeon clinical guidelines and evidence-based practice. Clinical
25 consensus groups will then be established for each cohort by the clinician-researcher. These
26 groups will include multidisciplinary representation such as surgeons, anaesthetists, nursing
27 and allied health, and will be led by the discipline heads. Clinical consensus groups will
28 attend regular meetings facilitated by the clinician-researcher to discuss components of care
29 to be included in the standardised perioperative pathways, including acceptable bounds of
30 variation in practice. The pathways will optimise components of care differently across
31 cohorts based on current evidence and joint medical decision making, including, but not
32 limited to, preoperative optimisation, postoperative analgesia, surgical antibiotic prophylaxis,
33 anticoagulation protocols and mobilisation after surgery. An 'informal' approach will be
34 utilised to achieve consensus on the perioperative pathways whereby a set of pre-defined
35 components will be discussed at each meeting and agreed upon by group members using both
36 evidence and their own perspectives to inform discussion (28). Items will be documented by
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3 the facilitator and relevant documentation will be sent to each group member for further
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5 review as required following each meeting. Following this process, pathways will be
6
7 circulated by each group member to their individual teams for feedback and critical
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9 modifications will then be made by the consensus groups at additional meetings which will
10
11 facilitate implementation during the next two stages.
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16 An additional goal of this phase will be to establish consensus from both the taskforce and
17
18 clinical consensus groups on a plan to implement the pathways. A draft implementation plan
19
20 will be created by the task force. This plan will be reviewed by the clinical consensus groups
21
22 for modifications as required and each member will serve as “champions” to drive
23
24 implementation. Components of the implementation plan may include education and training
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26 sessions for nursing and allied health and establishing audit and feedback processes on the
27
28 wards.
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33 A separate stakeholder engagement group will be formed to represent the views of patient
34
35 representatives, engage frontline clinical staff in implementation, and facilitate rapid
36
37 feedback regarding implementation challenges to the care pathway implementation support
38
39 team. Researchers involved in qualitative data collection will observe this process through
40
41 naturalistic observation however, they will not have a role in determining components of the
42
43 pathways. During this stage, learnings obtained from implementation of pathways for the hip
44
45 and knee replacement cohort will also be analysed by the research team to further understand
46
47 the process of implementation using a consensus approach.
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51 52 *Stage 3: Implementation* 53 54

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56 In the implementation stage, installation of the care pathways will be guided by the planned
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58 implementation supports formalised in the preparation phase. It will be critical to monitor the
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3 implementation process during this stage and adjust supports accordingly. Care pathway
4
5 toolkits including education and documentation resources will be finalised and disseminated
6
7 to clinical staff and patients at this stage to foster prompt widespread practice change. Further
8
9 monitoring of the degree of engagement and cohesion between clinical leadership and
10
11 frontline clinical staff will be achieved using participant observations. Particular attention
12
13 will be paid to the capacity of frontline clinical staff to absorb and apply new care pathways,
14
15 avoiding “bottlenecks” between care pathway development and implementation. This stage
16
17 will also be supported by an iterative audit and feedback process and data analytics to
18
19 identify gains made and update external benchmarking comparisons over time. Audit and
20
21 feedback will relate to process (implementation) outcomes, health services outputs, and
22
23 patient-level outcomes and this feedback will be communicated with staff at regular
24
25 discipline meetings.
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31 *Stage 4: Sustainment*

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35 The sustainment stage involves the continued application of the structures and processes of
36
37 the care pathways to realise tangible improvements in patient outcomes. At this stage, care
38
39 variation reduction becomes a standing item on regular Patient Safety and Quality Committee
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41 meeting agendas. “Roadshow” presentations to the stakeholder engagement groups, frontline
42
43 clinical staff and hospital leadership groups can continue bi-directional communication and
44
45 feedback loops to identify new areas of care variance prioritised for future care pathways. We
46
47 also plan to translate our findings via policy maker round tables and engagement and training
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49 with other private hospitals.
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Table 1 Overview of implementation strategies

Implementation stage	Implementation strategy	Description
<i>Exploration</i>	Build a coalition	Recruit and cultivate relationships with partners in the implementation effort by formally establishing a care pathway support team
<i>Preparation</i>	Conduct local consensus discussions	Establish a structure for local providers and other stakeholders to form cohort-specific clinical consensus groups to discuss the processes of care and standardisation of pathways
	Co-develop a formal implementation blueprint	Co-develop a formal blueprint for iterative care pathway prioritisation and implementation
<i>Implementation</i>	Develop and implement care pathway toolkits	Develop, test, and introduce quality improvement tools and educational materials
	Audit and provide feedback	Embed a comprehensive system audit around care variation, clinical and process outcomes over specified time periods and disseminate to clinicians and administrators to monitor, evaluate, and modify provider behaviour
<i>Sustainment</i>	Facilitate relay of clinical data to providers	Undertake formal monitoring and evaluation and develop a reporting structure and channels of communication for care pathway development, implementation, and outcomes

Recruitment

Semi-structured interviews and focus groups with hospital staff

A purposive sample of staff who have been previously involved in the development of perioperative pathways or provision of care for the hip and knee replacement surgical cohorts, and staff currently involved in the development and implementation of the new pathways for the four new surgical cohorts will be recruited. Staff will be identified by MUH co-investigators. Research staff not employed by MUH will approach the identified staff

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3 members either by email invitation or face-to-face to request their participation in the
4
5 interviews, indicating that they have been identified by the research team as a key stakeholder
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7 in the development and implementation of the pathways. This approach is designed to avoid
8
9 the potential impact of any existing relationships between hospital staff and co-investigators.
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11 A brief explanation of the study and a written participant information form will be provided
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13 to the staff members. Staff members will be provided with time to review the information and
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15 ask any questions of the research staff prior to their decision to consent to participate in the
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17 interviews and focus groups, or not.
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23 *Participant observations with hospital staff*

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25 Staff attending relevant meetings will be recruited, such as planned support team project
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27 meetings, clinical consensus group meetings, stakeholder engagement group meetings,
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29 patient safety and quality committees, and ward based clinical meetings. Attendance of these
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31 meetings by external staff will be through invitation from hospital co-investigators. Study
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33 information and a participant information form will be provided prior to the initial meeting
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35 where participant observations will take place.
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40 **OUTCOMES**

41 42 43 **Primary outcomes**

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46 A summary of the primary outcome measures for this study can be found in Table 2.
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48 Implementation outcomes including acceptability, appropriateness, feasibility, adoption,
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50 fidelity and sustainment, and penetration, will be used to understand the impact of the
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52 implementation strategies and implementation using a consensus-building approach on
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54 secondary outcomes (29).
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Table 2 Summary of primary outcome measures

<i>Acceptability</i>	Provider knowledge and satisfaction with aspects of the perioperative pathways and their implementation will be collected via qualitative interviews and participant observation
<i>Appropriateness</i>	Appropriateness will be assessed both retrospectively based on the experiences piloting the intervention for the hip and knee replacement cohorts using qualitative interviews, as well as for the four prospective cohorts using participant observation
<i>Feasibility</i>	Feasibility will be measured both retrospectively using pilot data from the hip and knee replacement cohorts and prospectively for the four new cohorts of interest using interviews and participant observation
<i>Adoption</i>	Participant observations of the clinical consensus-building process will be used to measure the reasons pertaining to the intention, initial decision, or action to integrate the perioperative care pathways into routine clinical practice
<i>Fidelity and sustainment</i>	Regular audits of adherence to the care pathways will provide an indication of variations to practice over time, including potential modifications and tailoring of the pathways by frontline staff (e.g., nurses) to better fit within their work routines

<i>Penetration</i>	Penetration will be assessed by the number of eligible patients who receive the care pathway as intended according to planned audits
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Secondary outcomes

Secondary outcomes assessed will include both process outcomes and clinical outcomes:

- Hospital or intensive care unit LOS for each cohort will be collected from routine administrative data systems.
- Patient-reported experience measures (PREMs) collected via patient surveys.
- Patient-reported outcome measures (PROMs) collected via patient surveys e.g., health-related quality of life questionnaires.
- Discharge destination collected from routine administrative data systems.
- Hospital-acquired complication rates collected from routine incident reporting systems.
- Hospital readmission rates collected from routine administrative data systems.

Selected PREMs and PROMs for the prostatectomy cohort are currently routinely collected at some site hospitals by specialist nurse practitioners and recorded in the patient's medical records. These include the Prostate Cancer Distress Screen (30), the International Prostate Symptom Score (IPSS) (31), Incontinence Questionnaire-Urinary Incontinence Short Form (32) and the Sexual Health Inventory for Men (33). Research staff will assist with sending out surveys (see Supplementary File 1), prior to the routine six-month follow up assessment for up to 50-100 patients both before and after pathway implementation where patients consent, standardising an existing clinical interaction for comparison. Specific PROMs and PREMs

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3 measures for the remaining pathways will be determined during the consensus building
4 process and if agreed, these measures will only be collected for research purposes where
5 patients consent, prospectively.
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10 **Data collection**

11 *Qualitative interviews and focus groups*

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16 Semi-structured one-on-one interviews or focus groups will be conducted over a 12-month
17 period with key clinical and non-clinical hospital staff and patient/consumer representatives,
18 focussing retrospectively on the pilot hip and knee replacement cohorts and prospectively for
19 each of the four new cohorts. Interview guides will be piloted prior to data collection and will
20 include questions pertaining to participants knowledge and experiences of implementing the
21 standardised perioperative pathways, as well as barriers and facilitators to this process (see
22 Supplementary File 2 and Supplementary File 3 for planned interview guides). Interviews
23 and focus groups will be conducted by one experienced qualitative researcher (LP) via
24 videoconference or face-to-face at participants' preferred time and location, lasting between
25 30-60 minutes. The researcher will conduct all interviews in a private room suited to the
26 interviewee, where interviews will be digitally recorded and transcribed verbatim. Field notes
27 will also be made by the interviewer including initial thoughts, interpretations and analysis of
28 the data collected. Audio and written data will be immediately saved in a password protected
29 file on an encrypted password protected computer.
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50 *Qualitative participant observation*

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52 Data collectors will conduct naturalistic participant observations within the planned support
53 team project meetings, clinical consensus group meetings, stakeholder engagement group
54 meetings, patient safety and quality committee, and ward-based clinical meetings (34). Each
55 observation session is anticipated to last between one to two hours. Fieldnotes will be taken
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1
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3 to spatially contextualise events within the study aims (35). These observations will not be
4
5 guided by a pre-determined schedule, but rather, they will inductively evolve in real-world
6
7 practice environments. This includes how staff converse with one another, how they plan and
8
9 make decisions together about perioperative care (i.e., implementation, communication
10
11 pathways, leadership), and how decision-making processes evolve and take shape across
12
13 different meetings with different stakeholders.
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16 17 18 *Quantitative clinical outcomes data*

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21 Data on clinical outcomes will be collected from administrative databases. These data include
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23 measures such as hospital LOS, discharge destination, acquired complications, and
24
25 readmission. Data from routine administrative databases has high levels of agreement with
26
27 the medical record for both length of stay (93%) and discharge destination (91%) data, but
28
29 some limitations are acknowledged when capturing acquired complications (36, 37). Those
30
31 data not routinely collected within existing administrative databases will be collected
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33 prospectively or via retrospective electronic medical review.
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39 **Sample size**

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42 Qualitative data pertaining to the implementation of the perioperative clinical pathways will
43
44 use the concept of theoretical saturation to determine the observation and interview sample
45
46 size (38). Based on prior studies, we anticipate conducting 30 interviews and 15-20 meeting
47
48 observations (39, 40). Staff will be recruited using convenience time-frame sampling which
49
50 removes opportunistic recruitment of staff and patients, and any researcher or hospital
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52 selection bias.
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57 For quantitative data, a power calculation was undertaken for each of the four cohorts based
58
59 on the mean and standard deviation of LOS for each at a site hospital in the 2020 and 2021
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3 financial years, an estimated important reduction in LOS, two sided $\alpha=0.05$ and 80% power.
4
5 For spinal surgery, for example, reduction of mean LOS from 4.28 (SD: 4.66) to 2.78 (the
6
7 peer group average) required 152 patients pre- and post-intervention, which is achievable
8
9 with twelve months' follow-up. Bariatric surgery, on the other hand, requires only 6 months.
10
11 Overall, MUH LOS for cardiac surgery is in line with its peer group, so for this cohort the
12
13 target is intensive unit LOS, which is higher than that of peers. The cohorts requiring longer
14
15 follow-up periods will be prioritised for earlier intervention where feasible. It is important to
16
17 note that the research team does not view LOS as the most important clinical outcome for
18
19 these four cohorts; it is used for sample size estimation because it is an administrative
20
21 outcome where there is a prospect of measuring relevant quantitative change in the time
22
23 available to the study. Moreover, relevant data on means and standard deviations is routinely
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25 available, permitting sample size calculation.
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31 32 **DATA ANALYSIS**

33 34 35 **Qualitative**

36 37 38 *Qualitative interview and observation analysis*

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42 Fieldnotes and interview transcripts will be imported into Nvivo20 for data management.

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44 Data will be analysed thematically (41, 42) by two experienced qualitative analysts (primary
45
46 and secondary) (LP and MS or EFA) working together to ensure the process is rigorous, and
47
48 to enable them to discuss the major and minor themes arising inductively and their
49
50 concomitant categories until consensus agreement can be achieved. The secondary analyst
51
52 will examine a subset of the complete dataset, to ensure methodological veracity during the
53
54 analytic process.
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59 60 **Quantitative**

Quantitative analysis of clinical endpoints

Data will be analysed by three researchers (LP, GA and MNS) using SPSS. Descriptive statistics will be used to summarise demographic data. For LOS, historical data will be sourced from administrative databases to identify any secular trend and take this into account in attributing any pre-post change to intervention. For other clinical outcomes, PREMs and PROMs will be descriptive only and restricted to 50-100 patients from the prostatectomy cohort and any other cohort where these outcomes are available, while hospital acquired complications and hospital readmission rates will be compared pre- and post-intervention. The estimated between-group difference and the 95% confidence intervals (95% CI) will be reported and for significant testing, p values <0.05 will be considered statistically significant.

Patient and Public Involvement

Input and feedback was obtained from the site hospital's Clinical Leadership Committee and the Clinical Disciplines on aspects of the study design, such as the planned implementation strategies and outcome measures. Patients were not involved in the design of this study, however, patient consumer input and feedback will be sought from the site hospital's consumer advisory committee where resources for patients are developed.

DISCUSSION

Translating standardised clinical consensus pathways into current practice has proven complex and challenging. Whilst the efficacy of such pathways on process outcomes, such as LOS and postoperative complications has been well-established, evidence suggests suboptimal implementation into healthcare settings with inconsistent adherence to some recommendations (14, 23, 25, 26, 43). Reported issues with sustainability of new care pathways following implementation further highlight the complexities of this process (44). There is no universal way to implement perioperative pathways of proven efficacy into

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2
3 hospital settings. Studies evaluating the success and effectiveness of care pathways can
4
5 provide a basis for service providers however, inconsistent reporting on the methods used for
6
7 implementation, as well as barriers and facilitators, make determining the optimal approach
8
9 difficult. The focus of this research is to evaluate the process of implementing perioperative
10
11 care pathways into a private hospital facility through a consensus-building approach, where
12
13 key stakeholders will work together to conduct 'local consensus decisions' (45). The
14
15 pragmatic nature of the study will deliberately make use of and augment existing practice
16
17 structures, staffing and approaches to implement these consensus pathways. This can provide
18
19 valuable insights into implementation during routine clinical practice and is thus, potentially
20
21 generalisable and transferrable to similar healthcare contexts.
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27 Successful implementation of perioperative care pathways is dependent upon numerous
28
29 factors due to the multifaceted nature required for change (46, 47, 48, 49). A thorough
30
31 understanding of the social and organisational contexts is required to optimise
32
33 implementation into hospital settings and ensure sustainability (49, 50). It is important to
34
35 ascertain the views of clinicians and patients involved in implementation to gain a deeper
36
37 understanding of the acceptability of the pathway and the use of a consensus-building process
38
39 (51). Previous studies examining provider and patient perceptions of implementing ERAS
40
41 pathways have reported many barriers to successful implementation (52, 53, 54). Ineffective
42
43 communication between team members, lack of hospital resources, increased workload and
44
45 negative provider attitudes to the proposed interventions have been cited as key issues that
46
47 must be addressed to optimise implementation and sustainability (44, 47, 53). These themes
48
49 are not isolated to surgical cohorts alone, with similar themes impacting on implementation
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51 of standardised pathways reported for other areas, such as mental health (47) and asthma
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57 (55).
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3 The utilisation of semi-structured interviews with key clinical and non-clinical staff is
4 designed to provide insight into the attitudes and experiences of the process of
5
6 implementation. This will enable an exploration of the barriers and facilitators to successfully
7
8 adopting a new standardised process of care. The degree of engagement and cohesion
9
10 between clinical leadership and frontline clinical staff will be monitored using participant
11
12 observations; with particular attention paid to the capacity of staff to absorb and apply new
13
14 care pathways into practice. The inclusion of a variety of staff members from different
15
16 disciplines and different surgical cohorts will provide a deeper understanding of the processes
17
18 of implementation for a variety of surgical procedures, where different cohorts may have
19
20 different views and experiences of implementing consensus-based pathways.
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27 The insights obtained through these methods aim to contribute to the growing knowledge
28
29 base about the factors that impact upon effective implementation of perioperative pathways
30
31 into hospital settings utilising a consensus approach. The application of implementation
32
33 science methods and use of the EPIS framework (27) will enable us to characterise the
34
35 processes of implementation and evaluate factors that may impact upon implementation at
36
37 different phases of the process. This enables forward thinking about sustainability and
38
39 optimising implementation in the future by adopting a learning health system model, whereby
40
41 reliable outcomes are consistently delivered and improved with each care experience (56).
42
43 Other clinical settings may find this knowledge useful to inform integration and adaptations
44
45 of similar pathways into routine care to reduce unwarranted variation.
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51 **Word count:** 4174 words
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54 **List of Abbreviations:**
55

56 EPIS Exploration, Preparation, Implementation, and Sustainment Framework;
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3 ERAS Enhanced Recovery After Surgery;
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6 IT Information Technology;
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10 LOS Length of stay;
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13 MUH Macquarie University Hospital;
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17 PREMs Patient-reported experience measures;
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20 PROMs Patient-reported outcome measures;
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24 SD Standard deviation
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27 USA United States of America
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30 **DECLARATIONS:**

31 **Ethics and dissemination:**

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37
38 Approval to conduct this study has been obtained from the Macquarie University Human
39
40 Research Ethics Medical Sciences Committee (Reference No: 520221219542374). Research
41
42 governance authorisation has been provided by the MQ Health Clinical Research Executive.
43

44 A waiver for consent will be sought from participants for data obtained in this study.

45
46 PROMs/PREMs data being collected for clinical purposes will seek informed patient consent
47
48 for de-identified data to be used for research purposes. The findings of this study will be
49
50 disseminated through peer-reviewed publications, conference presentations, and summaries
51
52 or reports for key stakeholders and partners in the field.
53
54
55

56 **Protocol amendments:**

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58
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1
2
3 Approval from the study investigators, Human Research Ethics Committee, and research
4
5 governance will be sought for any protocol amendments. Amendments will be reported in the
6
7 published manuscript as a deviation from the protocol.
8
9

10 11 **Consent for publication:** 12

13
14 Not applicable.
15
16

17 18 **Availability of data and materials:** 19

20
21 Data sharing is not applicable to this article as no datasets were generated or analysed during
22
23 the current study.
24
25

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29
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31
32

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51 52 **Authors' contributions:** 53

54
55 The study was conceived by MS, AH, EF-A, GA, JCL, JB, GG, PDH, KC, KH, AP, CH, DG,
56
57 LAE, LT, and RP and all authors contributed to the study design. LP, CH and MS wrote the
58
59
60

1
2
3 initial draft of the manuscript. All authors contributed to and approved the final version of the
4
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6
7

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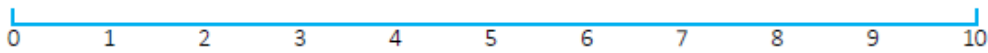
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For peer review only



PROSTATE CANCER DISTRESS SCREEN

The experience of prostate cancer is for many men a difficult time. I would like to ask you a few brief questions to check how you have been feeling and ask about your main concerns. Thinking about how you have been feeling over the past week including today, how distressed do you feel on a scale of '0', no distress to '10', extreme distress? (circle)



No distress

Extreme distress

This is a list of problems that some men with prostate cancer experience. Do any of these problems apply to you? (Read the list below, tick if yes)

Practical Problems

- Work
- Financial/Insurance

Family Problems

- Partner

Emotional Problems

- Depression
- Uncertainty about the future
- Nervousness
- Sadness
- Worry
- Loss of interest in usual activities

Treatment Problems

- Understanding treatments
- Making a decision
- Information about my illness

Physical Problems

- Pain
- Fatigue
- Sexual
- Urinary
- Bowel
- Hot Flashes
- Weight Gain
- Weight Loss
- Loss of Muscle Mass
- Memory/Concentration
- Sleep

Other Problems (please list)

Which of these are the **most important concerns** for you right now? (Please list)

Which of these concerns would you like help with?

For men with a rating of ≥ 4 consider further assessment and referral to appropriate support services.

Person completing form:

Date: ___ / ___ / ___

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ICIQ-UI-SF: CONFIDENTIAL

Many people leak urine some of the time. We are trying to find out how many people leak urine, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

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1. How often do you leak urine? (Tick one box)

- never
- about once a week or less often
- two or three times a week
- about once a day
- several times a day
- all the time

2. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)? (Tick one box)

- none
- a small amount
- a moderate amount
- a large amount

3. Overall how much does leaking urine interfere with your everyday life?

Please circle a number between 0 (not at all) and 10 (a great deal)

- 0 1 2 3 4 5 6 7 8 9 10
- not at all a great deal

4. When does urine leak? (Please tick all that apply to you)

- never – urine does not leak
- leaks before you can get to the toilet
- leaks when you cough or sneeze
- leaks when you are asleep
- leaks when you are physically active/exercising
- leaks when you have finished urinating and are dressed
- leaks for no obvious reason
- leaks all the time

Thank you very much for answering these questions.

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International Prostate Symptom Score (IPSS)

Patient Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Determine Your BPH Symptoms Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying- How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency- How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency- How often you have found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency- How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream- How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining- How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping- How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:		+	+	+	+	+

Total International Prostate Symptom Score= _____

1-7 mild symptoms - 8-19 moderate symptoms - 20-35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatis-	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6



Sexual Health Inventory for Men (SHIM)

Instructions

Each question has five possible responses. Circle the number that best describes your own situation. Select only one answer for each question.

Over the last six months:

1. How do you rate your confidence that you could keep an erection?

1	2	3	4	5
Very low	Low	Moderate	High	Very high

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (more than half the time)	Almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (more than half the time)	Almost always or always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

1	2	3	4	5
Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (more than half the time)	Almost always or always

SUPPLEMENTARY FILE 2

Topic Guide: Staff interviews

Title	Implementation of evidence and consensus-based perioperative care pathways
Principal Investigator	Dr Mitchell Sarkies, Senior Research Fellow and NHMRC Emerging Leadership Fellow, Australian Institute of Health Innovation, Macquarie University mitchell.sarkies@mq.edu.au
Co-investigators	A/Prof Andrew Hirschhorn, Prof Jeffrey Braithwaite, Dr Gaston Arnolda, Dr Emilie Francis-Auton, Dr Janet Long, Ms Lisa Pagano

The semi-structured interviews will be conducted retrospectively for key clinical and non-clinical hospital staff who were previously involved in the development of perioperative pathways for the elective hip and knee replacement surgical cohorts; and prospectively for staff currently involved in the development and implementation of new pathways. The aims of the interview are to:

- Determine the experiences of staff involved in implementing standardised peri-operative pathways.
- Explore the stakeholder knowledge of the care pathways within the hospital setting.
- Assess the integrity, fidelity to and feasibility of the intervention.
- To understand the key barriers and facilitators to implementation of standardised peri-operative pathways from the perspective of both clinical and non-clinical hospital staff.
- To synthesize data from both patient groups to gain a broader understanding of how standardised care pathways are implemented and the impact of these pathways.

QUESTIONS:

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2
3 *Thank you for taking part in this interview to examine the implementation of standardised*
4 *peri-operative surgical pathways at Macquarie University Hospital. The questions will focus*
5 *on your experiences, familiarity with the pathway, perspective on whether they're being*
6 *adhered to, and any barriers or facilitators to their implementation.*

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11 *Participation in this interview is voluntary and if at any time you do not wish to continue,*
12 *please let me know. Participation or refusal to participate will not affect your employment.*

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15 *With your permission, this interview will be audio recorded so that it can be transcribed and*
16 *analysed. Do you have any questions before we start?*

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22 1. Demographic questions:

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24 - Can you please introduce yourself and your role at Macquarie University Hospital?
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26 - How long have you worked in healthcare?
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28 - How many of those have been at Macquarie University Hospital?
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37 2. What was your experience/what has been your experience implementing the
38 [SURGICAL COHORT] peri-operative pathway/s?
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49 3. How familiar are you with the particulars of the clinical pathway/s? Can you talk
50 through some of the changes from previous practice?
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- 52
53 - What worked?
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55 - What didn't work
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3 4. What are your views on the standardised clinical pathways that were
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5 implemented/are being implemented?
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- 7
8 - Strengths
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10 - Weaknesses
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18 5. Did you and other clinicians tend to follow the new processes/procedures?
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- 20 - Why do think that is?
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25 6. What challenges, if any, did you encounter in implementing the clinical pathways?
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30 Prompts;

- 31
32 - Workload and time
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34 - Staffing
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36 - Personal preference/views
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38 - Inter-professional collaboration
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40 - Other
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45 7. What was important to facilitating the implementation of the clinical pathways?
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50 Prompts;

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52 - Organisation
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54 - Resources
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56 - Staffing/Inter-professional collaboration
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58 - Support/Monitoring of fidelity/quality
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3 - Other
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8 8. Were there any other lessons learned about implementing standardised clinical
9 pathways?
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17 *Additional probing question:*
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19 9. What are your suggestions to improve future implementation of standardised clinical
20 pathways for [SURGICAL COHORT] surgery?
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30 10. What do you see as the effects and value of implementing standardised clinical
31 pathways for [SURGICAL COHORT] surgery?
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41 11. Overall, how feasible is/was it to implement standardised clinical pathways for
42 [SURGICAL COHORT] surgery at Macquarie University Hospital or private hospital
43 settings more generally?
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55 12. Is there anything else you would like to add that has not been covered here?
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Topic Guide: Surgeons

Title	Implementation of evidence and consensus-based perioperative care pathways
Principal Investigator	Dr Mitchell Sarkies, Senior Research Fellow and NHMRC Emerging Leadership Fellow, Australian Institute of Health Innovation, Macquarie University mitchell.sarkies@mq.edu.au
Co-investigators	A/Prof Andrew Hirschhorn, Prof Jeffrey Braithwaite, Dr Gaston Arnolda, Dr Emilie Francis-Auton, Dr Janet Long, Ms Lisa Pagano

The semi-structured interviews will be conducted retrospectively for key clinical and non-clinical hospital staff who were previously involved in the development of perioperative pathways for the elective hip and knee replacement surgical cohorts; and prospectively for staff currently involved in the development and implementation of new pathways. The aims of the interview are to:

- Determine the experiences of staff involved in implementing standardised peri-operative pathways.
- Explore the stakeholder knowledge of the care pathways within the hospital setting.
- Assess the integrity, fidelity to and feasibility of the intervention.
- To understand the key barriers and facilitators to implementation of standardised peri-operative pathways from the perspective of both clinical and non-clinical hospital staff.
- To synthesize data from both patient groups to gain a broader understanding of how standardised care pathways are implemented and the impact of these pathways.

QUESTIONS:

1. Demographic questions:
 - Can you please introduce yourself and your role at Macquarie University Hospital?
 - How long have you worked in healthcare?
 - How many of those have been at Macquarie University Hospital?
 - *Can ask further about elements of their role as needed*

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8 2. What was your experience/what has been your experience implementing the
9 [SURGICAL COHORT] peri-operative pathway/s?
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17 3. How familiar are you with the particulars of the clinical pathway/s? Can you talk
18 through some of the changes from previous practice?
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20 • What worked?
21 • What didn't work?
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27 4. What are your views on the standardised clinical pathways that were
28 implemented/are being implemented?
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30 • Strengths
31 • Weaknesses
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36 5. What are your perceptions of why MQ health was looking to standardise pathways?
37 Alternate question - What do you think about the organisation's approach to try to
38 reduce clinical variation through standardising clinical pathways?
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42 Prompt – do you see clinical variation as being an issue?
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- 47 6. Option 1: What challenges, if any, did you encounter in implementing the clinical
48 pathways?
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52 Option 2: What challenges do you think clinicians would face when attempting to
53 implement consensus-based clinical pathways?
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56 Prompts;
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- 58 • Workload and time
59 • Staffing
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- Personal preference/views/autonomy
 - Inter-professional collaboration
 - Other

7. Option 1: What was important to facilitating the implementation of the clinical pathways?

Prompts;

- Organisation
- Resources
- Staffing/Inter-professional collaboration
- Support/Monitoring of fidelity/quality
- Other

8. What do you see as the effects and value of implementing standardised clinical pathways for [SURGICAL COHORT] surgery?

9. How would you measure the success of a clinical pathway of the [SURGICAL] clinical cohort?

10. Overall, how feasible is/was it to implement standardised clinical pathways for [SURGICAL COHORT] surgery at Macquarie University Hospital or private hospital settings more generally?

11. Is there anything else you would like to add that has not been covered here?



SPIRIT 2013 Checklist: Recommended items to address in a clinical trial protocol and related documents*

Section/item	Item No	Description	Page No.
Administrative information			
Title	1	Descriptive title identifying the study design, population, interventions, and, if applicable, trial acronym	1
Trial registration	2a	Trial identifier and registry name. If not yet registered, name of intended registry	N/A
	2b	All items from the World Health Organization Trial Registration Data Set	N/A
Protocol version	3	Date and version identifier	Ethics protocol
Funding	4	Sources and types of financial, material, and other support	23
Roles and responsibilities	5a	Names, affiliations, and roles of protocol contributors	1
	5b	Name and contact information for the trial sponsor	N/A
	5c	Role of study sponsor and funders, if any, in study design; collection, management, analysis, and interpretation of data; writing of the report; and the decision to submit the report for publication, including whether they will have ultimate authority over any of these activities	23
	5d	Composition, roles, and responsibilities of the coordinating centre, steering committee, endpoint adjudication committee, data management team, and other individuals or groups overseeing the trial, if applicable (see Item 21a for data monitoring committee)	23
Introduction			
Background and rationale	6a	Description of research question and justification for undertaking the trial, including summary of relevant studies (published and unpublished) examining benefits and harms for each intervention	4-6
	6b	Explanation for choice of comparators	N/A
Objectives	7	Specific objectives or hypotheses	6

1				
2	Trial design	8	Description of trial design including type of trial (eg, parallel group, crossover, factorial, single group), allocation ratio, and framework (eg, superiority, equivalence, noninferiority, exploratory)	6-7
3				
4				
5				
6				
7				
8	Methods: Participants, interventions, and outcomes			
9				
10	Study setting	9	Description of study settings (eg, community clinic, academic hospital) and list of countries where data will be collected. Reference to where list of study sites can be obtained	7
11				
12				
13				
14	Eligibility criteria	10	Inclusion and exclusion criteria for participants. If applicable, eligibility criteria for study centres and individuals who will perform the interventions (eg, surgeons, psychotherapists)	7-8
15				
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18				
19	Interventions	11a	Interventions for each group with sufficient detail to allow replication, including how and when they will be administered	8-12
20				
21				
22		11b	Criteria for discontinuing or modifying allocated interventions for a given trial participant (eg, drug dose change in response to harms, participant request, or improving/worsening disease)	N/A
23				
24				
25				
26		11c	Strategies to improve adherence to intervention protocols, and any procedures for monitoring adherence (eg, drug tablet return, laboratory tests)	9-12
27				
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31		11d	Relevant concomitant care and interventions that are permitted or prohibited during the trial	N/A
32				
33				
34	Outcomes	12	Primary, secondary, and other outcomes, including the specific measurement variable (eg, systolic blood pressure), analysis metric (eg, change from baseline, final value, time to event), method of aggregation (eg, median, proportion), and time point for each outcome. Explanation of the clinical relevance of chosen efficacy and harm outcomes is strongly recommended	13-17
35				
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43	Participant timeline	13	Time schedule of enrolment, interventions (including any run-ins and washouts), assessments, and visits for participants. A schematic diagram is highly recommended (see Figure)	16-17
44				
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47				
48	Sample size	14	Estimated number of participants needed to achieve study objectives and how it was determined, including clinical and statistical assumptions supporting any sample size calculations	17-18
49				
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54	Recruitment	15	Strategies for achieving adequate participant enrolment to reach target sample size	17-18
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57	Methods: Assignment of interventions (for controlled trials)			
58				
59	Allocation:			
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1				
2	Sequence	16a	Method of generating the allocation sequence (eg, computer-	N/A
3	generation		generated random numbers), and list of any factors for	
4			stratification. To reduce predictability of a random sequence,	
5			details of any planned restriction (eg, blocking) should be	
6			provided in a separate document that is unavailable to those	
7			who enrol participants or assign interventions	
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10	Allocation	16b	Mechanism of implementing the allocation sequence (eg,	N/A
11	concealment		central telephone; sequentially numbered, opaque, sealed	
12	mechanism		envelopes), describing any steps to conceal the sequence	
13			until interventions are assigned	
14				
15	Implementation	16c	Who will generate the allocation sequence, who will enrol	N/A
16			participants, and who will assign participants to interventions	
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19	Blinding	17a	Who will be blinded after assignment to interventions (eg, trial	N/A
20	(masking)		participants, care providers, outcome assessors, data	
21			analysts), and how	
22				
23		17b	If blinded, circumstances under which unblinding is	N/A
24			permissible, and procedure for revealing a participant's	
25			allocated intervention during the trial	
26				
27				
28	Methods: Data collection, management, and analysis			
29				
30	Data collection	18a	Plans for assessment and collection of outcome, baseline, and	15-17
31	methods		other trial data, including any related processes to promote	
32			data quality (eg, duplicate measurements, training of	
33			assessors) and a description of study instruments (eg,	
34			questionnaires, laboratory tests) along with their reliability and	
35			validity, if known. Reference to where data collection forms	
36			can be found, if not in the protocol	
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39		18b	Plans to promote participant retention and complete follow-up,	N/A
40			including list of any outcome data to be collected for	
41			participants who discontinue or deviate from intervention	
42			protocols	
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44				
45	Data	19	Plans for data entry, coding, security, and storage, including	16-18
46	management		any related processes to promote data quality (eg, double data	
47			entry; range checks for data values). Reference to where	
48			details of data management procedures can be found, if not in	
49			the protocol	
50				
51				
52	Statistical	20a	Statistical methods for analysing primary and secondary	18-19
53	methods		outcomes. Reference to where other details of the statistical	
54			analysis plan can be found, if not in the protocol	
55				
56		20b	Methods for any additional analyses (eg, subgroup and	N/A
57			adjusted analyses)	
58				
59				
60				

	20c	Definition of analysis population relating to protocol non-adherence (eg, as randomised analysis), and any statistical methods to handle missing data (eg, multiple imputation)	N/A
Methods: Monitoring			
Data monitoring	21a	Composition of data monitoring committee (DMC); summary of its role and reporting structure; statement of whether it is independent from the sponsor and competing interests; and reference to where further details about its charter can be found, if not in the protocol. Alternatively, an explanation of why a DMC is not needed	N/A
	21b	Description of any interim analyses and stopping guidelines, including who will have access to these interim results and make the final decision to terminate the trial	N/A
Harms	22	Plans for collecting, assessing, reporting, and managing solicited and spontaneously reported adverse events and other unintended effects of trial interventions or trial conduct	Ethics protocol
Auditing	23	Frequency and procedures for auditing trial conduct, if any, and whether the process will be independent from investigators and the sponsor	N/A
Ethics and dissemination			
Research ethics approval	24	Plans for seeking research ethics committee/institutional review board (REC/IRB) approval	22
Protocol amendments	25	Plans for communicating important protocol modifications (eg, changes to eligibility criteria, outcomes, analyses) to relevant parties (eg, investigators, REC/IRBs, trial participants, trial registries, journals, regulators)	22
Consent or assent	26a	Who will obtain informed consent or assent from potential trial participants or authorised surrogates, and how (see Item 32)	13, 22
	26b	Additional consent provisions for collection and use of participant data and biological specimens in ancillary studies, if applicable	N/A
Confidentiality	27	How personal information about potential and enrolled participants will be collected, shared, and maintained in order to protect confidentiality before, during, and after the trial	22
Declaration of interests	28	Financial and other competing interests for principal investigators for the overall trial and each study site	22
Access to data	29	Statement of who will have access to the final trial dataset, and disclosure of contractual agreements that limit such access for investigators	22

1				
2	Ancillary and	30	Provisions, if any, for ancillary and post-trial care, and for	Ethics protocol
3	post-trial care		compensation to those who suffer harm from trial participation	
4				
5	Dissemination	31a	Plans for investigators and sponsor to communicate trial	Ethics protocol
6	policy		results to participants, healthcare professionals, the public,	
7			and other relevant groups (eg, via publication, reporting in	
8			results databases, or other data sharing arrangements),	
9			including any publication restrictions	
10				
11		31b	Authorship eligibility guidelines and any intended use of	N/A
12			professional writers	
13				
14				
15		31c	Plans, if any, for granting public access to the full protocol,	N/A
16			participant-level dataset, and statistical code	
17				
18				
19	Appendices			
20				
21	Informed consent	32	Model consent form and other related documentation given to	Ethics protocol
22	materials		participants and authorised surrogates	
23				
24	Biological	33	Plans for collection, laboratory evaluation, and storage of	N/A
25	specimens		biological specimens for genetic or molecular analysis in the	
26			current trial and for future use in ancillary studies, if applicable	
27				

*It is strongly recommended that this checklist be read in conjunction with the SPIRIT 2013 Explanation & Elaboration for important clarification on the items. Amendments to the protocol should be tracked and dated. The SPIRIT checklist is copyrighted by the SPIRIT Group under the Creative Commons "[Attribution-NonCommercial-NoDerivs 3.0 Unported](https://creativecommons.org/licenses/by-nc-nd/3.0/)" license.

BMJ Open

IMPLEMENTATION OF CONSENSUS-BASED PERIOPERATIVE CARE PATHWAYS TO REDUCE CLINICAL VARIATION FOR ELECTIVE SURGERY IN AN AUSTRALIAN PRIVATE HOSPITAL: A MIXED METHODS PRE-POST STUDY PROTOCOL

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SCHOLARONE™
Manuscripts

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2
3 **IMPLEMENTATION OF CONSENSUS-BASED PERIOPERATIVE CARE**
4
5 **PATHWAYS TO REDUCE CLINICAL VARIATION FOR ELECTIVE SURGERY IN**
6
7 **AN AUSTRALIAN PRIVATE HOSPITAL: A MIXED METHODS PRE-POST**
8
9 **STUDY PROTOCOL**
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11
12

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12 **ABSTRACT**

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15
16 **Introduction:** Addressing clinical variation in elective surgery is challenging. A key issue is
17 how to gain consensus between largely autonomous clinicians. Understanding how the
18 consensus process works to develop and implement perioperative pathways and the impact of
19 these pathways on reducing clinical variation can provide important insights into the
20 effectiveness of the consensus process. The primary objective of this study is to understand
21 the implementation of an organisationally supported, consensus approach to implement
22 perioperative care pathways in a private healthcare facility and to determine its impact.
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33 **Methods:** A mixed-methods Effectiveness-Implementation Hybrid (Type III) pre-post study
34 will be conducted in one Australian private hospital. Five new consensus-based perioperative
35 care pathways will be developed and implemented for specific patient cohorts: spinal surgery,
36 radical prostatectomy, cardiac surgery, bariatric surgery and total hip and knee replacement.
37
38 The individual components of these pathways will be confirmed as part of a consensus-
39 building approach and will follow a four-stage implementation process using the Exploration,
40 Preparation, Implementation, and Sustainment (EPIS) framework. The process of
41 implementation, as well as barriers and facilitators, will be evaluated through semi-structured
42 interviews and focus groups with key clinical and non-clinical staff, and participant
43 observation. We anticipate completing 30 interviews and 15-20 meeting observations.
44
45 Administrative and clinical end-points for at least 152 participants will be analysed to assess
46 the effectiveness of the pathways.
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7 **Ethics and dissemination:** This study received ethical approval from Macquarie University
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9 Human Research Ethics Medical Sciences Committee (Reference No: 520221219542374).

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11 The findings of this study will be disseminated through peer-reviewed publications,
12
13 conference presentations, and reports for key stakeholders.
14
15

16
17 **Keywords:** Implementation Science, Clinical variation, Perioperative pathways, Consensus,
18
19 Elective surgery, Private providers
20
21

22 23 **Strengths and Limitations:**

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25
26 • The pragmatic nature of the study will deliberately make use of existing practice
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28 structures and approaches to implement the consensus pathways and to obtain patient-
29
30 related outcomes.
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34 • Multiple forms of qualitative data collection will be used to ensure rigour and a
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36 diverse range of perspectives will be gathered.
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39 • An understanding of the barriers and facilitators to adopting new standardised
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41 processes of care will be obtained which will provide a deeper understanding of the
42
43 experiences of implementation at different time periods across multiple surgical
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45 cohorts.
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48 • Due to the pragmatic nature of the study, pre-post comparison of some clinical
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50 outcomes will be limited to a smaller sample size from one surgical cohort only.
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INTRODUCTION

Addressing clinical variation is a fundamental component of health system improvement.

Whilst in some circumstances variation can be beneficial (e.g., when it represents innovation, or responses to individual patient need or preference), variation in healthcare processes that are unrelated to patient needs or those that differ from evidence-informed guidelines can compromise patient care, create inefficiencies, and contribute to health inequality (1, 2). This is a growing problem both in Australia and internationally, where on average, 60% of recommended care according to best practice guidelines is delivered to patients (3, 4, 5, 6, 7).

In addition, 30% of all care provided could be considered “low value” or waste, and 10% results in some form of iatrogenic harm (1, 4, 5). For example, care processes and outcomes for certain surgical patient cohorts have been found to differ substantially between hospitals in both public and private sectors (8). Data from Australia and the United States of America (USA) demonstrate a high degree of variation in length of stay (LOS), rates of transfer to inpatient rehabilitation following hip and knee arthroplasty (9), and specific to private hospitals, higher unplanned stay (>2 hours) in recovery after surgery (8). Considering the increasing number of elective surgeries and associated hospitalisations undertaken in private hospitals in Australia (10) and elsewhere (11, 12, 13), reducing unwarranted clinical variation in these settings is critical to generating higher value care, improving patient outcomes, and reducing healthcare expenditure.

A number of studies have examined ways to reduce unwarranted clinical variation, such as through the implementation of evidence-based perioperative care pathways for surgical cohorts (14, 15, 16). Enhanced recovery after surgery (ERAS) models are one such example involving the implementation of multimodal, evidence-based perioperative pathway designed to achieve early recovery and optimal patient outcomes (17). However, despite many studies

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3 demonstrating the efficacy of some strategies in reducing variation, the optimal methods of
4 developing and implementing such strategies into complex healthcare systems remain
5 unclear. More evidence is needed on how best to implement and sustain these changes, as
6 well as the barriers and facilitators to different methods of implementation to reduce
7 unwarranted variation.
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15 Evidence-informed perioperative care pathways designed to standardise the management of
16 surgical patients to the best evidence-informed practice have been shown to reduce variation
17 and improve patient outcomes (18). Perioperative care refers to the care of patients before,
18 during, and after surgical procedures involving anaesthesia (19). Care leading up to a surgical
19 procedure involves the reduction of modifiable risks, often in a preoperative clinic, through
20 patient education, medication optimisation, and other prophylactic treatments. After surgery,
21 the focus is on expediting recovery and minimising the risk of complications by optimising
22 such things as pain relief, antibiotic regimens to reduce infection risks, anticoagulation
23 protocols to avoid blood clotting, and early mobility to return to normal function. Private
24 hospitals in most countries have historically relied on accredited medical practitioners to
25 individually develop their own perioperative care protocols using a combination of their
26 experience, past practice, and clinical practice guidelines (20). Such protocols, when
27 implemented as frontline care, can create variation in care delivery based on provider
28 preferences.
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48 Implementing changes to patient care is complex and challenging, requiring concerted efforts
49 over time. This challenge is well documented and usually involves the provision of resources
50 to support change efforts, shifting professional roles, and altering cultural norms (21, 22).

51
52
53 Rather than a “one size fits all” approach, pathways need to be developed to suit the
54 particular needs of the patient cohort and surgical discipline, as well as local resources
55 available. However, there is no universal approach to implementing these pathways. In many
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3 private hospitals, medical practitioners tend to operate with a high degree of professional
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5 autonomy, which necessitates a consensus-building approach between providers for any
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7 standardisation of care processes.
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10 11 **Objectives**

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14 The primary objective of this study is to determine successful processes to implementing
15
16 perioperative care pathways in a private hospital setting using an organisationally supported
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18 consensus approach for surgical cohorts, including: i) spinal surgery; ii) radical
19
20 prostatectomy; iii) cardiac surgery; iv) bariatric surgery and; v) hip and knee replacement
21
22 surgery. The secondary objective is to assess the impact on administrative and, where
23
24 possible, clinical and patient-reported outcomes. We hypothesise that a consensus-based
25
26 approach to care pathway development and implementation will lead to high levels of fidelity
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28 to best practice perioperative care processes and improve patient outcomes.
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34 35 **METHODS**

36 37 38 **Study design**

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41 This protocol follows the 'SPIRIT 2013 Statement: Defining standard protocol items for
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43 clinical trials' guidelines for reporting (see Supplementary File 1). A mixed-methods
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45 Effectiveness-Implementation Hybrid (Type III) pre-post study will be used to evaluate the
46
47 implementation of evidence and consensus-based perioperative pathways, prioritising
48
49 assessment of effectiveness of the implementation strategies. Whilst improving clinical
50
51 outcomes is an important goal of any change process, standardisation of perioperative
52
53 pathways has already been demonstrated to confer benefit to clinical outcomes (14, 23, 24,
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55 25, 26). As such, clinical outcomes will be considered secondary in this study. The
56
57 perioperative care pathways will be implemented once consensus has been reached and
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3 outcomes will be compared to those observed before pathway development and integration
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5 into routine care, as a control period.
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8 9 **Study Setting**

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12 The study will be conducted over a two-year period from October 2022 to December 2024 at
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14 Macquarie University Hospital (MUH). MUH is located in Sydney, Australia and is a
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16 university-owned, private teaching hospital that focusses on clinical care, teaching and
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18 research. MUH comprises 144 beds, 16 operating theatres, and is staffed by over 200
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20 surgeons and other health professionals.
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23 24 25 **Eligibility criteria**

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28 Hospital staff and patients will be considered as study participants for the surgical cohorts:
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30 spinal surgery, radical prostatectomy, cardiac surgery, bariatric surgery and hip and knee
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32 replacement surgery. Data from hospital staff participants will primarily be used to examine
33
34 the implementation of perioperative care pathways. Administrative data and data from
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36 consenting prostatectomy patients will be used firstly, to conduct a process evaluation and
37
38 secondly, to evaluate impacts on patient-related outcomes.
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43 *Hospital staff:* Local hospital staff involved in the delivery of clinical care or development
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45 and implementation of care pathways (i.e., both clinicians and non-clinical staff) will be
46
47 considered eligible to participate in the implementation component of this study.
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51 *Patients:* Those admitted during the relevant study periods, seeking care for any of the
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53 clinical cohorts of interest will be considered eligible for this study.
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57 There are no specific exclusion criteria for this study.
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Intervention

Development and implementation of the cohort-specific standardised perioperative pathways will follow a six-step process nested within four implementation stages using the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework (27). The EPIS Framework guides projects through key stages of the implementation process and highlights important factors influencing implementation success within the broader “outer context” (system) and the proximal “inner context” (organisation) across each EPIS stage. The proposed implementation strategies are summarised in Table 1. The general implementation strategies will be tailored to each new patient cohort utilising a consensus-building approach. Our implementation science approach will examine this consensus-building process to support successful implementation of the pathways.

Stage 1: Exploration

The exploration stage will aim to understand the existing and emerging needs of both clinicians and patients, and to identify the optimal modifications and supports required for the implementation strategy to address those needs. This could include modifications to existing information technology (IT) processes or the introduction of organisational support and educational resources for staff members to implement the pathways. To achieve this objective, a care pathway implementation support team will be established comprising members of the research team and key hospital stakeholders. Stakeholders will include a coalition of both clinical partners, such as clinical education coordinators, and non-clinical partners, such as hospital administrators, to ensure a wide breadth of expertise are included. The primary goal for the team will be to act as a vehicle for organisational leadership that builds capacity in clinical improvement and implementation science methodology. Individual roles within the team will be clarified across the project to reduce the risk of any duplicative

1
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3 efforts and improve the visibility of activities across different patient cohorts where pathways
4 will be implemented. The team will meet monthly for the duration of the study to discuss
5
6 goals and action items relating to the project to facilitate implementation of the perioperative
7
8 pathways. For example, an important aim for the support team will be to reduce the time-
9
10 burden for clinicians during pathway implementation and to establish actions that will
11
12 minimise potential time pressures.
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16 17 18 *Stage 2: Preparation* 19

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21 The objective of the preparation stage is to use a consensus-building approach to develop and
22
23 standardise perioperative care pathways for each surgical cohort, and to use learnings from
24
25 the hip and knee replacement surgery cohorts retrospectively to facilitate successful
26
27 implementation. During this stage, perioperative pathways will be drafted by a clinician-
28
29 researcher in a hospital leadership position (AH) and senior management staff, based on a
30
31 combination of 'current' surgeon clinical guidelines and evidence-based practice. Clinical
32
33 consensus groups will then be established for each cohort by the clinician-researcher. These
34
35 groups will include multidisciplinary representation such as surgeons, anaesthetists, nursing
36
37 and allied health, and will be led by the discipline heads. Clinical consensus groups will
38
39 attend regular meetings facilitated by the clinician-researcher to discuss components of care
40
41 to be included in the standardised perioperative pathways, including acceptable bounds of
42
43 variation in practice. The pathways will optimise components of care differently across
44
45 cohorts based on current evidence and joint medical decision making, including, but not
46
47 limited to, preoperative optimisation, postoperative analgesia, surgical antibiotic prophylaxis,
48
49 anticoagulation protocols and mobilisation after surgery. An 'informal' approach will be
50
51 utilised to achieve consensus on the perioperative pathways whereby a set of pre-defined
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53 components will be discussed at each meeting and agreed upon by group members using both
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3 evidence and their own perspectives to inform discussion (28). Items will be documented by
4 the facilitator and relevant documentation will be sent to each group member for further
5 review as required following each meeting. Following this process, pathways will be
6 circulated by each group member to their individual teams for feedback and critical
7 modifications will then be made by the consensus groups at additional meetings which will
8 facilitate implementation during the next two stages.
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18 An additional goal of this phase will be to establish consensus from both the taskforce and
19 clinical consensus groups on a plan to implement the pathways. A draft implementation plan
20 will be created by the task force. This plan will be reviewed by the clinical consensus groups
21 for modifications as required and each member will serve as “champions” to drive
22 implementation. Components of the implementation plan may include education and training
23 sessions for nursing and allied health and establishing audit and feedback processes on the
24 wards.
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35 A separate stakeholder engagement group will be formed to represent the views of patient
36 representatives, engage frontline clinical staff in implementation, and facilitate rapid
37 feedback regarding implementation challenges to the care pathway implementation support
38 team. Researchers involved in qualitative data collection will observe this process through
39 naturalistic observation however, they will not have a role in determining components of the
40 pathways. During this stage, learnings obtained from implementation of pathways for the hip
41 and knee replacement cohort will also be analysed by the research team to further understand
42 the process of implementation using a consensus approach.
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55 *Stage 3: Implementation*

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3 In the implementation stage, installation of the care pathways will be guided by the planned
4 implementation supports formalised in the preparation phase. It will be critical to monitor the
5 implementation process during this stage and adjust supports accordingly. Care pathway
6 toolkits including education and documentation resources will be finalised and disseminated
7 to clinical staff and patients at this stage to foster prompt widespread practice change. Further
8 monitoring of the degree of engagement and cohesion between clinical leadership and
9 frontline clinical staff will be achieved using participant observations. Particular attention
10 will be paid to the capacity of frontline clinical staff to absorb and apply new care pathways,
11 avoiding “bottlenecks” between care pathway development and implementation. This stage
12 will also be supported by an iterative audit and feedback process and data analytics to
13 identify gains made and update external benchmarking comparisons over time. Audit and
14 feedback will relate to process (implementation) outcomes, health services outputs, and
15 patient-level outcomes and this feedback will be communicated with staff at regular
16 discipline meetings.

36 *Stage 4: Sustainment*

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40 The sustainment stage involves the continued application of the structures and processes of
41 the care pathways to realise tangible improvements in patient outcomes. At this stage, care
42 variation reduction becomes a standing item on regular Patient Safety and Quality Committee
43 meeting agendas. “Roadshow” presentations to the stakeholder engagement groups, frontline
44 clinical staff and hospital leadership groups can continue bi-directional communication and
45 feedback loops to identify new areas of care variance prioritised for future care pathways. We
46 also plan to translate our findings via policy maker round tables and engagement and training
47 with other private hospitals.

Table 1 Overview of implementation strategies

Implementation stage	Implementation strategy	Description
<i>Exploration</i>	Build a coalition	Recruit and cultivate relationships with partners in the implementation effort by formally establishing a care pathway support team
<i>Preparation</i>	Conduct local consensus discussions	Establish a structure for local providers and other stakeholders to form cohort-specific clinical consensus groups to discuss the processes of care and standardisation of pathways
	Co-develop a formal implementation blueprint	Co-develop a formal blueprint for iterative care pathway prioritisation and implementation
<i>Implementation</i>	Develop and implement care pathway toolkits	Develop, test, and introduce quality improvement tools and educational materials
	Audit and provide feedback	Embed a comprehensive system audit around care variation, clinical and process outcomes over specified time periods and disseminate to clinicians and administrators to monitor, evaluate, and modify provider behaviour
<i>Sustainment</i>	Facilitate relay of clinical data to providers	Undertake formal monitoring and evaluation and develop a reporting structure and channels of communication for care pathway development, implementation, and outcomes

Recruitment

Semi-structured interviews and focus groups with hospital staff

A purposive sample of staff who have been previously involved in the development of perioperative pathways or provision of care for the hip and knee replacement surgical cohorts, and staff currently involved in the development and implementation of the new pathways for the four new surgical cohorts will be recruited. Staff will be identified by MUH

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3 co-investigators. Research staff not employed by MUH will approach the identified staff
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5 members either by email invitation or face-to-face to request their participation in the
6
7 interviews, indicating that they have been identified by the research team as a key stakeholder
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9 in the development and implementation of the pathways. This approach is designed to avoid
10
11 the potential impact of any existing relationships between hospital staff and co-investigators.
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13 A brief explanation of the study and a written participant information form will be provided
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15 to the staff members. Staff members will be provided with time to review the information and
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17 ask any questions of the research staff prior to their decision to consent to participate in the
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19 interviews and focus groups, or not.
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25 *Participant observations with hospital staff*

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27 Staff attending relevant meetings will be recruited, such as planned support team project
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29 meetings, clinical consensus group meetings, stakeholder engagement group meetings,
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31 patient safety and quality committees, and ward based clinical meetings. Attendance of these
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33 meetings by external staff will be through invitation from hospital co-investigators. Study
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35 information and a participant information form will be provided prior to the initial meeting
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37 where participant observations will take place.
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42 **OUTCOMES**

43 **Primary outcomes**

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46 A summary of the primary outcome measures for this study can be found in Table 2.
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48 Implementation outcomes including acceptability, appropriateness, feasibility, adoption,
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50 fidelity and sustainment, and penetration, will be used to understand the impact of the
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52 implementation strategies and implementation using a consensus-building approach on
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54 secondary outcomes (29).
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Table 2 Summary of primary outcome measures

<i>Acceptability</i>	Provider knowledge and satisfaction with aspects of the perioperative pathways and their implementation will be collected via qualitative interviews and participant observation
<i>Appropriateness</i>	Appropriateness will be assessed both retrospectively based on the experiences piloting the intervention for the hip and knee replacement cohorts using qualitative interviews, as well as for the four prospective cohorts using participant observation
<i>Feasibility</i>	Feasibility will be measured both retrospectively using pilot data from the hip and knee replacement cohorts and prospectively for the four new cohorts of interest using interviews and participant observation
<i>Adoption</i>	Participant observations of the clinical consensus-building process will be used to measure the reasons pertaining to the intention, initial decision, or action to integrate the perioperative care pathways into routine clinical practice
<i>Fidelity and sustainment</i>	Regular audits of adherence to the care pathways will provide an indication of variations to practice over time, including potential modifications and tailoring of the pathways by frontline staff (e.g., nurses) to better fit within their work routines

<i>Penetration</i>	Penetration will be assessed by the number of eligible patients who receive the care pathway as intended according to planned audits
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Secondary outcomes

Secondary outcomes assessed will include both process outcomes and clinical outcomes:

- Hospital or intensive care unit LOS for each cohort will be collected from routine administrative data systems.
- Patient-reported experience measures (PREMs) collected via patient surveys.
- Patient-reported outcome measures (PROMs) collected via patient surveys e.g., health-related quality of life questionnaires.
- Discharge destination collected from routine administrative data systems.
- Hospital-acquired complication rates collected from routine incident reporting systems.
- Hospital readmission rates collected from routine administrative data systems.

Selected PREMs and PROMs for the prostatectomy cohort are currently routinely collected at some site hospitals by specialist nurse practitioners and recorded in the patient's medical records. These include the Prostate Cancer Distress Screen (30), the International Prostate Symptom Score (IPSS) (31), Incontinence Questionnaire-Urinary Incontinence Short Form (32) and the Sexual Health Inventory for Men (33). Research staff will assist with sending out surveys (see Supplementary File 2), prior to the routine six-month follow up assessment for up to 50-100 patients both before and after pathway implementation where patients consent, standardising an existing clinical interaction for comparison. Specific PROMs and PREMs

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3 measures for the remaining pathways will be determined during the consensus building
4 process and if agreed, these measures will only be collected for research purposes where
5 patients consent, prospectively.
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10 **Data collection**

11 *Qualitative interviews and focus groups*

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16 Semi-structured one-on-one interviews or focus groups will be conducted over a 12-month
17 period with key clinical and non-clinical hospital staff and patient/consumer representatives,
18 focussing retrospectively on the pilot hip and knee replacement cohorts and prospectively for
19 each of the four new cohorts. Interview guides will be piloted prior to data collection and will
20 include questions pertaining to participants knowledge and experiences of implementing the
21 standardised perioperative pathways, as well as barriers and facilitators to this process (see
22 Supplementary File 3 and Supplementary File 4 for planned interview guides). Interviews
23 and focus groups will be conducted by one experienced qualitative researcher (LP) via
24 videoconference or face-to-face at participants' preferred time and location, lasting between
25 30-60 minutes. The researcher will conduct all interviews in a private room suited to the
26 interviewee, where interviews will be digitally recorded and transcribed verbatim. Field notes
27 will also be made by the interviewer including initial thoughts, interpretations and analysis of
28 the data collected. Audio and written data will be immediately saved in a password protected
29 file on an encrypted password protected computer.
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50 *Qualitative participant observation*

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52 Data collectors will conduct naturalistic participant observations within the planned support
53 team project meetings, clinical consensus group meetings, stakeholder engagement group
54 meetings, patient safety and quality committee, and ward-based clinical meetings (34). Each
55 observation session is anticipated to last between one to two hours. Fieldnotes will be taken
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3 to spatially contextualise events within the study aims (35). These observations will not be
4
5 guided by a pre-determined schedule, but rather, they will inductively evolve in real-world
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7 practice environments. This includes how staff converse with one another, how they plan and
8
9 make decisions together about perioperative care (i.e., implementation, communication
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11 pathways, leadership), and how decision-making processes evolve and take shape across
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13 different meetings with different stakeholders.
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16 17 18 *Quantitative clinical outcomes data* 19

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21 Data on clinical outcomes will be collected from administrative databases. These data include
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23 measures such as hospital LOS, discharge destination, acquired complications, and
24
25 readmission. Data from routine administrative databases has high levels of agreement with
26
27 the medical record for both length of stay (93%) and discharge destination (91%) data, but
28
29 some limitations are acknowledged when capturing acquired complications (36, 37). Those
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31 data not routinely collected within existing administrative databases will be collected
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33 prospectively or via retrospective electronic medical review.
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38 39 **Sample size** 40

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42 Qualitative data pertaining to the implementation of the perioperative clinical pathways will
43
44 use the concept of theoretical saturation to determine the observation and interview sample
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46 size (38). Based on prior studies, we anticipate conducting 30 interviews and 15-20 meeting
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48 observations (39, 40). Staff will be recruited using convenience time-frame sampling which
49
50 removes opportunistic recruitment of staff and patients, and any researcher or hospital
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52 selection bias.
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57 For quantitative data, a power calculation was undertaken for each of the four cohorts based
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59 on the mean and standard deviation of LOS for each at a site hospital in the 2020 and 2021
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3 financial years, an estimated important reduction in LOS, two sided $\alpha=0.05$ and 80% power.
4
5 For spinal surgery, for example, reduction of mean LOS from 4.28 (SD: 4.66) to 2.78 (the
6
7 peer group average) required 152 patients pre- and post-intervention, which is achievable
8
9 with twelve months' follow-up. Bariatric surgery, on the other hand, requires only 6 months.
10
11 Overall, MUH LOS for cardiac surgery is in line with its peer group, so for this cohort the
12
13 target is intensive unit LOS, which is higher than that of peers. The cohorts requiring longer
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15 follow-up periods will be prioritised for earlier intervention where feasible. It is important to
16
17 note that the research team does not view LOS as the most important clinical outcome for
18
19 these four cohorts; it is used for sample size estimation because it is an administrative
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21 outcome where there is a prospect of measuring relevant quantitative change in the time
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23 available to the study. Moreover, relevant data on means and standard deviations is routinely
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25 available, permitting sample size calculation.
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31 32 **DATA ANALYSIS**

33 34 35 **Qualitative**

36 37 38 *Qualitative interview and observation analysis*

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42 Fieldnotes and interview transcripts will be imported into Nvivo20 for data management.

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44 Data will be analysed thematically (41, 42) by two experienced qualitative analysts (primary
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46 and secondary) (LP and MS or EFA) working together to ensure the process is rigorous, and
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48 to enable them to discuss the major and minor themes arising inductively and their
49
50 concomitant categories until consensus agreement can be achieved. The secondary analyst
51
52 will examine a subset of the complete dataset, to ensure methodological veracity during the
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54 analytic process.
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59 60 **Quantitative**

Quantitative analysis of clinical endpoints

Data will be analysed by three researchers (LP, GA and MNS) using SPSS. Descriptive statistics will be used to summarise demographic data. For LOS, historical data will be sourced from administrative databases to identify any secular trend and take this into account in attributing any pre-post change to intervention. For other clinical outcomes, PREMs and PROMs will be descriptive only and restricted to 50-100 patients from the prostatectomy cohort and any other cohort where these outcomes are available, while hospital acquired complications and hospital readmission rates will be compared pre- and post-intervention. The estimated between-group difference and the 95% confidence intervals (95% CI) will be reported and for significant testing, p values <0.05 will be considered statistically significant.

Patient and Public Involvement

Input and feedback was obtained from the site hospital's Clinical Leadership Committee and the Clinical Disciplines on aspects of the study design, such as the planned implementation strategies and outcome measures. Patients were not involved in the design of this study, however, patient consumer input and feedback will be sought from the site hospital's consumer advisory committee where resources for patients are developed.

Ethics and dissemination:

Approval to conduct this study has been obtained from the Macquarie University Human Research Ethics Medical Sciences Committee (Reference No: 520221219542374). Research governance authorisation has been provided by the MQ Health Clinical Research Executive. A waiver for consent will be sought from participants for data obtained in this study. PROMs/PREMs data being collected for clinical purposes will seek informed patient consent for de-identified data to be used for research purposes. The findings of this study will be

1
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3 disseminated through peer-reviewed publications, conference presentations, and summaries
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5 or reports for key stakeholders and partners in the field.
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9 **Word count:** 3571 words
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12 **List of Abbreviations:**
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14 EPIS Exploration, Preparation, Implementation, and Sustainment Framework;
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18 ERAS Enhanced Recovery After Surgery;
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22 IT Information Technology;
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26 LOS Length of stay;
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30 MUH Macquarie University Hospital;
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34 PREMs Patient-reported experience measures;
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38 PROMs Patient-reported outcome measures;
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42 SD Standard deviation
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46 USA United States of America
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49 **DECLARATIONS:**
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52 **Protocol amendments:**
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55 Approval from the study investigators, Human Research Ethics Committee, and research
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57 governance will be sought for any protocol amendments. Amendments will be reported in the
58
59 published manuscript as a deviation from the protocol.
60

Consent for publication:

Not applicable.

Availability of data and materials:

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

Competing interests:

The authors declare that they have no competing interests.

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Authors' contributions:

The study was conceived by MS, AH, EF-A, GA, JCL, JB, GG, PDH, KC, KH, AP, CH, DG, LAE, LT, and RP and all authors contributed to the study design. LP, CH and MS wrote the initial draft of the manuscript. All authors contributed to and approved the final version of the manuscript.

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4
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6
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STANDARD PROTOCOL ITEMS: RECOMMENDATIONS FOR INTERVENTIONAL TRIALS

SPIRIT 2013 Checklist: Recommended items to address in a clinical trial protocol and related documents*

Section/item	Item No	Description	Page No.
Administrative information			
Title	1	Descriptive title identifying the study design, population, interventions, and, if applicable, trial acronym	1
Trial registration	2a	Trial identifier and registry name. If not yet registered, name of intended registry	N/A
	2b	All items from the World Health Organization Trial Registration Data Set	N/A
Protocol version	3	Date and version identifier	Ethics protocol
Funding	4	Sources and types of financial, material, and other support	23
Roles and responsibilities	5a	Names, affiliations, and roles of protocol contributors	1
	5b	Name and contact information for the trial sponsor	N/A
	5c	Role of study sponsor and funders, if any, in study design; collection, management, analysis, and interpretation of data; writing of the report; and the decision to submit the report for publication, including whether they will have ultimate authority over any of these activities	23
	5d	Composition, roles, and responsibilities of the coordinating centre, steering committee, endpoint adjudication committee, data management team, and other individuals or groups overseeing the trial, if applicable (see Item 21a for data monitoring committee)	23
Introduction			
Background and rationale	6a	Description of research question and justification for undertaking the trial, including summary of relevant studies (published and unpublished) examining benefits and harms for each intervention	4-6
	6b	Explanation for choice of comparators	N/A
Objectives	7	Specific objectives or hypotheses	6

1				
2	Trial design	8	Description of trial design including type of trial (eg, parallel group, crossover, factorial, single group), allocation ratio, and framework (eg, superiority, equivalence, noninferiority, exploratory)	6-7
3				
4				
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7				
8	Methods: Participants, interventions, and outcomes			
9				
10	Study setting	9	Description of study settings (eg, community clinic, academic hospital) and list of countries where data will be collected. Reference to where list of study sites can be obtained	7
11				
12				
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14	Eligibility criteria	10	Inclusion and exclusion criteria for participants. If applicable, eligibility criteria for study centres and individuals who will perform the interventions (eg, surgeons, psychotherapists)	7-8
15				
16				
17				
18				
19	Interventions	11a	Interventions for each group with sufficient detail to allow replication, including how and when they will be administered	8-12
20				
21				
22		11b	Criteria for discontinuing or modifying allocated interventions for a given trial participant (eg, drug dose change in response to harms, participant request, or improving/worsening disease)	N/A
23				
24				
25				
26		11c	Strategies to improve adherence to intervention protocols, and any procedures for monitoring adherence (eg, drug tablet return, laboratory tests)	9-12
27				
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30				
31		11d	Relevant concomitant care and interventions that are permitted or prohibited during the trial	N/A
32				
33				
34	Outcomes	12	Primary, secondary, and other outcomes, including the specific measurement variable (eg, systolic blood pressure), analysis metric (eg, change from baseline, final value, time to event), method of aggregation (eg, median, proportion), and time point for each outcome. Explanation of the clinical relevance of chosen efficacy and harm outcomes is strongly recommended	13-17
35				
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43	Participant timeline	13	Time schedule of enrolment, interventions (including any run-ins and washouts), assessments, and visits for participants. A schematic diagram is highly recommended (see Figure)	16-17
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48	Sample size	14	Estimated number of participants needed to achieve study objectives and how it was determined, including clinical and statistical assumptions supporting any sample size calculations	17-18
49				
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54	Recruitment	15	Strategies for achieving adequate participant enrolment to reach target sample size	17-18
55				
56				
57	Methods: Assignment of interventions (for controlled trials)			
58				
59	Allocation:			
60				

1				
2	Sequence	16a	Method of generating the allocation sequence (eg, computer-	N/A
3	generation		generated random numbers), and list of any factors for	
4			stratification. To reduce predictability of a random sequence,	
5			details of any planned restriction (eg, blocking) should be	
6			provided in a separate document that is unavailable to those	
7			who enrol participants or assign interventions	
8				
9				
10	Allocation	16b	Mechanism of implementing the allocation sequence (eg,	N/A
11	concealment		central telephone; sequentially numbered, opaque, sealed	
12	mechanism		envelopes), describing any steps to conceal the sequence	
13			until interventions are assigned	
14				
15	Implementation	16c	Who will generate the allocation sequence, who will enrol	N/A
16			participants, and who will assign participants to interventions	
17				
18				
19	Blinding	17a	Who will be blinded after assignment to interventions (eg, trial	N/A
20	(masking)		participants, care providers, outcome assessors, data	
21			analysts), and how	
22				
23		17b	If blinded, circumstances under which unblinding is	N/A
24			permissible, and procedure for revealing a participant's	
25			allocated intervention during the trial	
26				
27				
28	Methods: Data collection, management, and analysis			
29				
30	Data collection	18a	Plans for assessment and collection of outcome, baseline, and	15-17
31	methods		other trial data, including any related processes to promote	
32			data quality (eg, duplicate measurements, training of	
33			assessors) and a description of study instruments (eg,	
34			questionnaires, laboratory tests) along with their reliability and	
35			validity, if known. Reference to where data collection forms	
36			can be found, if not in the protocol	
37				
38				
39		18b	Plans to promote participant retention and complete follow-up,	N/A
40			including list of any outcome data to be collected for	
41			participants who discontinue or deviate from intervention	
42			protocols	
43				
44				
45	Data	19	Plans for data entry, coding, security, and storage, including	16-18
46	management		any related processes to promote data quality (eg, double data	
47			entry; range checks for data values). Reference to where	
48			details of data management procedures can be found, if not in	
49			the protocol	
50				
51				
52	Statistical	20a	Statistical methods for analysing primary and secondary	18-19
53	methods		outcomes. Reference to where other details of the statistical	
54			analysis plan can be found, if not in the protocol	
55				
56		20b	Methods for any additional analyses (eg, subgroup and	N/A
57			adjusted analyses)	
58				
59				
60				

	20c	Definition of analysis population relating to protocol non-adherence (eg, as randomised analysis), and any statistical methods to handle missing data (eg, multiple imputation)	N/A
Methods: Monitoring			
Data monitoring	21a	Composition of data monitoring committee (DMC); summary of its role and reporting structure; statement of whether it is independent from the sponsor and competing interests; and reference to where further details about its charter can be found, if not in the protocol. Alternatively, an explanation of why a DMC is not needed	N/A
	21b	Description of any interim analyses and stopping guidelines, including who will have access to these interim results and make the final decision to terminate the trial	N/A
Harms	22	Plans for collecting, assessing, reporting, and managing solicited and spontaneously reported adverse events and other unintended effects of trial interventions or trial conduct	Ethics protocol
Auditing	23	Frequency and procedures for auditing trial conduct, if any, and whether the process will be independent from investigators and the sponsor	N/A
Ethics and dissemination			
Research ethics approval	24	Plans for seeking research ethics committee/institutional review board (REC/IRB) approval	22
Protocol amendments	25	Plans for communicating important protocol modifications (eg, changes to eligibility criteria, outcomes, analyses) to relevant parties (eg, investigators, REC/IRBs, trial participants, trial registries, journals, regulators)	22
Consent or assent	26a	Who will obtain informed consent or assent from potential trial participants or authorised surrogates, and how (see Item 32)	13, 22
	26b	Additional consent provisions for collection and use of participant data and biological specimens in ancillary studies, if applicable	N/A
Confidentiality	27	How personal information about potential and enrolled participants will be collected, shared, and maintained in order to protect confidentiality before, during, and after the trial	22
Declaration of interests	28	Financial and other competing interests for principal investigators for the overall trial and each study site	22
Access to data	29	Statement of who will have access to the final trial dataset, and disclosure of contractual agreements that limit such access for investigators	22

1				
2	Ancillary and	30	Provisions, if any, for ancillary and post-trial care, and for	Ethics protocol
3	post-trial care		compensation to those who suffer harm from trial participation	
4				
5	Dissemination	31a	Plans for investigators and sponsor to communicate trial	Ethics protocol
6	policy		results to participants, healthcare professionals, the public,	
7			and other relevant groups (eg, via publication, reporting in	
8			results databases, or other data sharing arrangements),	
9			including any publication restrictions	
10				
11		31b	Authorship eligibility guidelines and any intended use of	N/A
12			professional writers	
13				
14		31c	Plans, if any, for granting public access to the full protocol,	N/A
15			participant-level dataset, and statistical code	
16				
17				
18				
19	Appendices			
20				
21	Informed consent	32	Model consent form and other related documentation given to	Ethics protocol
22	materials		participants and authorised surrogates	
23				
24	Biological	33	Plans for collection, laboratory evaluation, and storage of	N/A
25	specimens		biological specimens for genetic or molecular analysis in the	
26			current trial and for future use in ancillary studies, if applicable	
27				

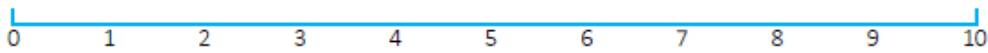
*It is strongly recommended that this checklist be read in conjunction with the SPIRIT 2013 Explanation & Elaboration for important clarification on the items. Amendments to the protocol should be tracked and dated. The SPIRIT checklist is copyrighted by the SPIRIT Group under the Creative Commons "[Attribution-NonCommercial-NoDerivs 3.0 Unported](https://creativecommons.org/licenses/by-nc-nd/3.0/)" license.

Reference: Chan A-W, Tetzlaff JM, Altman DG, Laupacis A, Gøtzsche PC, Krleža-Jerić K, Hróbjartsson A, Mann H, Dickersin K, Berlin J, Doré C, Parulekar W, Summerskill W, Groves T, Schulz K, Sox H, Rockhold FW, Rennie D, Moher D. SPIRIT 2013 Statement: Defining standard protocol items for clinical trials. *Ann Intern Med.* 2013;158(3):200-207.



PROSTATE CANCER DISTRESS SCREEN

The experience of prostate cancer is for many men a difficult time. I would like to ask you a few brief questions to check how you have been feeling and ask about your main concerns. Thinking about how you have been feeling over the past week including today, how distressed do you feel on a scale of '0', no distress to '10', extreme distress? (circle)



No distress

Extreme distress

This is a list of problems that some men with prostate cancer experience. Do any of these problems apply to you? (Read the list below, tick if yes)

Practical Problems

- Work
- Financial/Insurance

Family Problems

- Partner

Emotional Problems

- Depression
- Uncertainty about the future
- Nervousness
- Sadness
- Worry
- Loss of interest in usual activities

Treatment Problems

- Understanding treatments
- Making a decision
- Information about my illness

Physical Problems

- Pain
- Fatigue
- Sexual
- Urinary
- Bowel
- Hot Flashes
- Weight Gain
- Weight Loss
- Loss of Muscle Mass
- Memory/Concentration
- Sleep

Other Problems (please list)

Which of these are the **most important concerns** for you right now? (Please list)

Which of these concerns would you like help with?

For men with a rating of ≥ 4 consider further assessment and referral to appropriate support services.

Person completing form:

Date: ___ / ___ / ___

ICIQ-UI-SF: CONFIDENTIAL

Many people leak urine some of the time. We are trying to find out how many people leak urine, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

1. How often do you leak urine? (Tick one box)

- never
- about once a week or less often
- two or three times a week
- about once a day
- several times a day
- all the time

2. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)? (Tick one box)

- none
- a small amount
- a moderate amount
- a large amount

3. Overall how much does leaking urine interfere with your everyday life?

Please circle a number between 0 (not at all) and 10 (a great deal)

- 0 1 2 3 4 5 6 7 8 9 10
- not at all a great deal

4. When does urine leak? (Please tick all that apply to you)

- never – urine does not leak
- leaks before you can get to the toilet
- leaks when you cough or sneeze
- leaks when you are asleep
- leaks when you are physically active/exercising
- leaks when you have finished urinating and are dressed
- leaks for no obvious reason
- leaks all the time

Thank you very much for answering these questions.

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International Prostate Symptom Score (IPSS)

Patient Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Determine Your BPH Symptoms Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying- How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency- How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency- How often you have found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency- How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream- How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining- How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping- How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:		+	+	+	+	+

Total International Prostate Symptom Score= _____

1-7 mild symptoms - 8-19 moderate symptoms - 20-35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatis-	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6



Sexual Health Inventory for Men (SHIM)

Instructions

Each question has five possible responses. Circle the number that best describes your own situation. Select only one answer for each question.

Over the last six months:

1. How do you rate your confidence that you could keep an erection?

1	2	3	4	5
Very low	Low	Moderate	High	Very high

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (more than half the time)	Almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (more than half the time)	Almost always or always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

1	2	3	4	5
Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (more than half the time)	Almost always or always

SUPPLEMENTARY FILE 3

Topic Guide: Staff interviews

Title	Implementation of evidence and consensus-based perioperative care pathways
Principal Investigator	Dr Mitchell Sarkies, Senior Research Fellow and NHMRC Emerging Leadership Fellow, Australian Institute of Health Innovation, Macquarie University mitchell.sarkies@mq.edu.au
Co-investigators	A/Prof Andrew Hirschhorn, Prof Jeffrey Braithwaite, Dr Gaston Arnolda, Dr Emilie Francis-Auton, Dr Janet Long, Ms Lisa Pagano

The semi-structured interviews will be conducted retrospectively for key clinical and non-clinical hospital staff who were previously involved in the development of perioperative pathways for the elective hip and knee replacement surgical cohorts; and prospectively for staff currently involved in the development and implementation of new pathways. The aims of the interview are to:

- Determine the experiences of staff involved in implementing standardised peri-operative pathways.
- Explore the stakeholder knowledge of the care pathways within the hospital setting.
- Assess the integrity, fidelity to and feasibility of the intervention.
- To understand the key barriers and facilitators to implementation of standardised peri-operative pathways from the perspective of both clinical and non-clinical hospital staff.
- To synthesize data from both patient groups to gain a broader understanding of how standardised care pathways are implemented and the impact of these pathways.

QUESTIONS:

1
2
3 *Thank you for taking part in this interview to examine the implementation of standardised*
4 *peri-operative surgical pathways at Macquarie University Hospital. The questions will focus*
5 *on your experiences, familiarity with the pathway, perspective on whether they're being*
6 *adhered to, and any barriers or facilitators to their implementation.*

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11 *Participation in this interview is voluntary and if at any time you do not wish to continue,*
12 *please let me know. Participation or refusal to participate will not affect your employment.*

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15 *With your permission, this interview will be audio recorded so that it can be transcribed and*
16 *analysed. Do you have any questions before we start?*

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22 1. Demographic questions:

- 23
24 - Can you please introduce yourself and your role at Macquarie University Hospital?
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26 - How long have you worked in healthcare?
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28 - How many of those have been at Macquarie University Hospital?
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37 2. What was your experience/what has been your experience implementing the
38 [SURGICAL COHORT] peri-operative pathway/s?
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49 3. How familiar are you with the particulars of the clinical pathway/s? Can you talk
50 through some of the changes from previous practice?
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- 52
53 - What worked?
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55 - What didn't work
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3 4. What are your views on the standardised clinical pathways that were
4
5 implemented/are being implemented?
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- 7
8 - Strengths
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10 - Weaknesses
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18 5. Did you and other clinicians tend to follow the new processes/procedures?
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- 20 - Why do think that is?
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25 6. What challenges, if any, did you encounter in implementing the clinical pathways?
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30 Prompts;

- 31
32 - Workload and time
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34 - Staffing
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36 - Personal preference/views
37
38 - Inter-professional collaboration
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40 - Other
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45 7. What was important to facilitating the implementation of the clinical pathways?
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49

50 Prompts;

- 51
52 - Organisation
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54 - Resources
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56 - Staffing/Inter-professional collaboration
57
58 - Support/Monitoring of fidelity/quality
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3 - Other
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8 8. Were there any other lessons learned about implementing standardised clinical
9 pathways?
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17 *Additional probing question:*
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19 9. What are your suggestions to improve future implementation of standardised clinical
20 pathways for [SURGICAL COHORT] surgery?
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30 10. What do you see as the effects and value of implementing standardised clinical
31 pathways for [SURGICAL COHORT] surgery?
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41 11. Overall, how feasible is/was it to implement standardised clinical pathways for
42 [SURGICAL COHORT] surgery at Macquarie University Hospital or private hospital
43 settings more generally?
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55 12. Is there anything else you would like to add that has not been covered here?
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SUPPLEMENTARY FILE 4

Topic Guide: Surgeons

Title	Implementation of evidence and consensus-based perioperative care pathways
Principal Investigator	Dr Mitchell Sarkies, Senior Research Fellow and NHMRC Emerging Leadership Fellow, Australian Institute of Health Innovation, Macquarie University mitchell.sarkies@mq.edu.au
Co-investigators	A/Prof Andrew Hirschhorn, Prof Jeffrey Braithwaite, Dr Gaston Arnolda, Dr Emilie Francis-Auton, Dr Janet Long, Ms Lisa Pagano

The semi-structured interviews will be conducted retrospectively for key clinical and non-clinical hospital staff who were previously involved in the development of perioperative pathways for the elective hip and knee replacement surgical cohorts; and prospectively for staff currently involved in the development and implementation of new pathways. The aims of the interview are to:

- Determine the experiences of staff involved in implementing standardised perioperative pathways.
- Explore the stakeholder knowledge of the care pathways within the hospital setting.
- Assess the integrity, fidelity to and feasibility of the intervention.
- To understand the key barriers and facilitators to implementation of standardised peri-operative pathways from the perspective of both clinical and non-clinical hospital staff.
- To synthesize data from both patient groups to gain a broader understanding of how standardised care pathways are implemented and the impact of these pathways.

QUESTIONS:

1. Demographic questions:
 - Can you please introduce yourself and your role at Macquarie University Hospital?
 - How long have you worked in healthcare?
 - How many of those have been at Macquarie University Hospital?

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- *Can ask further about elements of their role as needed*
2. What was your experience/what has been your experience implementing the [SURGICAL COHORT] peri-operative pathway/s?
3. How familiar are you with the particulars of the clinical pathway/s? Can you talk through some of the changes from previous practice?
- What worked?
 - What didn't work?
4. What are your views on the standardised clinical pathways that were implemented/are being implemented?
- Strengths
 - Weaknesses
5. What are your perceptions of why MQ health was looking to standardise pathways?
Alternate question - What do you think about the organisation's approach to try to reduce clinical variation through standardising clinical pathways?

44 Prompt – do you see clinical variation as being an issue?

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6. Option 1: What challenges, if any, did you encounter in implementing the clinical pathways?

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Option 2: What challenges do you think clinicians would face when attempting to implement consensus-based clinical pathways?

58 Prompts;

- 59
60
- Workload and time

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- Staffing
 - Personal preference/views/autonomy
 - Inter-professional collaboration
 - Other

7. Option 1: What was important to facilitating the implementation of the clinical pathways?

Prompts;

- Organisation
- Resources
- Staffing/Inter-professional collaboration
- Support/Monitoring of fidelity/quality
- Other

8. What do you see as the effects and value of implementing standardised clinical pathways for [SURGICAL COHORT] surgery?

9. How would you measure the success of a clinical pathway of the [SURGICAL] clinical cohort?

10. Overall, how feasible is/was it to implement standardised clinical pathways for [SURGICAL COHORT] surgery at Macquarie University Hospital or private hospital settings more generally?

11. Is there anything else you would like to add that has not been covered here?