Evidence Based Implementation of Guidelines

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Terminology

Guidelines

- Summary of best available evidence
- “Guide” decisions
- Brief!
- Developed by many groups
- Varying quality
- Guidelines can be considered as systematic statements to help clinicians and patients make decisions about care

- Executing or applying a process, standard, policy.
- “Standards of care”
- Hospital, Health Department “Policy”

Guidelines and Implementation

- ? Never the twain shall meet
- AGREE criteria
- GLIA criteria

- A group of interventions related to a disease process that when executed together result in a better outcome than when implemented individually
  - IHI

Bundles

- Grouping "key components" of diagnostic or treatment issues for a given presentation.
- Asthma (pseudo bundle)
    - Assessment of severity
    - Spirometry
    - Spacers
    - Steroids
    - Interim asthma plan
    - NOT CXR / antibiotics / nebulisers

One way…

Written Guidelines

- Often Bulky
- ANZCA acute pain guidelines 348 pages!
- Often sent with cover letter
- Usually have one of two fates…

DAHLE
70g/qm
DAHLE
TESTING PAPER
70g/qm

Another strategy…

Recent e-mails

- Current strategies
  - Dear Colleagues,

  Could you please have a look at this sliding scale protocol and implement. I believe this will improve our practice
  - Dr X

  - Dear Colleagues,
  - This form will become part of the medical record. As cannulas are a significant cause of problems this may be a useful tool to reduce problems.
  - Dr X

Insert
Home
Page
Up
Delete
End
Page

- These were forwarded – forwarded – forwarded
- The sliding scale was very confusing
- Increased workload
- What evidence is there that I should do this?
    - Who wrote this, why – no ownership

Problems - cannulas

- How will the form get into the medical record?
  - Does this mean I'll see it
  - will it take over my life?
  - Will people fill it in?
- How can cannulas be a problem?
- All doctors wash their hands – benefit proved centuries ago. They were clean when they went in – it's the nurses!
- My patients don't get cannula infections

Problems

- Simple strategy
  - Write a protocol
  - Disseminate via e-mail
- Complex organisation
  - Clinicians knowledge
  - Clinician resistance
  - Clerical, forms in notes…and out of hours?
  - People reading forms, looking for them in the notes
  - Multiple wards

- PEOPLE RESIST CHANGE

WHY?

Resistance to Change

- What's wrong with the old way?
- What's better about this way?
- How much work does it mean for me?
- I've been doing it this way for years.
- So, everything I used to do was wrong?
- These guidelines are 348 pages long...

Why we resist change

- Our own clinical experience
  - Evidence vs anecdote
- Natural history of the illness
- Ritual
- A need to do something
- Patients' expectation (real or assumed)

Barriers

- Anecdotal medicine
  - My patients are different
- I know how to…
  - I don’t believe the evidence
  - I don’t know that I don’t know
- I don’t follow recipes

How do we get evidence into practice?

- We know what the answer isn't!

Dissemination does not = Implementation

- An analogy to Evidence Based Medicine
- EBM Triad
  - Best available evidence
  - Applied to an individual patient
  - Judiciously used
- ? Needs implementation tools

EBI Triad

- Best available evidence
  - On implementation
- Applied to an individual unit / department
  - They're not all the same
    - Rehab v ED
    - ED 1 v ED 2
- Judiciously used
  - The Implementer as a "broker"

Most interventions can be successful in some circumstances, but none are effective in all.

- Focus on departmental issues rather than individual clinicians
    - Cannulas
        - Rates on infection
        - Effects on LOS
        - M and M figures
    - Insulin
        - Evidence for glycaemic control
        - Results of our performance

Key Features 2

- Be Specific
  - What do you want to change?
    - Cannulas
      - Early infections – wash hands
      - Infections on days 3,4…15 – change them earlier
      - Sites of cannula

Key features 3

- Identify barriers early
  - Patient barriers
    - Beliefs / anecdotes
  - Individual clinician barriers
    - Don't like EBM / challenged / work load / cook book / too proscriptive / lack of knowledge
  - Department team
    - Multidisciplinary
  - Organisation / processes
    - Eg IT in our ED

Key features 4

- Ownership
- Get the team involved early in
  - Understanding the evidence-practice gap
  - Having the desire to change “metanoia”
  - Being involved in development of tools
  - Being integral to the implementation

- Guideline Features
  - Workable documents
  - Bundles
  - Based on good evidence
  - Simple not complex
  - Doesn't require major structural or organisational changes
  - Specific

Key features 6

- Guideline (Bundle) Implementation
  - Audit and feedback
  - Reminders
  - Education (detailing)
  - Opinion Leaders
  - Passive strategies generally ineffective

Key features 7

- Simplify what you are trying to achieve
- ANZCA pain guidelines as written will sit on a shelf (or cause it to collapse)
- Need to pick the eyes out of it

- 2 pages in the guideline
- Key Messages box
- Morphine is an effective and appropriate analgesic for acute cardiac pain
- Nitroglycerine is an effective and appropriate agent in the treatment of acute ischaemic chest pain
- Oxygen..

ACS Pathway

- **Pain relief**
- Anginine 300 – 600ug SL if systolic BP > 100mmHg
- Morphine 2.5mg increments until pain free
- Consider GTN infusion

TGL series

- Any of the following regimens can be expected to cure the majority of acute uncomplicated lower UTI in nonpregnant women. Use:

1 **trimethoprim** 300 mg orally, daily for 3 days
OR
2 **cephalexin** 500 mg orally, 12-hourly for 5 days
OR
3 **amoxycillin+clavulanate** 500+125 mg orally, 12-hourly for 5 days
OR
4 **nitrofurantoin** 50 mg orally, 6-hourly for 5 days.

- Fluoroquinolones should not be used as first-line drugs as they are the only orally active drugs available for infections due to *Pseudomonas aeruginosa* and other multiresistant bacteria.
- If resistance to all the above drugs is proven, a suitable alternative is:
- **norfloxacin** 400 mg orally, 12-hourly for 3 days.
- Treatment failures are usually due to a resistant organism, re-infection with a similar organism, or an unsuspected underlying abnormality of the urinary tract for which further investigations should be considered.
- If relapse occurs, pyelonephritis should be considered and treatment given for 10 to 15 days.

Summary

- An evidence base exists that can guide your efforts to implement change.
- The principles are like EBM
    - Best available evidence
    - Applied to an individual group
    - Judiciously used

- Simplify as much as possible
- Involve those you want to change early and give them a sense of ownership
- Know your barriers.