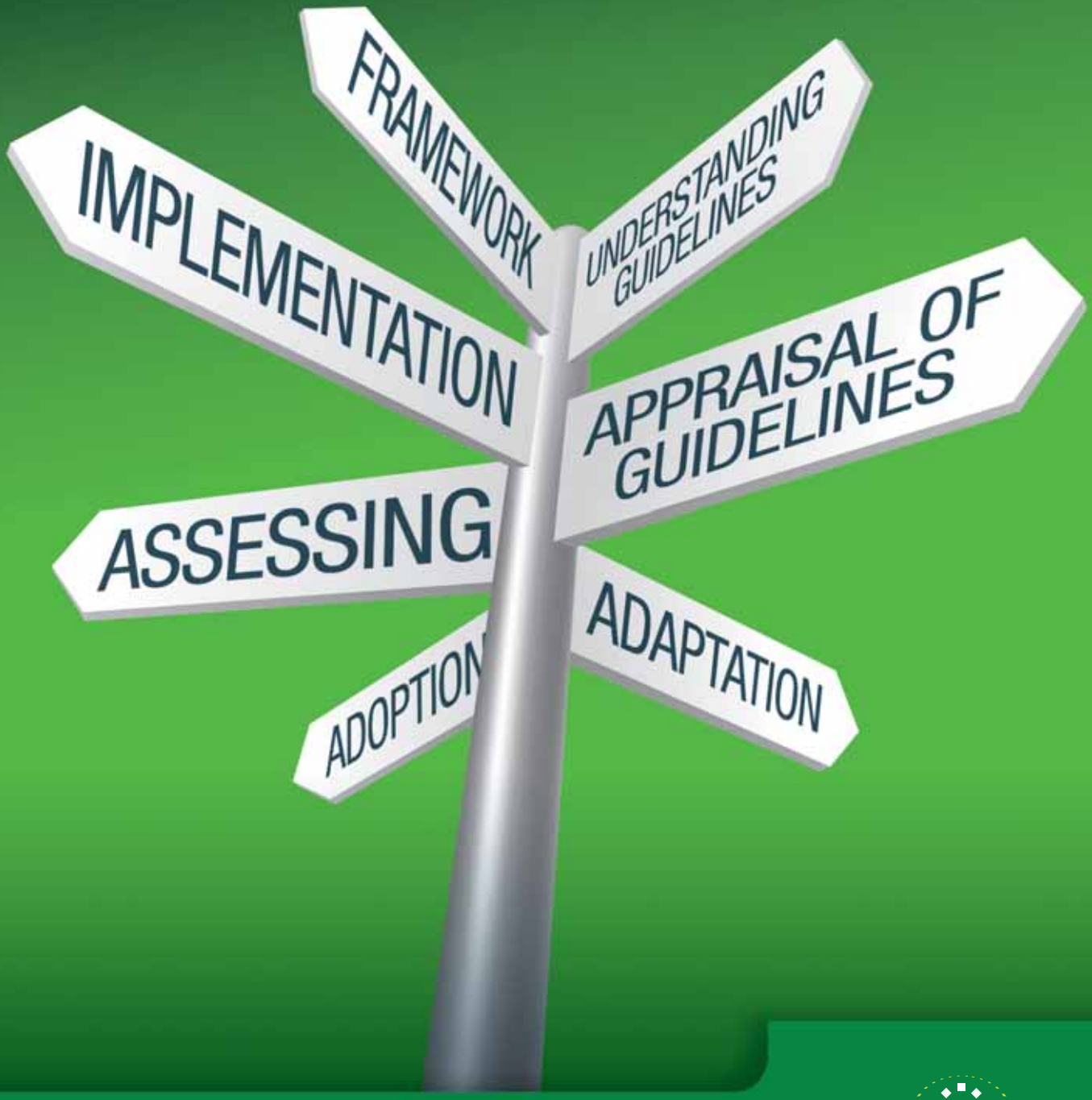
Guidance on the Adaptation of Clinical Practice Guidelines: Getting Evidence into Practice



A guide to assist nurses and midwives to utilise clinical practice guidelines in order to get evidence into practice.

FEBRUARY 2009

National Council for the Professional Development *of* Nursing *and* Midwifery

An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

Mission Statement of the National Council

The purpose of the Council is to promote and develop the professional roles of nurses and midwives in partnership with stakeholders in order to support the delivery of quality nursing and midwifery care to patients/clients in a changing healthcare environment.

Published by

National Council for the Professional Development of Nursing and Midwifery
6-7 Manor Street Business Park, Manor Street, Dublin 7
T: 353 1 882 5300. F: 353 1 868 0366.
e: admin@ncnm.ie w: www.ncnm.ie

Contents

Introduction

The National Council for the Professional Development of Nursing and Midwifery (National Council) supports the use of clinical practice guidelines to assist clinicians in getting evidence into practice. Irish organisations have embraced clinical practice guidelines to support appropriate and evidence-based care. The National Council through its various frameworks and guidance has encouraged and ensured the use of clinical practice guidelines for provision of care in the context of multidisciplinary services and patient care pathways (National Council 2006a, 2006b, 2008a,b). The National Council through its continuing education funding has supported training at local level regarding development and implementation of clinical guidelines and implementation of evidence-based practice (Appendix A provides examples of continuing education funding). Data gathered in 2004 showed that 48% of services reported that research-based nursing or midwifery practice guidelines were developed but only 38% had developed multidisciplinary guidelines. Additionally, there was variation across the (at that time) Health Board areas and the data suggested that smaller services were less likely to have developed clinical practice guidelines (National Council 2006c).

Development and updating of high-quality clinical practice guidelines require substantial resources (Fervers et al 2006). Many guideline programs throughout the world use similar strategies to achieve similar goals, resulting in many guidelines being developed on the same topic. The literature suggests that unnecessary duplication of effort could be avoided if existing guidelines were adapted rather than developed de novo (Graham & Harrison 2005, Fervers et al 2006).

The National Council is pleased therefore to present this paper to inform and provide definitions, potential benefits and processes for adaptation of clinical practice guidelines. A step-by-step guidance framework is provided to assist nurse and midwife managers and nurses and midwives at all levels of clinical practice to adapt or adopt previously developed guidelines to their own area of practice. This is in the context of multidisciplinary provided care.

Guidance on the Adaptation of Clinical Practice Guidelines: Getting Evidence into Practice

Irish Policy Context

Healthcare provision in Ireland is continuously developing within a quality and standards driven agenda (DoHC 2001, Government of Ireland 2008, HSE 2009). The Health Information and Quality Authority (HIQA) was established in 2007 with the purpose of driving improvements in Ireland's health and social care services (HIQA 2008).

Reporting directly to the Minister for Health and Children, the role of the Authority is to "promote safety and quality in the provision of health and personal social services for the benefit of the health and welfare of the public". Many of the objectives of the Authority are outlined in their Business Plan 2008 and include the development of protocols for standards setting and defining performance measures and indicators (HIQA 2008, p. 18).

Nurses and midwives increasingly need to base decisions and actions on the best possible evidence in order to contribute to improvements in patient care and maintain professional accountability (An Bord Altranais 2000a,b, Wilson 2002).

The Health Service Executive (HSE) (2009) outline the actions required in relation to the development of primary care teams and the role of shared guidelines and protocols to support clinical practice in the community.

Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety

The publication of the *Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety* (Government of Ireland 2008) details a review of international models of evidence-based practice and asserts that supporting evidence-based practice (EBP) is a 'critical element of a health system which aims to deliver safe and high quality care' (p. 150).

> *Clinical guidelines are a key intervention to support evidence-based practice and are often used in conjunction with ICPs and managed care (p. 149).*

The *Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety* further states that:

> *It is essential in any healthcare system that healthcare professionals, multi-disciplinary teams, organisations and the wider healthcare service are able to use information to monitor the safety and quality of the services that are being provided so as to enable the sharing of good practice, make improvements as required and inform the planning of services. Clinical effectiveness embraces this approach as part of a well-governed healthcare system, and involves a number of processes and behaviours at the various levels of healthcare in order to drive safety and quality. The requirements for good clinical effectiveness include access for healthcare professionals to the most up-to-date information and evidence-based practice relating to the condition or specialty area, and the undertaking of effective clinical audit by individuals, teams, organisations and the wider health system in a well led, organised and effectively managed manner, with strong clinical leadership to support and drive the activity. Clinical effectiveness also includes establishing clinical standards, guidelines and indicators that enable healthcare professionals to monitor their individual team and organisation's performance against nationally and where possible, internationally recognised comparative parameters. It further involves ensuring that staff are supported, educated and trained in clinical audit, information models and the use of information to inform and improve their service (p. 11).*

The National Council has contributed to the clinical effectiveness agenda through its various frameworks and processes. It has provided guidance on the process of implementation of integrated care pathways (ICPs) (National Council 2006b) and has supported evidence-based practice and research by funding continuing education programmes in accordance with agreed criteria (National Council 2007).

Advanced Nurse and Midwife Practitioners (ANPs/AMPs) are the only nurse and midwives in Ireland subject to

review of continuing competence in order to retain a title (National Council 2008c). The National Council supports life long learning through providing guidelines on portfolio development (National Council 2006a). These guidelines are aimed at individual nurses and midwives working at the forefront of healthcare delivery, for the purpose of assisting them to identify, reflect upon and record the contribution they make to direct and indirect care, encouraging them to store records of their development in a coherent and structured manner and providing guidance and information on achieving their individual professional goals within the context of the needs of the health service. The National Council *Framework for the Establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts* (National Council 2008b) requires services to have developed multi-disciplinary evidence-based guidelines to support scope of practice and caseload management within a structured framework. Clinical nurse and midwife specialist posts are also guided by a framework, which outlines that specialist clinical practice is research and evidence-based and that decisions may be made utilising protocol driven guidelines (National Council 2008a).

Clinical Governance and Clinical Practice Guidelines

Clinical governance is a framework through which health services organisations are accountable for continuously improving the quality of services and upholding high standards of clinical care to ensure patient safety (National Council 2006b).

National recommendations and guidelines have the potential to promote equality of access for all and care based on the best available evidence. However, they also present challenges and potential conflict for nurses in terms of accountability for decisions and actions in utilising clinical practice guidelines (Hewitt-Taylor 2003). Accountability is a complex concept in healthcare and is recognised as a key driver for safety and quality of care (Government of Ireland 2008). The key principles of good governance include having clear lines of accountability at individual, team and system level within an organisation.

The *Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety* (Government of Ireland 2008) recommends that all healthcare organisations should have in place a governance framework that clearly describes responsibilities, levels of delegated authority, reporting relationships and accountability within the organisation. The recommendation of a system of clinical directorates within organisations further seeks to ensure that the clinical director would be accountable for all aspects of patient safety and quality within the directorate.

In the context of clinical governance the use of clinical guidelines can be translated into quality indicators to measure and improve the quality of care. Rates of adherence to guidelines can also serve as a measure of quality and temporal changes in these rates may be a marker of success of quality improvement efforts within clinical directorates and organisations as a whole (Clayton 2003, Maynard 2003, Government of Ireland 2008).

Evidence-Based Practice (EBP)

EBP is not a new concept in healthcare; its popularity has been augmented by suggestions that patients may have received care based on the unproven opinions of individual clinicians rather than on the evidence of their efficacy (Hewitt-Taylor 2003, Mc Sherry &Taylor 2003). In evidence-based practice the best methods of providing aspects of healthcare are identified and this knowledge is used to assist professionals in clinical decision making (Hewitt-Taylor 2003). Sackett et al (1996) suggest that evidence-based medicine is about integrating individual clinical expertise and the best external evidence, therefore, it is a conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

EPB may be best expressed as a component of an evidence-based healthcare approach which comprises three stages (Government of Ireland 2008):

- producing evidence
- making evidence available
- using evidence for decisions regarding individual patients (evidence-based clinical practice and evidence-based patient choice) or for populations or groups of patients (evidence-based public health and health service management).

Evidence-based guidelines claim to embody a combination of best evidence and judgement, designed to ensure that recommendations are valid and reliable. They are standardised specifications of care that apply to the general

condition in an attempt to eliminate variations in the standard and availability of healthcare between regions (Mead 2000, Hewitt-Taylor 2003, Hurwitz 2004). These concepts have been linked to the development of national recommendations and guidelines such as those developed by the National Institute for Clinical Excellence (NICE) in the UK (set up in 1999 to appraise new technologies, including drugs) and the Scottish Intercollegiate Guidelines Network (SIGN).

The *Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety* (Government of Ireland 2008, p. 151) makes several recommendations related to evidence-based practice:

R7.1 A leadership role in relation to the analysis of international evidence and research, and to the production of evidence-based information and guidance for use in policy-making, system reform, and individual patient and professional interactions should be developed.

R7.2 A rolling programme should be developed by the Department of Health and Children, HIQA, and HSE to deliver evidence-based service frameworks covering the major health conditions within the public healthcare system, similar to the National Service Frameworks model in the UK. Such frameworks should be reviewed periodically to encompass new evidence on effectiveness and performance.

R7.3 A substantial strand in publicly funded health research strategies, focusing on patient safety and quality, should be developed by the Health Research Board.

R7.4 Evidence-based national standards should be developed, with multi-disciplinary input, in both primary and secondary care settings, and for the transition between care settings.

If nurses and midwives are to engage in the realisation of the recommendations of the *Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety*, then there are specific issues relating to clinical practice guidelines that need to be reviewed and considered. This paper aims to support nurses and midwives to engage in the process of utilisation of clinical practice guidelines and provides a guide for adaptation of such guidelines.

International Literature and Clinical Practice Guideline Developments

Clinical guidelines and multi-disciplinary pathways of care are rapidly becoming an established and essential feature of modern day healthcare practice (New Zealand Guideline Group 2001, Wilson 2002) across the globe and are likely to be a part of clinical practice and governance structures for some time to come (Tuffnell 2002, Keeley 2003). Considerable time, money and energy have gone into the development of evidence-based guidelines for improving clinical practice. They are intended to offer concise instructions on how to provide healthcare services (Woolf et al 1999) and generally they contain a set of individual recommendations covering one specific disease area (Burgers et al 2003).

Guidelines are a tool for consistency of care and may be seen as a way of closing the gap between what clinicians do and what scientific evidence supports (Field & Lohr 1990, Keeley 2003). There are substantial benefits to the introduction of clinical guidelines but they are dependant upon the guidelines themselves being developed, presented and implemented in a robust and appropriate way (Tuffnell 2002). The benefits of guideline use occur as a result of consistency of care offered across groups of patients and by groups of professionals. It is suggested that clinical guidelines can increase practitioner's accountability by identifying the consensus view on best practice and therefore what course of action is reasonable to expect clinicians to take (Thomas et al 1999). Clear guidance will reduce errors and provide a clear standard for care to be subsequently or even prospectively audited, this framework then creates an environment for learning, either in the gathering of the knowledge to develop the guideline or in the implementation phase for staff and patients alike (Tuffnell 2002).

Difficulties with guidelines generally arise from poor guideline development or implementation rather than intrinsic problems with the guidelines themselves. Some would suggest there is a tension between the use of clinical guidelines as a method of promoting consistent, evidence-based practice and a decrease in individual autonomy (Hewitt-Taylor 2003). Tuffnell (2002) further argues that some difficulties arise from the principles of 'clinical freedom' and the infringement of it by guidelines; however, if guidelines are well written they will include a framework that allows departure from the guideline as long as clear and reasonable explanations are present and those reasons are contemporaneously documented in the patient record (Joint Commission on Accreditation of

Healthcare Organizations 2000, Tuffnell 2002, Grol & Buchan 2006).

Out of date or ineffective guidelines also create concern (Shekelle et al 2001, Tuffnell 2002) and new information about the magnitude of benefits and harms may make the pre-existing guideline invalid (Shekelle et al 2001). These concerns can be addressed by having built-in review periods or by using a model such as described by Shekelle et al (2001), which advocates a process, based on expert opinion and focused literature reviews to assess when guidelines need updating.

The key attributes of clinical guidelines include:

- Ease of use i.e. the guideline being written in an easily understood way with built-in points of referral for senior help (Tuffnell 2002).
- Wide initial consultation. A wide review of the guideline by members of a multidisciplinary team will ensure 'ownership' and buy in which will encourage use of the guideline.
- Evidence base supporting the guideline and referencing from the appropriate sources of evidence incorporated into the final document.
- Explicit reference to clinical aspects of care within the guideline will make the guideline more useful in its application to patient management, increasing its likelihood of implementation.

Clarification of Terminology: What are Guidelines?

Definitions

Clinical Practice Guidelines are 'systematically developed statements to assist practitioners and consumer decisions about appropriate healthcare for specific clinical circumstances' (Field & Lohr 1990).

A guideline is a principle or criterion that guides or directs action (An Bord Altranais 2000b).

Clinical Practice Guidelines can be used to reduce inappropriate variations in practice and promote the delivery of high quality, evidence-based healthcare (Clinical Resource and Audit Group (CRAG) 1993).

The New Zealand Guidelines Group (NZGG 2001) has a broad definition of clinical practice guidelines:

"Guidelines provide guidance in decision making at each level of interaction; between health professional and consumer, between purchaser and provider, and between 'funder' and purchaser".

The NZZG further define clinical practice guidelines as:

- decision tools to close gaps between current and optimal practice
- mechanisms to improve the quality of healthcare and decrease costs and utilisation
- recommendations devised to influence decisions about health interventions
- tools to outline procedures to be followed thus helping doctors make decisions
- processes to operationalise the implementation of evidence-base practice.

It has been suggested that the term 'guideline' be applied only to a systematically developed advisory statement devised according to validated scientific methodologies (Mead 2000). There is some disagreement in the literature over which documents should be called guidelines and as a result the term is often used interchangeably with protocols (NZGG 2001).

The NZZG define five different types of guidelines:

- **Best Practice Guideline:** (also called practice guidelines, clinical guidelines, statements of best practice and boundary guidelines) ..."systematically developed statements of best practice and consumer decisions about appropriate health or disability care for specific circumstances, taking into account evidence for effectiveness and competing claims ... and form a fundamental basis for planning".
- **Protocol:** "specific guidelines which are expected to be followed in detail with little scope for variation..." Protocol guidelines are used in specialty high-risk areas e.g. emergency resuscitation, or where legislation regulates the practice e.g. forensic psychiatry.
- **Consensus Based Guideline:** The most common form of guideline development is agreement among a group of experts.

- **Evidence-Based Guideline:** Developed after the systematic retrieval and appraisal of information from the literature; "they usually include strategies for describing the strength of the evidence and try to clearly separate opinions from evidence.... they make statements not just about which of two treatment options is 'better' but quantify the absolute differences in outcome, including both benefits and harms".
- **Explicit Evidence-Based Guideline:** Developed as an evidence-based guideline, "but also projects the healthcare outcomes (benefits, harms, utilization and costs) of the change in practice on a defined population".

In summary guidelines that have recommendations based on evidence with built in review dates are considered to be of greater value to practitioners and consumers because the decisions are likely to result in improved consumer outcomes (Grol et al 1998, NZGG 2001).

Aim of Clinical Practice Guidelines

Good clinical guidelines aim to improve the quality of healthcare (An Bord Altranais 2000b) and clinical effectiveness (Government of Ireland 2008). They can change the process of healthcare and improve people's chances of getting as well as possible.

Clinical guidelines can:

- provide recommendations for the treatment and care of people by health professionals
- be used to develop standards to assess the clinical practice of individual health professionals
- be used in the education and training of health professionals
- help patients to make informed decisions
- improve communication between patient and health professional (National Institute for Health and Clinical Excellence (NICE) 2007).

The purpose of clinical practice guidelines is to identify effective diagnostic, screening and treatment strategies and encourage the use of these to improve the quality of healthcare and thus consumer outcomes. However, defining quality in healthcare can be difficult. One example of quality in healthcare is 'providing the right care, at the right time, for the right person, in the right way'. Quality healthcare should be appropriate, accessible effective, safe and provided by someone who is competent and accountable for practice (NZGG 2001).

There are guidelines available from various institutions. Appendix B provides examples of two such guidelines:

- National Institute for Health and Clinical Excellence (NICE)
    - Acutely ill Patients in Hospital. Quick Reference Guide. Recognition of and response to acute illness in adults in hospital.
- Scottish Intercollegiate Guidelines Network (SIGN)
    - Management of patients with dementia. Quick Reference Guide. This guide provides a summary of the main recommendations in the SIGN guideline on Management of Patients with Dementia.

These guidelines are available on the NICE and SIGN websites respectively. They may be used for educational and not-for-profit purposes. Specific copyright information is available from the websites.

Finding, Selecting and Assessing Clinical Practice Guidelines

As the number of clinical practice guidelines submitted for publication increases there is a need to ensure that they satisfy certain minimum requirements. Several agencies such as National Institute for Clinical Excellence (NICE) in the UK, the National Federation of Cancer Centres (FNCLCC) in France, the Agency for Quality in Medicine in Germany (AZQ) and the Scottish Intercollegiate Guidelines Network (SIGN) and, The World Health Organisation are using the Appraisal of Guidelines Research and Evaluation (AGREE) framework in the context of their guideline programmes (AGREE 2003).

Finding guidelines to use in clinical practice is becoming increasingly easier. Organisations developing guidelines are now publishing them in a variety of accessible formats including peer–reviewed journals, agency

reports and web sites. Many directories are also available and the National Library of Medicine's MEDLINE has designated *guideline* as a "publication type" in its search fields and *practice guideline* as a major subject heading (Joint Commission on Accreditation of Healthcare Organizations 2000).

Before selecting appropriate clinical practice guidelines an organisation must target an area requiring improvement. According to the Joint Commission's priority process (Joint Commission on Accreditation of Healthcare Organizations 2000), improvements that are powerful and worthy of organisations resources will:

- have a positive impact on a large number of patients
- eliminate or reduce instability in critical clinical processes
- decrease patient, staff or organisation risk
- ameliorate serious problems
- optimise the likelihood of consistency achieving desired clinical outcomes.

Increasingly clinicians and clinical managers must choose from numerous, sometimes differing and occasionally contradictory guidelines (Graham et al 2003, Keeley 2003, GRADE Working Group 2004, Graham & Harrison 2005). Determining which guidelines are quality products worthy of adoption can be daunting (Graham & Harrison 2005). Many authors with expertise in the area of clinical guideline appraisal assert that every effort should be made to identify existing guidelines that have been rigorously developed and to adopt or adapt them for local use (Cluzeau et al 1999, Feder et al 1999, GRADE Working Group 2004, Graham & Harrison 2005, Vlayen et al 2005, Fervers et al 2006).

The Appraisal of Guidelines Research and Evaluation (AGREE) Instrument

The Appraisal of Guidelines Research and Evaluation (AGREE) Instrument is rapidly becoming accepted as the gold standard for guideline appraisal (Graham & Harrison 2005). The AGREE instrument is designed to assess the process of guideline development and how well this process is reported. It does not however assess the clinical content of the guideline or the quality of the evidence that underpins the recommendations (AGREE Collaboration 2003).

AGREE criteria for high quality clinical practice guidelines:

1. Scope and purpose: Contains a specific statement about the overall objective(s), clinical questions, and describes the target population.
2. Stakeholder involvement: Provides information about the composition, discipline and relevant expertise of the guideline development group and involves patients in their development. Target users are clearly defined and have been piloted prior to publication.
3. Rigour of development: Provides detailed information on the search strategy, the inclusion and exclusion criteria for selecting the evidence, and the methods used to formulate the recommendations. The recommendations are explicitly linked to the supporting evidence and there is a discussion of the health benefits, side effects and risks. They have been externally reviewed before publication and provide detailed information about the procedure for updating the guideline.
4. Clarity and presentation: Contains specific recommendations on appropriate patient care and considers different possible options. The key recommendations are easily found. A summary document and patients' leaflets are provided.
5. Applicability: Discusses the organisational changes and cost implications for applying the recommendations and presents review criteria for monitoring the use of the guidelines.
6. Editorial independence: Includes an explicit statement that the views or interests of the funding body have not influenced the final recommendations. Members of the guideline group have declared possible conflicts of interest.

Clinical Practice Guideline Implementation

According to Grol and Buchan (2006) most guidelines need well-developed, well-executed and sustained implementation programs. Tailoring guidelines to an organisation ultimately will embrace the full implementation process, which starts after deciding to use particular clinical practice guidelines and choosing specific recommendations in it to implement. It continues with modification of the guideline, getting acceptance from clinicians on the implementation team and approval from the organisation, pilot testing, monitoring, revision and ultimately updating after the implementation when new evidence emerges. Strategies targeting factors associated with behavioural change in a logical sequence may improve uptake of the guideline along with recognising system changes which also require consideration (Carey et al 2009).

The elements that go into producing guidelines are the key to their successful implementation, this includes that all stakeholders are involved in the process and that ownership is widely developed (Wright & Tuffnell 2002). Multidisciplinary involvement in guideline development is desirable and has the potential to promote valid, reliable and implementable practice recommendations (Eccles et al 1996, Graham et al 2003). Implementation should be integral to the whole process of guideline development. In many cases implementation failure has been related to factors extrinsic to the guideline itself, e.g. organisational and provider-specific obstacles inherent in a particular system of care. In other cases factors intrinsic to the guideline have contributed to implementation failure for example, ambiguity, inconsistency, and incompleteness of the guideline itself (Shiffman et al 2005).

Guideline implementation involves "the concrete activities and interventions undertaken to turn policies into desired results" (Field & Lohr 1990). Shiffman et al (2005) defines *implementability* as a set of characteristics that predict the relative ease of implementation of guideline recommendations. Measures of successful implementation include improved adherence to guideline-prescribed processes of care and ultimately improved patient outcomes (Shiffman et al 2005).

Adoption or Adaptation of Clinical Practice Guidelines

Terms to consider in the process of writing guidelines are those such as *adoption,* which is the incorporation of a guideline into routine procedures or practice at the end of the implementation (that is, *integration*) in contrast to *adaptation,* which is the process of modifying a guideline to make it more suitable for purpose or setting in which it will be used or to increase its acceptability for the population using it (Joint Commission on Accreditation of Healthcare Organizations 2000).

Mead (2000) asserts that if local adaptation increases ownership of the guideline, then there is an increased likelihood of it being used. The process of adaptation should be carried out by applying a framework in order to maintain the guideline's integrity. A number of appraisal tools have been developed for this reason and in particular a conceptual framework has been developed by Graham et al (2003) which provides a stepped approach for organising and making decisions about which high quality guidelines to adopt. The cycle developed by Graham et al (2003) was originally intended for use by organisations and groups wanting to implement best practice, however, the authors articulate that most steps in the process are also helpful in guiding evaluation of guidelines by individual clinicians (Graham & Harrison 2005).

Framework for Clinical Practice Guidelines Evaluation and Adaptation Cycle

The Practice Guidelines Evaluation and Adaptation Cycle as described by Graham & Harrison (2005) is a framework for organising and making decisions about which high quality guidelines to adopt or adapt.

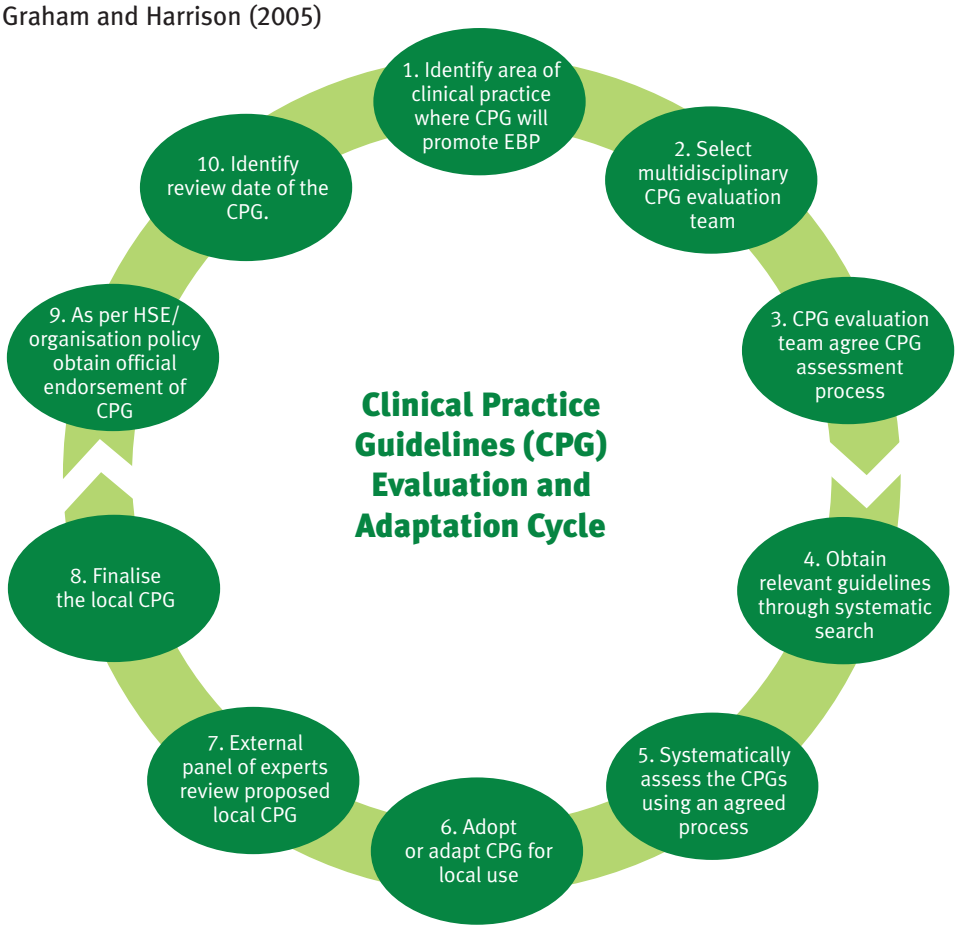
The National Council have further adapted this framework with the intention of providing nurses and midwives with the relevant strategies needed to appropriately select and evaluate clinical practice guidelines and subsequently adopt or adapt them for local use.

There are ten steps involved in the clinical practice guideline (CPG) cycle:

1. Identify area of clinical practice where CPG will promote EBP.
2. Select multidisciplinary CPG evaluation team.
3. CPG evaluation team agree CPG assessment process.
4. Obtain relevant guidelines through systematic search.
5. Systematically assess the CPGs using an agreed process.
6. Adopt or adapt CPG for local use.
7. External panel of experts review proposed local CPG.
8. Finalise the local CPG.
9. As per HSE/ organisation policy obtain official endorsement of CPG.
10. Identify review date of the CPG.

Clinical Practice Guidelines (CPG) Evaluation and Adaptation Cycle

Adapted from Graham and Harrison (2005)



1. Identify area of clinical practice where CPG will promote EBP

The identification of a suitable clinical practice area to promote EBP forms a possible starting point for CPG selection and appraisal. Often common clinical conditions, which are encountered on a daily basis by a variety of healthcare professionals, prove to be associated with wide variations in practice and produce care gaps and therefore variability in care delivered to patients (Graham et al 2003). The more problematic the clinical condition and associated burden the more likely the desire for introducing a CPG. Potential areas can emerge from an assessment of the major causes of morbidity and mortality for a given population. This may be guided by DoHC policy, HSE Service Plans or local service/ organisational issues. Additionally uncertainty about appropriateness of healthcare processes or effectiveness in improving patient outcomes may prove to be a priority or the need to conserve resources in providing care may be a key driver to select an area for guideline development (Shekelle et al 1999).

2. Select multidisciplinary CPG evaluation team

An appropriate multidisciplinary CPG evaluation team will comprise interested clinicians and key stakeholders who will be affected by the selection and implementation of the CPG. The team should include patient and community representatives to reflect the inclusive and consultative nature of the process. A multidisciplinary CPG evaluation team is particularly important if the guideline addresses trans-disciplinary issues such as referral criteria and treatment issues that impact on several provider groups or require changes in behaviour of more than one professional carer group (Mc Nicol et al 1993, Graham et al 2003). Another advantage of a multidisciplinary CPG evaluation team is that it reduces the potential for bias that might result if only one provider group were involved in evaluating and selecting a guideline for local use.

Roles required within the CPG evaluation team are those of team leader, specialist resource, technical support, and administrative support. CPG evaluation team members are invited to participate as individuals working in their field: their role is to develop recommendations for practice based on the available evidence and their knowledge of the practicalities of clinical practice (Shekelle et al 1999). The role of team leader is crucial in order to ensure that the group functions effectively and achieves its aims. This role is best managed by someone who is familiar with the management of the clinical condition and the scientific literature and who also possesses both clinical skills and group processing skills.

3. CPG evaluation team agree CPG assessment process

There are a number of CPG appraisal processes as previously outlined in this paper such as the AGREE Instrument (2003). Utilising such a process allows comparison of similar guidelines using the same criteria, which in turn allows for unbiased critical comparison. Prior to searching for any guidelines, the group should decide on the criteria that will be used to the select the particular guidelines that will be subjected to the evaluation. Whatever criteria are chosen these should be documented in order to ensure reproducibility of the process by which the CPG evaluation team selected the specific guidelines to review (Graham et al 2003). Having selected the appraisal instrument for use and depending on the explicitness of the instrument user manual explaining how appraisal items should be interpreted it may be useful to devote some group time to ensure that members are comfortable with how to interpret items comprising the instrument.

4. Obtain relevant guidelines through systematic search

A systematic search for all relevant guidelines is necessary so that guidelines which members of the group may not be familiar with are not overlooked. Searching should take place in a logical sequence and this should be documented in order to avoid omission or duplication of effort. Databases such as MEDLINE, EMBASE and the Cochrane Library are good starting points. Important sources for rigorously developed guidelines from the UK include National Institute of Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Initiative (SIGN). In August 2007 other sources of guidelines, RMAG, NIRAAC and CREST became known as the Guidelines and Audit Implementation Network (GAIN).

The US National Guideline Clearinghouse (NGC) provides significant information regarding guidelines. It has strict pre-screening criteria which must be satisfied before guidelines will be accepted into their clearinghouse. The NGC is updated weekly and will facilitate and guide comparison of guidelines particularly in areas of methodology. Appendix 3 provides a comprehensive list of websites which may be used by the CPG evaluation team.

5. Systematically assess the CPGs using agreed process

Once all the searches are complete and all possible guidelines of interest are retrieved and the selection criteria applied to them then the assessment of individual CPGs can take place. It is recommended that each guideline be

appraised by at least 2 group members. However reliability of the assessment is greatly increased if four or more appraisers from different professional and specialty backgrounds participate (AGREE 2003, Graham et al 2003).

Determining if the guideline is valid involves 3 separate but related steps (Graham & Harrison 2005):

- appraising the quality of the CPG as a whole
- determining the currency of the CPG
- assessing the content of the recommendations.

Appraising the quality of the CPG as a whole

The AGREE instrument is considered the gold standard and should be applied to all guidelines meeting the minimum inclusion criteria. In reality it may not be practical or possible given time constraints and the number of appraisers who are available to carry out this activity on all relevant guidelines. A quick guide to identifying higher quality evidence-based guidelines is proposed by Graham and Harrison (2005). The domain "rigour of development" from the AGREE instrument is considered the most important domain comprising 7 items which specifically focus on the degree to which the guideline development process was evidence based and how evidence and research were incorporated into the recommendations. The group agrees an acceptable quality score with a minimum "cut off" score. Where guidelines fail to reach the minimum score they are automatically excluded from further appraisal. This process saves time and effort and eliminates guidelines at an early stage especially those guidelines that are weak and probably would not survive the full appraisal process.

Determining the currency of the CPG

CPGs that meet the minimum quality criteria must be assessed to determine their currency. Checking the currency involves reviewing the date of publication and expected review date. Review of the bibliography and references to check on the dates of original research studies cited also confirms currency. Checking with guideline developers as to their plans to their update published guidelines may also be useful.

Assessing the content of the recommendations

The use of a guideline appraisal instrument will provide little detailed information on the actual recommendations being advanced in specific guidelines (Graham et al 2003, Graham & Harrison 2005). It is essential at this point to consider a content analysis of the recommendations contained in the guideline. It is advisable that at least one or two clinicians who have expertise in the content area generate a table or matrix comparing each guideline in terms of specific recommendations made and evidence supporting each recommendation. This table can provide the focus for individual clinician's considerations regarding the strength of evidence supporting the recommendations and can focus the group's deliberations regarding the content of each guideline. Many guidelines will have evidence of varying strength and a table such as this can identify recommendations with the strongest evidence particularly associated with clinical usefulness. There are classification schemes in the literature that can be utilised (Shekelle et al 1999).

6. Adopt or adapt CPG for local use

Having addressed the methodological quality of the guidelines using the appraisal instrument and then compared the content of the recommendations and strength of evidence supporting each recommendation, the CPG evaluation team then need to decide to adopt or adapt a guideline that fits best with the specific practice setting.

Adopting a guideline involves choosing the best guideline and accepting all recommendations as written but this may not be feasible or practical (Graham & Harrison 2005). Alternatively the CPG evaluation team may decide to take recommendations that are supported with strong evidence from many guidelines and repackage them into a new local guideline. Some concerns are expressed by guidelines developers regarding local adaptation especially where modification of the recommendations for local use may ignore the evidence. Local adaptation of existing guidelines should never involve changing the evidence-based recommendations unless the supporting evidence changes (Graham et al 2003). Whenever recommendations are modified in any way the rationale for this change should be explicitly stated in the resulting local guideline document.

7. External panel of experts review proposed local CPG

Once the CPG evaluation team has decided on the local guideline, the next step is to send draft recommendations for review to local practitioners, key stakeholders and organisation policy makers. This process of seeking feedback ensures that those who are most likely to use the guideline have had an opportunity to review and offer their feedback. It permits policy makers the opportunity to consider the impact of implementing the recommendations on

the organisation and begin to prepare for its future adoption. As a result of feedback the multidisciplinary CPG evaluation team has an opportunity to revise the guideline in advance of the final draft been put forward for endorsement by the organisation. Seeking feedback from practitioners can also act as a first wave of dissemination.

In the case of guideline adaptation depending on the extent of the adaptation process it may be necessary to involve external experts in a review from a content, validity, clarity and applicability point of view (Graham & Harrison 2005). This can help ensure that recommendations from existing guidelines have not been taken out of context or adapted inappropriately. External reviewers should cover three areas: people with expertise in clinical content who can review the guideline to verify the completeness of the literature review and ensure clinical sensibility, experts in systematic reviews, guideline development or both who can review the method by which the guideline was developed, and the potential users of the guidelines who can judge its usefulness (Shekelle 1999).

8. Finalise the local CPG

The CPG evaluation team should respond to any recommendations from the practitioner, policy makers and independent reviewers and modify the guideline where appropriate. Changes made to the document as a result of this feedback should be documented citing the rationale for the change. Likewise where the CPG evaluation team chooses not to modify the guideline despite the feedback received the decision for this should also be made explicit.

9. As per HSE/ organisation policy obtain official endorsement of CPG

This is an administrative function whereby the HSE/organisation formally adopts the proposed guideline and gives it official sanction for use. Once the organisation provides it seal of approval the guideline is ready for dissemination and implementation. If plans for dissemination and implementation of recommendations have not been considered, they should be at this point (Graham & Harrison 2005).

10. Identify review date of the CPG

The CPG evaluation team should develop a plan for when and how the local CPG will be reviewed and updated or provide a guideline expiry date. This will ensure that the CPG is re-examined on a regular basis and as new evidence emerges it is incorporated into the guidelines. Depending on the extent of the changes in the guideline recommendations required by new evidence, the CPG evaluation team may want to simply seek practitioner and policy maker feedback on the changes or start the entire guideline evaluation cycle over again. The CPG review and changes made to the CPG must be documented.

Conclusion

Clinical practice guidelines have the potential to improve process of care as well as patient outcomes, however their beneficial effects are contingent on successful implementation (Graham & Harrison 2005). A guided framework such as the one outlined in this document provides the key steps involved when considering adopting/adapting guidelines and recommendations that are most suitable to a particular practice area.

The *HSE Service Plan* (HSE 2009), the *Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety* (Government of Ireland 2008) and other government initiatives all combine to provide an explicit blueprint for a model of healthcare for the future that will be driven at a strategic level. In order to make these strategic plans a reality the application of evidence-based healthcare at national, regional and local level will be required. These requirements may be met through a proposed licensing framework (Government of Ireland 2008) where a clear legal duty is imposed on the Board of Management of each facility to put and keep in place arrangements for the purpose of monitoring and improving the safety and quality of healthcare. The use of national standards and robust clinical practice guidelines as recommended by the *Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety* (Government of Ireland 2008) are cited as significantly contributing to such improvements.

This paper provides definitions, a guided framework for adopting/adapting clinical practice guidelines and resources for implementing evidence-based practice. Clinical practice guidelines with recommendations based on evidence with built in review dates are considered to be of greater value to clinicians and patients because the decisions are likely to result in improved patient outcomes. Nurses and midwives are well placed to support the implementation of clinical practice guidelines in order to promote evidence-based practice and a quality agenda. The National Council recommends that nurse and midwife managers and nurses and midwives in clinical practice give serious consideration to the use of clinical practice guidelines and the processes provided in this paper. The National Council welcomes discussions with service providers, nurse and midwife managers and individual nurses and midwives with regard to clinical practice guidelines and evidence-based practice. The National Council will continue to provide seminars, funding grants and other resources to support the implementation of clinical practice guidelines.

References

AGREE Collaboration (2003) Development and validation of an international appraisal instrument for assessing the quality of clinical practice guidelines: the AGREE project. *Quality & Safety in Healthcare* 12(1), 18-23.

An Bord Altranais (2000a) *Scope of Nursing and Midwifery Practice Framework*. An Bord Altranais, Dublin.

An Bord Altranais (2000b) *Guidance to Nurses and Midwives on the Development of Policies, Guidelines and Protocols*. An Bord Altranais, Dublin.

Burgers J.S., Grol R.P., Zaat J. O., Spies T.H., van der Bij A.K. & Mokkink H.G. (2003) Characteristics of effective clinical guidelines for general practice. *British Journal of General Practice* 53(486), 15-19.

Carey M., Buchan H. & Sanson-Fisher R. (2009) The cycle of change: implementing best-evidence clinical practice. *International Journal for Quality in Healthcare* 21(1), 37-43.

Clayton J. (2003) Clinical governance and best value: a toolkit for quality. In *Clinical Governance and Best Value: Meeting the Modernisation Agenda* (Pickering S. & Thompson J. eds.) Churchill Livingstone, Edinburgh.

Clinical Resource & Audit Group (CRAG) (1993) *Clinical Guidelines: A Report of a Working Party.* Scottish Office Home and Health Department, Edinburgh.

Cluzeau F.A., Littlejohns P., Grimshaw J.M. Feder G. & Moran S.E. (1999) Development and application of a generic methodology to assess the quality of clinical guidelines. *International Journal for Quality in Healthcare* 11(1), 21-28.

Department of Health & Children (2001) *Quality and Fairness: A Health Service for You.* The Stationary Office, Dublin.

Eccles M, Clapp Z., Grimshaw J, Adams P.C., Higgins B., Purves I. & Russell I. (1996) North of England evidence based guidelines development project: methods of guideline development. *British Medical Journal* 312(7033), 760-761.

Feder G., Eccles M., Grol R., Griffiths C. & Grimshaw J. (1999) Clinical guidelines: using clinical guidelines. *British Medical Journal* 318(7185), 728-730.

Fervers B., Burgers J.S., Haugh M.C., Latrielle J., Mlika-Cabanne N., Paquet L., Coulombe M., Poirier M. & Burnard B. (2006) Adaptation of clinical guidelines: literature review and proposition for a framework and procedure. *International Journal for Quality in Healthcare* 18(3), 167-176.

Field M.J. & Lohr K.N. (1990) *Clinical Practice Guidelines: Directions for a New Program.* National Academy Press, Washington.

Government of Ireland (2008) *Building A Culture of Patient Safety: Report of the Commission on Patient Safety and Quality Assurance*. The Stationary Office, Dublin.

GRADE Working Group (2004) Grading quality of evidence and strength of recommendations. *British Medical Journal* 328(7454), 1490.

Graham D.I., Harrison M.B. & Brouwers M. (2003) Evaluating and adapting practice guidelines for local use: a conceptual framework. In *Clinical Governance and Best Value: Meeting the Modernisation Agenda* (Pickering S. & Thompson J. eds.) Churchill Livingstone, Edinburgh.

Graham I.D. & Harrison M.B. (2005) Evaluation and adaptation of clinical practice guidelines. *Evidence Based Nursing* 8(3), 68-72.

Grol R. & Buchan H. (2006) Clinical guidelines: what can we do to increase their use? *Medical Journal of Australia* 185(6), 301.

Grol R., Dalhuijsen J., Thomas S., Veld C., Rutten G. & Mokkink H. (1998) Attributes of clinical guidelines that influence use of guidelines in general practice: observational study. *British Medical Journal* 317(7162), 858-861.

Health Information and Quality Authority (2008) *Health Information and Quality Authority: Business Plan 2008*. HIQA, Dublin.

Health Service Executive (2009) *HSE National Service Plan 2009*. Retrieved on January 7, 2009 from http://www.hse.ie/eng/Publications/corporate/HSE_National_Service_Plan_2009.html

Hewitt-Taylor J. (2003) National recommendations and guidelines. *Journal of Nursing Management* 11(3), 158-163.

Hurwitz B. (2004) How does evidence based guidance influence determinations of medical negligence? *British Medical Journal* 329(7473), 1024-1028

Joint Commission on Accreditation of Healthcare Organizations (2000) *Selecting and Implementing Clinical Practice Guidelines in Hospitals.* JCAHP, Illinois.

Keeley P.W. (2003) Clinical Guidelines. *Palliative Medicine* 17(4), 368-374.

Maynard A. (2003) An economic approach to clinical governance. In *Clinical Governance and Best Value: Meeting the Modernisation Agenda* (Pickering S. & Thompson J. eds.) Churchill Livingstone, Edinburgh.

Mead P. (2000) Clinical guidelines: promoting clinical effectiveness or a professional minefield. *Journal of Advanced Nursing* 31(1), 110-116.

Mc Nicoll M., Layton A. & Morgan G. (1993) Team working: the key to implementing guidelines? *Quality and Safety in Healthcare* 2(4), 215-216.

Mc Sherry R. & Taylor S. (2003) Developing best practice. In *Clinical Governance and Best Value: Meeting the Modernisation Agenda* (Pickering S. & Thompson J. eds.) Churchill Livingstone, Edinburgh.

National Council for the Professional Development of Nursing and Midwifery (2006a) *Guidelines for Portfolio Development for Nurses and Midwives 2nd edn.* NCNM, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2006b) *Improving the Patient Journey: Understanding Integrated Care Pathways.* NCNM, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2006c) *Review of the Baseline Summary of Research Activity in Irish Nursing and Midwifery.* NCNM, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2007) *Criteria and Process for the Allocation of Continuing Education Funding.* NCNM, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2008a) *Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts.* Intermediate Pathway 3rdedn. NCNM, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2008b) *Framework for the Establishment of Advanced Nurse/Midwife Practitioner Posts 4th edn.* NCNM, Dublin.

National Council for the Professional Development of Nursing and Midwifery (2008c) *Accreditation of Advanced Nurse/Midwife Practitioners.* NCNM, Dublin.

National Institute for Health and Clinical Excellence (2007) About Clinical Guidelines. Retrieved on January 1, 2009 from www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice_and_the _nhs.jsp

New Zealand Guidelines Group (2001) *Handbook for the Preparation of Explicit Evidence – Based Clinical Practice Guidelines.* New Zealand Guidelines Group, Wellington.

Shekelle P., Woolf S.H., Eccles M. & Grimshaw J. (1999) Developing clinical guidelines. *Western Journal of Medicine* 170(6), 348-351.

Shekelle P., Eccles M.P., Grimshaw J.M & Woolf S.H. (2001) When should clinical guidelines be updated? *British Medical Journal* 323(7305), 155-157.

Shiffman R.N., Dixon J., Brandt C., Abdelwaheb E., Hsiao A., Michel G. & O'Connell R. (2005) The Guideline Implementability Appraisal (GLIA): development of an instrument to identify obstacles to guideline implementation. *BMC Medical Informatics & Decision Making* 5(23) http://www.biomedcentral.com/1472-6947/5/23

Sackett D.L., Rosenberg, W.M., Muir Gray J.A., Haynes B.R., Richardson W. S (1996) Evidence based medicine: what it is and what it isn't. *British Medical Journal* 312 (7023), 71.

Thomas L.H., Mc Coll E., Cullum N., Rousseau N. & Soutter J. (1999) Clinical guidelines in nursing , midwifery and the therapies: a systematic review. *Journal of Advanced Nursing* 30(1), 40-50.

Tuffnel D.J. (2002) Why clinical guidelines? A medical perspective. In *Clinical Guidelines: law, policy and practice* (Tingle J. & Foster C. eds.) Cavendish Publishing Ltd., London.

Vlayen J., Aertgeerts B., Hannes K., Sermeus W. & Ramaekers D. (2005) A systematic review of appraisal tools for clinical practice guidelines: multiple similarities and one common deficit. *International Journal for Quality in Healthcare* 17(3), 235-242.

Wilson J.H. (2002) Why clinical guidelines? A nursing perspective. In *Clinical Guidelines: law, policy and practice* (Tingle J. & Foster C. eds.) Cavendish Publishing Ltd., London.

Woolf S.H., Grol R., Hutchinson A., Eccles M. & Grimshaw J. (1999) Potential benefits, limitations, and harms of clinical guidelines. *British Medical Journal* 318(7182), 527-530.

Wright J. & Tuffnell D.J (2002) Implementing Clinical Guidelines. In *Clinical Guidelines: law, policy and practice* (Tingle J. & Foster C. eds.) Cavendish Publishing Ltd., London.

APPENDIX A

National Council Continuing Education Funding Examples

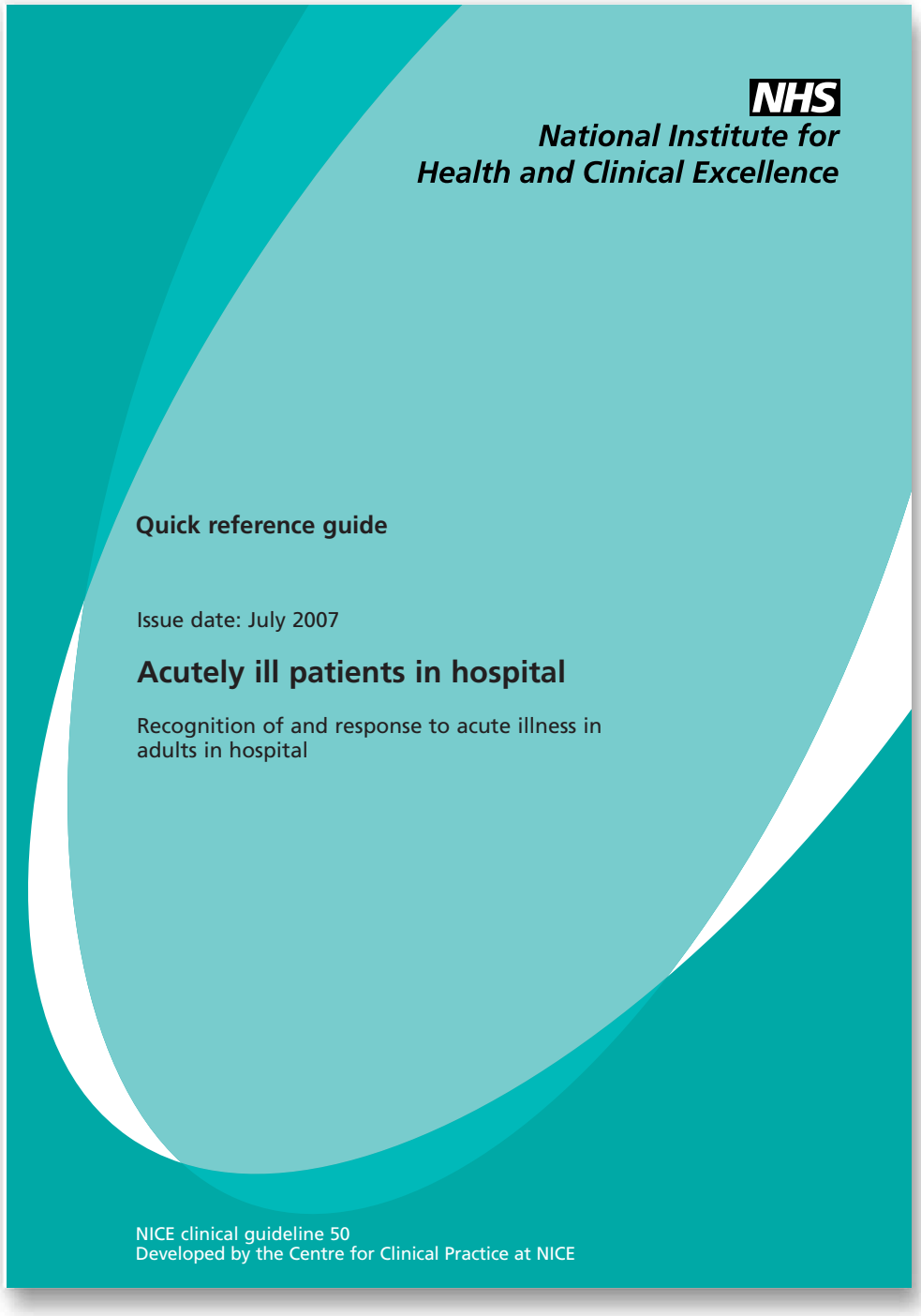
HSE NorthWest	Regional Approach to Policy & Guideline Development in Nursing & Midwifery	2003
HSE South	Protocol, Policy and Guideline Development for Practice Nurses	2004
HSE NorthEast	Policy, Procedure & Guideline Training Programme	2004
HSE SouthEast	Project to Facilitate the Process Of Guideline/Policy/Protocol Development/Dissemination/Implementation/Evaluation on a Regional Basis	2005
HSE East	National Programme Protocols, policies and guideline training for Professional Development Co-ordinator for Practice Nursing	2005
HSE North East	Policy, Procedure & Guideline Training Programme	2005
HSE SouthEast	Implementation of Community Nursing Practice Guidelines Policies and Procedures	2008

APPENDIX B

Examples of Clinical Practice Guidelines

National Institute for Health and Clinical Excellence (NICE)

Acutely ill Patients in Hospital. Quick Reference Guide. Recognition of and response to acute illness in adults in hospital.



Acutely ill patients in hospital

Contents

Introduction

Any patient in hospital may become acutely ill. However, the recognition of acute illness is often delayed and its subsequent management may be inappropriate. This may result in late referral and avoidable admissions to critical care, and may lead to unnecessary patient deaths, particularly when the initial standard of care is suboptimal.

The NICE clinical guideline makes evidence-based recommendations on the recognition and management of acute illness in acute hospitals. More information, including the evidence from which the recommendations were derived, is available from www.nice.org.uk/CG050

Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. If the patient agrees, carers and relatives should have the opportunity to be involved in decisions about treatment and care.

National Institute for Health and Clinical Excellence
MidCity Place
71 High Holborn
London
WC1V 6NA

www.nice.org.uk

ISBN 1-84629-440-1

This guidance is written in the following context

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

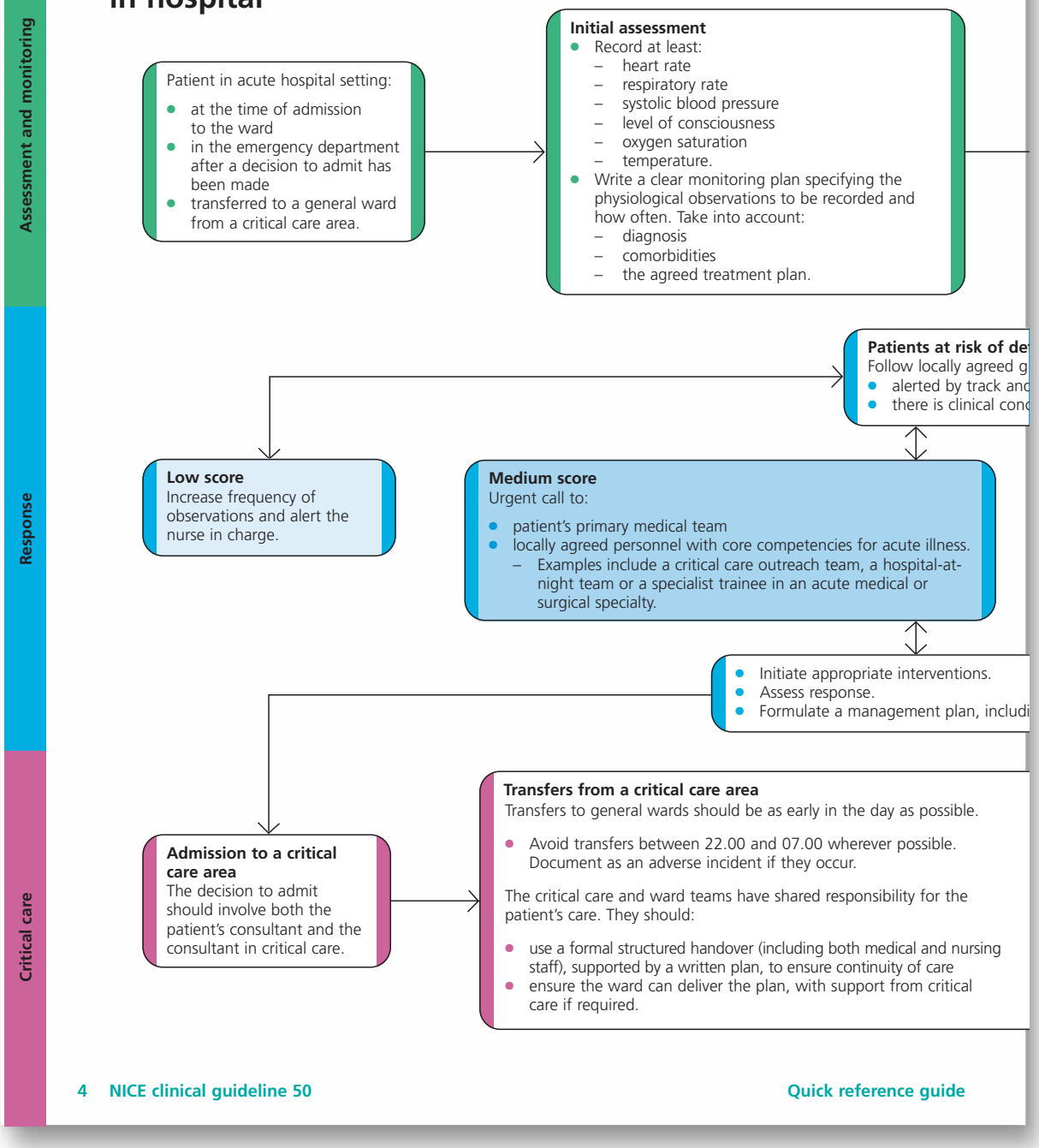
Key priorities for implementation

- Adult patients in acute hospital settings, including patients in the emergency department for whom a clinical decision to admit has been made, should have:
  - physiological observations recorded at the time of their admission or initial assessment
  - a clear written monitoring plan that specifies which physiological observations should be recorded and how often. The plan should take account of the:
    - patient's diagnosis
    - presence of comorbidities
    - agreed treatment plan.

  Physiological observations should be recorded and acted upon by staff who have been trained to undertake these procedures and understand their clinical relevance.
- Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings.
  - Physiological observations should be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.
  - The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy.
- Staff caring for patients in acute hospital settings should have competencies in monitoring, measurement, interpretation and prompt response to the acutely ill patient appropriate to the level of care they are providing. Education and training should be provided to ensure staff have these competencies, and they should be assessed to ensure they can demonstrate them.
- A graded response strategy for patients identified as being at risk of clinical deterioration should be agreed and delivered locally. It should consist of the following three levels.
  - Low-score group:
    - Increased frequency of observations and the nurse in charge alerted.
  - Medium-score group:
    - Urgent call to team with primary medical responsibility for the patient.
    - Simultaneous call to personnel with core competencies for acute illness. These competencies can be delivered by a variety of models at a local level, such as a critical care outreach team, a hospital-at-night team or a specialist trainee in an acute medical or surgical specialty.
  - High-score group:
    - Emergency call to team with critical care competencies and diagnostic skills. The team should include a medical practitioner skilled in the assessment of the critically ill patient, who possesses advanced airway management and resuscitation skills. There should be an immediate response.
- If the team caring for the patient considers that admission to a critical care area is clinically indicated, then the decision to admit should involve both the consultant caring for the patient on the ward and the consultant in critical care.

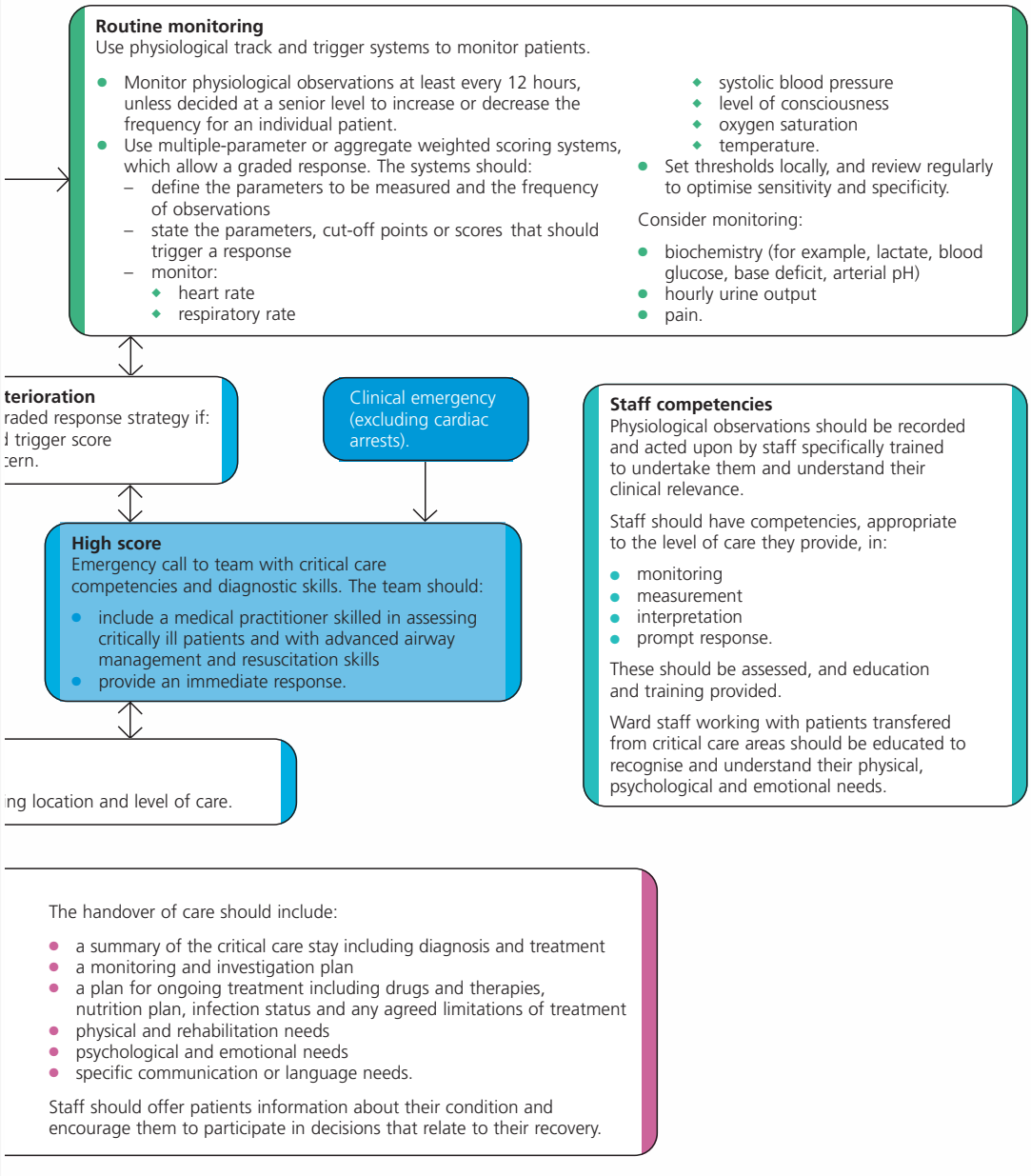
Continued on page 6

Recognition of and response to acute illness in adults in hospital



Acutely ill patients in hospital

Recognition of and response to acute illness in adults in hospital



NICE clinical guideline 50 Quick reference guide 5

Key priorities for implementation *continued*

- After the decision to transfer a patient from a critical care area to the general ward has been made, he or she should be transferred as early as possible during the day. Transfer from critical care areas to the general ward between 22.00 and 07.00 should be avoided whenever possible, and should be documented as an adverse incident if it occurs.
- The critical care area transferring team and the receiving ward team should take shared responsibility for the care of the patient being transferred. They should jointly ensure:
  - there is continuity of care through a formal structured handover of care from critical care area staff to ward staff (including both medical and nursing staff), supported by a written plan
  - that the receiving ward, with support from critical care if required, can deliver the agreed plan.

  The formal structured handover of care should include:
  - a summary of critical care stay, including diagnosis and treatment
  - a monitoring and investigation plan
  - a plan for ongoing treatment, including drugs and therapies, nutrition plan, infection status and any agreed limitations of treatment
  - physical and rehabilitation needs
  - psychological and emotional needs
  - specific communication or language needs.

Implementation

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/CG050).

- Slides highlighting key messages for local discussion.
- Implementation advice on how to put the guidance into practice and national initiatives which support this locally.
- Costing tools:
  - costing report to estimate the national savings and costs associated with implementation
  - costing template to estimate the local costs and savings involved.
- Audit criteria to monitor local practice.

Further information

Ordering information

You can download the following documents from www.nice.org.uk/CG050

- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – information for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and summaries of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone the NHS Response Line on 0870 1555 455 and quote:

- N1287 (quick reference guide)
- N1288 ('Understanding NICE guidance').

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see the website (www.nice.org.uk).

- Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition. NICE clinical guideline 32 (2006). Available from: www.nice.org.uk/CG032

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be posted on the NICE website (www.nice.org/CG050).

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital (NICE clinical guideline 50).

Who should read this booklet?

This quick reference guide is for nurses, doctors, therapists and other staff who care for acutely ill patients. It contains what you need to know to put the guideline's recommendations into practice.

Who wrote the guideline?

The guideline was developed by the Centre for Clinical Practice at NICE following the short clinical guideline process. The Centre worked with an independent group of healthcare professionals (including consultants from relevant specialties and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk

Where can I get more information about the guideline on acutely ill patients in hospital?

The NICE website has the recommendations in full with summaries of the evidence they are based on, a summary of the guideline for patients and carers, and tools to support implementation (see inside back cover for more details).

National Institute for
Health and Clinical Excellence
MidCity Place
71 High Holborn
London
WC1V 6NA

www.nice.org.uk

N1287 1P 50k Jul 07

ISBN 1-84629-440-1

Scottish Intercollegiate Guidelines Network (SIGN)

Management of patients with dementia. Quick Reference Guide. This guide provides a summary of the main recommendations in the SIGN guideline on Management of Patients with Dementia.

SIGN
Scottish Intercollegiate Guidelines Network

NHS Quality Improvement Scotland

86 Management of patients with dementia
Quick Reference Guide

February 2006

COPIES OF ALL SIGN GUIDELINES ARE AVAILABLE ONLINE AT WWW.SIGN.AC.UK

MINI-MENTAL STATE EXAMINATION (MMSE)

Patient_____ Date_____

Examiner _____

Maximum	Score	
		Orientation
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we (state) (country) (town) (hospital) (floor)?
		Registration
3	( )	Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _____
		Attention and Calculation
5	( )	Serial 7s: 1 point for each correct answer. Stop after 5 answers. Alternatively spell 'world' backward. (Do both and take the best score)
		Recall
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct answer.
		Language
2	( )	Name a pencil and watch.
1	( )	Repeat the following 'No ifs, ands, or buts'
3	( )	Follow a 3-stage command: 'Take a paper in your hand, fold it in half, and put it on the floor.'
1	( )	Read and obey the following: CLOSE YOUR EYES
1	( )	Write a sentence.
1	( )	Copy the design shown.

Total Score _____

ASSESS level of consciousness along a continuum _____
Alert Drowsy Stupor Coma

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on **Management of patients with dementia.**

Recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

INFORMATION FOR PATIENTS AND CARERS

C **Patients and carers should be offered information tailored to the patient's perceived needs.**

C **Healthcare professionals should be aware that:**
- **many people with dementia can understand this diagnosis, receive information and be involved in decision making**
- **some people with dementia may not wish to know their diagnosis**

D
- **in some situations disclosure of a diagnosis of dementia may be inappropriate.**

☑
- The wishes of the person with dementia should be upheld at all times.
- The diagnosis of dementia should be given by a health care professional skilled in communication or counselling.
- Where diagnosis is not disclosed there should be a clear record of the reasons.
- Patients and carers should be provided with information about the services and interventions available to them at all stages of the patient's journey of care.
- Information should be offered to patients and carers in advance of the next stage of the illness.

SOURCES OF FURTHER INFORMATION

Alzheimer Scotland – Action on Dementia
22 Drumsheugh Gardens, Edinburgh EH3 7RN
Tel: 0131 243 1453 • 24 hour freephone helpline 0808 808 3000
Website: www.alzscot.org.uk

Age Concern Scotland
Causewayside House, 160 Causewayside, Edinburgh, EH9 1PR
Tel: 0845 833 0200 • Fax: 0845 833 0759
Email: enquiries@acscot.org.uk •
Website: www.ageconcernscotland.org.uk

Help the Aged in Scotland
11 Cranton Square, Edinburgh, EH5 1HX
Tel: 0131 551 6331 • Email: infoscot@helptheaged.org.uk

Mental Health Foundation Scotland
5th Floor, Merchants House, 30 George Square, Glasgow, G2 1EG
Tel: 0141 572 0125
Email: Scotland@mhf.org.uk • Website: www.mentalhealth.org.uk

ABBREVIATIONS

DSM-IV	Diagnostic and Statistical Manual, 4th edition
MMSE	Mini-Mental State Examination
NINCDS-ADRDA	National Institute of Neurologic, Communicative Disorders and Stroke–AD and related Disorders Association
NINDS-AIRENS	National Institute of Neurological Disorders and Stroke Association Internationale pour la Recherche et l'Enseignement en Neurosciences
SPECT	single photon emission controlled tomography

DIAGNOSIS

B — **DSM-IV or NINCDS-ADRDA criteria should be used for the diagnosis of Alzheimer's disease.**

B — **The Hachinski Ischaemic Scale or NINDS-AIRENS criteria may be used to assist in the diagnosis of vascular dementia.**

C — **Diagnostic criteria for dementia with Lewy bodies and fronto-temporal dementia should be considered in clinical assessment.**

INITIAL COGNITIVE TESTING

B — **In individuals with suspected cognitive impairment, the MMSE should be used in the diagnosis of dementia.**

☑ — Initial cognitive testing can be improved by the use of Addenbrooke's Cognitive Examination.

SCREENING FOR COMORBID CONDITIONS

☑ — Physical investigations including laboratory tests should be selected on clinical grounds according to history and clinical circumstances.

B — **As part of the assessment for suspected dementia, the presence of comorbid depression should be considered.**

THE USE OF IMAGING

C — **Structural imaging should ideally form part of the diagnostic workup of patients with suspected dementia.**

C — **SPECT may be used in combination with CT to aid the differential diagnosis of dementia when the diagnosis is in doubt.**

NEUROPSYCHOLOGICAL TESTING

B — **Neuropsychological testing should be used in the diagnosis of dementia, especially in patients where dementia is not clinically obvious.**

NON-PHARMACOLOGICAL INTERVENTIONS

BEHAVIOUR MANAGEMENT

B — **Behaviour management may be used to reduce depression in people with dementia.**

CAREGIVER INTERVENTION PROGRAMMES

B — **Caregivers should receive comprehensive training on interventions that are effective for people with dementia.**

COGNITIVE STIMULATION

B — **Cognitive stimulation should be offered to individuals with dementia.**

MULTISENSORY STIMULATION AND COMBINED THERAPIES

☑ — For people with moderate dementia who can tolerate it, multisensory stimulation may be a clinically useful intervention.

☑
- Multisensory stimulation is not recommended for relief of neuropsychiatric symptoms in people with moderate to severe dementia.
- Bright light therapy is not recommended for the treatment of cognitive impairment, sleep disturbance or agitation in people with dementia.
- In people with dementia who show behavioural disturbance despite the use of psychotropic medication, aromatherapy may influence behaviour but cannot be recommended as a direct alternative to antipsychotic drugs, nor for the reduction of specific behavioural problems.
- The use of aromatherapy to reduce associated symptoms in people with dementia should be discussed with a qualified aromatherapist who can advise on contraindications.

RECREATIONAL AND PHYSICAL ACTIVITIES

B — **Recreational activities should be introduced to people with dementia to enhance quality of life and well-being.**

☑ — For people with dementia a combination of structured exercise and conversation may help maintain mobility.

REALITY ORIENTATION THERAPY

D — **Reality orientation therapy should be used by a skilled practitioner, on an individualised basis, with people who are disorientated in time, place and person.**

PHARMACOLOGICAL INTERVENTIONS

CHOLINESTERASE INHIBITORS

B — **Donepezil, at daily doses of 5 mg and above can be used:**
- **to treat cognitive decline in people with Alzheimer's disease**
- **for the management of associated symptoms in people with Alzheimer's disease**

B — **Galantamine, at daily doses of 16 mg and above can be used:**
- **to treat cognitive decline in people with Alzheimer's disease and people with mixed dementias**
- **for the management of associated symptoms in people with Alzheimer's disease.**

B — **Rivastigmine, at daily doses of 6mg and above can be used:**
- **to treat cognitive decline in people with Alzheimer's disease**
- **to treat cognitive decline in people with dementia with Lewy bodies**
- **for the management of associated symptoms in people with Alzheimer's disease and dementia with Lewy bodies**

ANTIPSYCHOTICS

A — **If necessary, conventional antipsychotics may be used with caution, given their side effect profile, to treat the associated symptoms of dementia.**

☑
- An individualised approach to managing agitation in people with dementia is required.
- Atypical antipsychotics with reduced sedation and extrapyramidal side effects may be useful in practice, although the risk of serious adverse events such as stroke must be carefully evaluated.
- In patients who are stable antipsychotic withdrawal should be considered.
- Where antipsychotics are inappropriate cholinesterase inhibitors may be considered.

ANTIDEPRESSANTS

D — **Antidepressants can be used for the treatment of comorbid depression in dementia providing their use is evaluated carefully.**

☑ — Trazodone may be considered for patients with depressive symptoms and dementia associated agitation.

HERBAL MEDICINES

☑
- People with dementia who wish to use *Ginkgo biloba* should consult a qualified herbalist for advice and should be made aware of possible interactions with other prescribed drugs.
- People with dementia who wish to use *Salvia officinalis* should consult a qualified herbalist for advice.

APPENDIX C

Useful Websites

The following is a suggested list of interesting internet sites to assist with the development of clinical practice guidelines. This list is by no means exhaustive and reading widely on the subject is encouraged. Terms used in searching these websites should include: clinical practice guidelines, clinical pathway, evidence based practice, algorithms of care, clinical protocols, guideline development, guideline implementation.

http://www.aetna.com/about/cov_det_policies.html
Aetna clinical policy bulletins.

http://www.ahrq.gov/clinic/index.html#online
Agency for Healthcare Research and Quality (AHRQ).

http://www.agreecollaboration.org/
Agree is an international collaboration of researchers and policy makers who seek to improve the quality and effectiveness of clinical practice guidelines by establishing a shared framework for their development, reporting and assessment. The group includes core European countries, Canada, New Zealand and the USA.

http://www.aqumed.de/
AQuMed was established in 1995 in order to appraise, initiate, and organise national and regional health quality programmes on behalf of the self-governing bodies of the German healthcare system in cooperation with national and international partners.

http://www.cchsa.ca
Canadian Council on Health Services Accreditation.

http://www.cochranelibrary.com/clibhome/clib.htm
Cochrane Collaboration – evidence-based medicine databases.

http://www.cma.ca
The Canadian Medical Association publishes a number of guidelines.

http://www.crd.york.ac.uk/CRDWeb/
Database of Abstracts of Reviews of Effectiveness (DARE)

http://www.ebmny.org/cpg.html
Evidence-based Medicine Resource Center with a link to a National Guideline Clearinghouse, an alphabetical listing of clinical guidelines by agency and subjects.

http://embase.com
EMBASE.com is a biomedical and pharmacological bibliographic database, which provides access to the most up-to-date citations and abstracts from biomedical and drug literature via EMBASE and Medline.

http://www.eguidelines.co.uk
The eGuidelines website contains comprehensive and practical information for clinical effectiveness.

http://www.e-p-a.org/
European Pathway Association is an international network of clinical pathway/ care pathway networks, user groups, academic institutions, supporting organisations and individuals who want to support the development, implementation and evaluation of clinical / care pathways.

http://www.esqh.net/
European Society for Quality in Healthcare is a not-for-profit organisation dedicated to the improvement of quality in European healthcare. It consists of European members, all of whom are National Societies for Quality in Healthcare.

http://www.fnrh.freeserve.co.uk/
Forensic nursing resource homepage.

http://www.guideline.gov
The National Guideline Clearinghouse – American site for guideline distribution.

http://gain-ni.org
In August 2007 RMAG, NIRAAC and CREST became the Guidelines and Audit Implementation Network (GAIN) and will keep regional audit and guidelines in the forefront of service improvement.

http://health.nih.gov/
National Institutes of Health (NIH) – health information index, United Kingdom Department of Health and Human Services.

http://www.hiqa.ie/
The Health Information and Quality Authority was established in May 2007 as part of the government's health reform programme and is committed to operating to the highest standards of corporate governance.

http://www.isqua.org/
The International Society for Quality in Healthcare, is a non-profit, independent organisation with members in more than 70 countries. ISQua works to provide services to guide health professionals, providers, researchers, agencies, policy makers and consumers to achieve excellence in healthcare delivery to all people, and to continuously improve the quality and safety of care.

http://www.intute.ac.uk/healthandlifesciences/nursing/
A guide to Internet resources in nursing, midwifery and allied health professionals.

http://www.joannabriggs.edu.au/
The Joanna Briggs Institute brings together a range of practice-orientated research activities to improve the effectiveness of clinical practice and healthcare outcomes.

http://www.library.nhs.uk
NHS National Electronic Library for Health, with guideline collection.

http://www.medic8.com/ClinicalGuidelines.htm
United Kingdom medical search engine and health website directory.

http://mdm.ca/cpgsnew/cpgs/index.asp
The Clinical Practice Guidelines, Canadian Medical Association InfoBase has a list of clinical practice guidelines and developers providing full-text access to guidelines. Examples of links: Alberta Clinical Practice Program, Canadian Asthma Consensus Group, Canadian Paediatric Society, Canadian Society of Nephrology, Guidelines and Protocols Advisory Committee and Health Canada.

http://www.mja.com.au/public/guides/guides.html
Clinical guidelines published by the Medical Journal of Australia represent the consensus opinion of experts based on review of scientific literature. Topics include: Cardiology, Endocrinology, General Medicine, Geriatrics, Haematology, Immunology and Allergy, Infectious Diseases, Nutrition, Obstetrics and Gynaecology and Women's Health Paediatrics, Psychiatry, Respiratory Medicine and Rheumatology.

http://www.nhmrc.gov.au
Australian Government National Health and Medical Research Council has a guide to the development, implementation and evaluation of clinical practice guidelines.

http://www.nice.org.uk
National Institute for Health and Clinical Excellence, United Kingdom.

http://nurseweb.ucsf.edu/www/arwwebpg.htm
Internet resources for nurse practitioners including health information gateways, clinical practice guidelines and evidence based healthcare.

http://www.nzgg.org.nz
New Zealand Guidelines Group provides access to guidelines and tools for development.

http://www.ottawahospital.on.ca/hp/dept/nursing/pathways/index-e.asp
Clinical Pathways – Ottawa General Hospital.

http://www.psychguides.com/
Expert consensus guidelines series presents practical clinical recommendations based on a wide survey of

expert opinion.

http://www.rcn.org.uk
The Royal College of Nursing United Kingdom.

http://www.rmlibrary.com/sites/medclini.htm
Resource library with medical clinical guidelines.

http://www.rsmpress.co.uk/jicp.htm
The Royal Society of Medicine Press Limited, link to the Journal of Integrated Care Pathways.

http://www.shef.ac.uk/~scharr/ir/guidelin.html
Links with a number of sites that provide examples of guidelines or a description of guideline development methodologies.

http://www.sign.ac.uk/
Scottish Intercollegiate Guidelines Network was set up to encourage the development and dissemination of clinical guidelines.

http://www.tg.com.au/home/index.html
Therapeutic Guidelines Limited derives guidelines for therapy from the latest worldwide literature, interpreted by Australian experts. All therapeutic guidelines are available on a subscription basis.

http://www.uic.edu/depts/lib/lhsp/resources/guidelines.shtml
Provides links for clinical practice and prevention guidelines.

http://www.york.ac.uk/inst/crd/ehcb.htm
The Centre for Reviews and Dissemination is a department of the University of York and is part of the National Institute for Health Research.
CRD undertakes high quality systematic reviews that evaluate the effects of health and social care interventions and the delivery and organisation of healthcare.

Disclaimer

The National Council for the Professional Development of Nursing and Midwifery does not accept liability for any injury, loss or damage incurred by use of or reliance on the information. The National Council for the Professional Development of Nursing and Midwifery cannot guarantee and assumes no legal liability or responsibility for the accuracy, currency or completeness of the information on the websites listed. It is the responsibility of the user to make their own decisions about accuracy, currency, reliability and correctness of information contained on the sites listed. These websites or linkage to other websites should not be taken as an endorsement or a recommendation of any content, products or services.

Notes

National Council for the
Professional Development
of **Nursing** *and* **Midwifery**

An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

National Council for the Professional Development of Nursing and Midwifery
6-7 Manor Street Business Park, Manor Street, Dublin 7

T: 353 1 882 5300. F: 353 1 868 0366.

e: admin@ncnm.ie w: www.ncnm.ie