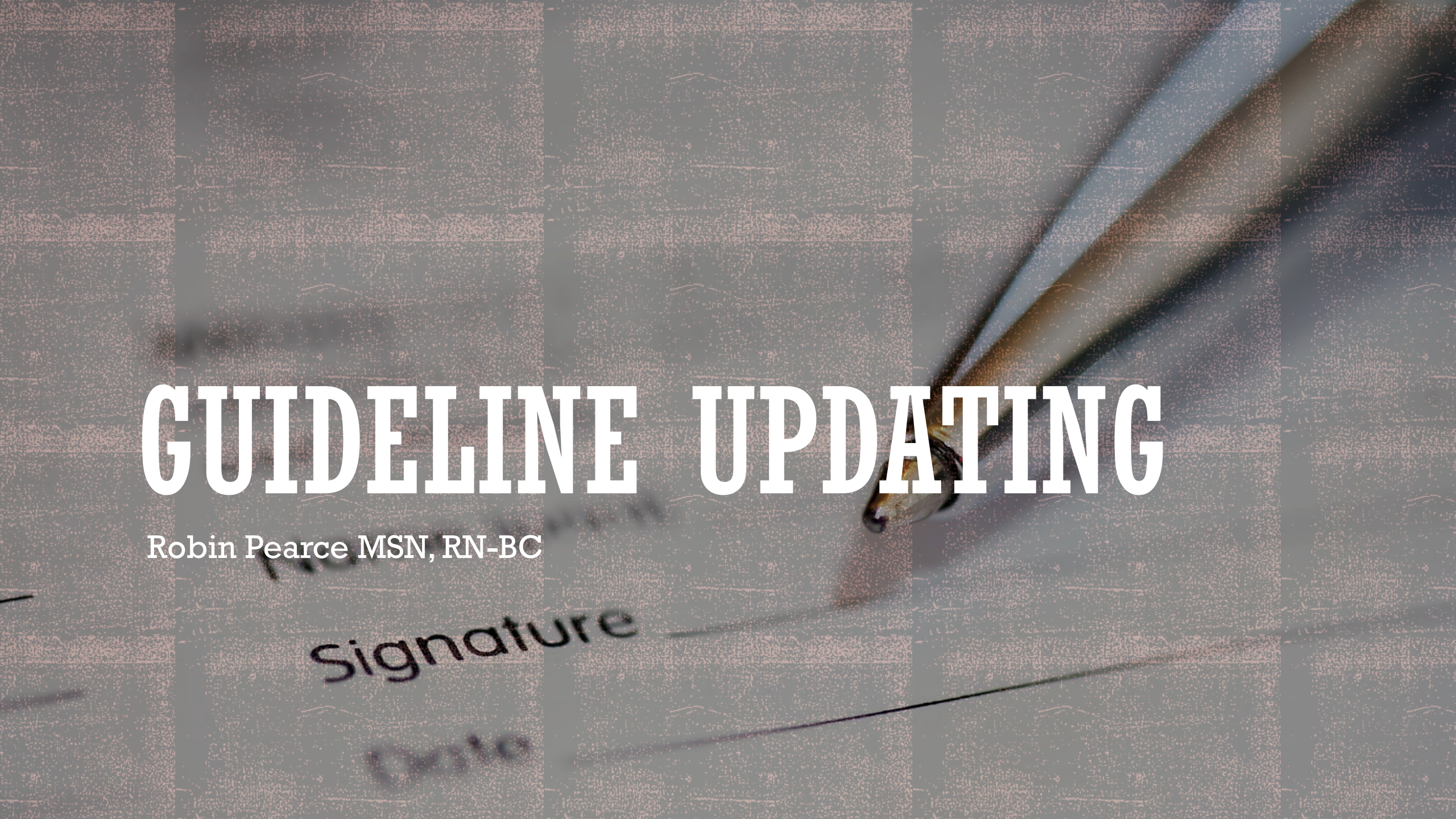
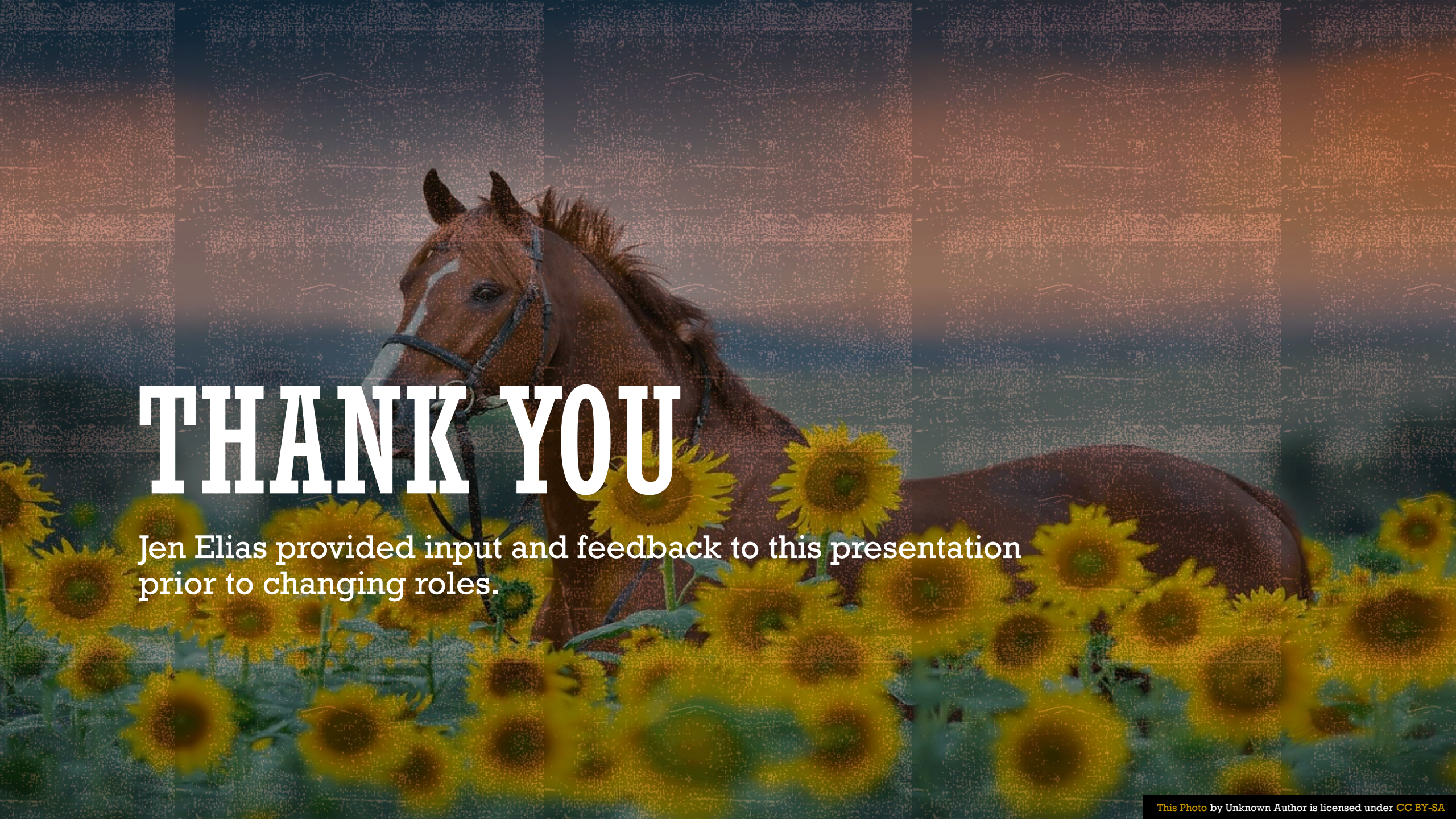


GUIDELINE UPDATING

Robin Pearce MSN, RN-BC



THANK YOU

Jen Elias provided input and feedback to this presentation prior to changing roles.

THE GRAY BOOK SAYS,

- All trauma centers must have evidence-based clinical practice guidelines, protocols, or algorithms that are reviewed at least every three years.
- Clinical practice guidelines, protocols or algorithms may be developed or revised in response to new evidence or *opportunities for improvement*.
- Clinical practice guidelines provide an opportunity to standardize practice, which facilitates training, allows for auditing of practices, and tends to improve the quality of care.

HOW DO I DECIDE WHERE TO START?

- Where are your PI issues?
  - Geriatric patients
  - Rib fracture patients
  - DVT/PE events
- Patient Complaints?
  - Pain management
  - Length of stay
  - Delays in treatment

DIG A LITTLE DEEPER

- For example: in your TQIP data you are under performing in your TBI patient cohorts:
  - Age of patients
  - Time to monitoring
  - Time to anticoagulation
  - Mortality

HIT THE SEARCH ENGINE

- Look for best practice/research articles on your area of concern
  - Six years is too old
  - Use the screening tools
  - Size matters
  - Variety is a good thing

Levels of Evidence

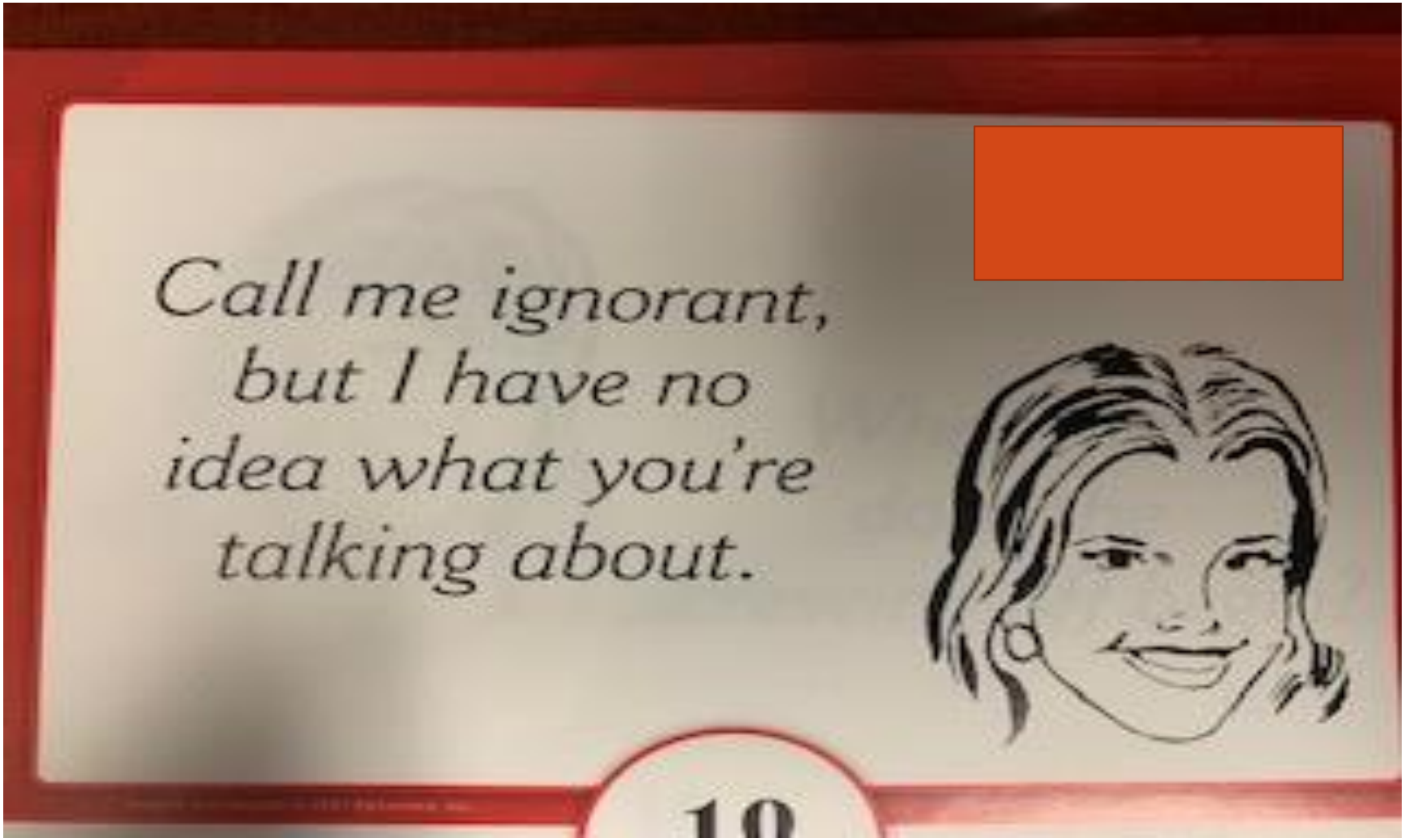
Level of evidence (LOE)	Description
Level I	Evidence from a systematic review or meta-analysis of all relevant RCTs (randomized controlled trial) or evidence-based clinical practice guidelines based on systematic reviews of RCTs or three or more RCTs of good quality that have similar results.
Level II	Evidence obtained from at least one well-designed RCT (e.g. large multi-site RCT).
Level III	Evidence obtained from well-designed controlled trials without randomization (i.e. quasi-experimental).
Level IV	Evidence from well-designed case-control or cohort studies.
Level V	Evidence from systematic reviews of descriptive and qualitative studies (meta-synthesis).
Level VI	Evidence from a single descriptive or qualitative study.
Level VII	Evidence from the opinion of authorities and/or reports of expert committees.

Table 1. Modified presentation of the Oxford Centre for Evidence-Based Medicine levels of evidence [5].

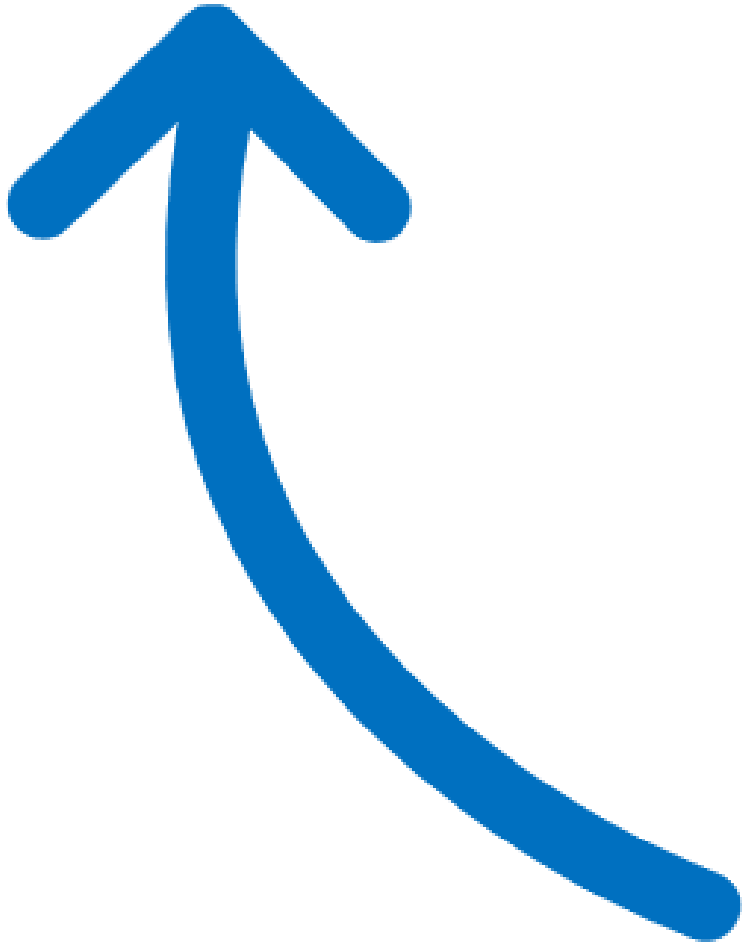
Grade of Recommendation	Level of Evidence	Type of Study
A	1a	SR (with homogeneity) of RCTs and of prospective cohort studies
	1b	Individual RCT with narrow confidence interval, prospective cohort study with good followup
	1c	All or none studies, all or none case series
B	2a	SR (with homogeneity) of cohort studies
	2b	Individual cohort study
	2c	Outcomes research, ecological studies
	3a	SR of case control studies, SR of 3b and better studies
	3b	Individual case control study, nonconsecutive cohort study
C	4	Case series/case report, poor quality cohort studies
D	5	Expert opinion, bench research

Table 2. Similarities between the SORT and OCEBM grading systems.

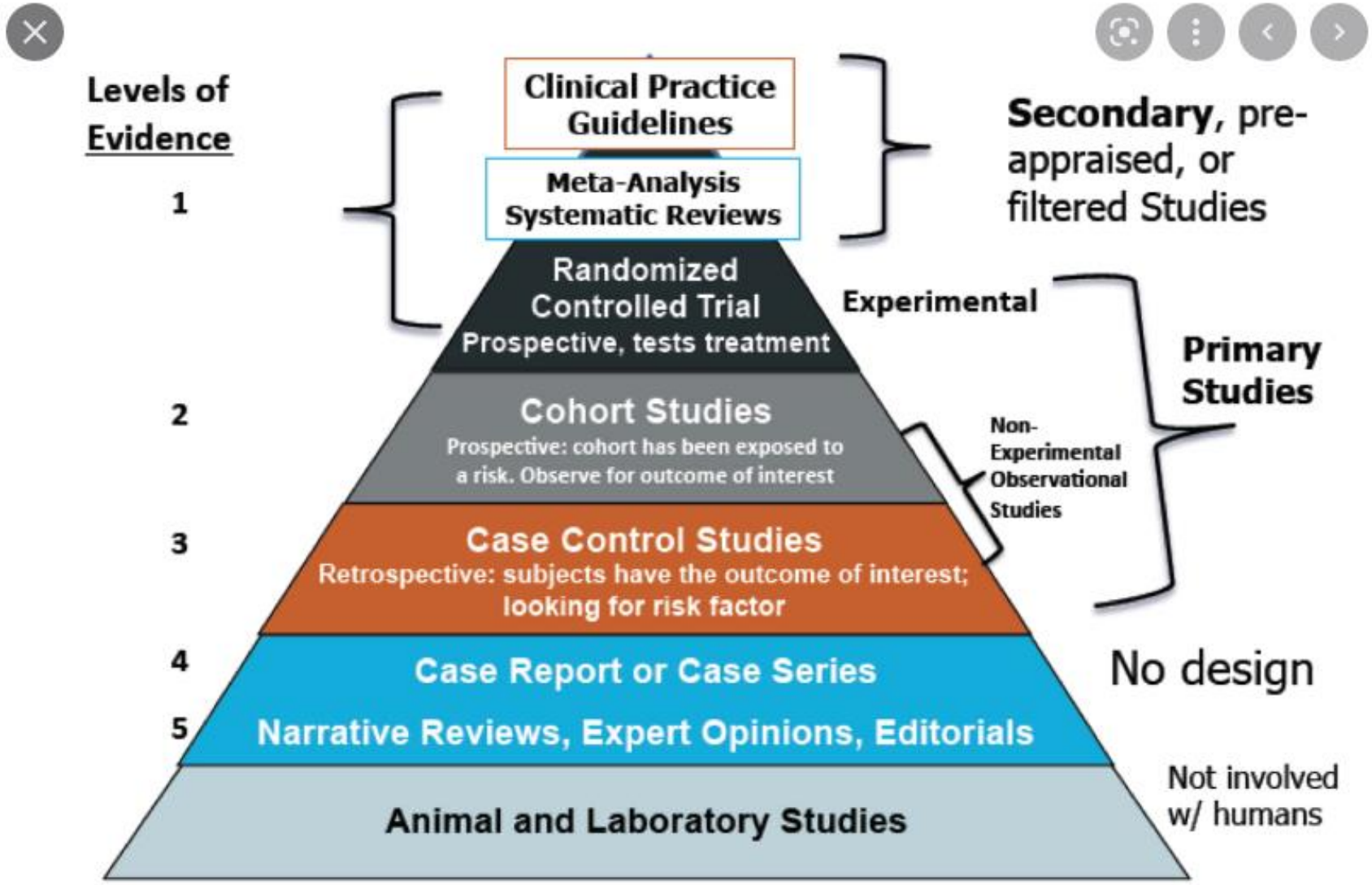
Grading System		
	SORT*	OCEBM**
A	Recommendation based on consistent and good quality patient-oriented evidence	Consistent level 1 studies
B	Recommendation based on inconsistent or limited-quality patient oriented evidence	Consistent level 2 or 3 studies or extrapolations from level 1 studies
C	Recommendation based on consensus, usual practice, disease-oriented evidence, case series for studies of treatment or screening, and/or opinion	Level 4 studies or extrapolations from level 2 or 3 studies
D		Level 5 evidence or troublingly inconsistent or inconclusive studies of any level


Call me ignorant,
but I have no
idea what you're
talking about.

Level One Evidence-
The BEST



Level V-IV Evidence-Not the Strongest


Levels of Evidence
1
2
3
4
5
Clinical Practice Guidelines
Meta-Analysis Systematic Reviews
Randomized Controlled Trial
Prospective, tests treatment
Cohort Studies
Prospective: cohort has been exposed to a risk. Observe for outcome of interest
Case Control Studies
Retrospective: subjects have the outcome of interest; looking for risk factor
Case Report or Case Series
Narrative Reviews, Expert Opinions, Editorials
Animal and Laboratory Studies
Secondary, pre-appraised, or filtered Studies
Experimental
Non-Experimental Observational Studies
Primary Studies
No design
Not involved w/ humans

AVAILABLE ACS CLINICAL PRACTICE GUIDELINES

- Acute Pain Management in Trauma Patients
- Child Abuse, Elder Abuse and Intimate Partner Violence
- Geriatric Trauma Management
- Imaging Guidelines
- Management of Orthopaedic Trauma
- Management of Traumatic Brain Injury
- Massive Transfusion in Trauma
- Palliative Care
- Spine Injury (This is new and has come out in the last couple of months)

https://www.facs.org/quality-programs/trauma/tqp/center-programs/tqip/best-practice

GERIATRIC GUIDELINE UPDATE

- Suggested resources:
  - *Resources for Optimal Care of the Injured Patient 2022 Standards*
  - Best Practices Guideline for Acute Pain Management in Trauma Patients
  - Best Practices Guidelines for Trauma Center Recognition of Child Abuse, Elder Abuse, and Intimate Partner Violence
  - Geriatric Trauma Management
  - Imaging Guidelines
  - Management of Orthopaedic Trauma
  - Best Practices in the Management of Traumatic Brain Injury
  - Palliative Care Best Practices Guidelines

I HAVE A STACK OF ARTICLES, NOW WHAT?

- Compare the best practice articles and/or literature to your current guidelines
- Are there areas where you have gaps or outdated information?
- Are the areas that are deficient potentially impacting your PI?
- Review with your TMD

ANOTHER LAYER OF REVIEW

- ACS documents with gap analysis built in
  - Best Practices Guidelines for Acute Pain Management in Trauma Patients
  - Child Abuse, Elder Abuse, and Intimate Partner Violence*
  - Best Practices for Palliative Care
  - Best Practice Guidelines: Spine Injury

Table 18. Pain Management Gap Analysis

Pain Management Review	Met	Partially Met	Unmet	Priority	Comments
Regulatory requirements and recommendations are met and are consistent with the patient's age, condition, and ability to understand.					
Pain management recommendations are in place and contemporary.					
Pain management guidelines are in place and consistent with the patient population needs.					
Pain assessment documentation is consistent for patient population's pain level assessment.					
Pain assessment and reassessment expectations are defined.					

IS THE DEFICIENCY AFFECTING OUTCOMES?

Yes

- Write up a draft
- Liaison review
- Operations review
- Formalize update
  - Make sure to have PI indicators built in!
- Follow your facilities review process
- Update the date of review on the policy

No

- Write up a summary of the articles reviewed
- Document why no changes are needed
- Have a folder for review information that you can pull out for site review if needed
- Update the date of review on the policy
- Check your references

NEW GUIDELINE-NOW WHAT?

Do you need new equipment or processes to support your guideline?

Having these things in place prior to the roll out will help with compliance.

The impacted team members need education

Documentation of the education is a must.

Don't forget your providers!

Monitor your built in PI metrics

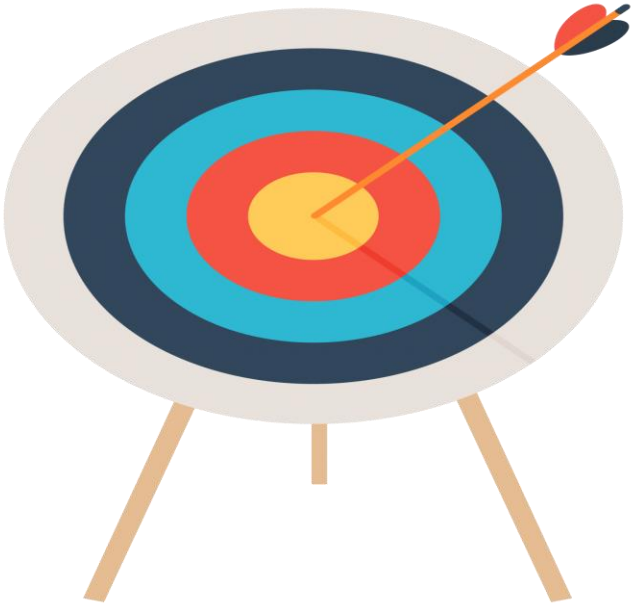
Do you need to tweak your guideline?

Were there groups or individuals that were impacted that you missed?

METRIC REVIEW

Hit the target?

- Wonderful! Please buy a lottery ticket



Missed the target?

- Do you need additional education?
- Do you need a different type of education?
- Are you monitoring the wrong metric?
- Are your providers not supporting the change?

SUGGESTIONS FOR SUCCESS

Start small and hopefully with your passion

Get buy-in from your TMD

If it impacts any other service line or ancillary group involve them from the start

Get your team together-no slugs allowed

Use a project plan or your operations meeting minutes to keep people on track

Use your data to help with buy-in

QUESTIONS?

WANT TO GET INVOLVED?
ROBIN.PEARCE@HEALTHONECARES.COM