W24: ICS Core Curriculum (Free): Implementation of evidence based practice for continence care in developing worlds

Workshop Chair: Sakineh Hajebrahimi, Iran

04 September 2019 11:00 - 12:30

Start	End	Topic	Speakers
11:00	11:05	introduction	Sakineh Hajebrahimi
11:05	11:25	quality and level of evidence for continence care	Sajjad Rahnama'i
11:25	11:45	practical guideline adaptation for developing countries	Morteza Ghojazaheh
11:45	12:05	Implementation of the best evidence framework for developing worlds	Sakineh Hajebrahimi
12:05	12:25	evaluation and clinical audit	Kate Sloane
12:25	12:30	Questions	All

Aims of Workshop

Aim: to support health service staff in the adaptation and implementation of national evidence-based clinical guidelines .

Objectives:

- Provide training and capacity building for health service staff in recognition of the best evidence and adaptation of guidelines.
- Up-skill and support staff with the implementation of clinical guidelines using an evidence-based and effective approach.

- Provide workshops for guideline adaption groups to assist them in planning implementation of their clinical guidelines using templates, tools and resources.

- Provide practical support and resources for health service staff.

Learning Objectives

Overview and introduction to implementation science.

Target Audience

Urology, Urogynaecology, Conservative Management

Advanced/Basic

Intermediate

Suggested Learning before Workshop Attendance

http://health.gov.ie/national-patient-safety-office/ncec/

http://joannabriggs.org/education

Introduction

Sakineh Hajebrahimi professor of urology from Tabriz University of Medical Sciences and research center for EBM , Iran and Sajjad Rahnama'i, assistant professor of urology department of Maastricht University, Netherland, Urologist at Uniklinik RWTH,Aachen-Germany

Urinary incontinence, the involuntary loss of urine, is a highly prevalent condition worldwide. The common types of urinary incontinence in older people are stress incontinence and urge incontinence. Stress incontinence is the involuntary leaking of urine during efforts or exertion, or while sneezing or coughing. Urge incontinence, or overactive bladder syndrome, involves a constellation of symptoms including frequency, urgency and leakage immediately preceded by urgency. The prevalence of urinary incontinence reported in population-based studies ranges from 9.9% to 36.1%. Based on our recent systematic review, prevalence of urinary incontinence in the developing world ranged from 2.8 in Nigeria to 57.7 in Iran. Factors that influence the change in prevalence are a key area of interest, and knowledge of these would provide the opportunity for an appropriate planning for preventive, primary and secondary care programs. Following five steps is defined for identification and clarification of the practice problem or issues:

i) Find and select the appropriate knowledge that provides solution for the identified issues (e.g. Guidelines).
ii) Adapt the knowledge to the local practice and system.
iii) Assess local barriers and facilitating factors of knowledge use.
iv) Select implement interventions to promote knowledge use.
v) Monitor the uptake, evaluate the impact of using the knowledge, and sustain knowledge use.

This workshop will focus on these 5 steps to introduce practical ways for promoting of the continence care in developing world.

Quality and level of evidence for continence care

Sajjad Rahnama'i, assistant professor of urology department of Maastricht University, Netherland,urologist at Uniklinik RWTH,Aachen-Germany

While medicine has many facets, including direct patient care, public health, and research endeavors, the common goal of all medical ventures is improving the quality of patients' lives. This common underlying goal can serve as the "destination" to guide all medical journeys and endeavors, regardless of which facet or field of medicine is the stage for the patient's medical journey. In 1996, David Sackett, defined evidence-based medicine (EBM) as *the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.*

Ideally clinical decision making should be founded on the highest level of evidence available. Conceptually, evidence starts simply with what is observed. Every individual observation is an isolated piece of evidence. To generate higher quality evidence, however, it is important to compile, organize, and evaluate those individual observations in a systematic way. Thus, while an anecdotal observation constitutes evidence regarding a single event, a more organized compilation of several observed events can constitute a case series, a higher level of evidence. An even more organized way to evaluate an event or an intervention is to use systematic observation, as in an uncontrolled or controlled trial. A meta-analysis provides even higher quality evidence by systematically grouping together and synthesizing the results of multiple trials. Thus, the more systematic the approach that is taken to gathering and organizing evidence, ranging from the individual anecdote up to the meta-analysis of controlled trials, the higher quality the evidence Kristy M. et al. in 2007 reported that only 3 of 10 published urological studies provided high levels of evidence and only approximately 1 of 20 met the criteria for level I evidence. Guidelines can have different purposes, dealing with clinical questions such as intervention, diagnosis, prognosis, aetiology and screening. To

address these clinical questions adequately, guideline developers need to include different research designs. This consequently requires different evidence hierarchies that recognise the importance of research designs relevant to the purpose of the guideline.In this workshop we will report the level and source of the evidences that is used in the 19 recent guidelines for incontinence. Furthermore in a simple search in Trip database from 2860 retrieved documents since 2013, only 51 is from LMICs. None of the developed guidelines is from developing world. We will discuss more about quality of the evidences in continence care.

Practical guideline adaptation for developing countries

Morteza Ghojazaheh, associate professor physiology and medical statistician, *Tabriz University of Medical Sciences, Iran*

A clinical practice guideline is defined as "systematically developed statements to assist practitioner and patient decisions on appropriate health care for specific clinical circumstances." It is seen as a way to translate evidence from research to clinical practice, and its production and utilization are remarkably increased during the past few decades.

One of the many benefits of guidelines is to improve the consistency of care. To ensure the quality of the guidelines, transparency on the development process is considered crucial, in particular a rigorous approach to the development is needed, and various skills and experts should be involved. For some institutions, especially those in developing countries, the availability of such resources is often limited. A recent systematic review on diabetes guidelines in non-western countries found that 79% of the guidelines were based on recommendations from other national or international guidelines. Nevertheless, an adaptation of a guideline produced in one cultural and organizational setting for use in another setting (trans-contextual adaptation8) needs to ensure that the resulting and final recommendations could still preserve its validity.

The overall aim of adaptation is to take advantage of existing guidelines to enhance the efficient production and use of high-quality adapted guidelines. Several approaches to adoption and adaptation of guidelines to local situation have been proposed and endorsed, such as the ADAPTE collaboration and the "Systematic Guidelines Review method."

Basically, the approaches should involve systematic search and selection of guidelines, a quality assessment of the guidelines, and a transparent approach during recommendation formulation, plus an external peer review and a formal endorsement procedure. While this approach involves relatively complex processes and certain expertise, these are scarce sources in low-resourced countries. We practically will assess the quality of a guideline by using the instrument developed by the Appraisal of Guidelines, Research and Evaluation Collaboration (AGREE II). The AGREE II instrument contains 23 key items organized in 6 methodological domains: scope and purpose (items 1-3), stakeholder involvement (items 4-6), rigor of development (items 7-14), clarity of recommendations (items 15-18), applicability (items 19-21), and editorial independence (items 22-23). Then you can compare your individual scores for each item and come to consensus on discrepant scores.

After that step formulating of the recommendation can be done in a panel.
Implementing evidence-based practice principles in guideline adaptation will help the efforts in low-resource countries to improve their quality care practice through the use of high-quality practice guidelines. In addition, these countries should aim to improve their capacity in assessing and selecting the guidelines as part of the adaptation process.

In view of the potential impact of CPGs on health care delivery and patient outcomes, it is crucial that clinical guidelines should be of optimal quality.

Although promising as a technique for making use of already developed guidelines, the ADAPTE method had not been field-tested, in particular for use by groups lacking the resources or skills of commissioned guideline panels we discuss more in this part.

Implementation of the best evidence framework for developing worlds

Sakineh Hajebrahimi professor of urology from Tabriz University of Medical Sciences and research center for EBM, Iran)

Many reports have indicated that current evidence-based guidelines are underused by physicians and others, and that there are many barriers to an effective translation of recommendations into day-to-day care. There is therefore a need to develop more effective ways to communicate key information to both caregivers and patients, and to promote appropriate health behaviors. Despite the range of treatment options available, relatively few people with incontinence find a total cure. The importance of daily management with toileting and containment cannot be underestimated.

JBI considers evidence-based healthcare as decision-making that considers the feasibility, appropriateness, meaningfulness and effectiveness of healthcare practices.

The best available evidence, the context in which care is delivered, the individual patient and the professional judgment and expertise of the health professionals inform this process. JBI regards evidence-based healthcare as a cyclical process. Global healthcare needs, as identified by clinicians or patients/ consumers, are addressed through the generation of research evidence that is effective, but also feasible, appropriate and meaningful to specific populations, cultures and settings.

This evidence is collated and the results are appraised, synthesized and transferred to service delivery settings and health professionals who utilize it and evaluate its impact on health outcomes, health systems and professional practice.

Therefore, in order to provide those who work in and use health systems globally with world class information and resources, JBI:

- Considers international evidence related to the feasibility, appropriateness, meaningfulness and effectiveness of healthcare interventions (evidence generation)
- Includes these different forms of evidence in a formal assessment called a systematic review (evidence synthesis)
- Globally disseminates information in appropriate, relevant formats to inform health systems, health professionals and consumers (evidence transfer)
- Has designed programs to enable the effective implementation of evidence and evaluation of its impact on healthcare practice (evidence implementation)

It is this unique approach that is encompassed in the JBI Model of Evidence-based Healthcare

Implementation reports are a simple way to focus on a clinical topic of interest, where research evidence is used to impact clinical practice through the audit process and implementation of evidence-based strategies. These projects are carried out by a team of clinicians, but driven largely by the project lead on top of their already demanding clinical workloads. The generation of solutions based on how things could be done differently is no easy task, and it relies on not only knowledge but also the ability and personality to inspire others to work together.

The ability to influence and manage change is central to these projects, and the determination to continue despite barriers is commendable. May you be inspired by their achievements after learning more about this method in the workshop.

Evaluation and Clinical Audit

Kate Sloane, Clinical Nurse Consultant Australia

Clinical audit is an essential step in evaluating the implementation of evidence – based practice. It is part of a continuous quality improvement program. The purpose of clinical audit is to improve the quality of care services by systematically reviewing clinical practice against set criteria. It encourages individuals to follow professional standards and work toward patients receiving the best quality care in a given clinical arena.

Clinical audit is a cyclical process which involves measuring a clinical outcome or process against well-defined standards, established using the principles of evidence-based medicine. The process links into both clinical effectiveness and clinical governance. Clinical audit involves five stages: preparing for audit, selecting criteria, measuring performance, making improvements, and sustaining improvements. Using a framework to guide an audit or evaluation process can promote clarity and impetus for a clinician. SMART criteria and the PDSA cycle are examples of audit and evaluation tools. Analysis of audit data assists with identifying areas of need where additional education, training and cultural support for behaviour change may be required. Repeating the audit cycle monitors the impact of improvements or sustained best practice.

There are different methods of collecting data for the purpose of audit and evaluation. Prospective audit occurs in the practice arena, may be observational in nature and requires explicit criteria. There can be an associated notion of a clinician “being watched” and results may be inflated if the observation leads to behaviour change. Prospective audit is time consuming, however it provides an opportunity to give immediate feedback on performance, and positive reinforcement to improve or maintain practice. Retrospective audit involves audit of existing data and is generally easier to complete. It requires good information technology, or availability of medical records. The absence of data may not indicate omission of care. Rather it may represent cultural practices around documentation and is a limitation in retrospective audit.

Barriers to audit can include lack of clarity around purpose, resources, expertise in design, engagement of staff and poor professional culture, relationships and interdisciplinary trust.
Success can be promoted via support of senior management, structured audit activities, using the latest evidence and frequent re-auditing. Strong emphasis on a no blame ethos, acknowledging achievements, and providing access to feedback nurtures success.

Guideline production and dissemination do not guarantee widespread adoption of best -evidence based practice, and standardising practice does not always standardise behaviour. Compliance is often influenced by “human factors”. This may involve skill-set, training, capacity for clinical reasoning, experience, practice scope, supervision, attitude, time and team work.

A clinical audit process is essential for monitoring the implementation of evidence-based practice. Clinical audit indicates if the guideline is being used, compliance to the available evidence, and whether the use of the guideline is producing the intended result. Maintaining the audit cycle is important due to the inherent complexity and influences in the clinical arena.

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