Clinical Practice Guideline (CPG) – Development Policy

1. The development of Clinical Practice Guidelines (CPGs) is one of the functions which PHECC has been tasked with under SI 575 2004.
   " prepare clinical practice guidelines for pre-hospital emergency care and make such guidelines available to pre-hospital emergency care service providers and such other persons as it may consider appropriate"

2. Requirements

a. There is a legal requirement to publish CPGs to enable PHECC registered practitioners to administer medications.

b. In keeping with legislation, medications used in pre-hospital emergency care by PHECC registered practitioners, will be listed on CPGs.

c. Medications listed on CPGs shall specify the dose and route.

d. A supporting medication formulary shall be published for each medication listed on a CPG.

e. There shall be two distinct CPG categories;
   i. Practitioner CPGs for PHECC registered practitioners.
   ii. Responder CPGs for PHECC certified responders.

f. Within each category a CPG may overlap two or more clinical levels.

3. Rationale

a. MAC shall develop CPGs in the best interest of the patient. Healthcare economics may be considered but will not necessarily be a deciding factor in progressing a CPG, particularly if there is a significant benefit for the patient.

b. The CPGs will not be published in isolation. They are subject to the 'Care Principles' published for each Responder or Practitioner level.

4. Guideline Development Process

a. There are 3 distinct elements to the creation and publication of CPGs.
   i. Prioritisation,
   ii. Drafting and Approval, and
   iii. Maintenance

5. Prioritisation

a. A request for a new or updated CPG may be initiated by a practitioner, responder, patient interest group or member of Council or its committees.

b. The publication of evidence based medicine (EBM), such as new ILCOR guidelines, is a catalyst for updating CPGs.

c. The request for a new or updated CPG shall be circulated electronically to all MAC members for scoring on the prioritisation matrix (Appendix A). The prioritised scores will be presented at

the next MAC meeting for consideration. Should level (ii) (put on a schedule to be addressed within 6 months) or level (iii) (scheduled to be addressed immediately) be determined, development will proceed to the evidence collection stage.

d. EBM and critical appraisal will be circulated electronically to the members for scoring on the evidence prioritisation matrix (Appendix B). The prioritised scores will be presented at the next MAC meeting for consideration.

e. MAC may request a sub group to draft a CPG or topic specific CPGs.

f. CPGs shall be agreed by MAC using three pillars
   i. Evidence based medicine as the primary decider.
   ii. Agreed principles of care.
   iii. Clinical judgement in the absence of the first two.

6. Drafting and Approval

a. MAC must pass a formal resolution to agree the preparation of a draft CPG (new or amended).

b. The draft CPG (**in print ready format**) will be circulated electronically to all members for consideration.

c. Once agreed, the CPG (**in print ready format**) will be circulated electronically, and all members afforded a two month window to highlight any reservations (via Delphi process). This cycle (6.a to 6.c) will be repeated if required. This will become the final CPG if un-opposed.

d. The CPG Quality Assurance Criteria (Appendix D) shall be verified by MAC Chair indicating agreement with the process.

e. Final (Un-opposed) CPGs will be retained in PDF format for recommendation to Council on an annually basis. (In exceptional circumstances the time scale will be compressed).

f. CPGs will be published annually if required.

7. Maintenance

a. Each CPG shall be reviewed at least once every three years.

b. Maintenance and evaluation shall be completed on an ongoing basis for CPGs (Appendix C)

c. Any MAC member may propose a review of an existing CPG by referral through the prioritisation evaluation process.

d. In the event of an urgent patient safety concern, any MAC member may request a priority review from the Chair of MAC in conjunction with the Medical Advisor to the Director who will initiate appropriate action.

e. Amendment or an interim directive shall be co-signed by the Director and Chair of MAC or the PHECC Medical Advisor.

Appendix A - CPG Prioritisation Matrix

Probability Score	**A - Frequency of occurrence**	Score Awarded 1- 5
1	Highly unlikely to occur	
2	Unlikely to occur	
3	Likely to occur	
4*	Very likely to occur	
5*	Extremely likely to occur	
Score Awarded		
Probability Score	**B - Direct patient safety issue**	
1	Negligible: Little or no risk to life/limb	
2	Minor: risk to life/limb	
3	Serious: risk to life/limb	
4*	Very serious: risk to life/limb	
5*	Catastrophic: risk to life/limb	
Score Awarded		
Probability Score	**C - Enhanced patient comfort**	
1	Pain/distress/anxiety nil	
2	Pain/distress/anxiety minimal	
3	Pain/distress/anxiety moderate	
4	Pain/distress/anxiety severe	
5	Pain/distress/anxiety very severe	
Score Awarded		
Probability Score	**D - Wider health service integration**	
1	Implementable by individual service provider only	
2	Roll out throughout all pre-hospital service providers	
3	Conducive to continuing treatment in receiving hospital	
4	In line with official guidelines across all healthcare services	
5	Internationally recognised best practice across healthcare services	
Total Score Awarded		
Level (i): 0 – 10 = No action, retain on file and review status on an annual basis Level (ii): 11 – 15 = Put on a schedule to be addressed within 6 months Level (iii): 16 – 20 = Scheduled to be addressed immediately **A score of 4 or above in **BOTH** categories A and B will automatically fall into Level (iii)*		

Appendix B - CPG Prioritisation Evidence Based Matrix

Probability Score	**Evidence based**	
1	Evidence from expert committee reports or opinions or clinical experience of respected authorities, or both	
2	Evidence from at least one controlled study without randomisation	
3	Evidence from at least one other type of quasi-experimental study	
4	Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies, and case-control studies	
5	Evidence from at least one randomised controlled trial	
	Score Awarded	

Appendix C – Maintenance and evaluation matrix

Score	**Maintenance**	
1	One year since last reviewed	
2	Two years since last reviewed	
3	Probable clinical issue identified	
4	Three years since last reviewed	
5	Urgent clinical issue identified	
	Score Awarded	

	Evaluation	
Access	What proportion of practitioners have been up-skilled for the CPG	
Quality	What outcome benefits are accruing from the CPG	
Efficiency	What are the costs/ opportunity costs associated with the continuation of the CPG	
Implementation	What barriers to implementation are identified	
New evidence	Evidence to suggest a change required in CPG	

Appendix D - CPG Quality Assurance Criteria Rating Template

Domain	Criteria	Yes	No
Feasibility	1. National health policy, programmes and relevant existing guidelines are specifically considered.		
Scope and Purpose	2. The overall objective(s) of the guideline is (are) specifically described.		
	3. The health question(s) covered by the guideline is (are) specifically described.		
	4. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.		
Stakeholder Involvement	5. The guideline development group includes individuals from all the relevant professional groups and intended users.		
	6. The views and preferences of the population to whom the guideline will apply (patients, public etc.) are sought and representatives are included on the guideline development group.		
	7. The intended users of the guideline are clearly defined.		
Editorial Independence	8. The views of the funding body have not influenced the content of the guideline. The funding body or source of funding is clearly described or there is an explicit statement of no funding.		
	9. Competing interests of guideline development group members are recorded and addressed with a clear description of the measures taken to minimise the influence of these interests on guideline development.		
Rigour of Development	10. Systematic methods have been used to search for evidence on effectiveness and cost-effectiveness to ensure that clinical guidelines are based on best available evidence. The full search strategy should be clearly outlined.		
	11. The criteria for selecting the evidence are clearly described with reasons for including and excluding evidence clearly stated.		
	12. The strengths and limitations of the body of evidence are clearly described with the methods/tools for assessing the quality of the evidence documented.		
	13. The methods used for formulating the recommendations are clearly described		
	14. The health benefits, side effects, risks, cost-effectiveness, resource implications and health service delivery issues have been considered in formulating the recommendations.		
	15. The recommendations have been graded for quality of evidence and strength of recommendation with an explicit link between the recommendations and the supporting evidence.		
	16. The guideline has been externally reviewed prior to its publication. There is a clear description of the selection process for external reviewers and how the information gathered was used by the guideline development group.		
	17. A procedure for updating the guideline is provided and includes an explicit time interval.		
Clarity of Presentation	18. The recommendations are specific, clear and easily identifiable with the intent or purpose of the recommended action clearly outlined.		
	19. The different options for management of the condition or health issue are clearly presented with a description of the population or clinical situation most appropriate to each option.		
	20. Key recommendations are easily identifiable.		
Applicability	21. The guideline describes facilitators and barriers to its application.		
	22. The guideline provides advice and/or tools on how the recommendations can be put into practice.		
	23. The potential budget impact and resource implications (equipment, staff, training etc.) of applying the recommendations have been considered.		
	24. The guideline presents monitoring and/or auditing criteria to assess adherence to recommendations and the impact of implementing the recommendations.		

Overall Guideline Assessment	Rate the overall quality of this guideline (Lowest possible quality = 1, highest possible quality = 4)	1	2	3	4
	I would recommend this guideline for use	No	Yes with modification		Yes
Name:					

Version History

Version	Date	Details
1	Feb 15	New Policy