1 BACKGROUND

A significant gap exists between evidence-based clinical practice guidelines on the one hand, and actual approaches to the delivery of care on the other. Despite wide dissemination, clinical practice guidelines have had limited impact on changing healthcare professional behaviour.

Facilitators and barriers to physician adherence to clinical practice guidelines were identified based upon a recent comprehensive review of the literature (Caban et al., 1999; Cochrane et al., 2007).

Nonvariceal upper gastrointestinal bleeding (NVUGIB) causes substantial lack of knowledge of the specific guidelines for the management of NVUGIB. The efficacy of clinical practice guidelines on the other hand, and actual approaches to the delivery of care on the other.

2 PURPOSE

To review factors that determine health-care providers’ adherence to NVUGIB clinical practice guidelines

To determine the underlying causes of non-adherence to NVUGIB guidelines in Canada

3 METHODS

Semi-structured interviews were conducted by telephone with 22 selectively sampled Canadian healthcare professionals actively practicing with NVUGIB patients.

Participants were chosen from a representative sample of six community or academic-based hospitals across Canada that had taken part in a national Canadian Audit on the management of NVUGIB.

The qualitative data (KII interviews) were captured using audiorecording. The audiotapes were transcribed, and personal data of the participants removed.

The data were then categorized, coded and tabulated using the N’Vivo software (e.g., Miles & Huberman, 1984; Silverman, 1993).

The interview questions addressed themes related to specific prioritized NVUGIB guidelines.

Communication of prior evidence-based recommendations was found to impact healthcare professionals’ adherence to NVUGIB guidelines.

4 RESULTS

Substantive lack of knowledge of the specifics of the NVUGIB guidelines (ER, ICU, and nurses)

Very few people would know where the policy would be in the first place, let alone what was in the policy or who would enforce it, so it’s just kind of the whole guidelines itself is almost non-existent.69

— Nurse

Limited belief in the value of guidelines (ER, ICU)

It’s a bit of a sticky area because frankly the evaluation, resuscitation is like, baseball and apple pie and these are standard things that we’re taught in medical school. The approach to a patient with a bleed is assessing their vitals, etc. So if guidelines simply reiterate that we should provide good medical care. I don’t think there are any specific guidelines, in my opinion, that are useful.69

— GI

Limited belief in the value of available tools to support implementation of specific guidelines (GI)

I think it’s because there’s just so many things. You can have some kind of scale or scoring system for absolutely every clinical scenario and it’s just another layer of work that the physicians aren’t willing to do.69

— GI

It’s the utility of these scoring systems over the expert review. A physician’s general assessment is perhaps marginal many times.69

— ER physician

Lack of knowledge of the roles and responsibilities of each healthcare professional involved in the care of NVUGIB patients (ER, ICU, GI)

I think the gastroenterologists and the emergency physicians, we sometimes forget what each other’s role is. (...) I think there is a knowledge gap between an emergency physician and a gastroenterologist on how they treat a patient with a NVUGIB bleed. (...) As emergency physicians we could do better in terms of knowing what the risk factors are, knowing what questions to ask when we do our initial evaluation and that way, we’d be able to better communicate with the gastroenterologists. On the other hand, I think the gastroenterologists should understand that we do see other things and we just don’t GI bleeds all the time, that we shouldn’t know as much as they do.69

— ER physician

Limited effective collaboration among respective healthcare professionals in the care of patients with NVUGIB (ER, ICU, GI)

We’rePantucal** crazy at our centre (...) anyone who is sick enough to get into our acute care area with an ongoing bleed or we suspect has an ongoing bleed, we give a pump inhibitor (...) we’re using it very liberally for upper bleeds.69

— ER physician

Overuse. (...) We have some surgeons now prescribing it and we have the ICU using it excessively. The emergency morbidity and mortality protocol (OPP) for who are hardly bleeding or that they think are bleeding (bleeding on or off a pump) would probably be inappropriate utilization of a medication, which has a very nice additional property, its use has been expanded throughout the hospital.69

— GI

5 DISCUSSION & IMPLICATIONS

Variability of knowledge and skills of healthcare professionals (for example, ER physician knowledge and skills in endoscopic procedures)

We have 1 thing that a more variable skill set of our endoscopy nurses as well. Some of them are really good and some of them haven’t a clue what decisions we’re trying to use when we’re dealing with acute bleeds.69

— GI

Perceived oversuite of IV PPI treatment with limited concern regarding cost side effect implications (all participants)

We’regenerous. It’s not a written protocol but our unwritten protocol is that anyone coming in with a GI bleed gets the pump inhibitor. We’rePantucal** crazy at our centre (...) anyone who is sick enough to get into our acute care area with an ongoing bleed or we suspect has an ongoing bleed, we give a pump inhibitor (...) we’re using it very liberally for upper bleeds.69

— ER physician

Conducting this type of in-depth behavioral research will support the development of tailored multi-faceted educational and training programs that will address the gaps and facilitate healthcare professional understanding of and commitment to, adhere to NVUGIB guidelines.

The effectiveness of this program will be assessed in a national cluster randomized clinical trial that assesses whether it’s stable enough, (...) we don’t need to come in right now. (...) So, there’s sort of a catch 22 situation.69

— ER physician

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ASSESSMENT OF REASONS FOR NON-ADHERENCE TO NONVARICEAL UPPER GASTROINTESTINAL BLEEDING (NVUGIB) GUIDELINES

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BACKGROUND

A significant gap exists between evidence-based clinical practice guidelines on the one hand, and actual approaches to the delivery of care on the other hand. Despite wide dissemination, clinical practice guidelines have had limited impact on changing healthcare professional behavior. Facilitators and barriers to physician adherence to clinical practice guidelines were identified based upon a recent comprehensive review of the literature (Caban et al., 1999; Cochrane et al., 2007).

PURPOSE

To review factors that determine healthcare providers’ adherence to NVUGIB practice guidelines

To determine the underlying causes of non-adherence to NVUGIB guidelines in Canada

METHODS

Semi-structured interviews were conducted by telephone with 22 selectively sampled Canadian healthcare professionals actively practicing with NVUGIB patients.

RESULTS

Substantive lack of knowledge of the specifics of the NVUGIB guidelines (ER, ICU, and nurses)

- Very few people would know where the policy would be in the first place. Let alone what was in the policy or who would be enforcing it, so it’s just kind of the whole guidelines itself is almost non-existent.

Limited belief in the value of guidelines (ER, ICU)

- This is a, it’s sort of a scary area because frankly the evaluation, resuscitation is like, baseball and apple pie and these are standard things that we’re taught in medical school. The approach to a patient with a bleed is assessing their vitals, etc. So if guidelines framed simply, reiterate that we should provide good medical care. I don’t think there are any specific guidelines, in my opinion, that are useful.

Lack of knowledge of the roles and responsibilities of each healthcare professional involved in the care of NVUGIB patients (ER, ICU, GI)

- I think the gastroenterologists and the emergency physicians, we sometimes forget what each other’s role is. (...) I think there is a knowledge gap between an emergency physician and a gastroenterologist on how they would be involved with a patient with a NVUGIB bleed. (...) As emergency physicians we could do better in terms of knowing what the risk factors are, knowing what questions to ask when we do our initial evaluation and that way, we’d be able to better communicate with the gastroenterologists. On the other hand, I think the gastroenterologists should understand that we do see these things and we just don’t do GI bleeds all the time, that we shouldn’t know as much as they do.

Limited effective collaboration among respective healthcare professionals in the care of patients with NVUGIB (ER, ICU, GI)

- It’s the utility of these scoring systems over their applicability. A physician’s general assessment is perhaps marginal many times.

Lack of knowledge and skills of healthcare professionals (for example, ER physician)

- We have to think a more variable skill set of our endoscopy nurses as well. Some of them are really good and some of them haven’t a clue what devices we’re trying to use when we’re dealing with acute bleeds.

Perceived overuse of IV PPI treatment with limited concern regarding cost or side effect implications (all participants)

- We’re generous. It’s not a written protocol but our unwritten protocol is that anyone coming in with a GI bleed gets the pump inhibitor. We’re Pantalec (...). crazy at our centre (...) anyone who is sick enough to get into our acute care area with an ongoing bleed or we suspect has an ongoing bleed, we give a pump inhibitor (...) we’re using it very liberally for upper bleeds.

- Overuse. (...) We have some surgeons now prescribing it and we have the ICU using it excessively. The emergency morbidity scoring system (for example, PPI) who are hardly bleeding or that the doctors would not be able to improve. We’re using it excessively. The emergency morbidity scoring system (for example, PPI) who are hardly bleeding or that the doctors would probably be inappropriate utilization of a medication, which has a very nice additional purpose, its use has been expanded throughout the hospital.

- Varied knowledge and skills of healthcare professionals (for example, ER physician)

- There’s a sort of catch 22 situation.

DISCUSSION & IMPLICATIONS

Knowledge, attitude, skill, and behavioural, context specific gaps were found to impact healthcare professionals’ adherence to NVUGIB guidelines.

This in-depth research illustrates the value of understanding the barriers to non-adherence of guidelines and frames the causes behind those barriers across interprofessional healthcare teams.

Conducting this type of in-depth behavioral research will support the development of tailored multi-faceted educational and training programs that will address the gaps and facilitate healthcare providers’ understanding of and commitment to, adhere to NVUGIB guidelines.

The effectiveness of the program is then assessed in a national cluster randomized clinical trial that assesses the effects of tailored educational and behavioral intervention designed as a result of the barriers identified.