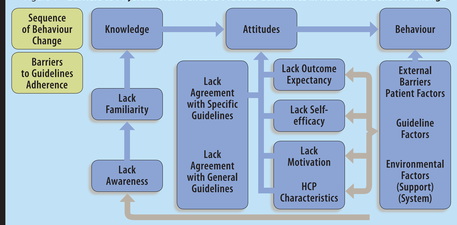
ASSESSMENT OF REASONS FOR NON-ADHERENCE TO NONVARICEAL UPPER GASTROINTESTINAL BLEEDING (NVUGIB) GUIDELINES

Sean Hayes AXDEV Group Ian Hawes AstraZeneca Canada Inc. Martin Dawes Department of Family Medicine, McGill University Alan Barkun Division of Gastroenterology, McGill University

1 Background

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

Figure 1 **Barriers to Physician Adherence to Practice Guidelines in Relation to Behavior Change**



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- Nonvariceal upper gastrointestinal bleeding (NVUGIB) causes substantial morbidity and mortality.
- Guidelines for the management of patients with NVUGIB exist, but are inconsistently applied by healthcare providers, resulting potentially in sub-optimal care and patient outcomes.
- Recognizing the challenge in the implementation of clinical guidelines to actual practice, a needs assessment was carried out to assess healthcare providers' barriers to the implementation of NVUGIB guidelines in Canada.

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.

PROFESSION	NUMBER OF PARTICIPANTS (n)
ER physicians	5
ICU physicians	4
Gastroenterologists	4
Nurses (e.g., Endoscopy and GI nurses)	6
Directors (e.g., director of pharmacy, director of professional services)	3
TOTAL (n)	22

- 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 interview questions addressed themes related to specific prioritized NVUGIB guidelines.
- The qualitative data (KII interviews) was captured via audiotapes. The audiotapes were independently transcribed and the names 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).
- A multidisciplinary team interpreted the results and suggested recommendations included in this report.

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 be enforcing it, so it's just kind of the whole guidelines itself is almost non-existent."
— Nurse

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

"This is a, it's sort 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, the guidelines frankly, simply reiterate that we should provide good medical care. I don't think there are any specific guidelines, in my opinion, that are useful."
— 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."
— GI

"It's the utility of these scoring systems over top of an experienced physician's general assessment is perhaps marginal many times."
— GI

Lack of knowledge of the roles and responsibilities of each healthcare professionals 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 assess 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 do GI bleeds all the time, that we shouldn't know as much as they do."
— ER physician

Limited effective collaboration among respective healthcare professionals in the care of patients with NVUGIB (ER, ICU, GI) (for example, lack of agreement amongst ER, ICU and GI on a definition of "urgent endoscopy")

"They'll (gastroenterologists) say, 'Oh, this guy's too unstable for me to scope. He needs further resuscitation.' Then when you've resuscitated and made them stable they say, 'Well now that he's stable enough, (...) we don't need to come in right now". (...) So, there's sort of a catch 22 situation."
— ER physician

Variability of knowledge and skills of healthcare professionals (for example, nurses' knowledge and skills in endoscopic procedures)

"We have I 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."
— GI

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 Pantaloc** 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."*
— ER physician

"Overuse. (...) We have some surgeons now prescribing it and we have the ICU using it excessively. The emergency doctors are starting patients (on IV PPI) who are hardly bleeding or that they thought were bleeding. It would probably be inappropriate utilization of a medication, which has a very nice additional purpose, its use has been expanded throughout the hospital."
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5 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 importantly 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 behavioural programs that will address the gaps and facilitate healthcare providers' 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 a tailored educational and behavioral intervention designed as a result of the barriers identified.

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WHERE SCIENCE MEETS PRACTICE: APPLICATION OF CLINICAL PRACTICE GUIDELINES IN THE INTERPROFESSIONAL CLINICAL REALITIES OF TODAY

SUZANNE MURRAY AXDEV GROUP ALAN BARKUN DIVISION OF GASTROENTEROLOGY, MCGILL UNIVERSITY MARTIN DAWES DEPARTMENT OF FAMILY MEDICINE, MCGILL UNIVERSITY MARTIN DUPUIS AXDEV GROUP SEAN HAYES AXDEV GROUP

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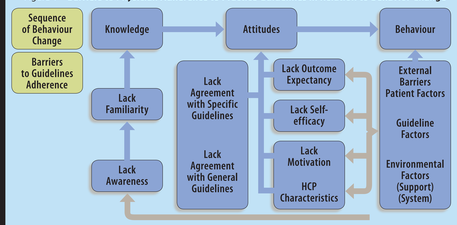

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