Prescriptive care?  
Guidelines and protocols

The first of two articles on the development and implementation of guidelines and protocols describes a series of workshops on research utilisation. The authors also attempt to explain some of the confusing terminology in the area of prescriptive care. The second article, which will appear in the near future, will attempt to answer the questions arising from the workshops described here.

Date of acceptance: December 4 1996.

Health professionals are keen to offer clients and patients the best possible professional care within the organisational and economic constraints of current society. Purchasers or commissioners of health care are seeking efficient and effective services which meet the needs of their population.

Making decisions about care is problematic. Is there a preferred course of action in any condition or situation? What will affect outcome? Is the process of care more important than the outcome? Who should define what is important? Which services should be offered, to whom, by whom and where?

In the past, nurses have used procedure books or manuals to guide aspects of their care. More recently, they have been encouraged to become critical thinkers and autonomous practitioners in preference to following more prescriptive manuals. However, discussion about guidelines, protocols, and critical care pathways is increasing, both in the literature and the work environment.

At the centre of these discussions is the principle of evidence-based health care. If there is scientific evidence for a preferred course of action, and a strategy that will result in optimal care at minimum cost, should nurses not follow such a prescription? There are a number of questions about evidence-based health care which need to be answered, such as ‘What constitutes evidence?’ and ‘Who is making the definition?’. Putting these aside, it is undoubtedly true that a vast glut of information, combined with the finite resources of money, time and skills, is one of two forces which has driven the development of guidelines and protocols.

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The second, probably more significant force has been the institution of general management and market conditions in the NHS. These reforms set up controls on a large number of previously autonomous health professionals whose activities had significant cost implications for the government (Traynor 1996). Guidelines can, therefore, be both prescriptions for excellent care and management tools for cost containment and quality assurance.

CONFUSION OVER TERMINOLOGY

The definition of guidelines is a confusing issue – just as definitions were when audit and quality assurance were introduced. Several recent articles have been devoted to disentangling this terminology (Antrobus 1996, Duff et al 1996, Humphris 1994). One of the first aims of the RCN’s Clinical Guidelines Steering Group was to clarify and agree terminology.

Guidelines The most widely quoted definition of guidelines described them as: ‘Systematically developed and utilised statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances’ (Institute for Medicine 1992). A slightly modified version of this was recently adopted by the NHS Executive (1996). Guidelines are envisaged as broad statements of good practice with optional and mandatory elements, but little operational detail (Duff 1994).

Protocols According to the Scottish Clinical Resource and Audit Group, clinical guidelines adopted for local use become protocols. Jenkins (1991) defined protocols as: ‘Precise guidelines with a structured and logical approach to a closely specified clinical problem.’ In England it is more usual to use the terms national and local guidelines.

Standards Quality assurance initiatives led to the development of standards, which may appear in different formats. According to Grimshaw and Russell (1993), standards are authoritative statements of minimum level, excellent level, or the range of acceptable performance or results. However, the Dynamic Standard Setting System (DySSSy) (RCN 1990) developed by the RCN provided both an objective of care and the guidance.
about how it may be achieved, thus introducing some of the elements of guidelines. Critical care pathways Confusing the issue further are critical care pathways – also described as anticipated recovery pathways, healthcare protocols and collaborative care plans (Wigfield and Boon 1996). These detail the flow or process of care over a specific time period for an individual patient with a particular diagnosis. A critical pathway is envisaged as 'a multidisciplinary approach to assessing, planning, implementing, monitoring and evaluating care' (Wigfield and Boon 1996). It is not clear how critical pathways fit in with the clinical protocols or standards and their use raises several questions. Are they a further step down the ‘specification’ path from national to local guidelines or protocols? Are they based on research? Should they be audited?

LINKING GUIDELINES AND RESEARCH
Guidelines have many uses – Duff et al (1996) provide a useful list – but currently much emphasis is being laid on their use as a vehicle for implementing research (Haines and Jones 1994). Crucially, discussions of guideline development stress that recommendations must be based on research. Some authors have stated that protocols should be similarly underwritten (Antrobus 1996). However, where the research base underpinning alternative ways of managing care is unavailable, an ‘optional’ element may be introduced in the conversion of national guidelines to more specific protocols at a local level. This element may be presented as optional (Eddy 1992). Duff et al (1996) suggested: ‘It is these optional elements which may be adapted when clinical guidelines are interpreted for local use.’

Whether or not critical care pathways are synonymous with local protocols, many articles discussing their use fail to mention research at all (Layton 1993, Wigfield and Boon 1996). A recent study of guidelines used by health visitors suggests that the content was seldom research based and it lacked reliability and validity (Appleton 1996).

It was through considering this interface between research and the realities of practice that our own interest in guidelines and protocols arose. Organising a series of workshops on research utilisation, we decided to explore the use of protocols as vehicles for translating the results of research into practice. Would the creation of clinical protocols be a useful and feasible exercise for practitioners who wanted to ensure that their practice was, as far as possible, based on the best possible evidence?

THE WORKSHOPS
Nine four-day workshops organised and sponsored by The Foundation of Nursing Studies (FoNS) took place in a range of NHS trusts between September 1994 and December 1995. The 206 participants included registered general nurses, registered mental health nurses, health visitors and midwives, at all grades (Box 1).

Most of the participants had little or no experience of research. The main objectives were to enable participants to:

- Access and critically appraise research
- Introduce and manage changes in practice based on research.

Two exercises centred on clinical protocols. Participants worked in small groups and reported back in a general session.

Exercise 1 Participants considered some of the organisational issues involved in drawing up protocols:

- What format should a clinical protocol take? Define a protocol
- What types of knowledge should be used to draw up clinical protocols?
- Who should participate in preparing protocols?
- How should the production of protocols be organised?
- How should the relevant information be collected and collated?
- How might the organisation in which you work affect these processes?

Although participants had 90 minutes to discuss these issues, some groups did not progress beyond the first question. This underlines the confusion of terminology discussed earlier and reflects the thinking current in 1994 when the workshop materials were produced. Participants and facilitators had their own ideas about what protocols were. Only a small number of participants had reflected on the type of knowledge – conceptual, clinical, empirical – that might be included in guidelines or protocols, but most recognised and welcomed a multidisciplinary input into the production of guidelines and protocols, and the importance of patient/client involvement. Many participants had not fully appreciated how complex and time consuming guideline production could be, and were sceptical about how it might be achieved.

Exercise 2 Participants developed a clinical protocol for an area of care previously selected by a democratic voting process involving all participants. Some of the topics chosen are shown in Box 2.

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Box 1. Distribution of grades of staff attending workshops
Something unexpected occurred during this voting and selection stage. The facilitators had anticipated that although the participants would split into groups to build their protocols, a universal topic would be taken. However, while some groups accepted this, others were adamant that the single topic selected was not appropriate for them. Further difficulties arose where different professionals in the same group had to negotiate with each other to select a topic on which they wished to work. This illustrated two points:

- The difficulties of multidisciplinary working should not be underestimated— even within professional groups which have close ideological and professional links.
- Busy practitioners were unwilling to compromise, and 'waste precious time' investigating a topic which did not have direct relevance to their everyday work.

This exercise requested that participants draw up a protocol. Although participants were free to use their own scheme, the facilitators did provide some guidance. This was based on the Conduct and Utilisation of Research in Nursing Project (CURN 1983) which outlined five essential components of a clinical protocol:

- Discussion of the need for change
- Description of the new practice or innovation
- Summary of the current research in the area
- Description of how the implementation will occur, and the resources required
- Strategy for evaluating the innovation.

These components represented the state of thinking in 1994. It is difficult to place this type of document in the current definitions of guidelines, protocols and pathways, although the steps above provide a useful framework. Crucially, the components indicated the central place of research evidence within protocols. The purpose was to transform the knowledge, methods and technology inherent in research into the knowledge, methods and technology useful to practitioners.

**HOW THE GROUPS FARED**

The groups had approximately one month to gather up the relevant information and write their protocols. This was an artificially short time, but illustrated the difficulties of arranging regular meetings, and accessing evidence from libraries and professional bodies. These difficulties were particularly acute in settings where practitioners no longer had the time or facilities to meet regularly to discuss their work. Despite these limitations, most groups were able to collect information and devise a protocol. It is worth noting that:

- For some topics there was no research evidence at all
- In other cases research was available but participants did not access it, either because they did not know it existed, or because they did not have time or resources
- Participants found it difficult to analyse critically and synthesise the results of several studies.

**Box 2. Some topics chosen for development of guidelines/protocols**

- Lifting and handling
- Named nurse
- Sexual relationships among mental health patients
- Criteria for removal of patient from a ward
- Senile dementia
- Day care
- Nursing handover
- Nursing assessment
- Use of gloves in clinical areas
- Mouth care procedures
- Care of intravenous cannulae
- Intravenous drug administration
- Hydration before death
- Resuscitation

- The 'level' of evidence, or its validity was seldom addressed
- Methods for evaluating the guideline/protocol were suggested infrequently.

**NURSES' RESERVATIONS ABOUT GUIDELINES**

Some nurses may argue that the guidelines/protocols approach is not compatible with nursing's philosophy or its way of working. Many would echo Hart's contention (1993) that although guidelines allow some latitude, 'protocols seem too firm for the uncertain business of clinical practice'.

Similar concerns have been raised in nursing about whether guidelines constrain professional practice and whether or not they are applicable to truly holistic and individualised patient care (Appleton 1996). Nurses in our workshops— particularly those working in mental health— found the idea of guidelines and protocols directly contradicted the way they worked with clients.

This problem stems from a wider movement within the NHS to manage scientific knowledge. Other areas of activity have become accountable to a management structure, and now managerial control is being extended to clinical decision-making through service requirements and contractual obligations (Charlton 1993).

The nature of the evidence used in guidelines/protocols also causes difficulties. Three aspects are important here:

- The type of evidence
- Its availability
- Its strength.

For professionals working within the scientific model, objective evidence is the most persuasive, and this is graded according to research design. Designs that are perceived as least susceptible to bias, such as randomised controlled trials, are most highly regarded.
In this model 'professional opinion is normally regarded as the lowest form of evidence' (Grimshaw 1995).

Many nurses do not believe in this hierarchical grading of research evidence and regard other research methodologies as equally appropriate for understanding the social world of health and illness. Box 2 shows that the types of topics important to nursing work do not always lend themselves easily to the guidelines/protocol approach, and often lack any research evidence. As Morgan and Fennessy (1996) noted, this shortage of research may be reflected in a shortage of national clinical guidelines for nursing.

DEVELOPMENT

It seems likely that many areas of nursing, health visiting and midwifery might well benefit from prescriptive care in one form or another. This will be particularly true for the more 'technical' aspects of care, such as wound dressing and catheter care. The idea of organising the best possible way to deliver care in particular circumstances is attractive to all professionals, but the means of production may cause resistance:
- How should practitioners be involved in the sophisticated and time-consuming activity of developing guidelines or protocols at a local level?
- What is needed to ensure equitable multidisciplinary development of guidelines or protocols?
- How far can initiatives driven by government health policy be 'owned' at a local level?

CONCLUSION

In this article we describe our experiences of exploring guidelines and protocols with practitioners in a workshop setting, and set this against the wider movement of guideline development. Our aim was to expose the complexity of this area, offer some practical insights, and to raise some central questions.

In the second article, Caroline Alexander will try to answer some of these questions using examples of guideline and pathway development. These have been initiated by practitioners who see this as the best way to achieve effective care.