

SELECT: Evaluation and Implementation of Clinical Practice Guidelines A Guidance Document from the American Professional Wound Care Association[©]

American Professional Wound Care Association

INTRODUCTION

This guidance document has been developed by a panel of thought and content leaders in wound care and guideline development. The authors outline simple and focused strategies for healthcare professionals to identify, appraise, implement, and evaluate clinical practice guidelines (CPGs) in their respective care settings (eg, hospital, home care, long-term care, rehabilitation facilities, and hospice). Recognizing the challenges of implementing CPGs, the authors recommend 6 steps based on an interprofessional team approach to address practice culture, organizational structure, interprofessional relationships, and available resources.

WHAT ARE CPGs?

CPGs or best practice guidelines are general practice recommendations to aid clinical decision making for specific clinical situations.¹ They are usually developed by following a step-by-step process to include the best available evidence from research, clinical experience (expert knowledge/expert knowing/expert opinion), and patient preferences. Guidelines should be updated on a regular basis to make sure that recommendations are current. As a reminder, CPGs are not fixed protocols, and their application should be tailored to the needs and circumstances of the individual patient and specific care setting. To make this clearer, related key concepts and terms are discussed in Table 1.

WHAT ARE THE BENEFITS TO IMPLEMENT CPGs?

Good clinical practice should be based on interventions/approaches that have been proven to work or what the authors called "evidence." In general, there are 3 broad categories of evidence: scientific findings (through research), clinical knowledge (expert knowledge/expert knowing/expert opinion), and patient preference (considering clinical circumstances and healthcare resources available). CPGs summarize key

evidence, and implementation of a high-quality CPG can serve a few important objectives.

For patients, CPGs

- promote autonomy and patients' perspectives,
- increase satisfaction with care, and
- foster a high quality of care.

For professionals, CPGs

- offer a quick and succinct summary of evidence to inform practice,
- inspire excellence in care delivery,
- benchmark standards of safe care,
- provide guidance for development of care protocols and algorithms,
- maintain consistency of care, and
- stimulate the introduction of innovative practice.

For payers and policy makers, CPGs

- facilitate cost-effective use of healthcare resources,
- evaluate the quality and outcomes of care delivery,
- link recommendations to required interprofessional team members,
- provide resources for patient-centered care,
- promote patient safety and quality improvement, and
- improve clinical outcomes.

SIX STEPS TO SUCCESSFUL CPG IMPLEMENTATION

Introducing the SELECT Mnemonic

Over the last few decades, many CPGs have been developed for the prevention and management of various wound types. However, these guidelines are not the same but vary in the development methodologies, selection of supporting evidence, format, potential biases, and clinical relevance. As a result, clinicians often find it difficult to choose the appropriate guideline to integrate into their own practices. Even when high-quality guidelines are identified, just telling clinicians

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Table 1.

KEY CONCEPTS

Clinical practice guidelines (CPGs) are “systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.”¹² CPGs are not standards of practice or policies and procedures (see below).

Best practice guidelines are the same as CPGs, and the terms are used interchangeably.

Standards of practice are specific requirements for practice and reflect what a reasonably prudent clinician would do with the specific type of patient in a specific circumstance. They are applied in all relevant clinical situations. They are mandated legal requirements and reflect minimal standards for practice.

Policies and procedures are directives of a region or facility that we recommend be synchronized with guidelines and up-to-date evidence. Like individual facility floor directives, they are required to be followed to protect clinicians and facilities.

about these CPGs does not always lead to actual application in patient care. It has been estimated that as low as 20% of clinical practice is based on CPG recommendations.³ The authors propose 6 steps in the mnemonic, SELECT (Table 2), to achieve successful implementation of CPG.

What is SELECT?

SELECT stands for Search, Explore evidence, Locate, Evaluate, Choose and customize, and Translate CPGs into practice. These steps are illustrated in a circular fashion in Figure 1 to emphasize the continuous cycle of quality improvement and ever-changing nature of evidence. Each part of SELECT will be described in more detail.

S—SEARCH

The first step to start the CPG implementation process could include a needs assessment to search for practice areas that

require improvement. The information will help build a case for the resources and time that are required for the process.

What Should Clinicians Search for in Clinical Practice?

Problems or deficits. What are the existing problems, concerns, or difficulties in providing wound care (eg, high prevalence or incidence rate of pressure ulcers)?

Impending change. What are the implications of change in practice for the system (facility, organization)? What are the potential impacts or threats as a result of changes in organizational structure and care processes (eg, changes in staffing, budget, or equipment)?

Opportunities. What are the benefits of introducing the CPG (eg, new technologies, evidence-informed practice, training programs, consultants or suppliers, change in practice culture)?

Strengths. What strengths can be enhanced by implementing the CPG (eg, a wound care resource team, wound care as a quality indicator, build interprofessional relationships)?

New directions. How could CPG implementation promote new levels of performance (eg, new computerized monitoring system, risk management reporting structure)?

Mandated training. Are there internal or external forces dictating that the CPG could be implemented (eg, Centers for Medicare & Medicaid [CMS] F-Tag 314 for long-term care, present on admission/hospital-acquired condition [POA/HAC] indicator)?

Table 2.

SELECT MNEMONIC FOR CPG IMPLEMENTATION

S	Search	Search one’s practice to identify wound care issues and need for change—needs assessment
E	Explore evidence	Explore evidence available for inclusion in CPGs (RCT, explore evidence to validate the identified clinical concerns and determine the scope and potential solutions).
L	Locate	Locate CPGs relevant to the required changes/best practice—search literature and Web sites, ask experts and professional associations
E	Evaluate	Evaluate the quality of the process that was undertaken to develop the CPG—AGREE tool and/or quality of recommendations using GRADE
C	Choose and customize	Choose the best guideline recommendations and adapt them to one’s setting, ie, customize them for the local environment (contextualize)
T	Translate CPGs into practice	Initiate a process for translating the evidence into practice—using a multilayered approach that incorporates the specific environment readiness for change and stakeholders

Figure 1.
SELECT FOR TRANSFERRING CPG INTO CLINICAL PRACTICE

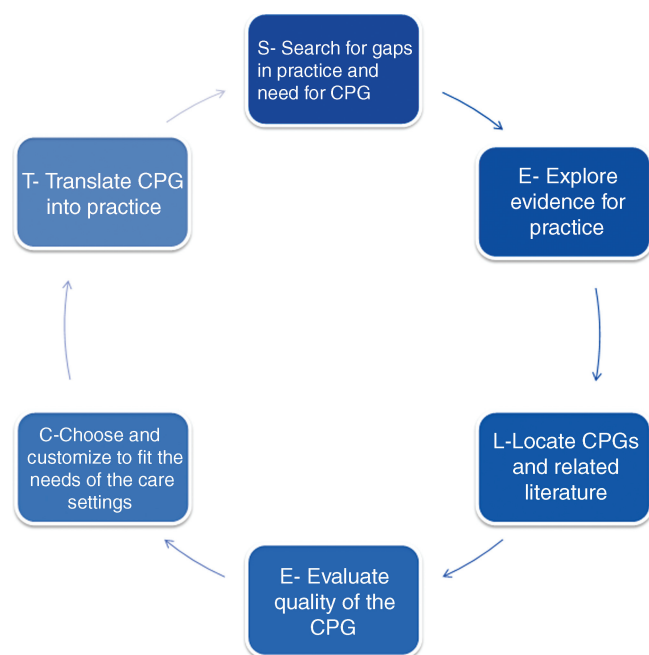
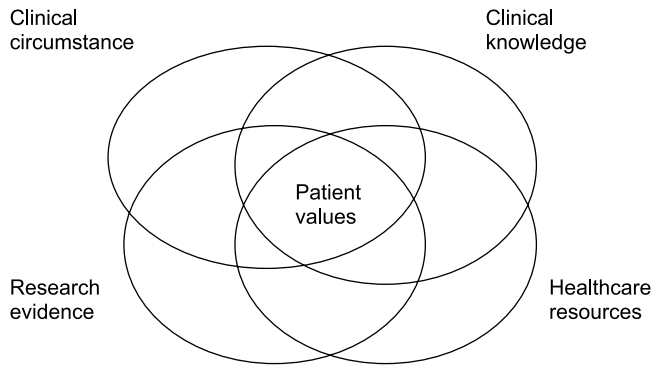


Figure 2.**THE INTERPLAY OF RESEARCH EVIDENCE AND OTHER CONSIDERATIONS IN CLINICAL DECISION MAKING****E—EXPLORE EVIDENCE**

Once the need for a practice change has been identified, clinicians will want to explore and review the available evidence to validate their concern, understand the scope of the problem, and identify potential approaches solutions for the issue.

Explore Evidence and Its Implications in Practice

Although research evidence is often used to address clinical questions, additional information^{4,5} is required to determine if the findings are appropriate, effective, and easy to be integrated into practice:

- Patient values: patient preferences, cultural norms, family dynamics
- Clinical circumstances: severity of illness, location of care settings, interprofessional relationship, practice culture
- Clinical knowledge: expert knowledge/expert knowing/expert opinion, experience, expertise and skills
- Healthcare resources: costs, time, manpower, and leadership to champion change.

The various types of information provide unique perspectives for clinical decision making; they should not be considered in isolation. The intricate relationships are best described in Figure 2 by 4 overlapping and interlocking rings with patient values placed at the center of this conceptual model.

Explore the Various Types of Research Evidence

Gathering and interpreting research evidence are time consuming. It is important to remember that not all research evidence is equal, but it varies in terms of quality, relevance, and strength. The quality of evidence is affected by study designs that are used to minimize error and bias. Relevance refers to the extent that research findings can be applied in a specific care setting. The strength of evidence describes the magnitude and consistency that the treatment effect is ob-

served in clinical studies. Table 3 defines characteristics of research evidence.

Randomized controlled trials (RCTs) are often considered by some to provide the best quantitative evidence to compare the effectiveness of different treatments with randomization; each subject has a fair and equal chance of receiving the intervention under investigation to minimize potential for bias. When multiple RCTs are combined into a systematic review or meta-analysis, the strength of the evidence can be enhanced by a much larger sample size. For many financial, practical, or ethical reasons, RCTs are not always feasible. RCTs also impose stringent entry criteria that include only a subgroup of eligible subjects who may not represent the everyday patients encountered in clinical practice. As such, results of RCTs are not always relevant, applicable, and generalizable to the diverse patient population or applied to address the common clinical questions.

Observational data, pragmatic trial, real-life study, or “practical clinical research” may be more applicable to guidelines that affect a patient population with a high degree of variable presentations, especially where cost alternatives need to be considered.⁶ To achieve this, it is recognized that there may need to be some relaxation of the experimental control exercised in more academically based research.⁷ The alternative is nonrandomized studies with controlled groups for comparison, that is, longitudinal or cross-sectional cohort studies or case-control studies. They are useful to address questions about diagnosis (eg, What are the symptoms associated with venous disease?) and prognosis (eg, How long does it take for a pressure ulcer to heal?). The key criticism of these studies is the potential confounding factors that may have biased the findings and conclusions. Qualitative studies are valuable to answer questions about how people feel, what works in a specific situation, why things occur, and what patients prefer. Recently, 4 levels of evidence for

Table 3.**CHARACTERISTICS OF RESEARCH EVIDENCE**

Characteristics of Evidence	Definition	Common Problems
Quality	Minimal likelihood of bias and error	Significant bias: patients who participated in the study are handpicked by the researcher
Relevance	Meaning and applicability to a specific care setting	Irrelevant application: findings from acute-care hospitals are applied to a home-care setting
Strength	Consistency of the findings	Inconsistent findings: the same dressing is tested in 2 studies with opposite results

qualitative studies have been proposed: generalizable studies, conceptual studies, descriptive studies, and single-case study.⁸ Individuals' opinions (expert knowledge/expert knowing/expert opinion) and case studies/series provide useful information especially in the absence of higher-level evidence, but their results must be interpreted with caution because of potential biases. For individual wound care studies, it is often difficult to find appropriate end points or outcome measures to show small differences between interventions. Furthermore, it is important to avoid generalizing the results from these studies as different related products or devices (even share the similar mechanism) may not be equal or interchangeable.⁹⁻²⁴

What needs to be emphasized is the notion that no one type of evidence is perfect. Various types of studies are required to answer different questions. Consistent with this perspective, the Oxford Centre for Evidence-Based Medicine Levels of Evidence provides an example of levels of evidence.²⁵ The World Union of Wound Healing Societies depicts the contribution of each category of evidence as contributing equally to the provision of optimal patient care (Figure 3). Instead of a hierarchical structure, evidence is arranged around patient preference, the center or focus of evidence-informed practice.²⁶

Finding Research Evidence Quickly

A well-prepared guideline should include a general discussion of the evidence and how it is linked to the recommendations. Another good source is a well-conducted systematic review,

such as a Cochrane review. Web sites such as <http://www.woundpedia.com> provide preappraised guidelines and articles for guidance. In the absence of preappraised information, clinicians and research methodologists may conduct a systematic review to identify all the available evidence and to assess its applicability to practice, but this process is very time consuming.

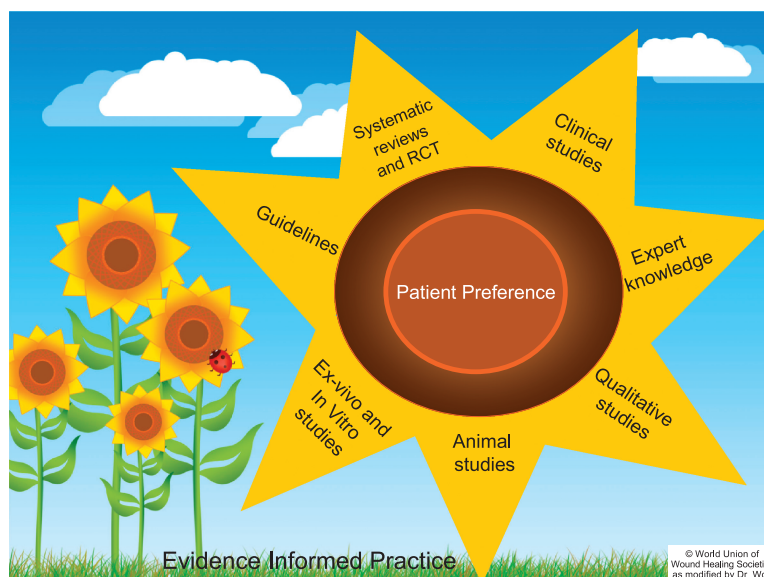
L—LOCATE

CPGs can easily be located and accessed through the Internet. Google is a commonly used search engine, with access to a number of Web sites and databases related to practice guidelines, but the results can be overwhelming. Alternatively, Google Scholar (<http://scholar.google.ca>), which includes only peer-reviewed sources, may be preferred. Credible professional organizations and wound care societies are often involved in the development of CPGs, and their Web sites may have direct links to current and archived CPGs. Some of these are available to nonmembers, as well as members. Published guidelines are indexed in specific databases, such as MEDLINE, CINAHL, EMBASE, and PubMed. Table 4 lists other common Internet sources that could be considered for locating CPGs.

Successful searching combines the use of appropriate search terms and search engines. Mindful selection of search terms will help to limit and focus search results. To obtain more precise results, adding more words may narrow the search results to a better match. Most databases will have predesigned

Figure 3.

WUWHS CATEGORIES OF EVIDENCE



Abbreviation: WUWHS = World Union of Wound Healing Societies.

subject headings (eg, MeSH terms) and have the capacity to limit search results by publication types to retrieve guidelines. A recent literature search yielded guidelines that pertain to the management of various chronic wound types (using the following MeSH terms: skin ulcer, leg ulcer, foot ulcer, varicose ulcer, pressure ulcer).²⁷ Where available, consultation with a knowledgeable librarian can be valuable. Networking with local and professional contacts may identify other unpublished works and guidelines that are in preparation for publication.

E—EVALUATE EVIDENCE

Several guidelines have been developed with the aim to improve the quality of care for patients with pressure ulcers, leg ulcers, and diabetic foot ulcers. Guidelines vary greatly in their quality. Therefore, before adopting and adapting one of these documents for one's clinical practice setting, it is recommended that several guidelines be evaluated and compared.

The authors propose a few guiding principles for evaluating existing guidelines:

- Guidelines should be based on the best available evidence (including expert knowledge, patient preference).
- Description of the quality, relevance, and strength of the evidence should be clear and precise.
- Guidelines should detail probable outcomes: comparing benefits with harmful adverse effects or risks.
- Guideline development should involve multiprofessional groups and should include consumers.
- Guidelines should be comprehensive to avoid bias.
- Recommendations should be flexible to be adapted for local conditions.

Table 4.

INTERNET SOURCES FOR LOCATING CPGs

- American College of Physicians (http://www.acponline.org/clinical_information/guidelines)
- American Medical Association (<http://www.ama-assn.org>)
- American Professional Wound Care Association (<http://www.apwca.org>)
- Canadian Association of Wound Care (<http://www.cawc.net>)
- Centers for Disease Control and Prevention (<http://www.cdc.gov>)
- Centre for Reviews and Dissemination (<http://www.york.ac.uk/inst/crd>)
- European Pressure Ulcer Advisory Panel (<http://www.epuap.org>)
- Healthcare Standards: Official Directory (not free) ECRI Institute (https://www.ecri.org/Products/Pages/healthcare_standards_directory.aspx)
- National Guideline Clearinghouse (<http://www.guidelines.gov>)
- National Institute of Health and Clinical Excellence (UK National Health Service) (<http://www.nice.org.uk>)
- National Pressure Ulcer Advisory Panel (<http://www.npuap.org>)
- Registered Nurses Association of Ontario (<http://www.mao.org>)
- Royal College of Nursing (<http://www.rcn.org.uk>)
- The Cochrane Collaboration (<http://www.cochrane.org>)
- The Joanna Briggs Institute (www.joannabriggs.edu.au/about/home.php)
- World Council of Enterostomal Therapists (WCET) (<http://www.wcetn.org>)
- Wound Healing Society (<http://www.woundheal.org>)
- Wound Ostomy and Continence Nurses Society (<http://www.wocn.org>)
- WoundPedia (<http://www.woundpedia.com>)

- Guidelines should describe the support services and costs associated with various options.
- Guidelines should be revised regularly.

Clinicians and/or facility administrators may choose to evaluate guidelines themselves, but there are several groups and journals that provide pre-evaluated guidelines, such as WoundPedia as previously mentioned, professional, governmental, and wound care associations (eg, Agency for Healthcare Research and Quality [formerly Agency for Health Care Policy and Research], American Professional Wound Care Association, Registered Nurses Association of Ontario, and the Wound, Ostomy and Continence Nurses Society [WOCN]) and scientific journals (eg, *Journal of the American Medical Society*, *New England Journal of Medicine*, *British Medical Journal*).

There are well-established criteria to evaluate the methodological quality of RCTs.²⁸ One of the simplest validated tools for evaluating RCTs is the Jadad scale, which considers 3 domains: randomization methods, double-blinding, and follow-up of dropouts.²⁹ An international, interprofessional working group developed a more elaborate system for grading the quality of clinical recommendations (GRADE—grading recommendations assessment, development and evaluation).³⁰ It takes into account methodological flaws of the reviewed studies, the consistency of results across different studies, the generalizability of research results to the wider patient base, and the magnitude of treatment effect.

Appraisal of Guidelines for Research & Evaluation Tool

The Appraisal of Guidelines for Research & Evaluation (AGREE) Tool provides standardized questions that guide the evaluation of guideline development methodology.³¹ This excellent tool has been used extensively and is generally accepted for assessing the quality of guideline development. The instructions for questions in the 6 domains are clear and explicit and should be reviewed carefully to comprehend the purpose of each domain.

The following are the domains of the AGREE tool: scope and purpose, stakeholder involvement, rigor of development, clarity and presentation, applicability, editorial independence, and evaluating new guidelines.

When a new guideline crosses the desk, how can clinicians decide if they should consider the information for adoption or modification of existing practice? The authors recommend following these steps:

- (1) Assess to see if there are any new recommendations.
- (2) Assess the quality of the supporting evidence.
- (3) Assess for applicability and compare with current practice.
 - (a) If applicable, incorporate new recommendations into existing best practices.
 - (b) If not applicable, stop and drop.

In response to increased focus on improved quality and applicability of clinical research, the US National Institutes of Health has announced a new grading system recognizing other qualities necessary for improved new research grading processes, trial design, conduct, and reporting systems.³²

Comparative effectiveness research (CER) is the process of identifying the most effective interventions for a specific population and then delivering the right intervention to the right patient at the right time. Through the American Recovery and Reinvestment Act of 2009, the US Government allocated \$1.1 billion in support of CER for the development of processes that can collect, standardize, and compare medical data with the ability to recognize patterns, compare patient populations, and identify the most effective treatments to improve patient outcomes.

C—CHOOSE AND CUSTOMIZE THE CPG: 4 S's

After evaluating a new CPG or several guidelines, the process continues as clinicians choose and customize for their practice setting. Choosing which CPG or CPGs to use involves balancing the 4 S's: setting requirements, system partnerships, stakeholder considerations, and the selection process. Once the CPG or CPGs are chosen, it may be necessary to customize them to a particular setting.

There are several excellent guides for helping with the "choose and customize" phase of SELECT. The Institute of Medicine's Guidelines for Clinical Practice (1992) contains several relevant chapters. The former Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), now known as The Joint Commission, published a handbook with many examples in 2000, *Selecting & Implementing Clinical Practice Guidelines in Hospitals*.³³

When considering the 4 S's, one should reflect on the following factors:

- *Setting requirements.* There may be regulatory considerations, such as in the United States, CMS HAC/POA Policy (October 2008); CMS Guidance to Surveyors for Long-term-Care Facilities; and individual state or provincial department of health requirements. In addition, guidelines that are specific to a particular setting must be taken into consideration, such as the American Medical Directors Association pressure ulcer guidelines for US long-term-care settings. Examples of national and international considerations include the World Union of Wound Healing Societies' recommendations and the European and US National Pressure Ulcer Advisory panels' (EPUAP's/NPUAP's) pressure ulcer guidelines.
- *System partnerships.* Facilities may be part of a collaborative network or system. The adopted guideline should be customized to meet particular standards of practice, fit organizational structures, and promote interprofessional relationships. Examples include the Ascension Health Skin Bundle, the Institute

for Healthcare Improvement initiatives, and the New Jersey Hospital Association Collaborative (NO ULCERS).

- *Stakeholder considerations.* Stakeholders represent individuals or groups (eg, point-of-care staff, educators, risk management staff, administrators, researchers, patients, and families) who will be affected by, or are integral to, CPG implementation. The adopted guidelines should be customized to ensure individual roles and functions are consistent with the existing guidelines from various professional societies and affiliations, for example, the American Physical Therapy Association guidelines and the WOCN guidelines.

- *Selection process.* The process for choosing and customizing should be specific to the facility or region that will implement it. It may be done by a committee, task force, and/or by individuals.

Customizing the CPG may involve many different activities from reformatting it to fit with the facility template to tweaking it to work electronically. The reader is referred to chapter 3, "Tailoring Guidelines to the Institutions" in the JCAHO guide.³³

T—TRANSLATE THE CPGs INTO PRACTICE

Translating CPG into practice is a complex and arduous process. The authors identified 8 key "S" factors that should be considered as part of an environmental scan prior to implementation of a CPG: significance; stakeholders; systems and structure; social factors, skills, and support; surveillance; seminar, educational tool kits, enablers, and mentors; and sharing implementation stories.

Significance

How important is it to implement the CPG? How would implementation of a CPG impact existing practice?

The intention behind CPGs is to streamline and improve the quality of healthcare and outcomes for patients. The significance can be demonstrated by comparing the benefits of instituting a CPG (promote healing, reduce pain, shortened length of service) with the potential risks of not implementing the CPG (wound infection, amputation, increased utilization of health services and medications). Specific ruling and regulations may also provide an impetus for change. For example, the CMS HAC/POA ruling that does not pay the higher Medical Severity Diagnostic-Related Group for specific hospital-acquired conditions such as pressure ulcers has prompted many organizations to implement pressure ulcer prevention CPGs.

Stakeholders

To what extent do the stakeholders support the implementation?

Reactions to shifting practice paradigm and health system redesign to meet the recommendations of CPGs can be negative and unpredictable; there is a need to lobby for support from the

key stakeholders and pay attention to aligning expectations and interpretations for quality patient care. The implementation is likely to be successful if a critical mass of stakeholders “buys into” the idea of change.^{34,35}

Systems and Structures

What are the communication and decision-making processes?

There are multiple parallel structures and systems within care settings that determine lines of authority, allocation of responsibilities, communication, and decision-making processes. The implementation group could identify these organizational structures and steps to promote efficient allocation of resources and delivery systems redesign.³⁵ The organizational structure or healthcare delivery models may need to be redesigned for adherence to CPG recommendations. The authors suggest that care-setting policies and procedures be revised and are congruent with recommendations. To achieve this, a committee of key representatives from all care-related areas could be assembled to identify patient care issues for improvement, set priorities, and to design an implementation program. Multiple implementation strategies could be suggested, and the group of experienced practitioners could decide on a final plan.

Social Factors

What are the values, attitudes, and beliefs of the care setting toward the implementation of CPGs? What is the institution's readiness to change?

Values, attitudes, and beliefs that support evidence-based practice can be different, depending on the professional subgroups within healthcare organizations. Healthcare cultures that emphasize group affiliation, teamwork, and coordination have been associated with greater success in the implementation of continuous quality improvement practices.

Skills and Support

Who are the leaders to support the implementation? Are there human, physical, and financial resources to support CPG implementation?

Leadership plays a central role in translating CPGs into practice. Supportive (transformational) leaders are facilitators who have the personal attributes, vision, time, patience, and motivation to foster team building, trust, and open communication using both formal and informal opportunities. Support at the patient's point of care is also critical. Some institutions have found that having “change champions” with specialized knowledge in the practice area is key to achieving this outcome.³⁶

Surveillance

What mechanisms are in place to measure and monitor outcomes? Asking the question, “How are we doing?” as an ongoing process is important.

The authors recommend that appropriate monitoring and feedback mechanisms be in place to evaluate adherence to CPG recommendations, end-users' experiences with the guidelines, and patient outcomes. Although chart audits are commonly used, other possible methodologies may include self-administered questionnaires, interviews, and focus-group discussions. Evaluation could also include an assessment of whether there are sufficient resources (supplies, equipment, and staff) to provide care in a manner that is consistent with the CPG.

Seminars, Educational Tool Kit, Enablers, and Mentors

Dissemination of printed educational material and didactic educational sessions have been shown to be generally ineffective in changing practice.^{34,37,38} Interactive educational platforms especially if delivered in more than 1 session are more likely to result in desired changes. Small group sessions (academic detailing) or one-to-one visits (outreach visits) with hands-on training and interactive discussion could be considered to address potential barriers, anxiety, and concerns about CPG implementation. Education or training could start with small groups of champions or key opinion leaders who will be trainers or change agents to train their fellow colleagues. Designing online or Web-based learning as part of an educational plan may involve more extensive resources and planning.^{34,35,39,40}

Reminders in the form of enablers (eg, pocket cards in user-friendly, just-in-time concise formats) with specific recommendations are helpful enablers for practice. Local champions are experienced practitioners and change agents with additional communication, negotiation, and team-building skills. Key opinion leaders are respected colleagues that are acknowledged as experts in a field or discipline. The availability of a mentor or preceptor will be beneficial to facilitate skills acquisition and knowledge transfer when the initial attempt runs into roadblocks. The expertise of opinion leaders is often recognized by their innovative ideas and ability to integrate complex ideas into practice. Ongoing formal or informal feedback should be timely and constructive to motivate change.

Utilization of multiple interventions (but not every strategy is necessary) is prudent to overcome potential barriers to change and is more likely to be effective. Remember to integrate the following adult learning principles into the implementation process⁴¹⁻⁴⁴:

- Learning is a discovery of the personal meaning.
- Learning occurs within a social and relational context.
- Learning is built on an accumulation of life experiences and knowledge that may include work-related activities, family responsibilities, and previous education.
- There are different types of learners (eg, concrete, abstract, and so on).
- Adult learners need to be free to direct themselves.

- Adult learners are more likely to engage in learning if they know why they have to learn.
- Learning should be practical and relevant, with a focus on how new knowledge can be applied in real-life situations.
- The most potent motivators for learning include factors such as increased job satisfaction, self-esteem, and quality of life.

Sharing Implementation Stories (Success and Progress)

Communities of practice (CoP) are groups of people who share their successes and concerns for a practice (eg, clinical practice, research, administration, and so on) and who collectively improve practice with regular group activities.⁴⁵ Members of the CoP create conduits to nurture new knowledge, stimulate innovation, or share existing tacit knowledge (known from experience but cannot be measured or quantified with usual quantitative methodologies). This structure treats all members as equals, allowing the group to tackle common problems in knowledge transfer and compare and contrast the strengths and weaknesses of patient care solutions for themselves as practitioners and for different healthcare systems.

SUMMARY

CPGs are developed to bridge the gap between evidence and practice. However, the task of locating, evaluating, selecting, and implementing CPGs is complex and can be daunting. This guidance document describes a simplified 6-step SELECT process to utilize available resources with an interprofessional team to improve practice that is informed by evidence. ●

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