



*Template*  
*for the*  
*Development of Clinical Guidelines*  
*for*  
*Nurse Practitioners*

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## Using this Template

Other than the statement of intent, disclaimer and scope of practice statement, there is no set format for Nurse Practitioner clinical guidelines. There are many possible subheadings but the only useful ones are those that are relevant to - and best describe the practice. The suggested headings listed below can be combined or deleted if not relevant.

### 1. Title

Unless diagnosis is confirmed title should reflect the presentation - rather than a condition (e.g. chest pain - not myocardial infarction, ankle trauma, not sprained ankle, calf pain, not DVT)

### 2. Statement re local implementation of guidelines & proposed Nurse Practitioner role

A short description regarding the setting the Nurse Practitioner will be working in, and how the guideline might be utilised in relation to the local conditions may provide clarity for those unfamiliar with the Nurse Practitioner role.

### 3. Statement of Intent of a Clinical Guideline and Disclaimer

Include a statement to clearly indicate that the guideline should always be used with regard to clinical judgment to determine the plan of care for each patient or client. Reassure users that reasonable steps have been taken to ensure that the guidelines were properly prepared and are based on the best information available at the time of publication. For example wording for the intent and the disclaimer might be:

The information provided in this Clinical Guideline ("the Clinical Guideline") is intended for information purposes only. Clinical Guidelines are designed to improve the quality of health care and decrease the use of unnecessary or harmful interventions. This Clinical Guideline has been developed by clinicians and researchers for use within the ..... Health Service. It provides advice regarding the care and management of patients presenting with ..... by the nurse practitioner - .....

While every reasonable effort has been made to ensure the accuracy of this Clinical Guideline, no guarantee can be given that the information is free from error or omission. The recommendations do not indicate an exclusive course of action or serve as a definitive mode of patient care. Variations, which take into account individual circumstances, clinical judgement and patient choice, may also be appropriate. Users are strongly recommended to confirm by way of independent sources that the information contained within the Clinical Guideline is correct.



The information in this Clinical Guideline is NOT a substitute for proper diagnosis, treatment or the provision of advice by an appropriate health professional.

This Clinical Guideline may also include references to the quality of evidence used in its formulation. Where this has not been located, the Clinical Guideline includes references to support the recommended care. Providing a reference to another source does not constitute an endorsement or approval of that source or any information, products or services offered through that source.

The Minister for Health, the State of Western Australia, and their employees and agents shall accept no liability for any act or omission occurring in reliance on this Clinical Guideline and for any consequences of any such act or omission.

#### **4. Scope of Practice**

Identify the patients suitable for management by a Nurse Practitioner alone (e.g. description of age range, gender, clinical severity, clinical description and co-morbidity).

Specify where the patient presentation fits on the Nurse Practitioners Scope of Practice (e.g. mild hypertension <140/90; mild dehydration i.e. < 8-10%, minor wounds excluding the face etc.)

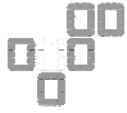
Identify those patients who should be managed in consultation with (or only) by a medical practitioner. Use "flags" (e.g. \* or ★) to highlight potential problems, signs & symptoms or when to urgently refer any obvious & immediate exclusions (e.g. suspected ischaemia, impending airway compromise e.g. epiglottitis; haemodynamically unstable; significant drug reactions etc.) Flags may also be used to highlight possible pitfalls in clinical decision-making, e.g. failure to rule out meningitis when the presentation is a flu like illness or appendicitis.

#### **5. Introduction**

Briefly describe the symptoms for which care is sought/presenting issues. This may include some information related to the epidemiology, risk factors, differential diagnoses and aetiology of the presentation.

#### **6. Required Patient Assessment**

The goal of assessment is to obtain information that will enable a specific diagnosis to be made of the condition/disease state and its severity. Findings from the assessment may also indicate the point of referral to a medical practitioner - e.g. if they fall outside the Nurse Practitioner's patient population in terms of severity or disease state.



### *6a. Patient History*

Onset and duration of presenting symptoms

Presence of known risk factors for the symptoms (e.g. smoking; family history etc.)

Previous medical history

Current medications

Other relevant information, e.g. recent overseas travel etc.

### *6b. Physical Assessment*

While a normal physical assessment of the patient is presumed, on many occasions specific assessments will be required (e.g. digital rectal examinations in cases where enlargement of the prostate is implicated in lower urinary tract symptoms). Include the need for any physical assessment that may be age, gender or past medical history dependant. Justify with a reference.

## 7. Investigations

Specify the relevant diagnostic investigations such as pathology and medical imaging, which will assist in making a definitive diagnosis. For investigations used infrequently or which are controversial or expensive, include a reference to the evidence supporting the practice.

Include any required pathology tests - including biochemistry, haematology and microbiology normal levels or ranges and test results, which will indicate a need for further consultation.

## 8. Interpretation of Findings

If there are several possible diagnoses, consider including a decision tree (algorithm) that illustrates the pathway used to arrive at the diagnosis. Identify any clinical differences for specific populations e.g. geriatric or paediatric that may apply. Listing "pearls of practice" (e.g. rebound tenderness is less likely in geriatric patients with appendicitis) may also be useful. Support these recommendations with a reference.

Summarise the options for treatment that arise from the presentation, history, physical assessment and results of investigations. Support the inclusion of each alternative in the list of options with a reference to the relevant evidence.

## 9. Recommended Management - Presenting condition

Describe the recommendations for the actual care or treatment/procedure e.g. dressings, removal of foreign body; splinting/plastering; bed rest; patient education; counselling; etc. Where options for treatment exist, include a brief statement outlining the evidence supporting the recommendation.



*Notes:*

Flowcharts are one way of demonstrating a clear decision pathway for the inclusion/ exclusion or treatment modality for the target population. They may also be useful to identify obvious pitfalls (potential traps or unusual presentations).

Tables are helpful to identify signs & symptoms that differentiate between mild, moderate or severe. Use of severity scores may assist in identifying the patients who need to be referred

In the absence of empirical evidence, recommendations for clinical treatment should reflect the consensus of opinion of the local stakeholders. Where the treatment is based on consensus, include a statement that identifies the source of the recommendation/s and list the names of those contributing to the consensus at the end of the document.

#### 10. Formulary of Drugs Relevant to Presenting Condition

Specify orders for relevant medications. Include the generic name, dose/route/frequency, therapeutic class, schedule indications/contraindications/cautions/side effects and/or inter-actions as applicable.

Suggest therapeutic dosages for medications for specific populations (children, neonates, aged and or renal or hepatic impaired patients).

List any IV fluids associated with and outlined in the clinical guideline.

*Note:* Evidence may exist which supports the use of medications not listed in the formulary. The need for such medication/s may indicate the patient's condition falls outside the Nurse Practitioner's scope of practice in terms of patient population, severity of condition or disease state.

#### 11. Associated Care

Cultural considerations and/or co-morbidities may require consultation/referral to other health care providers or agencies (interpreter service, allied health professionals etc.)

#### 12. Expected Outcomes

Expected outcomes should be specified for all recommended interventions. This will facilitate the evaluation of the services provided by Nurse Practitioners, and enable audits to be conducted on specific elements of the service they provide.



*Describe:*

The expected response with regard to timeframe. Failure to achieve the expected response in the given time may be an indication of the need to refer the patient to other health professionals.

Actions that will be taken if outcome(s) not achieved.

Arrangements for follow up and resources for referral to other members of the health care team.

### 13. Fitness for Discharge

If there is likelihood of admission to hospital, specify the criteria that the patient should meet before being discharged home.

### 14. Discharge Advice

Include information regarding:

Change/s in the patient's condition which should prompt him/her to seek advice

Specific medication instructions

Specific care (of plasters, dressings etc.)

### 15. Follow up

Include information regarding routine follow up appointments, required or anticipated referrals and the issue of certificates (Medical, Workers Comp, etc.)

### 16. References

The goal of referencing is to enable other readers to locate the source information. Thus the use of other resources - e.g. existing clinical guidelines, flow charts, tables, etc. need to be fully referenced using a recognised referencing system (e.g. APA) that includes:

- author or organisation
- year of publication or authorship
- title of the source
- journal or website if applicable
- date web site accessed
- relevant page numbers, table numbers, etc.
- References may include:
  - journal articles, conference proceedings ; (primary reference)
  - hospital protocols/hospital handbooks (secondary references or expert opinion)



- web sites from relevant organisations - SIGN, NICE, Guidelines Clearing House, Joanna Briggs Institute, Cochrane etc.).

Use of a reference database is recommended to manage references.

Note: "Endnotes" in the "Word" word processing software do not equate to the bibliographic database 'Endnote'.

### **17. Authorship/Endorsement/Review**

The names of the guideline developers, the name of the body sponsoring the guideline and a list of names, signatures, dates and roles of those endorsing it should appear at the end of the document.

The date of endorsement and the date when the guideline should be reviewed must also be included. New clinical guidelines need to be reviewed within one year to confirm their feasibility in the practice area.

Subsequently reviews should occur at least every two years - or earlier if there is practice or population change.

### **18. Clinical Protocols**

Any clinical protocols/procedures to which the guideline refers will also require approval by those endorsing the Clinical Guideline. Attach these documents as an Appendix to the Guideline.

Ideally the practice recommended in the protocol will be evidence based, but for a variety of reasons, the practice setting may not always be conducive to the use of best evidence.

## **OTHER CONSIDERATIONS**

### **Language**

The guidelines should be of a written standard expected for professional papers

The language should be scientific, specific, clear and unambiguous and where possible written in "plain" English

Avoid using Lay descriptors unless used in patient discharge advice information.

Where abbreviations are used, the full description should be included for the first time with its abbreviation or acronym. For subsequent use the shortened form can be used. Where many specialty-specific abbreviations need to be used, consider attaching a list of abbreviations to the guideline.



## Clarity of Expression

While there is always room for the use of clinical judgement when using guidelines, the recommendations made in the guideline should be specific in regard to the patient population, care priorities, assessment and management.

An example of a specific recommendation [for management] is:

“Prescribe antibiotics for children of two years or older with acute otitis media if the complaint:”

- lasts longer than three days or
- increases after the consultation despite adequate treatment with painkillers (& ref)

In these cases amoxycillin should be given for 7 days (supplied with a dosage scheme).

An example of a vague recommendation is:

“Antibiotics are indicated for cases with an abnormal or complicated course.”<sup>1</sup>

## Draft Guidelines

“Watermarks” are useful to identify draft documents

“Footers” may be useful to identify which version of draft document is being submitted and the date of writing

Use of the “Track Changes” tool easily identify changes to a draft version

## Proof Reading

Guideline developers often find it difficult to detect errors or ambiguities in their own work. It is therefore recommended that guidelines (and protocols) are carefully proof read by a health care professional with strong English language skills.<sup>2</sup>



*SUGGESTED* FORMAT FOR A CLINICAL GUIDELINE

**Note:**

The format suggested here is not prescriptive. It represents one way of presenting a clinical guideline that is easy to follow. Other formats are acceptable

**Title**

Statement re local implementation of guidelines & proposed Nurse Practitioner role

Statement of Intent of a Clinical Guideline and Disclaimer

SCOPE OF PRACTICE		
PRACTITIONER	SCOPE	OUTCOMES
Nurse Practitioner - (Name of Specialty)	Which patients will the NP treat	What will be the measurable outcome? (Outcome for patient after treatment)
Medical Practitioner ± NPC	Which patients will the NP refer to a Medical Practitioner	Criteria for referral
PATIENT ASSESSMENT		
PATIENT HISTORY	INFORMATION	OUTCOMES
Presenting symptoms	What information will be gathered about the presenting symptoms	Expected outcome (measurable)
Known risk factors for the presenting symptoms		
Previous medical history	Relevant medical, surgical and obstetric history	



Medications	Current medications	
Other relevant information		
<b>PHYSICAL ASSESSMENT</b>	<b>INFORMATION</b>	<b>OUTCOMES</b>
Usual physical examination	Record findings	Measurable expected outcomes
Indications for specific examinations	List any examinations relevant to the presenting problem - inc. gender specific	
<b>INVESTIGATIONS</b>		
<b>INDICATIONS</b>	<b>INVESTIGATIONS</b>	<b>OUTCOME</b>
Quantification of presenting symptoms	Test/strategy	<p>e.g. Indications will exist for all investigations ordered</p> <p>Results from all investigations will be used when determining the future management of the patient.</p>
Routine investigations	Given the presentation, what investigations are required?	
<i>Pathology</i>		
Why the test is indicated?	Name of test	
<i>Imaging</i>		
Why the test is indicated?	Name of test	
<i>Haematology/Biochemistry</i>		



Why the test is indicated?	Name of test	
Other investigations		
Why the test is indicated?	Name of test	
<b>FOLLOW UP AND EDUCATION</b>		
<b>INTERVENTION</b>	<b>INFORMATION</b>	<b>OUTCOMES</b>
Follow up appointments	When Required investigations prior to review	e.g. Underlying disease will be detected at follow up
Patient education and discharge advice	What is required in terms of: self care specific care (of plasters, dressings etc.) use of medications, follow up appointments and indications to return.	Measurable expected outcomes
Certificates and Letters	Absence from work/ attendance certificates Letter to patient's GP	Certificates are provided when required

**References**

1. The AGREE Collaboration. *Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument*. 2001 [cited 10 May 2007]; Available from: [www.agreecollaboration.org](http://www.agreecollaboration.org).
2. New South Wales Department of Health. *Clinical Practice Guidelines for Nurse Practitioners in NSW*. 2005 [cited 28th February 2007]; Available from: [http://www.health.nsw.gov.au/nursing/pdf/np\\_clin\\_glines\\_paper3.pdf](http://www.health.nsw.gov.au/nursing/pdf/np_clin_glines_paper3.pdf).