CEBA Guidelines

- Evidence-based medicine typically focused on a single issue (e.g., use of cisatracurium, pregnancy testing)
- Search of all relevant databases for relevant published articles including PUBMED, EMBASE, PUBMED CENTRAL, GOOGLE SCHOLAR. The database search and/or meta-analysis should be of sufficient quality that it could lead to a peer-reviewed publication.
- Address discrepancies in the literature and discrepancies with any national / organizational guideline-making entity such as ACA, AHA, ASA, ASRA, etc.
- Use CEBA format (see website: https://www.mc.vanderbilt.edu/vunet/vumc.php?site=anesfaculty&doc=38656)
- CEBA guidelines should be reviewed and either reaffirmed or updated every 3 years with a new literature search, or sooner if there have been new publications from expert consensus groups, national guideline-making entities (e.g., ACA, AHA, ASA, ASRA, etc.), original research, or local changes in clinical practice that would significantly alter the guideline summary points.

Clinical Guidelines

- The intention of the clinical guidelines is to provide a framework that can guide all members of the anesthesia care team in the provision of anesthetic care for particular procedures or subsets of procedures in a consistent fashion.
- Clinical guidelines typically consist of anesthetic care pathways using evidence-based medicine and national guidelines from relevant entities (e.g., ACA, AHA, ASA, ASRA, etc.) whenever possible and appropriate. As such, a thorough literature search for applicable evidence is the first and most important step in guideline development. The Biomedical Library staff can assist you in performing this search.
- Disagreement between local clinical guidelines and national guidelines may occur, particularly for issues where expert opinion and low level evidence-based medicine predominate. These discrepancies should be explicitly noted and a rationale supporting the local clinical guidelines should be provided in the document.
- Clinical guidelines need to include sufficient practical information for those expected to implement or act on the recommendation to do so successfully. The guidelines may be principally focused on the mechanics of delivering anesthesia care for unique procedures or circumstances. In such cases, only limited evidence may be available to support some of the recommendations. The best available published information to support the recommendations should be provided in the guideline.
- Ideally, clinical guidelines should be developed by collaborative teams consisting of at least one member from each group of relevant providers (anesthesiology attendings, residents, and CRNAs). Guidelines need to be vetted by the majority of the anesthesia care team members who typically provide anesthesia for these procedures, the specialty team leader and the Division Chief, and when possible and relevant, by the surgeons involved in these procedures.
  - Examples of Clinical Guidelines:
    - Management Guidelines for VPEC Laboratory Abnormalities
Regional Anesthesia in the Anticoagulated Patient
https://vpims.mc.vanderbilt.edu/Anesthesia/Protocols/General/2010%20Internal%20website%20anticoagulation%20recommendations%20chart.pdf

Clinical guidelines should be reviewed and either reaffirmed or updated every 3 years with a new literature search, or sooner if new evidence or external guidance (e.g., publications from expert consensus groups, national guideline making entities such as ACA, AHA, ASA, ASRA, etc.) or local changes in clinical practice have emerged that would significantly alter guideline recommendations.

Format for the clinical guidelines includes:

I. Recommended elements of care in a succinct presentation at the beginning of the document. Algorithms or charts may be helpful. Shorter versions are likely to have better compliance. Please superscript reference numbers and then list numbered references at the end of the document.

II. Discussion of clinical issues providing rationale with published evidence, whenever possible, and including superscripted reference numbers. When clinical issues or recommendations that lack high-level evidence will be included in the anesthetic care pathway / guideline (e.g., to pursue the goal of providing more consistent care to a selected patient cohort), these issues or recommendations should be clearly identified as not being supported by high-level evidence.

III. References.

Clinical Protocols

Clinical protocols are intended for use in procedures that require complete standardization of care and where deviation from the protocol would invalidate the intended result. Examples of Clinical Protocols include:

- Abciximab (Reopro®) Dosing Information
- Portions of transplant protocols addressing immunosuppression and other transplant issues.

Use of relevant references is also required when possible.

Ideally, protocols should be vetted by the majority of the anesthesia care team members who typically provide anesthesia for these procedures, the specialty team leader and the Division Chief, and when possible and relevant, by the surgeons involved in these procedures.

Clinical protocols should be reviewed and either reaffirmed or updated every year with a new literature search, or sooner if there have been new publications from expert consensus groups, national guideline making entities (e.g., ACA, AHA, ASA, ASRA, etc.), original research, or local changes in clinical practice that would significantly alter the guideline summary points.

Departmental Clinical Policies

Departmental clinical policies are intended to describe a course of action adopted by the department, medical center, or university governing specific issues (e.g., VUMC Dental Injury During Anesthesia Policy