# Model CARI Guideline

The CARI Guidelines should include the following sections:

***The guideline/s***

The guideline recommendations should be clearly outlined and the supporting evidence level/s stated (**Levels I or II evidence**). These should be enclosed by a text box. Each recommendation should address benefits and harms according to the level of risk in different patient subgroups. If no Level I or II evidence exists, the statement "No recommendations possible based on Level I or II evidence" should be inserted in the text box.

***Suggestions for clinical care***

This section can be used to list information that is useful for readers of the document to see but which does not warrant the status of an official recommendation. Examples include the intervals at which certain groups of patients should be reviewed, suggestions for patient education and support, and surgical techniques. This is the appropriate place to include data from **Level III and IV evidence** sources (i.e. evidence from comparative studies such as cohort studies, case-control studies and evidence from case series). This section replaces the "Practice Tips" section that previously appeared in guidelines.

***Background***

The background should describe the condition to be detected, treated or prevented. Management options available for the condition should be stated along with outcomes of interventions that are both beneficial and harmful to the patient. A brief statement about the clinical importance of the problem, what is known about the problem, and the objectives of the guideline should also be included.

***Search strategy***

The CARI Research Officer will make available to the writer of each guideline details of the search strategy used, databases searched and search dates.

***What is the evidence?***

This section should list the guideline writers' summaries of RCTs; it is not necessary to write a full systematic review. Each relevant study should be summarised in one paragraph (i.e. number of patients, interventions used, results of outcomes measured etc). A brief critical appraisal addressing the strength of evidence, size of effect and relevance of effect should also be included.

*Levels of evidence to be used are as follows:*

Level I: Evidence obtained from a systematic review of all relevant RCTs

Level II: Evidence obtained from at least one properly designed RCT

Level III: Evidence obtained from well-designed pseudo randomised controlled trials or comparative studies (i.e. cohort studies, case control studies, interrupted time series etc)

Level IV: Evidence obtained from case series (either post-test or pretest/post-test)

| Type of evidence (dimension) | Definition |
|---|---|
| **Strength of evidence** | |
| *Level* | The study design used, as an indicator of the degree to which bias has been eliminated by design (see levels outlined above). |
| *Quality* | The methods used by investigators to minimise bias within a study design. |
| *Statistical precision* | The P value or alternatively, the precision of the estimate of the effect (as indicated by the confidence interval). It reflects the degree of certainty about the existence of a true effect. |
| **Size of effect** | The distance of the study estimate from the 'null' value and the inclusion of only clinically important effects in the confidence interval. |
| **Relevance of evidence** | The usefulness of the evidence in clinical practice, particularly the appropriateness of the outcome measures used. |

Source: NHMRC 2000

## ***Summary of the evidence***

This section should summarise the evidence presented above. The four Table templates provided should be used to present the evidence (Table 1 – Characteristics of included studies; Table 2 – Quality of randomised trials; Table 3a – Results for continuous outcomes; Table 3b – Results for dichotomous outcomes). These should be included as Appendices.

## ***What do the other guidelines say?***

Other guidelines in circulation (e.g. K/DOQI, UK Renal Association, Canadian Society of Nephrology guidelines, etc) that pertain to the subtopic should be included here – the CARI Office can assist with this task. If there is disagreement between these and the CARI guidelines, the conflict should be discussed, and reasons provided.

## ***Implementation and audit***
This section should include clear methods of implementation of the guideline, allowing for monitoring of compliance. In doing so, it should provide outcomes that can be measured and the provision for doing so. For example, in peritoneal dialysis, one could suggest that all instances of catheter blockage, catheter leakage and tunnel infection be recorded on a form attached to each patient's notes and in a unit database, and that the unit be asked to produce quarterly statistics on these events.

## ***Suggestions for future research***
If the recommendations have identified areas needing further research, the topics should be mentioned here along with suggestions of possible study designs for undertaking the research.

## ***Conflict of interest declaration***
Each Guideline Group member and Steering Committee member must read and sign this document and forward it to the Chair of the CARI Steering Committee before commencing work on a CARI guideline/the Steering Committee.

## ***References***
This section should contain a list of references from studies included in the Evidence and Background sections.

## ***Appendices***
Any relevant tables such as the 'Characteristics of Included Studies' should be included by guideline writers in this section. Sample table templates can be downloaded from the CARI website (www.cari.org.au) or obtained from the CARI Office (email: DeniseC2@chw.edu.au).