Step 1 of TRIP refers to Identifying a clinical problem

When it comes to TRIP – what we are trying to identify here is the Evidence-Practice Gap.

Understanding what SHOULD be done – that is, what does the evidence or best practice say?
Verse understanding what IS done – that is, what does current practice look like?
Are two very different concepts. Determining the evidence-practice gap is to know the difference between the two.

There are two key ways of identifying the evidence-practice gap [1]:

- New knowledge or evidence
  - Is this knowledge applied in practice?
    - YES: Prevent Relapse, monitor use
    - NO: Possible TRIP project
- Perceived problem in health care
  - Is there ‘evidence’ on best practice?
    - YES: Research Question
    - NO

The first is a top down approach when new evidence or knowledge has been generated, such as new guidelines released OR systematic review published resulting in the question, is this new evidence in line with the way we currently practice?

If so – there is no need to change anything – just monitor practice and support others to practice in this way.
If not – then this may trigger the need for a TRIP project to review current practice and implement the new evidence or knowledge if applicable in your setting or context.
The second way to identify an evidence practice gap is bottom-up approach – where there is a perceived problem in clinical practice this might be a bug bare of a clinician or frustration experienced by a team.

In this instance it leads to the question – is there evidence on best practice to address this clinical problem? If evidence exists – and this is not currently being applied in practice – this could trigger the need for a TRIP project.

Alternatively, there might not be evidence, in this case it’s not a TRIP project your undertaking but instead generating a research question requiring further experimentation and exploration.

To summarise, this flow chart highlights the two key ways of identifying an evidence practice gap. A TRIP project may be borne out of new knowledge NOT currently reflected in practice OR a problem identified in practice, and care is not reflective of best practice or best evidence.

Now, when you reflect on your practice and go through the process of identifying the evidence-practice gap, you might find more than one. A good way to prioritise all of the evidence practice gaps you have generated – is to use a decision matrix.

This is a simple method to help to define what are your most important issues –

<table>
<thead>
<tr>
<th>Impact</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Low</td>
<td></td>
</tr>
</tbody>
</table>

This impact/prevalence or frequency matrix can be considered from both the healthcare provider point of view and also the patient/carer perspective.

It is important to consider two main questions

- What are the most common problems you encounter in practice?
- What can be the most problematic or has the biggest impact?

Ideally, you would want to prioritise the clinical issue that is both high impact and high frequency.

At this point it can be timely to engage the wider care team and any relevant stakeholders to further explore the evidence practice gap or problem that has been identified, this might bring a different perspective from what you thought and is a key part of building early engagement in any TRIP project.

It can be tempting at this point to want to get in there to start fixing the perceived problem or implementing the new knowledge but we haven’t finished with our problem yet! The next webinar will help you to understand ‘how do you know it’s a problem’ and will create a solid foundation to commence your TRIP project upon.
References