PRISMA 2020 Checklist

Supplementary File 1

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	1
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	2-3
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	4-6
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	6
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	7
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	8
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	8 plus Supplementary File 3
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	8 plus Supplementary File 2
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	9
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	N/A
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	10
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	9-10
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	10
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	N/A
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	10
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	10
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A

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Section and Topic	Item #	Checklist item	Location where item is reported
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	11
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	11
Study characteristics	17	Cite each included study and present its characteristics.	
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	28 plus Supplementary File 6
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	11-17 and 19-38
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	N/A
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	37
	23b	Discuss any limitations of the evidence included in the review.	37
	23c	Discuss any limitations of the review processes used.	41
	23d	Discuss implications of the results for practice, policy, and future research.	37-42
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	7
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	7
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	45
Competing interests	26	Declare any competing interests of review authors.	45

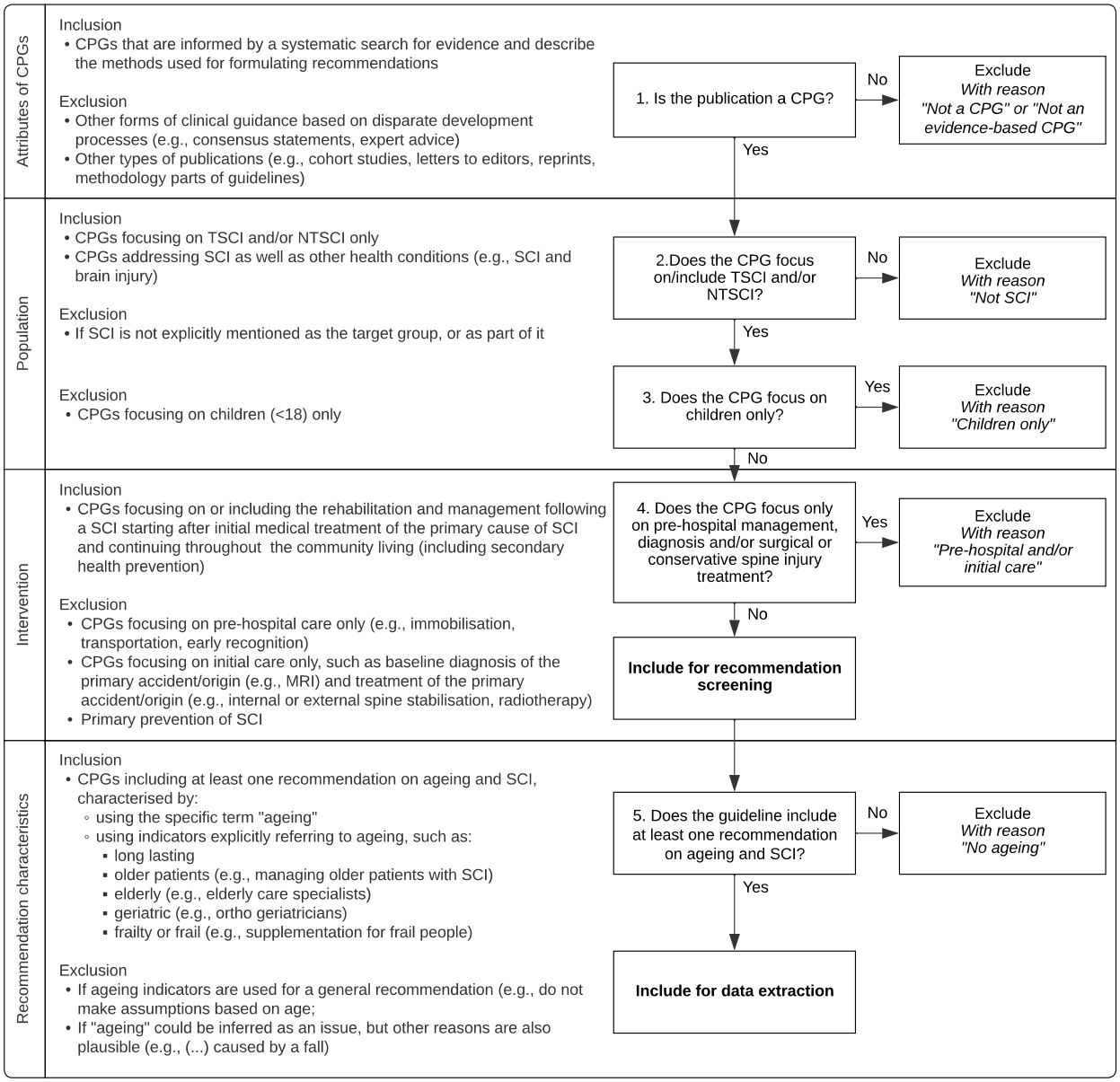
PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	59

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

Supplementary file 2



Supplementary file 3

Search strategy for PubMed	
Search	Query
#40	#38 AND #37 AND Filters*
#39	#38 AND #37
#38	#35 OR #36
#37	#27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34
#36	#5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26
#35	#1 OR #2 OR #3 OR #4
#34	"Practice Guideline"[Publication Type]
#33	Guideline[Publication Type]
#32	"Practice guideline*"[Title/Abstract]
#31	"Clinical Guideline*"[Title/Abstract]
#30	"Clinical Practice Guideline*"[Title/Abstract]
#29	"Best practice*"[Title/Abstract]
#28	"Practice guidelines as topic"[Title/Abstract]
#27	"Practice Guidelines as Topic"[MeSH Terms]
#26	"Quadripares*"[Title/Abstract]
#25	"Tetraplegia*"[Title/Abstract]
#24	"Quadriplegia*"[Title/Abstract]
#23	"Brown sequard syndrom*"[Title/Abstract]
#22	"Paraplegia*"[Title/Abstract]
#21	"Whiplash Injur*"[Title/Abstract]
#20	"Syringomyelia*"[Title/Abstract]
#19	"Spinal Cord Neoplasm*"[Title/Abstract]
#18	"Spinal Cord Compression*"[Title/Abstract]
#17	"Myelitis"[Title/Abstract]
#16	"Cervical Myelopath*"[Title/Abstract]
#15	"Myelopath*"[Title/Abstract]
#14	"Spinal Cord Disorder*"[Title/Abstract]
#13	"Spinal Cord Disease*"[Title/Abstract]
#12	"Central Cord Syndrome*"[Title/Abstract]
#11	"Spinal Cord Contusion*"[Title/Abstract]
#10	"Post Traumatic Myelopath*"[Title/Abstract]
#9	"Spinal Cord Laceration*"[Title/Abstract]
#8	"Spinal Cord Transection*"[Title/Abstract]
#7	"Spinal Cord Injur*"[Title/Abstract]
#6	"Traumatic Myelopath*"[Title/Abstract]
#5	"Spinal Cord Trauma*"[Title/Abstract]
#4	"Quadriplegia"[MeSH Terms]
#3	"Paraplegia"[MeSH Terms]
#2	"Spinal Cord Diseases"[MeSH Terms]
#1	"Spinal Cord Injuries"[MeSH Terms]
	*Filters: English, German, from 2012/1/1 - 2022/28/12

Supplementary file 4

Identified clinical Practice Guidelines				
From databases				
N°	Title	Author	Year	Source Link
1	Systematic review and practice policy statements on urinary tract infection prevention in adults with spina bifida	Tradewell, M. and Pariser, J.J. and Nimeh, T. and Elliott, S.P.	2018	https://www.embase.com/search/results?subaction=viewrecord&id=L622364064&from=export U2 - L622364064
2	Prioritization of risk situations in neuro-urology: guidelines from Association Française d'Urologie (AFU), Association Francophone Internationale des Groupes d'Animation de la Paraplégie (A.F.I.G.A.P.), Groupe de Neuro-urologie de Langue Française (GENULF), Société Française de Médecine Physique et de Réadaptation (SOFMER) and Société Interdisciplinaire Francophone d'UroDynamique et de Pelvi-Périnéologie (SIFUD-PP).	Hentzen C and Biardeau X and Turmel N and Haddad R and Bey E and Amarenco G and Denys P and Phé V and Perrouin-Verbe MA and Peyronnet B and Joussain C	2022	https://pubmed.ncbi.nlm.nih.gov/34402945/
3	Development of a swallowing risk screening tool and best practice recommendations for the management of oropharyngeal dysphagia following acute cervical spinal cord injury: an international multi-professional Delphi consensus.	McRae J and Smith C and Beeke S and Emmanuel A	2022	https://pubmed.ncbi.nlm.nih.gov/34904488/
4	Identification and Management of Cardiometabolic Risk after Spinal Cord Injury: Clinical Practice Guideline for Health Care Providers.	Nash MS and Groah SL and Gater DR Jr and Dyson-Hudson TA and Lieberman JA and Myers J and Sabharwal S and Taylor AJ	2018	https://pubmed.ncbi.nlm.nih.gov/30459501/
5	Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America.	Nicolle LE and Gupta K and Bradley SF and Colgan R and DeMuri GP and Drekonja D and Eckert LO and Geerlings SE and Köves B and Hooton TM and Juthani-Mehta M and Knight SL and Saint S and Schaeffer AJ and	2019	https://pubmed.ncbi.nlm.nih.gov/31506700/

		Trautner B and Wullt B and Siemieniuk R		
6	A Clinical Practice Guideline for the Management of Patients With Acute Spinal Cord Injury: Recommendations on the Type and Timing of Rehabilitation.	Fehlings MG and Tetreault LA and Aarabi B and Anderson P and Arnold PM and Brodke DS and Chiba K and Dettori JR and Furlan JC and Harrop JS and Hawryluk G and Holly LT and Howley S and Jeji T and Kalsi-Ryan S and Kotter M and Kurpad S and Kwon BK and Marino RJ and Martin AR and Massicotte E and Merli G and Middleton JW and Nakashima H and Nagoshi N and Palmieri K and Singh A and Skelly AC and Tsai EC and Vaccaro A and Wilson JR and Yee A and Burns AS	2017	https://pubmed.ncbi.nlm.nih.gov/29164029/
7	Acute Lower Extremity Fracture Management in Chronic Spinal Cord Injury: 2022 Delphi Consensus Recommendations.	Carbone LD and Ahn J and Adler RA and Cervinka T and Craven C and Geerts W and Hsu JR and Huang D and Karunakar MA and Kiratli BJ and Krause PC and Morse LR and Mirick Mueller GE and Nana A and Rogers E and Rivera JC and Spitler C and Weaver FM and Obremskey W	2022	https://pubmed.ncbi.nlm.nih.gov/36518619/
8	Psychological Treatments and Psychotherapies in the Neurorehabilitation of Pain: Evidences and Recommendations from the Italian Consensus Conference on Pain in Neurorehabilitation.	Castelnuovo G and Giusti EM and Manzoni GM and Saviola D and Gatti A and Gabrielli S and Lacerenza M and Pietrabissa G and Cattivelli R and Spatola CA and Corti S and Novelli M and Villa V and Cottini A and Lai C and Pagnini F and Castelli L and Tavola M and Torta R and Arreghini M and Zanini L and Brunani A and Capodaglio	2016	https://pubmed.ncbi.nlm.nih.gov/26924998/

		P and D'Aniello GE and Scarpina F and Brioschi A and Priano L and Mauro A and Riva G and Repetto C and Regalia C and Molinari E and Notaro P and Paolucci S and Sandrini G and Simpson SG and Wiederhold B and Tamburin S		
9	Management of Mental Health Disorders, Substance Use Disorders, and Suicide in Adults with Spinal Cord Injury: Clinical Practice Guideline for Health Care Providers	Bombardier et al	2021	https://www.embase.com/search/results?subaction=viewrecord&id=L2010579838&from=export U2 - L2010579838
10	Prevention of Venous Thromboembolism in Individuals with Spinal Cord Injury: Clinical Practice Guidelines for Health Care Providers, 3rd ed.: Consortium for Spinal Cord Medicine.	Consortium for Spinal Cord Medicine	2016	https://pubmed.ncbi.nlm.nih.gov/29339863/
11	Interventional management of neuropathic pain: NeuPSIG recommendations.	Dworkin RH and O'Connor AB and Kent J and Mackey SC and Raja SN and Stacey BR and Levy RM and Backonja M and Baron R and Harke H and Loeser JD and Treede RD and Turk DC and Wells CD	2013	https://pubmed.ncbi.nlm.nih.gov/23748119/
12	Neurogenic bowel dysfunction: Clinical management recommendations of the Neurologic Incontinence Committee of the Fifth International Consultation on Incontinence 2013.	Cotterill N and Madersbacher H and Wyndaele JJ and Apostolidis A and Drake MJ and Gajewski J and Heesakkers J and Panicker J and Radziszewski P and Sakakibara R and Sievert KD and Hamid R and Kessler TM and Emmanuel A	2018	https://pubmed.ncbi.nlm.nih.gov/28640977/
13	Evidence-based position paper on Physical and Rehabilitation Medicine (PRM) professional practice for persons with spinal cord injury. The European PRM position (UEMS PRM Section).	Rapidi CA and Tederko P and Moslavac S and Popa D and Branco CA and Kiekens C and Varela Donoso E and Christodoulou N	2018	https://pubmed.ncbi.nlm.nih.gov/29952157/
14	Rehabilitation of people with spinal cord damage due to tumor: literature review, international	New PW and Marshall R and Stubblefield MD and Scivoletto G	2017	https://pubmed.ncbi.nlm.nih.gov/27088581/

	survey and practical recommendations for optimizing their rehabilitation.			
15	Neurogenic bowel management in adults with spinal cord injury-new clinical practice guidelines from the consortium for spinal cord medicine	Johns, J. and Wilson, C. and Laredo, R. and Heinen, M. and Rodriguez, G.	2019	https://www.embase.com/search/results?subaction=viewrecord&id=L631879388&from=export U2 - L631879388
16	Clinical guidelines for the diagnosis and treatment of lower urinary tract dysfunction in patients with spinal cord injury.	Sekido N and Igawa Y and Kakizaki H and Kitta T and Sengoku A and Takahashi S and Takahashi R and Tanaka K and Namima T and Honda M and Mitsui T and Yamanishi T and Watanabe T	2020	https://pubmed.ncbi.nlm.nih.gov/32077161/
17	Clinical Practice Guideline to Improve Locomotor Function Following Chronic Stroke, Incomplete Spinal Cord Injury, and Brain Injury.	Hornby TG and Reisman DS and Ward IG and Scheets PL and Miller A and Haddad D and Fox EJ and Fritz NE and Hawkins K and Henderson CE and Hendron KL and Holleran CL and Lynskey JE and Walter A	2020	https://pubmed.ncbi.nlm.nih.gov/31834165/
18	Evidence-based scientific exercise guidelines for adults with spinal cord injury: an update and a new guideline.	Martin Ginis KA and van der Scheer JW and Latimer-Cheung AE and Barrow A and Bourne C and Carruthers P and Bernardi M and Ditor DS and Gaudet S and de Groot S and Hayes KC and Hicks AL and Leicht CA and Lexell J and Macaluso S and Manns PJ and McBride CB and Noonan VK and Pomerleau P and Rimmer JH and Shaw RB and Smith B and Smith KM and Steeves JD and Tussler D and West CR and Wolfe DL and Goosey-Tolfrey VL	2018	https://pubmed.ncbi.nlm.nih.gov/29070812/
19	Urodynamics in patients with spinal cord injury: A clinical review and best practice paper by a working	Schurch B and Iacovelli V and Averbeck MA and Stefano C and Altaweel W and Finazzi Agrò E	2018	https://pubmed.ncbi.nlm.nih.gov/28762566/

	group of The International Continence Society Urodynamics Committee.			
20	The CanPain SCI Clinical Practice Guideline for Rehabilitation Management of Neuropathic Pain after Spinal Cord: recommendations for model systems of care.	Guy SD and Mehta S and Harvey D and Lau B and Middleton JW and O'Connell C and Townson A and Truchon C and Wolfe D and Bradbury CL and Bryce TN and Casalino A and Côté I and Craven BC and Finnerup NB and Hitzig SL and Kras-Dupuis A and Moulin DE and Orenczuk S and Parrent AG and Potter P and Siddall PJ and Short C and Teasell R and Widerström-Noga E and Loh E	2016	https://pubmed.ncbi.nlm.nih.gov/27444716/
21	The CanPain SCI Clinical Practice Guidelines for Rehabilitation Management of Neuropathic Pain after Spinal Cord: Screening and diagnosis recommendations	Mehta, S. and Guy, S.D. and Bryce, T.N. and Craven, B.C. and Finnerup, N.B. and Hitzig, S.L. and Orenczuk, S. and Siddall, P.J. and Widerström-Noga, E. and Casalino, A. and Côté, I. and Harvey, D. and Kras-Dupuis, A. and Lau, B. and Middleton, J.W. and Moulin, D.E. and O'Connell, C. and Parrent, A.G. and Potter, P. and Short, C. and Teasell, R. and Townson, A. and Truchon, C. and Wolfe, D. and Bradbury, C.L. and Loh, E.	2016	https://www.embase.com/search/results?subaction=viewrecord&id=L611397507&from=export U2 - L611397507
22	The CanPain SCI clinical practice guidelines for rehabilitation management of neuropathic pain after spinal cord injury: 2021 update.	Loh E and Mirkowski M and Agudelo AR and Allison DJ and Benton B and Bryce TN and Guilcher S and Jeji T and Kras-Dupuis A and Kreutzwiser D and Lanizi O and Lee-Tai-Fuy G and Middleton JW and Moulin DE and O'Connell C and Orenczuk S and Potter P and Short C and Teasell R and	2022	https://pubmed.ncbi.nlm.nih.gov/35124700/

		Townson A and Widerström-Noga E and Wolfe DL and Xia N and Mehta S		
From greyliterature				
23	Rehabilitation after traumatic injury	NICE guideline	2022	www.nice.org.uk/guidance/ng211
24	Canadian Spinal Cord Injury Practice (Can-SCIP) Guideline	Bayley et al.	2021	https://kite-uhn.com/can-scip/recommendations
25	Best Practice Guidelines: Spine Injury	American College of Surgeons	2022	https://www.facs.org/media/k45gikqv/spine_injury_guidelines.pdf
26	Guidelines: neurogenic bowel dysfunction in spinal cord injury (long version) / Leitlinie: Neurogene Darmfunktionsstörung bei Querschnittlähmung (Langfassung)	Geng V., Böthig R., Hildesheim A., Kurze I., Leder E.D.	2020	https://link.springer.com/article/10.1007/s00053-020-00482-5
27	Diagnostik und Therapie von neurogenen Blasenstörungen	Haensch et al	2020	https://register.awmf.org/de/leitlinien/detail/030-121
28	Langzeitanwendung von Opioiden bei chronischen nicht-tumorbedingten Schmerzen: Empfehlungen der zweiten Aktualisierung der Leitlinie LONTS (Long-term opioid therapy for chronic noncancer pain: Recommendations of the second update of the LONTS guidelines)	Häuser W., Bock F., Hüppe M., Nothacker M., Norda H., Radbruch L., Schiltenwolf M., Schuler M., Tölle T., Viniol A., Petzke F. und Koautoren für die Konsensusgruppe der 2. Aktualisierung der S3-Leitlinie LONTS		https://link.springer.com/article/10.1007/s00482-020-00472-y
29	Nichtinvasive und invasive Beatmung als Therapie der chronischen respiratorischen Insuffizienz	Windisch et al.	2017	https://register.awmf.org/de/leitlinien/detail/020-008
30	Schwangerschaft, Geburt und Wochenbett bei Frauen mit Querschnittlähmung	Bertschy und Lange et al.	2018	Guidelines-Schwangerschaft-Geburt-und-Wochenbett-bei-Frauen-mit-Querschnittlaehmung-Langfassung.pdf (researchgate.net)
31	S2k-Leitlinie Prolongiertes Weaning	Schönhofer et al.	2019	https://register.awmf.org/de/leitlinien/detail/020-015
32	Evaluation and Management of Autonomic Dysreflexia and Other Autonomic Dysfunctions		2019	https://pva.org/research-resources/publications/clinical-practice-guidelines/ or

				https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8152175/
33	Pressure Ulcer Prevention and Treatment Following Spinal Cord Injury, 2nd edition		2014	https://pva.org/research-resources/publications/clinical-practice-guidelines/
34	Bone Health and Osteoporosis Management In Individuals With Spinal Cord Injury		2019	https://pva.org/research-resources/publications/clinical-practice-guidelines/
35	S2e-Leitlinie Ergebniserhebung in der Erstbehandlung nach neu erworbener Querschnittlähmung (Result survey in the initial treatment after newly acquired paraplegia)	Scheel-Sailer et al.	2020	https://register.awmf.org/de/leitlinien/detail/179-012
36	S2k-Leitlinie Lebenslange Nachsorge für Menschen mit Querschnittlähmung (Lifelong follow-up care for people with spinal cord injury) (Details to the literature search can also be found in: Evidence based clinical practice guideline for follow-up care after spinal cord injury (2022 --> rayyan 919410107)	Weidner and Eriks-Hoogland	2022	https://register.awmf.org/de/leitlinien/detail/179-014
37	S2e-Leitlinie Rehabilitation der unteren Extremität, der Steh- und Gehfunktion bei Menschen mit Querschnittlähmung (Rehabilitation of the lower extremity, the standing and walking function in people with paraplegia)	Scheel-Sailer	2018	https://register.awmf.org/de/leitlinien/detail/179-009
38	S2k-Leitlinie Atmung, Atemunterstützung und Beatmung bei akuter und chronischer Querschnittlähmung (Breathing, respiratory support and ventilation in acute and chronic paraplegia)	Weidner und Michel	2022	https://register.awmf.org/de/leitlinien/detail/179-011
39	Verbesserung der Funktionsfähigkeit der oberen Extremitäten bei zervikaler Querschnittlähmung (Improvement of the functionality of the upper extremities in cervical paraplegia)	Weidner and Sigrist-Nix	2020	https://register.awmf.org/de/leitlinien/detail/179-013

40	Urinary incontinence in neurological disease: assessment and management	NICE guideline	2012	https://www.nice.org.uk/guidance/cg148
41	S2k-Leitlinie Therapie des spastischen Syndroms	Platz et al.	2018	https://register.awmf.org/de/leitlinien/detail/030-078
42	The Prevention and Management of Pressure Ulcers in Primary and Secondary Care	NICE	2014	https://pubmed.ncbi.nlm.nih.gov/25340232/
43	AUA/SUFU Guidelines: Urodynamics	Winters et al.	2012	https://www.sciencedirect.com/science/article/abs/pii/S0022534712049610
44	EAU Guidelines on Neuro-Urology	Blok, Diaz, Popolo et al	2022	https://d56bochluxqnz.cloudfront.net/documents/full-guideline/EAU-Guidelines-on-Neuro-Urology-2022.pdf (guideline) https://uroweb.org/guidelines (website)
45	Canadian Urological Association guideline: Diagnosis, management, and surveillance of neurogenic lower urinary tract dysfunction – Full text	Kavanagh et al	2019	https://cuaj.ca/index.php/journal/article/view/5912/4109
46	Guide for Health Professionals on the Psychosocial Care of Adults with Spinal Cord Injury	Agency for Clinical Innovation	2014	https://aci.health.nsw.gov.au/__data/assets/pdf_file/0019/155233/Guide-Psychosocial-Care.pdf
47	Clinical Guideline for Standing Adults Following Spinal Cord Injury	Spinal Cord Injury Centre Physiotherapy Lead Clinicians United Kingdom and Ireland	2019	https://www.mascip.co.uk/best-practice/mascip-best-practice/ (website) https://www.mascip.co.uk/wp-content/uploads/2020/09/SCI-Standing-Clinical-Guidelines-Report-2019.pdf (guideline)
48	MASCIP Guidelines for Weight Management in Individuals with Spinal Cord Injury	Wong et al	2019	https://www.mascip.co.uk/best-practice/mascip-best-practice/ (website) https://www.mascip.co.uk/wp-content/uploads/2019/10/03-May-

				2018-Wong-et-al-MASCIP-Weight-Management-Guidelines-for-People-with-a-Spinal-Cord-Injury.pdf (guideline)
49	Prevention of VTE in non-orthopedic surgical patients. Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Methodology: Guyatt GH, Norris SL, Schulman S, et al. 2012. Methodology for the development of antithrombotic therapy and prevention of thrombosis guidelines. Antithrombotic Therapy and Prevention of Thrombosis, 9th ed.: American College of Chest Physicians EvidenceBased Clinical Practice Guidelines. Chest;141(2 Suppl):53S–70S	Gould MK, Garcia DA, Wren SM, et al	2012	https://pubmed.ncbi.nlm.nih.gov/22315263/ Methodology: https://pubmed.ncbi.nlm.nih.gov/22315256/
50	A Core Set of Outcome Measures for Adults With Neurologic Conditions Undergoing Rehabilitation: A CLINICAL PRACTICE GUIDELINE	Moore JL, Potter K, Blankshain K, Kaplan SL, O'Dwyer LC, Sullivan JE	2018	https://pubmed.ncbi.nlm.nih.gov/29901487/
51	Special considerations in the urological management of the older spinal cord injury patient	Chan et al	2018	https://doi.org/10.1007/s00345-018-2326-3
52	Canadian Best Practice Guidelines for the Prevention and Management of Pressure Ulcers in People With Spinal Cord Injury: A Resource Handbook for Clinicians	Houghton PE, Campbell KE et al.	2013	www.onf.org

Supplementary file 5

Standardisation of the grading systems

		Classification of the strength of recommendation			Classification of the quality of the evidence			
N°	Guideline's short Title	Strong	Weak	No recommendation possible	High	Moderate	Low	Very Low
1	NICE_Rehabilitation, 2022	In recommendations on activities or interventions that should (or should not) be offered, use directive language such as 'offer' (or 'do not offer'), 'advise', or 'ask about'. In keeping with the principles of shared decision-making, people may choose whether or not to accept what they are offered or advised. If there is a legal duty to apply a recommendation, or the consequences of not following a recommendation are extremely serious, the recommendation should use 'must' or 'must not' and be worded in the passive voice.	If there is a closer balance between benefits and harms (activities or interventions that could be used), use 'consider'.		**High:** We are very confident that the true effect lies close to that of the estimate of the effect	**Moderate:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different	**Low:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect	**Very low:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect
2	Consortium_Bone health, 2022	**1:** Strong recommendation ("We recommend…")	**2:** Weak recommendation ("We		**A:** High-quality evidence. Consistent evidence from	**B:** Moderate-quality evidence. Evidence from RCTs with important limitations	**C:** Low-quality evidence. Evidence for at least one critical	**D:** Very low-quality evidence: Lack of evidence for

			suggest…"/"One may…")		RCTs without important limitations or exceptionally strong evidence from observational studies	(inconsistent results, methodologic flaws, indirect or imprecise) or very strong evidence from observational studies	outcome from observational studies, case series, RCTs with serious flaws, or indirect evidence	at least 1 critical outcome from observational studies, case series, or RCTs with serious flaws or indirect evidence
3	German speaking society_Lifelong follow-up, 2022	**A:** Strongly recommended (shall/shall not) (Soll/soll nicht)	**B:** Recommended (should/should not) (Sollte/sollte nicht)	**0:** Open (Can be considered/can be waived)	Not reported	Not reported	Not reported	If only strength of consensus is given
4	Can-SCIP, 2021	**Strong:** if a directive language is used (e.g., provide)[a]	**Weak:** if an indrect language is used (e.g., consider providing)[a]		**Level A:** Recommendation supported by at least 1 meta-analysis, systematic review, or randomized controlled trial of appropriate size with relevant control group.	**Level B**: Recommendation supported by cohort studies that at minimum have a comparison group, well-designed single subject experimental designs, or small sample size randomized controlled trials.		**Level C:** Recommendation supported primarily by expert opinion based on their experience, though uncontrolled case series without comparison groups that support the recommendations are also classified here.
5	Sekido N_Urinary dysfunction, 2020	**A:** this action is strongly recommended **B:** this action is recommended **D:** Not performing this action is recommended	**C:** There is no clear evidence for recommending this action **C1:** the action	Pending: No decision has been made regarding the GoR	**Level 1:** Supported by multiple level I clinical studies (I: Large-scale RCTs (≥100	**Level 2:** Supported by a single level I clinical study or multiple level II clinical studies (II: Small-scale	**Level 3:** Supported by multiple level III clinical studies (III: Controlled studies carried out	**Level 5**: Supported by multiple level V clinical studies (V:

			can still be performed **C2:** Performing the action is not recommended		participants in each group) or RCTs with the number of participants fulfilling the pre-calculated statistical power with definitive results)	RCTs or RCTs with the number of participants not fulfilling the pre-calculated statistical power with definitive results. If the results were not definitive, then the level was reduced by one)	without randomized allocation) **Level 4:** Supported by multiple level IV clinical studies (IV: Prospective observational studies with no control)	Retrospective case studies or the opinions of specialists)
6	Consortium_Neurogenic bowel, 2020	Strong (panel opinion)	Moderate (panel opinion)		same as Consortium 2018	same as Consortium 2018	same as Consortium 2018	same as Consortium 2018
7	Consortium_Autonomic dysreflexia, 2020	Strong (panel opinion)	Moderate (panel opinion)		same as Consortium 2018	same as Consortium 2018	same as Consortium 2018	same as Consortium 2018
8	MASCIP_Weight management, 2019	Strong ("We recommend")	Conditional ("We suggest")		**A:** Highest quality evidence resulted from consistent results or metaanalysis of multiple randomised controlled trials (RCT)	**B:** The next highest level was defined by at least one well designed RCT.	**C:** Moderate to low level evidence came from controlled trials that were not randomised, cohort- or case-controlled studies, or from multiple time-series trials.	**D:** The lowest evidence (very low) was from expert clinical experience or from descriptive studies
9	International Consultation on Incontinence, 2018	**Grade A** recommendation usually depends on consistent Level 1 evidence and often means that the recommendation is effectively mandatory and placed within a clinical care pathway. Grade A	**Grade B** recommendation usually depends on consistent Level 2 and/or 3 studies, or ‘‘majority evidence’’ from RCTs	**Grade D** ‘‘No recommendation possible’’ would be used where the evidence is inadequate or conflicting and when expert opinion is delivered without a formal	**Level 1:** Evidence usually involves meta-analysis of trials (RCTs) or a good quality randomised controlled trial, or ‘‘all or none’’ studies in which no treatment is	**Level 2:** Evidence includes ‘‘low’’ quality RCT (e.g., <80% follow-up) or meta-analysis (with homogeneity) of good quality prospective ‘‘cohort studies.’’ These may include a single group when	**Level 3:** Good quality retrospective ‘‘case–control studies’’ where a group of patients who have a condition are matched appropriately (e.g., for age, sex,	**Level 4:** Evidence includes expert opinion where the opinion is based not on evidence but on ‘‘first principles’’ (e.g., physiological

		recommendation can follow from Level 2 evidence, but requires a greater body of evidence.	**Grade C** recommendation usually depends on Level 4 studies or ‘‘majority evidence’’ from Level 2/3 studies or Delphi processed expert opinion	analytical process, such as by Delphi	not an option, for example, in vesicovaginal fistula.	individuals who develop the condition are compared with others from within the original cohort group. There can be parallel cohorts, where those with the condition in the first group are compared with those in the second group.	etc.) with control individuals who do not have the condition. Good quality ‘‘case series’’ where a complete group of patients all, with the same condition/disease/therapeutic intervention, are described, without a comparison control group.	or anatomical) or bench research. The Delphi process can be used to give ‘‘expert opinion’’ greater authority. In the Delphi process a series of questions are posed to a panel; the answers are collected into a series of ‘‘options’’; the options are serially ranked; if a 75% agreement is reached then a Delphi consensus statement can be made.
10	UEMS_PRM, 2018	**A:** it must be normally applied	**B:** It is important, but can be applied not in all situations **C:** Less important, it can be applied on a voluntary basis **D:** Very low importance		**I:** Multiple Randomized Controlled Trials or Systematic Reviews of such studies	**II:** One Randomized Controlled Trial	**III:** Multiple Controlled nonrandomized Studies or Systematic Reviews of such studies	**IV:** Other studies

11	International Continence Society_Urodynamics, 2018	Strong[b]	Weak[b]	No classification possible[c]	No classification possible[c]	No classification possible[c]	No classification possible[c]
12	Consortium_Cardiometabolic risk, 2018	Strong (panel opinion)	Moderate (panel opinion) Low (panel opinion)	**A:** The guideline recommendation is supported by one or more level I studies. (I: Evidence based on randomized controlled clinical trials (or meta-analysis of such trials) of adequate size to ensure a low risk of incorporating false-positive or false-negative results.)	**B:** The guideline recommendation is supported by one or more level II studies. (II: Evidence based on randomized controlled trials that are too small to provide level I evidence. These may show either positive trends that are not statistically significant or no trends and are associated with a high risk of false-negative results.)	**C:** The guideline recommendation is supported only by level III (III: Evidence based on nonrandomized, controlled, or cohort studies; case series; case-controlled studies; or cross-sectional studies)	**C:** The guideline recommendation is supported only by level IV or V studies (IV: Evidence based on the opinion of respected authorities or expert committees as indicated in published consensus conferences or guidelines; V: Evidence that expresses the opinion of those individuals who have written and reviewed this guideline, based on experience, knowledge of the relevant literature, and discussions with peers)

13	Consortium_Venous thromboembolism, 2016	**1:** Strong recommendation ("We recommend…")	**2:** Weak recommendation ("We suggest…")	**A:** High-quality evidence. Consistent evidence from RCTs without important limitations or exceptionally strong evidence from observational studies	**B:** Moderate-quality evidence. Evidence from RCTs with important limitations (inconsistent results, methodologic flaws, indirect or imprecise) or very strong evidence from observational studies	**C:** Low-quality evidence. Evidence for at least one critical outcome from observational studies, case series, RCTs with serious flaws, or indirect evidence	
14	Consortium_Pressure ulcers, 2014	Strong (panel opinion)	Moderate (panel opinion) Low (panel opinion)	**Level** I: Large randomized trials with clear-cut results (and low risk of error)	Level II: Small randomized trials with uncertain results (and moderate to high risk of error)	Level III: Nonrandomized trials with concurrent or contemporaneous controls **Level IV:** Nonrandomized trials with historical controls	**Level V:** Case series with no controls
15	Canadian_Pressure ulcers, 2013	Not described	Not described	**Ia:** Evidence from meta-analysis or systematic review of randomized controlled trials	**Ib:** Evidence from at least one randomized controlled trial **IIa:** Evidence from at least one well-designed controlled study without randomization	**IIb:** Evidence from at least one other type of well-designed quasi-experimental study without randomization	**III:** Evidence from well-designed non-experimental descriptive studies, such as comparative, correlation, and case studies **IV:** Evidence from expert committee reports or opinions and/or clinical experiences of

							respected authorities
16	NICE_Urinary incontinence, 2012	In recommendations on activities or interventions that should (or should not) be offered, use directive language such as 'offer' (or 'do not offer'), 'advise', or 'ask about'. In keeping with the principles of shared decision-making, people may choose whether or not to accept what they are offered or advised. If there is a legal duty to apply a recommendation, or the consequences of not following a recommendation are extremely serious, the recommendation should use 'must' or 'must not' and be worded in the passive voice.	If there is a closer balance between benefits and harms (activities or interventions that could be used), use 'consider'.	**High:** We are very confident that the true effect lies close to that of the estimate of the effect	**Moderate:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different	**Low:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect	**Very low:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

[a] No strength of recommendation is given in the guideline. The author's assume that a directive language indicates a strong and an indirective language a weak recommendation.

[b] In the guideline it is stated that recommendations are given a grade, according to the classfication system adopted by the European Association of Urology (EAU) modified from the Oxford Centre for Evidence-Based Medicine Levels of Evidence and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach. However the link given in the guideline is no longer available. The actual version (March 2022) of the Guidelines Office Development Handbook from the European Association of Urology does not match with the gradings given in the guideline.
However what they do is rating the recommendation either strong or weak. Therefore, the strength of recommendation of this guidelie will be infered by the wording of the recommendation (e.g., we recommend = strong, we suggest = weak).

[c] In the guideline it is stated that they graded the quality of evidence, according to the classfication system adopted by the European Association of Urology (EAU) modified from the Oxford Centre for Evidence-Based Medicine Levels of Evidence and the Grading of Recommendations Assessment, Development and Evaluation (GRADE)

approach. However the link given in the guideline is no longer available. The actual version (March 2022) of the Guidelines Office Development Handbook from the European Association of Urology does not match with the gradings given in the guideline. It was therefore not possible to infer the quality of evidence.

Supplementary file 6

Quality assessment using the AGRE-REX

N°	Recommendation	AGREE-REX										Scoring justification	Source
		Item 1. Evidence	Item 2. Applicability to Target Users	Item 3. Applicability to Patients/Populations	Item 4. Values and Preferences of Target Users	Item 5. Values and Preferences of Patients/Populations	Item 6. Values and Preferences of Policy/Decision-Makers	Item 7. Values and Preferences of Guideline Developers	Item 8. Purpose	Item 9. Local Application and Adoption	**Average**		**Guideline short title, chapter, page**
1	1.4.6 If an older person with a traumatic injury is on a care pathway that does not routinely involve geriatrician support, consider referral to an orthogeriatrician, a surgical liaison or a perioperative physician (as appropriate).	**3**	**5**	**4**	**1**	**1**	**1**	7	7	**4**	**3,7**	*Item 1: The committee used their experience to recommend that older people have access to orthogeriatricians, surgical support or perioperative physicians. Doesn't assess any risk of bias related to the study designs of the supporting evidence, nor describes the consistency of the results. No reference is made, or in a superficial way, to this item. The recommendation does not describe the consistency of the results, publication bias, although it addresses the directness of the evidence to the clinical/health problem. The guideline does not describe the magnitude of the benefits and harms of this recommendation. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations. Also this recommendation describes how to tailor recommendations for application to individual patients or populations (e.g., based on age). *Item 4: It is not clear that they directly assess the values and preferences of the guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed in a direct way. *Item 7: The committee used their experience to formulate this recommendation. The recommendations in this guideline represent the view of NICE. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting, and/or the health system in which they are being implemented.	NICE_Rehabilitation, 2022 Chapter: 1.4 Developing a rehabilitation plan and making referrals Page: 27
2	1.4.7 For adults with a fragility fracture, assess bone health and refer as necessary, for example, to a specialist bone health clinic or outpatient service. Also see the NICE guideline on osteoporosis.	**1**	**6**	**1**	**1**	**1**	**1**	4	3	**3**	**2,3**	*Item 1: Evidence searches for general topics such as the rehabilitation needs of people with spinal cord injury are presented, but there are no specific searches to reach individual recommendations such as bone health assessment. Or at least the authors don´t mention this information in any of the sections of the guideline or in the supplements. *Item 2: The guideline addresses a health problem that is relevant to the intended target users. There is an alignment between target user's scope of practice and targeted populations. *Item 3: The authors did not describe the outcome information they analyzed to formulate the recommendation in the guideline document or in the supplements. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear thar the values and preferences of the patients were sought or considered. *Item 6: It is not clear thar the values and preferences of decision/policy makers were directly addressed. *Item 7: The authors state "The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available". However there is not a clear description of how guideline developer's values and preferences influenced their interpretation of the balance between benefits and harms. *Item 8: This recommendation is aligned with the implementation goals of the guideline. A section on "How the recommendations might affect services" for Recommendations 1.4.1 to 1.4.11 is presented (pg	NICE_Rehabilitation, 2022 Chapter: 1.4 Developing a rehabilitation plan and making referrals Page: 27

												97), but in a very general manner. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: It is not clear that the guideline developers considered the issues that can influence the adoption of the recommendations. At the end of the guideline (pg 135), there is a link to NICE tools and resources to help users put this guideline into practice. However the provided tools are common for all NICE guidelines and set out the common steps taken when putting evidence-based guidance into practice.	
3	1.4.9 Assess all adults over 65 who have a traumatic injury for their risk of falls in line with the recommendations on multifactorial risk assessment in the NICE guideline on falls.	**1**	**5**	**5**	**1**	**1**	**1**	**7**	**6**	**4**	**3,4**	*Item 1: The recommendation doesn't assess any risk of bias related to the study designs of the supporting evidence, nor describes the consistency of the results. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations. Also this recommendation describes how to tailor recommendations for application to individual patients or populations (e.g., based on age). *Item 4: It is not clear that they directly assess the values and preferences of the guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed directly. *Item 7: The committee used their experience to did this recommendation. The recommendations in this guideline represent the view of NICE. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting, and/or the health system in which they are being implemented.	NICE_Rehabilitation, 2022 Chapter: 1.4Developing a rehabilitation plan and making referrals Page: 27
4	1.11.30 Be aware that spinal orthoses, such as cervical collars and thoracolumbar spinal orthoses, may be poorly tolerated by some people, particularly older people or those with delirium, cognitive impairment or dementia.	**4**	**4**	**7**	**4**	**6**	**3**	**7**	**7**	**7**	**5,4**	*Item 1: The committee combined the available evidence with their experience and knowledge. The guideline addresses the directness of the evidence of the orthosis however not the toleration of the orthosis *Item 2: The recommendations address a health problem that is relevant to the intended target users. But there is not alignment between target user's scope of practice and targeted patients *Item 3: The recommendation includes outcomes that are relevant to the targeted patients/populations. They addressed an specific population (old) *Item 4: It is not clear that they directly assess the values and preferences of the guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. However, they say that People (and families and carers, if appropriate) should receive education on how to wear splints or orthoses to limit adverse effects *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: Evidence showed that spinal orthoses can help improve patient rehabilitation outcomes, and they are used in current practice. However, in the committee's experience, not all trauma populations see a benefit (for example, older people) and spinal orthoses can cause adverse events if improperly fitted. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: The recommendation assessed the setting, and/or the health system in which they are being implemented.The recommendation reflect current practice because Splints and orthoses are commonly used and are all low cost.	NICE_Rehabilitation, 2022 Chapter: 1.11 Physical rehabilitation Page: 57
5	1.11.17 Do not withhold aerobic exercise programmes from older people after a traumatic injury.	**1**	**6**	**6**	**1**	**1**	**1**	**7**	**6**	**4**	**3,7**	*Item 1: The recommendation doesn't assess any risk of bias related to the study designs of the supporting evidence, nor describes the consistency of the results. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations. Also this recommendation describes how to tailor recommendations for application to individual patients or populations (e.g., based on age). Outcomes: optimize respiratory function, increase endurance when doing rehabilitation exercises, and improve mobility. *Item 4: It is not clear that they directly assess the values and preferences of the guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed directly. *Item 7: The committee used their experience to did this recommendation. The recommendations in this guideline represent the view of NICE. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting, and/or the health system in which	NICE_Rehabilitation, 2022 Chapter: 1.11 Physical rehabilitation Page: 60

												they are being implemented. They say about this recommendation are not expected to have a significant resource impact or be difficult to implement.	
6	1.11.49 For people with a fragility fracture, measure vitamin D levels and consider a supplement. Also see the recommendations in the NICE guideline on osteoporosis: assessing the risk of fragility fracture and the NICE guideline on vitamin D: supplement use in specific population groups.	**1**	**6**	**1**	**1**	**1**	**1**	**4**	**3**	**3**	**2,3**	*Item 1: Evidence searches for general topics such as the rehabilitation needs of people with spinal cord injury are presented, but there are no specific searches to reach individual recommendations such as bone health assessment. Or at least the authors don´t mention this information in any of the sections of the guideline or in the supplements. *Item 2: The guideline addresses a health problem that is relevant to the intended target users. There is an alignment between target user's scope of practice and targeted populations. *Item 3: The authors did not describe the outcome information they analyzed to formulate the recommendation in the guideline document or in the supplements. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear thar the values and preferences of the patients were sought or considered. *Item 6: It is not clear thar the values and preferences of decision/policy makers were directily addressed. *Item 7: The authors state "The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available". However there is not a clear description of how guideline developer's values and preferences influenced their interpretation of the balance between benefits and harms. *Item 8: This recommendation is aligned with the implementation goals of the guideline. A section on "How the recommendations might affect services" for Recommendations 1.4.1 to 1.4.11 is presented (pg 97), but in a very general manner. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: It is not clear that the guideline developers considered the issues that can influence the adoption of the recommendations. At the end of the guideline (pg 135), there is a link to NICE tools and resources to help users put this guideline into practice. However the provided tools are common for all NICE guidelines and set out the common steps taken when putting evidence-based guidance into practice.	NICE_Rehabilitation, 2022 Chapter: 1.11 Physical rehabilitation Page: 60
7	1.11.47 Following assessment by a dietician specialising in trauma care, consider supplementation of dietary protein for people who are frail, have gastrointestinal health issues or have multiple injuries.	**3**	**6**	**4**	**1**	**1**	**1**	**7**	**5**	**5**	**3,7**	*Item 1: The committee agreed that there is a lack of awareness about the nutritional risks and needs following traumatic injury. The recommendation don't assess any risk of bias related to the study designs of the supporting evidence, not describes the consistency of the results. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The outcomes that are relevant to the targeted patients/populations are not clear. but this recommendation describes how to tailor recommendations for application to individual patients or populations (e.g., Individuals who are frail). *Item 4: It is not clear that they directly assess the values and preferences of the directly.guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: The committee used their experience to did this recommendation. The recommendations in this guideline represent the view of NICE. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting, and/or the health system in which they are being implemented. 'The recommendations are in line with current practice and will not need additional resources to implement'.	NICE_Rehabilitation, 2022 Chapter: 1.11 Physical rehabilitation Page: 60
8	1.15.21 For people with a spinal cord injury who are using a spinal orthosis (for example, cervical collar or thoraco-lumbar spinal orthosis), regularly assess them for complications such as pain, pressure sores, swallowing or breathing difficulties (particularly in older people or those with dementia or delirium).	**5**	**6**	**7**	**5**	**4**	**3**	**6**	**7**	**6**	**5,4**	*Item 1: The committee combined the available evidence with their experience and knowledge. The guideline addresses the directness of the evidence of the orthosis, however the outcomes are not directly addressed. *Item 2: The recommendations address a health problem that is relevant to the intended target users. *Item 3: The recommendation includes outcomes that are relevant to the targeted patients/populations. They addressed an specific population (old) *Item 4: It is not clear that they directly assess the values and preferences of the guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: Evidence showed that spinal orthoses can help improve patient rehabilitation outcomes, and they are used in current practice. However, in the committee's experience, not all trauma populations see a benefit (for example, older people) and spinal orthoses can cause adverse events if improperly fitted. *Item 8: This recommendation is aligned with the implementation goals of the guideline. The committee	NICE_Rehabilitation, 2022 Chapter: 1.15 Rehabilitation after spinal cord injury Page: 77

												agreed that it is important to maintain mobility and range of motion after a spinal cord injury. *Item 9: The recommendation assessed the setting, and/or the health system in which they are being implemented.They approach the costs item: some equipment, like robotics, can be expensive.	
9	2.1 We recommend that, in the context of bone health screening, all adult women and men with spinal cord injury (SCI), regardless of injury duration, should have measurements of serum 25-hydroxyvitamin D (25-(OH)D) done by a validated assay method; complete blood cell count; ionized calcium (or calcium adjusted for albumin), phosphate, intact parathyroid hormone, creatinine (and estimated glomerular filtration rate), bone-specific alkaline phosphatase and transaminases, hemoglobin A1C, and thyroid-stimulating hormone levels; and 24-hour urine collection for calcium and creatinine excretion. Clinical Consideration 2.1 These laboratory measurements should be done as soon as possible after the patient establishes ongoing care with their physician, or if there is significant loss of bone mineral density, an incident fracture, or a change in a medical condition or medication that might be expected to influence osteoporosis risk. Referral to an endocrinologist or appropriate subspecialist should be considered if there are unexplained serum or urine calcium levels (hyper or hypo) and/or if the workup is suggestive of hyperthyroidism or hyperparathyroidism. Referral to a nephrologist should be considered in those with chronic kidney disease stage 4 (CKD 4) (glomerular filtration rate [GFR] 15-29 mL/min) and CKD 5 (GFR 15 mL/min or less) or unexplained renal impairment.	**3**	**6**	**1**	**1**	**1**	**1**	**1**	**3**	**3**	**2,2**	*Item 1: The guideline reported a rationale for the recommendation. However, the guideline did not describe the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes (It's a general recommendation for lab testing for bone health screening). Also, the guideline does not report how the importance of outcomes to patients was determined. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers are aware of the implementation challenges and make a general advice for guideline implementers: "Successful implementation of this guideline requires health care professionals to partner with individuals with SCI/D and negotiate a joint understanding of their health, bone density results, and risk factors for fracture in order to enable selection of a mutually agreeable treatment plan tailored to the individual's impairments, health preferences, and resources". However, it is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	Consortium_Bone health, 2022 Chapter: 2. Laboratory screening Page: 27
10	3.1 We recommend that clinicians adhere to the 2019 ISCD Adult Official Positions	**3**	**6**	**1**	**1**	**1**	**1**	**1**	**3**	**3**	**2,2**	*Item 1: The guideline reported a rationale for the recommendation. However, the guideline did not describe the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of	Consortium_Bone health, 2022 Chapter: 3. Bone density testing with

	for Dual-energy X-ray absorptiometry in Patients with Spinal Cord Injury.											publication bias, the possibility of confounding factors. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes (It's a general recommendation for bone density testing). Also, the guideline does not report how the importance of outcomes to patients was determined. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers are aware of the implementation challenges and make a general advice for guideline implementers: "Successful implementation of the enclosed recommendations and ISCD Positions will require the SCI community to work collaboratively with health policymakers and payers to resolve feasibility dilemmas regarding bone density testing and the identification of patients with low bone mass or sublesional osteoporosis and high fracture risk who require therapy". However, it is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	dual-energy X-ray absorptiometry Page: 36
11	5.2 The following are recommendations for calcium intake as a combination of food and supplements (preference for dietary intake over supplements). Group and age calcium recommendation: Men and premenopausal women age 19-50 years: 1,000 mg/day Men 50-70 years: 1,000 mg/day Women 50-70 years: 1,000-1,200 mg/day Men and women 71+ years: 1,000-1,200 mg/day Not appropriate for individuals who are found to be hypercalcemic.	**6**	**6**	**7**	**1**	**1**	**1**	**6**	**7**	**5**	**4,4**	*Item 1: In general, they have a good review of the quality and results of the available evidence. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations in the clinical consideration section page 48. *Item 4: It is not clear that they directly assess the values and preferences of the guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: Members of the Bone Health and Osteoporosis Management Clinical Expert Panel formulated key questions (to guide the literature search and study inclusion) related to prevalence, assessment, and treatment of bone health in the spinal cord injury (SCI) population. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the health system	Consortium_Bone health, 2022 Chapter: 5. Calcium and vitamin D3: diet or supplements Page: 48
12	1. Regular monitoring of the cardiometabolic syndrome should be carried out as part of lifelong follow-up in persons with SCI (to be carried out by the general practitioner, depending on the care situation). With increasing age, also the risk of cardiovascular disease increases. The longer the SCI, the greater the loss of lean mass.[c]	**3**	**6**	**1**	**1**	**2**	**1**	**1**	**3**	**3**	**2,3**	*Item 1: The guideline reported a brief introduction for the recommendation. However, the guideline did not describe the evidence to support the recommendation. It is no clear that the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors were analyzed. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. Apparently the only outcome was the lifelong follow-up of patients. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: Although the authors mention that patient preferences were taking into account in the REPORT document (Pg 18) there is no information on how this was considered for the recommendation. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking.	German speaking society_Lifelong follow-up, 2022 Chapter: 3.3 Cardiovascular diseases Page: 16

												*Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers state in the REPORT document (pg 19) that "In order to ensure the transfer of knowledge and action, various complementary measures were undertaken, which are coordinated in a target manner". However, at least, in the English documents this information was not found.	
13	2. Since tetraplegics do not show classic symptoms of a cardiac infarction, an annual ECG or long-term ECG should be performed from 10 years after the onset of paralysis or if the patient is over 60 years of age.[c]	**3**	**6**	**1**	**1**	**2**	**1**	**1**	**3**	**3**	**2,3**	*Item 1: The guideline reported a brief introduction for the recommendation. However, the guideline did not describe the evidence to support the recommendation. It is no clear that the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors were analyzed. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. Apparently the only outcome was the lifelong follow-up of patients. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: Although the authors mention that patient preferences were taking into account in the REPORT document (Pg 18) there is no information on how this was considered for the recommendation. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers state in the REPORT document (pg 19) that "In order to ensure the transfer of knowledge and action, various complementary measures were undertaken, which are coordinated in a target manner". However, at least, in the English documents this information was not found.	German speaking society_Lifelong follow-up, 2022 Chapter: 3.3 Cardiovascular diseases Page: 16
14	10. Nutritional status should be obtained as part of lifelong follow-up for elevated cardiovascular risk factors. With increasing age, also the risk of cardiovascular disease increases. The longer the SCI, the greater the loss of lean mass.[c]	**3**	**6**	**1**	**1**	**2**	**1**	**1**	**3**	**3**	**2,3**	*Item 1: The guideline reported a brief introduction for the recommendation. However, the guideline did not describe the evidence to support the recommendation. It is no clear that the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors were analyzed. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. Apparently the only outcome was the lifelong follow-up of patients. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: Although the authors mention that patient preferences were taking into account in the REPORT document (Pg 18) there is no information on how this was considered for the recommendation. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers state in the REPORT document (pg 19) that "In order to ensure the transfer of knowledge and action, various complementary measures were undertaken, which are coordinated in a target manner". However, at least, in the English documents this information was not found.	German speaking society_Lifelong follow-up, 2022 Chapter: 3.3 Cardiovascular diseases Page: 16

15	1. As part of lifelong follow-up, symptoms of deep vein thrombosis should be asked about and clinically examined, specifically in the first year after SCI, pregnancy, hormonal contraception or in the presence of one of the following risk factors: smoking, diabetes, age > 45 years, AIS A. For further recommendations on thromboembolism prophylaxis, please refer to the AWMF S1 guideline: "Thromboembolism prophylaxis in paraplegia".	**3**	**6**	**1**	**1**	**2**	**1**	**1**	**3**	**3**	**2,3**	*Item 1: The guideline reported a brief introduction for the recommendation. However, the guideline did not describe the evidence to support the recommendation. It is no clear that the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors were analyzed. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. Apparently the only outcome was the lifelong follow-up of patients. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: Although the authors mention that patient preferences were taking into account in the REPORT document (Pg 18) there is no information on how this was considered for the recommendation. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers state in the REPORT document (pg 19) that "In order to ensure the transfer of knowledge and action, various complementary measures were undertaken, which are coordinated in a target manner". However, at least, in the English documents this information was not found.	German speaking society_Lifelong follow-up, 2022 Chapter: 3.3 Cardiovascular diseases Page: 17
16	2. A symptom-based search for respiratory disturbances during sleep (recommended because of the frequency of this condition and its increasing prevalence with age) and polygraphy/polysomnography should be performed if suspected.	**3**	**6**	**1**	**1**	**2**	**1**	**1**	**3**	**3**	**2,3**	*Item 1: The guideline reported a brief introduction for the recommendation. However, the guideline did not describe the evidence to support the recommendation. It is no clear that the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors were analyzed. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. Apparently the only outcome was the lifelong follow-up of patients. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: Although the authors mention that patient preferences were taking into account in the REPORT document (Pg 18) there is no information on how this was considered for the recommendation. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers state in the REPORT document (pg 19) that "In order to ensure the transfer of knowledge and action, various complementary measures were undertaken, which are coordinated in a target manner". However, at least, in the English documents this information was not found.	German speaking society_Lifelong follow-up, 2022 Chapter: 3.4 Respiratory system - respiration, ventilation, respiratory infections and sleep-related breathing disorders (b440-b449) Page: 17
17	1. In the context of lifelong follow-up, if the basic status is assured (standard vaccinations, as well as for indication and booster vaccinations), the vaccination status of influenza, pneumococci, herpes zoster, meningococci, Covid-19 should	**3**	**6**	**1**	**1**	**2**	**1**	**1**	**3**	**3**	**2,3**	*Item 1: The guideline reported a brief introduction for the recommendation. However, the guideline did not describe the evidence to support the recommendation. It is no clear that the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors were analyzed. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. Apparently the only outcome was the	German speaking society_Lifelong follow-up, 2022 Chapter: 3.5 Immune system, vaccinations and allergies (b435) Page: 17

	be specifically asked about and, if necessary, recommended.											lifelong follow-up of patients. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: Although the authors mention that patient preferences were taking into account in the REPORT document (Pg 18) there is no information on how this was considered for the recommendation. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers state in the REPORT document (pg 19) that "In order to ensure the transfer of knowledge and action, various complementary measures were undertaken, which are coordinated in a target manner". However, at least, in the English documents this information was not found.	
18	1. Colonoscopy shall be performed similar to the general population according to guidelines set by professional societies (recommended at age 50 years, with a follow-up examination every 10 years thereafter, or earlier depending on findings)[c]	**3**	**6**	**1**	**1**	**2**	**1**	**1**	**3**	**3**	**2,3**	*Item 1: The guideline reported a brief introduction for the recommendation. However, the guideline did not describe the evidence to support the recommendation. It is no clear that the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors were analyzed. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. Apparently the only outcome was the lifelong follow-up of patients. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: Although the authors mention that patient preferences were taking into account in the REPORT document (Pg 18) there is no information on how this was considered for the recommendation. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers state in the REPORT document (pg 19) that "In order to ensure the transfer of knowledge and action, various complementary measures were undertaken, which are coordinated in a target manner". However, at least, in the English documents this information was not found.	German speaking society_Lifelong follow-up, 2022 Chapter: 3.6 Digestive system and neurogenic bowel dysfunction Paragraph: 1 Page: 23
19	1. As part of lifelong follow-up, all individuals with SCI should have regular/annual evaluations for possible upper extremity problems (especially shoulder, elbow, wrist, and carpal tunnel syndrome).[c] 2. It is therefore advisable to carry out the checks on all patients, but to pay particular attention to elderly people and those who have been in a wheelchair for a long time.[c]	**3**	**6**	**1**	**1**	**2**	**1**	**1**	**3**	**3**	**2,3**	*Item 1: The guideline reported a brief introduction for the recommendation. However, the guideline did not describe the evidence to support the recommendation. It is no clear that the consistency of the results (i.e., similarity of results across studies), the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors were analyzed. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. Apparently the only outcome was the lifelong follow-up of patients. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: Although the authors mention that patient preferences were taking into account in the REPORT document (Pg 18) there is no information on how this was considered for the recommendation. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between	German speaking society_Lifelong follow-up, 2022 Chapter: 3.10 Musculoskeletal system Page: 31

												benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline developers state in the REPORT document (pg 19) that "In order to ensure the transfer of knowledge and action, various complementary measures were undertaken, which are coordinated in a target manner". However, at least, in the English documents this information was not found.	
20	Clinicians should discuss with the individual with SCI, family members and caregivers that there may be an increased risk of bladder cancer in individuals with neurogenic lower urinary tract dysfunction, particularly in those with a long history of neurogenic lower urinary tract dysfunction and complicating factors, such as recurrent urinary tract infections. Clinicians should educate individuals with SCI regarding the symptoms to look out for (for example, recurrent infection, recurrent catheter blockages, or hematuria), which mean they should see a healthcare professional.[e]	**3**	**6**	**1**	**1**	**1**	**1**	**1**	**3**	**3**	**2,2**	*Item 1: The guideline adopted the recommendation from the 2012 NICE guideline for Urinary incontinence in neurological disease. However there is no analysis on the specific evidence to support the recommendation. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline website has links to suggested online resources and tools identified by the Expert Panel members. However, it is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	Can-SCIP, 2021 Chapter: K. Bladder function Section: K.16.1
21	Educate women with SCI about the effects of perimenopausal and menopausal changes on sexual function, bone health, accelerated metabolic aging, and metabolic syndrome after SCI.	**3**	**6**	**1**	**1**	**1**	**1**	**1**	**3**	**3**	**2,2**	*Item 1: The guideline adopted the recommendation from the 2010 Consortium for Spinal Cord Medicine. However there is no analysis on the specific evidence to support the recommendation. *Item 2: The guideline addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline recommendations align with the implementation goals of the guideline. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline website has links to suggested online resources and tools identified by the Expert Panel members. However, it is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	Can-SCIP, 2021 Chapter: R. Sexual health & relationships Section: R12.7
22	3.1 In SCI patients, higher doses might be required to improve detrusor overactivity and/or bladder compliance, which means that adverse anticholinergic events, such as dry mouth, constipation and blurred vision, might be more problematic. In addition, especially in elderly patients, the	**4**	**6**	**6**	**1**	**1**	**1**	**2**	**7**	**6**	**3,8**	*Item 1: In general, they have a good review of the quality and results of the available evidence, not describes the consistency of the results. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations. Also this recommendation describes how to tailor recommendations for application to individual patients or populations (e.g., based on age). *Item 4: It is not clear that they directly assess the values and preferences of the guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed.	Sekido N_Urinary dysfunction, 2020 Chapter: 3. Pharmacological therapy Page: 283

	total anticholinergic load should be taken into account to prevent cognitive impairment. Eventually, the panel concluded that anticholinergic drugs are recommended for patients who have the risk factors for renal damage and symptomatic urinary tract infection or urinary incontinence.											*Item 7: It is not clear the opinion of the guideline developers. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting, and/or the health system in which they are being implemented. They say about this recommendation are not expected to have a significant resource impact or be difficult to implement.	
23	4.3 Individuals with SCI should not be uniformly placed on high-fiber diets. Increases in fiber intake from food or a supplement should be done gradually to assess tolerance. Daily Fiber Quantity Recommendations: Adequate intake for daily recommended fiber is 25 g for women and 38 g for men under 50 years of age. To account for decreased food intake with aging, for men and women over 50 the daily recommended amount is 21 g for women and 30 g for men.	**5**	**7**	**7**	**7**	**1**	**7**	**6**	**7**	**5**	**5,8**	*Item 1: In general, they have a good review of the quality and results of the available evidence, however placebo-controlled trials regarding both dietary fiber and fiber supplementation are lacking in the SCI population. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations. for example among the relevant outcomes is the relief of constipation. *Item 4: It is clear that they directly assess the values and preferences of the guide's target users such as health carers. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are addressed such as associations and consortiums *Item 7: It is clear the values of the guideline developers. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: the recommendation assessed the setting which they are being implemented.	Consortium_Neurogenic bowel, 2020 Chapter: 4. Diet, supplements, fiber, fluids, and probiotics Page: 27
24	5.1 Providers can use oral medications for bowel management; however, the evidence for their use is limited and there are no data to suggest the use of one medication over another. The standard dose of prucalopride is 2 mg, but in individuals older than 60 years, the dose is usually 1 mg daily.	**3**	**7**	**7**	**7**	**1**	**7**	**7**	**6**	**5**	**5,6**	*Item 1: The evidence for their use is limited and there are no data to suggest the use of one medication over another. Also they say that Multiple studies in the non-SCI population show good efficacy of osmotic and stimulant laxatives in treating constipation. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations. *Item 4: It is clear that they directly assess the values and preferences of the guide's target users *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are addressed such as associations and consortiums *Item 7: It is clear the values of the guideline developers. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: the recommendation assessed the setting which they are being implemented.	Consortium_Neurogenic bowel, 2020 Chapter: 5. Oral medications Page: 30
25	6.4 The routine use of enema formulations such as sodium phosphate (Phospho-Soda), soapsuds, or milk and molasses is not recommended; however, in selected individuals, intermittent use for constipation may be helpful. In 2014, the FDA released a warning that physicians should be consulted prior to the use of sodium phosphate enemas for individuals who are over the age of 55	**4**	**6**	**7**	**7**	**1**	**7**	**2**	**6**	**5**	**5,0**	*Item 1: It is need more evidence, Expert opinion does not generally support the use of phosphate enemas (such as Fleet) for individuals with SCI for bowel management. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations. *Item 4: It is clear that they directly assess the values and preferences of the guide's target users *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are addressed such as FDA. *Item 7: It is not clear the values of the guideline developers. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: the recommendation assessed the setting which they are being implemented.	Consortium_Neurogenic bowel, 2020 Chapter: 6. Use of suppositories, enemas, and irrigation Page: 34

26	2.20 If there is history of difficulty passing a catheter in a male, consider using a coudé catheter or consult urology. A coudé catheter is especially useful in those with a history of sphincterotomy and in older men, in particular those with a history of prostatic hypertrophy or transurethral resection of the prostate.	**6**	7	7	7	**1**	**1**	7	7	**3**	**5,1**	*Item 1: In general, they have a good review of the quality and results of the available evidence and this recommendation has a better quality review specially in old people. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients. For example they say that this recommendation is better in older men, in particular those with a history of prostatic hypertrophy or transurethral resection of the prostate. *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations. for example among the relevant outcomes is less trauma. *Item 4: It is clear that they directly assess the values and preferences of the guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed . *Item 7: It is clear the values of the guideline developers. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: it is not clear that recommendation assessed the setting which they are being implemented.	Consortium_Autonomic dysreflexia, 2020 Chapter: Autonomic Dysreflexia Page: 23
27	31. At present orlistat is the only licenced medication for the treatment of obesity. It is associated with increased rates of gastrointestinal events. This could include steatorrhea, fatty faecal incontinence or urgency of bowel movements. This impact of these medications should be considered in the context of bowel management. These effects can be reduced by adhering to a low-fat diet and distributing daily fat intake over three main meals. A multivitamin and mineral supplement may be considered whilst using this medication. If there is concern about micronutrient intake adequacy, a supplement providing the reference nutrient intake for all vitamins and minerals should be considered, particularly for vulnerable groups such as older people and young people.	**7**	7	7	**6**	**1**	**1**	7	7	7	**5,6**	*Item 1:They have a strong consensus, they have a good review of the quality and results of the available evidence *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients. *Item 3: The guideline includes outcomes that are relevant to the targeted patients/populations. For example among the relevant outcomes is increased rates of gastrointestinal events. *Item 4: It is clear that they directly assess the values and preferences of the guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered for example inquire for the adverse affects. *Item 6: The values and preferences of decision/policy makers are not addressed . *Item 7: It is clear the values of the guideline developers. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: it is clear that recommendation assessed the setting which they are being implemented. Also to the context, they explain that when using this medication one should consider using a multivitamin and mineral supplement. Also they explain that taking the medication need to be aware. These factors are of importance in the context of bowel management for people with a SCI.	MASCIP_Weight management, 2019 Chapter: Medical and Surgical interventions Page: 12
28	6.7 Postanal repair results in satisfactory outcome in the long term in patients with neurogenic sphincter weakness. However, this is a single center experience, which needs further confirmation. Postanal repair (...) is useful in the elderly or those with significant co-morbidities.	**3**	**3**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1,4**	*Item 1: The guideline is an update of the recommendations from the 4th International Consultations on Incontinence (2009) for the clinical management of neurogenic bowel dysfunction. The assessed recommendation is based in a single study. It does not describe the directness of the evidence, the precision of the results, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors. *Item 2: The guideline addresses a health problem that is relevant to the intended target users. There is no detailed information on the target user's scope of practice, the targeted populations, or the trade-offs between harms and benefits. *Item 3: The recommendation does not specify the outcome that was taken into account. It is not clear if the guideline evaluated the importance of outcomes to patients. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between	International Consultation on Incontinence, 2018 Chapter: Surgical treatment Page: 52

												benefits and harms is lacking. *Item 8: The implementation goals of the guideline, the anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline does not mention any information for the implementation of the recommendation. It is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	
29	35. It is recommended that Physical and Rehabilitation Medicine (PRM) physicians continue long-term follow-up of persons with SCI, also when ageing, aiming to meet the individualised needs of the person using diverse treatment strategies along the lifespan of these persons with a life-long disability (see also Evidence-Based Position Paper (EBPP)[f] for ageing persons with disabilities).	**2**	**3**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1,3**	*Item 1: The authors of the Evidence-based position paper did not formulate single questions to make the recommendations. After the review of the literature the recommendations were formulated. This particular recommendation was based on three references. However, the authors did not describe the consistency or precision of the results, the directness of the evidence, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors. *Item 2: The evidence-based position paper addresses a health problem that is relevant. However there is no clear description of to the intended target users, scope of practice or targeted populations. *Item 3: The recommendation assessed does not include outcomes (It's a general recommendation for the long term follow up of PRM specialists to SCI patients). It is not clear that the importance of outcomes to patients was sought. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directily addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The evidence-based position paper does not include any implementation goals. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The evidence-based position paper does not mention any information for the implementation of the recommendation. It is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	UEMS_PRM, 2018 Chapter: D. Recommendations on PRM management and process Page: 804
30	3.2.3 Special care should be taken of patients at risk for autonomic dysreflexia (mainly patients with SCI above T6), being aware of the clinical signs of the onset of the crisis (eg, head sweating, headache) and its management (stop the filling, tilting the table, nifedipine). Moreover, blood pressure assessment during the urodynamic study is advisable. Considering the high incidence of silent episodes of autonomic dysreflexia during the urodynamic, they recommended that monitoring of cardiovascular parameters during these procedures be routinely performed. The authors strongly recommended blood pressure monitoring during urodynamic especially for elderly SCI patients.	**2**	**3**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1,3**	*Item 1: The best practice paper reported a rationale for the recommendation. The authors did not formulate single questions to make the recommendations. After the review of the literature the recommendations were formulated. This particular recommendation was based on three references. However, the authors did not describe the consistency or precision of the results, the directness of the evidence, the magnitude of the benefits and harms, the likelihood of publication bias, the possibility of confounding factors. *Item 2: The best practice paper addresses a health problem that is relevant to the intended target users and there is an alignment between target user's scope of practice and targeted populations. *Item 3: The recommendation assessed does not include outcomes (It's a general recommendation for bone density testing). Also, the best practice paper does not report how the importance of outcomes to patients was determined. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directily addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The best practice paper does not include any implementation goals. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The evidence-based position paper does not mention any information for the implementation of the recommendation. It is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	International Continence Society_Urodynamics, 2018 Chapter: Urodynamics in SCI Paragraph: 3.3.2 Page: 586
31	1. Evidence-based guidelines for treating hypertension in the	**3**	**4**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1,6**	*Item 1: The guideline reported a rationale for the recommendation, based on evidence. However, the guideline did not describe the consistency or precision of the results, the directness of the evidence, the	Consortium_Cardiometabolic risk, 2018

	general population should be used to treat individuals with SCI. For most adults, a threshold for initiating pharmacological treatment and treatment target of 140/90 mm Hg is reasonable, although different targets may be considered in certain individuals and sub-populations. (...) The Eighth Joint National Committee (JNC 8) evidence-based guideline for the management of high blood pressure in adults recommends initiating pharmacological treatment to lower blood pressure at systolic blood pressure of 150 mm Hg or higher or diastolic blood pressure of 90 mm Hg or higher in adults age 60 or higher without diabetes or chronic kidney disease.1											magnitude of the benefits and harms, the likelihood of publication bias or the possibility of confounding factors. *Item 2: The guideline addresses a health problem that is relevant. However there is no clear description of to the intended target users, scope of practice or targeted populations. *Item 3: The recommendation assessed does not include outcomes (It's a general recommendation for pharmacotherapy for hypertension). Also, the guideline does not report if the importance of outcomes to patients was sought. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline does not include any implementation goals. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline does not mention any information for the implementation of the recommendation. It is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	Chapter: Pharmacotherapy for Hypertension Page: 28
32	2. Consider SCI-related factors when selecting an antihypertensive agent, such as the effect of thiazide diuretics on bladder management. (...)Hyponatremia, hypokalemia, or decline in renal function sometimes occur during the first nine months of thiazide use, and older patients may be especially vulnerable to renal electrolyte disturbances, gout, hyperglycemia, and hypotension.	**3**	**4**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1,6**	*Item 1: The guideline reported a rationale for the recommendation, based on evidence. However, the guideline did not describe the consistency or precision of the results, the directness of the evidence, the magnitude of the benefits and harms, the likelihood of publication bias or the possibility of confounding factors. *Item 2: The guideline addresses a health problem that is relevant. However there is no clear description of to the intended target users, scope of practice or targeted populations. *Item 3: The recommendation assessed does not include outcomes (It's a general recommendation for pharmacotherapy for hypertension). Also, the guideline does not report if the importance of outcomes to patients was sought. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline does not include any implementation goals. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline does not mention any information for the implementation of the recommendation. It is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	Consortium_Cardiometabolic risk, 2018 Chapter: Pharmacotherapy for Hypertension Page: 28
33	7.0 We recommend that anticoagulant thromboprophylaxis continue at least eight weeks after injury in SCI patients with limited mobility. The specific duration should be individualised for each patient, taking into consideration the level and completeness of the neurological injury, concomitant injuries and medical conditions,	**3**	**4**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1,6**	*Item 1: The guideline reported a rationale for the recommendation, based on evidence. However, the guideline did not describe the consistency or precision of the results, the directness of the evidence, the magnitude of the benefits and harms, the likelihood of publication bias or the possibility of confounding factors. *Item 2: The guideline addresses a health problem that is relevant. However there is no clear description of to the intended target users, scope of practice or targeted populations. *Item 3: The recommendation assessed does not include outcomes (It's a general recommendation for the duration of thromboprophylaxis). Also, the guideline does not report if the importance of outcomes to patients was sought. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the	Consortium_Venous thromboembolism, 2016 Chapter: Duration of Thromboprophylaxis Page: 16

	bleeding risk, functional status, and feasibility. Factors suggesting longer duration of thromboprophylaxis include motor complete injuries, lower-extremity fractures, older age, previous venous thromboembolism, cancer, and obesity.											development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline does not include any implementation goals. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline does not mention any information for the implementation of the recommendation. It is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	
34	1. Conduct an assessment of pressure ulcer risk factors in individuals with SCI at every appropriate opportunity. Assess the following risk factors for the development of pressure ulcers: - Demographic (age) - SCI-related, such as incontinence - Comorbid medical - Nutritional - Psychological, cognitive, contextual, and social - Support surface for bed, wheelchair, and all durable medical equipment (DME) surface such as shower/commode chair or bathroom equipment related. Use both a validated risk-assessment tool and clinical judgment to assess risk.	**3**	**4**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1,6**	*Item 1: The guideline reported a rationale for the recommendation, based on evidence. However, the guideline did not describe the consistency or precision of the results, the directness of the evidence, the magnitude of the benefits and harms, the likelihood of publication bias or the possibility of confounding factors. *Item 2: The guideline addresses a health problem that is relevant. However there is no clear description of to the intended target users, scope of practice or targeted populations. *Item 3: The recommendation assessed does not include outcomes (It's a general recommendation for the risk for the development of pressure ulcers.). Also, the guideline does not report if the importance of outcomes to patients was sought. *Item 4: It is not clear that the authors assessed the values and preferences of the guidelines target users. *Item 5: It is not clear that the values and preferences of the patients were sought or considered. *Item 6: It is not clear that the values and preferences of decision/policy makers were directly addressed. *Item 7: A clear description of the values and preferences that guideline developers brought to the development process or how values and preferences influenced their interpretation of the balance between benefits and harms is lacking. *Item 8: The guideline does not include any implementation goals. The anticipated impacts of recommendation adoption on individuals, organizations, and/or systems are not described. *Item 9: The guideline does not mention any information for the implementation of the recommendation. It is not clear that the guideline describes the degree of change required from current practice or articulates relevant factors important to its successful dissemination.	Consortium_Pressure ulcers, 2014 Chapter: Risk and Risk assessment Page: 11
35	4.2: 24-hour approach to pressure ulcer risk management Perform a comprehensive assessment of posture and positioning to evaluate pressure ulcer risk. Consider all surfaces in both recumbent and sitting positions that a person uses to participate in daily activities over the entire 24-hour period. (...) Long-term spinal cord injury phase: The risk of pressure ulcers may increase over time due to changes in function, strength, and mobility that typically occur with increasing duration of spinal cord injury and with aging. Physical changes increase pressure ulcer risk and may require more intensive pressure ulcer management practices.	**2**	**4**	**5**	**1**	**4**	**1**	**1**	**5**	**1**	**2,7**	*Item 1: there is not a review of the quality and results of the available evidence. They were based on the Consortium for Spinal Cord Medicine Clinical Practice Guidelines. The recommendation don't assess any risk of bias related to the study designs of the supporting evidence, not describes the consistency of the results. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The outcomes that are relevant to the targeted patients/populations are not clear enough. but this recommendation describes some important points *Item 4: It is not clear that they directly assess the values and preferences of the directly.guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. However they recommend to understanding the individual: The clinician gathers information during the assessment to understand the person,relevant issues, goals, functional abilities, lifestyle, and specific needs. *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: Not adressed. They were based on the Consortium for Spinal Cord Medicine Clinical Practice Guidelines. Pressure ulcer prevention and treatment following spinal cord injury: a clinical practice guideline for health-care professionals. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting, and/or the health system in which they are being implemented	Canadian_Pressure ulcers, 2013 Chapter: 24-hour approach to pressure ulcer risk management Page: 70

36	4.5: Reassessment Reassess pressure management using a 24-hour approach every 2 years, or more often if a pressure ulcer develops or there is a significant change in health status — including weight changes or functional ability — or if there are changes in living situation or a deterioration in the support surface/equipment. (...) Reassessment can achieve the following: Identify the impact of physical changes due to aging and increasing duration of spinal cord injury, including postural changes, muscle wasting, and spasticity.	**1**	**4**	**4**	**1**	**1**	**1**	**1**	**5**	**1**	**2,1**	*Item 1: they did not mention the source of the recommendation. there is not a review of the quality and results of the available evidence. The recommendation don't assess any risk of bias related to the study designs of the supporting evidence, not describes the consistency of the results. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The outcomes that are relevant to the targeted patients/populations are not clear enough. but this recommendation describes some important points *Item 4: It is not clear that they directly assess the values and preferences of the directly.guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: Not adressed. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting, and/or the health system in which they are being implemented.	Canadian_Pressure ulcers, 2013 Chapter: Reassessment Page: 77
37	6.17: Education about the need for regular reassessment Educate the individual with spinal cord injury to monitor the condition of seating equipment and support surfaces regularly to ensure the equipment remains effective for pressure management.	**2**	**3**	**5**	**1**	**1**	**1**	**1**	**5**	**5**	**2,7**	*Item 1: there is not a review of the quality and results of the available evidence.The recommendation don't assess any risk of bias related to the study designs of the supporting evidence, not describes the consistency of the results. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients. However not only the patients have to ensure the condition of seating. *Item 3: The outcomes that are relevant to the targeted patients/populations are not clear enough. but the introduction of this recommendation describes some important points regarding this item. *Item 4: It is not clear that they directly assess the values and preferences of the directly guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: Not adressed. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting in which they are being implemented. However they said 'As healthcare system changes have resulted in shorter rehabilitation stays, it is important periodically to reassess the suitability of the equipment chosen initially'.	Canadian_Pressure ulcers, 2013 Chapter: Reassessment of seating systems Page: 127
38	6.10: Cushion maintenance Teach the individual with spinal cord injury and the caregiver to: - Care for and maintain the wheelchair cushion - Monitor the cushion for signs of wear at an appropriate frequency - Set up the cushion properly, including orientation and monitoring for bottoming out - Replace the cushion if it is deteriorating - Avoid placing additional layers on top of the cushion unless deemed essential Aging changes affecting the skin can increase susceptibility to	**4**	**4**	**5**	**1**	**1**	**1**	**1**	**5**	**1**	**2,6**	*Item 1: it is not very clear if there was a evaluation of the quality of the available evidence. However, they said Research has not evaluated the performance characteristics of all cushion types and they cited some articles. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The outcomes that are relevant to the targeted patients/populations are approach. (for ex. function) *Item 4: It is not clear that they directly assess the values and preferences of the directly guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. However they recommed to understanding the individual: The clinician gathers information during the assessment to understand the person,relevant issues, goals, functional abilities, lifestyle, and specific needs. *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: Not adressed. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting in which they are being implemented. However they said 'As healthcare system changes have resulted in shorter rehabilitation stays, it is important periodically to reassess the suitability of the equipment chosen initially'.	Canadian_Pressure ulcers, 2013 Chapter: Wheelchair cushions Page: 120

	pressure ulcer development, and routine reassessment can ensure that cushion choice remains appropriate.												
39	6.18: Schedule for periodic reassessment Establish a mechanism for regular reassessment of performance of sitting support surfaces specific to pressure ulcer prevention and treatment. Schedule reassessment at least every 2 years, or sooner if any of the following occur: - Health status changes, including weight or medical changes - Changes in functional status - Equipment wear or disrepair - Pressure ulcer development - Changes in living situation	**2**	**4**	**5**	**1**	**1**	**1**	**1**	**5**	**5**	**2,8**	*Item 1: there is not a review of the quality and results of the available evidence.The recommendation don't assess any risk of bias related to the study designs of the supporting evidence, not describes the consistency of the results. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The outcomes that are relevant to the targeted patients/populations are clear. *Item 4: It is not clear that they directly assess the values and preferences of the directly guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: Not adressed. *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting in which they are being implemented. However they said 'As healthcare system changes have resulted in shorter rehabilitation stays, it is important periodically to reassess the suitability of the equipment chosen initially'.	Canadian_Pressure ulcers, 2013 Chapter: Reassessment of seating systems Page: 127
40	1.10.7 Discuss with the person, and their family members and carers, that there may be an increased risk of bladder cancer in people with neurogenic lower urinary tract dysfunction, in particular those with a long history of neurogenic lower urinary tract dysfunction and complicating factors, such as recurrent urinary tract infections. Tell them the symptoms to look out for (especially haematuria) that mean they should see a healthcare professional.	**6**	**6**	**5**	**1**	**1**	**1**	**7**	**5**	**6**	**4,2**	*Item 1: The evidence review was designed to assess the long-term risks that are attached to the use of different LUT management systems. The GDG considered that the outcomes under consideration are of high importance. The majority of studies were retrospective reviews of medical records. The nonrandomised comparisons between different catheterisation methods were prone to confounding from un-standardised management strategies being used for different population groups with different baseline risk profiles. Studies were therefore categorised as very low quality. Studies were mainly restricted to patients with spinal cord injury. *Item 2: The recommendations address a health problem that is relevant to the intended target users. Also there is an alignment between target user's scope of practice and targeted patients *Item 3: The outcomes that are relevant to the targeted patients/populations are approach. *Item 4: It is not clear that they directly assess the values and preferences of the directly guide's target users. *Item 5: The values and preferences of the target population have not been sought or considered. However they recommended to understanding the individual. *Item 6: The values and preferences of decision/policy makers are not addressed. *Item 7: The recommendations were made on the basis of the information that arose from the literature review and the clinical experience of the Guideline development group *Item 8: This recommendation is aligned with the implementation goals of the guideline *Item 9: It is not clear that the recommendation assessed the setting in which they are being implemented. However they approach the item of the Economic analysis	NICE_Urinary incontinence, 2012 Chapter: 1.10 Page: 39