Discussion There are many ways to speed up systematic review, some at risk of introducing bias. Without clear understanding of the reasons users request rapid review and their expectations for the evidence product, simply speeding the time frame may not address all of user needs for evidence they can implement quickly.
Implications for Guideline Developers/Users Until there is consensus on what the label rapid review describes, users will need to identify their own minimal standards and evaluate adherence. Developers should be clear about user expectations for using the evidence.

032 RAPID GUIDELINES: A SYSTEMATIC REVIEW

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Background Guidelines often take two or more years to be developed. This timeframe is not practical for providing guidance in situations when rapid advice is needed.
Objectives To describe current practices about the development of rapid guidelines and to provide advice about adequate methodology.
Methods We performed a systematic review, including grey literature, to identify (1) rapid guidelines, defined as guidelines produced in a shortened time frame, and (2) methodological manuals addressing its development.
Results We only documents by WHO and NICE that described methods and actual guidelines. The WHO handbook describes "rapid advice guidelines"; guidelines produced in response to a public health emergency in which WHO is required to provide rapid global leadership and guidance. This advice should be produced within 1 to 3 months and be evidence-informed, however, it may not be supported by full reviews of the evidence. We identified six WHO rapid guidelines and one methodological guidance paper based on a WHO guideline. NICE produces "short clinical guidelines"; guidelines that address only part of a care pathway, allowing rapid (11–13-month) development of guidance on aspects of care for which the NHS requires urgent advice. We identified 18 NICE short clinical guidelines.
Discussion Literature is lacking about rapid guidelines and the intended role appears to differ. Despite its relevance, there are few rapid guidelines published and clarity about the terminology is needed.
Implications for Guideline Developers We will provide a framework for those developing rapid guidelines, including practical advice and clarification about the terminology used.

033 USING RAPID REVIEWS TO INFLUENCE GUIDANCE DEVELOPMENT IN THE EMERGENCY DEPARTMENT SETTING

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Background Decision making within health care organisations often requires rapid response to emergent, controversial or high-impact issues affecting clinical and operational practices.
Context CT imaging without oral contrast for patients admitted into the Emergency Department (ED) for abdominal/pelvic pain has been proposed as a viable option to reduce the risk of contrast-induced nephropathy and allergic reactions, as well as emergency room delays and overall length of stay (LOS) in the ED. A centralised evidence assessment unit within a large health care organisation was asked to conduct a rapid evidence review to inform the development of evidence-based guidance.
Description of Best Practice A 5-step rapid review process was initiated, including: 1) Communicating with key stakeholders to determine relevant populations, interventions, comparisons, outcomes, timing and settings (PICOTS); 2) Conducting a comprehensive evidence search using a pre-established list of key databases and other sources to identify high-quality guidelines, systematic reviews and clinical trials evaluating the efficacy and diagnostic accuracy of conducting abdominal CT with and without oral contrast agents; 3) selecting and abstracting data from relevant studies; 4) evaluating and synthesising the literature; and 5) translating results for clinical/operational decision making. Findings of low- to moderate-quality evidence across outcomes, combined with operational and resource data, resulted in a decision not to implement the practice.
Lessons for Guideline Developers, Adaptors, Implementers, and/or Users Coupled with expert input from knowledgeable clinicians and stakeholders, rapid evidence reviews can be critical to shaping evidence-based guidance in Emergency Department settings.

034 DO MODELS OF RAPID GUIDELINE UPDATES FIT WITHIN THE CURRENT AUSTRALIAN GUIDELINE STANDARDS? AN EXAMPLE FROM THE NATIONAL STROKE FOUNDATION CLINICAL GUIDELINES

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Background Clinical guideline recommendations are developed to assist health professionals to make evidence-based decisions. This is reliant on having the most up-to-date evidence available. The current Australian National Health and Medical Research Council (NHMRC) standards require guidelines to be updated within five years. An online process which provides transparency and enables timely changes/updates, such as the wiki platform developed and used by the Cancer Council of Australia (CCA), would provide a more useful platform to update guidelines but is currently not considered within the NHMRC standards.
Objectives To evaluate if using the CCA wiki platform to update stroke guidelines would meet NHMRC standards.
Methods We reviewed a potential CCA wiki platform ("wiki") model against the existing NHMRC standards (2011) to determine compatibility and identify where changes to the wiki model might be required.
Results The processes utilising the wiki were methodologically robust and were deemed to comply with 45/50 of the mandatory elements of the NHMRC standards with minor changes needed to comply with the other five elements. Difficulties arise

predominantly due to the fact that the NHMRC standards are based on physically published guidelines.
Discussion A model of rapid guideline updates utilising a wiki platform is able to accommodate robust methodology and meets most of the current Australian standards.

035 WHAT DO GUIDELINE APPRAISAL TOOLS ASSESS? A SYSTEMATIC REVIEW

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Background Clinical practice guidelines should provide a rational basis for healthcare decisions; however, their quality is often poor.
Objectives To systematically identify and describe guideline appraisal tools and draw conclusions for guideline appraisal.
Methods We conducted a systematic search in MEDLINE, EMBASE and the Cochrane Library for English and German-language guideline appraisal tools published after 1995. Reference lists of included publications were also screened. Dimensions of guideline quality were then generated from these publications and from articles by Cluzeau 1999, Graham 2000 and Vlayen 2005. Finally, the questions contained in the appraisal tools were allocated to the quality dimensions and summarised.
Results Overall, 40 appraisal tools were included and 13 quality dimensions identified. The main focus was the identification, assessment and presentation of evidence in guidelines. Questions on dealing with norms and values in guideline development, patient involvement, conflicts of interest, or implementation of guidelines into clinical practice were rare. The tools often assessed the appropriate documentation of the guideline development process (e.g. reporting of the search strategy), without addressing the appraisal of content of the development process (e.g. appropriateness of the search strategy) and the appraisal of clinical content.
Discussion Because many appraisal tools do not contain questions on norms and values or on potential conflicts of interest of guideline authors, important aspects potentially influencing the reliability of guidelines are not covered. In addition, an appraisal of content of the guideline development process and an appraisal of clinical content are often lacking.

036 DEVELOPMENT OF A STATEWIDE GUIDELINES PROGRAM USING THE ADAPTE FRAMEWORK

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Background The legislature passed comprehensive health reform legislation in 2009 directing the state to "set standards for safe and effective care", including development of "best practice guidelines and standards that can be uniformly applied across public and private health care".
Objectives Develop guideline methodology and guidelines for statewide clinicians and payers.
Methods Employed ADAPTE framework for guideline development. Initial guidelines selected for development included three low back pain (LBP) topics: general evaluation and management of LBP (results described below), advanced imaging for LBP, and percutaneous interventions for LBP. Existing (seed) guidelines identified by searching 17 databases. Quality evaluated using modified AGREE II instrument. Multidisciplinary guideline development group selected and adapted seed guidelines. Stakeholder, peer review and public comments were solicited.
Results Thirteen seed guidelines were identified and 10 met minimal inclusion criteria for LBP evaluation and management topic. Dual quality rating found five of good or fair quality. Final seed guideline selected based on quality and scope. Key recommendations were adopted for state Medicaid programme, including conservative and chiropractic care only in first month and no advanced imaging without clinical "red flags". A consumer booklet was developed and distributed to consumer, provider, and payer groups. Over 2500 booklets were distributed, with over 11,000 page views on the website. The initial guideline process took over one year to complete.
Discussion Starting a new multi-stakeholder guideline development programme requires substantial investments of methodological expertise, staff time, funds and political capital, but can substantially impact state health policy decisions.

037 UPDATING AN ADAPTED CPG: WHEN IS ENOUGH ENOUGH?

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Background Within 2 years of releasing a low back pain clinical practice guideline (CPG), the Alberta Ambassador Guideline Adaptation Programme was required to update its adapted guideline. No guidance or 'how to' manuals were located.
Objectives To develop a process for updating an adapted guideline. To expedite the process by determining which components can be removed without compromising rigour.
Methods CPGs and systematic reviews published since the release of the CPG were identified and appraised, and discordant and new recommendations were tabulated. The Guideline Development Group (GDG) was surveyed to identify new interventions of interest. Evidence from systematic reviews was included for 'do not know' recommendations and new interventions.
Results The original guideline had 50 recommendations, eight of which were in the 'do not know' category. This expanded to 85 recommendations in the update: 43 unchanged, 32 on GDG-nominated new interventions, and 10 revised. The updated CPG has 33 'do not know' recommendations. One of the original eight 'do not know' recommendations was changed based on new evidence.
Discussion The challenge of maintaining the integrity and high standards of the original guideline meant that the update consumed more time and resources than planned. Clearly, some components of the process can be jettisoned without jeopardising the methodological rigour and comprehensiveness of the final product.
Implications The next update will be streamlined, including only new seed guidelines that meet the quality criteria of the