

'expedient' risks methods with unacceptable threats to validity; and towards ideal, an unaffordable standard not worth the incremental costs. Examples highlight the tool's utility.

**Conclusions** Negotiating and reporting compromises in methodological quality can lead to sensible, transparent methodological choices acceptable to both CPG developers and sponsors.

#### 026 WHAT ORGANISATIONAL RESOURCES HAVE TO BE CONSIDERED WHEN ADAPTING GUIDELINES IN THE CONTEXT OF LOW AND MIDDLE INCOME COUNTRIES (LMIC)? THE ARGENTINEAN EXPERIENCE

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**Background** Adapting guidelines in resource-constraints countries represents a great challenge. Availability of organisational resources has to be considered before implementing this methodology.

**Objectives** a) To compare the availability of different organisational resources during seven guidelines adaptation initiatives facilitated by the National Academy of Medicine (Argentina) between 2005 and 2013; b) to analyse the relevance of each type of resource category for adapting guidelines in the context of LMIC.

**Methods** 7 guidelines adaptation initiatives facilitated by the NAM since 2005 and 2013 are described. Organisational resources were categorised in 4 categories: organisational culture, human resources, economic resources, and condition resources (or states) within the organisation. Conservation of resources (COR) theory was used as the theoretical basis for analysing the relevance of each type of resource for the guideline adaptation process.

**Results** Four of the 7 initiatives completed the whole process and produced an evidence-based guideline; 1 was interrupted and 2 are still ongoing although 1 of them shows a considerable delay. Among all organisational resource categories, culture and human resource were perceived as the most critical, particularly in what respects to the availability in the guideline developer group of change agents (i.e. internal and external facilitation); disposition to change and motivation and an appropriate mix of skills including leadership, communication, team work, technical competences.

**Discussion** Guidelines adapting in resource-constraint countries is not easy, although possible if different critical organisational resources are provided from the outset of the process.

**Implications for Guideline Developers/Users** A minimum organisational resource threshold is necessary for guarantying guidelines adaptation in the context of LMIC.

#### 027 DETERMINANTS OF GUIDELINE USE AMONG PRIMARY CARE PHYSIOTHERAPISTS IN WESTERN SWEDEN: A CROSS-SECTIONAL STUDY

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**Background** The understanding of attitudes, knowledge, and behaviour related to evidence-based practice (EBP), in particular evidence-based clinical practice guidelines, in primary care physical therapy is limited.

**Objectives** To investigate self-reported attitudes, knowledge, behaviour, prerequisites, and barriers related to EBP and, in particular, guidelines among physical therapists (PTs) in primary care, and to explore associations of self-reported use of guidelines with these social-cognitive factors.

**Methods** Cross-sectional survey of PTs (n=400) in primary care in western Sweden using a web-based, validated questionnaire. Logistic regression analysis was used.

**Results** The response rate was 67.8%. Most PTs (82%–96%) had positive attitudes toward EBP and guidelines. Thirty-three percent reported being aware of guidelines, 13% knew where to find guidelines, and only 9% reported having easy access to guidelines. Less than half reported using guidelines frequently. The most important barriers to using guidelines were lack of time, poor availability and limited access to guidelines, that they are too general and take too long to read. Positive attitudes to EBP and guidelines, knowledge of where to find guidelines, self-efficacy, easy access, ability to integrate patient preferences, and encouragement of EBP in the workplace were associated with frequent use of guidelines.

**Discussion** Use of guidelines was not as frequent as could be expected in view of the positive attitudes. Attitudes, knowledge, self-efficacy, easy access, ability to integrate patient preferences, and encouragement of EBP may promote guideline use.

**Implications for Guideline Developers/Implementers** The identified barriers and determinants can be addressed in the development of guideline implementation strategies.

#### 028 HOW DO CLINICIANS LIKE AND UNDERSTAND TRUSTWORTHY GUIDELINES? RANDOMISED CONTROLLED TRIAL USING CLICKERS IN EDUCATIONAL SESSIONS

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**Background** Clinical practice guidelines (CPG) often have shortcomings in presentation formats that limit dissemination at the point of care. As part of the DECIDE project we have developed multilayered CPG presentation formats. Comprehensive user-testing of the formats has provided us with alternative presentation formats now ready for randomised trials but also an important insight: Insufficient conceptual understanding of guideline methodology (e.g. strength of recommendations and quality of evidence) may hamper application of CPG recommendations in practice.

**Objectives** To determine physicians' understanding, attitudes and preferences concerning trustworthy guidelines in traditional and new presentation formats (DECIDE A and B).

**Methods** In this randomised controlled trial we will recruit 100 physicians attending a standardised lecture with 3 components: 1) presentation of clinical scenario, 2) explanations of key concepts of trustworthy CPG (e.g. GRADE, AGREE II) and 3) presentation of a current trustworthy CPG relevant to the scenario,

displayed in traditional PDF format and DECIDE A and B formats. Throughout the lecture participants will answer questions with 'Clickers' and be randomly assigned to alternative presentation formats by concealed allocation and blinding, through the use of eyepatches.

**Results** We will present results from the trial at the conference.

**Discussion** If our approach of integrating randomised trials into educational sessions is feasible and provides valid results we will conduct multiple such trials in DECIDE.

**Implications for Guideline Developers and Users** Optimised GL presentation formats and sufficient conceptual understanding, as researched in this trial, should facilitate the uptake of trustworthy CPG and application of research evidence in practice.

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### CLINICAL PRACTICE GUIDELINES FOR AUSTRALIAN GENERAL PRACTITIONERS: HOW IMPLEMENTABLE ARE THEY?

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**Background** Many guidelines have been published that are relevant to Australian general practitioners. However, it is unclear whether these guidelines have the attributes required for facilitating implementation.

**Objectives** To determine the proportion of current Australian general practice guidelines that have incorporated the attributes required for facilitating implementation.

**Methods** We conducted an audit of the National Health and Medical Research Council Clinical Guidelines Portal to identify guidelines published between 2007 and 2011 that listed general practitioners (GPs) as a primary user and examined them for attributes identified in literature as facilitating implementation.

**Results** A total of 146 guidelines targeting Australian GPs were identified in our study. Approximately 46% of these guidelines were developed by "collaborating authors", with 27% and 19% developed by "government organisations" and "not-for-profit organisations", respectively. Almost half (43%) of the guidelines did not state the methodology used, with 33% using "expert opinion" and only 16% using "systematic literature reviews". Only 14% of the guidelines were endorsed by professional colleges and only 10% of the guidelines were government-approved. Additional resources to facilitate guideline uptake were included for only 23% of the guidelines.

**Discussion** While some attributes of implementation have been incorporated into general practice guidelines, many are absent from most of these guidelines. Given the rapid growth in evidence-based guidelines in Australia, it is imperative that clinical practice guidelines incorporate the attributes necessary for facilitating implementation.

**Implications for Guideline Developers/Users** Developing an evidence-based guideline implementability framework may be useful for improving the development and dissemination of guidelines.

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### PRIMARY CARE PHYSICIANS' VIEWS ON RELEVANCE OF CLINICAL GUIDELINE RECOMMENDATIONS: DELPHI PANEL

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**Background** National clinical guideline developers, such as the UK's National Institute for Health and Clinical Excellence (NICE), produce high quality guidelines, yet primary care practitioners (PCPs) may question the relevance of the evidence and recommendations to a primary care (PC) population.

**Objectives** To evaluate PCPs' views about the relevance of NICE clinical guidelines to PC.

**Methods** An online Delphi panel of 28 PCPs, recruited regionally and nationally, reviewed 14 guideline recommendations: 8 supported by PC relevant evidence and 6 by evidence from elsewhere. Panellists scored recommendations twice, on a scale of 1–9 (9 = highly relevant for PC), before and then again after reading a summary of the evidence, including study setting and population. They also commented on factors influencing guideline validity and PC implementability.

**Results** 25 PCPs (89%) completed the Delphi. Overall mean scores were 7.4 (range 6.2–8.2) before reading the evidence summary, and 6.6 (4.6–8.3) after. Mean scores for the 8 recommendations supported by PC evidence were 7.4 before and 7.2 after (change -0.2). Mean scores for the 6 with evidence from elsewhere were 7.4 before and 5.8 after (change -1.6). Factors perceived to influence implementation included clarity, brevity, and relevance to PC.

**Discussion** PCPs' ratings of PC guideline validity dropped when they became aware that substantial supporting evidence for the guidelines had come from non PC settings. The relevance of the evidence to PC patients was important.

**Implications for Guideline Developers/Users** Developers should explicitly describe the relevance of available evidence for PCPs and their patients.

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### IF RAPID REVIEWS ARE THE ANSWER, WHAT IS THE QUESTION?

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**Background** The Institute of Medicine recommended standards for systematic review, but some guideline developers find the standards time and resource intensive. Rapid reviews are becoming a popular method to appraise and summarise evidence. But what are rapid reviews and do they replace or rely on systematic review?

**Objectives** To clarify major differences between rapid reviews and systematic reviews, especially aims, methods and uses for guidelines and policy.

**Methods** Overview of reviews and examination of organisational policies for rapid review focusing on reasons users request rapid review, methods used to produce them, and the uses of those syntheses.

**Results** There is no standards methodology for producing rapid review, nor is there consistency in intended use. Some organisations rely on systematic reviews to produce rapid review, while others incorporate short cuts in systematic review process. In addition to faster production, some users of rapid review are seeking product that is more clinically relevant and ready for implementation.