

**Discussion** Even though the focus group procedures varied, there was significant overlap and repetition in the feedback received on the same guideline resources. The patient focus group facilitated by a clinician engaged participants in discussions oriented to clinical issues. The comic book was considered to be a novel communication vehicle by clinicians but not so by public.

**Implications for Guideline Developers/Users** Involving a motivated Lay Committee facilitated by someone not directly related to the project seems to be a valuable alternative to other focus groups of patients which may require more effort and resources.

#### 053 IMPLEMENTING NUTRITION GUIDELINES THROUGH PRACTICE TOOLS FOR REGISTERED DIETITIANS

K Kren, L Moloney, P Ziegler, A Acosta. *Academy of Nutrition and Dietetics, Chicago, USA*

10:1136/bmjqs-2013-002293.84

**Background** Evidence Based Dietetics Practice Toolkits are resources intended to assist registered dietitians (RDs) in implementing nutrition guidelines derived from systematic reviews.

**Objectives** Surveys, sent at least one year past publication, were used to explore who uses toolkits, how toolkits are used, and if RDs find toolkits useful for implementation of guidelines.

**Methods** A standard questionnaire was sent to 1379 individuals for six toolkits (Celiac Disease, Critical Illness, Diabetes, Heart Failure, Oncology, and Paediatric Overweight) in 2011 and 2012, using Survey Monkey.

**Results** Responses received were 131 (9%), of which 42% were RDs in practice >15 years, in direct care (63%), and in settings of outpatient (51%) and inpatient (31%). Respondents mostly used toolkits for patient care (66%), nutrition counselling (40%) and development of forms (37%). Regarding the tools provided, 66% of respondents indicated that they found the summary of nutrition care and patient education materials to be very/some-what useful or useful. The same was true for 63% for the case studies, 61% for the flowchart of patient encounters, 60% for the patient encounter process instructions and 56% for the sample documentation forms. Some respondents (24%) seldom or never used the guidelines prior to toolkit use; however, 65% indicated that the toolkit was useful in translating the guidelines to practice.

**Discussion** The implementation of guidelines is often overlooked yet is crucial to changing practice. These toolkits allow a useful strategy for assisting with implementation. Similar practice tools, tailored to practitioners and setting, may be useful in guideline implementation for a variety of conditions.

#### 054 TRANSFORMING EVIDENCE FROM MULTIPLE GUIDELINES INTO USER FRIENDLY CLINICAL PRACTICE TOOLS FOR REMOTE CANCER TREATMENT-RELATED SYMPTOM MANAGEMENT: THE COSTARS PROJECT

<sup>1,2</sup>D Stacey, <sup>2,3</sup>M Carley, <sup>3</sup>M Harrison, <sup>4</sup>Pan-Canadian Oncology Symptom Triage and Remote Support (COSTARS), Group. <sup>1</sup>University of Ottawa, Ottawa, Canada; <sup>2</sup>Ottawa Hospital Research Institute, Ottawa, Canada; <sup>3</sup>Queen's University, Kingston, Canada; <sup>4</sup>Canada

10:1136/bmjqs-2013-002293.85

**Objectives** To transform evidence from guidelines for clinical practice tools for remote management of patients experiencing symptoms related to cancer treatment. Clinical practice protocols

are defined as user-friendly knowledge translation tools to support patient care. These tools narrow the know-do gap by presenting the best available evidence from guidelines while using a format that is sensitive to how nurses think and what nurses do.

**Methods** Mixed methods descriptive study guided by CAN-IMPLEMENT©. The process involved: a) conducting a systematic search for guidelines; b) developing symptom-specific protocols using evidence from quality appraised clinical practice guidelines; c) reaching consensus on the clinical practice protocol template, and d) validating the clinical practice protocols.

**Results** Clinical practice protocols were developed and validated for 13 symptoms using 42 clinical practice guidelines with a median of 3 guidelines per protocol (range 1 for bleeding to 7 vomiting). For the first two protocols, source guideline AGREE rigour subscale ratings ranged from 8% to 86% (median 60.1; diarrhoea; 40.5 fever). The protocols were developed using guidelines, symptom severity questions included the Edmonton Symptom Assessment System, and iterative feedback from practicing nurses. Usability testing revealed: high readability, just the right amount of information, and appropriate terms. Access to protocols needs to be tailored to individual practices (e.g. electronic application, access to paper-based versions). Nurses requested training and support to implement them.

**Discussion** These tools, created from guidelines, transform evidence into user-friendly protocols for use by nurses when guiding patients at home to better manage their cancer treatment-related symptoms.

#### 055 USE OF NON-RANDOMISED STUDIES IN THE GUIDELINE PROCESS: THE GRADE APPROACH

N Santesso, R Mustafa, H Schunemann, C4-GEP Methodology Group. *McMaster University, Hamilton, Canada*

10:1136/bmjqs-2013-002293.86

**Background** The GRADE approach to guideline development requires a review of the best available evidence which includes randomised controlled trials (RCTs) and non-randomised studies (NRS).

**Objectives** Describe the use of NRS as a replacement, a sequence, or a complement for RCTs, in a World Health Organization guideline using the GRADE approach.

**Methods** We searched the literature using no study type limits for the effect of screening and treatment of precancerous lesions on patient or population important outcomes and for baseline risks. We assessed quality of the evidence using GRADE.

**Results** Depending on the outcomes, we found few to no RCTs. When there was low/very low overall quality evidence from RCTs, we used NRS studies with no independent control groups to compare proportions between groups and calculate a relative effect of treatment and this evidence replaced the RCT evidence with similar/higher quality evidence. We found no evidence in RCTs for long-term outcomes, such as spontaneous abortion. Therefore, we used data from NRS (cohort studies) for premature delivery (a surrogate) to provide sequential evidence. For evidence about baseline risk of precancerous lesions and other outcomes, we used NRS a complement to the RCT data.

**Discussion** Data from NRS provided evidence in three ways. One key criterion to consider when grading this evidence is indirectness due to indirect comparisons, surrogate outcomes or varying population risks.