THE APPREHENSION AND APPLICATION OF CLINICAL PRACTICE GUIDELINE OF PHYSICAL THERAPISTS IN THAILAND

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THE APPREHENSION AND APPLICATION OF CLINICAL PRACTICE GUIDELINE OF PHYSICAL THERAPISTS IN THAILAND

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ABSTRACT

Nowadays, clinical practice guidelines (CPG) have an important role in the health care services of Thailand. However, the situation of apprehension and application concerning the CPGs by physical therapists who are working in hospitals has not been researched. Therefore by using a questionnaire, this study surveyed the knowledge and attitudes of physical therapists as well as their ability to apply CPGs in hospitals.

The questionnaires were mailed to 120 physical therapists who are currently working in hospital settings. The survey was conducted between August and September, 2008. 101 questionnaires were returned (84.2% response rate). These results showed that more than 70% of the respondents had a clear knowledge regarding the definition of evidence-based practice but did not understand the definition, characteristics and content of CPGs. In addition, more than 50% of the respondents had a positive attitude towards CPGs. About 61% of the respondents had at least one physical therapy guideline in the department. About 84% of the respondents had a department that reported regular CPG use. However, about 50% of the physical therapists did not use CPGs. The possible reasons for this were lack of proper knowledge of CPGs, a limited amount of time and difficulty in accessing resources. Therefore, important factors in successful use of CPGs would be to promoted proper understanding of CPGs and convenient access the available resources.

KEY WORDS: KNOWLEDGE/ ATTITUDE/ USE/ CLINICAL PRACTICE GUIDELINE/ PHYSICAL THERAPY

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ความเข้าใจและการใช้แนวทางการให้บริการของนักกายภาพบำบัดในประเทศไทย
THE APPREHENSION AND APPLICATION OF CLINICAL PRACTICE GUIDELINE OF PHYSICAL THERAPISTS IN THAILAND

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บทคัดย่อ

ปัจจุบันแนวทางการให้บริการมีบทบาทสำคัญในระบบบริการสุขภาพของประเทศไทย อย่างไรก็ตามยังไม่มีข้อมูลสถานการณ์ความเข้าใจและการใช้แนวทางการให้บริการของนักกายภาพบำบัดที่ทำงานในโรงพยาบาล ดังนั้นการศึกษาครั้งนี้จึงสำรวจความเข้าใจ ทัศนคติ และการใช้แนวทางการให้บริการของนักกายภาพบำบัดที่ทำงานในโรงพยาบาลโดยใช้แบบสอบถาม

แบบสอบถามถูกส่งทางไปรษณีย์ไปยังนักกายภาพบำบัดซึ่งทำงานในโรงพยาบาล จำนวน 120 คน การสำรวจทำระหว่างเดือนสิงหาคมถึงกันยายน 2551 แบบสอบถามตอบกลับจำนวน 101 ฉบับ (อัตราตอบกลับร้อยละ 84.2) ผลการสำรวจพบว่า นักกายภาพบำบัดมากกว่าร้อยละ 70 ของมีความรู้ชัดเจนเกี่ยวกับความหมายของการปฏิบัติงานโดยอิงหลักฐานแต่ยังขาดความรู้เกี่ยวกับความหมาย ลักษณะ และ เนื้อหาของแนวทางการให้บริการ นอกจากนี้ นักกายภาพบำบัดมากกว่าร้อยละ 50 มีทัศนคติที่ดีต่อแนวทางการให้บริการ ร้อยละ 61 จัดทำและมีแนวทางการให้บริการทางกายภาพบำบัดอย่างน้อยหนึ่งเรื่องในหน่วยงาน ร้อยละ 84 ใช้แนวทางการให้บริการอย่างไรก็ตามประมาณร้อยละ 50 ไม่ได้จัดทำและไม่ได้นำใช้แนวทางการให้บริการ เหตุผลที่เป็นไปได้คือ การขาดความรู้ที่ถูกต้องเกี่ยวกับแนวทางการให้บริการ ข้อจำกัดในเรื่องเวลา และการเข้าถึงแหล่งข้อมูลได้ยาก ดังนั้นปัจจัยสำคัญที่จะส่งเสริมให้เกิดการใช้แนวทางการให้บริการของนักกายภาพบำบัด คือการส่งเสริมให้มีความเข้าใจที่ถูกต้องเกี่ยวกับแนวทางการบริการ และการเข้าถึงแหล่งข้อมูลที่มีอยู่ได้สะดวก

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LIST OF ABBREVIATIONS

CPG	clinical practice guidelines
EBP	evidence-based practice
PT	physical therapy
RH	regional hospital
GH	general hospital
SH	speacialized hospital
UH	university hospital
PH	private hospital
cont.	continued

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CHAPTER I
INTRODUCTION

Clinical practice guidelines (CPG), especially physical therapy practice guidelines have been developed and increasingly used throughout the world over the last decade. The aims of the CPG are to improve the quality of health care and to close the gap between theory and actual practice, and thus to promote evidence-based medicine into daily practice as a standard for physical therapy professional(1-5). There are several factors that influence the implementation of clinical practice guidelines including social context, setting, organizational context and other reasons such as other professional staff, colleagues and patients(2, 3, 6, 7). The key influences consisting of knowledge about clinical practice guideline, attitude toward clinical practice guideline, benefit of clinical practice guideline and clinical practice guideline dissemination, implementation and evaluation determine the behavior in developing and using of the clinical practice guidelines (6-11). The conceptual framework of these issues demonstrates in Figure 1.1.

The development of clinical practice guideline is based on evidence-based practice by such methods being called “evidence-base practice guidelines”. However, a study demonstrated that physical therapists in several countries (e.g., USA., the United Kingdom and Australia) still lacked of knowledge and skill to use evidence-based practice guidelines(8). In term of the attitude toward clinical practice guidelines, most physical therapists had positive attitude. The positive attitude or belief would help the practitioners to improve the quality of care and increase the standardization of practice. In contrary, the negative attitude was that clinical practice guideline would result in the practice following the cookbook medicine. The practitioners also thought that clinical practice guideline could stop an innovation and reduced clinical freedom. There was a study showing the extent and local use of clinical practice guidelines in the United Kingdom hospitals. There were some awareness of clinical practice

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guideline activities, support of the development of national evidence-based clinical practice guideline and a planning of clinical practice guideline development by multi-professional group including physical therapist (7).

According to the literature, the prime benefits of clinical practice guidelines are to improve the quality of care (i.e., quality of decisions and quality of information used for decisions) received by patients, to support evidence-based care and to contribute to more effective care (1-11). However, harmful practices could be caused by lacking or misinterpreting of scientific evidence recommendation (11). Clinical practice guidelines also play roles to develop the profession of physical therapy: improving uniformity within the profession, decreasing variations in physical therapy management, revealing the tasks and responsibilities of the profession and promoting collaboration with other professions (1-11).

For clinical practice guideline dissemination, implementation and evaluation strategies, the processes included clinical audit, peer review, continuing education, leaders' belief, case note, patient mediated intervention, patient specific reminders and systematic review (3, 7, 10). However, limitations of clinical practice guideline implementation are due to having the gap between theory and practice (11).

In Thailand, the Development and Hospitals Quality Accreditation Organization is established since 1997. This organization has an aim to improve quality of health care service in hospitals. Most hospitals have to develop standard protocols for health care services that include a use of clinical practice guideline for accreditation from the Development and Hospitals Quality Accreditation Organization. However, the situation of the apprehension and application of clinical practice guideline among Thai physical therapists who are working in hospitals have not been evaluated. This study will survey knowledge, attitude, use and the circumstances of CPG commonly used. This data will promote the recognition about the benefit of clinical practice guideline and development of physical therapy professional in Thailand.

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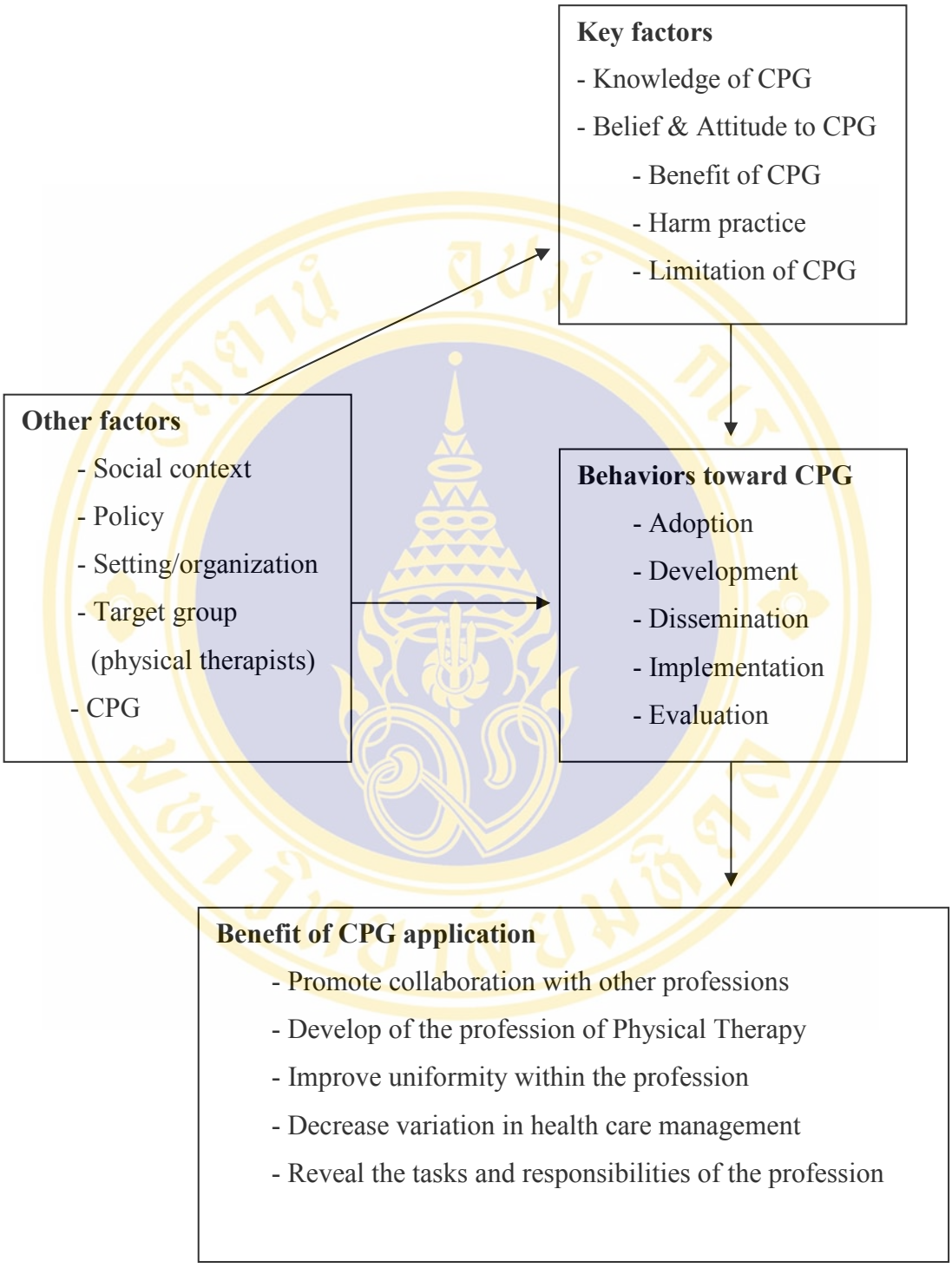

Figure 1.1 Demonstrates the conceptual framework of these issues.

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Research Questions

1. Do the physical therapists who are working in hospitals in Thailand have knowledge about clinical practice guidelines?
2. How do the physical therapists in hospitals in Thailand have attitudes toward CPG?
3. How are the local use CPG of the physical therapists who are working in hospitals in Thailand?

Purposes of the Study

General Objectives

To explore understanding of clinical practice guideline, attitude towards the CPG and perceived extent and benefits of their local uses among Thai physical therapists who are working in different types of hospitals.

Specific Objectives

Specifically, this study was conducted to describe the following:

1. The percentage of responses with regards to knowledge of clinical practice guidelines of the physical therapists in hospitals in Thailand.

2. The percentage of responses with regards to attitudes toward clinical practice guidelines of the physical therapists in hospitals in Thailand.

3. The percentage of responses with regards to benefits of their local use of the physical therapists in hospitals in Thailand.

4. The percentage of responses with regards to hospitals with current or planned future written strategies for the systematic development of clinical practice guideline among the physical therapists in hospitals in Thailand.

5. The percentage of responses with regards to responsibility for leading implementation of clinical practice guideline among the physical therapists in hospitals in Thailand.

6. The percentage of responses with regards to the CPG available and commonly used by Thai physical therapists.

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Scope of the Study

This study was a survey study. The questionnaires with regards to situations of the apprehension and applications of clinical practice guideline were mailed to the physical therapists who were working in different types of hospitals in Thailand.

Parameters of the Study

Percentages of items with regards to:

- knowledge of clinical practice guideline
- attitude toward clinical practice guideline
- use of clinical practice guideline

Advantage of the Study

1. The results of this study will promote understandings of the clinical practice guideline of physical therapy for the physical therapists who are working in hospitals in Thailand.
2. The results of this study will present attitudes towards clinical practice guideline and perceived extent and benefits of their local uses among Thai physical therapists who are working in hospitals
3. This survey study will be essential for developing the clinical practice guideline of physical therapy in Thailand.
4. This survey study will enhance collaborations within physical therapy profession and with other health care professions.

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CHAPTER II
LITERATURE REVIEW

2.1 Clinical Practice Guidelines (CPG)

2.1.1 Definitions of Clinical Practice Guidelines

Clinical practice guidelines are defined as "systematically developed statements designed to help practitioners and patients to make decisions about appropriate health care for specific circumstances" (12). Other terms of clinical practice guidelines are clinical guidelines, practice guidelines, evidence-based guidelines, evidence-based practice guidelines, national practice guidelines (NPGs) or national evidence-based guidelines and physical therapy practice guidelines (10, 12-15). Each term is slightly different in the meaning according to its purpose of use.

Practice guidelines are defined as being systematically drafted by experts, on the basis of best evidence and/or consensus developed statements then field-tested as therapeutic interventions in persons with definitive, suspected or health-threatening conditions, or directed at areas which have to do with good management and administration of the profession and its members (12).

Evidence-based guidelines are explicit descriptions of how patients should be evaluated and treated. The purpose of guidelines is to improve and assure the quality of care by reducing unacceptable variation in its provision (13). In addition, evidence-based practice guidelines are systematically developed statements to help practitioners and clients choosing proper health care for specific clinical circumstances and improving both a patient's health outcomes and the process of care (14).

Furthermore, the NPGs which are defined as guidelines developed under the patronages of a professional organization or national government also help practitioners in decision-making but, more importantly, are also needed to legitimate

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our position in the health care system (10, 12, 15).

Physical therapy practice guidelines are those that have been developed to address a specific physical therapy topic, for example a means of management of a specific patient population, or an intervention. Though the clinical practice guideline is specific physical therapy, it has been developed with consultation from any interested party such as other health care professional. As with multi-professional clinical practice guidelines, it should focus on patients in its development (1).

Clinical practice guidelines are evidence-based outlines of accepted management approaches which may be specific disease, problem or process. The goals of such guidelines are to identify all treatment options and possible outcomes, weight the benefits against the risk and cost, in the broadest context, factors in logistics, ethical, economic, societal and legal considerations. Ideally, clinical practice guidelines are derived from the data source available and used to guide health care professionals through a continuous quality improvement effort in which the process involved in health care delivery is analyzed, changes recommended, patient outcomes defined, variances from expected outcome evaluated and regularly reassessed (16).

2.1.2 Characteristics of Clinical Practice Guidelines

According to the literature, the key characteristics of clinical practice guidelines are as following: first, the clinical practice guideline shows a picture of the best available evidence of effectiveness for a particular condition or set of clinical circumstances (3, 6, 12). Clinical effectiveness is the provision of high quality treatments or services in a way that allows the recipients to achieve the maximum health gain. This will include the provision of interventions/services that are known to be an effective evidence-based practice, and providing those services within a system that allows the recipient to benefit to the maximum. This includes environment, time courtesy and safety (risk management) (1).

Other than the provision of care in accordance with high quality of evidence-based guidelines, clinical practice guidelines also include the evaluation of practice or

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services through the use, for example, clinical audit or outcome measures, in order to further improve the quality. It is sometimes reflected as the right person (competence) doing: the right thing (evidence based practice), in the right way (skills and competence), at the right time (providing treatment/services when the patients needs them), in the right place (location of treatment/services), with the right result (clinical effectiveness or maximizing health gain). It is the complete 'package' of patient experience, put in the context of basing practice on the 'best available evidence' (1).

Second, clinical practice guidelines offer explicit recommendations for practice with the most effective interventions in particular conditions. They are interpreted and invented from the best available evidences in the particular clinical context (12). Third, clinical practice guidelines provide flexible resources for decision making and how to use them for health care professionals and patients about the most effective and/or appropriate care for specific patient populations in particular clinical circumstance (1, 12). Fourth, clinical practice guidelines are developed from professional consensus to now scientific rigorous and systematic review of evidence and meta-analyses. These would minimize bias and maximize the validity of the recommendations by statement of strength of underlying evidence and expert judgment (1-4, 6, 17). Therefore, clinical practice guidelines are integrated from evidence-based practices (2-7).

2.1.3 Evidence-Based Practice (EBP)

Evidence-based practice (EBP) evolved from evidence-based medicine and now embraces the interventions of all professionals delivering in the health care services. Many authors have defined evidence-based medicine. Initially, Sackett et al in 1996 defined evidence-based medicine as ‘integrating clinical expertise with the best available external clinical evidence from systematic research (18). Bury in 1998 stated that the EBP was considered to be a vital component of clinical effectiveness which involved identifying the most effective treatment for an individual patient (19). Bury and Mead (1998) stated that the systematic review of evidence from a number of randomized control trials was considered to be the most rigorous, while other methodologies such as qualitative research would have lower status (20). Recently,

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Sackett et al (2000) redefined the EBP as “the conscientious, explicit and judicious use of current best evidence in making decision about the care of individual patients. This involves “integrating clinical expertise with the best available external clinical evidence from systematic research” (21). The concept of EBP on health care practitioners are to have the ability to ask important clinical questions, try to find the most appropriate evidence, empty it into a usable format, and incorporate it into their daily clinical practice (18, 19).

Furthermore, there are three steps needed to harness research evidence for health care practice. These steps include synthesizing the evidence, developing clinical policy from the evidence, and applying the policy at the right place, in the right way and at the right time. All steps must be negotiated to form a valid connection between evidences and the practice (22). However, many studies found that health professional practitioners expressed concern of the concept of the EBP, but they did not lead it into their daily clinical practice because of their lack of research experience, critical appraisal of evidence, time constraints, resource, and understanding of the scientific literature. Therefore, they would be disadvantaged in the practicing according to the concept of the EBP (23-28).

In the field of physical therapy, the results of Physiotherapy Evidence Database (PEDro) survey showed that the amount of trials and reviews had grown exponentially since the first trial was published in 1952 and the first review was published in 1982 (3, 29). There are many reasons why research evidence may not translate into evidence-based physical therapy. These reasons include current health policies, the complexity of physical therapist practice, incomplete access to the evidence, difficulty of the evident interpretation, organizational barriers and ineffectual continuing education programs (22). Consequently, the professionals have limited time to read the ever-growing mountain of research. Also, they are lack of confidence in undertaking literature search, critical appraisals and translate into practice. Thus, evidence-based practice guidelines would be beneficial if they are utilized to the daily work and facilitate changes of health care professionals’ behavior (30).

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To translate the evidence into recommendations takes three steps. The first step is to recognize; then the second step is to check for quality and reliability; and the last step is to summarize. Recommendations need to take many things into account i.e., the strength of evidence such as type of evidence, the quality of the studies, numbers of studies showing similar results, the similarity of the study populations and the population defined in the clinical practice guideline. The second composite is clinical relevance and applicability of evidence, for example, the similarity of the settings and context of the studies to those encountered in the area of clinical practice relevant to clinical practice guideline topic. The other part is the acceptability of the patients. It is also important that the guidelines discuss a range of options for patients and professionals. The relative benefits and risks should be clearly stated, which will assist in decision-making for the patients and clinicians (2).

The clinical practice guidelines should explicitly describe the link between the evidence review and recommendations that are usually subjected to a system of grading, directly based on the level of evidence (2). The levels of evidence and the grading of recommendations coded by National Institute of Clinical Excellence (NICE) are presented in table 1 and 2.

Table 2.1: Level type of evidence (31)

Ia : Evidence obtained from systematic review or meta-analysis of randomized controlled trials.
Ib : Evidence obtained from at least one randomized controlled trials.
IIa : Evidence obtained from at least one well-designed controlled study with randomization.
IIb : Evidence obtained from at least one other type well-designed quasiexperimental study.
III : Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
IV : Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities.

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Table 2.2: Grading of recommendations (31)

A : At least one randomized controlled trials as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level Ia and Ib in table 1). B : Well-conducted clinical studies but no randomized clinical trials on the topic of recommendation (evidence level IIa, IIb, III in table 1). C : Expert committee reports or opinions and/or clinical experience respected authorities. This grading indicates that directly applicable clinical or good quality studies are absent (evidence level IV in table 1).

Clinical practice guideline programs can be presented in several patterns including extensive versions with notes/references, flow chart, algorithms, patient version, risk tables, balance sheets, short version and one or two pages of summary. Most clinical practice guideline programs produced as a summary or short version are utilized in the United States, Canada, Australia, New Zealand and European countries (8).

The content and structure of clinical practice guidelines are based on the clinical reasoning process of the physical therapist. General scopes of clinical practice guidelines include several parts such as screening, prevention, diagnosis, treatment and management (2, 8). Most clinical practice guidelines are divided into introduction, diagnosis and treatment parts. The introduction part is generally divided into aim, scope and epidemiology. The diagnosis part is divided into referral, history taking, physical examination and assessment, measurement instruments, analysis and diagnosis and conclusion. The treatment part is divided into objectives, intervention, outcome measures and evaluation (2, 8, 15, 16, 32-35). In Thailand, the content of guideline to physical therapist practice is divided into definition of problems, criteria for diagnosis, PT consultation, intervention, discharge, format for recording related to PT standard and HA, referral and follow up (35).

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2.2 Knowledge of Clinical Practice Guideline among clinicians

Knowledge about clinical practice guidelines has been investigated in several aspects such as contents and recommendations of CPG, understanding about evidence-based practice and opinions about clinical usefulness of CPG (6, 36-38). Newton et al (6) explored knowledge of the contents and recommendations of three published clinical practice guidelines in general practitioners in the United Kingdom. The results showed that the clinical practice guidelines had medium to high ranging scales. However, other studies in the United Kingdom, Sweden and Australia reported that the clinicians were lack of understanding about evidence-based practice, contents and opinion of CPG and usefulness (36-38). For example, a survey reported by Barnard and Wiles (36) presented an unclear understanding about evidence-based practice in physiotherapists in the United Kingdom. The results of the knowledge of clinical practice guidelines in physicians and physical therapists in Sweden showed that more than half of the participants were unfamiliar with the content of the CPG and the concept of red flag (37). Another study in Australia also found that physical therapists lack of skill and knowledge of evidence-based practice (38).

2.3 Beliefs and Attitude toward Clinical Practice Guidelines

Over the past decade, there were many studies related to the topic of belief and attitude toward clinical practice guidelines i.e., belief about clinical practice guidelines, attitude toward evidence-based practice and clinical practice guidelines, benefit of CPG, ineffective or harmful practices and limitation of CPG (6-9, 30, 36-38).

Siriwardena explored general practitioners' attitude to clinical practice guidelines in the United Kingdom in 1995. The results presented that most of the practitioners had a positive attitude (9). In 1996, Newton et al surveyed general practitioners' attitudes to the clinical practice guidelines and found generally positive attitude (6, 7). In 2003, a study showed that physical therapists in the United Kingdom had a positive attitude to evidence-based guidelines (36). Jako et al conducted an international survey of the key informants from 18 prominent clinical practice guideline organizations. The results showed that most clinical practice guideline programs were established to

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improve the quality and effectiveness of health care (8). The general practitioners and physical therapists in Sweden also had generally positive attitudes to clinical practice guidelines (37). Physical therapists were found to have positive attitude toward evidence-based practice in Australia (38).

The attitude toward clinical practice guidelines of general practitioners and physical therapists were as followings; clinical practice guidelines would help practitioners to improve the quality of care, decrease the risk of litigation, help clinicians to learn more about diagnosing and managing particular conditions and increase the standardization of practice (6-9). However, there was the negative attitude which clinical practice guidelines would result in the practice following the cookbook medicine. They might also stop an innovation, reduced clinical freedom, reduced patients' confidence in clinicians and created more competitiveness between clinicians (6, 9).

Furthermore, the prime benefit of clinical practice guidelines is to improve the quality of care (i.e. quality of decisions and quality of information used for decisions) received by the patients, to support evidence-based care, to improve the structure and process of care, to improve cost-effectiveness, and to contribute to more effective care (1-11). Clinical practice guidelines are one of the main knowledge synthesis and dissemination processes through which clinicians and policy makers hope to strengthen the relationship between evidence for health care and the everyday work of health professionals (39). Clinical practice guidelines also play roles to develop the health profession: to improve uniformity within the profession, to decrease variations in health care management, to reveal the tasks and responsibilities of the profession and to promote collaboration with other professions (1-11).

Harmful practices can be caused by lacking or misinterpreting scientific evidence recommendation (11). Also, general practitioners and physical therapists were generally aware of clinical practice guidelines but they did not read CPG (3). Therefore, general practitioners might manage patients in sub-optimal, ineffective or even harmful practices (3, 7, 11). However, limitations of clinical practice guideline

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implementation had the gap between theory and practice (36). It might inform the patients' unrealistic expectation if clinical practice guidelines are attended by consumer version (3).

2.4 Development of Clinical Practice Guidelines

Clinical practice guidelines have been developed by many organizations. Since the early 1970s, the National Institutes of Health Consensus Development Program (NIHCDP) formed the first session of expert panel discussions about clinical practice guidelines. The following complete session and open discussion were conducted with a press conference. The American Medical Association (AMA) mailed questionnaires to experts and used simple voting instead of true consensus development. Other Health Maintenance Organizations (HMOs) have been developed the guidelines based on consensus groups in the United States (40). The Dutch Institute for Healthcare Improvement that is a professional organization in the Netherlands initiated the clinical practice guideline development in 1980s (15). The clinical practice guidelines were developed by the evidence-based approach, emphasizing the critical evaluation of evidence rather than expert opinion. Professional and other organizations have developed national and institution-based guidelines since the late 1980s using the explicit guideline development which is the method objecting to integrate scientific evidence and formal analytic methods (40).

Nowadays clinical practice guidelines are developed based on evidence to create recommendations (2, 41). Generally, the process of clinical practice guideline development is composed of organization and structure, preparation, clinical practice guideline development, validation, clinical practice guideline dissemination and implementation, clinical practice guideline evaluation and revision (2, 41). The first step of structure for the clinical practice guideline development varies for each program which is mainly carried out by professional societies or government agencies. The clinical practice guidelines are developed by the Guideline Development Group (GDG) which consists of experts from the field with clinical skill/expertise and people with skills relevant to clinical practice guideline methodology such as systematic reviewer, information scientist, epidemiologist, project leader and author. It is enviable

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to include relevant stakeholder and patients or patient representation in the GDG. The groups organized discussion of guidelines development processes around four domains including science, practice, politics and process and the used boundary work to mediate between these domains (41).

The process of preparation or initiation of the clinical practice guideline development consists of prioritizing and deciding on a topic and the number of criteria used. There should be an expectation that change is possible and desirable and that there is potential to improve the quality of care and patient outcome. Next, the process is refining subject area and defining questions, identifying the evidence from literature search, assessing and synthesizing the evidence and translating the evidence into recommendations. Then, the draft guideline should be tested or reviewed in the validation process. The draft clinical practice guidelines are sent to potential users to test practicality and clarity of the guideline and acceptability of the recommendations. For the dissemination and implementation of CPGs a standard strategy is developed, which can then be modified to the specific requirements of each individual guideline. The last process is the evaluation and revision of CPGs. The clinical practice guideline document should include a date on which it will be reviewed or updated in the light of new evidence that might be available. An acceptable timeframe for a review would be two to five years (2).

2.5 Dissemination, Implementation and Evaluation of Clinical Practice Guidelines

Effective dissemination is defined as the diffusion, distribution, awareness, acceptance, adoption and use of information (42). Many studies presented that these clinical practice guideline dissemination strategies were not effectively lead clinicians to the actual implementation (11, 43). The dissemination of clinical practice guidelines is publication of CPG organizing workshops and presentations at congresses in framework for clinical practice guideline development in physical therapy by World Confederation for Physical Therapy (WCPT) (2). The standard process of clinical therapy guideline disseminations as passive intervention or postal dissemination was found not to change practice in the Netherlands. In contrary, the example of active

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training strategy which consists of two sessions with education, group discussion, role playing, feedback, and reminders to implement clinical practice guidelines on physical therapy for low back pain showed moderately improved adherence to clinical practice guidelines (44-46).

For clinical practice guideline implementation and evaluation, the strategies used include clinical audit, peer review, continuing education, leaders' belief, case note, patient mediated intervention, patient specific reminders and systematic review (7, 8, 15). There are four groups of factors which determine the uptake and use of clinical practice guidelines including CPG, target group, social context and organizational context. The clinical practice guidelines should be feasible, scientifically justifiable, specific and yet differentiated, flexible, clear, readable, didactic and attractive. Second, physical therapists should have a positive attitude toward clinical practice guidelines, and be aware of their knowledge, skills and attitudes. Third, the routines of physical therapists and the expectations of patients and colleagues should be conforming to the recommendations in the clinical practice guidelines. Finally, the CPGs should not have negative financial consequences, give problems in organizing the care or require big structural changes related to staff or equipment (44).

Moreover, there are three steps of orientation, insight and change in the model for changing behavior of a health care professional. For first step, orientation of information would be informed and arouse interest to the clinical practice guidelines. Next, insight of the CPG would help practitioners to understand content and be inclined to change behavior. The last step is to change behavior that would implement in practice and maintain the changed behaviors (43).

For the evaluation, the guides concerning therapy, diagnosis, harm and prognosis for selecting articles that are most likely to provide valid results. Therapy should concern assignment of patients to treatments randomized and all patients who entered the trial properly accounted for attributed at its conclusion. Diagnosis should consist of an independent blind comparison with a reference standard. Harm should involve the clearly identified comparison groups that were similar with respect to important

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determinants of outcome (other than the interest). Prognosis should implicate a representative patient sample at a well-defined point in the course of disease.

The quality criteria for national clinical practice guidelines consist of validity, reproducibility, clinical applicability, differentiation, clinical flexibility, clarity, instruction and attractiveness. The validity pertains resulting in expected outcome (health, cost containment, justifiable satisfaction), based on careful and systematic analysis of the research literature, relation between research findings and clinical practice guideline is clear as well as strength of evidence (i.e., consensus versus evidence- based including experts' judgment behind them). The reproducibility should affect another task group that produces comparable recommendations and were interpreted and applied consistently by different professionals. Clinical applicability should be written from the perspective, needs and questions of the target population, integration in general practice and specific patient population situations to which they apply. The differentiation should take important factors into accounting the clinical practice guideline. The clinical flexibility should concern frequently occurring exceptions and room for own judgment, patients' preferences and adjustments to relevant circumstances in the work setting. The clarity is adequate and uniform use of professional language, logical presentation and defined important term. The didactic are designed following usual way of working and decision making, concrete recommendation, focus essential aspects of intervention, clearly exhausting of most important points and relative simple transition to educational aids and evaluation of instruments. The attractiveness is attention of the layout and included field test, justification and explanation (15).

Nowadays, worldwide trends of clinical practice guidelines have changed in many ways. First, regional clinical practice guidelines from professional group are changed to national clinical practice guideline programs. Second, informal consensus is changed to evidence-based practice. The clinical practice guideline is also changed from monodisciplinary to multidisciplinary and development from limited life-expectancy to living clinical practice guideline. Finally, clinical practice guidelines for clinicians improve to patient versions and patient involvement (41).

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2.6 Clinical Practice Guideline of Physical Therapists who are working in hospitals in Thailand

In Thailand, Development and Hospitals Quality Accreditation Organization is established in 1997. This organization has aimed for improving quality of healthcare service in hospitals. Most hospitals have to invent a standard for health care services including a use of clinical practice guideline to meet the accredit standard of the Development and Hospitals Quality Accreditation Organization. In physical therapy, clinical practice guidelines are also becoming more prominent, in order to enhance standard of physical therapy profession and collaboration of other health care profession.

However, the situation of the apprehension and application of clinical practice guideline among Thai physical therapists who work in hospitals have not been known. This study will survey about knowledge, attitude, use and the circumstances of the CPG commonly used. These data will promote clinical practice guideline development of physical therapy professional in Thailand.

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CHARTER III
METERIALS AND METHODS

3.1 Study Design

The design of this study was a cross-sectional survey of knowledge, attitude and usefulness of clinical practice guideline in physical therapists who were working in several types of hospital in Thailand.

3.2 Participants

Participants were 120 licensed physical therapists who were working in all regional hospitals, general hospitals, university hospitals, specialized hospitals, private hospitals and other types of hospitals.

Inclusion criteria of the hospital

All hospitals in Thailand which had the in-patient bed numbers of 300 or more were included in the study. Other inclusion criteria were as follows:

- having the Physical Therapy and/or Rehabilitation Department.
- having numbers of the full-time licensed physical therapists of 1 or more.

Table 3.1 Numbers of hospitals eligible for participating

Type of hospital settings (N=120)	Number of targeted hospitals
1. Regional hospital (N=30)	30
2. General hospital (N=46)	46
3. Specialized hospital (N=6)	6
4. University hospital (N=8)	8
5. Private hospital (N=24)	24
6. Others (N= 6)	6
Total	**120**

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The hospitals labeled as “others” included the hospitals serving specific organizations such as military or government organizations.

3.3 Instrumentation

A self-administered questionnaire was developed and used for data collection from the participants. (Appendix E)

Contents of the questionnaire

A questionnaire with both open and close-ended questions was constructed to explore how the licensed physical therapists who were working in several types of hospital perceived about knowledge, attitude and usefulness of clinical practice guideline.

This questionnaire consisted of 4 sections:

Section 1 : Demographic data

This section contained 13 questions designed to collect the demographic data of the participants and their hospitals. The data were the information of their hospital, physical therapy department and personal information including gender, age, highest educational level achieved, current employment setting, and number of years working in their hospital.

Section 2 : Physical therapists’ knowledge of the CPG

The second section consisted of 4 questions designed to determine knowledge of the CPG including definition of evidence-based practice, clinical practice guideline, information about the CPG and their opinions.

Section 3 : Physical therapists’ attitude of the CPG

The third section which was composed of 8 questions was designed to examine how the physical therapists had attitude toward the CPG.

For each question, the response was in Likert-type format with five respective codes ranging from:

1. Strongly agree
2. Agree

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3. Neutral

4. Disagree

5. Strongly disagree

Section 4 : Physical therapists' use of the CPG

The last section was designed to examine how the physical therapists used clinical practice guidelines in their hospitals as follows:

4.1 Development of the CPG for use

4.2 Implementation of the CPG

4.3 Evaluation of the CPG

4.4 Benefits of the physical therapists from using the CPG

3.4 Procedures

Development of the questionnaire

There were eight steps to develop the questionnaire and survey in this study as follows:

1. Defined purposes of the questionnaire through the following guiding questions.

- Do physical therapists who were working in hospitals had knowledge about clinical practice guidelines?
- How did the physical therapists have attitudes to the CPG?
- How were the situation of the use of the CPG and benefits of the use of the CPG by physical therapists who were working in hospitals in Thailand?

2. Reviewed the literature, which related to the research questions, all relevant factors to the CPG, and existing questionnaires and determined if they were applicable or adaptable for this study.

3. Constructed the outline that listed all pieces of the information required for the guiding questions by choosing the particular variables that most relevant to target population in this study.

4. Designed the questionnaire by forming series of questions that reflected the guiding question. The flows of contents were logically created, avoiding jumping around from idea to idea.

5. Sent the first draft of the questionnaire to 5 physical therapists who were the

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experts of the CPG for their recommendation.

6. Adjusted the first draft of questionnaire based on the opinions of the experts.

7. Sent the constructed questionnaire to 25 participants for the pilot testing to identify problems in content, wording and organization.

8. Revised the questionnaire according to the comment of the respondents.

The study was approved by the Siriraj Ethics Committee of Mahidol University and Mahidol University Institutional Review Board.

3.5 Data Collection

The questionnaires were mailed to the participants. Coding numbers were written on the stamped return envelopes in order to identify those who had not restored their questionnaires. All participants were enquired to return these questionnaires within two weeks. A postcard reminder was mailed to each who did not reply after the first two weeks. The second questionnaires were followed at fourth week after the first questionnaires were sent. On the acceptance of the response, the questionnaires were divided from envelopes to certify secretly.

3.6 Data Analysis

To develop a coding scheme for the data, the responses from the questionnaires were altered into numbers for data analysis. Data were reported by descriptive statistics in each section by using SPSS for Windows Release 11.0. Mean and standard deviation (SD) were analyzed for demographic characteristics of all respondents. Actual frequency and valid percent of frequency were analyzed in each variable of all sections.

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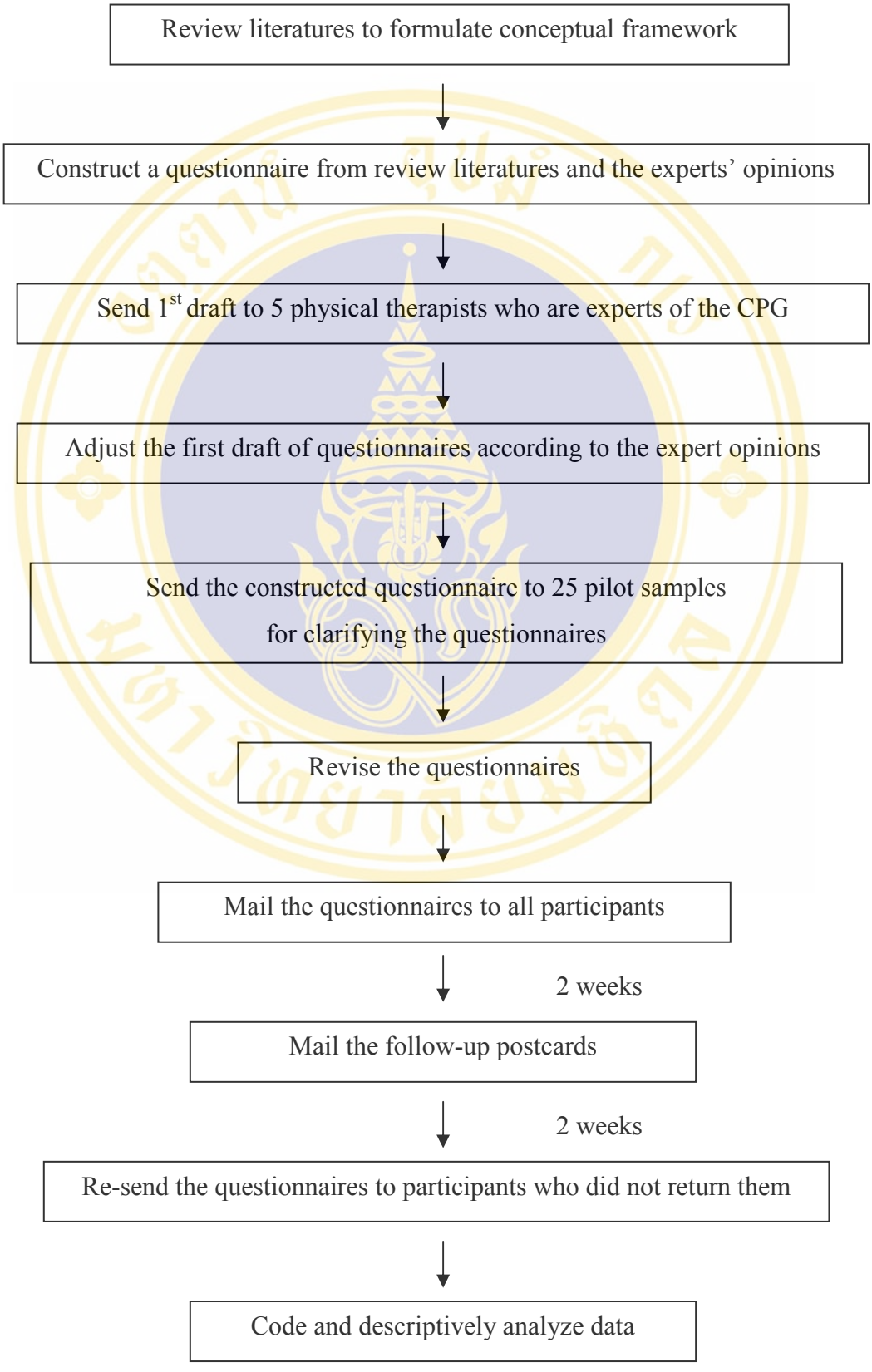
Research Diagram



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CHAPTER IV
RESULTS

4.1 Survey Data

The total number of the hospital settings that originally found to be eligible was 120, and then the questionnaires were sent to all of these settings. The responded participants in this study included 101 physical therapists working in 101 hospital settings that returned letters. Distributions of the targeted and responded hospitals are shown in Table 4.1. The results were analyzed from 101 responded questionnaires from the total 120 questionnaires that were sent out. The overall response rate for the survey was 84.2 percent.

Table 4.1 The distribution of responded questionnaires by types of hospital settings

Type of hospital settings (N=120)	Number of targeted hospitals	Number of responded hospitals (%)
1. Regional hospital (N=30)	30	27(26.7)
2. General hospital (N=46)	46	42(41.7)
3. Specialized hospital (N=6)	6	6(5.9)
4. University hospital (N=8)	8	7(6.9)
5. Private hospital (N=24)	24	19(18.8)
6. Others (N= 6)	6	-
Total	**120**	**101(84.2)**

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4.2 Questionnaire Section 1: Demographic Characteristics

4.2.1 Demographic characteristics of the physical therapists

The demographic characteristics of the physical therapists participating in this study are presented in Table 4.2.

The physical therapists' age ranged from 23 to 57 years with an average age of 39 years. They were 71 females (70.3%) and 30 males (29.7%). About 77 percent were the head of physical therapists and 22.8 percent were physical therapist staffs. The job role of the respondents were clinical service (98%), management of physical therapy department (79.2%), developing quality of hospital service (77.2%), academics (65.3%) and other roles (8.9%). The responses of other roles included health care promotion (3.9%), clinical instructor (3%) and promoting health care of the handicapped (2%). The ages of respondents were 1 to 35 years with an average 16 years of experience as a physical therapist.

4.2.2 Demographic characteristics of the hospital settings

The results of demographic characteristics of the hospital settings are shown in Table 4.3.

According to the survey response, 41.7 percent were general hospital, 26.7 percent were regional hospitals, 18.8 percent were private hospitals, 6.9 percent were university hospitals and 5.9 percent were specialized hospitals. The number of in-patient beds ranged from 300 to 1,600 with the average number of beds of 534.9. Approximately ninety four percent of the respondents provided health care services to general patients and about 6 percent provided services to specific conditions. Ninety eight percent of hospital settings had a standard for quality health care services, while 2 percent of hospital settings did not have one. Approximately sixty seven percent of the hospital settings were accredited by the Development and Hospital Quality Accreditation Organization, while about 32 percent were not accredited.

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4.2.3 Demographic characteristics of the physical therapy department

The results of demographic characteristics of the physical therapy department which the respondents worked for are shown in Table 4.4.

All respondents worked in the Department of Physical Therapy. There were 75.2% of departments which had practical/work training for physical therapy students, while 24.8 percent did not have such training program. Approximately 50 percent of the department also provided training for other discipline students, while about 50 percent did not. The respondents reported that the staffs in their departments consisted of physicians (67.3%), head of physical therapists (97%), physical therapists (97%), physical therapy assistants (94.1%) and others (54.5%). Physicians worked in their department as full time job (81.3%). The respondents in 66 hospitals replied that their departments had physicians from different disciplines including physical medicine and rehabilitation (95.5%), orthopedic surgeon (3%) and neurologist (1.5%). Numbers of the physicians in the department ranged from 1 to 8 with an average of 2.

The respondents reported that head of physical therapy (97.1%) worked full time in their department. Approximately, 79 percent of head of physical therapy had highest education level of bachelor degree, while about 21 percent of them had higher degree. Numbers of head of physical therapy in the department ranged from 1 to 9 with an average of 1.2. Eighty seven percent of the respondents reported that physical therapists worked full time in their department. Approximately 88 percents of physical therapist had highest education level of bachelor degree, while 12 percent of them had higher degree. The respondents reported that the numbers of physical therapists in their departments ranged from 1 to 60 with an average of 6.6.

The respondents reported that most physical therapy assistants (96.8%) worked full time in their department. Most physical therapy assistants (77.3%) earned highest education as lower bachelor degree. The numbers of physical therapy assistants in their departments ranged from 1 to 33 with an average of 5.6. The respondents reported that other staffs (94.3%) such as workers, nurses, officers worked full time in their department. Their highest education levels were lower than bachelor degree

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(68.3%). The respondents reported that the numbers of other staffs in their departments ranged from 1 to 26 with an average of 2.9. Furthermore, the total numbers of department staff ranged from 4 to 98 with an average of 15.7.

Table 4.2 Demographic characteristics of the physical therapists

Characteristics of physical therapists	Frequencies (valid percent) (N= 101)
Gender	
Male	30(29.7)
Female	71(70.3)
Age (years)	
Minimum	23
Maximum	57
Mean	39
SD	7.9
Current employment position	
Head of physical therapy	78(77.2)
Physical therapist	23(22.8)
Role of job (> 1 choice)	
Clinical service	99(98)
Management	80(79.2)
Academic	66(65.3)
Development of quality of hospital	78(77.2)
Others	9(8.9)
Number of years working	
Minimum	1
Maximum	35
Mean	16
SD	7.8

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Table 4.3 Demographic characteristics of the hospital settings

Characteristics of hospital settings	Frequencies (valid percent) (N= 101)
Type of hospital	
Regional	27(26.7)
General	42(41.7)
Specialized	6(5.9)
University	7(6.9)
Private	19(18.8)
Number of in-patient beds	
Minimum	300
Maximum	1,600
Mean	534.9
SD	255.1
Type of patients	
General	95(94.1)
Specific field	6(5.9)
Are there any quality assurance systems in your hospital?	
Yes	99(98)
No	2(2)
Have your hospital passed hospital quality accreditation?	
Yes	68(67.3)
No	33(32.7)

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Table 4.4 Demographic characteristics of the physical therapy departments and staff members

Characteristics	Frequencies (valid percent) (N= 101)
Name of department	
Physical therapy	101(100)
Is there any training for physical therapy students in your department?	
Yes	76(75.2)
No	25(24.8)
Is there any training for other discipline students in your department?	
Yes	50(49.5)
No	51(50.5)
Member of staff group	
Physician	68(67.3)
Head of physical therapy	98(97)
Physical therapist	99(98)
Physical therapy assistant	95(94.1)
Others	55(54.5)
Physicians (N=91)	
Full time	74(81.3)
Part time	17(18.7)
Discipline of physicians (N=66)	
PM&R	63(95.5)
Orthopedic	2(3)
Neurological	1(1.5)
Number of physicians in the department	
Minimum	1
Maximum	8
Mean	2
SD	1.5
Head of physical therapy (N=105)	
Full time	102(97.1)
Part time	3(2.9)
Highest education level (N=102)	
Bachelor degree	81(79.4)
Higher than Bachelor degree	21(20.6)

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Table 4.4 Demographic characteristics of the physical therapy departments and staff members (cont.)

Characteristics	Frequencies (valid percent) (N= 101)
Number of head of physical therapists in the department	
Minimum	1
Maximum	9
Mean	1.2
SD	1.1
Physical therapists (N=650)	
Full time	564(86.8)
Part time	86(13.2)
Highest education level (N=564)	
Bachelor degree	498(88.3)
Higher than Bachelor degree	66(11.7)
Number of physical therapists in the department	
Minimum	1
Maximum	60
Mean	6.6
SD	7.1
Physical therapy assistants (N=528)	
Full time	511(96.8)
Part time	17(3.2)
Highest education level (N=511)	
Under Bachelor degree	395(77.3)
Bachelor degree	102(20)
Higher than Bachelor degree	14(2.7)
Number of physical therapy assistants in the department	
Minimum	1
Maximum	33
Mean	5.6
SD	4
Other staffs (N=143)	
Full time	150(94.3)
Part time	9(5.7)

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Table 4.4 Demographic characteristics of the physical therapy departments and staff members (cont.)

Characteristics	Frequencies (valid percent) (N= 101)
Highest education level (N=142)	
Under Bachelor degree	97(68.3)
Bachelor degree	34(24)
Higher than Bachelor degree	11(7.7)
Number of other staffs in the department	
Minimum	1
Maximum	26
Mean	2.9
SD	3.7
Number of staff (N=99)	
Minimum	4
Maximum	98
Mean	15.7
SD	11.8

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4.3 Questionnaire Section 2: Physical Therapists' Knowledge of Clinical Practice Guidelines

The responses about knowledge of clinical practice guidelines are shown in Table 4.5.

Approximately 79% of the respondents reported that evidence-based practice based on a mixed between clinical experience and robust research, while 34.7% of the respondents replied that evidence based on robust research, 13.9% of the respondents viewed it emerged from clinical experience, and 4% of the respondents reported other views. The respondents reported that the definitions of clinical practice guideline were designed to help physical therapists to make decisions (78.2%), to provide rigorous recommendations (57.4%), to help the patient to make a decision (28.7%) and other opinions (6.9%). Furthermore, 48.5 percent of the respondents replied a choice of these answers, while about 19 percent of the respondents chose all three choices of these answers.

The main characteristics of clinical practice guideline were reported as offering advices about appropriate care (58.4%), giving suggestions about the most effective care (55.4%), helping physical therapists and patients to make decisions for health care (46.5%), being developed in a rigorous way (42.6%), and others (2%). More than 60 percent of the respondents replied one or two choice of the answers. Nevertheless, about 13 percent of the respondents chose four choices of these answers.

At least 60% of the respondents reported that content or details of clinical practice guidelines consisted of physical therapy management, criteria for physical therapy intervention, guideline for diagnosis, definition of problems, goals of treatment, treatment technique, outcome evaluation, stages of disease, referral and follow up medicine or discharging the physical therapy treatment, except criteria for physical therapy consultation (58.4%), format for recording related to physical therapy and hospital accreditation (53.5%). More than 85 percent of the respondents replied numbers of the choice equaling or more than 4 choices. However, approximately 24 percent of the respondents chose all seven choices of these answers.

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Table 4.5 Responses about knowledge of CPGs reported by physical therapists

Question	Frequencies (valid percent) (N=101)
What does evidence-based practice mean? (> 1 choice)	
1. Evidence from clinical experience	14(13.9)
2. Evidence from robust research	35(34.7)
3. Mixed	80(79.2)
Others	4(4)
What does clinical practice guideline define? (> 1 choice)	
1. Provide recommendations that passed systematic and rigorous consideration	58(57.4)
2. Design to help PT to make decision	79(78.2)
3. Design to help patient to make decision	29(28.7)
One choice of the answers	49(48.5)
Two choices of the answers	30(29.7)
Three choices of the answers	19(18.8)
Others	7(6.9)
What are the main characteristics of CPGs? (> 1 choice)	
1. Provide advice about appropriate care	59(58.4)
2. Provide advice about the most effective care	56(55.4)
3. PT and patient use as resources for making health care decision	47(46.5)
4. Be developed by data with least error and most accuracy	43(42.6)
One choice of the answers	37(36.6)
Two choices of the answers	35(34.7)
Three choices of the answers	15(14.8)
Four choices of the answers	13(12.9)
Others	2(2)

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Table 4.5 Responses about knowledge of CPGs reported by physical therapists (cont.)

Question	Frequencies (valid percent) (N=101)
What are the details or topics of CPGs? (> 1 choice)	
1. Definition of problems	79(78.2)
2. Guideline for PT diagnosis	80(79.2)
3. Criteria for referral to PT	59(58.4)
4. Criteria for physical therapy intervention	86(85.1)
5. Standard of PT and HA	54(53.5)
6. Criteria for referral and re-evaluation in MD or PT for discharge	65(64.4)
7. Detail of PT management	90(89.1)
Stage of disease	66(65.3)
Goal of treatment	72(71.3)
Treatment technique	72(71.3)
Evaluation criteria	71(70.3)
Others	7(6.9)
One choice of the answers	5(4.9)
Two choices of the answers	2(2)
Three choices of the answers	7(6.9)
Four choices of the answers	21(20.8)
Five choices of the answers	22(21.8)
Six choices of the answers	20(19.8)
Seven choices of the answers	24(23.8)

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4.4 Questionnaire Section 3: Physical Therapists' Attitude of Clinical Practice Guidelines

The responses of physical therapists' attitude toward clinical practice guidelines in hospital settings are shown in Table 4.6.

According to the questions related to the positive attitude, more than 85 percent of the respondents strongly agreed or agreed that clinical practice guidelines would improve quality of care (86.2%), improve uniformity within the profession (95.1%), and decrease variation in health care management (95%). Furthermore, 70 percent of the respondents agreed that the CPGs obtained scientific proof. However, at least 20 percent of the respondents were not certain that CPGs were used flexibly to suit needs of individual patients and obtained scientific proof. According to the questions related to negative attitude, approximately 95 percent of the respondents strongly agreed or agreed that the clinical practice guidelines led to 'cookbook' medicine. However, at least 29 percent of the respondents did not certain that clinical practice guidelines stopped innovation and reduced clinical freedom.

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Table 4.6 Information on attitude toward clinical practice guidelines in hospital settings by physical therapists (N=101)

1: Strongly agree
2: Agree
3: Not certain
4: Disagree
5: Strongly disagree

Questions related to	Frequency of ratings (valid percent)				
	1	2	3	4	5
1. Improve quality of care (N=101)	34(33.7)	53(52.5)	12(11.9)	1(1)	1(1)
2. Reduce clinical freedom (N=99)	5(5.1)	21(21.2)	43(43.4)	26(26.3)	4(4)
3. Improve uniformity within the professional (N=101)	33(32.7)	63(62.4)	2(2)	2(2)	1(1)
4. Stop an innovation (N=101)	6(5.9)	11(10.9)	30(29.7)	46(45.5)	8(7.9)
5. Be used flexibly to suit needs of individual patients (N=101)	5(5)	47(46.5)	34(33.7)	11(10.9)	4(4)
6. Decrease variation in health care management (N=100)	12(12)	83(83)	5(3)	2(2)	0
7. Obtain scientific proven (N=101)	9(8.9)	70(69.3)	21(20.8)	1(1)	0
8. Lead to cookbook medicine (N=101)	21(20.8)	75(74.3)	4(4)	1(1)	0

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4.5 Questionnaire Section 4: Physical Therapists' use of Clinical Practice Guidelines

The responses about the use of clinical practice guidelines in hospital settings are shown in Table 4.7.

Approximately fifty five percent of the respondents reported that their hospitals had physical therapy clinical practice guideline. However, for those respondents who did not have a clinical practice guideline, 6.9 percent reported that they were developing one, 16.8 percent replied that they have a plan to develop one in the near future while 21.8 percent did not have any plan. According to the respondents from 62 hospitals who had or were developing the physical therapy clinical practice guidelines; approximately 50% of them reported the strategies of CPG development were adopting CPG from Thai Physical Therapy Council, creating peer group review. Approximately 35% of the respondents reported that they developed the CPG by adopting CPGs from books or textbooks, or from other sources. However, 30% of the respondents developed clinical practice guidelines by local consensus conference, cooperation of hospital meeting and others. The respondents reported numbers of physical therapy clinical practice guideline used in their departments ranged from 1 to 20 guidelines with an average of 3 guidelines. The lists of CPGs were reported by the respondents in this study that showed in appendix H.

Most respondents stated that the influencing factors for developing a clinical practice guideline were quality health care service improvement (91.7%) and safety of patients (68.3%). Most respondents (86.9%) also replied that their hospitals had discouraging factors of developing clinical practice guideline, including limit of time (76%) and lack of skill for developing guideline (54%). However, 13.1% of the respondents reported that they did not have any discouraging factors of developing clinical practice guidelines.

Approximately 85 percent of the respondents reported that they used clinical practice guidelines. In addition, more than 50 percent of the respondents replied that they used the guidelines everyday. Approximately 54 percent of the respondents

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reported that their hospitals had the CPG evaluation. About 64% of the respondents reported a major discouraging factor for evaluating clinical practice guidelines was a limit of time. At least 50 percent of the respondents reported that their department evaluated clinical practice guidelines by using outcome or use of health care service (60.7%), methods of evaluating CPGs (50%), following CPG implementation (50%). Most respondents reported that evaluating CPG strategies were case note (74.1%). Many respondents also reported that they evaluated the clinical practice guidelines by peer review (51.9%), patient mediated intervention or patient specific reminders (44.4%), and clinical audit (33.3%). Frequencies of CPG evaluation were reportedly varied. From 20-25 percent of the respondents evaluated the clinical practice guideline every month (25%), every 3 months (20.8%), and every year (25%).

Finally, more than 50% of the respondents reported that the benefits of clinical practice guideline were to improve the quality of care by patients (75%), to improve uniformity within the profession (75%), to promote more effective care 69.2%), to endorse collaboration with other profession (65.4), to develop the physical therapy profession (55.8%) and to support evidence-based care (53.8%).

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Table 4.7 Information on use of clinical practice guidelines in hospital settings by physical therapists

Question	Frequencies (valid percent)
Does your hospital have physical therapy clinical practice guideline? (N=101)*[1]	
Yes	55(54.5)
No, but be developing	7(6.9)
No	22(21.8)
No, but have a plan to do in the future	17(16.8)
How does your hospital develop clinical practice guideline? (>1choice) (N=62)*[2]	
Adopt from Thai physical therapy professional organization	33(53.2)
Adopt from other sources	21(33.9)
Review within department meeting	30(48.4)
Review within hospital meeting	16(25.8)
Conference outside hospital	14(22.6)
Adopt from book or textbook	22(35.5)
Others	7(11.3)
How many clinical practice guidelines does the department have? (N=62)*[2]	
Minimum	1
Maximum	20
Mean	3
SD	2.9
What are the influencing factors for developing a CPG? (N=62)*[2] (> 1 choice)	
Policy of hospital	29(48.3)
Improving quality health care service	55(91.7)
Safety of patients	41(68.3)
Others	12(20)
Missing	2

*[1] = No. of total responses

*[2] = No. of respondents' hospital having and be developing CPG

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Table 4.7 Information on use of clinical practice guidelines in hospital settings by physical therapists (cont.)

Question	Frequencies (valid percent)
Does your work setting have discouraging factors of developing clinical practice guidelines? (N=62)*[2]	
Yes	53(86.9)
No	8(13.1)
Missing	1
Discouraging factors of developing CPG (N=53)*[3] (>1 choice)	
Lack of textbook	15(30)
Limit of time	38(76)
Lack of knowledge to develop CPG	27(54)
Others	7(14)
Missing	3
Do you use clinical practice guideline? (N=62)*[2]	
Yes	52(85.2)
No	9(14.8)
Missing	1
How often do you use clinical practice guideline? (N=52)*[4]	
Everyday	28(56)
At least 1 per week	9(18)
At least 1 per month	4(8)
At least 1 per year	3(6)
Others	6(12)
Missing	2
Does your department evaluate clinical practice guideline? (N=52)*[4]	
Yes	28(53.8)
No	24(46.2)

*[2] = No. of respondents who having CPG

*[3] = No. of respondents who having discouraging factor for developing CPG

*[4] = No. of respondents who using CPG

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Table 4.7 Information on use of clinical practice guidelines in hospital settings by physical therapists (cont.)

Question	Frequencies (valid percent)
Discouraging factors for evaluating CPG (N=24)*[5] (> 1 choice)	
Lack of textbook	9(40.9)
Limit of time	14(63.6)
Lack of knowledge to developing CPG	7(31.8)
Others	2(9.1)
Missing	2
What does your department evaluate clinical practice guideline? (N=28)*[6] (> 1 choice)	
Outcome or use of health care service	17(60.7)
Methods to evaluate clinical practice guidelines	14(50)
Methods to promote the update of clinical practice guidelines	6(21.4)
Follow to use clinical practice guideline	14(50)
Others	1(3.6)
How does your department evaluate clinical practice guideline? (N=28)*[6] (> 1 choice)	
Case note	20(74.1)
Patient mediated intervention or reminder	12(44.4)
Clinical audit	9(33.3)
Peer review	14(51.9)
Continuing education	5(18.5)
Targeting of opinion leaders	8(29.6)
Financial	1(3.7)
Others	1(3.7)
Missing	1

*[5] = No. of respondents who having discouraging for evaluating CPG

*[6] = No. of respondents who evaluating CPG

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Table 4.7 Information on use of clinical practice guidelines in hospital settings by physical therapists (cont.)

Question	Frequencies (valid percent)
How often do you evaluate clinical practice guideline? (N=28)*[6]	
Few per week	1(4.2)
1 per week	1(4.2)
1 per month	6(25)
6 per year	2(8.3)
4 per year	5(20.8)
2 per year	3(12.5)
1 per year	6(25)
Missing	4
In your opinion, what are the benefits of clinical practice guideline? (N=52)*[4] (>1 choice)	
Improve the quality of care by patients	39(75)
Support evidence-based care	28(53.8)
Improve structure and process of health care service	24(26.2)
Advance cost effectiveness	10(19.2)
Contribute to more effective care	36(69.2)
Develop of the profession of Physical Therapy	29(55.8)
Improve uniformity within the profession	39(75)
Reveal the tasks and responsibilities of the profession	20(38.5)
Promote collaboration with other professions	34(65.4)
Others	1(1.9)

*[4] = No. of respondents who using CPG

*[6] = No. of respondents who evaluating CPG

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4.6 Responses of questionnaires in different types of hospital settings by physical therapists

4.6.1 Demographic characteristics of the physical therapists in different types of hospital settings

The demographic characteristics of the physical therapists participating who were working in different types of hospital settings in this study are presented in Table 4.8.

The physical therapists' average age ranged from 37.8 to 40.1 years in different types of hospital settings. The respondents in all types of hospital setting were females more than males except private hospitals. More than 70 percent of the respondents in all hospital settings were the head of physical therapists except specialized hospitals. More than 65 percent of the respondents in all types of hospital settings reported job roles were clinical services and management of physical therapy department. Moreover, more than 50 percent of the respondents in all types of hospital settings reported their job role as developing quality of hospital service and academics except the respondents in university hospitals. The respondents had average experiences in physical therapy practice ranged from 15 to16.7 years.

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Table 4.8 Demographic characteristics of the physical therapists in different types of hospital settings

Characteristics of physical therapists	Frequencies (valid percent)				
	RH (N=27)	GH (N=42)	SH (N=6)	UH (N=7)	PH (N=19)
Gender					
Male	6(22.2)	15(35.7)	2(33.3)	3(42.9)	4(21.1)
Female	21(77.8)	27(64.3)	4(66.7)	4(57.1)	15(78.9)
Age (years)					
Minimum	25	24	23	27	26
Maximum	57	57	54	53	53
Mean	40.1	39	39.3	38.4	37.8
SD	7.1	7.9	13	10.4	6.9
Current employment position					
Head	19(70.4)	34(81)	3(50)	5(71.4)	17(89.5)
Physical therapist	8(29.6)	8(19)	3(50)	2(28.6)	2(10.5)
Role of job (> 1 choice)					
Clinical service	27(100)	41(97.6)	6(100)	7(100)	18(94.7)
Management	19(70.4)	34(81)	4(66.7)	6(85.7)	17(89.5)
Academic	17(63)	30(71.4)	6(100)	3(42.9)	10(52.6)
Development of quality of	22(81.5)	33(78.6)	4(66.7)	3(42.9)	16(84.2)
hospital		7(16.7)	1(16.7)	-	3(15.8)
Others	2(7.4)				
Number of years working		1	1	4	3
Minimum	3	35	31	28	30
Maximum	32	16.1	16.3	15	15.2
Mean	16.7	8.1	13	8.9	7.1
SD	6.6				

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4.6.2 Demographic characteristics of the different hospital settings

The results of demographic characteristics of the different hospital settings are shown in Table 4.9.

According to the survey response in different types of hospital settings, average number of in-patient beds ranged from 400.3 to 946.4 beds. The greatest number of in-patient beds was reported by the university hospital settings, while the least number of in-patient beds was reported by the private hospital settings. More than 85 percent of the respondents provided health care services to general patients in all types of hospital setting except 33.3 percent of specialized hospital settings provided services to specific conditions. All of general specialized and university hospital settings had a standard for quality health care services, while a regional hospital and a private hospital did not have it. More than 60 percent of all types of hospital settings were accredited by the Development and Hospital Quality Accreditation Organization.

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Table 4.9 Demographic characteristics of the different types of hospital settings

Characteristics of physical therapists	Frequencies (valid percent)				
	RH (N=27)	GH (N=42)	SH (N=6)	UH (N=7)	PH (N=19)
Number of in-patient beds					
Minimum	452	300	300	425	300
Maximum	1,600	700	1,000	1,500	750
Mean	724.3	407.3	521.7	946.4	400.3
SD	248.1	88.9	263.9	376.5	105
Type of patients					
General	24(88.9)	42(100)	4(66.7)	6(85.7)	19(100)
Specific fields	3(11.1)	-	2(33.3)	1(14.3)	-
Are there any quality assurance systems in your hospital?					
Yes	26(96.3)	42(100)	6(100)	7(100)	18(94.7)
No	1(3.7)	-	-	-	1(5.3)
Have your hospital passed hospital quality accreditation?					
Yes	20(74.1)	26(61.9)	4(66.7)	5(71.4)	13(68.4)
No	7(23.9)	16(38.1)	2(33.3)	2(28.6)	6(31.6)

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4.6.3 Demographic characteristics of the physical therapy department in different types of hospital settings

The results of demographic characteristics of the physical therapy department which the respondents worked for are shown in Table 4.10.

All respondents in every type of hospital setting worked in the Department of Physical Therapy. All departments in university hospital setting had practical/work training for physical therapy students, while 78.9 percent of the department in private hospital settings did not have such training program. More than 65 percent of the department in university, regional and specialized hospital settings also provided training for other discipline students, while more than 55 percent in private and general hospital settings did not. The respondents in all types of hospital settings reported that the staffs in their departments consisted of physicians, head of physical therapists, physical therapists, physical therapist assistants and others. All physicians worked full time in the department of all hospital settings. The respondents in regional, university and private hospital settings replied that their departments had all physicians from physical medicine and rehabilitation disciplines, while other disciplines of physician were orthopedic surgeon (7.1%) in general hospital settings and neurologist (33.3%) in specialized hospital settings. An average numbers of the physicians in the department ranged from 1.3 to 4.17.

The respondents reported that all heads of physical therapy in all types of hospital settings except private hospital settings worked full time in their department. All heads of physical therapy in specialized and university hospital settings had highest education level as bachelor degree, while at least 20 percent of them in regional, general and private hospital settings had higher degree. An average numbers of head of physical therapy in the department ranged from 1 to 1.5. The respondents reported that more than 90 percent of physical therapists in all types of hospital settings except private hospitals worked full time in their department. More than 85 percent of head of physical therapy in all types of hospital settings except university hospitals had highest education level of bachelor degree, while about 21 percent of them in university hospital settings had higher degree. The respondents in all types of hospital settings

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reported that the average numbers of physical therapists in their departments ranged from 3.9 to 11.7. The greatest numbers of physical therapists in the departments were in university hospital settings.

The respondents reported that all physical therapy assistants in all types of hospital settings except private and general hospitals worked full time in their department. More than 80 percent of physical therapy assistants earned highest education with lower bachelor degree. An average numbers of physical therapy assistants in the departments ranged from 4 to 7.3. The respondents reported that more than 90 percent of other staffs in all types of hospital settings worked full time in their department. Their highest education levels were under bachelor degree (>60%) in all types of hospital settings. The respondents in all types of hospital settings reported that average numbers of other staffs in their departments ranged from 1.4 to 4. Furthermore, the average of total number of department staff ranged from 10.5 to 21.6.

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Table 4.10 Demographic characteristics of the physical therapy departments and staff members in different types of hospital setting

Characteristics	Frequencies (valid percent)				
	RH N=27	GH N=42	SH N=6	UH N=7	PH N=19
Name of department	27(100)	42(100)	6(100)	7(100)	19(100)
Physical therapy					
Is there any training for physical therapy students in your department?					
Yes	23(85.2)	38(90.5)	4(66.7)	7(100)	4(21.1)
No	4(14.8)	4(9.5)	2(33.3)	-	15(78.9)
Is there any training for other discipline students in your department?					
Yes	20(74.1)	18(42.9)	4(66.7)	6(85.7)	2(10.5)
No	7(25.9)	24(57.1)	2(33.3)	1(14.3)	17(89.5)
Member of staff group					
Physician	25(92.6)	28(66.7)	3(50)	3(42.9)	9(47.4)
Head of physical therapy	27(100)	41(97.6)	6(100)	6(85.7)	18(94.7)
Physical therapist	25(92.6)	42(100)	5(83.3)	7(100)	19(100)
Physical therapy assistant	27(100)	37(88.1)	6(100)	6(85.7)	19(100)
Others	18(66.7)	22(52.4)	3(50)	2(28.6)	10(52.6)
Physicians (N=91)	(n=25)	(n= 35)	(n=3)	(n=3)	(n=25)
Full time	25(100)	35(100)	3(100)	3(100)	8(32)
Part time	-	-	-	-	17(68)
Discipline of physicians (N=66)	(n=25)	(n=28)	(n=3)	(n=3)	(n=7)
PM&R	25(100)	26(92.9)	2(66.7)	3(100)	7(100)
Orthopedic	-	2(7.1)	-	-	-
Neurological	-	-	1(33.3)	-	-
Number of physicians (N=62)	(n=22)	(n=28)	(n=3)	(n=3)	(n=6)
Minimum	1	1	2	1	1
Maximum	4	4	5	8	5
Mean	2	1.3	3.3	4	4.17
SD	1.1	0.7	1.5	3.6	1.6

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Table 4.10 Demographic characteristics of the physical therapy departments and staff members in different types of hospital setting (cont.)

Characteristics	Frequencies (valid percent)				
	RH N=27	GH N=42	SH N=6	UH N=7	PH N=19
Head of physical therapy (N=105)	(n=26)	(n=40)	(n=6)	(n=6)	(n=27)
Full time	26(100)	40(100)	6(100)	6(100)	24(88.9)
Part time	-	-	-	-	3(11.1)
Highest education level (N=102)	(n=26)	(n=40)	(n=6)	(n=6)	(n=24)
Under Bachelor degree	-	-	-	-	-
Bachelor degree	20(76.9)	32(80)	6(100)	6(100)	17(70.8)
Higher than Bachelor degree	6(23.1)	8(20)	-	-	7(29.2)
Number of head of physical therapists(N=88)	(n=18)	(n=40)	(n=6)	(n=6)	(n=18)
Minimum	1	1	1	1	1
Maximum	1	1	1	1	6
Mean	1	1	1	1	1.5
SD	0	0	0	0	1.5
Physical therapists (N=650)	(n=179)	(n=161)	(n=21)	(n=82)	(n=207)
Full time	178(99.4)	145(90.1)	21(100)	82(100)	138(66.7)
Part time	1(0.6)	16(9.9)	-	-	69(33.3)
Highest education level (N=564)	(n=178)	(n=145)	(n=21)	(n=82)	(n=138)
Under Bachelor degree	-	-	-	-	-
Bachelor degree	156(87.6)	123(84.8)	20(95.2)	65(79.3)	134(97.1)
Higher than Bachelor degree	22(12.4)	22(15.2)	1(4.8)	17(20.7)	4(2.9)
Number of physical therapists (N=98)	(n=26)	(n=41)	(n=5)	(n=7)	(n=19)
Minimum	4	1	1	3	1
Maximum	15	16	7	19	44
Mean	6.9	3.9	4.2	11.7	7.1
SD	2.4	3.4	2.8	6.5	9.6

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Table 4.10 Demographic characteristics of the physical therapy departments and staff members in different types of hospital setting (cont.)

Characteristics	Frequencies (valid percent)				
	RH N=27	GH N=42	SH N=6	UH N=7	PH N=19
Physical therapy assistants (N=528)	(n=159)	(n=169)	(n=24)	(n=38)	(n=138)
Full time	159(100)	162(95.9)	24(100)	38(100)	128(92.8)
Part time	-	7(4.1)	-	-	10(7.2)
Highest education level (N=511)	(n=159)	(n=162)	(n=24)	(n=38)	(n=128)
Under Bachelor degree	131(82.4)	97(59.9)	22(91.7)	32(84.2)	113(88.3)
Bachelor degree	22(13.8)	58(35.8)	2(8.3)	6(15.8)	14(10.9)
Higher than Bachelor degree	6(3.8)	7(4.3)	-	-	1(0.8)
Number of physical therapy assistants (N=94)	(n=26)	(n=37)	(n=6)	(n=6)	(n=19)
Minimum	2	1	1	4	2
Maximum	13	12	7	8	33
Mean	6.1	4.6	4	6.3	7.3
SD	2.6	2.5	3	1.6	7.2
Other staffs (N=159)	(n=80)	(n=56)	(n=7)	(n=2)	(n=14)
Full time	72(90)	56(100)	7(100)	2(100)	13(92.9)
Part time	8(10)	-	-	-	1(7.1)
Highest education level (N=142)	(n=64)	(n=56)	(n=7)	(n=2)	(n=13)
Under Bachelor degree	39(60.9)	47(83.9)	6(85.7)	2(100)	3(23.1)
Bachelor degree	15(23.5)	8(14.3)	1(14.3)	-	10(76.9)
Higher than Bachelor degree	10(15.6)	1(1.8)	-	-	-
Number of other staffs (N=53)	(n=18)	(n=21)	(n=3)	(n=1)	(n=10)
Minimum	1	1	1	2	1
Maximum	26	6	3	2	2
Mean	4	2.7	2.3	2	1.4
SD	5.9	1.7	1.2	-	0.5
Number of staff (N=99)	(n=26)	(n=41)	(n=6)	(n=7)	(n=19)
Minimum	10	4	5	9	4
Maximum	46	31	18	36	98
Mean	18.4	11.2	10.5	20	21.6
SD	7.6	6.1	4.8	9.4	21.2

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4.6.4 Responses about knowledge of CPGs reported by physical therapists in different types of hospital setting

The responses about knowledge of clinical practice guidelines reported by physical therapists in different types of hospital setting are shown in Table 4.11.

More than 75% of the respondents in all types of hospital setting except respondents in university hospital settings reported that evidence-based practice based on a mixed between clinical experience and robust research. These choices included the completed definitions of clinical practice guideline i.e., designed to help physical therapists to make decisions, to provide rigorous recommendations and to help the patient to make a decision. Furthermore, more than 14.3 percent of the respondents in regional, private, general and university hospital settings replied all three choices of the answers while the all respondent in specialized hospital did not choose all choices.

The choices of main characteristics of clinical practice guideline included offering advices about appropriate care, giving suggestions about the most effective care, helping physical therapists and patients to make decisions for health care and being developed in a rigorous way. Approximately 43 percent of the respondents in university hospitals and more than 10 percent of the responses in specialized, general and private hospitals chose four choices of these answers while 7.4 percent of the respondents in regional hospitals did.

More than 25% of the respondents reported that content or details of clinical practice guidelines consisted of physical therapy management, criteria for physical therapy intervention, guideline for diagnosis, definition of problems, goals of treatment, treatment technique, outcome evaluation, stages of disease, referral and follow up medicine or discharging the physical therapy treatment, criteria for physical therapy consultation, format for recording related to physical therapy and hospital accreditation while all respondents in specialized and university hospitals did not choose all choices of these answers .

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Table 4.11 Responses about knowledge of CPGs reported by physical therapists in different types of hospital setting

Question	Frequencies (valid percent)				
	RH (N=27)	GH (N=42)	SH (N=6)	UH (N=7)	PH (N=19)
What does EBP mean?					
1. Evidence from clinical experience	1(3.7)	7(16.7)	2(33.3)	1(14.3)	3(15.8)
2. Evidence from robust research	7(25.9)	17(40.5)	3(50)	4(57.1)	4(21.1)
3. Mixed	23(85.2)	33(78.6)	5(83.3)	4(57.1)	15(78.9)
Others	2(7.4)	1(2.4)	0	-	1(5.3)
What does CPG defines?					
1. Provide recommendations that passed systematic and rigorous consideration	17(63)	27(64.3)	3(50)	2(28.6)	9(47.4)
2. Design to help PT to make decision	24(88.9)	32(76.2)	5(83.3)	5(71.4)	13(68.4)
3. Design to help patient to make decision	9(33.3)	10(23.8)	1(16.7)	3(42.9)	6(31.6)
chose one choice	12(44.4)	21(50)	3(50)	3(42.9)	10(52.6)
chose two choices	7(25.9)	15(35.7)	3(50)	2(28.6)	3(15.8)
chose three choices	8(29.6)	6(14.3)	-	1(14.3)	4(21.1)
Others	1(3.7)	3(7.1)	-	1(14.3)	2(10.5)
What are the main characteristics of CPGs?					
1. Provide advice about appropriate care	17(63)	21(50)	4(66.7)	5(71.4)	12(63.2)
2. Provide advice about the most effective care	15(55.6)	26(61.9)	2(33.3)	4(57.1)	9(47.4)
3. PT and patient use as resources for making health care decision	11(40.7)	17(40.5)	2(33.3)	6(85.7)	11(57.9)
4. Be developed by data with least error and most accuracy	12(44.4)	15(35.7)	4(66.7)	4(57.1)	8(42.1)
chose One choice	9(33.3)	20(47.6)	2(33.3)	2(28.6)	5(26.3)
chose Two choices	10(37.1)	12(28.6)	3(50)	1(14.3)	9(47.4)
chose Three choices	6(22.2)	5(11.9)	-	1(14.3)	3(15.8)
chose Four choices	2(7.4)	5(11.9)	1(16.7)	3(42.9)	2(10.5)
Others	-	1(2.4)	-	-	1(5.3)

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Table 4.11 Responses about knowledge of CPGs reported by physical therapists in different types of hospital setting (cont.)

Question	Frequencies (valid percent)				
	RH (N=27)	GH (N=42)	SH (N=6)	UH (N=7)	PH (N=19)
What are details or topics of CPGs?					
1. Definition of problems	26(96.3)	30(71.4)	5(83.3)	3(42.9)	15(78.9)
2. Guideline for PT diagnosis	24(88.9)	28(66.7)	6(100)	5(71.4)	17(89.5)
3. Criteria for referral to PT	17(63)	25(59.5)	2(33.3)	3(42.9)	12(63.2)
4. Criteria for physical therapy intervention	22(81.5)	35(83.3)	4(66.7)	7(100)	18(94.7)
5. Standard of PT and HA	15(55.6)	23(54.8)	3(50)	1(14.3)	12(63.2)
6. Criteria for referral and re-evaluation in MD or PT for discharge	20(74.1)	22(52.4)	5(83.3)	3(42.9)	15(78.9)
7. Detail of PT management	24(88.9)	37(88.1)	5(83.3)	6(85.7)	18(94.7)
Stage of disease	14(51.9)	27(64.3)	4(66.7)	5(71.4)	16(84.2)
Goal of treatment	20(74.1)	25(59.5)	4(66.7)	6(85.7)	17(89.5)
Treatment technique	22(81.5)	28(66.7)	4(66.7)	5(71.4)	13(68.4)
Evaluation criteria	18(66.7)	27(64.3)	5(83.3)	5(71.4)	16(84.2)
Other	3(11.1)	2(4.8)	-	-	2(10.5)
chose One choice	-	4(9.5)	-	1(14.3)	-
chose Two choices	1(3.7)	1(2.4)	-	-	-
chose Three choices	-	4(9.5)	1(16.7)	2(28.6)	-
chose Four choices	7(25.9)	8(19.1)	1(16.7)	1(14.3)	3(15.8)
chose Five choices	4(18.5)	10(23.8)	1(16.7)	1(14.3)	6(31.6)
chose Six choices	5(18.5)	5(11.9)	3(50)	2(28.6)	5(26.3)
chose Seven choices	9(33.3)	10(26.2)	-	-	5(26.3)

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4.4 Responses about attitude of to clinical practice guidelines by physical therapists in different types of hospital settings

The responses of physical therapists' attitude toward clinical practice guidelines in different hospital settings are shown in Table 4.12.

According to the questions related to the positive attitude, more than 70 percent of the respondents in all types of hospital settings strongly agreed or agreed that clinical practice guidelines would improve quality of care, improve uniformity within the profession, and decrease variation in health care management and obtained scientific proof. However, at least 20 percent of the respondents in all types of hospital setting were not certain that CPGs were used flexibly to suit needs of individual patients and obtained scientific proof except university hospital settings. According to the questions related to negative attitude, more than 80 percent of the respondents strongly agreed or agreed that the clinical practice guidelines led to 'cookbook' medicine. However, at least 40 percent of the respondents in all types of hospital settings did not certain that CPGs reduced clinical freedom. However, more than 50 percent of the respondents in all type of hospital settings strongly disagreed or disagreed that clinical practice guidelines stopped an innovation except 42.9 percent of the respondents in university hospitals did not them.

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Table 4.12 Information on attitude toward clinical practice guidelines in different hospital settings by physical therapists (N=101)

Rating scales: 1: Strongly agree, 2: Agree, 3: Neutral, 4: Disagree, 5: Strongly disagree

Questions related to	Frequency of ratings (valid percent)					
	1	2	3	4	5	Missing
1. Improve quality of care						
- RH	10(37)	15(55.6)	2(7.4)	-	-	-
- GH	13(31)	21(50)	6(14.3)	1(2.4)	1(2.4)	-
- SH	3(50)	3(50)	-	-	-	-
- UH	2(28.6)	3(42.9)	2(28.6)	-	-	-
- PH	6(31.6)	11(57.9)	2(10.5)	-	-	-
-Total (N=101)	34(33.7)	53(52.5)	12(11.9)	1(1)	1(1)	-
2. Reduce clinical freedom						
- RH	1(3.7)	6(22.2)	11(40.7)	7(25.9)	1(3.7)	1
- GH	1(2.4)	11(26.8)	20(48.8)	8(19.5)	1(2.4)	1
- SH	-	-	1(16.7)	5(83.3)	-	-
- UH	2(28.6)	2(28.6)	2(28.6)	-	1(14.3)	-
- PH	1(5.3)	2(10.5)	9(47.4)	6(31.6)	1(5.3)	-
-Total (N=99)	5(5.1)	21(21.2)	43(43.4)	26(26.3)	4(4)	2
3. Improve uniformity with the professional						
- RH	11(40.7)	15(55.6)	1(3.7)	-	-	-
- GH	12(28.6)	29(69)	1(2.4)	-	-	-
- SH	3(50)	3(50)	-	-	-	-
- UH	2(28.6)	4(57.1)	-	-	1(14.3)	-
- PH	5(26.3)	12(63.2)	-	2(10.5)	-	-
-Total (N=101)	33(32.7)	63(62.4)	2(2)	2(2)	1(1)	-
4. Stop an innovation						
- RH	2(7.4)	2(7.4)	6(22.2)	14(51.9)	3(11.1)	-
- GH	2(4.8)	7(16.7)	16(38.1)	16(83.3)	1(2.4)	-
- SH	-	-	-	5(83.3)	1(16.7)	-
- UH	1(14.3)	1(14.3)	3(42.9)	2(28.6)	-	-
- PH	1(5.3)	1(5.3)	5(26.3)	9(47.4)	3(15.8)	-
-Total (N=101)	6(5.9)	11(10.9)	30(29.7)	46(45.5)	8(7.9)	-

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Table 4.12 Information on attitude toward clinical practice guidelines in different hospital settings by physical therapists (N=101) (cont.)

Questions related to	Frequency of ratings (valid percent)					
	1	2	3	4	5	Missing
5. Be used flexibly to suit needs of individual patients						
- RH	2(7.4)	17(63)	7(25.9)	1(3.7)	-	-
- GH	2(4.8)	18(42.9)	16(38.1)	6(14.3)	-	-
- SH	-	2(33.3)	2(33.3)	2(33.3)	-	-
- UH	-	2(28.6)	1(14.3)	1(14.3)	3(42.9)	-
- PH	1(5.3)	8(42.1)	8(42.1)	1(5.3)	1(5.3)	-
-Total (N=101)	5(5)	47(46.5)	34(33.7)	11(10.9)	4(4)	-
6. Decrease variation in health care management						
- RH	2(7.4)	24(88.9)	1(3.7)	-	-	-
- GH	3(7.3)	36(82.8)	2(4.9)	-	-	1
- SH	-	5(83.3)	-	1(16.7)	-	-
- UH	1(14.3)	6(85.7)	-	-	-	-
- PH	6(31.6)	12(63.2)	-	1(5.3)	-	-
-Total (N=101)	12(12)	83(83)	3(3)	2(2)	-	1
7. Obtain scientific proven						
- RH	4(14.8)	18(66.7)	5(18.5)	-	-	-
- GH	3(7.1)	28(66.7)	10(23.8)	1(2.4)	-	-
- SH	-	6(100)	-	-	-	-
- UH	-	5(85.7)	2(28.6)	-	-	-
- PH	2(10.5)	13(68.4)	4(21.1)	-	-	-
-Total (N=101)	9(8.9)	70(69.3)	21(20.8)	1(1)	-	-
8. Lead to cookbook medicine						
- RH	6(22.2)	20(74.1)	1(3.7)	-	-	-
- GH	6(14.3)	36(85.7)	-	-	-	-
- SH	2(33.3)	3(50)	1(16.7)	-	-	-
- UH	4(57.1)	2(28.6)	-	1(14.3)	-	-
- PH	3(15.8)	14(73.7)	2(10.5)	-	-	-
-Total (N=101)	21(20.8)	75(74.3)	4(4)	1(1)	-	-

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4.6 Responses about the use of clinical practice guidelines in different types of hospital settings by physical therapists

Since, the information about the use of clinical practice guidelines in different types of hospital setting would be useful in the future, the addition analysis were conducted. The responses about the use of clinical practice guidelines in different types of hospital settings by physical therapists are shown in Table 4.13.

The respondents who were working in different types of hospital setting reported parallel percentages of having CPGs. More than 50% of the respondents in all three settings replied that they had physical therapy clinical practice guidelines while more than 60 percent of the respondents in specialized and university hospitals did not have. However, the respondents in regional hospitals reported an average numbers of 5 physical therapy clinical practice guidelines used in their departments which were more than numbers of the CPGs in other types of hospital settings that averagely had 2 guidelines. The similarity was observed in the common strategy of CPG development in regional, general and private hospital settings as adopting from Thai Physical Therapy Professional Council i.e., reported by more than 50 percent of the respondents. Moreover, more than 50 percent of the respondents in regional, university and private hospitals reported another common strategy of CPG development as peer group review. In addition, 50% of the respondents in regional hospitals reported another strategy in developing clinical practice guidelines as adopting CPGs from books or textbooks. Furthermore, all respondents in specialized hospitals reported most common strategy in developing CPGs as conference outside hospital.

More than 90% of the respondents from all settings except university hospitals reported that the main influencing factor to develop a clinical practice guideline was quality health care service improvement. More than 75% of the respondents in specialized, private, and regional hospitals reported another factor for developing CPGs as safety of patients, while approximately 54% of the respondents in general hospital viewed safety of patients as an influencing factor. Furthermore approximately 60% of the respondents in specialized, university and regional hospitals reported another influencing factor as the hospital policy. All respondents from university and

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private hospitals replied that their hospitals had discouraging factors of developing clinical practice guideline while more than 12% of the respondents in general hospitals and regional hospitals and 50% in specialized hospitals did not. More than 50% of the respondents in all types of hospital setting except specialized hospitals were reported to have discouraging factors for developing CPGs as a limit of time and lack of skill for developing CPG. However, all respondents in specialized hospitals reported discouraging factors for developing CPGs as lack of textbook.

All physical therapists from regional and specialized hospitals reported that they used clinical practice guidelines while more than 15% of the respondents in general hospitals and private hospitals did not. Besides, 33.3% of the respondents in university hospitals used CPG. Furthermore, more than 50% of the respondents in all types of hospital settings except private hospitals replied that frequency of guideline using was everyday. In addition, approximately 40% of the responses in private hospitals reported that they used the clinical practice guidelines everyday.

All respondents in specialized and university hospital and about 55% of the responses in regional hospitals and private hospitals reported that their hospitals did clinical practice guideline evaluation. Conversely, 55% of the responses in general hospital reported that their department did not evaluate clinical practice guidelines. Most respondents from general hospitals reported the reason of lack of time (80%) to evaluating CPGs while most respondents in regional hospitals reported as a lack of time (57.1%) and textbook (57.1%). Similarly, most responses in private hospitals reported to lack of textbook (60%). More than 65% of the respondents in university, private and general hospitals reported main method for evaluating CPGs to be using outcome or use of health care service and methods of evaluating CPGs, while 80% of the respondents in specialized and regional hospitals reported following clinical practice guideline. More than 65% of the respondents in all types of hospital settings except university hospitals reported that the major evaluating CPG strategy was case note. Physical therapists in the regional hospitals also reported the evaluating CPG as patient mediated intervention or patient specific reminders (55.6%), while at least 50% of the respondents in general, specialized and private hospitals reported the evaluating

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CPGs as peer review (i.e., 100%, 66.7% and 50%, respectively). Physical therapists in regional hospitals reported frequencies of evaluating CPG as every week (33.3%) and once a year (33.3%). Furthermore, physical therapists in general hospitals evaluated clinical practice guidelines as every month (25%), every 3 months (25%), every 6 month (25%) and once a year (25%). All physical therapists in specialized hospitals evaluated clinical practice guidelines every 3 months. All physical therapists in university hospitals evaluated CPGs every 2 months. Additionally, 25 % physical therapists also reported frequency of evaluating CPG from few per week to once a year.

Finally, the respondents in regional hospitals agreed to all choices i.e., the benefit of clinical practice guidelines except advance cost effectiveness, improving structure and process of health care service, and revealing the tasks and responsibilities of the profession. As well, most physical therapists in general hospitals did not view the advance cost effectiveness as the benefit. However, physical therapists in private hospitals reported benefit of CPG as improving uniformity within the profession (81.1%), endorsing collaboration with other profession (81.8%), improving the quality of care by patients (63.6%), and improving structure and process of health care service (54.5%). The respondents in specialized hospitals reported all choices as the benefit of CPGs except advance cost effectiveness.

The responses about frequencies of guideline evaluation are shown in Table 4.13.

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Table 4.13 Responses about the use of clinical practice guidelines in different types of hospital settings by physical therapists

Question	Frequencies (valid percent)				
	RH (N=27)	GH (N=42)	SH (N=6)	UH (N=7)	PH (N=19)
Does your hospital have physical therapy clinical guideline? *1					
Yes	17(63)	23(54.8)	2(33.3)	2(28.6)	11(57.9)
No, but be developing	1(3.7)	2(4.8)	-	1(14.3)	3(15.8)
No	6(22.2)	10(23.8)	2(33.3)	1(14.3)	3(15.8)
No, but have plan to do in the future	3(11.1)	7(16.7)	2(33.3)	3(42.9)	2(10.5)
How your hospital does develop CPG? *2					
Adopt from Thai physical therapy professional organization	11(61.1)	13(52)	-	1(33.3)	8(57.1)
Adopt from other source	8(44.4)	8(32)	-	-	5(35.7)
Review within department meeting	12(66.7)	8(32)	1(50)	2(66.7)	7(56)
Review within hospital meeting	7(38.9)	5(20)	1(50)	-	3(21.4)
Conference outside hospital	3(16.7)	5(20)	2(100)	-	4(28.6)
Adopt from book or textbook	9(50)	8(32)	-	-	5(35.7)
Others	1(5.6)	3(12)	1(50)	-	2(14.3)
How many CPGs does the department have? *2					
Minimum	2	1	1	1	1
Maximum	20	5	2	5	5
Mean	5.4	2.2	1.5	2.3	1.9
SD	4.4	1.3	0.7	1.4	1.2
What are the influencing factors for developing a CPG strategy? *2					
Policy of hospital	10(58.8)	10(41.7)	2(100)	2(66.7)	5(35.7)
Improving quality health care service	16(94.1)	22(91.7)	2(100)	2(66.7)	13(92.9)
Safety of patients	13(76.5)	13(54.2)	2(100)	1(33.3)	12(85.7)
Other	5(29.4)	3(12.5)	-	1(33.3)	3(21.4)
Missing	1	1	-	-	-

*1 = No. of total responses

*2 = No. of respondents' hospital having and be developing CPG

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Table 4.13 Responses about the use of clinical practice guidelines in different types of hospital settings by physical therapists (cont.)

Question	Frequencies (valid percent)				
	RH (N=27)	GH (N=42)	SH (N=6)	UH (N=7)	PH (N=19)
Does your work setting have discouraging factors of developing CPG? *2					
Yes	14(77.8)	21(87.5)	1(50)	3(100)	14(100)
No	4(22.2)	3(12.5)	1(50)	-	-
Missing	-	-	-	-	-
Discouraging factors of developing CPG *3					
Lack of textbook	3(21.4)	5(26.3)	1(100)	1(33.3)	5(38.5)
Limit of time	12(85.7)	15(78.9)	-	3(100)	8(61.5)
Lack of knowledge to develop CPG	8(57.1)	11(57.9)	-	1(33.3)	7(53.8)
Others	-	3(15.8)	-	-	4(21.4)
Missing	-	2	-	-	1
Do you use CPG? *2					
Yes	18(100)	20(83.3)	2(100)	1(33.3)	11(78.6)
No	-	4(16.7)	-	2(66.7)	3(21.4)
Missing	-	1	-	-	-
How often do you use CPG? *4					
Everyday	11(61.1)	10(52.6)	2(100)	1(100)	4(40)
At least 1 per week	4(22.2)	3(15.8)	-	-	2(20)
At least 1 per month	-	3(15.8)	-	-	1(10)
At least 1 per year	1(5.6)	1(5.3)	-	-	1(10)
Others	2(11.1)	2(10.5)	-	-	2(20)
Missing	-	1	-	-	1
Does your department evaluate CPG? *4					
Yes	10(55.6)	9(45)	2(100)	1(100)	6(54.5)
No	8(44.4)	11(55)	-	-	5(45.5)

*2 = No. of respondents' hospital having CPG

*3 = No. of respondents who having discouraging factor for developing CPG

*4 = No. of respondents who using CPG

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Table 4.13 Responses about the use of clinical practice guidelines in different types of hospital settings by physical therapists (cont.)

Question	Frequencies (valid percent)				
	RH (N=27)	GH (N=42)	SH (N=6)	UH (N=7)	PH (N=19)
Discouraging factors for evaluating CPG *5					
Lack of textbook	4(57.1)	2(20)	-	-	3(60)
Limit of time	4(57.1)	8(80)	-	-	2(40)
Lack of knowledge to developing CPG	3(42.9)	2(20)	-	-	2(40)
Others	2(28.6)	-	-	-	-
Missing	1	1	-	-	-
How does your department evaluate CPG? *6					
Outcome or use of health care service	4(40)	6(66.7)	-	1(100)	6(100)
Methods to evaluate CPG	2(20)	7(77.8)	1(50)	-	4(66.7)
Methods to promote the update of CPG	2(20)	2(22.2)	-	-	2(33.3)
Follow to use CPG	8(80)	3(33.3)	2(100)	-	1(16.7)
Others	-	-	-	-	1(16.7)
How does your department evaluate CPG? *6					
Case note	6(66.7)	6(66.7)	2(100)	-	6(100)
Patient mediated intervention or reminder	5(55.6)	4(44.4)	1(50)	-	2(33.3)
Clinical audit	3(33.3)	3(33.3)	1(50)	-	2(33.3)
Peer review	3(33.3)	6(66.7)	2(100)	-	3(50)
Continuing education	2(22.2)	2(22.2)	1(50)	-	-
Targeting of opinion leaders	2(22.2)	3(33.3)	2(100)	-	1(16.7)
Financial	-	1(11.1)	-	-	-
Others	-	-	-	1(100)	-
Missing	1	-	-	-	-

*5 = No. of respondents who having discouraging for evaluating CPG

*6 = No. of respondents who evaluating CPG

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Table 4.13 Responses about the use of clinical practice guidelines in different types of hospital settings by physical therapists (cont.)

Question	Frequencies (valid percent)				
	RH (N=27)	GH (N=42)	SH (N=6)	UH (N=7)	PH (N=19)
How often do you evaluate CPG? *6					
Few per week	-	-	-	-	1(20)
1 per week	1(11.1)	-	-	-	-
1 per month	3(33.3)	2(25)	-	-	1(20)
6 per year	-	-	-	1(100)	1(20)
4 per year	1(11.1)	2(25)	1(100)	-	-
2 per year	1(11.1)	2(25)	-	-	1(20)
1 per year	3(33.3)	2(25)	-	-	1(20)
Missing	1	1	1	-	1
In your opinion, what are the benefits of CPG? *6					
Improve the quality of care by patients	16(88.9)	14(70)	2(100)	-	7(63.6)
Support evidence-based care	10(55.6)	12(60)	1(50)	-	5(45.5)
Improve structure and process of health care service	4(22.2)	13(65)	1(50)	-	6(54.5)
Advance cost effectiveness	3(16.7)	3(15)	-	-	4(36.4)
Contribute to more effective care	14(77.8)	16(80)	1(50)	-	5(45.5)
Develop of the profession of Physical Therapy	11(61.1)	12(60)	1(50)	-	5(45.5)
Improve uniformity within the profession	14(77.8)	14(70)	2(100)	-	9(81.8)
Reveal the tasks and responsibilities of the profession	4(22.2)	11(55)	1(50)	-	4(36.4)
Promote collaboration with other professions	11(61.1)	13(65)	1(50)	-	9(81.8)
Others	-	-	-	-	-
Missing	-	-	-	1(100)	1(1.9)

*4 = No. of respondents who using CPG

*6 = No. of respondents who evaluating CPG

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CHAPTER V
DISCUSSION

This study emphasized an exploration of how physical therapists who were working in several types of hospitals presented their understanding, attitude and using of the clinical practice guideline. The overall response rate for the questionnaire data were 84.2 percents. Since the questionnaires were sent to all medium to large hospitals in Thailand, the survey results should be considered to adequately represent the target population.

From the completed questionnaires, the majority of the respondents (77.2%) reported that they were head of physical therapist who played the role in developing quality of hospital. Their experiences as a physical therapist ranged from one to thirty-five years with the mean experience of 16 years. All of them worked in the physical therapy department. Therefore, these respondents would be considered to qualify to answer all of the survey questions.

The workplaces of the respondents consisted of various types of hospital settings i.e., general hospitals (41.7%), regional hospitals (26.7%), private hospitals (18.8%), university hospitals (5.9%) and specific hospitals (5.9%) and a medical hospital (1%). The number of in-patient beds ranged from 300 to 1,600 beds. Furthermore, 98% of the hospital settings had a standard for health care services. In addition, 67.3% of the hospital settings were accredited from Development and Hospital Quality Accreditation Organization. Approximately 75 percents of the departments in this study had physical therapy students for training, while 49.5% of these departments had other discipline students. These departments had number of staff ranged from 1 to 50 physical therapists. Total number of physical therapy service teams ranged from 4 to 83 with an average of 14. Accordingly, these hospitals would represent the targeted setting in terms of size and qualification.

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5.1 Physical Therapists' Knowledge of Clinical Practice Guidelines

The knowledge about clinical practice guidelines observed in this study consisted of the understanding of evidence-based practice, the definition of clinical practice guideline, the characteristics of CPG and details of CPGs. First, most of the respondents (79.2%) in this study reported that evidence-based practice were the combination between clinical experience and robust research. Similarly, Barnard and Wile in 2001 presented understanding about evidence-based practice in physiotherapists in the United Kingdom. Most of the subjects viewed it as a mixed (36). These results are similar to a widely accepted definition of evidence-based practice (3, 18-21).

Approximately 19 percent of the respondents in this study chose all three choices that the CPG was designed to help physical therapists to perform decision making, to provide rigorous recommendations and to help patients to make decision. Similarly, the general definition of clinical practice guidelines is "systematically developed statements designed to help practitioners and patients to make decisions about appropriate health care for specific circumstances" (12). Interestingly, approximately 49 percent and 30 percent of physical therapists in Thailand replied two and one choice of these answers respectively. The choice that they usually omitted was that the clinical practice guidelines were designed to help patients to make decision.

Approximately 13 percent of the respondents in this survey completed all 4 choices of the key characteristics of clinical practice guideline including offering advices about appropriate care, giving suggestion of the most effective care, being resources for physical therapists and patients to make health care decision and being developed in a rigorous way. The results were similar to the widely accepted characteristics of clinical practice guideline in the health community throughout the world (1-4, 6). The results showed that approximately 86 percent of the physical therapists in this study did not perceive all the choices of key characteristics of the CPG. This implies that Thai physical therapists might not be recognizing the complete characteristics of clinical practice guidelines.

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In the study, approximately 24 percent of the respondents completed the details of clinical practice guidelines consisting of physical therapy management, criteria for physical therapy intervention, guideline for diagnosis, definition of problems, goals of treatment, treatment technique, outcome evaluation, stages of disease, referral and follow up medicine or discharging the physical therapy treatment, criteria for physical therapy consultation, format for recording related to physical therapy and hospital accreditation. These results were similar to the widespread topics of guidelines as in the surveys in the Netherlands, the United Kingdom and USA (2, 8, 10-15, 33-35). The results of development and implementation of national clinical practice guidelines in physical therapy in the Netherlands in 2000 showed that topics of CPGs had therapy, diagnosis, harm, prognosis and physical therapy process such as referral data, history taking, physical examination, analysis, formulation of treatment plan, treatment, and evaluation (15).

With the same purpose, Newton et al in 1996 explored knowledge of the contents and recommendations of three published clinical practice guidelines in general practitioners in the United Kingdom. The results also showed that the respondents had medium to high ranging scales of the knowledge (6). In contrary, other studies in the United Kingdom and Australia reported that the clinicians were lack of understanding about contents and opinion of clinical practice guidelines and usefulness (37, 38). However, approximately 76 percent of the physical therapists in this study did not choose all the choices of contents of physical therapy management that should be in the CPG. The results probably imply that Thai physical therapists were still lack of understanding of the content of clinical practice guidelines.

According to the survey results, many physical therapists in Thailand still have inadequate knowledge of the CPG especially, the definition of evidence-based practice, definition of clinical practice guidelines, main characteristics of CPGs and contents of CPGs. First, about 22 percent of the respondents did not have adequate understanding of definition of evidence-based practice. Secondly, approximately 80 percent of the responses did not completely understand definitions of clinical practice guidelines. Thirdly, about 87 percent of them had partial understanding about the main

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characteristics of the clinical practice guidelines. The last, about 76 percent of the respondents did not completely recognizing all details of clinical practice guidelines. This is likely due to the shortage of good disseminating CPG and education program about clinical practice guidelines. Therefore, an important thing to solve this problem is Thai Physical Therapy Professional Council might need to provide continuing education concerning clinical practice guideline such as an interactive education program (15).

5.2 Physical Therapists' Attitude of Clinical Practice Guidelines

Most of the respondents indicated a positive attitude to clinical practice guideline such as CPGs would improve uniformity with the profession, decrease variation in health care management, improve quality of care and obtain scientific proven. These similar favorable attitudes to the concept of clinical practice guidelines have also been reported in other studies in the Untied Kingdom, Sweden, Australia (6-8, 36). Overmeer et al in Sweden in 2005 showed that 54% of the physicians and 56% of the physical therapists agreed that clinical practice guidelines were useful in clinical practice (37). Iles et al in Australia in 2006 presented that most of the respondents had positive attitude toward CPGs (38). Siriwardena in the United Kingdom in 1995 presented that most respondents had similar positive attitude to clinical practice guidelines as in this study which were effective in improving patient care (9).

However, a negative attitude chosen by most respondents in this study was clinical practice guidelines might lead to 'cookbook' medicine (95.1%). The respondents in the previous studies also viewed that the CPG might stop an innovation, reduced clinical freedom, reduce patients' confidence in clinicians and create more competitiveness between clinicians (6, 9). Interestingly, about 70 percent of the physical therapists in this study disagreed and were not certain that clinical practice guidelines stop an innovation and reduce clinical freedom. These results were different than the previous studies. This was likely due to a lack of complete understanding of guidelines or belief as well as the differences of health care policy or each hospital policy. Therefore, an important thing to solve this problem is to provide knowledge of clinical practice guidelines for physical therapists; the possible

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orientation is to inform, arouse their interest and insight to understand the content of guidelines in order to gain insight into their own way of working; then, Thai Physical Therapy Council might also play a major role to encourage physical therapists to gain the positive attitudes toward clinical practice guidelines (43).

5.3 Physical Therapists' Use of Clinical Practice Guidelines

More than half of the respondents reported that their hospitals had at least one physical therapy clinical practice guideline. Differently, Renvoize et al in the United Kingdom in 1997 presented that 19 percent of the respondents reported that their hospitals had written strategies to develop clinical practice guidelines; the amount of this seems to be occurring in the absence of the agreement of the strategic framework (7). Moreover, the respondents in this study reported numbers of physical therapy clinical practice guideline in their hospitals with an average of 3 guidelines.

The most influencing factor to the development of clinical practice guidelines was improvement of the quality health care service (91.7%). Similar to this study, the previous studies showed that the factor leading to CPG development was to improve clinical outcomes (6, 7). The clinical practice guideline is a product of this influence because clinicians provide critics, monitors and auditors with a tool which they evaluate the practice against standards (1-3, 12). Interestingly, most of the respondents replied that their hospitals had discouraging factors of developing clinical practice guideline. The major discouraging factors included a limit of time (76%) and lack of skill for developing clinical practice guideline (54%). To solve these obstacles, Thai Physical Therapy Organization should establish formal responsible team for developing the CPG or a process for promoting physical therapists who are working in hospitals to have better knowledge and skill in developing the clinical practice guideline.

In this study, approximately 50% of the respondents reported that they adopted the clinical practice guideline from Thai Physical Therapy Council or created by a peer group review. Similarly, Renvioze et al in 1997 showed that the most popular methods of developing CPG in the United Kingdom were the adopting of national

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clinical practice guidelines, and peer group review (7). The results in both studies have the parallel trend of developing CPG strategies.

However, most respondents in this study whose their departments had clinical practice guidelines (85.2%) reported that they often used clinical practice guidelines. This seemed to be good acceptance of CPGs because most respondents in the study also had a positive attitude towards CPGs. Furthermore, more than half of the respondents replied that frequency of use of clinical practice guidelines were everyday. At least 50 percent of the respondents also reported that their hospitals had evaluating CPGs process by using outcome or use of health care service, standard methods of evaluating CPGs and following CPG implementation. Most of the respondents reported the evaluating CPG strategies as case note. Differently, Renvioze et al in 1997 in the United Kingdom showed that most respondents reported evaluating CPG strategies as clinical audit (97%), peer review (83%) and continuing education (79%) (7). Interestingly, approximately 18 percent of the respondents in this study reported continuing education as the evaluating guideline strategy. This is likely due to lack of right understanding about the evaluating guidelines strategy. Therefore, an important thing to solve this problem is that Thai Physical Therapy Organization showed proper knowledge about the strategy for evaluating CPGs in physical therapists and arouse them to use and evaluate clinical practice guidelines. In addition, all respondents in this study reported that frequency of CPG evaluation at least once a year. A possible reason is the hospital policy.

Finally, the respondents reported that benefits of clinical practice guideline were to improve the quality of care by patients (75%), to improve uniformity within the profession (75%) and to promote more effective care (69.2%). Similar attitudes of favorable benefits of clinical practice guideline have also been reported in other studies (1-11, 41).

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5.4 Responses of Clinical Practice Guidelines by Physical Therapists in Different Types of Hospital Settings

Further analyses were conducted by comparing the results among different types of hospital settings i.e., regional hospitals, general hospitals specialized, university and private hospitals.

5.4.1 Responses of knowledge of clinical practice guidelines by physical therapists in different types of hospital settings

The results showed the different levels of knowledge of CPG that including definition of EBP, definition of CPG, main characteristics of CPG and content of CPG. More than 75% of the respondents in all types of hospital setting had clear understanding about definition of evidence-based practice. Among these, 29.6 percent of the respondents were in regional hospital settings which presented the highest percentage among all types of hospital setting. Among all types of hospital setting, the highest percentages of respondents who had clear knowledge of main characteristic of CPG was in the university hospitals while the least of percentages was in the regional hospitals. Finally, the respondents in regional hospitals who had full understanding about content of CPG were the highest proportion among all types of hospital settings. Moreover, more than 25 percent of the respondents in general and private hospitals had full understanding about content of CPG.

Surprisingly, most respondents in specialized hospitals were lacked of knowledge of CPG in term of definition, main characteristic and content. The possibly reasons are that the specialized hospitals reportedly having less number of physical therapy assistants and staff in their department compared to other hospital settings. Interestingly, 57.1 percent of respondents in university hospital settings had clear understanding about definition of evidence-based practice, while more than 75 percent of the respondents lack of knowledge of CPG as definition and content of CPG. It is possible that 57.1 percent of the respondents in university hospitals did not have job roles as academic and development of quality of hospital.

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5.4.2 Responses of attitude to clinical practice guidelines by physical therapists in different types of hospital settings

In this study, more than 70 percent of physical therapists in all types of hospital setting had the positive attitude to CPG i.e., guidelines would improve quality of care, improve uniformity within the profession, and decrease variation in health care management and obtained scientific proof. However, more than 80 percent of the respondents in all types of hospital settings had negative attitude to CPG that the clinical practice guidelines led to practice following 'cookbook' medicine. Moreover, more than half of the respondents in all types of hospital settings had trend to have a positive perception as CPG did not stop an innovation. Interestingly, more than half of the respondents in university hospitals strongly disagreed or disagreed that CPG should be used flexibly to suit needs of individual patients plus they had negative attitude that CPG might reduce clinical freedom. It is possible that most respondents in university hospitals would need more knowledge about CPG.

5.4.3 Responses of use of clinical practice guidelines by physical therapists in different types of hospital settings

More than 55 percent of the respondents in regional, general and private hospital settings reported to own physical therapy clinical practice guidelines. However, more than 65 percent of the respondents in specialized and university hospitals reported that their department did not have physical therapy clinical practice guidelines. The possible reasons are most respondents in specialized and university hospitals were lack of knowledge of CPG. Moreover, it is also possible that the specialized hospitals had less number of physical therapy assistants and staff in their department than other hospital settings while 57.1 percent of the respondents in university hospitals did not have job roles as academic and development of quality of hospital.

More than 55 percent of the responses in regional, university and private hospitals had the similar method of developing clinical practice guidelines as adopting CPG from Thai physical therapy professional council or creating peer group review. Fifty two of the respondents in general hospitals reported method of developing CPGs as adopting CPG from Thai Physical Therapy Professional Council. Moreover, the

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32% of them reported evaluating CPG strategies as adopting from other source, peer review and adopting from book or textbook. Furthermore, all respondents in specialized hospitals reported most commonly used strategy for developing CPGs was conference outside hospital. However, 50 percent of the respondents in regional hospitals adopted CPGs from book or textbook. The reasons might be that the regional hospitals are large hospitals and have more resources for hospital quality development so have more budgets and books or textbooks for developing CPGs.

However, there were reportedly different average numbers of physical therapy clinical practice guideline used in the departments i.e., 5.4 guidelines in the regional hospitals, while approximately 2.2 guidelines in the other hospital settings. It is possible that these were the consequences of differences of the hospital policy and staff number.

The respondents in regional hospitals reported influencing factor to develop clinical practice guideline as quality health care service improvement (94.1%), safety of patients (76.5%) and hospital policy (58.8%). It is possible that regional hospitals are government organization which their roles are to develop strategies for standard health care service. Interestingly, more than 75% of the respondents in private hospitals reported factors for developing CPGs as quality health care service improvement and safety of patients. It is possible that private hospitals must have a standard of health care service for increasing client satisfaction and economic output. All respondents from private and university hospitals replied that their hospitals had discouraging factors of developing clinical practice guideline while more than 12% of the respondents in general, specialized and regional hospital did not. The possible reasons are that the respondents in university hospitals were lack of knowledge about CPG. It is also possible that private hospitals do not have financial support from the government. However, more than half of the respondents in four types of hospital settings reported to have discouraging factors for developing CPGs as a limit of time and lack of skill for developing CPG while the respondents in specialized hospital reported as having discouraging factor for developing CPGs as lack of textbook. Therefore, an important thing to solve this problem is providing the financial support

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for developing CPG and cooperating with Thai Physical Therapy Professional Council for clinical practice guideline management.

Most respondents in four types of hospital settings reported that they used clinical practice guidelines while most respondents in university hospital did not use them. The possible reason is that most respondents in university setting still lacked of knowledge and some respondents reported negative attitude in some statement. However, there is a trend of good acceptance of CPG because more than 50% of the respondents in all hospital settings except private hospitals replied that frequency of clinical practice guideline using were everyday. In addition, approximately 40% of the responses in private hospitals reported that they used the clinical practice guidelines everyday. All respondents in specialized and university hospitals evaluated CPG. Approximately 55% of the responses of regional hospitals and private hospitals reported that their hospitals did CPG evaluation. Conversely, 55% of the responses of general hospital reported that their department did not evaluate clinical practice guidelines. Since, numbers of the responses of general hospitals reported as a lack of time to evaluating clinical practice guidelines more than the response in regional and private hospitals.

There were differences in term of evaluating CPG in three types of hospital settings. More than 65% of the respondents in university, private and general hospitals reported that they used outcome or benefit of health care service as the methods of evaluating CPGs. All respondents in specialized hospitals and 80% of the responses in regional hospitals reported that they followed clinical practice guideline. It is possible that each hospital settings had different hospital policies. More than 65% of the respondents in all types of hospital settings except university hospitals reported that the common evaluating CPG strategy was case note. Interestingly, at least 50 percent of physical therapists in the university, private and general hospital used peer review, while 33.3 percent of physical therapists in regional hospitals did. Physical therapists in all hospital settings reported different frequencies of evaluating CPG. The possible reason is the frequencies of evaluating CPG are mainly based on the policy of each setting.

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Finally, 36.4 percent of the respondents in private hospital reported the benefit of clinical practice guidelines as advance cost effectiveness, while only 16 percent of the respondents in regional and general hospitals reported so. However, none of the respondents in specialized hospitals reported benefit of CPG as advance cost effectiveness. It is possible that the economic output is the major goal of private hospitals setting.

Limitation of the Study

1. The hospital settings selected and included in the survey were medium to large sizes which included several types of hospital such as university hospitals, specific hospital, regional hospitals, general hospitals, private hospitals. These hospital settings must have numbers of the in-patient beds of 300 or more. Therefore, the survey does not represent most physical therapists who are working in hospitals in Thailand, especially ones who work in small hospital or primary health care unit.

2. For some questions, the number of the respondents in each type of hospital might be too small for the comparison so the analyses were not undertaken.

Implication of the study results

According to this survey study, some physical therapists who are working in hospital reported to have unclear understanding, a negative attitude and did not use clinical practice guideline. In order to maximize the effectiveness of physical therapy practice, some suggestions are proposed as follows:

1. Thai Physical Therapy Council may play a major role in promoting physical therapists who are working in hospitals to have better knowledge and skill of developing clinical practice guideline. The possible orientation is to inform, arouse their interest and insight to understand the definition of guideline, the characteristic of guideline and content of guidelines in order to gain insight into their own way of working. Then, there would be more effective to encourage

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physical therapists to accept the guideline by gaining the positive attitude towards clinical practice guideline. Next, the process should encourage physical therapists to change behavior of utilizing the guideline through the implementation in daily practice and to promote maintenance of the implementing guideline (39).

2. The Physical Therapy Council may endorse the development and adopting the proper clinical practice guidelines for use in Thailand. The standard CPG should be feasible, scientifically justifiable, specific and yet differentiated.

3. The clinical practice guideline should be consistent with appropriate social or setting context as well as the expectations of patients and colleagues. Moreover, by sustaining the proper organizational context through the guidelines, there should lead to problems in organizing the care or requiring big structural changes related to staff or equipment.

4. There also should be a process to enhance collaboration within physical therapy profession as the guidelines also play roles to develop the health profession: by improving uniformity within the profession, decreasing variations in health care management, revealing the tasks and responsibilities of the profession and promoting collaboration with other professions (2-11).

Suggestion for Further Study

1. This survey study indicates understanding, attitude and use of clinical practice guidelines in physical therapists who are working in hospitals with high level of care i.e., one with number of the in-patient beds of 300 or more in Thailand. These hospitals were accredited standard of health care service, so they must have clinical practice guideline. However, most physical therapists in Thailand work in hospitals which have number of in-patient beds less than 300 beds. Therefore, it is interesting to further examine the apprehension and the application between physical therapists in primary care or smaller hospital setting i.e., having number of the in-patient beds less than 300 beds and private practice

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such as clinic.

2. According to this study, more than half of physical therapists had proper understanding and a positive attitude to clinical practice guidelines. The clinical practice guideline were apparently used by half of physical therapists whose their departments had their own clinical practice guidelines. Consequently, it is interesting to further examine the effect of use clinical practice guidelines on physical therapy services. This information would validate the clinical practice guideline and encourage further uses. This would also help professional development.

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CHAPTER VI
CONCLUSION

The results of this survey study revealed knowledge of clinical practice guidelines, attitude toward CPGs and using CPGs in physical therapists who were working in hospitals in Thailand.

This survey study presented knowledge of clinical practice guidelines including the definition of evidence-based practice, definition of clinical practice guideline, key characteristics of clinical practice guideline, content or details of clinical practice guidelines that were similar to the wide-ranging knowledge of clinical practice guideline in the health community throughout the world. First, most respondents was clear understanding of evidence-based practice. Second, approximately 20 percent of physical therapists knew complete definition of clinical practice guidelines, while most physical therapists partly understood the definition, especially one stating that they were designed to help patients make health care decision. Thirdly, about 13 percent of the physical therapists recognized all of the main characteristics. Lastly, approximately 24 percent of physical therapists had knowledge of content or details of CPGs, while some of them were lack of some contents of CPGs. This is likely to be due the lack of good dissemination CPG and education program about CPG.

In term of the attitude to CPG, the majority of the physical therapists in Thailand indicated a positive attitude to the clinical practice guideline in 4 of the 8 statements such as CPGs would decrease variation in health care management and get better uniformity within the professional. Furthermore, most of the respondents had trend of positive attitude to clinical practice guidelines in 2 of 8 statements such as CPGs would be used flexibly to suite needs of individual patients and did not stop an innovation. Furthermore, most respondents were not certain and disagreed that clinical practice guideline might reduce clinical freedom. However, most of them also showed

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a negative in attitude that clinical practice guidelines might lead to 'cookbook' medicine. Furthermore, most respondents replied neutral view that CPG might reduce clinical freedom.

More than half of respondents had physical therapy clinical practice guideline in their departments and almost all among this group had used clinical practice guidelines. Furthermore, more than half of ones who have clinical practice guidelines used them everyday and also evaluated them. All of the respondents did the CPG evaluation at least once per year. Most physical therapists in Thailand reported that main benefits of using clinical practice guideline were to improve the quality of care by patients and to improve uniformity within the profession.

In order to encourage the physical therapists who are working in hospitals to implement clinical practice guideline in routine practice, there should be a process for promoting therapists to have better knowledge and skill of developing clinical practice guideline. The possible orientation is to inform, arouse their interest and insight to understand the content of clinical practice guidelines in order to gain insight into their own way of working. Then, there would be more effective to encourage physical therapists to accept the guideline by gaining the positive attitude towards clinical practice guideline. There also should be process to encourage physical therapists to change behavior of utilizing the clinical practice guideline. To accomplish these goals, there should be a professional organization or agency which takes these issues as one of their mission.

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APPENDIX

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APPENDIX A
EXPERT INFORMATION LETTER

วัน เดือน ปี

เรื่อง ขอความอนุเคราะห์วิจารณ์และให้ข้อเสนอแนะแบบสอบถามเกี่ยวกับสถานการณ์ความรู้ ทัศนคติ และการใช้แนวทางการให้บริการของนักกายภาพบำบัด

เรียน นักกายภาพบำบัดผู้เชี่ยวชาญในเรื่องแนวทางการให้บริการทางกายภาพบำบัด

สิ่งที่ส่งมาด้วย แบบสอบถามเรื่อง“ความเข้าใจและการใช้แนวทางการให้บริการทางกายภาพบำบัดของนักกายภาพบำบัด”

เนื่องด้วยข้าพเจ้า นางสาวกัลยาวดี จันทะโร นักศึกษาปริญญาโท สาขากายภาพบำบัด มหาวิทยาลัยมหิดล มีความประสงค์ทำวิทยานิพนธ์เรื่อง “ความเข้าใจและการใช้แนวทางการให้บริการของนักกายภาพบำบัดในประเทศไทย” โดยมี ผศ.ดร.มัณฑนา วงศ์ศิรินวรัตน์ เป็นอาจารย์ที่ปรึกษา และ มี ผศ.ดร.สายพิณ ประเสริฐสุขดี เป็นอาจารย์ที่ปรึกษาร่วม ในงานวิจัยนี้จะใช้แบบสอบถามเป็นเครื่องมือในการวิจัย เพื่อสำรวจความเข้าใจและการใช้แนวทางการให้บริการทางกายภาพบำบัดของนักกายภาพบำบัดซึ่งทำงานในโรงพยาบาล เพื่อให้ได้ข้อเสนอแนะที่จะนำมาปรับปรุงแบบสอบถามที่ถูกต้องเหมาะสมในการวิจัย จึงจำเป็นต้องขอความร่วมมือจากผู้เชี่ยวชาญเกี่ยวกับแนวทางการให้บริการทางกายภาพบำบัด ในการวิจารณ์และให้ข้อเสนอแนะเกี่ยวกับความรู้ ทัศนคติ และการใช้แนวทางการให้บริการทางกายภาพบำบัดของนักกายภาพบำบัด

จึงใคร่ขอความร่วมมือจากท่านในการวิจารณ์และให้ข้อเสนอแนะเกี่ยวกับแบบสอบถาม และขอความกรุณาส่งคืนแก่ผู้วิจัยภายในวันที่_____ ตามที่อยู่ที่ที่ระบุบนซองจดหมายตอบกลับ

จึงเรียนมาเพื่อโปรดพิจารณาให้ความอนุเคราะห์และขอขอบพระคุณเป็นอย่างสูง

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ขอแสดงความนับถือ

.....

(นางสาวกัลยาวดี จันทะโร)

นักศึกษาปริญญาโทกายภาพบำบัด

.....

(ผศ.ดร.มัณฑนา วงศ์ศิรินวรัตน์)

อาจารย์ที่ปรึกษาวิทยานิพนธ์

หากท่านมีข้อสงสัยประการใด กรุณาติดต่อ นางสาวกัลยาวดี จันทะโร

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APPENDIX B
QUESTIONNAIRE FOR EXPERTS

กรุณาเขียนข้อความวิจารณ์หรือให้ความเห็นเกี่ยวกับแบบสอบถาม ลงในแบบสอบถามนี้

แบบสอบถามแนวทางการให้บริการทางกายภาพบำบัด (Clinical Practice Guideline)

โปรดทำเครื่องหมาย ✓ ลงใน ☐ หรือเติมข้อความลงในช่องที่เว้นว่างไว้

ตอนที่1 ข้อมูลทั่วไป

1. ชื่อโรงพยาบาล: _____

- ***จำนวนเตียง***ของผู้ป่วยในที่เปิดให้บริการ_____เตียง

2. ประเภทของโรงพยาบาล

☐ โรงพยาบาลทั่วไปและศูนย์

☐ โรงพยาบาลเฉพาะทาง

☐ โรงพยาบาลมหาวิทยาลัย

☐ โรงพยาบาลเอกชน

3. ลักษณะของผู้ป่วย ที่ให้การบริการทางกายภาพบำบัด

☐ ผู้ป่วยทั่วไป (มีการดูแลผู้ป่วยหลายสาขา)

☐ ผู้ป่วยเฉพาะทาง ระบุ_____

4. โรงพยาบาล***มี***ระบบพัฒนาคุณภาพโรงพยาบาล (HA)หรือไม่

☐ ไม่มี

☐ มี

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5. โรงพยาบาล***ผ่านการรับรอง***ของระบบคุณภาพโรงพยาบาล (HA) หรือไม่

☐ ไม่ผ่าน และไม่มีการวางแผนเพื่อรับการรับรอง HA

☐ ไม่ผ่าน และมีการวางแผนเพื่อรับการรับรอง HA

☐ ไม่ผ่าน และอยู่ระหว่างดำเนินการเพื่อรับการรับรอง HA

☐ ผ่าน HA ตั้งแต่ปีพ.ศ._____จะมีตรวจการรับรอง HA อีก เมื่อ_____

6. ข้อมูลเกี่ยวกับงานกายภาพบำบัด

ชื่อหน่วยงาน_____

7. ข้อมูลผู้ตอบแบบสอบถาม

เพศ ☐ ชาย ☐ หญิง

ตำแหน่ง_____

-ลักษณะงานที่รับผิดชอบ (ตอบได้มากกว่า 1 ข้อ)

☐ งานรักษา/ให้บริการผู้ป่วย

☐ งานบริหารภายในหน่วยงาน

☐ งานวิชาการ

☐ งานพัฒนาคุณภาพโรงพยาบาล (HA)

☐ อื่นๆ ระบุ

จำนวนปีที่ทำงานเป็นนักกายภาพบำบัด_____ปี

8. จำนวนและคุณวุฒิของบุคลากรในหน่วยงานกายภาพบำบัด

ตำแหน่ง	Full time (คน)			Part time (ชม./สัปดาห์)
	สูงกว่าปริญญาตรี	ปริญญาตรี	ต่ำกว่าปริญญาตรี	
แพทย์ ระบุสาขา_____ หัวหน้านักกายภาพบำบัด นักกายภาพบำบัด เจ้าพนักงานกายภาพบำบัด ผู้ช่วยนักกายภาพบำบัด อื่นๆระบุ_____				

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9. งานด้านการเรียนการสอน

หน่วยงานของท่าน*มีนักศึกษากายภาพบำบัด*มาฝึกงานหรือดูงานหรือไม่

☐ ไม่

☐ มี ระบุ_____

☐ อื่นๆ ระบุ_____

ตอนที่ 2 ความรู้เกี่ยวกับ Clinical Practice Guideline หรือแนวทางการบริการทางกายภาพบำบัด

1. ท่านคิดว่า ***ความหมายของ "การให้บริการโดยอ้างอิงหลักฐาน (Evidence-based practice")*** คือ.... (ตอบได้มากกว่า 1 ข้อ)

☐ ความรู้ที่ได้จากประสบการณ์การปฏิบัติงาน

☐ ความรู้ที่ได้จากผลงานวิจัยที่ได้รับการพิสูจน์

☐ รวมความรู้ที่ได้จากประสบการณ์การปฏิบัติงานและผลงานวิจัยที่ได้รับการพิสูจน์

☐ อื่นๆ ระบุ_____

2. ท่านคิดว่า ***ความหมายของ "แนวทางการบริการ (Clinical Practice Guideline)"*** คือ.... (ตอบได้มากกว่า 1 ข้อ)

☐ ประกอบด้วยคำแนะนำต่างๆที่ผ่านการพิจารณาอย่างเข้มงวดและเป็นระบบแล้ว

☐ เครื่องมือที่นักกายภาพบำบัดใช้ในการตัดสินใจให้บริการทางกายภาพบำบัดต่างๆ

☐ เป็นเครื่องมือที่ช่วยให้ผู้ป่วยร่วมตัดสินใจในการรับบริการทางกายภาพบำบัดต่างๆ

☐ รวมข้อที่ 1,2และ3

3. ท่านคิดว่า ***ลักษณะสำคัญของ "แนวทางการบริการทางกายภาพบำบัด (Clinical Practice Guideline)"*** คือ.... (ตอบได้มากกว่า 1 ข้อ)

☐คำแนะนำเกี่ยวกับ**การรักษาที่เหมาะสม**กับผู้ป่วยแต่ละรายอย่างมีประสิทธิภาพซึ่งได้รับการพิสูจน์แล้ว

☐คำแนะนำเกี่ยวกับวิธีการรักษาที่มี**ประสิทธิภาพสูงสุด**ซึ่งได้รับการพิสูจน์แล้วสำหรับแต่ละภาวะ

☐ นักกายภาพบำบัดและผู้ป่วยใช้เป็นแหล่งข้อมูลที่ช่วยในการตัดสินใจในการรักษา

☐ พัฒนามาจากข้อมูลวิจัยที่มีข้อผิดพลาดน้อยที่สุด และมีความถูกต้องมากที่สุด

☐ **อื่นๆระบุ**_____

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4. ท่านคิดว่า **หัวข้อ/รายละเอียดของ *"แนวทางการบริการทางกายภาพบำบัด (Clinical Practice Guideline)"*** คือ.... (ตอบได้มากกว่า 1 ข้อ)

☐คำจำกัดความของปัญหาหรือกลุ่มอาการ

☐แนวทางวินิจฉัยทางกายภาพบำบัด

☐การส่งปรึกษาทางกายภาพบำบัด

☐เกณฑ์ในการให้การรักษาทางกายภาพบำบัด

☐มาตรฐานวิชาชีพกายภาพบำบัดและ HA

☐การส่งรักษาต่อ,นัดประเมินซ้ำทางการแพทย์และการรักษากายภาพบำบัดใน visit สุดท้าย

☐การรักษาทางกายภาพบำบัด(ระยะ,เป้าหมาย,เหตุผล,วิธีการรักษาที่ใช้และการวัดผล)

ตอนที่ 3 ทัศนคติเกี่ยวกับแนวทางการบริการทางกายภาพบำบัด

โปรดทำเครื่องหมาย ✓ลงใน ☐ ลงในช่องว่าง

แนวทางบริการทางกายภาพบำบัด	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
1.สามารถเพิ่มประสิทธิภาพในการบริการผู้ป่วย					
2.ลดอิสระในการปฏิบัติงานทางคลินิก					
3.ทำให้การบริการทางกายภาพบำบัดเป็นมาตรฐานเดียวกัน					
4.ยับยั้งไม่ให้เกิดนวัตกรรมหรือวิธีการใหม่ในการดูแลผู้ป่วย					
5.สามารถนำไปใช้กับผู้ป่วยที่มีความหลากหลายได้					
6.การให้บริการอยู่บนพื้นฐานที่ใช้โดยทั่วไป					
7. ได้รับการพิสูจน์ทางวิทยาศาสตร์					
8.เป็นคู่มือในการให้บริการทางกายภาพบำบัด					

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ตอนที่ 4 การใช้แนวทางการบริการทางกายภาพบำบัด

1. ปัจจุบันหน่วยงานของท่าน***มี*** Clinical Practice Guideline ทางกายภาพบำบัดหรือไม่

☐ อยู่ระหว่างการจัดทำ

☐ มี

☐ ไม่มี } ถ้าตอบว่าไม่มี จบการตอบแบบสอบถาม

☐ ไม่มี แต่มีการวางแผนจัดทำในอนาคต }

2. Clinical Practice Guideline หน่วยงานของท่าน ***นำมาจากที่ใดหรือทำขึ้นด้วยวิธีการใด***

☐ อ้างอิงจากองค์กรวิชาชีพกายภาพบำบัด

☐ สมาคมกายภาพบำบัดแห่งประเทศไทย

☐ คณะกรรมการวิชาชีพกายภาพบำบัด

☐ สภากายภาพบำบัด

☐ อ้างอิงจากแหล่งข้อมูลอื่น ระบุ_____

☐ จากการประชุมหรือจัดทำขึ้นภายในหน่วยงานกายภาพบำบัด

☐ จากการประชุมหรือจัดทำขึ้นโดยหน่วยงานภายในโรงพยาบาล

☐ ได้จากการประชุมวิชาการนอกหน่วยงาน

☐ จากหนังสือหรือตำราเรียน

☐ อื่นๆ ระบุ _____

3. ปัจจุบันหน่วยงานของท่าน**มี** Clinical Practice Guideline ทางกายภาพบำบัด ***จำนวนทั้งหมด***_____ เรื่อง มีรายละเอียดดังนี้

<u>ตัวอย่าง</u>

ชื่อเรื่อง Clinical Practice Guideline	จำแนกประเภทตาม	หัวข้อ/รายละเอียด
การดูแลผู้ป่วยอัมพาตครึ่งซีก	☑งานกายภาพบำบัด ☑สหวิชาชีพ(care map)	-คำจำกัดความของปัญหาหรือกลุ่มอาการ -แนวทางวินิจฉัยทางกายภาพบำบัด -ส่งปรึกษาทางกายภาพบำบัด -เกณฑ์ในการให้การรักษาทางกายภาพบำบัด -มาตรฐานวิชาชีพกายภาพบำบัดและ HA -การส่งรักษาต่อ,นัดประเมินซ้ำทางการแพทย์และการรักษากายภาพบำบัดครั้งสุดท้าย -การรักษาทางกายภาพบำบัด(ระยะ,เป้าหมาย,เหตุผล,สิ่งที่ให้ในการรักษาและวัดผล)

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มี Clinical Practice Guideline ทางกายภาพบำบัด***ที่มีในหน่วยงาน***

ชื่อเรื่อง Clinical Practice Guideline	จำแนกประเภทตาม	รายละเอียด/หัวข้อ

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4. ***เหตุผลสำคัญที่สุดในการจัดทำ*** Clinical Practice Guideline ทางกายภาพบำบัด ของหน่วยงานของท่าน คือ... (ตอบได้มากกว่า 1 ข้อ)

☐ นโยบายของโรงพยาบาล
☐ พัฒนาคุณภาพงานการให้บริการ
☐ ความปลอดภัยของผู้ป่วย
☐ อื่นๆระบุ_____

5. หน่วยงานของท่านพบ***ปัญหาหรืออุปสรรค*** ในการจัดทำClinical Practice Guideline ทางกายภาพบำบัดหรือไม่ ในกรณีมีปัญหาให้ระบุปัญหา

☐ ไม่มีปัญหา
☐ มี คือ ☐ ไม่มีหนังสือหรือตำราอ้างอิง
☐ มีข้อจำกัดเรื่องเวลาในการจัดทำ
☐ ไม่มีความรู้วิธีการจัดทำอย่างถูกต้อง
☐ อื่นๆระบุ_____

6. หน่วยงานของท่าน***ได้นำ*** Clinical Practice Guideline ทางกายภาพบำบัด ***ไปใช้งานจริง***หรือไม่

☐ ไม่ได้นำไปใช้ ☐ นำไปใช้

7. เจ้าหน้าที่ในหน่วยงานของท่าน***ได้ปฏิบัติตาม*** Clinical Practice Guideline ทางกายภาพบำบัด มากน้อยเพียงใด ระบุความถี่

☐ ทุกวัน
☐ อย่างน้อยสัปดาห์ละ 1 ครั้ง
☐ อย่างน้อยเดือนละ 1 ครั้ง
☐ อย่างน้อยปีละ 1 ครั้ง
☐ อื่นๆ ระบุ_____

8. หน่วยงานของท่านได้***มีการประเมิน*** Clinical Practice Guideline ทางกายภาพบำบัดหรือไม่

☐ไม่มี ☐ มี

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9. หน่วยงานของท่านได้***มีการประเมิน*** Clinical Practice Guideline ทางกายภาพบำบัด***ในเรื่องใด (เช่น การนำไปใช้,ประโยชน์) และด้วยวิธีการใด*** โปรด ระบุ_____

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10. ***ความถี่ที่หน่วยงานของท่านได้ทำการประเมิน*** Clinical Practice Guideline ทางกายภาพบำบัดที่จัดทำขึ้น (เช่นสัปดาห์ละครั้ง, เดือนละครั้ง)_____

11. เมื่อได้ใช้แล้ว ***ท่านคิดว่าประโยชน์***ของ Clinical Practice Guideline ทางกายภาพบำบัด คือ_____

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ขอบคุณสำหรับความร่วมมือในการตอบแบบสอบถาม

หากท่านมีข้อวิจารณ์หรือความคิดเห็นนอกเหนือจากแบบสอบถามนี้ กรุณา ระบุ.....

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หากท่านมีข้อเสนอแนะหรือความคิดเห็นนอกเหนือจากแบบสอบถามนี้ กรุณาระบุ...

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.....ขอบคุณสำหรับข้อเสนอแนะค่ะ

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APPENDIX C
PARTICIPANT INFORMATION LETTER

วัน เดือน ปี

เรื่อง ขอความอนุเคราะห์ตอบแบบสอบถาม

เรียน หัวหน้านักกายภาพบำบัดหรือผู้ได้รับมอบหมาย

สิ่งที่ส่งมาด้วย 1. แบบสอบถามเรื่อง "ความเข้าใจและการใช้แนวทางการให้บริการของนักกายภาพบำบัดในประเทศไทย"

2. ซองสำหรับส่งแบบสอบถามกลับ 1 ซอง

เนื่องด้วยข้าพเจ้า นางสาวกัลยาวดี จันทะโร นักศึกษาปริญญาโท คณะกายภาพบำบัดและการเคลื่อนไหวประยุกต์ มหาวิทยาลัยมหิดล กำลังดำเนินการจัดทำวิทยานิพนธ์เรื่อง "ความเข้าใจและการใช้แนวทางการให้บริการของนักกายภาพบำบัด (clinical practice guidelines)" โดยมี ผศ.ดร.มัณฑนา วงศ์ศิรินวรัตน์ เป็นอาจารย์ที่ปรึกษา และ ผศ.ดร.สายพิณ ประเสริฐสุขดี เป็นอาจารย์ที่ปรึกษาร่วม ในงานวิจัยนี้จะใช้แบบสอบถามเพื่อสำรวจความเข้าใจ ทัศนคติและการใช้แนวทางการให้บริการของนักกายภาพบำบัดซึ่งทำงานในโรงพยาบาล ประโยชน์ที่คาดว่าจะได้รับคือ ข้อมูลจากการสำรวจจะเป็นแนวทางในการส่งเสริมความเข้าใจ การมีทัศนคติที่ดี และการนำแนวทางการให้บริการทางกายภาพบำบัดไปใช้ ซึ่งนำไปสู่การพัฒนาแนวทางการให้บริการทางกายภาพบำบัดที่เป็นมาตรฐานและเพิ่มความร่วมมือภายในวิชาชีพและระหว่างวิชาชีพต่างๆ เพื่อให้การให้บริการทางกายภาพบำบัดอย่างมีมาตรฐาน

ผลการศึกษาของการวิจัยครั้งนี้ได้จากข้อมูลจากแบบสอบถามที่แนบมาด้วยนี้ จึงใคร่ขอเชิญท่านตอบแบบสอบถาม และขอรับรองว่าจะใช้ข้อมูลในแบบสอบถามนี้ตามวัตถุประสงค์ของการศึกษาเท่านั้น โดยชื่อของท่านจะไม่ถูกเผยแพร่ในการศึกษานี้ไม่ว่าในกรณีใดๆทั้งสิ้น รหัสเลขที่บนซองสำหรับส่งแบบสอบถามกลับ มีไว้สำหรับช่วยในการติดตามการตอบกลับของแบบสอบถามเท่านั้น ทั้งนี้แบบสอบถามจะถูกแยกออกจากซองทันทีเมื่อได้รับกลับมา เพื่อไม่ให้ทราบแหล่งที่มาของแบบสอบถาม เมื่อท่านตอบแบบสอบถามเรียบร้อยแล้ว ขอความกรุณาส่งคืนแก่ผู้วิจัยภายในวันที่_____โดยสอดในซองติดแสตมป์ที่แนบมาพร้อมนี้

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ขอขอบพระคุณล่วงหน้าเป็นอย่างสูง

ขอแสดงความนับถือ

….....

นางสาวกัลยาวดี จันทะโร

นักศึกษาปริญญาโท (กายภาพบำบัด)

.....

ผศ.ดร.มัณฑนา วงศ์ศิรินวรัตน์

อาจารย์ที่ปรึกษาวิทยานิพนธ์

หากท่านมีข้อสงสัยประการใด กรุณาติดต่อ นางสาวกัลยาวดี จันทะโร

ที่อยู่ : 133 ซ.สมเด็จพระปิ่นเกล้า 7 ถ.สมเด็จพระปิ่นเกล้า แขวงบางยี่ขัน เขตบางพลัด กทม.10700

โทร. : 0-85909-0543

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APPENDIX D
PARTICIPANT INFORMATION SHEET

เอกสารชี้แจงผู้เข้าร่วมการวิจัย
(Participant Information Sheet)

ในเอกสารนี้อาจมีข้อความที่ท่านอ่านแล้วยังไม่เข้าใจ โปรดสอบถามหัวหน้าโครงการวิจัย หรือผู้แทนให้ช่วยอธิบายจนกว่า จะเข้าใจดี ท่านอาจจะขอเอกสารนี้กลับไปอ่านที่บ้านเพื่อปรึกษาหารือกับญาติพี่น้อง เพื่อนสนิท แพทย์ประจำตัวของท่าน หรือแพทย์ท่านอื่น เพื่อช่วยในการตัดสินใจเข้าร่วมการวิจัย

ชื่อโครงการวิจัย ความเข้าใจและการใช้แนวทางการให้บริการของนักกายภาพบำบัดในประเทศ ไ ท ย

The Apprehension and Application of Clinical Practice Guideline of Physical Therapists in Thailand

ชื่อหัวหน้าโครงการ นางสาวกัลยาวดี จันทะโร

สถานที่วิจัย โรงพยาบาลประเภทต่างๆ มีขนาด 300 เตียง ในประเทศไทย

ผู้ให้ทุน ไม่มี

การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อสำรวจความเข้าใจ ทัศนคติ การใช้และ ประโยชน์ของการใช้แนวทางการให้บริการของนักกายภาพบำบัดที่ทำงานในโรงพยาบาล ซึ่งประโยชน์ที่คาดว่าจะได้รับคือ ใช้ข้อมูลที่ได้มาเพื่อพัฒนาแนวทางการให้บริการทางกายภาพบำบัดในประเทศไทย ให้เป็นมาตรฐาน และก่อให้เกิดการเพิ่มความร่วมมือภายในวิชาชีพและสาขาวิชาชีพอื่นๆในการให้บริการทางคลินิกที่มีประสิทธิภาพ ท่านได้รับเชิญให้เข้าร่วมการวิจัยนี้เพราะเป็นนักกายภาพบำบัดที่กำลังทำงานในโรงพยาบาลแต่ละประเภทที่มีขนาดอย่างน้อย 300 เตียง ในประเทศไทย ซึ่งการศึกษานี้จะใช้เวลาในการศึกษา 1 ปี โดยท่าน หรือในเอกสารนี้เรียกว่า “ผู้เข้าร่วมวิจัย” จะได้รับการปฏิบัติมีดังนี้ คือ

ผู้เข้าร่วมวิจัยจะที่ถูกสุ่มจากโรงพยาบาลแต่ละประเภท ซึ่งจำแนกไว้ดังนี้

- โรงพยาบาลศูนย์
- โรงพยาบาลทั่วไป
- โรงพยาบาลมหาวิทยาลัย
- โรงพยาบาลเอกชน
- โรงพยาบาลอื่นๆ

ซึ่งโรงพยาบาลแต่ละประเภทมีลักษณะดังนี้ คือ

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- มีเตียงผู้ป่วยใน 300 เตียงขึ้นไป
- มีแผนกกายภาพบำบัด หรือ กลุ่มงานเวชกรรมฟื้นฟู
- มีนักกายภาพบำบัดประจำอย่างน้อย 1 คน

โดยให้นักกายภาพบำบัดจำนวน 120 คน จากโรงพยาบาลแต่ละประเภททั้งหมดที่เข้าเกณฑ์คัดเลือกประชากร และส่ง ***แบบสอบถามเรื่องความเข้าใจและการใช้แนวทางการให้บริการทางคลินิก*** ซึ่งประกอบด้วยคำถามจำนวน 36 ข้อ เพื่อศึกษาความรู้ ทัศนคติ และการใช้แนวทางการให้บริการ ซึ่งประกอบด้วย 4 ส่วน คือ

ส่วนที่ 1 : ข้อมูลทั่วไปของหน่วยงานและผู้ตอบแบบสอบถาม

ประกอบด้วยคำถามทั้งปลายเปิดและปลายปิด เพื่อให้ทราบคุณลักษณะของผู้เข้าร่วมและหน่วยงานของผู้เข้าร่วมการศึกษา เกี่ยวกับ เพศ อายุ ตำแหน่ง ลักษณะงานที่รับผิดชอบ จำนวนปีที่ทำงานของผู้เข้าร่วมการศึกษา จำนวนและคุณวุฒิของบุคลากรในหน่วยงานกายภาพบำบัด และงานด้านการเรียนการสอนและประเภทของโรงพยาบาล ลักษณะของผู้ป่วย และการรับรองคุณภาพโรงพยาบาล

ส่วนที่ 2 : ความรู้เกี่ยวกับแนวทางการให้บริการ

ประกอบด้วยคำถามปลายปิดและมีการเติมข้อความในกรณีที่มีความคิดเห็นนอกเหนือคำตอบที่มีเพื่อให้ทราบถึงความรู้เกี่ยวกับแนวทางการให้บริการของผู้เข้าร่วมการศึกษา มีรายละเอียดดังนี้ คือ

- คำนิยามของการให้บริการโดยอ้างอิงหลักฐาน
- คำนิยามของแนวทางการให้บริการ
- ลักษณะสำคัญของแนวทางการให้บริการ
- ส่วนประกอบเกี่ยวกับหัวข้อหรือรายละเอียดของแนวทางการให้บริการ

ส่วนที่ 3 : ทัศนคติต่อแนวทางการให้บริการ

ประกอบด้วยคำถามปลายปิดซึ่งแต่ละคำถามมีคำตอบเป็นลำดับแสดงทัศนคติที่มีต่อแนวทางการให้บริการสำหรับผู้เข้าร่วมการศึกษามีทั้งหมด 5 ระดับ คือ

1. เห็นด้วยอย่างยิ่ง
2. เห็นด้วย
3. ไม่แน่ใจ
4. ไม่เห็นด้วย
5. ไม่เห็นด้วยอย่างยิ่ง

ส่วนที่ 4 : การใช้แนวทางการให้บริการ

ส่วนสุดท้ายนี้ ทำขึ้นเพื่อให้ทราบถึงการใช้แนวทางการให้บริการของผู้เข้าร่วมวิจัยในหน่วยงานของตนเอง ซึ่งประกอบด้วยทั้งคำถามปลายเปิดและปลายปิด ดังนี้

- สถานการณ์การมีแนวทางการให้บริการและการวางแผนจัดให้มีในอนาคต
- การพัฒนาแนวทางการให้บริการของหน่วยงาน
- การใช้แนวทางการให้บริการของหน่วยงาน
- การประเมินแนวทางการให้บริการของหน่วยงาน
- ประโยชน์ของการใช้แนวทางการให้บริการ

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การวิจัยในครั้งนี้ไม่ก่อให้เกิดความเสี่ยงและอันตรายใดๆต่อผู้เข้าร่วมการวิจัย เพราะเป็นเพียงการตอบแบบสอบถาม ซึ่งเป็นวิธีการที่ใช้กันอย่างแพร่หลายทั้งในทางคลินิกและในการวิจัย ซึ่งไม่มีรายงานถึงอันตรายที่จะเกิดขึ้น

หากผู้เข้าร่วมวิจัยมีข้อข้องใจเกี่ยวกับการวิจัยจะสอบถาม หรือเกิดเหตุการณ์ไม่พึงประสงค์ใดๆจากการวิจัยหรือไม่เข้าใจในการวิจัยครั้งนี้ สามารถติดต่อสอบถามได้ที่ นางสาวกัลยาวดี จันทะโร อาคารสำนักงานมหาวิทยาลัยมหิดล (เดิม) ชั้น 4 198/2 ถ.เชิงสะพานพระปิ่นเกล้า แขวงบางยี่ขัน เขตบางพลัด กทม. 10700 โทรศัพท์ 0-2433-7090-2 ในวันและเวลาราชการ หรือ โทรศัพท์ 0-85909-0543 ได้ทุกเวลา

ก่อนที่จะลงนามในใบยินยอมให้ทำการวิจัยนี้ ข้าพเจ้าได้อ่านเอกสารชี้แจงแล้วถึง วัตถุประสงค์ของการวิจัย วิธีการวิจัย อันตราย หรืออาการที่อาจเกิดขึ้นจากการวิจัย รวมทั้งประโยชน์ที่จะเกิดขึ้นจากการวิจัยอย่างละเอียดและมีความเข้าใจดีแล้ว

ผู้วิจัยรับรองว่าจะตอบคำถามต่างๆ ที่ข้าพเจ้าสงสัยด้วยความเต็มใจ ไม่ปิดบังซ่อนเร้นจนข้าพเจ้าพอใจ

การวิจัยในครั้งนี้ไม่มีค่าตอบแทนให้ และผู้เข้าร่วมวิจัยไม่ต้องรับผิดชอบค่าใช้จ่ายใด ๆ

หากมีข้อมูลเพิ่มเติมทั้งด้านประโยชน์และโทษที่เกี่ยวข้องกับการวิจัยนี้ ผู้วิจัยจะแจ้งให้ทราบโดยไม่ปิดบังซ่อนเร้น

ข้อมูลส่วนตัวของผู้เข้าร่วมการวิจัยจะถูกเก็บรักษาไว้ ไม่เปิดเผยต่อสาธารณะเป็นรายบุคคล แต่จะรายงานผลการวิจัยเป็นข้อมูลส่วนรวม ข้อมูลของผู้เข้าร่วมการวิจัยเป็นรายบุคคลอาจมีคณะบุคคลบางกลุ่มเข้ามาตรวจสอบได้ เช่น ผู้ให้ทุนวิจัย, สถาบัน หรือองค์กรของรัฐที่มีหน้าที่ตรวจสอบ, คณะกรรมการจริยธรรมฯ เป็นต้น

ผู้เข้าร่วมการวิจัยมีสิทธิ์ถอนตัวออกจากโครงการเมื่อใดก็ได้ โดยไม่ต้องแจ้งให้ทราบล่วงหน้า

หากท่านได้รับการปฏิบัติที่ไม่ตรงตามที่ได้ระบุไว้ในเอกสารชี้แจงนี้ ท่านจะสามารถแจ้งให้ประธานคณะกรรมการจริยธรรมการวิจัยในคน ทราบได้ที่ สำนักงานคณะกรรมการจริยธรรมการวิจัยในคน ตึกอดุลยเดชวิกรม ชั้น 6 ร.พ.ศิริราช เบอร์โทร. (02)419-6405-6 FAX (02)419-6405

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APPENDIX E
QUESTIONNAIRE FOR PARTICIPANT

แบบสอบถาม

เรื่องความเข้าใจและการใช้แนวทางการให้บริการของนักกายภาพบำบัดในโรงพยาบาลในประเทศไทย

คำชี้แจง **โปรดทำเครื่องหมาย ✓ ลงใน ☐ หรือเติมข้อความลงในช่องที่เว้นว่างไว้**

ตอนที่ 1 ข้อมูลทั่วไป

ข้อมูลผู้ตอบแบบสอบถาม

1. เพศ ☐ ชาย ☐ หญิง อายุ_____ปี

2. ตำแหน่ง_____

3. ลักษณะงานที่รับผิดชอบ (ตอบได้มากกว่า 1 ข้อ)
   - ☐ งานรักษา/ให้บริการผู้ป่วย
   - ☐ งานบริหารภายในหน่วยงาน
   - ☐ งานวิชาการ
   - ☐ งานพัฒนาคุณภาพโรงพยาบาล (HA)
   - ☐ อื่นๆ ระบุ_____

4. ***จำนวนปีที่ทำงาน***เป็นนักกายภาพบำบัด_____ปี

ข้อมูลเกี่ยวกับโรงพยาบาล

5. ประเภทของโรงพยาบาล
   - ☐ โรงพยาบาลศูนย์
   - ☐ โรงพยาบาลทั่วไป
   - ☐ โรงพยาบาลเฉพาะทาง
   - ☐ โรงพยาบาลมหาวิทยาลัย
   - ☐ โรงพยาบาลเอกชน
   - ☐ อื่นๆ ระบุ_____

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6. ***จำนวนเตียง***ของผู้ป่วยในที่เปิดให้บริการรวมทั้งโรงพยาบาล_____เตียง

7. ลักษณะของผู้ป่วย ที่ให้การบริการทางกายภาพบำบัด

☐ ผู้ป่วยทั่วไป (มีการดูแลผู้ป่วยหลายสาขา)

☐ ผู้ป่วยเฉพาะทาง ระบุ_____

8. โรงพยาบาล***มี***ระบบพัฒนาคุณภาพโรงพยาบาล (HA) หรือไม่

☐ ไม่มี ☐ มี

9. โรงพยาบาล***ผ่านการรับรอง***ของระบบคุณภาพโรงพยาบาล (HA) หรือไม่

☐ ไม่ผ่าน และไม่มีการวางแผนเพื่อรับการรับรอง HA

☐ ไม่ผ่าน แต่มีการวางแผนเพื่อรับการรับรอง HA

☐ ไม่ผ่าน โดยอยู่ระหว่างดำเนินการเพื่อรับการรับรอง HA

☐ ผ่าน HA ตั้งแต่ปีพ.ศ._____จะมีตรวจการรับรอง HA อีก เมื่อ_____

ข้อมูลเกี่ยวกับงานกายภาพบำบัด

10. ชื่อหน่วยงาน_____

11. **จำนวนและคุณวุฒิของบุคลากรในหน่วยงานกายภาพบำบัด**

ตำแหน่ง	ในกรณีไม่มี	Full time (คน)			Part time (คน)
		สูงกว่าปริญญาตรี	ปริญญาตรี	ต่ำกว่าปริญญาตรี	
แพทย์ระบุสาขา_____ หัวหน้านักกายภาพบำบัด นักกายภาพบำบัด เจ้าพนักงานกายภาพบำบัด ผู้ช่วยนักกายภาพบำบัด อื่นๆระบุ_____	☐ ☐ ☐ ☐ ☐ ☐ ☐				

12. หน่วยงานของท่าน*มีนักศึกษากายภาพบำบัด*มาฝึกปฏิบัติงานทางคลินิกหรือไม่

☐ ไม่มี

☐ มี ระบุสถาบัน_____

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13. หน่วยงานของท่านมีนักเรียน/นักศึกษาสาขาอื่นมาฝึกงานหรือดูงานหรือไม่

☐ ไม่มี

☐ มี ระบุสาขาวิชา_____

ตอนที่ 2 ความรู้เกี่ยวกับแนวทางการให้บริการทางกายภาพบำบัด

1. ท่านคิดว่า **ความหมายของ *"การให้บริการโดยอ้างอิงหลักฐาน (Evidence-based practice)"*** คือ.... (ตอบได้มากกว่า 1 ข้อ)

☐ ความรู้ที่ได้จากประสบการณ์การปฏิบัติงาน

☐ ความรู้ที่ได้จากผลงานวิจัยที่ได้รับการพิสูจน์

☐ รวมความรู้ที่ได้จากประสบการณ์การปฏิบัติงานและผลงานวิจัยที่ได้รับการพิสูจน์

☐ อื่นๆ ระบุ_____

2. ท่านคิดว่า ***ความหมายของ "แนวทางการให้บริการ (Clinical Practice Guideline)"*** คือ.... (ตอบได้มากกว่า 1 ข้อ)

☐ ประกอบด้วยคำแนะนำต่างๆที่ผ่านการพิจารณาอย่างเข้มงวดและเป็นระบบแล้ว

☐ เครื่องมือที่นักกายภาพบำบัดใช้ในการตัดสินใจให้บริการทางกายภาพบำบัด

☐ เป็นเครื่องมือที่ช่วยให้ผู้ป่วยร่วมตัดสินใจในการรับบริการทางกายภาพบำบัด

☐ อื่นๆ ระบุ_____

3. ท่านคิดว่า ***ลักษณะสำคัญของ "แนวทางการให้บริการ (Clinical Practice Guideline)"*** คือ.... (ตอบได้มากกว่า 1 ข้อ)

☐ คำแนะนำเกี่ยวกับ**การรักษาที่เหมาะสม**กับผู้ป่วยแต่ละรายอย่างมีประสิทธิภาพซึ่งได้รับการพิสูจน์แล้ว

☐ คำแนะนำเกี่ยวกับวิธีการรักษาที่มี**ประสิทธิภาพสูงสุด**ซึ่งได้รับการพิสูจน์แล้วสำหรับแต่ละภาวะ

☐ นักกายภาพบำบัดและผู้ป่วยใช้เป็น**แหล่งข้อมูลที่ช่วยในการตัดสินใจ**ในการรักษา

☐ พัฒนามาจากข้อมูลวิจัยที่**มีข้อผิดพลาดน้อยที่สุด** และมีความ**ถูกต้องมากที่สุด**

☐ อื่นๆระบุ_____

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4. ท่านคิดว่า ***"แนวทางการให้บริการทางกายภาพบำบัด (Clinical Practice Guidelines for physical therapist)"*** ควร**มีหัวข้อ/รายละเอียดของ**.... (ตอบได้มากกว่า 1 ข้อ)

☐ คำจำกัดความของปัญหาหรือกลุ่มอาการ

☐ แนวทางวินิจฉัยทางกายภาพบำบัด

☐ เกณฑ์การส่งปรึกษาทางกายภาพบำบัด

☐ เกณฑ์การให้การรักษาทางกายภาพบำบัด

☐ มาตรฐานวิชาชีพกายภาพบำบัดและ HA

☐ เกณฑ์การส่งรักษาต่อ,นัดประเมินซ้ำทางการแพทย์และการรักษากายภาพบำบัดในVisit สุดท้าย

☐ รายละเอียดของการรักษาทางกายภาพบำบัด โปรดระบุ ☐ ระยะของโรคหรือภาวะกลุ่มอาการ

☐ เป้าหมายของการรักษา

☐ วิธีหรือเทคนิคการรักษาที่ใช้

☐ เกณฑ์การวัดผล

☐อื่นๆ ระบุ_____

ตอนที่ 3 ทัศนคติเกี่ยวกับแนวทางการให้บริการทางกายภาพบำบัด

<u>คำชี้แจง</u> **โปรดทำเครื่องหมาย ✓ ลงในช่องตามความคิดเห็นของท่าน**

แนวทางบริการทางกายภาพบำบัด	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
1. ช่วยเพิ่มประสิทธิภาพในการบริการผู้ป่วย					
2. ลดความเป็นอิสระในการปฏิบัติงานทางคลินิก					
3. ทำให้การบริการทางกายภาพบำบัดเป็นมาตรฐานเดียวกัน					
4. ยับยั้งไม่ให้เกิดนวัตกรรมหรือวิธีการใหม่ในการดูแลผู้ป่วย					
5. สามารถนำไปใช้กับผู้ป่วยที่มีความหลากหลายได้					
6. การให้บริการอยู่บนพื้นฐานที่ใช้โดยทั่วไป					
7. ได้รับการพิสูจน์ทางวิทยาศาสตร์					
8. เป็นคู่มือในการให้บริการทางกายภาพบำบัด					

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ตอนที่ 4 การใช้แนวทางการให้บริการทางกายภาพบำบัด

1. ปัจจุบันหน่วยงานของท่าน***มี*** Clinical Practice Guideline ทางกายภาพบำบัดหรือไม่

☐ อยู่ระหว่างการจัดทำ

☐ มี

☐ ไม่มี } ถ้าตอบว่า**ไม่มี** จบการตอบแบบสอบถาม

☐ ไม่มี แต่มีการวางแผนจัดทำในอนาคต }

2. Clinical Practice Guideline หน่วยงานของท่าน ***นำมาจากที่ใดหรือทำขึ้นด้วยวิธีการใด***

☐ อ้างอิงจากองค์กรวิชาชีพกายภาพบำบัด

- ☐ สมาคมกายภาพบำบัดแห่งประเทศไทย
- ☐ คณะกรรมการวิชาชีพกายภาพบำบัด
- ☐ สภากายภาพบำบัด

☐ อ้างอิงจากแหล่งข้อมูลอื่น ระบุ_____

☐ จากการประชุมหรือจัดทำขึ้นภายในหน่วยงานกายภาพบำบัด

☐ จากการประชุมหรือจัดทำขึ้นโดยหน่วยงานภายในโรงพยาบาล

☐ ได้จากการประชุมวิชาการนอกหน่วยงาน

☐ จากหนังสือหรือตำราเรียน

☐ อื่นๆ ระบุ _____

3. ปัจจุบันหน่วยงานของท่าน**มี** Clinical practice guideline ทางกายภาพบำบัด ***จำนวนทั้งหมด***

_____เรื่อง โปรดระบุชื่อเรื่อง จำแนกประเภท โดยมีรายละเอียดดังตัวอย่างต่อไปนี้

ตัวอย่าง

ชื่อเรื่อง Clinical Practice Guideline	**จำแนกประเภทตาม**	**หัวข้อ/รายละเอียด**
การดูแลผู้ป่วยอัมพาตครึ่งซีก	☑งานกายภาพบำบัด ☑สหวิชาชีพ(care map)	-คำจำกัดความของปัญหาหรือกลุ่มอาการ -แนวทางวินิจฉัยทางกายภาพบำบัด -ส่งปรึกษาทางกายภาพบำบัด -เกณฑ์ในการให้การรักษาทางกายภาพบำบัด -มาตรฐานวิชาชีพกายภาพบำบัดและ HA -การส่งรักษาต่อ,นัดประเมินซ้ำทางการแพทย์และการรักษากายภาพบำบัดครั้งสุดท้าย -การรักษาทางกายภาพบำบัด(ระยะ,เป้าหมาย, เหตุผล,สิ่งที่ให้ในการรักษาและวัดผล)

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ชื่อเรื่อง Clinical Practice Guideline	จำแนกประเภทตาม	หัวข้อ/รายละเอียด

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4. ***เหตุผลสำคัญที่สุดในการจัดทำ*** Clinical Practice Guideline ทางกายภาพบำบัด ของหน่วยงานของท่าน คือ... (ตอบได้มากกว่า 1 ข้อ)

☐ นโยบายของโรงพยาบาล
☐ พัฒนาคุณภาพงานการให้บริการ
☐ ความปลอดภัยของผู้ป่วย
☐ อื่นๆระบุ_____

5. หน่วยงานของท่านพบ***ปัญหาหรืออุปสรรค*** ในการจัดทำ Clinical Practice Guideline ทางกายภาพบำบัดหรือไม่

☐ ไม่มีปัญหา
☐ มี โปรดระบุ
- ☐ ไม่มีหนังสือหรือตำราอ้างอิง
- ☐ มีข้อจำกัดเรื่องเวลาในการจัดทำ
- ☐ ไม่มีความรู้วิธีการจัดทำอย่างถูกต้อง
- ☐ อื่นๆระบุ_____

6. หน่วยงานของท่าน***ได้นำ*** Clinical Practice Guideline ทางกายภาพบำบัด ***ไปใช้งานจริง***หรือไม่

☐ ไม่ได้นำไปใช้
☐ นำไปใช้

7. ท่าน***ได้ปฏิบัติตาม*** Clinical Practice Guideline ทางกายภาพบำบัด มากน้อยเพียงใด ระบุความถี่

☐ ทุกวัน
☐ อย่างน้อยสัปดาห์ละ 1 ครั้ง
☐ อย่างน้อยเดือนละ 1 ครั้ง
☐ อย่างน้อยปีละ 1 ครั้ง
☐ อื่นๆ ระบุ_____

8. หน่วยงานของท่านได้***มีการประเมิน*** Clinical Practice Guideline ทางกายภาพบำบัดหรือไม่

☐ไม่มี
☐ มี

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9. หน่วยงานของท่านได้***มีการประเมิน*** Clinical Practice Guideline ทางกายภาพบำบัด***ในเรื่องใด***

- ☐ ผลลัพธ์หรือประโยชน์ในให้บริการทางคลินิก
- ☐ วิธีการประเมินแนวทางการให้บริการทางคลินิก
- ☐ วิธีการส่งเสริมการใช้แนวทางการให้บริการทางคลินิก
- ☐ การติดตามการนำไปใช้แนวทางการให้บริการทางคลินิก
- ☐ อื่นๆ โปรด ระบุ_____

10. หน่วยงานของท่านได้***มีการประเมิน*** Clinical Practice Guideline ทางกายภาพบำบัด***ด้วยวิธีการใด***

- ☐ บันทึกรายงานของผู้ป่วย (Case notes)
- ☐ ความพึงพอใจของผู้ป่วย (Patient mediated interventions or patient specific reminders)
- ☐ ตรวจสอบทางคลินิก (Clinical audit)
- ☐ ประชุมสัมมนาภายในหน่วยงาน (Peer review)
- ☐ การทำศึกษาอย่างต่อเนื่อง (Continuing education)
- ☐ บรรลุเป้าหมายของผู้นำหรือนโยบายของหน่วยงาน (Targeting of opinion leaders)
- ☐ เป้าหมายทางการเงิน (Financial)
- ☐ อื่นๆ โปรด ระบุ_____

11. ***ความถี่ที่หน่วยงานของท่านได้ทำการประเมิน*** Clinical Practice Guideline ทางกายภาพบำบัดที่จัดทำขึ้น (เช่น สัปดาห์ละครั้ง, เดือนละครั้ง) โปรดระบุ_____

12. เมื่อได้ใช้แล้ว ***ท่านคิดว่าประโยชน์***ของ Clinical Practice Guideline ทางกายภาพบำบัด

- ☐ เพิ่มคุณภาพในการให้บริการผู้ป่วย
- ☐ ส่งเสริมให้บริการโดยอิงหลักฐาน
- ☐ ปรับปรุงโครงสร้างและกระบวนการในการให้บริการ
- ☐ ปรับปรุงต้นทุนในการให้บริการอย่างมีประสิทธิภาพ
- ☐ ส่งเสริมให้เกิดการให้บริการอย่างมีประสิทธิภาพ
- ☐ พัฒนาองค์กรวิชาชีพ
- ☐ เพิ่มการให้บริการที่เป็นมาตรฐานเดียวกันภายในวิชาชีพและลดความแตกต่างในการให้บริการ
- ☐ แสดงให้เห็นถึงงานและความรับผิดชอบต่อวิชาชีพ
- ☐ ส่งเสริมให้เกิดความร่วมมือกับสหสาขาวิชาชีพอื่นๆ
- ☐ อื่นๆ โปรด ระบุ_____

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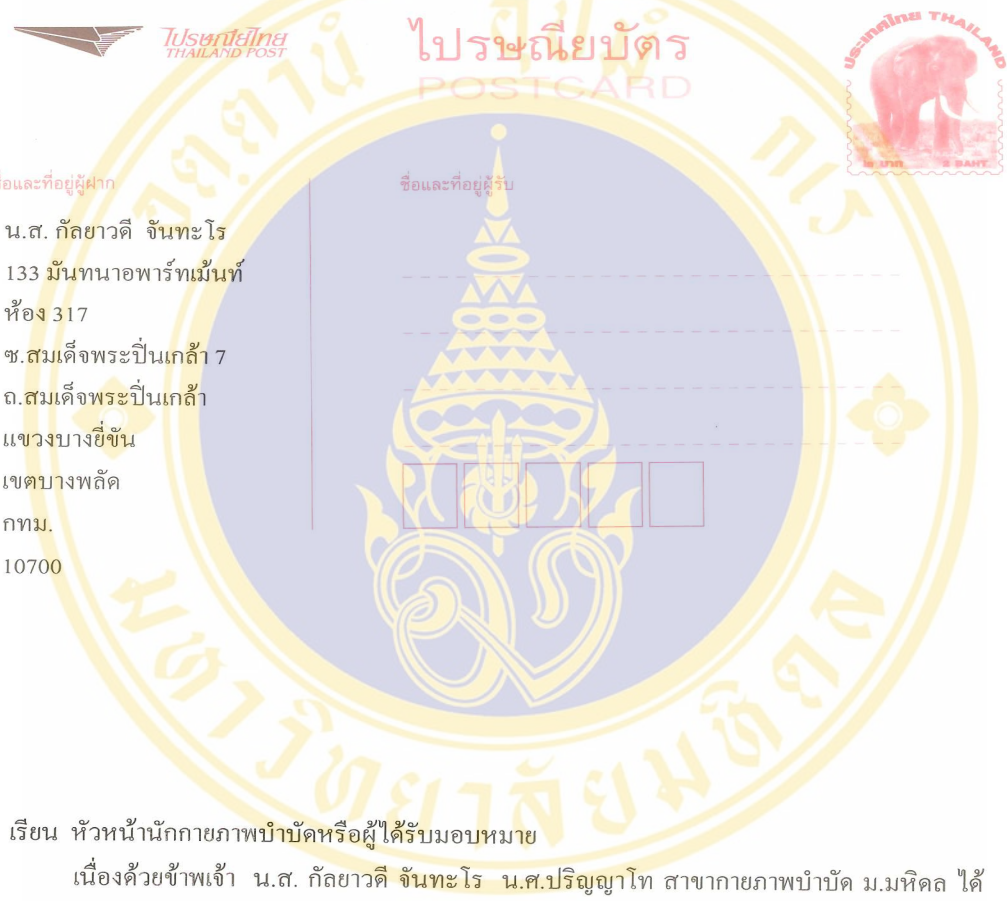
APPENDIX F
FOLLOW-UP POSTCARD



เรียน หัวหน้านักกายภาพบำบัดหรือผู้ได้รับมอบหมาย

เนื่องด้วยข้าพเจ้า น.ส. กัลยาวดี จันทะโร น.ศ.ปริญญาโท สาขากายภาพบำบัด ม.มหิดล ได้ส่งหนังสือ ลงวันที่ 22 กันยายน 2551 พร้อมแบบสอบถาม เพื่อขอความร่วมมือจากท่านกรอกแบบสอบถามเรื่อง "ความเข้าใจและการใช้แนวทางการให้บริการของนักกายภาพบำบัดในประเทศไทย" ไปยังท่านแล้วนั้นจดหมายฉบับนี้ติดต่อมายังท่านเพื่อติดตามความคืบหน้าของแบบสอบถามและใคร่ขอความอนุเคราะห์จากท่านส่งแบบสอบถามกลับคืนให้ผู้วิจัยโดยเร็วที่สุด

หากจดหมายฉบับแรกที่ส่งไปนั้นไม่ถึงมือท่านหรือขัดข้องประการใด กรุณาติดต่อผู้วิจัยที่ โทร 0-85909-543 หรือ kala_physiotherapist@hotmail.com, jantaro_ann@yahoo.com จะเป็นพระคุณยิ่ง

จึงเรียนมาเพื่อขอความอนุเคราะห์จากท่าน

ขอแสดงความนับถือ

น.ส. กัลยาวดี จันทะโร

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APPENDIX G
COVER LETTER OF THE RE-SENT QUESTIONNAIRE

วัน เดือน ปี

เรื่อง ขอความอนุเคราะห์ตอบแบบสอบถาม

เรียน หัวหน้านักกายภาพบำบัดหรือผู้ได้รับมอบหมาย

สิ่งที่ส่งมาด้วย 1. แบบสอบถามเรื่อง "ความเข้าใจและการใช้แนวทางการให้บริการ (clinical practice guidelines) ของนักกายภาพบำบัดในประเทศไทย"

2. ซองสำหรับส่งแบบสอบถามกลับ 1 ซอง

เนื่องด้วยข้าพเจ้า นางสาวกัลยาวดี จันทะโร นักศึกษาปริญญาโท คณะกายภาพบำบัดและการเคลื่อนไหวประยุกต์ มหาวิทยาลัยมหิดล กำลังทำวิทยานิพนธ์เรื่อง "ความเข้าใจและการใช้แนวทางการให้บริการของนักกายภาพบำบัด" โดยมี ผศ.ดร. มัณฑนา วงศ์ศิรินวรัตน์ เป็นอาจารย์ที่ปรึกษาและผศ.ดร.สายพิณ ประเสริฐสุขดี เป็นอาจารย์ที่ปรึกษาร่วม ในงานวิจัยนี้จะใช้แบบสอบถามเพื่อสำรวจความเข้าใจ ทัศนคติและการใช้แนวทางการให้บริการของนักกายภาพบำบัดที่ทำงานในโรงพยาบาล ประโยชน์ที่คาดว่าจะได้รับคือ ข้อมูลจากการสำรวจจะช่วยส่งเสริมความเข้าใจ การมีทัศนคติที่ดี และการนำแนวทางการให้บริการทางกายภาพบำบัดไปใช้ให้เกิดประโยชน์สูงสุด ซึ่งนำไปสู่การพัฒนาแนวทางการให้บริการทางกายภาพบำบัดที่เป็นมาตรฐานและเพิ่มความร่วมมือภายในวิชาชีพและระหว่างวิชาชีพต่างๆ เพื่อบริการทางกายภาพบำบัดมีมาตรฐาน

เนื่องด้วยข้าพเจ้าได้ส่งแบบสอบถามไปแล้วจำนวน 1 ฉบับก่อนหน้านี้แล้วยังไม่ได้รับตอบกลับจากท่าน ดังนั้นข้าพเจ้าจึงส่งแบบสอบถามมาใหม่อีกในครั้งนี้ เพื่อให้ได้ข้อมูลที่ครบถ้วนและก่อให้เกิดประโยชน์สูงสุด การวิจัยครั้งนี้จะสำเร็จได้ต้องอาศัยความร่วมมือจากท่านในการตอบแบบสอบถาม จึงใคร่ขอความกรุณาได้โปรดท่านตอบแบบสอบถามนี้ และขอรับรองว่าจะใช้ข้อมูลในแบบสอบถามนี้ตามวัตถุประสงค์ของการศึกษาเท่านั้น โดยชื่อของท่านและหน่วยงานของท่านจะไม่ถูกเผยแพร่ไม่ว่าในกรณีใดๆทั้งสิ้น รหัสเลขที่บนซองสำหรับส่งแบบสอบถามกลับ มีไว้สำหรับช่วยในการติดตามการตอบกลับของแบบสอบถามเท่านั้น ทั้งนี้แบบสอบถามจะถูกแยกออกจากซองทันทีเมื่อได้รับกลับมา เพื่อไม่ให้ทราบแหล่งที่มาของแบบสอบถาม

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จึงใคร่ขอความอนุเคราะห์จากท่านในการตอบแบบสอบถามและขอความกรุณาส่งคืนแก่ผู้วิจัย ภายในวันที่_____ โดยสอดในซองติดแสตมป์ที่แนบมาพร้อมนี้

จึงเรียนมาเพื่อขอความอนุเคราะห์และขอขอบพระคุณล่วงหน้าเป็นอย่างสูง

ขอแสดงความนับถือ

…….

นางสาวกัลยาวดี จันทะโร

นักศึกษาปริญญาโทกายภาพบำบัด)

…….

ผศ.ดร.มัณฑนา วงศ์ศิรินวรัตน์

อาจารย์ที่ปรึกษาวิทยานิพนธ์

หากท่านมีข้อสงสัยประการใด กรุณาติดต่อ นางสาวกัลยาวดี จันทะโร

ที่อยู่ : 133 ซ.สมเด็จพระปิ่นเกล้า 7 ถ.สมเด็จพระปิ่นเกล้า แขวงบางยี่ขัน เขตบางพลัด กทม. 10700

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APPENDIX H
REPORTS OF CPGS ON PHYSICAL THERAPY

Table H.1 The list of CPGs the participants in this study reported to have in their department. The CPGs were grouped according to physical therapy clinical practice areas.

CPGs on physical therapy for patients with:	Number of CPGs
1. Musculoskeletal conditions	79
1.1 musculoskeletal disorders	2
1.2 cervical pain	1
1.3 cervical spondylosis	2
1.4 shoulder pain	2
1.5 shoulder stiffness	7
1.6 spine fracture	1
1.7 low back pain (LBP)	14
1.8 herniated nucleus pulposus (HNP)	3
1.9 spinal stenosis	1
1.10 back surgery	1
1.11 laminectomy	2
1.12 bone surgery	1
1.13 collie's fracture	1
1.14 dequervain's syndrome	1
1.15 femur fracture	3
1.16 neck of femur fracture	5
1.17 lower extremity fracture and dislocation	5
1.18 anthoscopy	1
1.19 hip prosthesis	2

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CPGs on physical therapy for patients with:	Number of CPGs
1.20 total hip arthoplasty (THA)	3
1.21 total hip replacement (THR)	2
1.22 knee pain	1
1.23 knee osteoarthritis (OA knee)	2
1.24 total knee replacement (TKR)	7
1.25 anterior cruciate ligament reconstruction	1
1.26 joint stiffness	1
1.27 plantar fascilitis	1
1.28 amputation	6
1.29 brachial plexus injury (BPI)	1
2. Neurological conditions	55
2.1 cerebrovascular accident or stroke (CVA)	20
2.2 hemiplegia	21
2.3 plegia	2
2.4 head injury	4
2.5 craniotomy	1
2.6 facial palsy	1
2.7 spinal cord injury	3
2.8 cervical spine fracture with neurological deficit	1
2.9 paraplegia/tetraplegia	1
2.10 qudriplegia	1
3. Cardiovascular/ cardiopulmonary disorders	30
3.1 cardiovascular disorders	4
3.2chest drainage	1
3.3 lung abcess	1
3.4 breast cancer	3
3.4 pneumonia	2
3.5 chronic obstructive pulmonary disease (COPD)	6
3.6 hypertension	1
3.7 heart disease	3

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CPGs on physical therapy for patients with:	Number of CPGs
3.8 myocardial infarction (MI)	5
3.9 coronary artery disease (CAD)	1
3.10 coronary artery bypass graft surgery (CABG)	2
3.11 cardiovascular thoracic surgery (CVT)	1
4. Others	5
4.1 diabetes mellitus (DM)	3
4.2 pre/post operative abdominal surgery	1
4.3 aging	1

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APPENDIX I
MAHIDOL UNIVERSITY ETHICS CERTIFICATE OF APPROVAL

COA. No. MU-IRB 2008/065.1408

Documentary Proof of Mahidol University Institutional Review Board

Title of Project: The Apprehension and Application of Clinical Practice Guideline of Physical Therapists in Thailand
(Thesis for Master Degree)

Principle Investigator: Miss Kalayawadee Jantaro

Name of Institution: Faculty of Physical Therapy and Applied Movement Sciences

Approval includes: 1) MU-IRB Submission form version received date 7 August 2008
2) Participant Information sheet version date 13 August 2008
3) Questionnaire version received date 3 June 2008

Mahidol University Institutional Review Board is in full compliance with International Guidelines for Human Research Protection such as Declaration of Helsinki, The Belmont Report, CIOMSGuidelines and the International Conference on Harmonization in Good Clinical Practice (ICH-GCP)

Date of Approval: 14 August 2008

Date of Expiration: 13 August 2009

Signature of Chairman: .....
(Professor Shusee Visalyaputra)

Signature of Head of the Institute: .....
(Associate Professor Sansanee Chaiyaroj)
Vice President for Research and Academic Affairs

Office of the President, Mahidol University, 999 Phuttamonthon 4 Rd., Salaya, Phuttamonthon District, Nakhon Pathom 73170. Tel. (662) 8496223-5 Fax. (662) 8496223

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APPENDIX J

SIRIRAJ ETHICS CERTIFICATE OF APPROVAL

2 PRANNOK Rd. BANGKOKNOI
BANGKOK 10700

Tel. (662) 4196405-6
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MAHIDOL UNIVERSITY
Since 1888

Siriraj Ethics Committee

Certificate of Approval **COA no.Si 428/2008**

Protocol Title : The Apprehension and Application of Clinical Practice Guideline of Physical Therapists in Thailand.

SiEC number : 318/2551(EC4)

Principal Investigator/Affiliation: Miss Kalayawadee Jantaro
Faculty of Physical therapy and applied movement science, Mahidol University

Research site : Faculty of Medicine Siriraj Hospital

Approval includes :

1. EC Submission Form
2. Proposal
3. Participant Information Sheet
4. Questionnaire

Approval date : August 21, 2008

Expired date : August 20, 2009

This is to certify that Siriraj Ethics Committee is in full Compliance with International Guidelines For Human Research Protection such as the Declaration of Helsinki, the Belmont Report, CIOMS Guidelines and the International Conference on Harmonization in Good Clinical Practice (ICH-GCP).

Prof. Jariya Lertakyamanee, M.D.
Chairperson

August 25, 2008
date

(Clin. Prof. Teerawat Kulthanan, M.D.)
Dean of Faculty of Medicine Siriraj Hospital

August 28, 2008
date

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BIOGRAPHY

NAME	Miss Kalayawadee Jantaro
DATE OF BIRTH	17 February 1982 (2525)
PLACE OF BIRTH	Yala, Thailand
INSTITUTIONS ATTENDED	Mahidol University, 2000-2003 Bachelor of Science (Physical Therapy) Mahidol University, 2006-2008 Master of Science (Physical Therapy)
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