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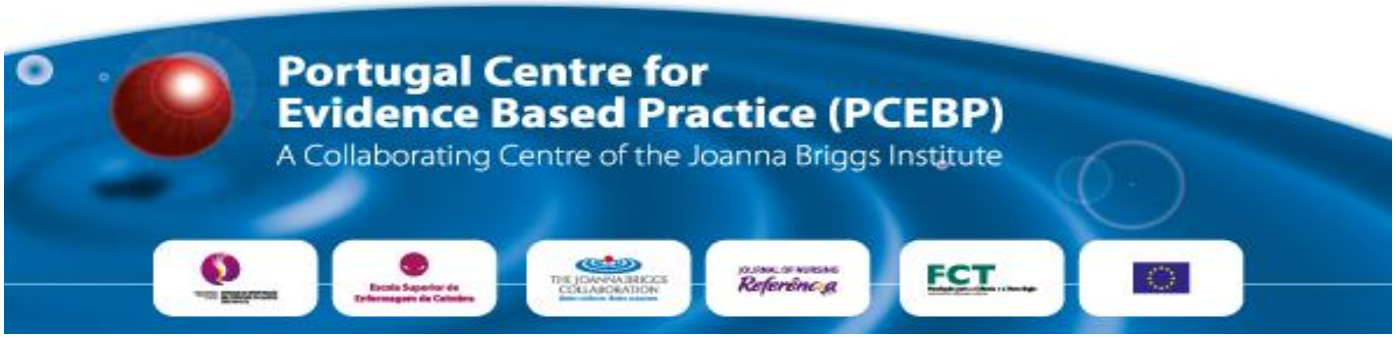
escola superior de enfermagem de coimbra

UNIDADE DE INVESTIGAÇÃO EM CIÊNCIAS DA SAÚDE

Phi Xi Chapter



Systematic reviews impact on their own and students‘ skills

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Joanna Briggs Collaboration

http://joannabriggs.org/JBC.aspx

Overview

Presentation: 50 minutes; Discussion 30 minutes

1) Introduction to SR and the concept of aggregating data from qualitative and quantitative research
   - why we need it in the health care
   - How SR and synthesis of evidence can contribute to the education of health care staff

2) Introduction to systematic review as meta-analysis and meta-synthesis

3) How SR can be used to develop competencies of the staff

- how we use it in my institution
- experience that competencies have developed

4) PCEBP personal experience on developing SR

Evidence-Based Practice (EBP)

- Pearson et al (2005) state that evidence-based practice is clinical decision-making that considers the best available evidence; the context in which the care is delivered; client preference; and the professional judgment of the health professional (p 209).

Evidence-based Health Care

- Evidence based health care takes place when decisions that affect the care of patients are taken with *due weight* accorded to *all valid, relevant information* (Hicks, 1997)

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Evidence is…

- '…the available facts, circumstances etc supporting or otherwise a belief, proposition etc or indicating whether a thing is true or valid…'

(Pearsall and Trumble, 1995)

- "…any statement, record, testimony which tends to prove the existence of a fact in issue"

(Nygh and Butt 1997, p435)

FAME

The following elements should be taken into consideration when applying the evidence - recommendations should be graded accordingly.

F – Feasibility; specifically:

- What is the cost effectiveness of the practice?
- Is the resource/practice available?
- Is their sufficient experience/levels of competency available?

A – Appropriateness; specifically:

- Is it culturally acceptable?
- Is it transferable/applicable to the population of interest?
- Is it easily adaptable to a variety of circumstances?

M – Meaningfulness; specifically:

- Is it associated with positive experiences?
- Is it not associated with negative experiences?

E – Effectiveness; specifically:

- Was there a beneficial effect?
- Is it safe? (i.e. is there a lack of harm associated with the practice?)

The JBI Model of Evidence-*Informed* Healthcare

Evidence-Based *or* Evidence-Informed?

Evidence-Based:

"cook book" approach - resistance of professionals

Evidence-Informed:

There is more to clinical-decision making than evidence alone. Evidence forms only one part of the process.

Evidence based healthcare considers the best available evidence, patient preference, context and clinical judgement.

Evidence synthesis
Why we need it in the health care?

Rituals have a place

Don't throw the baby out with the bathwater

THREE TRANSLATION GAPS (Alan Pearson, Zoe Jordan, and Zachary Munn, 2011)

From Discovery to Clinical Application

From Knowledge Need to Discovery

From Clinical Application to Action IMPACT

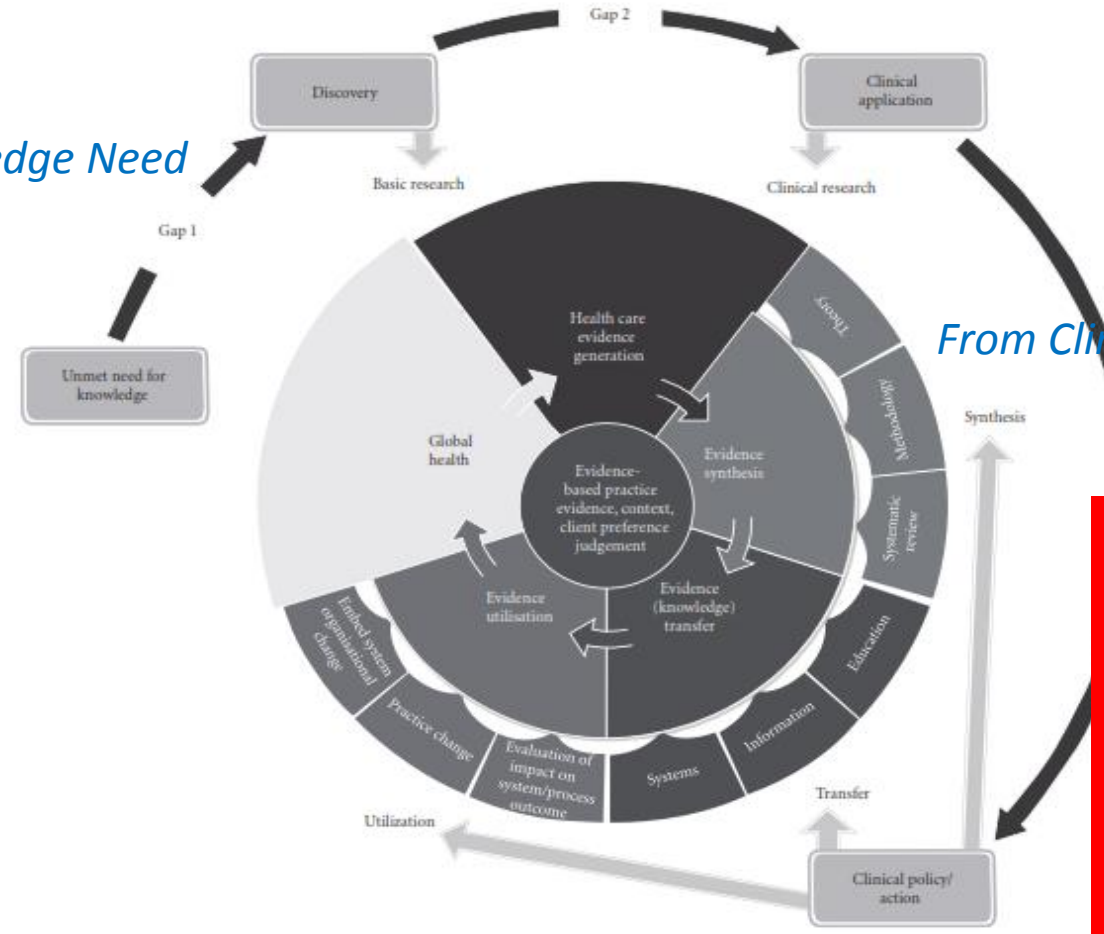


FIGURE 4: The relationship between the translation science cycle and evidence-based health

Leadership?
Line staff?
Knowledge?
Attitude?
Best available evidence?

EIP – Barriers

Barriers to Evidence-Based Practice Implementation - Results of a Qualitative Study (Rapp et al., 2010)

Results - The most significant obstacles emanated **from the behavior of supervisors and front-line staff.**

- **A lack of synergy profoundly impeded implementation**.

It means - Organizations , Leadership and Line staff are crucial

BMC Health Services Research

EIP – Barriers

A systematic review of barriers to and facilitators of the use of evidence by policymakers (Oliver et al. 2014).

- Thirteen systematic reviews were included.

Results - Most frequently reported barriers to evidence uptake:

- Poor access to good quality relevant research;
- Lack of timely research output.

It means - The best available evidence is not available

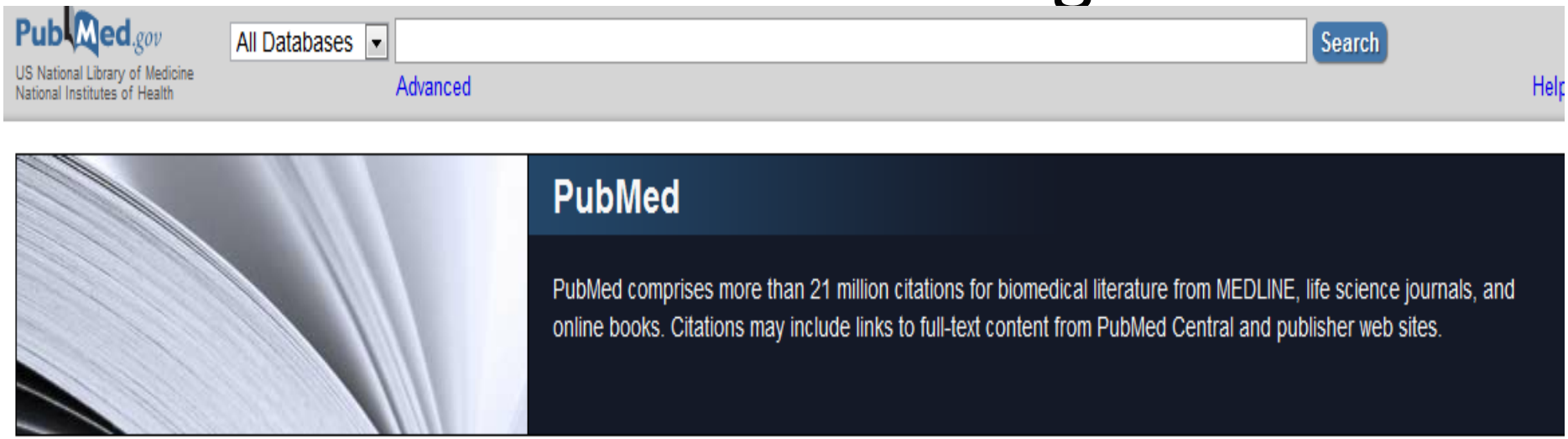
How SR and synthesis of evidence can contribute to the education of health care staff

BECAUSE we need students, nurses and professors develop skills:
Questions (clinical or research);
Search answers to inform practice and education.

Why do we need to train reviewers to develop systematic reviews (evidence synthesis)?

BECAUSE:

Source of knowledge



- PubMed comprises more than 21 million citations for biomedical literature from MEDLINE, life science journals, and online books.
- It was noticed that the only people reading research were other researchers

Making Evidence Accessible to Busy Clinicians

- Systematic reviews (don’t have time)
- Summaries
- Abstracts
- Practice sheets
- Evidence-based clinical guidelines

Access to clinical decision support and tools/resources to facilitate evidence informed practice

- Resources such as:

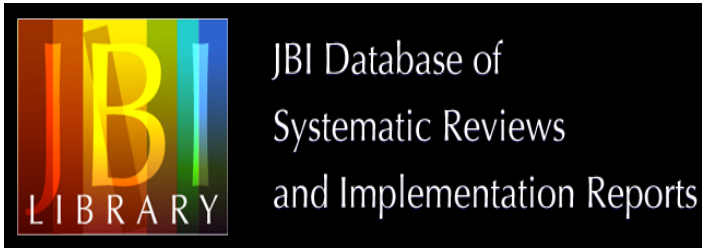
Databases

Cochrane Library

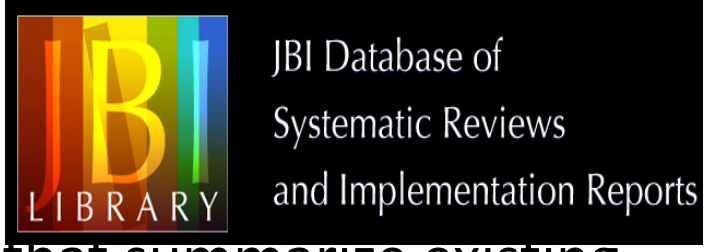
Guidelines

CDC Centers for Disease Control and Prevention

Comprehensive, bundled services (JBI COnNECT+ brought to you by OVID)



JBI's content database contains :



- Evidence Summaries- Literature reviews that summarize existing international literature on common healthcare interventions and activities
- Evidence Based Recommended Practices- Database of procedures, based on the best available evidence, that describe and/or recommend practice on various clinical topics
- Best Practice Information Sheets- Series of information guideline sheets produced specifically for practicing health professionals
- Systematic Reviews- Collection of comprehensive systematic reviews of international research literature completed by trained JBI reviewers
- Consumer Information Sheets- Standardized summaries, designed just for consumers of healthcare (patient/client, relatives, care providers)
- Plus, Systematic Review Protocols and Technical Reports

Fornecida a melhor evidência disponível para que a prática possa ser informada.

Guideline Summary NGC-8722

Guideline Title

(1) Prevention of falls and fall injuries in the older adult. (2) Pr
2011 supplement.

Bibliographic Source(s)

Registered Nurses' Association of Ontario (RNAO). Prevention of f
supplement. Toronto (ON): Registered Nurses' Association of Onta

Registered Nurses' Association of Ontario (RNAO). Prevention of f

Volume 10
Issue 2
2006
ISSN: 1329-1874

Best Practice

Evidence based information sheets for health professionals

Solutions, techniques and pressure in wound cleansing

Recommendations

These recommendations are based on the best available clinical evidence at the time of the conduct of this review. However, there is an urgent need to support these findings with rigorous research as some of the conclusions are based on single studies with a limited sample size.

Information Source

This *Best Practice* information sheet, which updates and supersedes the JBI information sheet of the same title published in 2003, has been derived from a systematic review conducted in 2004.[1,2] The primary references on which this information sheet is based are available in the systematic review report available from The Joanna Briggs Institute[1] www.joannabriggs.edu.au

Solutions

Fourteen RCTs were eligible for inclusion of which four trials involved patients with lacerations, one trial each involved patients with traumatic wounds, open fractures or ulcers, and seven studies involved patients in the postoperative period. The studies evaluated patients in hospital emergency departments, wards and community settings. No trials were identified that used EUSol, hydrogen peroxide or chlorhexidine solutions.

Tap water vs No cleansing

Infection *(n=5 trials)*

Pooling the results of the five trials undertaken on postoperative patients showed no statistically significant difference in the infection rate between wounds that were cleansed with tap water compared with those not cleansed (OR 0.80; 95% CI 0.29-2.3).

Grades of Recommendation

These Grades of Recommendation have been based upon the JBI developed Grades of Effectiveness [3]

- **Grade A** Effectiveness established to a degree that merits application
- **Grade B** Effectiveness established to a degree that suggests application
- **Grade C** Effectiveness established to a degree that warrants consideration of applying the findings
- **Grade D** Effectiveness established to a limited degree
- **Grade E** Effectiveness not established

EVIDENCE-BASED
CARE SHEET

Fall Prevention in Hospitalized Patients

What We Know

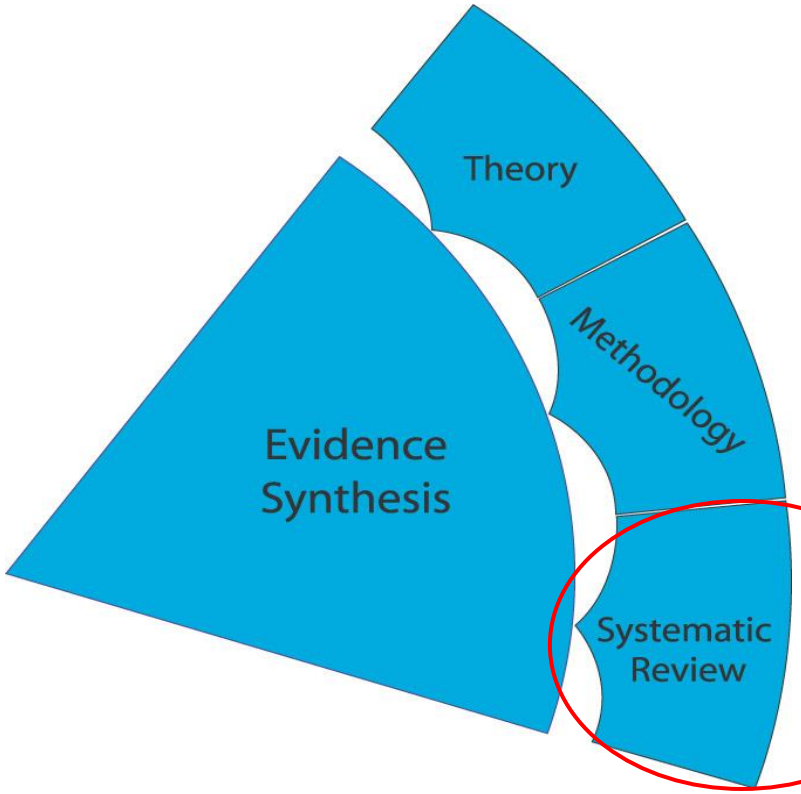
› Up to 12% of hospitalized patients fall at least once during their hospital stay; falls can lengthen hospital stays and result in poor quality of life, increased costs, admission to a long-term care facility, serious physical injuries, and death[1,3,4,5]

- Falls are the most common adverse events reported in hospitals in the United States[1]
- Inpatient falls lead to injury in up to 33% of cases and serious injury in up to 6%[1,5,7]

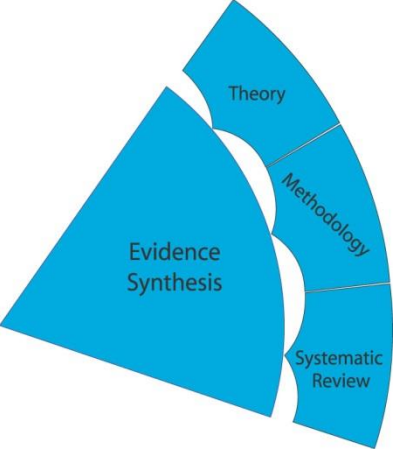
› The causes of inpatient falls are multifactorial. Patients with multiple risk factors are at increased risk of falling[1,3,4,5,11,12]

- Risk factors for falling can be classified as intrinsic (e.g., older age, balance disorders, history of falls, decreased vision, altered cognitive status, or history of arthritis, heart attack, stroke, postural blood pressure changes, syncope, dizziness, or chronic lung disease), extrinsic (e.g., polypharmacy and use of certain medications known to increase fall risk [e.g., benzodiazepines, sedatives, neuroleptics, antidepressants, anticonvulsants, class I antiarrhythmics, and diuretics]), and environmental (e.g., inadequate lighting, slippery floors, lack of handrails, and inadequate nurse/patient staffing ratios).[1,3,4,5,6,7,10,11,12] (For more information, see *Evidence-Based Care Sheet … Falls, Accidental: Risk Assessment*)
  - In a study of 124 patient units in 11 hospitals, investigators found that missed nursing care (e.g., failure to provide routine patient care related to ambulation, toilet assistance, patient assessment, responding to a call

Evidence synthesis
Systematic Review



Pull together or synthesize the evidence to reach some conclusions



Evidence synthesis
Systematic Review

1. The synthesis of evidence of **effects**
2. The synthesis of **qualitative** evidence
3. The synthesis of **text and opinion**
4. The synthesis of **economic** evidence
5. The synthesis of evidence related to **descriptive studies** without comparators
6. The synthesis of evidence related to **prognosis**
7. The synthesis of evidence related to **diagnosis**
8. The synthesis of the findings from **surveys**
9. Methodology for **Mixed method** reviews
10. Methodology for **Umbrella/Overview reviews**
11. **Scoping** reviews

A Mixed Methods Approach to Evidence Synthesis

<Lippincott, Williams and Wilkins publication blurb>

Alan Pearson
Heath White
Fiona Bath-Hextall
Susan Salmond
Joao Apostolo
Pamela Kirkpatrick
Craig Lockwood

- Combines both quantitative and qualitative findings and addresses multiple forms of evidence
- Regarding feasibility, appropriateness, meaningfulness, and effectiveness.
- Separate analyses and synthesis are performed on the corresponding data.

Systematic Review

- Also called "Research Synthesis"
- Is an attempt to integrate empirical data for the purpose of:
  - uncovering the international evidence and
  - producing statements about that evidence to guide decision making
- Requires explicit and exhaustive reporting of the methods used in synthesis

Systematic Review

- The notion of and methods for establishing credibility in systematic reviews has been extensively developed and debated
- In terms of quantitative evidence:
  - Emphasis on reducing *bias* and increasing *validity*
  - Degree of credibility established through critique and by applying levels of evidence (quantitative design)
- In terms of qualitative evidence:
  - Emphasis on *rigour* of research design and *transferability*
- Degree of credibility established through critique and by applying levels of credibility (Findings are: Unequivocal, Credible, Not Supported)

Meta-analysis or narrative

- Quantitative evidence
  - Questions of **Effectiveness,** Feasibility and/or Appropriateness
- Use of statistical methods to combine the results of various independent, similar studies
- More precise calculation of one estimate of treatment effect than could be achieved by any of the individual, contributing studies
- Only forms a part of the systematic review in which it appears

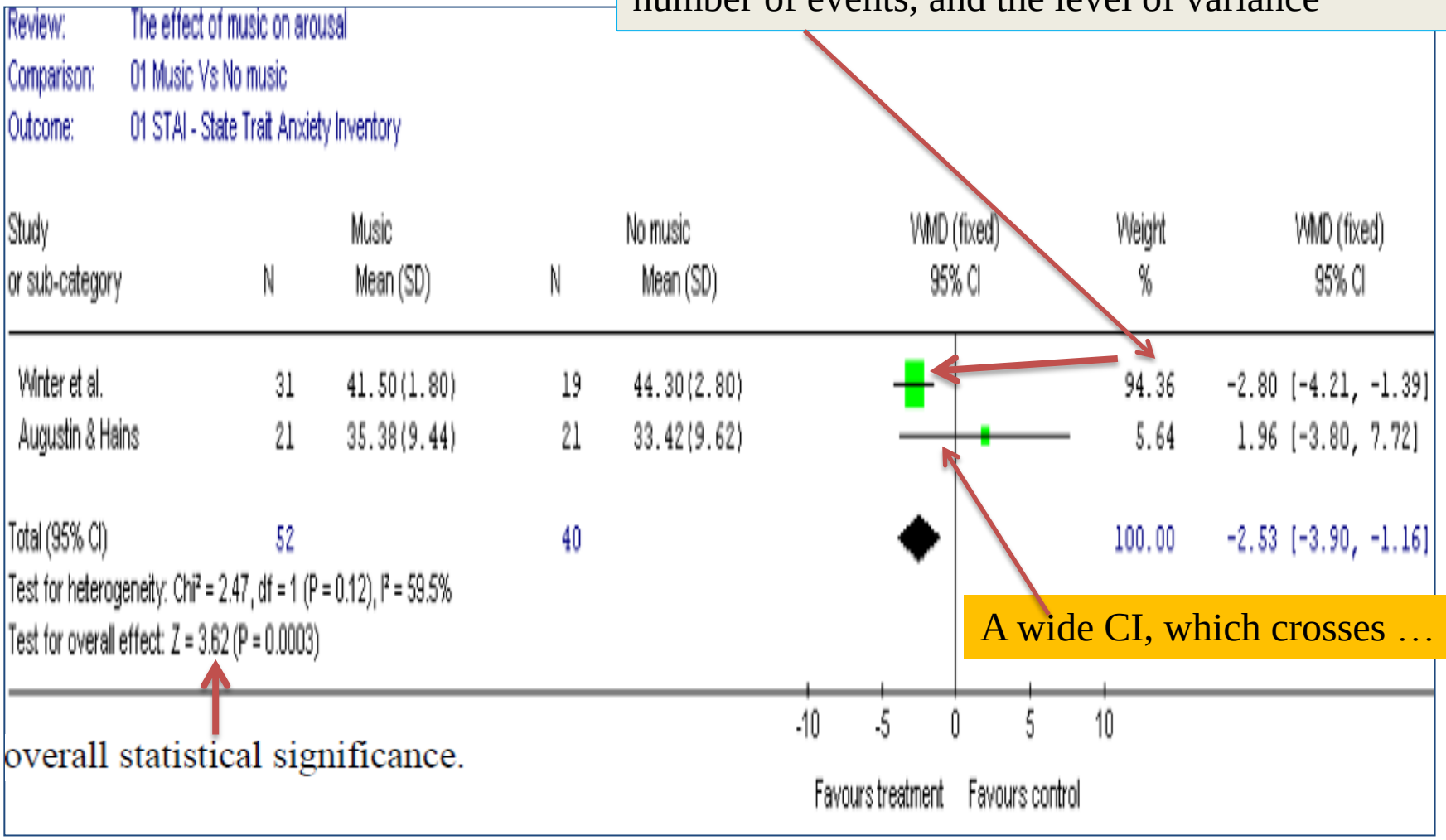
Meta-synthesis

- Qualitative evidence
  - Questions of **Meaningfulness,** Feasibility and/or Appropriateness
- Qualitative analysis of a number of independent qualitative research studies and text
- Use of qualitative methods of combining the findings of individual studies
- Only forms a part of the systematic review in which it appears

Quantitative RESULTS

- Single studies rarely, if ever, provide definitive conclusions regarding the effectiveness of an intervention
    - Narrative systematic review
    - Meta-analysis

Each study being allocated a weighted percentage. This can depend on the number of participants, the number of events, and the level of variance



A wide CI, which crosses …

overall statistical significance.

Heterogeneity

Three types of heterogeneity:

- Clinical heterogeneity
  - differences between studies in the characteristics of their populations, interventions and outcomes
- Methodological heterogeneity
  - differences between studies in their study designs and quality
- Statistical heterogeneity
  - variation of effects between studies

I^2 Index

Suggestion:

- consider as low I^2 values of 25%,
- moderate I^2 values of 50%, and
- high heterogeneity I^2 values of 75% (Higgins et al 2003)

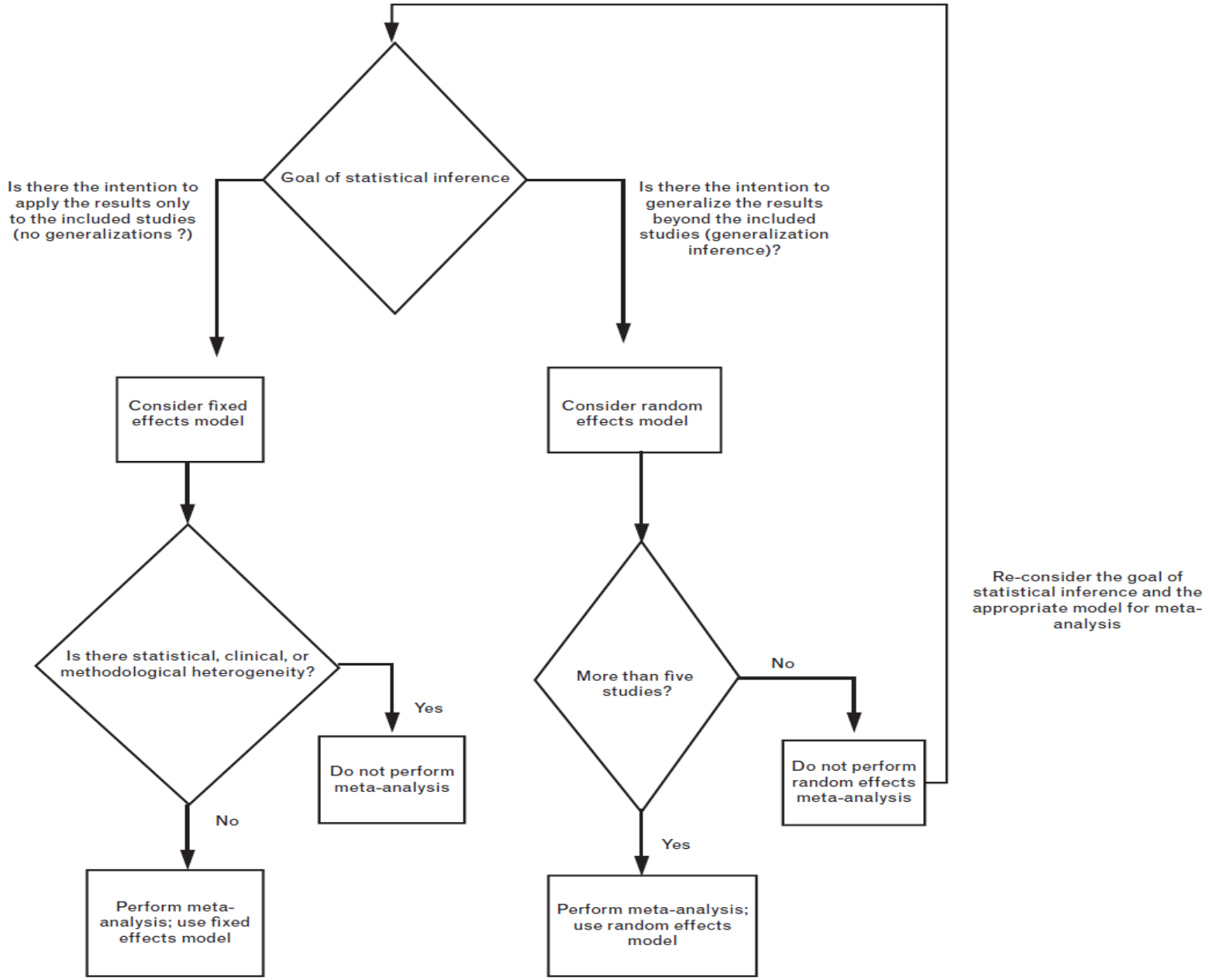
$$I^2 = \left(\frac{Q - df}{Q} \right) \times 100\%$$

I^2 Index

- With a small number of studies (< 20) and/or average sample size (N <80) the statistical power for I^2 procedure is less than the recommended value of 80% (Huedo-Medina et al 2006).
- With a small number of studies (< 20), the interval around I^2 should be interpreted very cautiously (Huedo-Medina et al 2006).

New Guidance Effectiveness Reviews: MA Statistical Models

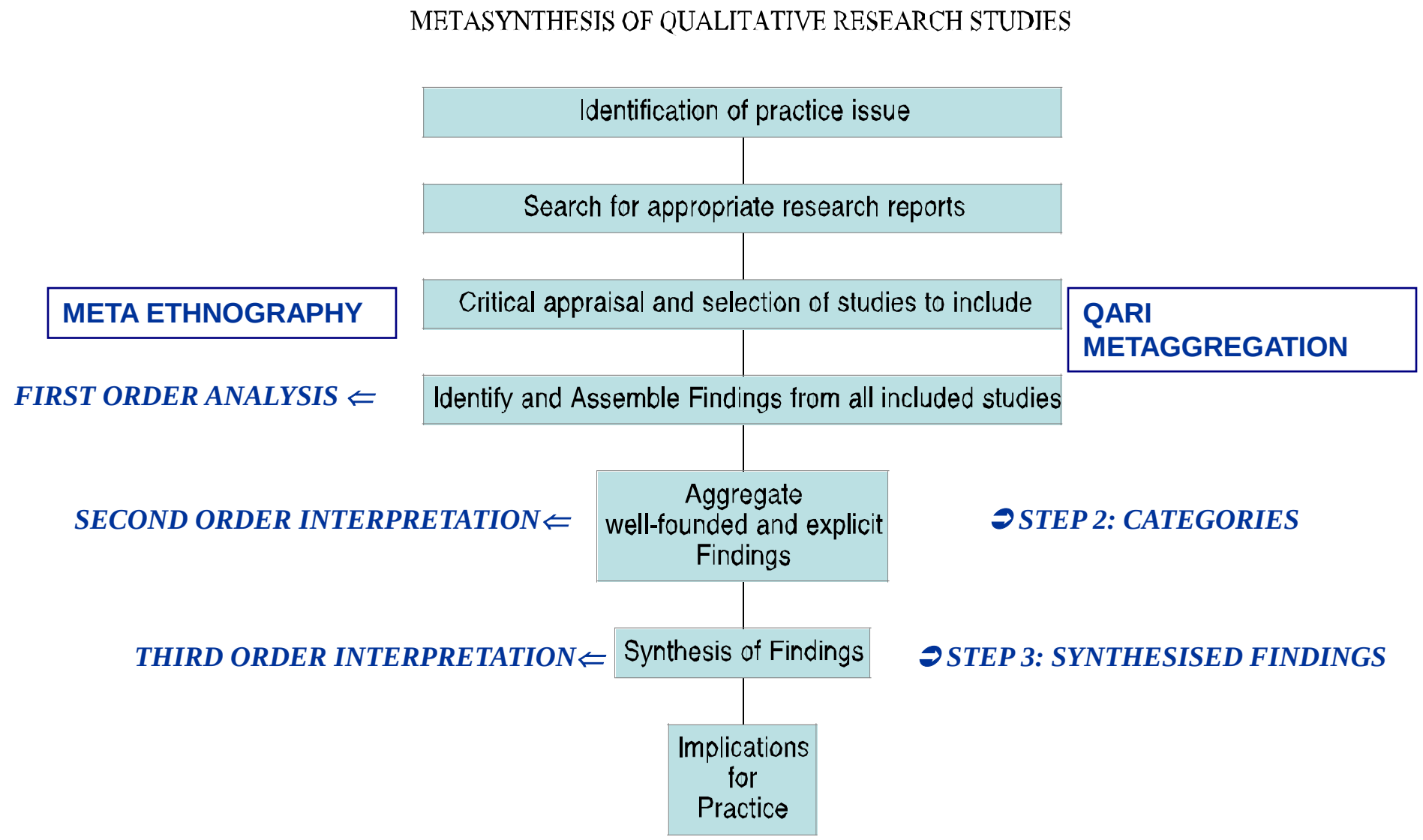
(Tufanaru et al 2015, International Journal of Evidence-Based Healthcare)

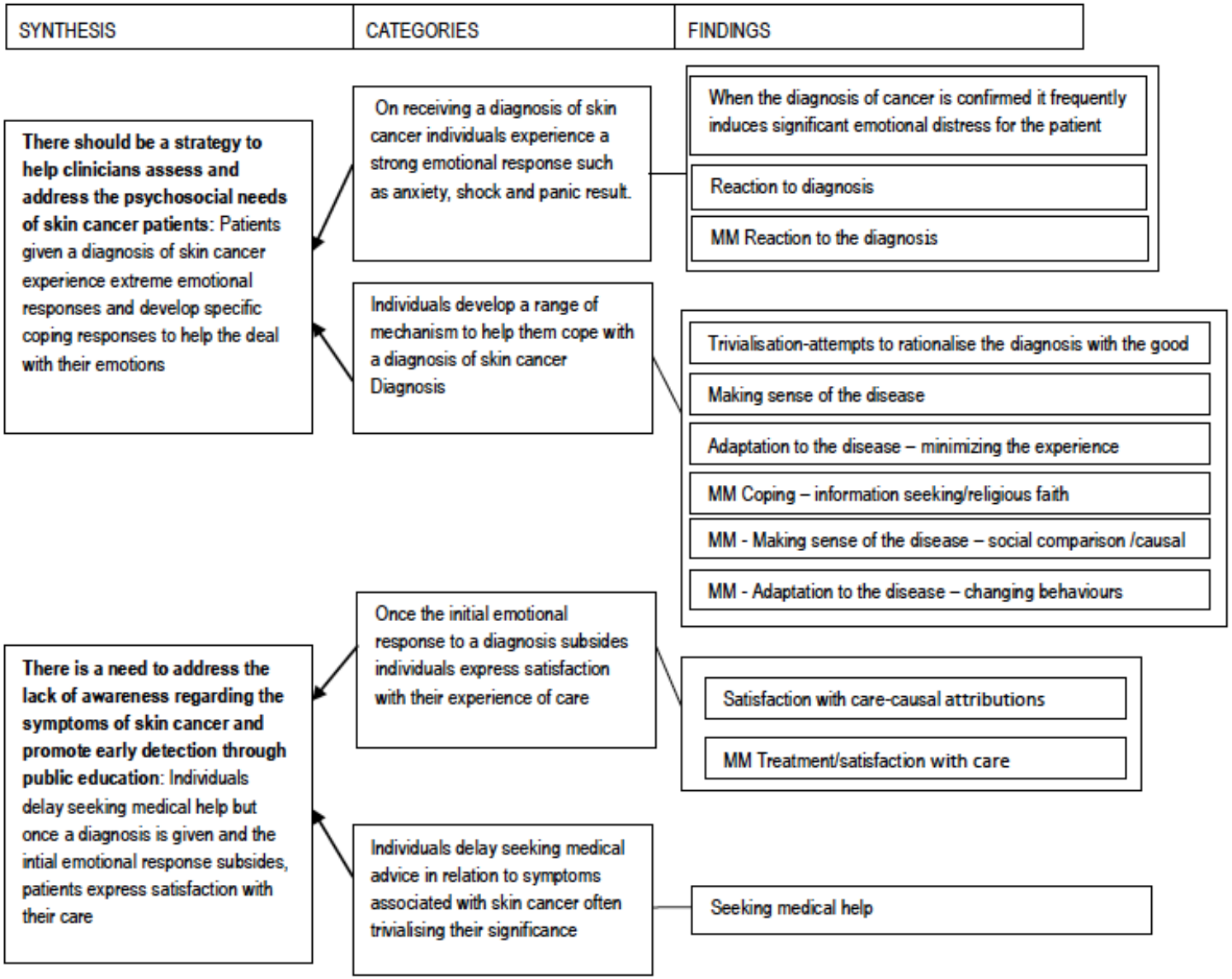


Qualitative RESULTS

Meta-synthesis –

- Assemble conclusions;
- Categorise these conclusions into groups on the basis of similarity in meaning;
- Aggregate these to generate a set of statements
- These statements are referred to as synthesized findings –
- Can be used as a basis for evidence based practice

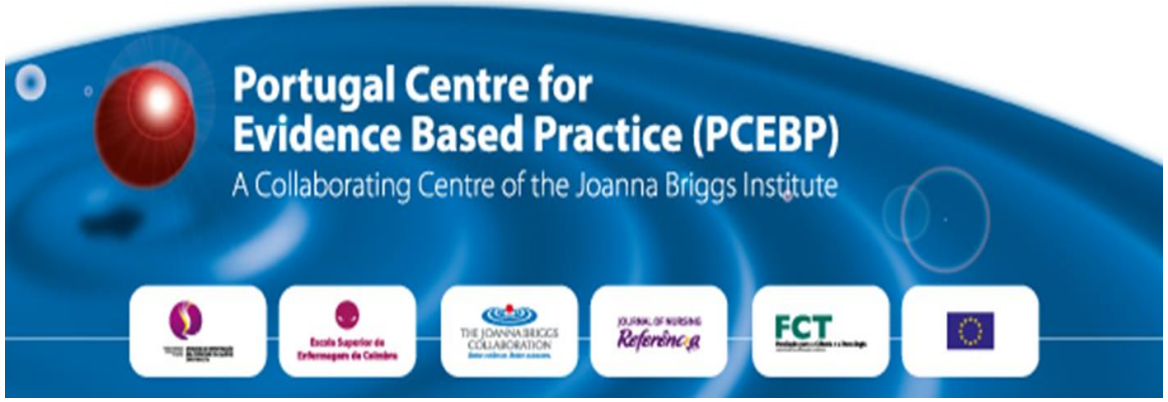

METASYNTHESIS OF QUALITATIVE RESEARCH STUDIES
Identification of practice issue
Search for appropriate research reports
Critical appraisal and selection of studies to include
Identify and Assemble Findings from all included studies
Aggregate well-founded and explicit Findings
Synthesis of Findings
Implications for Practice
META ETHNOGRAPHY
QARI METAGGREGATION
FIRST ORDER ANALYSIS ⇐
SECOND ORDER INTERPRETATION ⇐
THIRD ORDER INTERPRETATION ⇐
➲ STEP 2: CATEGORIES
➲ STEP 3: SYNTHESISED FINDINGS


SYNTHESIS
CATEGORIES
FINDINGS
There should be a strategy to help clinicians assess and address the psychosocial needs of skin cancer patients: Patients given a diagnosis of skin cancer experience extreme emotional responses and develop specific coping responses to help the deal with their emotions
On receiving a diagnosis of skin cancer individuals experience a strong emotional response such as anxiety, shock and panic result.
When the diagnosis of cancer is confirmed it frequently induces significant emotional distress for the patient
Reaction to diagnosis
MM Reaction to the diagnosis
Individuals develop a range of mechanism to help them cope with a diagnosis of skin cancer Diagnosis
Trivialisation-attempts to rationalise the diagnosis with the good
Making sense of the disease
Adaptation to the disease – minimizing the experience
MM Coping – information seeking/religious faith
MM - Making sense of the disease – social comparison /causal
MM - Adaptation to the disease – changing behaviours
There is a need to address the lack of awareness regarding the symptoms of skin cancer and promote early detection through public education: Individuals delay seeking medical help but once a diagnosis is given and the intial emotional response subsides, patients express satisfaction with their care
Once the initial emotional response to a diagnosis subsides individuals express satisfaction with their experience of care
Satisfaction with care-causal attributions
MM Treatment/satisfaction with care
Individuals delay seeking medical advice in relation to symptoms associated with skin cancer often trivialising their significance
Seeking medical help

3) How SR can be used to develop competencies of the staff

- how we use it in my institution
- experience that competencies have developed

4) PCEBP personal experience on developing SR



- Seminars

- SRTP Programs

- Published SRL and ongoing protocols
(Effect; Scoping; Comprehensive/Mixed Methods; Umbrella)

SRTP Programs

- Seminars:
- professors/hospital staff
– improving teaching/quality of care; PhD program

Examples of titles

- Effectiveness of haloperidol prophylaxis in critically ill patients with a high risk for delirium: a systematic review of quantitative evidence.
- Effectiveness of the use of bedrails in preventing falls among hospitalized older adults: systematic review protocol
- Effectiveness of heparin versus 0.9% saline flushing to maintain patency of central venous catheters in adults: a systematic review protocol of quantitative evidence.
- The use of non-pharmacological nursing interventions on the comfort of cancer patients: A comprehensive systematic review
- The use of non-pharmacological nursing interventions on the comfort of cancer patients: A comprehensive systematic review

Tusind tak

Questions?????

Economic Evidence

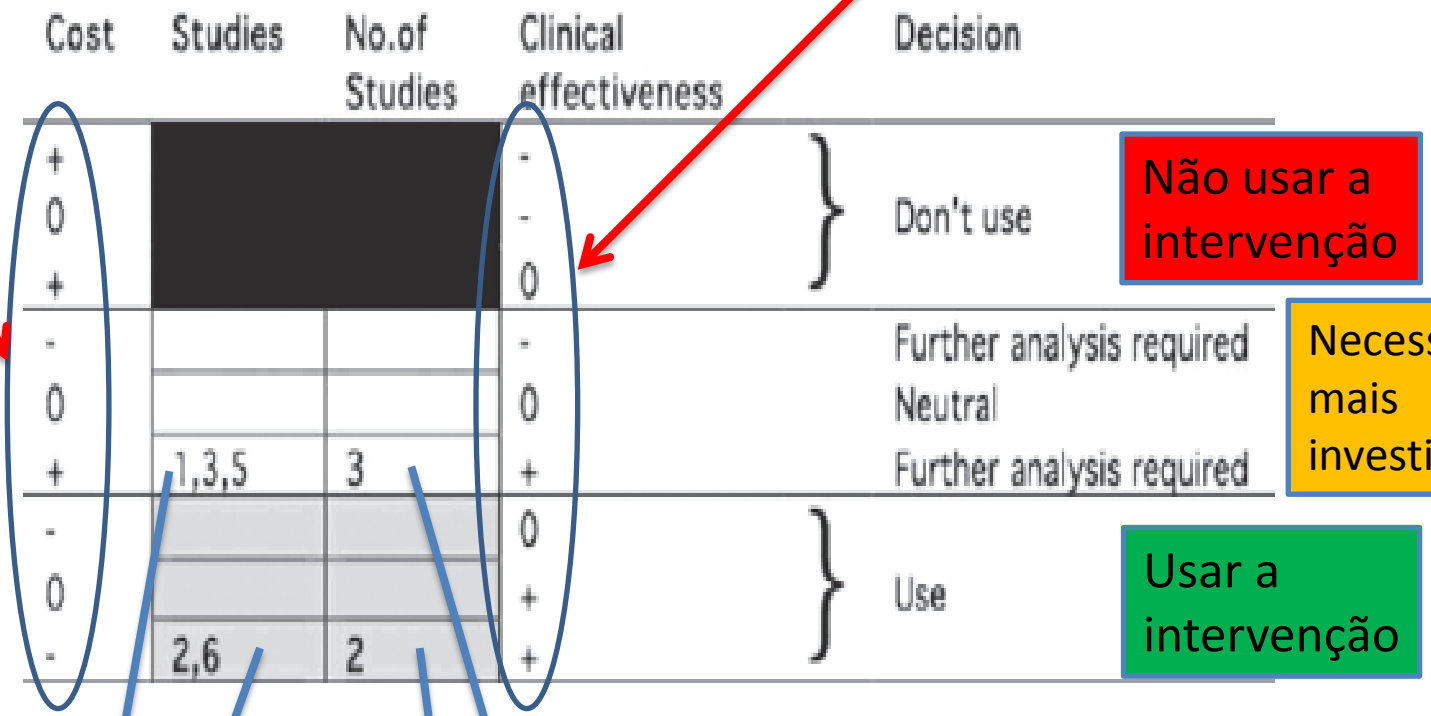
Methods, measures, benefits

Types of studies	Costs or measures	Benefits or Consequence measures	Comments
Cost Minimization Analysis (CMA)	Costs measured in monetary units (e.g.. Dollars)	Not measured	CMA is not a form of full economic analysis, the assumption is that benefits or consequences are the same, therefore the preferred option is the cheapest
Cost Effectiveness Analysis (CEA)	Costs measured in monetary units (e.g.. Dollars)	Benefits measured in natural units (e.g.. mmHg, cholesterol levels, symptom free days, years of life saved)	Results are expressed as dollars per case or per injury averted. Different incremental summary economic measures are reported (e.g.. Incremental cost-effectiveness ratio)
Cost Utility Analysis (CUA)	Costs measured in monetary units (e.g.. Dollars)	Benefits expressed in summary measures as combined quantity and quality measures (e.g.. QALY, DALY etc)	Two dimensions of effects measured (quality and length of life); results are expressed for example as cost per QALY
Cost Benefit Analysis (CBA)	Costs measured in monetary units (e.g.. Dollars)	Benefits measured in monetary units (e.g.. Dollars)	Benefits are difficult to measure monetarily, values used are Net Present Value (NPV) and Benefit Cost Ratio (BCR)

Resultados de estudos económicos

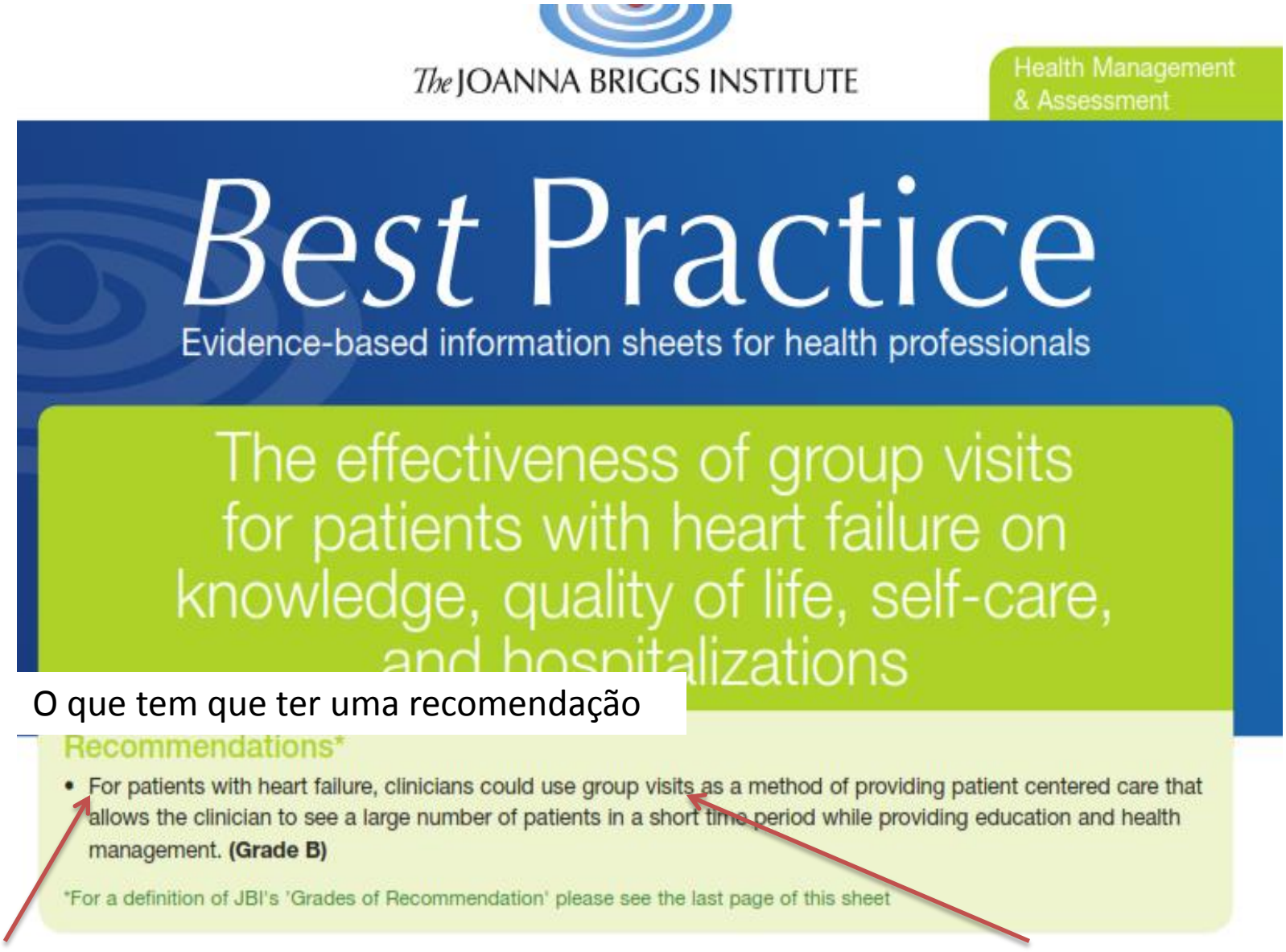
Relativo ao custo

Relativo à eficácia clínica



Identificação dos estudos

Número de estudos



O que tem que ter uma recomendação

A população (idade, sexo, condição clínica…)

Intervenção

International rule!

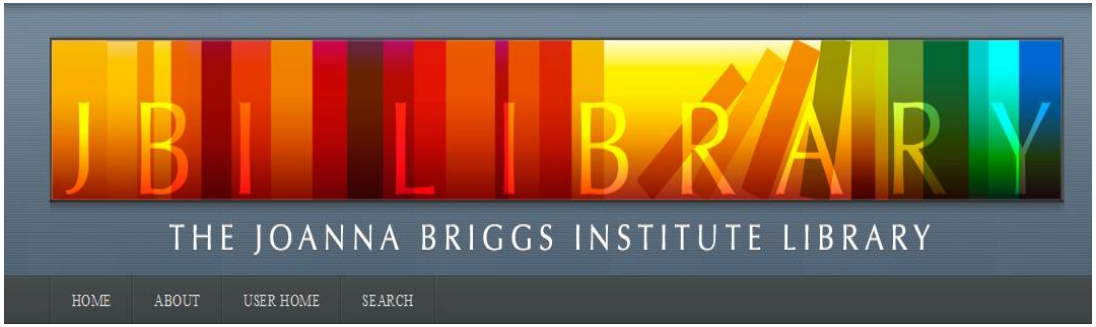
Acta joined the ICMJE and EQUATOR network initiatives to improve presentation of study results, not only to an increase in potential publication but also for international dissemination of articles. Therefore, the following international guides must be used:

*Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups (published in the Int. Journal for Quality in Health Care, 2007).

Studies or trials	Statements
Randomized clinical trial	CONSORT
Systematic reviews and meta-analyzes	PRISMA
Observational studies in epidemiology	STROBE
Qualitative studies	COREQ*

Revisão Sistemática segundo a abordagem JBI

- Registar título
- Protocolo e sua submissão
- Realização da revisão com recurso ao JBI-SUMARI
- Submissão do relatório final da revisão.
- PDF



JBI Critical Appraisal Checklist for Systematic Reviews and Research Syntheses

Reviewer _____ Date _____
Author _____ Year _____ Record Number

		Yes	No	Unclear	Not applicable
1.	Is the review question clearly and explicitly stated?	☐	☐	☐	☐
2.	Were the inclusion criteria appropriate for the review question?	☐	☐	☐	☐
3.	Was the search strategy appropriate?	☐	☐	☐	☐
4.	Were the sources and resources used to search for studies adequate?	☐	☐	☐	☐
5.	Were the criteria for appraising studies appropriate?	☐	☐	☐	☐
6.	Was critical appraisal conducted by two or more reviewers independently?	☐	☐	☐	☐
7.	Were there methods to minimize errors in data extraction?	☐	☐	☐	☐
8.	Were the methods used to combine studies appropriate?	☐	☐	☐	☐
9.	Was the likelihood of publication bias assessed?	☐	☐	☐	☐
10.	Were recommendations for policy and/or practice supported by the reported data?	☐	☐	☐	☐
11.	Were the specific directives for new research appropriate?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

_____

_____

Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement

Table 1. **Checklist of Items to Include When Reporting a Systematic Review or Meta-Analysis**

Section/Topic	Item #	Checklist Item	Reported on Page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome-level assessment (see Item 12).	
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group and (b) effect estimates and confidence intervals, ideally with a forest plot.	
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., health care providers, users, and policy makers).	
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review level (e.g., incomplete retrieval of identified research, reporting bias).	
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	

Table 2. **Substantive Specific Changes Between the QUOROM Checklist and the PRISMA Checklist***

Section/Topic	Item	QUOROM	PRISMA	Comment
Abstract		√	√	QUOROM and PRISMA ask authors to report an abstract. However, PRISMA is not specific about format.
Introduction	Objective		√	This new item (4) addresses the explicit question the review addresses using the PICO reporting system (which describes the participants, interventions, comparisons, and outcome[s] of the systematic review), together with the specification of the type of study design (PICOS); the item is linked to Items 6, 11, and 18 of the checklist.
Methods	Protocol		√	This new item (5) asks authors to report whether the review has a protocol and if so how it can be accessed.
Methods	Search	√	√	Although reporting the search is present in both QUOROM and PRISMA checklists, PRISMA asks authors to provide a full description of at least one electronic search strategy (Item 8). Without such information it is impossible to repeat the authors' search.
Methods	Assessment of risk of bias in included studies	√	√	Renamed from "quality assessment" in QUOROM. This item (12) is linked with reporting this information in the results (Item 19). The new concept of "outcome-level" assessment has been introduced.
Methods	Assessment of risk of bias across studies		√	This new item (15) asks authors to describe any assessments of risk of bias in the review, such as selective reporting within the included studies. This item is linked with reporting this information in the results (Item 22).
Discussion		√	√	Although both QUOROM and PRISMA checklists address the discussion section, PRISMA devotes three items (24–26) to the discussion. In PRISMA the main types of limitations are explicitly stated and their discussion required.
Funding			√	This new item (27) asks authors to provide information on any sources of funding for the systematic review.

* A tick indicates the presence of the topic in QUOROM or PRISMA.

Verificar se há revisões que tenham sintetizado a evidência

- Any entity considering doing a JBI review should first check there are no existing systematic reviews on the topic (e.g. check JBI, Cochrane, Medline and CRD as a minimum);

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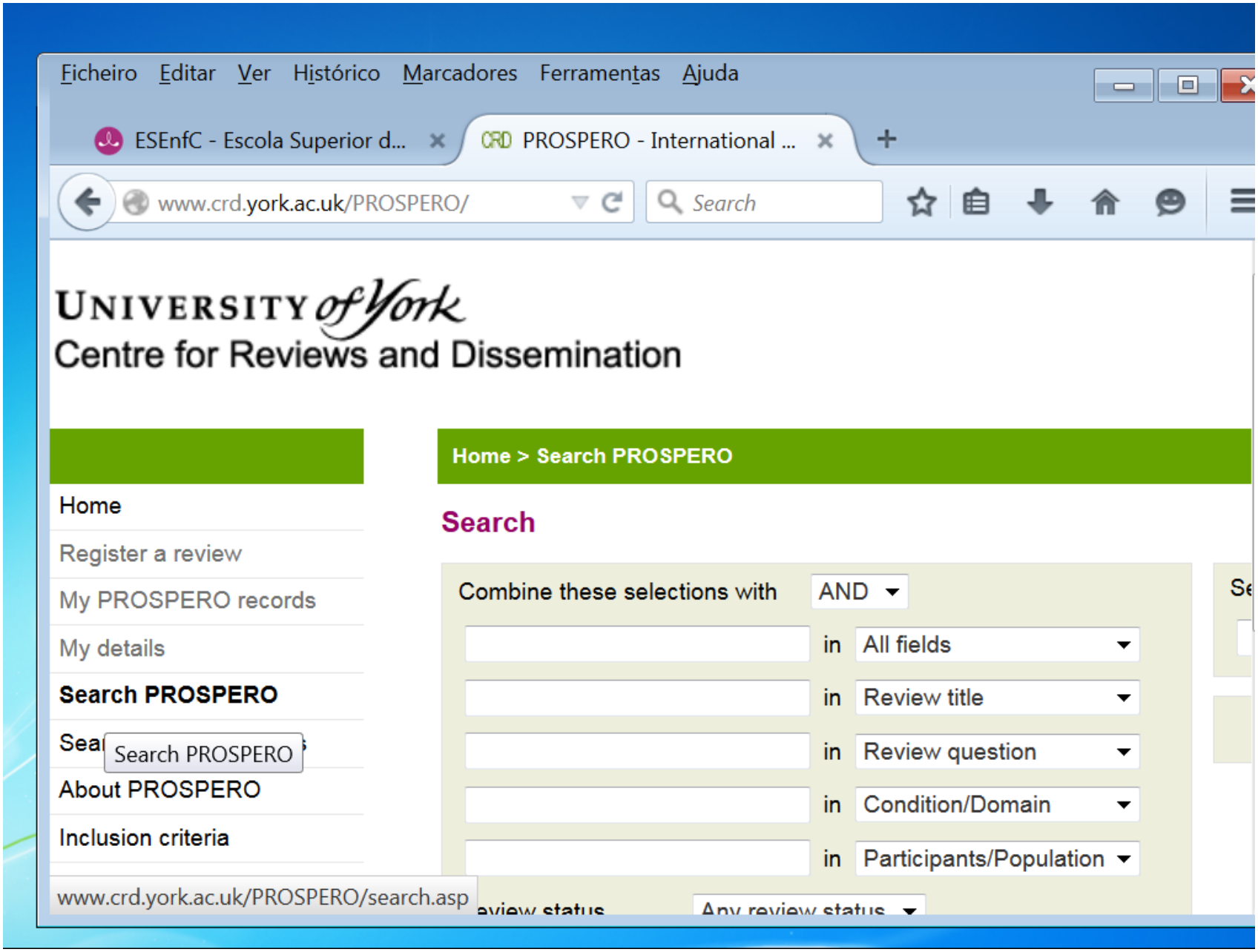
- check that there are no existing protocols on the topic (e.g. check JBI, Cochrane and PROSPERO as a minimum);
- and check the Title Registration Page to ensure the title has not been registered by another entity in the preceding 6 months.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Home
Register a review
My PROSPERO records
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About PROSPERO
Inclusion criteria
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Search
Combine these selections with AND
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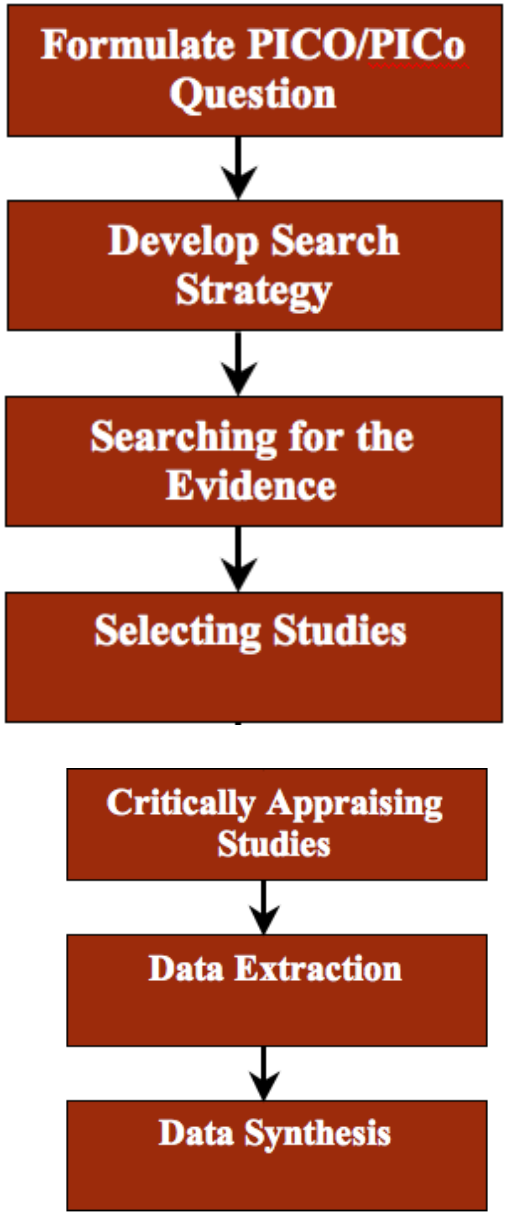
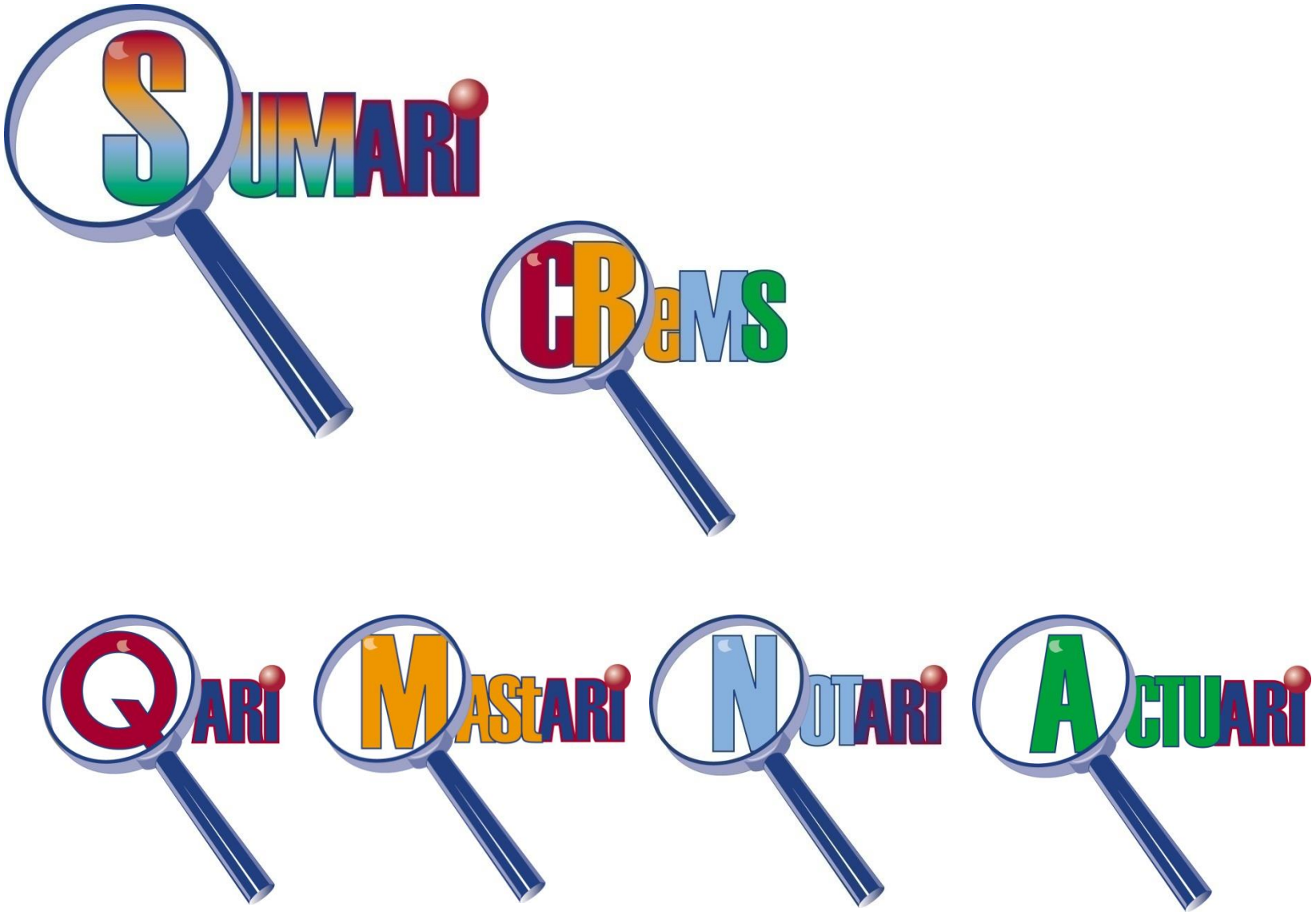
in Review title
in Review question
in Condition/Domain
in Participants/Population

The JBI SRL


Formulate PICO/PICo Question
Develop Search Strategy
Searching for the Evidence
Selecting Studies
Critically Appraising Studies
Data Extraction
Data Synthesis


SUMARI
CReMS
QARI
MAStARI
NOTARI
ACTUARI

The JBI Software

System for the
Unified
Management,
Assessment and
Review of
Information

JBI CReMS - JBI Comprehensive Review Management System

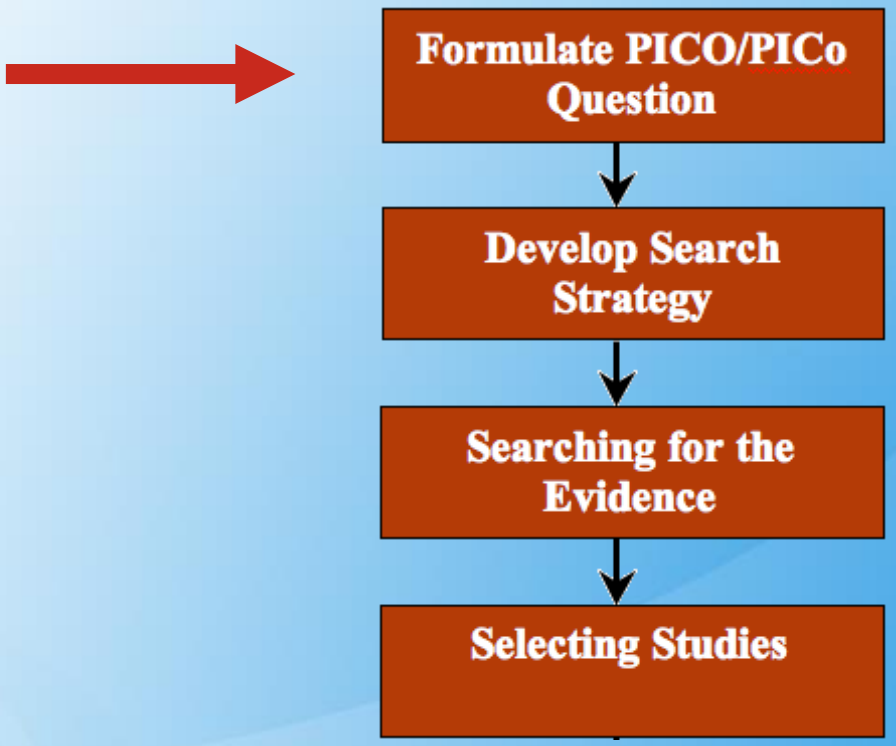
JBI QARI - JBI Qualitative Assessment and Review Instrument

JBI NOTARI - JBI Narrative, Opinion and Text Assessment and Review Instrument

JBI MAStARI - JBI Meta Analysis of Statistics Assessment and Review Instrument

JBI ACTUARI - JBI Analysis of Cost, Technology and Utilisation Assessment and Review Instrument.

Developing a Review question and inclusion criteria



Question Development

- Aim is to inform readers of the nature and detail of the review, and to provide guidance to the development of review criteria
- A good question supports the review, a poor question risks confounding the review
- A good question responds to identified priorities and needs

Question Development

- Reviews of effects & economics:
  - **P**opulation
  - **I**ntervention
  - **C**omparator
  - **O**utcome
- Reviews of qualitative & Textual data:
  - **P**opulation
  - Phenomena of **I**nterest
  - **Co**ntext

Scoping: PCC (Population, Concept, Context)

Questions of the effects of interventions

- Population:
  - The most important characteristics, including:
    - demographic factors of the population (e.g. age, gender, ethnicity)
    - socioeconomic factors
    - the setting (e.g. hospital, community etc)

Questions of the effects of interventions

- Intervention and Comparator
  - Primary intervention of interest (treatment group)
  - Comparator (control group)
    - Passive (placebo, no treatment, standard care, or a waiting list control)
    - Active (variation of the intervention, a drug, or kind of therapy)

Questions of the effects of interventions

- **Outcomes**
  - Identify the primary outcome/s in order to reach a clinically relevant conclusion
  - Secondary outcomes may be required
- Outcomes: (e.g. mortality; strokes or myocardial infarction; symptoms; quality of life; demands on caregivers; restrictions on lifestyle; cost and resource use…)
-
- Consider how outcomes may be measured: (e.g. blood pressure, number of strokes; disability scales…).

Example: Question of the effects

- Are antiseptic washes more effective than non-antiseptic washes at preventing nosocomial infections in patients undergoing surgery?

Example: Question of the effects

Active

Intervention

Comparison

- Are antiseptic washes more effective than non-antiseptic washes at preventing nosocomial infections in patients undergoing surgery?

Outcome

Population

Example Qualitative

- What are caregivers experiences of providing home-based care to persons with HIV/AIDS in Africa?

Example Qualitative

Population

Phenomena of interest

- What are caregivers experiences of providing home-based care to persons with HIV/AIDS in Africa?

Context

Example Scoping

- What non-pharmacological interventions have been implemented and evaluated to provide comfort in patients with incurable and advanced disease in paliative care?

PCC (Population, Concept, Context)

Example Scoping

Population

-Patients with 18 years of age or older, assisted by palliative care teams.

Concept

-Non-pharmacological interventions implemented and evaluated in palliative care, to provide comfort.

Context

-Palliative Care. This will include, exclusively, home care, hospices or palliative care units.

Make some stronger statements explaining the rationale for the scoping review in more concrete terms. This is one of the hardest things about scoping reviews
Scoping reviews don't have immediately obvious value unless it's clearly stated.
This is where topic expertise comes.
- State what the scoping review will achieve by mapping the evidence in a certain way
What are the 'big questions' in field of non-pharmacological interventions for the care of patients in palliative care?
It appears that this review is intended as a basis for a future potential systematic review, so what evidence needs to be examined and mapped to provide directions for this review?
What is it about the state of the evidence that means that a review of effectiveness or experience cannot/should not be undertaken yet? Is the evidence disparate?
(e.g. includes a diverse and heterogeneous mix of interventions/populations/approaches/terminology etc) so moving straight to a systematic review would be hard.
Or are there important questions about the nature of the evidence that need to be answered before a precise question of effectiveness can be pitched?

– it's easy to say why a systematic review of effectiveness is useful and necessary – they tell us what the most effective intervention is.
Having this objective stated up front in the protocol will help your team immensely when it comes to selecting studies, extracting data, and mapping the evidence and explaining what it means

PICO / PICo / PCC

- Constructing a well-built clinical question is a fundamental skill
- Divide your question following the PICO/PICo/PCC model
- The question operationalizes the review by forming the basis for inclusion and exclusion criteria

Aim

JBI Database of Systematic Reviews & Implementation Reports 2014;**12**(10) 121 - 151

The effectiveness of cleansing solutions for wound treatment: a systematic review

Paulo Queirós, RN, PhD[1]
Eduardo Santos, RN[1]
João Apóstolo, RN, PhD[1]
Daniela Cardoso, RN[1]
Madalena Cunha, RN, PhD[2]
Manuel Rodrigues, RN, PhD, Aggregation[1]

EX: The objective of this review is to identify and synthesize the best available evidence on the effectiveness of cleansing solutions for wound treatment in clinical practice.

Review Questions

EX: More specifically, the review focuses on the following questions:

- Does the effectiveness of different cleansing solutions influence infection and wound healing rates?
- Which cleansing solution is more effective for reducing wound infection rates?
- Which cleansing solution is more effective for increasing wound healing rates?
- Is the effectiveness of cleansing solutions affected by wound aetiology?

Group Work 1

- Write a PICO question
- Reporting back

Protocol (RS)

- Background
- Objectivos
- Questão de Revisão
- Critérios para considerar estudos para a revisão
  - Tipo de participantes
  - Tipo de intervenções
  - Tipo de medidas de resultados
  - Tipo de estudos
- Estratégia de pesquisa
- Métodos da revisão
  - Avaliação da qualidade metodológica
  - Extracção de dados
  - Síntese dos dados
- Referências

Background (RS)

Questions to consider:

- Does the background cover all the population, phenomenon of interest and the context for the systematic review (PICO)?
- Are operational definitions provided?
- Are the inclusion criteria putted into context?
- Do systematic reviews already exist on the topic?
- Why is this review important?

Background (RS)

- Justify the conduct of the review
- Approximately 1000 words
- The background section should conclude with a statement that:
  - A preliminary search for existing systematic reviews on the topic have been conducted (state the databases searched e.g. JBI Library, Cochrane Library, CINAHL, PubMed, PROSPERO where relevant).
  - If there is an existing systematic review, it should be specified how the proposed review will differ.

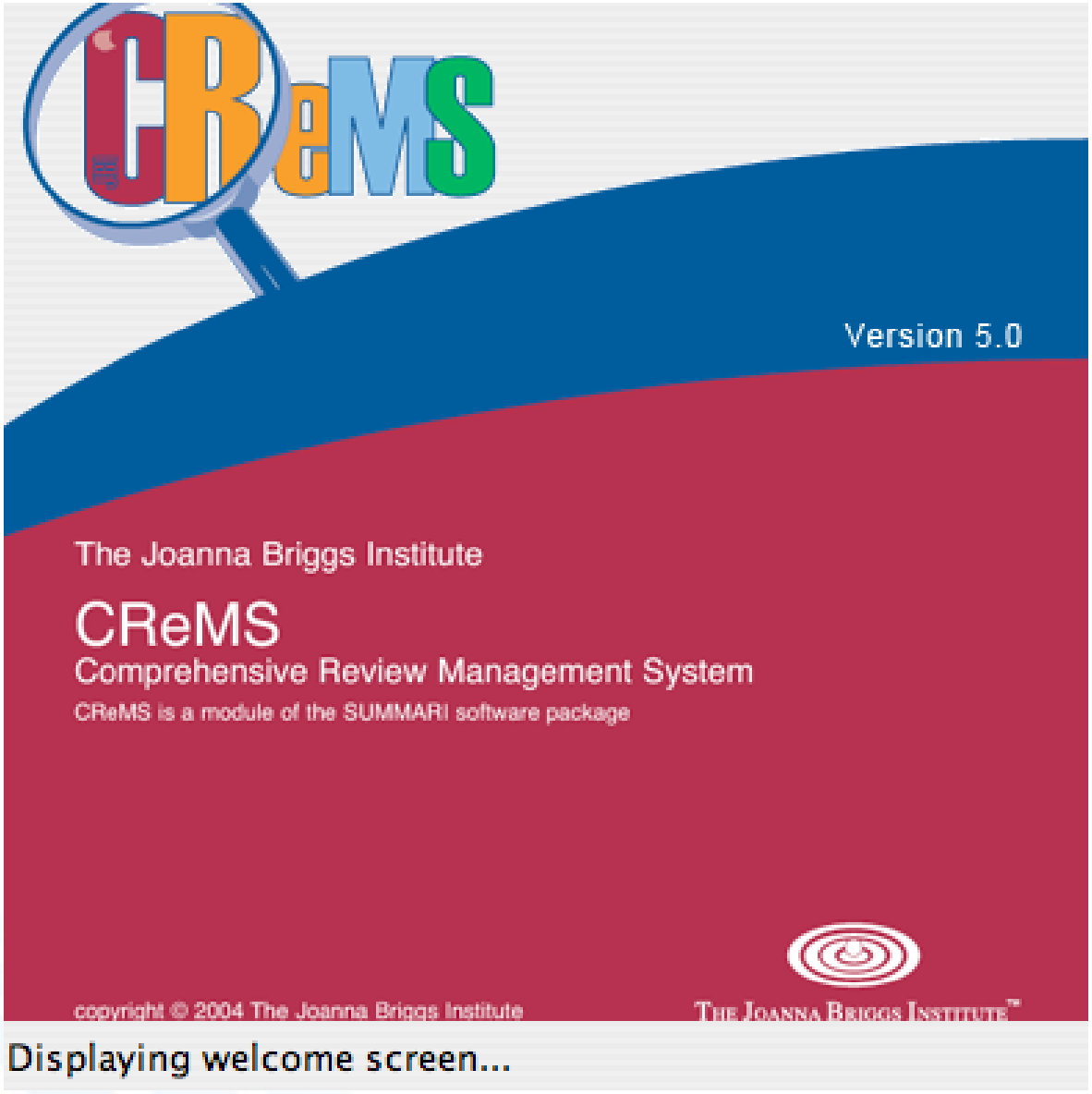
Inclusion/Exclusion criteria

The protocol describes the criteria that will be used to select the literature. It is important to be precise in defining the inclusion criteria, as the reader of the review report needs to know the focus and limitations of the review. Inclusion criteria address:

- The types of studies to be included (for example, randomized controlled trials, pseudo-randomized controlled trials; or interpretive studies);
- The intervention, activity or phenomenon of interest (and, in an effectiveness review, a comparator);
- The outcome(s) of interest;
- The specific study population(s);
- Language of publication (for example, English only; or English, German, Spanish and Japanese, etc);
- The time period (for example, study reports published or made available 2000–2011)

The exclusion criteria should either be explicitly stated or inherently apparent in the inclusion criteria.

Exemple - The effectiveness of cleansing solutions for wound treatment in clinical practice
http://joannabriggslibrary.org/index.php/jbisrir/article/view/527/1227


CReMS
Version 5.0
The Joanna Briggs Institute
CReMS
Comprehensive Review Management System
CReMS is a module of the SUMMARI software package
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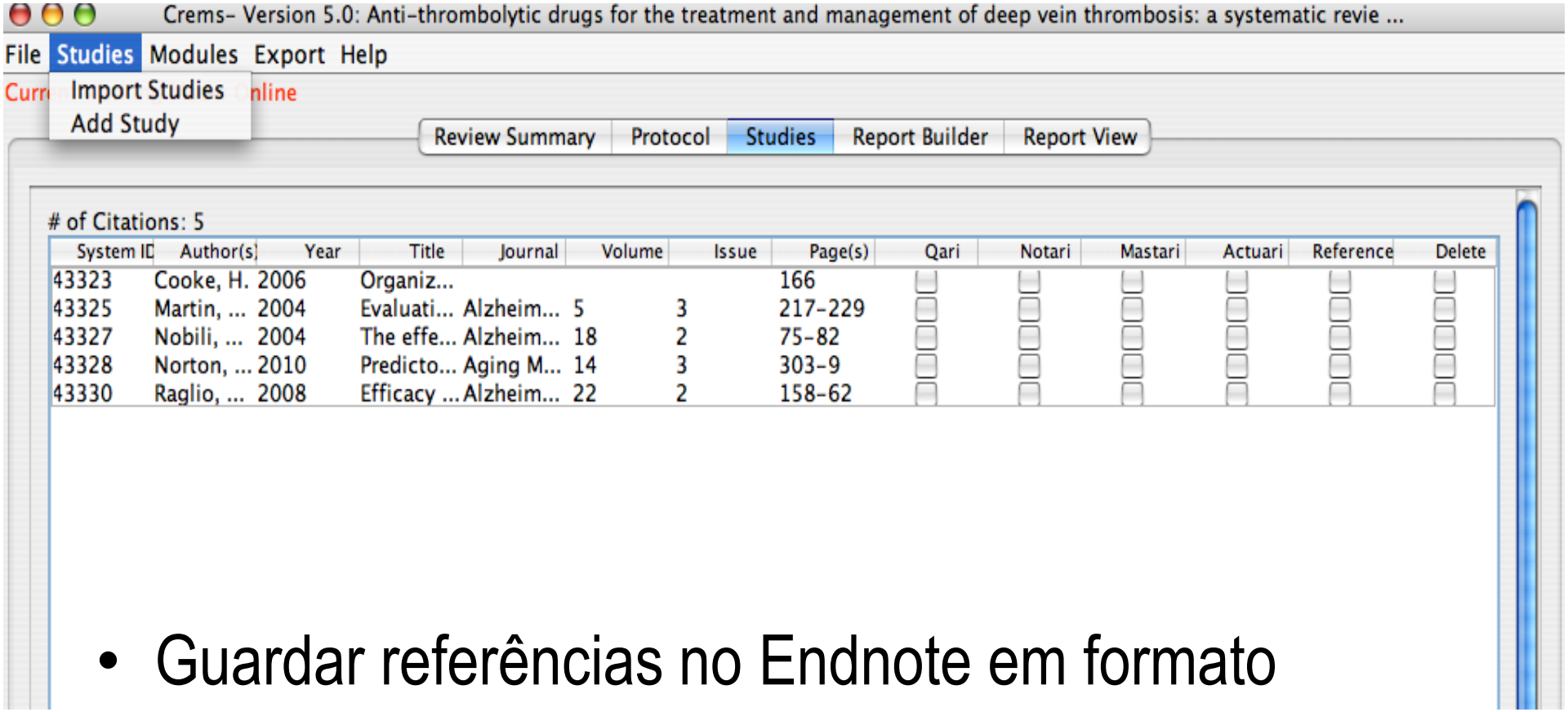
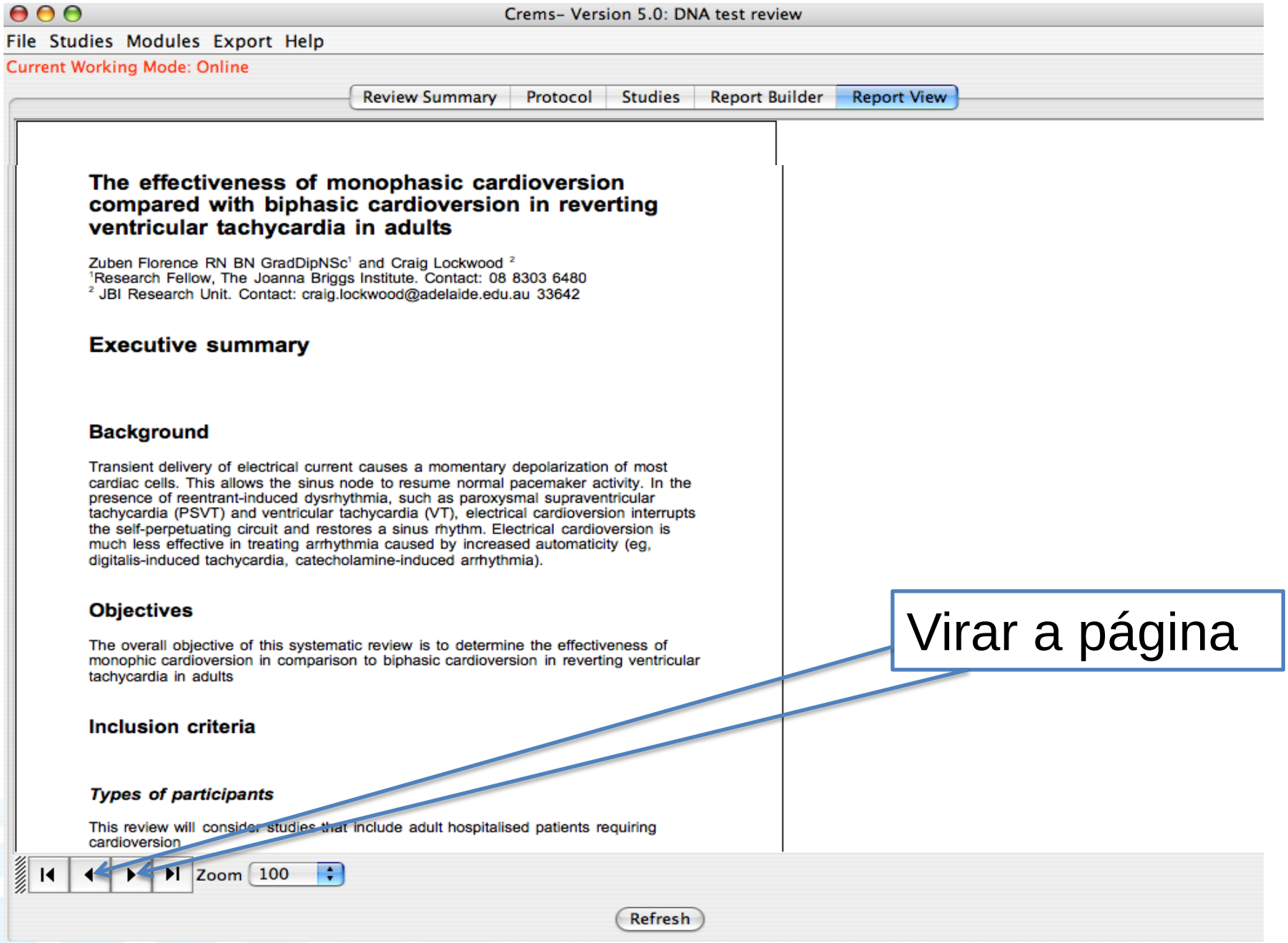
Displaying welcome screen...

CReMS



- Guardar referências no Endnote em formato “author-date” e em xml.
- Importar os estudos (REF.)


Crems– Version 5.0: DNA test review
File Studies Modules Export Help
Current Working Mode: Online
Review Summary
Protocol
Studies
Report Builder
Report View
The effectiveness of monophasic cardioversion compared with biphasic cardioversion in reverting ventricular tachycardia in adults
Zuben Florence RN BN GradDipNSc[1] and Craig Lockwood [2]
[1]Research Fellow, The Joanna Briggs Institute. Contact: 08 8303 6480
[2] JBI Research Unit. Contact: craig.lockwood@adelaide.edu.au 33642
Executive summary
Background
Transient delivery of electrical current causes a momentary depolarization of most cardiac cells. This allows the sinus node to resume normal pacemaker activity. In the presence of reentrant-induced dysrhythmia, such as paroxysmal supraventricular tachycardia (PSVT) and ventricular tachycardia (VT), electrical cardioversion interrupts the self-perpetuating circuit and restores a sinus rhythm. Electrical cardioversion is much less effective in treating arrhythmia caused by increased automaticity (eg, digitalis-induced tachycardia, catecholamine-induced arrhythmia).
Objectives
The overall objective of this systematic review is to determine the effectiveness of monophic cardioversion in comparison to biphasic cardioversion in reverting ventricular tachycardia in adults
Inclusion criteria
Types of participants
This review will consider studies that include adult hospitalised patients requiring cardioversion
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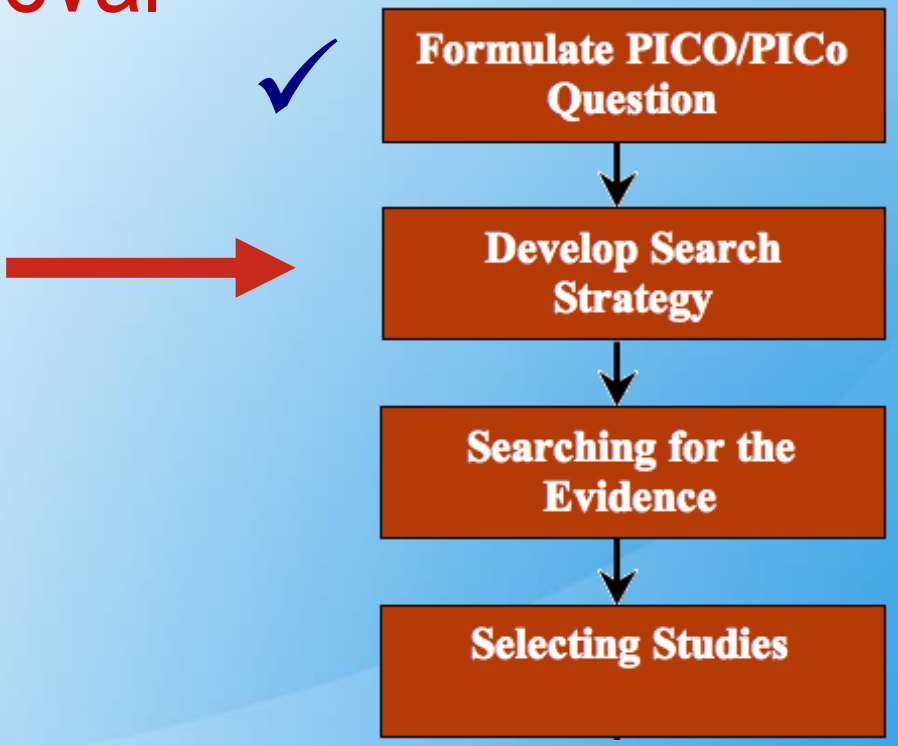
Developing a Search Strategy: A guide to evidence based information retrieval



Developing a search strategy is a real skill

Search Strategy

- Features of search strategy
  - Sensitivity – ability to identify all the relevant studies
  - Specificity – ability to exclude irrelevant studies, also known as precision
- Inverse relationship between sensitivity and specificity – means that a large number of articles retrieved may not be relevant to the review question
  - High sensitivity will tend to have low specificity

Search Strategy Steps

- Initial Search
  - initial search of MEDLINE, CINAHL, followed by analysis of text words in the title and abstract
- Second Search
  - all identified key words and index terms across all databases
- Third Search
  - references of identified studies, unpublished studies, grey literature, government and societal websites, experts etc

Search strategy

JBI Database of Systematic Reviews & Implementation Reports 2014;**12**(10) 121 - 151

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- Studies published in English, Spanish and Portuguese published from January 1990 to January 2013 were considered for inclusion in this review

Included Databases

For published studies	For unpublished studies
• CINAHL Plus with Full Text, MedicLatina, Academic Search Complete, MEDLINE with Full Text, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials, Nursing & Allied Health Collection: Comprehensive (via EBSCO); • LILACS; • Elsevier - Science Direct (via b-on – Online Knowledge Library); • Embase; • Scopus; • JBI Library; • ACP online; • BioMed Central; • Health Technology Assessment database; • Scielo - Scientific Electronic Library Online.	• 'Grey Literature Report' from New York Academy of Medicine; • Mednar; • Scirus.com website; • National Library of Australia's Trove service; • ProQuest – Nursing and Allied Health Source Dissertations; • Banco de teses da CAPES (www.capes.gov.br); • RCAAP – Repositório Científico de Acesso Aberto de Portugal.

MEDLINE

Search Formula	Limiters	Results
(TI wound*) AND (AB infect* OR AB heal* OR AB clean*) AND (AB irrigat* OR AB bath* OR AB shower* OR AB water* OR AB "sodium chloride" OR AB detergent* OR AB povidone-iodine OR AB hydrotherapy OR AB chlorhexidine)	Published Date from: 19900101-20131231; Language: English, Portuguese, Spanish	789

Scopus

Search Formula	Results
(TITLE(wound*) AND TITLE-ABS-KEY(infect* OR heal* OR clean*) AND TITLE-ABS-KEY(irrigat* OR bath* OR shower* OR water* OR "sodium chloride" OR detergent* OR povidone-iodine OR hydrotherapy OR chlorhexidine OR polihexanide)) AND SUBJAREA(mult OR agri OR bioc OR immu OR neur OR phar OR mult OR medi OR nurs OR vete OR dent OR heal) AND PUBYEAR > 1989 AND (LIMIT-TO(LANGUAGE, "English") OR LIMIT-TO(LANGUAGE, "Spanish") OR LIMIT-TO(LANGUAGE, "Portuguese"))	1840

'Grey Literature Report' from New York Academy of Medicine

Search Formula	Limiters	Results
Words in the Full text wound* AND (infect* OR heal* OR clean*)	Published Date from: 1990-2013	0

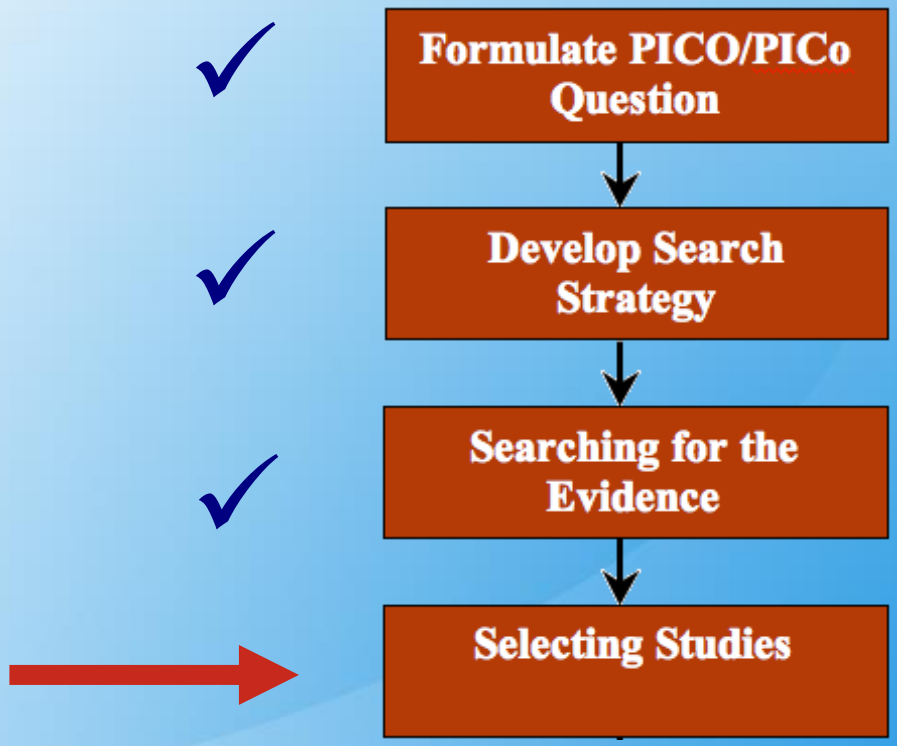
ACP Hospitalist

Search Formula	Results
with all of the words » "wound cleansing"	18

ACP Internist

Search Formula	Results
with all of the words » "wound cleansing"	10

Selecting Studies



Selection Process

- Aims to select only those studies that address the review question and that match the inclusion criteria documented in your protocol
- Scan titles and abstracts
- If uncertain? - Retrieve - scan full text
- The selection should be:
  - Transparent
  - Reproducible

Example

- Is the article published in the stated years?
- Does the population studied meet the criteria?
  - E.g. adults or children or both?
- Does the study look at the interventions or phenomena stated in the research question
  - E.g. oral or I.V. administration
- Is it the correct study design?
  - E.g. RCT or meta-analysis

Inclusion Criteria

Participants	Patients aged 18 years or more in any setting, excluding malnourished patients, and with chronic and acute wounds, excluding obstetric wounds
Interven-tion	Any cleansing or antiseptic solution or chemicals
Outcome	Primary outcome: infection rate Secondary outcome: healing rate
Types of studies	Any experimental study design, including randomized controlled trials, non-randomized controlled trials, or other quasi-experimental studies, including before and after studies.

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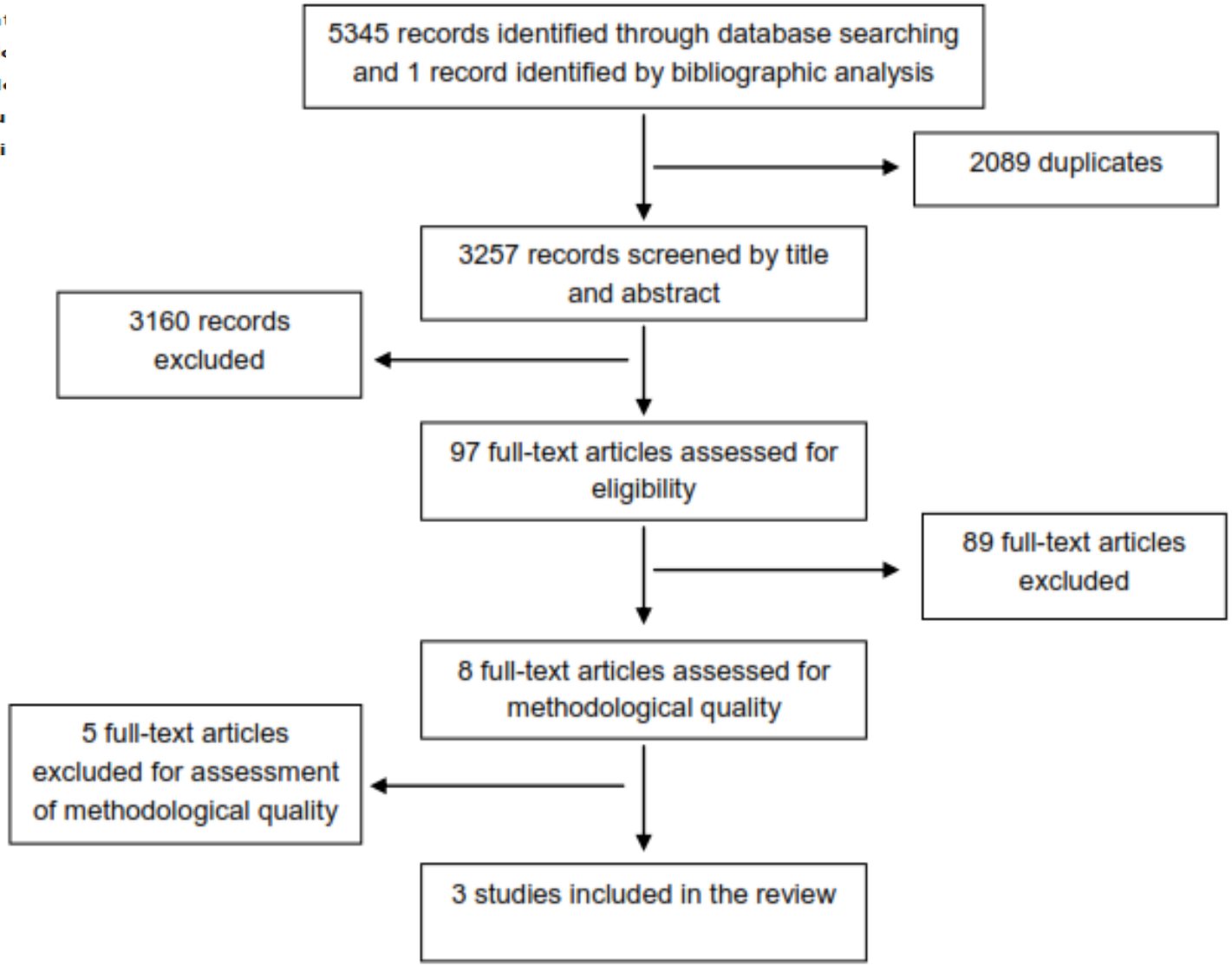
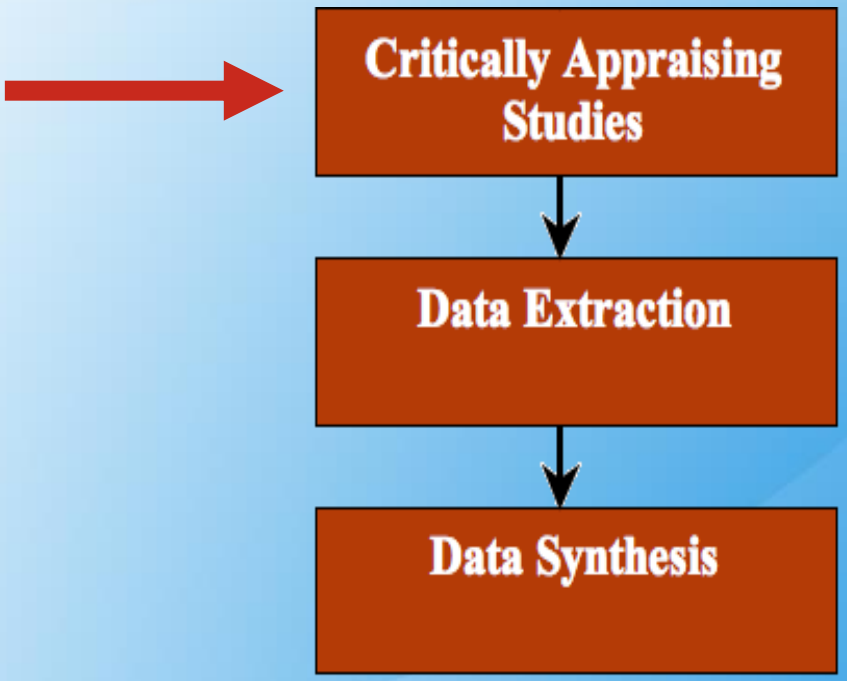
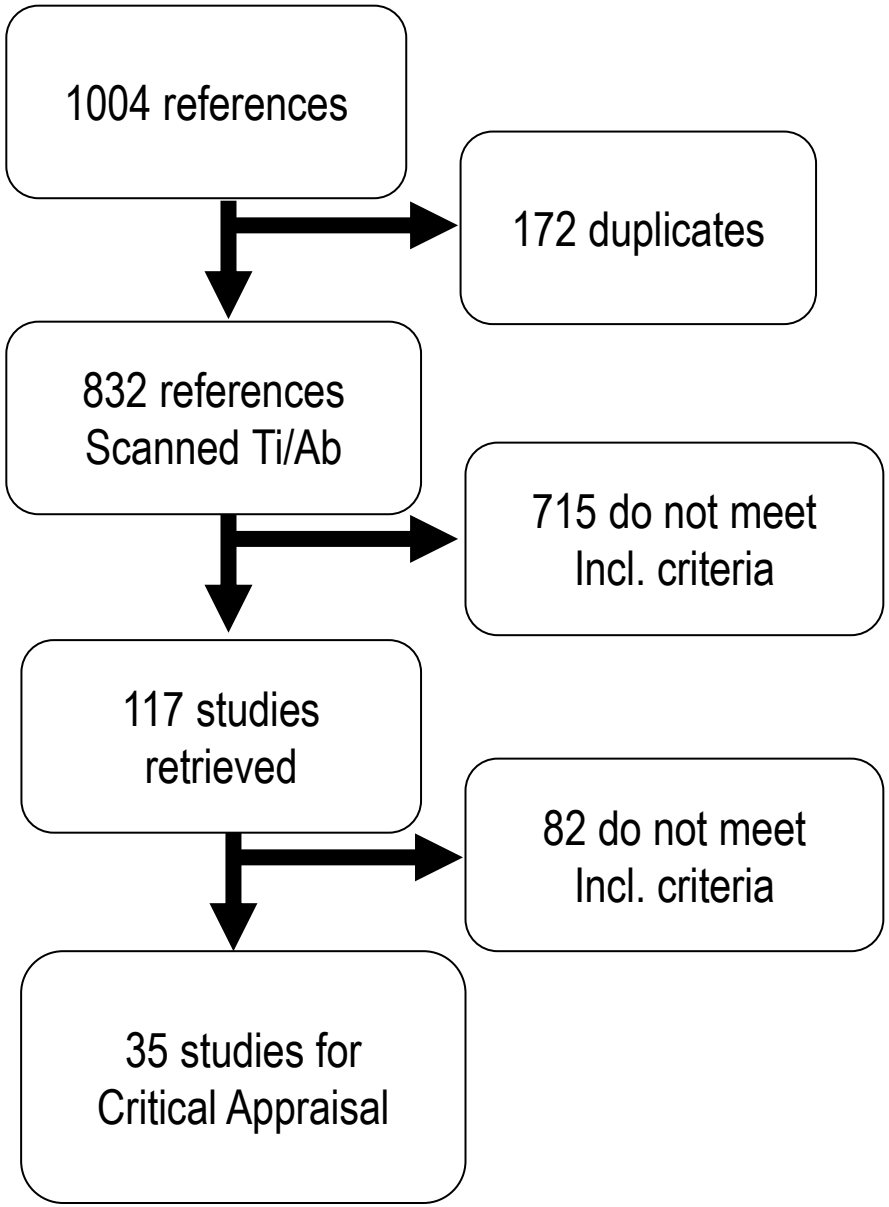


Figure 1: Flowchart for the search and study selection process

The Critical Appraisal of Studies





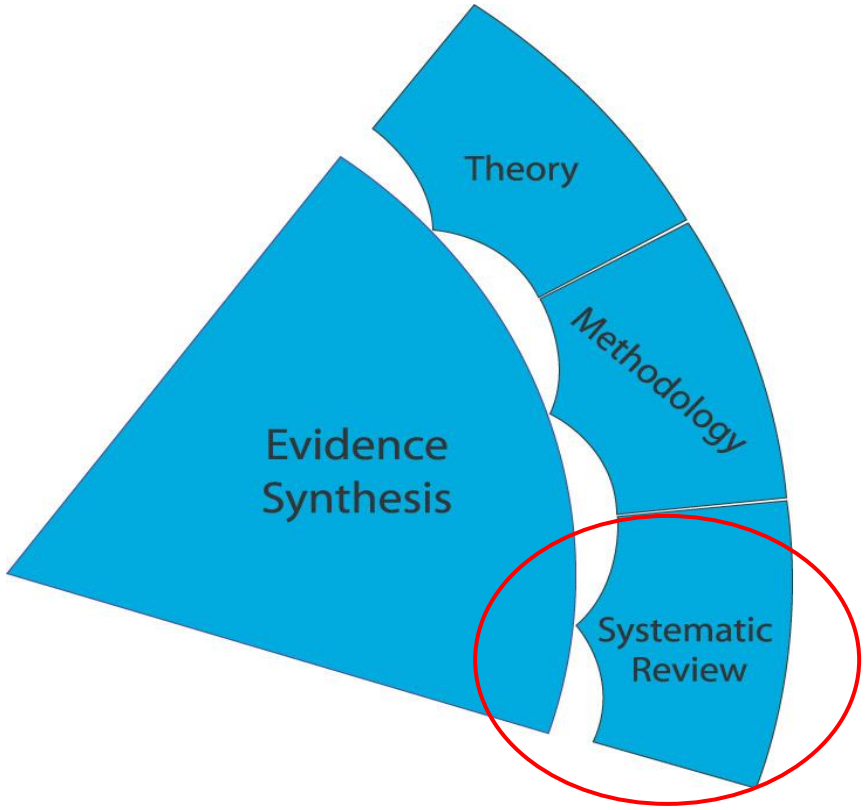
Why Critically Appraise?

- Combining results of poor quality research may lead to biased or misleading estimates of effectiveness

The Aims of Critical Appraisal

- To establish validity
  - to establish the risk of bias

Evidence synthesis
Systematic Review



CRITICAL APRAISAL

To establish validity (Quality)

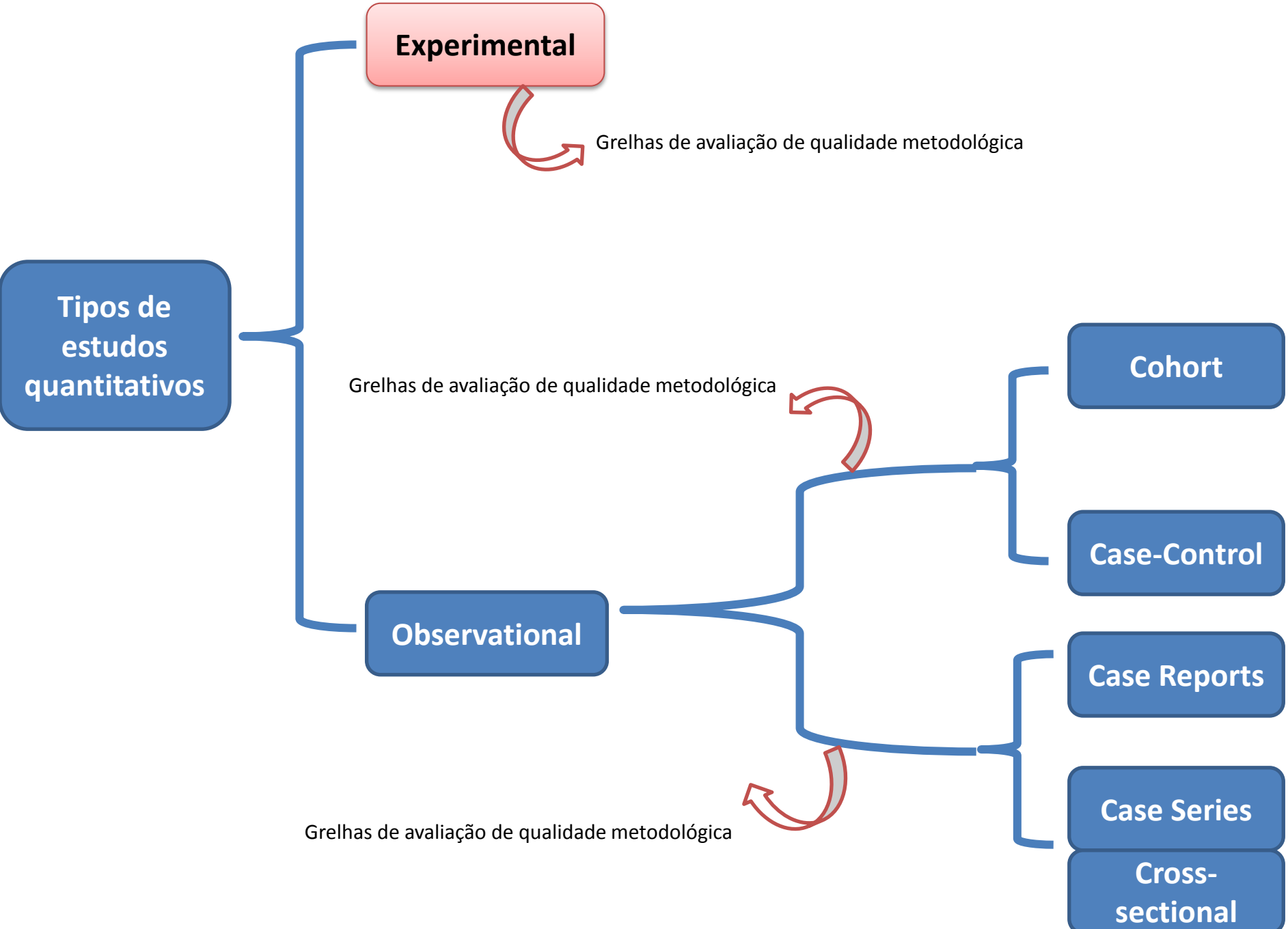
Sources of Bias

Bias, or systematic error, may impact on experimental research from a variety of avenues.

- Selection
- Performance
- Detection
- Attrition

Assessing the Risk of Bias

Type of bias	Quality assessment	Population	
		Allocation	
Selection	Allocation concealment	Treatment	Control
Performance (Differences in the intervention)	Blinding (Avoided by blinding of investigators and/or participants to group)	Exposed to intervention	Not exposed
Detection (Outcome/ measurement)	Blinding (Avoided by blinding of outcome assessor)	Population	Population
Attrition (Withdrawals and exclusions between groups)	ITT follow up (Avoided by accurate reporting of losses and reasons for withdrawal) (Use of ITT analysis)	Follow up	Follow up


Tipos de estudos quantitativos
Experimental
Grelhas de avaliação de qualidade metodológica
Observational
Grelhas de avaliação de qualidade metodológica
Cohort
Case-Control
Grelhas de avaliação de qualidade metodológica
Case Reports
Case Series
Cross-sectional

CASP CHECKLISTS

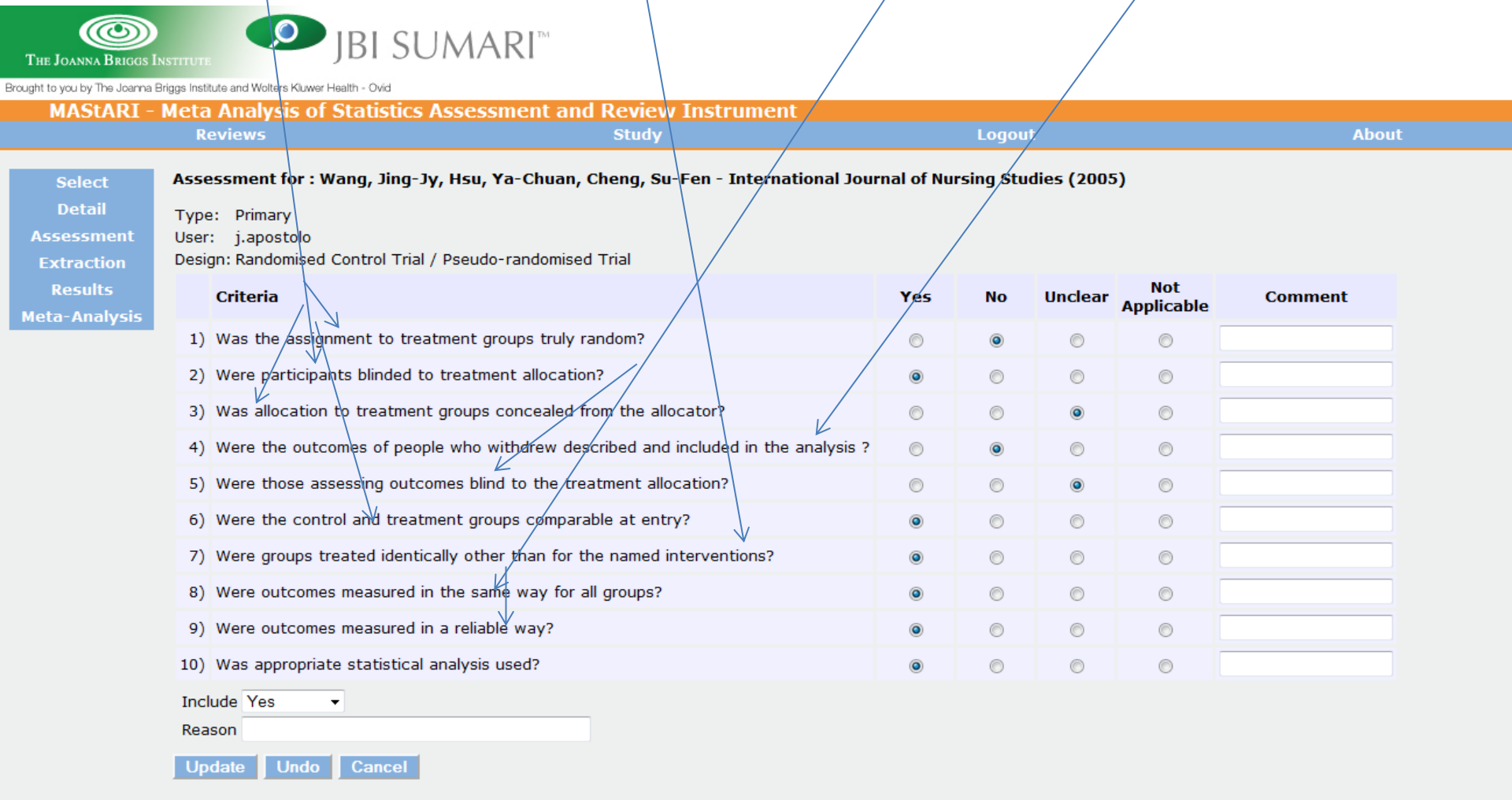
http://www.casp-uk.net/#!casp-tools-checklists/c18f8

- CASP Checklists (click to download)
- CASP Systematic Review Checklist
- CASP Qualitative Checklist
- CASP Randomised Controlled Trial Checklist
- CASP Case Control Checklist
- CASP Cohort Study Checklist
- CASP Clinical Prediction Rule Checklist
- CASP Diagnostic Checklist
- CASP Economic Evaluation Checklist

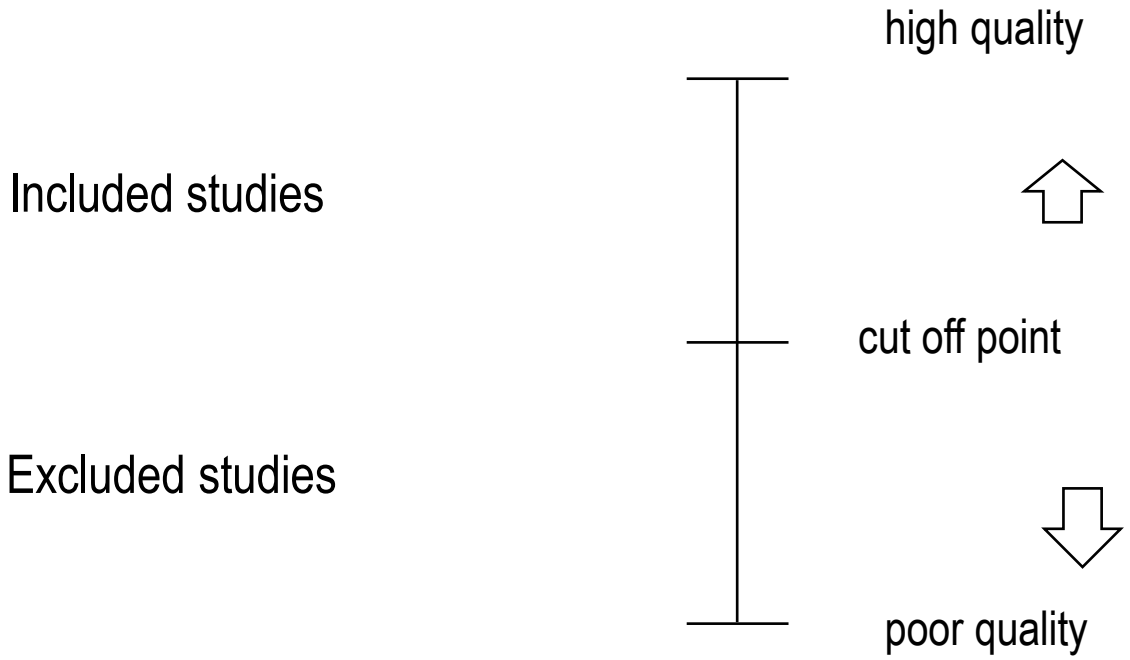
Bias: Selection (allocation), Performance (intervention), Detection (outcome) and Attrition.

MAStARI – Assessment

RCT/Pseudo-randomised trial



Assessing Study Quality as a Basis for Inclusion in a Review



You may decide 6/10 or 8/10. You may exclude any study which fails question 1 and you're not convinced the randomization process was adequate

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Number of studies included	Number of studies excluded
3	5

Table 2: Randomized controlled trial/pseudo-randomized trial

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
[8] Moscati et al., 2007	U	N	Y	N	U	Y	Y	Y	Y	Y
[17] Griffiths et al., 2001	U	Y	Y	Y	Y	U	Y	Y	Y	Y
[27] Walker and Smith, 2013	U	U	U	N	Y	Y	Y	Y	Y	Y
%	0.00	33.33	66.67	33.33	66.67	66.67	100.00	100.00	100.00	100.00

Y = yes; N = no; U = unclear

MAStARI – Assessment
Cohort and Case-control studies

	Criteria	Yes	No	Unclear	Not Applicable
1)	Is sample representative of patients in the population as a whole?	○	○	○	○
2)	Are the patients at a similar point in the course of their condition/illness?	○	○	○	○
3)	Has bias been minimised in relation to selection of cases and of controls?	○	○	○	○
4)	Are confounding factors identified and strategies to deal with them stated?	○	○	○	○
5)	Are outcomes assessed using objective criteria?	○	○	○	○
6)	Was follow up carried out over a sufficient time period?	○	○	○	○
7)	Were the outcomes of people who withdrew described and included in the analysis?	○	○	○	○
8)	Were outcomes measured in a reliable way?	○	○	○	○
9)	Was appropriate statistical analysis used?	○	○	○	○

MAStARI – Assessment
Descriptive/case series studies

	Criteria	Yes	No	Unclear	Not Applicable
1)	Was study based on a random or pseudo-random sample?	○	○	○	○
2)	Were the criteria for inclusion in the sample clearly defined?	○	○	○	○
3)	Were confounding factors identified and strategies to deal with them stated?	○	○	○	○
4)	Were outcomes assessed using objective criteria?	○	○	○	○
5)	If comparisons are being made, was there sufficient descriptions of the groups?	○	○	○	○
6)	Was follow up carried out over a sufficient time period?	○	○	○	○
7)	Were the outcomes of people who withdrew described and included in the analysis?	○	○	○	○
8)	Were outcomes measured in a reliable way?	○	○	○	○
9)	Was appropriate statistical analysis used?	○	○	○	○

As the word ‘pseudo’ suggests, pseudo-random numbers are not random in the way you might expect, at least not if you're used to dice rolls or lottery tickets. Essentially, PRNGs are algorithms that use mathematical formulae or simply precalculated tables to produce sequences of numbers that appear random

MAStARI Data Extraction Instrument

Author | Record Number

Journal

Year

Reviewer

Method

Setting

Participants
(male or female)

Number of Participants

Group A | Group B | Group C

Interventions

Intervention A

Intervention B

Outcome Measures

Outcome Description	**Scale/Measure**

Results

Dichotomous Data

Outcome	Treatment Group Number/total number	Control Group Number/total number

Continuous Data

Outcome	Treatment Group Mean & SD (number)	Control Group Mean & SD (number)

Authors Conclusion

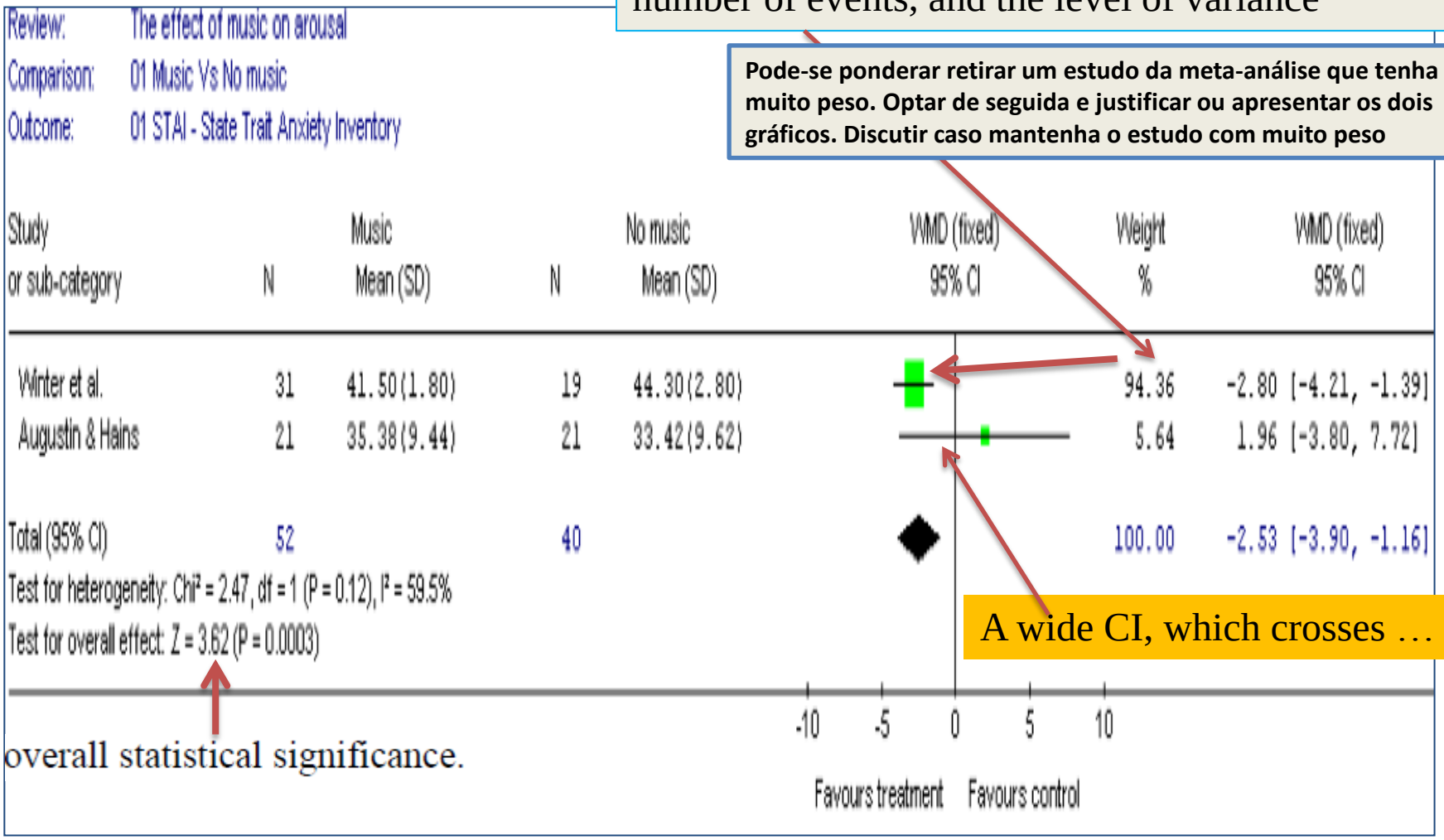
Reviewers Conclusion

When meta-analysis can be used

- Meta analysis can be used if studies:
  - have the same population
  - use the same intervention administered in the same way.
  - measure the same outcomes
- Homogeneity
  - studies are sufficiently similar to estimate an average effect.

Each study being allocated a weighted percentage. This can depend on the number of participants, the number of events, and the level of variance

Pode-se ponderar retirar um estudo da meta-análise que tenha muito peso. Optar de seguida e justificar ou apresentar os dois gráficos. Discutir caso mantenha o estudo com muito peso



A wide CI, which crosses …

overall statistical significance.

Tests of Heterogeneity

- Measure extent to which observed study outcomes differ from calculated study outcome

- Visually inspect Forest Plot. Size of CI
- χ^2 Test for homogeneity
- We don't want this to be less than 0.05

Quantifying inconsistency

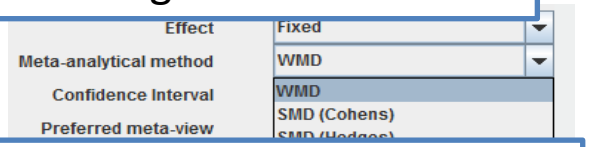
$$I^2 = \left(\frac{Q - df}{Q} \right) \times 100\%$$

- 0% to 40%: might not be important;
- 30% to 60%: may represent moderate heterogeneity*;
- 50% to 90%: may represent substantial heterogeneity*;
- 75% to 100%: considerable heterogeneity*.

Q is the chi-squared statistic and df is its degrees of freedom (Higgins 2002, Higgins 2003).
*The importance of the observed value of I^2 depends on (i) magnitude and direction of effects and (ii) strength of evidence for heterogeneity (e.g. P value from the chi-squared test, or a confidence interval for I^2).

http://handbook.cochrane.org/chapter_9/9_5_2_identifying_and_measuring_heterogeneity.htm

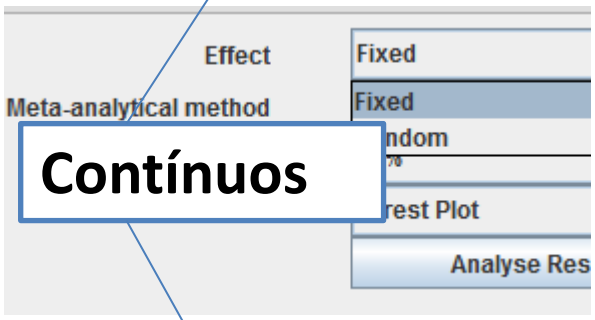
WMD – Escalas iguais



Fixed
(não há heterogeneidade)

SMD (Cohens) – Escalas diferentes

SMD (Hedge's) – Escalas diferentes



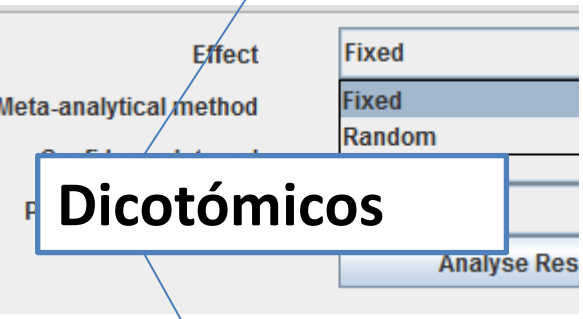
Contínuos

Produzem resultados semelhantes mas o Hedge's é preferível porque inclui um ajuste para corrigir o bias de amostras pequenas

Random
(há heterogeneidade)

WMD (Der Simonian & Laird) – escalas iguais

SMD (Der Simonian & Laird) – escalas diferentes



Dicotómicos

Fixed
(não há heterogeneidade)

- RR (Mantel-Haenszel)

M-H é geralmente o preferido na meta-análise, porque é o mais robusto

- OR (Mantel-Haenszel)
- Peto OR

Peto OR: apropriado quando as taxas de eventos são muito baixas e tamanhos de efeito não são excessivamente grandes.
Pode ser imprecisa, se o efeito dos tratamentos é grande, e quando os tamanhos de amostra entre os grupos de tratamento e controle são desequilibrados.

Random
(há heterogeneidade)

- RR (Der Simonian & Laird)
- OR (Der Simonian & Laird)

MAStARI - Intervention

MAStARI – Continuous Results

MAStARI - Meta Analysis of Statistics Assessment and Review Instrument

Reviews | Study | Logout | About

Select
Detail
Assessment
Extraction
Results
Meta-Analysis

Continuous Results for: Wang, Jing-Jy, Hsu, Ya-Chuan, Cheng, Su-Fen - International Journal of Nursing Studies (2005)

Intervention	Result		
	Mean	SD	N
Re			
V			
Co			

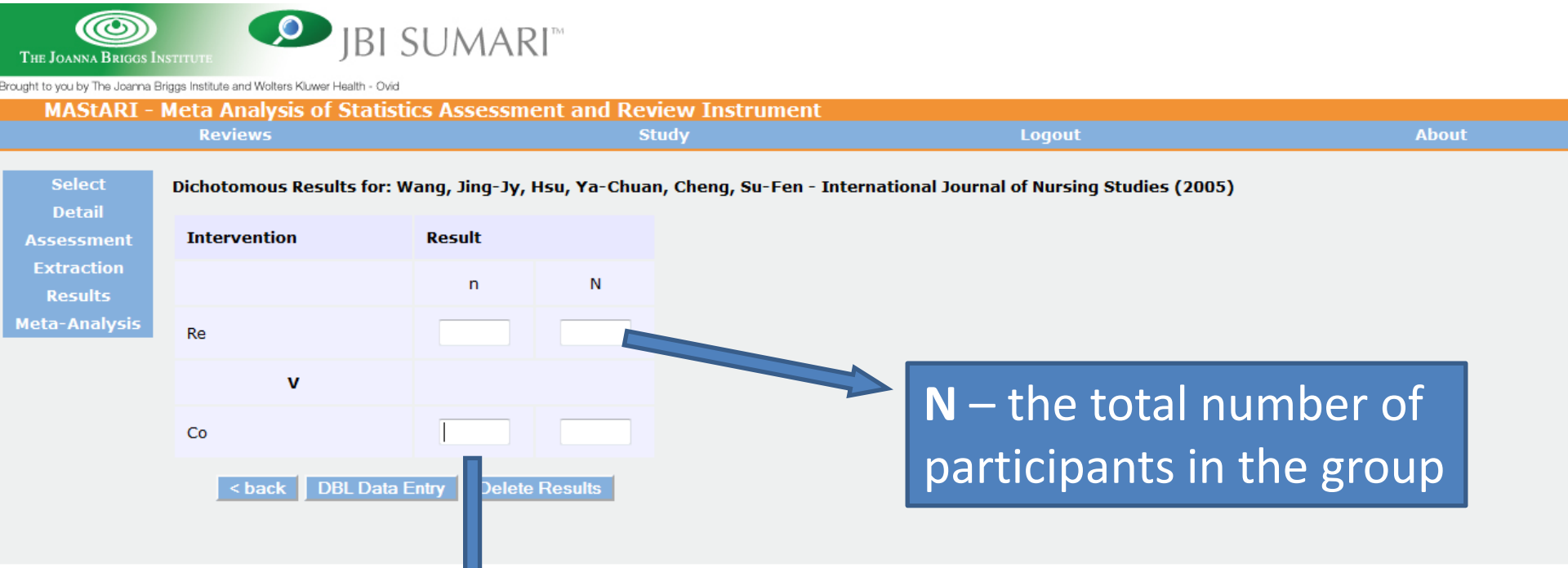
< back | DBL Data Entry | Delete Results

Table 2. Evolution of Experimental and Control Groups of Nursing Home Elders on Cognition and Depressive Symptoms

		Baseline		Postinterv ention		Paired *t*-test (baseline/postinterv ention)		Mean difference (baseline) /postintervention)		Repeated measures	
Outcomes	Groups	*M*	*SD*	*M*	*SD*	*t*	*p*[a]	*M*	*SD*	*F*	*p*
Cognition (MoCA)	EG	17.22	5.04	19.00	5.82	−2.388	.013	1.78	3.58	8.581	.005
	CG	16.88	4.68	15.88	4.82	1.659	.055	−1.00	3.01		
Depressive symp-toms (GDS-15)	EG	6.17	4.36	5.61	3.70	1.084	.145	0.57	2.50	1.090	.302
	CG	6.88	3.88	7.08	3.59	−0.397	.348	−0.20	2.52		

Note EG = experimental group; CG = control group; MoCA = Montreal Cognitive Assessment; GDS-15 = Geriatric Depression Scale-15.
[a]One-tailed.

MAStARI – Dichotomous Results



N – the total number of participants in the group

n – the number of participants having the outcome of interest

MAStARI

No quadro resumo dos artigos consegue-se ver em que fase o artigo está. Se já foi avaliado, se foi incluído ou excluído.

MAStARI - Meta Analysis of Statistics Assessment and Review Instrument

Reviews | Study | Logout | About

Select
Detail
Assessment
Extraction
Results
Meta-Analysis

Studies in "The effectiveness of nonpharmacological nursing interventions in elderly with depressive disorders: a systematic review"

This page is used to manage the retrieved Studies. From this page, Studies can be selected to perform assessment and extraction and to develop Findings. The drop down box can be used to filter studies as new, included, excluded, extracted or finished.

All filter

# of Citations: 4

Author	Title	Journal	Year	Status	Assessment	Actions
Jing-Jy Wang	The effects of reminiscence on depressive symptoms and mood status of older institutionalized adults in Taiwan	INTERNATIONAL JOURNAL OF GERIATRIC PSYCHIATRY	2005	Extraction	Complete	Edit Delete
Jing-Jy Wang, Ya-Chuan Hsu, Su-Fen Cheng	The effects of reminiscence in promoting mental health of Taiwanese elderly	International Journal of Nursing Studies	2005	Extraction	Complete	Edit Delete
ddd	ddd	ddd	2012	Included	Complete	Edit Delete
rrrrr	rrrrr	rrrrr	2011	New	Awaiting Final	Edit Delete

1 10 records per page

Add

MAStARI - Extraction

MAStARI Meta Analysis of Statistics Assessment and Review Instrument

Reviews | Study | Logout | About

Select
Detail
Assessment
Extraction
Results
Meta-Analysis

Extraction Details: Wang, Jing-Jy, Hsu, Ya-Chuan, Cheng, Su-Fen - International Journal of Nursing Studies (2005) - Randomised Control Trial / Pseudo-randomised Trial
Study Information

* denotes field which will appear in report appendix

Method *	longitudinal quasi-experimental design
Setting	elderly people residing in community care facilities and at home.
Participants *	94 institutionalized and home older adults aged 65 years or older, capable of verbal communication, able to speak either Mandarin or Taiwanese, and demonstrating no obvious cognitive impairments.
# Participants	Group A: 46 Group B: 48
Interventions	Interventions A: * Reminiscence - weekly for approximately 30 min to 2 h over a period of 4 months.
	Interventions B: * control - any intervention
Authors Conclusion	
Reviewers Comments *	
Complete	No

MAStARI - Results

MAStARI - Meta Analysis of Statistics Assessment and Review Instrument

Reviews | Study | Logout | About

Select
Detail
Assessment
Extraction
Results
Meta-Analysis

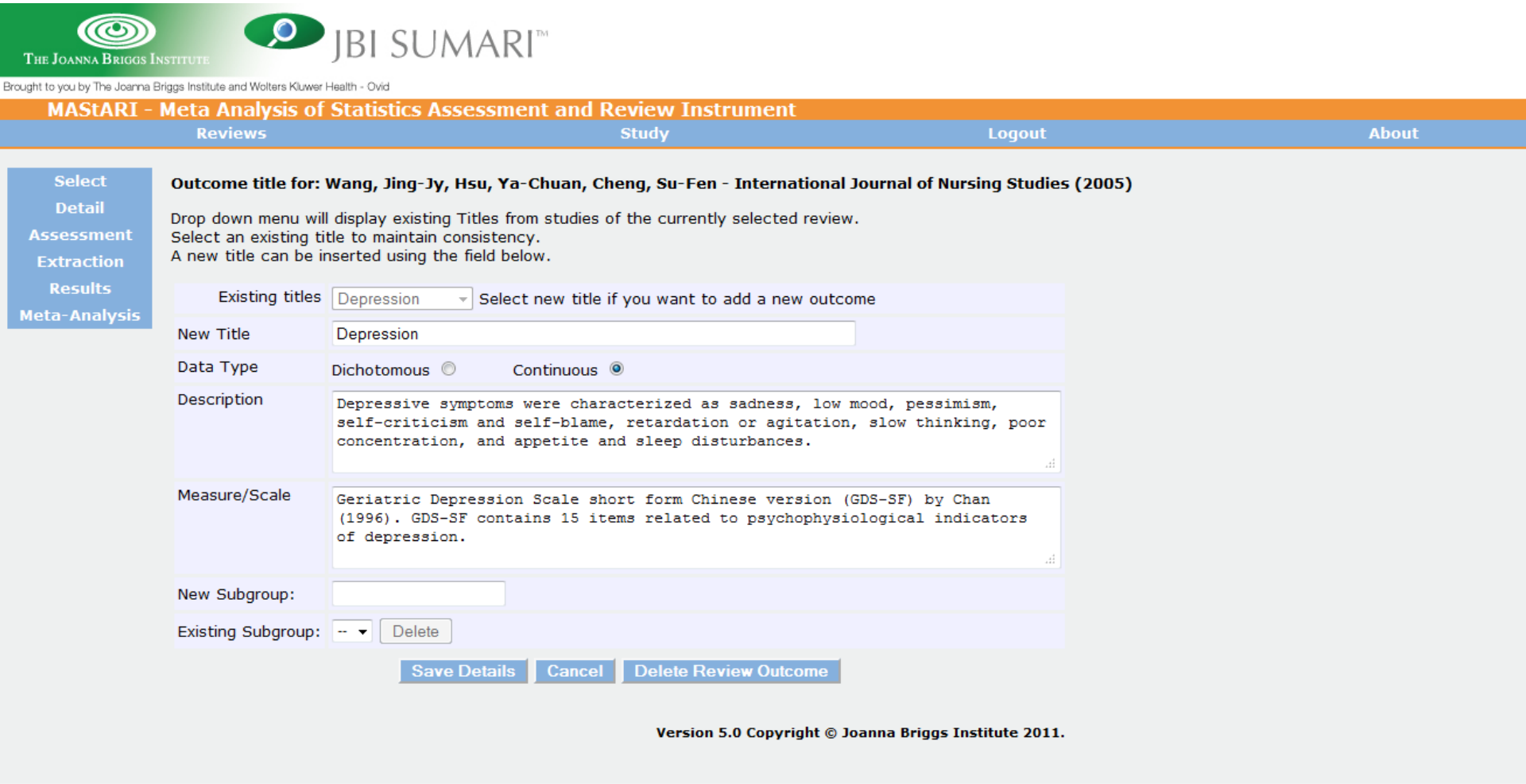
Results For: Wang, Jing-Jy, Hsu, Ya-Chuan, Cheng, Su-Fen - International Journal of Nursing Studies (2005)
Randomised Control Trial / Pseudo-randomised Trial

Review Outcome	Intervention A	Intervention B	
Depression	Re	Co	Results Delete Outcome
depression Y/N	Re	Co	Results Delete Outcome

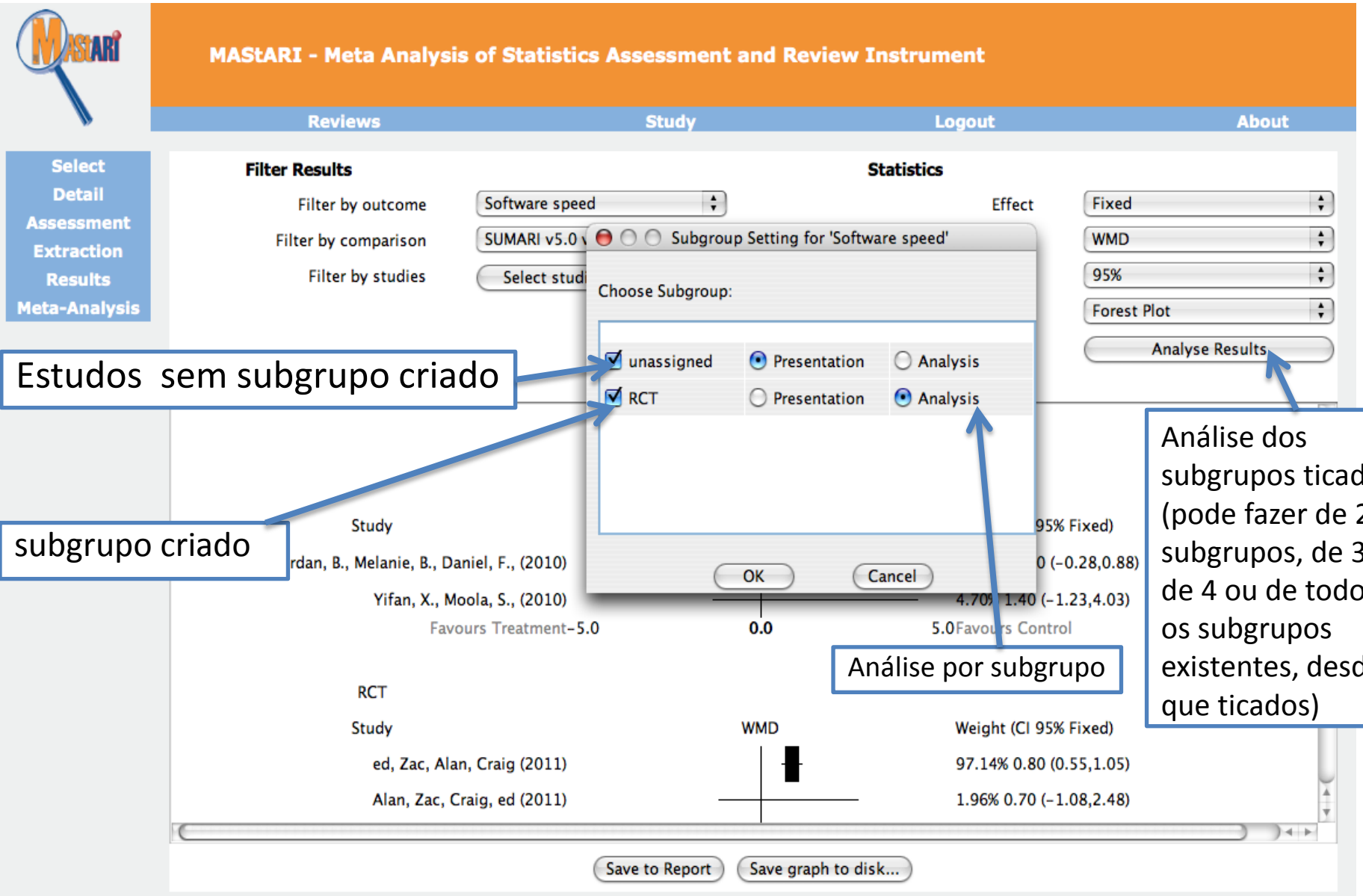
Add Review Outcome

MAStARI - Outcome

Como criar um outcome?



MAStARI – Subgroup analysis



Síntese de estudos qualitativos JBI-QARI

Qualitative Methodologies

Action/Description	Subjectivity Structures of Consciousness	Analytical
Ethnography	Phenomenology	Conceptual/Analytical
Grounded Theory	Ethnomethodology	Historical
Action Research	Hermeneutic	Discourse Analysis
Case Studies	Phenomenography	Biographical/textual/narrative
Descriptive		Cultural/media analysis
Programme Evaluation		Deconstructive analysis

Congruity between Paradigm, Methodology and Methods

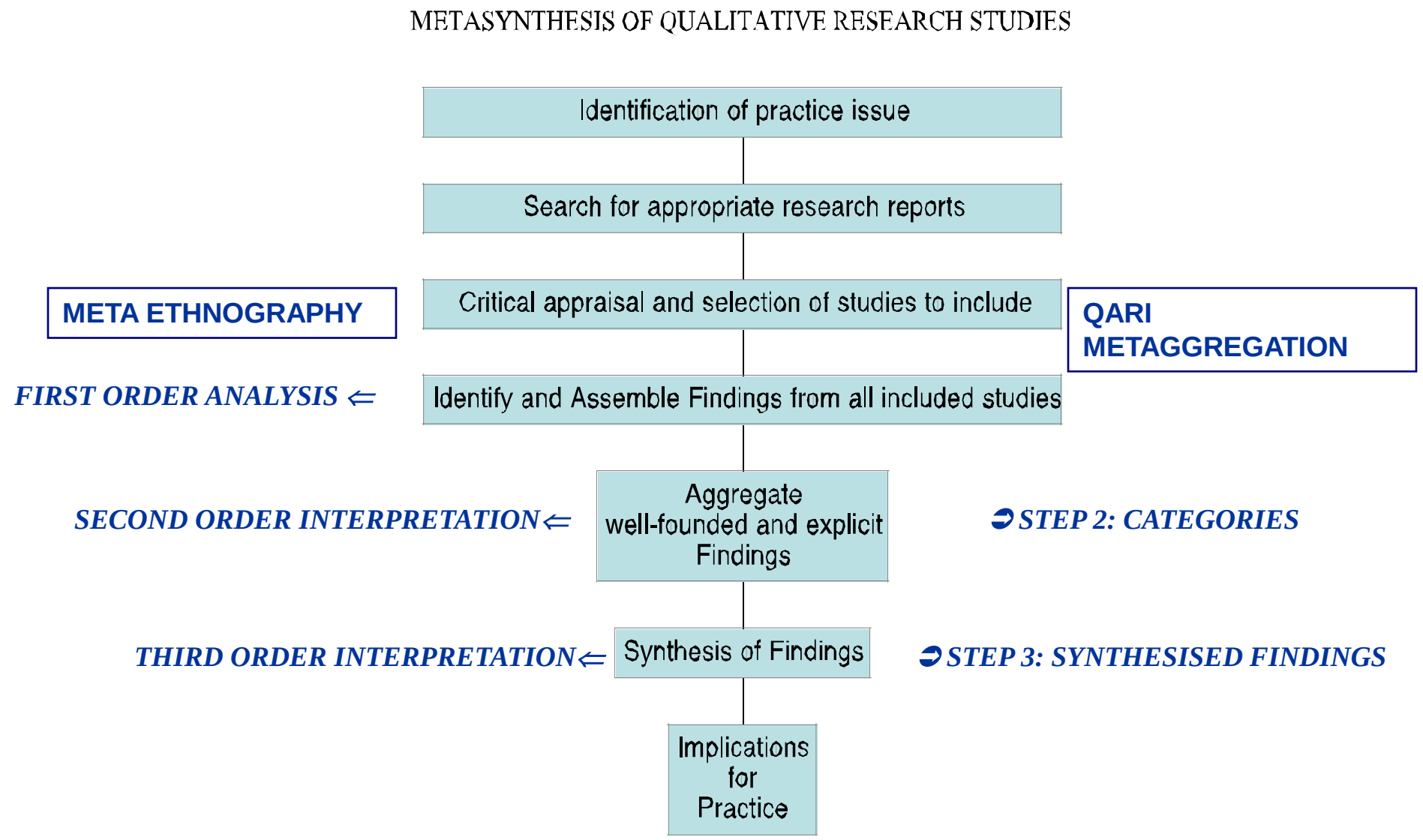
Quality - Qualitative studies

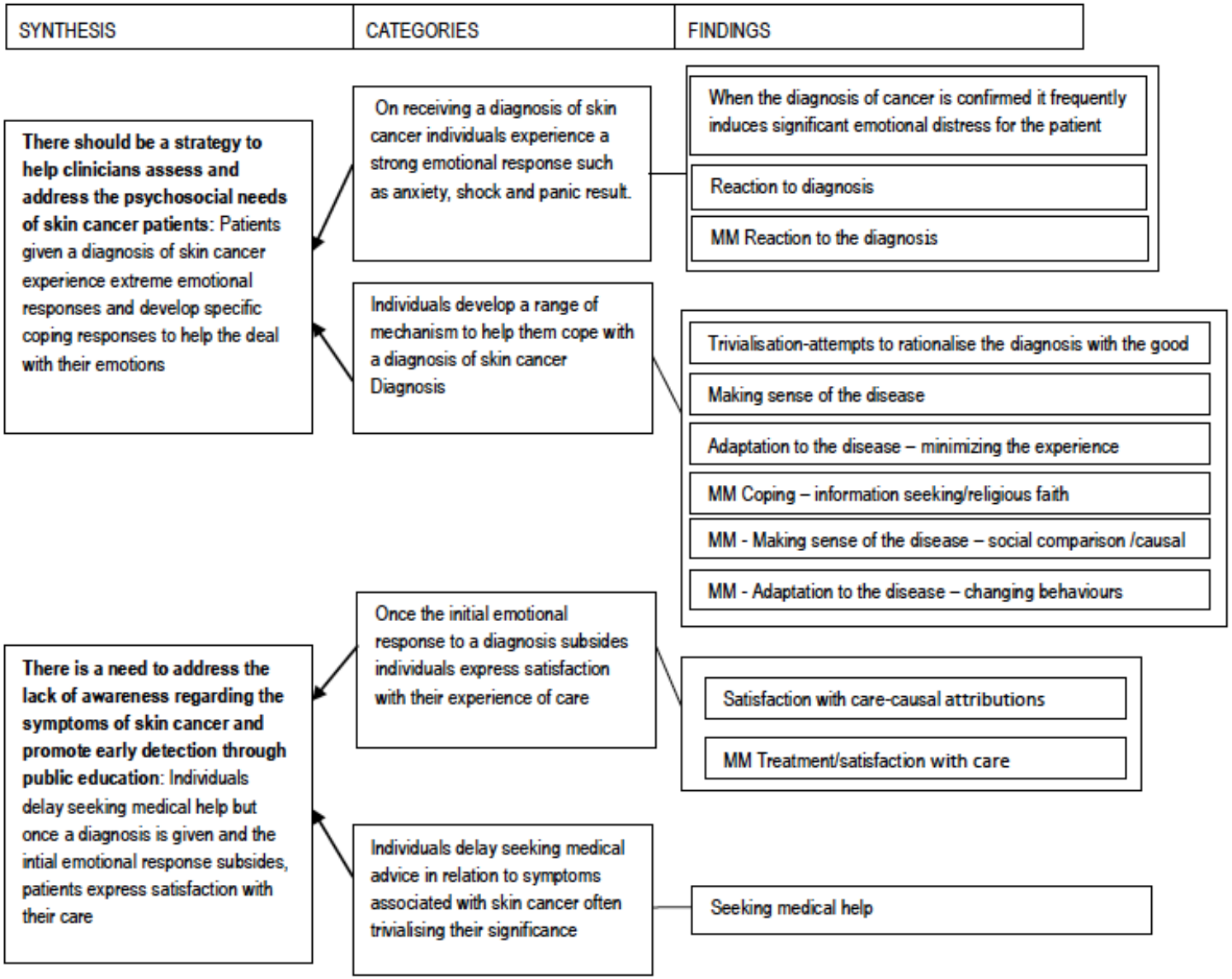
Analogous criteria for paradigmatic assumptions

Quantitative	Qualitative
Reliability Confiabilidade (Reprodutividade das medidas)	**Dependability** Confiança/Segurança (Consistência da Qualidade -grelha) Ontology; Epistemology; Methodology
Internal Validity	**Credibility** Findings: Unequivocal, credible, unsupported).
External Validity	**Transferability**

QARI – Assessment (final)

	Criteria	Primary	Secondary	Yes	No	Unclear	Not Applicable
1)	There is congruity between the stated philosophical perspective and the research methodology.	Yes	Yes	⊙	○	○	○
2)	There is congruity between the research methodology and the research question or objectives.	Yes	Yes	⊙	○	○	○
3)	There is congruity between the research methodology and the methods used to collect data.	Yes	Yes	⊙	○	○	○
4)	There is congruity between the research methodology and the representation and analysis of data.	Yes	Yes	⊙	○	○	○
5)	There is congruity between the research methodology and the interpretation of results.	Yes	Yes	⊙	○	○	○
6)	There is a statement locating the researcher culturally or theoretically.	Yes	Yes	⊙	○	○	○
7)	The influence of the researcher on the research, and vice-versa, is addressed.	Yes	Yes	⊙	○	○	○
8)	Participants, and their voices, are adequately represented.	Yes	Yes	⊙	○	○	○
9)	The research is ethical according to current criteria or, for recent studies, there is evidence of ethical approval by an appropriate body.	Yes	Yes	⊙	○	○	○
10)	Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.	Yes	Yes	⊙	○	○	○


METASYNTHESIS OF QUALITATIVE RESEARCH STUDIES
Identification of practice issue
Search for appropriate research reports
Critical appraisal and selection of studies to include
Identify and Assemble Findings from all included studies
Aggregate well-founded and explicit Findings
Synthesis of Findings
Implications for Practice
META ETHNOGRAPHY
QARI METAGGREGATION
FIRST ORDER ANALYSIS ⇐
SECOND ORDER INTERPRETATION ⇐
THIRD ORDER INTERPRETATION ⇐
➲ STEP 2: CATEGORIES
➲ STEP 3: SYNTHESISED FINDINGS


SYNTHESIS
CATEGORIES
FINDINGS
There should be a strategy to help clinicians assess and address the psychosocial needs of skin cancer patients: Patients given a diagnosis of skin cancer experience extreme emotional responses and develop specific coping responses to help the deal with their emotions
On receiving a diagnosis of skin cancer individuals experience a strong emotional response such as anxiety, shock and panic result.
When the diagnosis of cancer is confirmed it frequently induces significant emotional distress for the patient
Reaction to diagnosis
MM Reaction to the diagnosis
Individuals develop a range of mechanism to help them cope with a diagnosis of skin cancer Diagnosis
Trivialisation-attempts to rationalise the diagnosis with the good
Making sense of the disease
Adaptation to the disease – minimizing the experience
MM Coping – information seeking/religious faith
MM - Making sense of the disease – social comparison /causal
MM - Adaptation to the disease – changing behaviours
There is a need to address the lack of awareness regarding the symptoms of skin cancer and promote early detection through public education: Individuals delay seeking medical help but once a diagnosis is given and the intial emotional response subsides, patients express satisfaction with their care
Once the initial emotional response to a diagnosis subsides individuals express satisfaction with their experience of care
Satisfaction with care-causal attributions
MM Treatment/satisfaction with care
Individuals delay seeking medical advice in relation to symptoms associated with skin cancer often trivialising their significance
Seeking medical help

Recommendations arising

- There is a real need to increase knowledge of skin cancer so that people do not delay in seeking medical help as early diagnosis can dramatically improve both prognosis and the patient experience since early lesions are treated more simply compared with larger or neglected lesions.
- Health professionals caring for these patients need to understand the psychosocial concerns of this patient group in order to design services appropriately and to provide patients with the support they need and information that they can easily understand.

Levels of Credibility- Qualitative

Unequivocal - relates to evidence beyond reasonable doubt

Credible - those that are, albeit interpretations, plausible in light of data and theoretical framework.

Not Supported - when 1 nor 2 apply and when most notably findings are not supported by the data

- Should not be included in synthesis to inform practice

Levels of Evidence and Grades of Recommendation

- Following the GRADE guidance JBI has developed its own unique Levels of Evidence and Grades of recommendation.

GRADE: (Grading of Recommendations Assessment, Development and Evaluation)

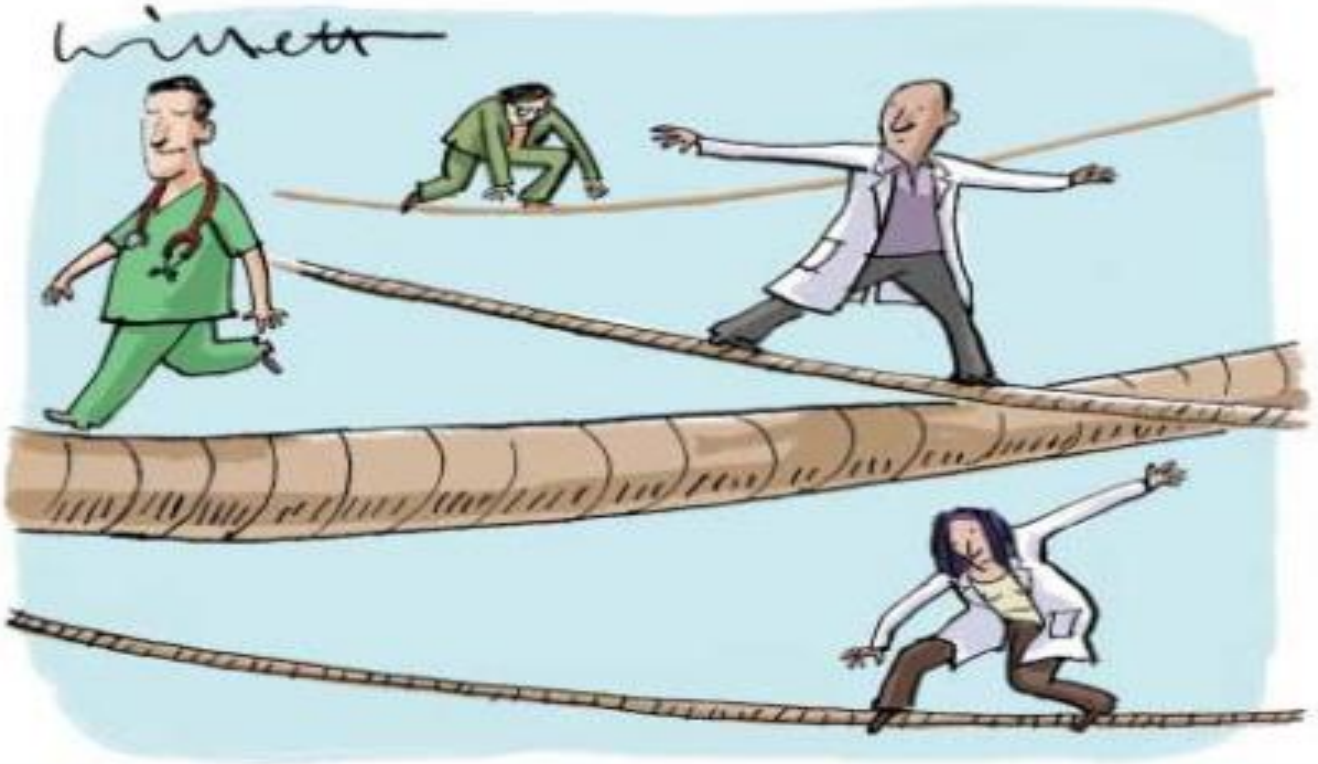
Grading quality

GRADE Working Group

Clinical guidelines are onl
make it easier for users to

Summary

Users of clinical practice guid
need to know how much
recommendations. Systemati
judgments can reduce errors
have developed a system for
the strength of recommenda
wide range of interventions
present a summary of our a
guideline user. Judgments ab
tion require consideration of
harms, the quality of the ev
into specific circumstances, a
It is also important to consider costs (resource utilisation) before
making a recommendation. Inconsistencies among systems for



Levels of Evidence

- According to **study design** allows to assign a Pre-Ranking
  - Except the levels of evidence for costs – They are not based purely on study design.

- Should not be used as a definitive measure of the best available evidence.
- Should not act as a substitute for critical appraisal and clinical reasoning

Levels of Evidence - Effectiveness

Level 1 – Experimental Designs	Level 1.a – Systematic review of Randomized Controlled Trials (RCTs)
	Level 1.b – Systematic review of RCTs and other study designs
	Level 1.c – RCT
	Level 1.d – Pseudo-RCTs
Level 2 – Quasi-experimental Designs	Level 2.a – Systematic review of quasi-experimental studies
	Level 2.b – Systematic review of quasi-experimental and other lower study designs
	Level 2.c – Quasi-experimental prospectively controlled study
	Level 2.d – Pre-test – post-test or historic/retrospective control group study
Level 3 – Observational – Analytic Designs	Level 3.a – Systematic review of comparable cohort studies
	Level 3.b – Systematic review of comparable cohort and other lower study designs
	Level 3.c – Cohort study with control group
	Level 3.d – Case – controlled study
	Level 3.e – Observational study without a control group
Level 4 – Observational – Descriptive Studies	Level 4.a – Systematic review of descriptive studies
	Level 4.b – Cross-sectional study
	Level 4.c – Case series
	Level 4.d – Case study
Level 5 – Expert Opinion and Bench	Level 5.a – Systematic review of expert opinion

Levels of Evidence - Diagnosis

Level 1 – Studies of Test Accuracy among consecutive patients	Level 1.a – Systematic review of studies of test accuracy among consecutive patients
	Level 1.b – Study of test accuracy among consecutive patients
Level 2 – Studies of Test Accuracy among non-consecutive patients	Level 2.a – Systematic review of studies of test accuracy among non-consecutive patients
	Level 2.b – Study of test accuracy among non-consecutive patients
Level 3 – Diagnostic Case control studies	Level 3.a – Systematic review of diagnostic case control studies
	Level 3.b – Diagnostic case-control study
Level 4 – Diagnostic yield studies The likelihood that a test or procedure will provide the informati on needed to establish a diagnosis	Level 4.a – Systematic review of diagnostic yield studies
	Level 4.b – Individual diagnostic yield study
Level 5 – Expert Opinion and Bench Research	Level 5.a – Systematic review of expert opinion
	Level 5.b – Expert consensus
	Level 5.c – Bench research/ single expert opinion

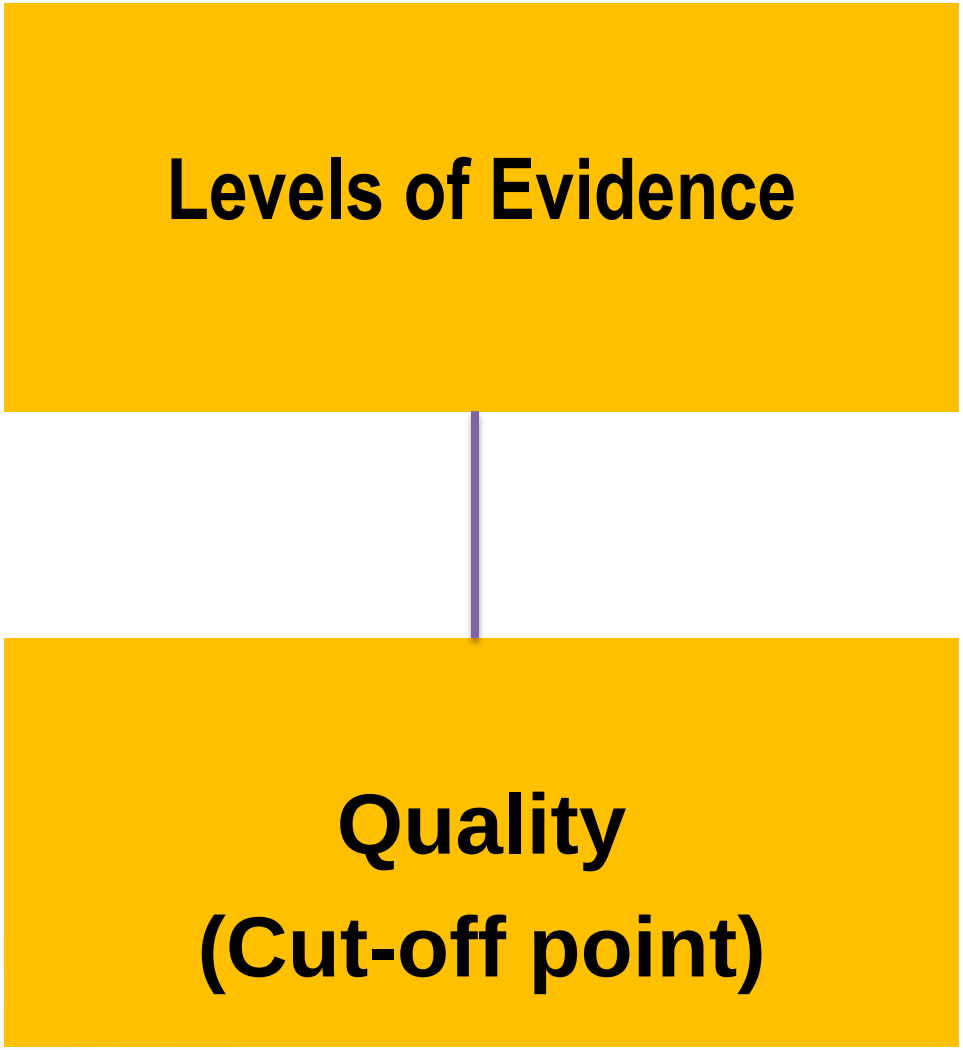
Levels of Evidence - Prognosis

Level 1 – Inception Cohort Studies	Level 1.a – Systematic review of inception cohort studies
	Level 1.b – Inception cohort study (initial diagnosis and followed)
Level 2 – Studies of All or none	Level 2.a – Systematic review of all or none studies
	Level 2.b – All or none studies
Level 3 – Cohort studies	Level 3.a – Systematic review of cohort studies (or control arm of RCT)
	Level 3.b – Cohort study (or control arm of RCT)
Level 4 – Case series/Case Controlled/ Historically Controlled studies	Level 4.a – Systematic review of Case series/Case Controlled/ Historically Controlled studies
	Level 4.b – Individual Case series/Case Controlled/ Historically Controlled study
Level 5 – Expert Opinion and Bench Research	Level 5.a – Systematic review of expert opinion
	Level 5.b – Expert consensus
	Level 5.c – Bench research/ single expert opinion

Levels of Evidence - Meaningfulness	
Level 1	Qualitative or mixed-methods systematic review
Level 2	Qualitative or mixed-methods synthesis
Level 3	Single qualitative study
Level 4	Systematic review of expert opinion
Level 5	Expert opinion

Levels of Evidence - Economic Evaluations

Level 1	Decision model with assumptions and variables informed by systematic review and tailored to fit the decision making context.
Level 2	Systematic review of economic evaluations conducted in a setting similar to the decision makers.
Level 3	Synthesis/review of economic evaluations undertaken in a setting similar to that in which the decision is to be made and which are of high quality (comprehensive and credible measurement of costs and health outcomes, sufficient time period covered, discounting, and sensitivity testing).
Level 4	Economic evaluation of high quality (comprehensive and credible measurement of costs and health outcomes, sufficient time period covered, discounting and sensitivity testing) and conducted in setting similar to the decision making context.
Level 5	Synthesis / review of economic evaluations of moderate and/or poor quality (insufficient coverage of costs and health effects, no discounting, no sensitivity testing, time period covered insufficient).
Level 6	Single economic evaluation of moderate or poor quality (see directly above level 5 description of studies).


Levels of Evidence
Quality
(Cut-off point)

GRADE quality of the evidence - Quantitative

Initially

High — RCT

Moderate

Low — Observational

Very Low

Example of **Downgrading** factores:

- Risk of bias
- Imprecision of results

Ex: Imprecision of results (-1 if wide confidence interval; -2 if very wide confidence interval)

Example of **Upgrading** factores:

- Dose response
- Large magnitude of effect
- (etc)

Ex: Large magnitude of effect (+1 level if a large effect; +2 if a very large effect)

GRADE quality of the evidence - Qualitative

Initially

High — Qualitative

Moderate

Low — Text Opinion

Very Low

Example of **Downgrading** factores:

- **Dependability (consistência)** (5 items - critical appraisal)
- **Credibility** (Findings: Unequivocal, credible, unsupported).

Quality of Evidence (**Qualitative**)

- Dependability (5 items - critical appraisal)

Ontology; Epistemology; Methodology

	Criteria	Primary	Secondary	Yes	No	Unclear	Not Applicable
1)	There is congruity between the stated philosophical perspective and the research methodology.	Yes	Yes	⊙	○	○	○
2)	There is congruity between the research methodology and the research question or objectives.	Yes	Yes	⊙	○	○	○
3)	There is congruity between the research methodology and the methods used to collect data.	Yes	Yes	⊙	○	○	○
4)	There is congruity between the research methodology and the representation and analysis of data.	Yes	Yes	⊙	○	○	○
5)	There is congruity between the research methodology and the interpretation of results.	Yes	Yes	⊙	○	○	○
6)	There is a statement locating the researcher culturally or theoretically.	Yes	Yes	⊙	○	○	○
7)	The influence of the researcher on the research, and vice-versa, is addressed.	Yes	Yes	⊙	○	○	○
8)	Participants, and their voices, are adequately represented.	Yes	Yes	⊙	○	○	○
9)	The research is ethical according to current criteria or, for recent studies, there is evidence of ethical approval by an appropriate body.	Yes	Yes	⊙	○	○	○
10)	Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.	Yes	Yes	⊙	○	○	○

Quality of Evidence (**Text opinion**)
- Dependability - 5 items - critical appraisal

Assessment for : Pearson A - Journal (2012)

Type: Primary
User: alan

	Criteria	Yes	No	Unclear	Not applicable	Comment
1)	Is the source of the opinion clearly identified?	○	○	○	○	
2)	Does the source of the opinion have standing in the field of expertise?	○	○	○	○	
3)	Are the interests of patients/clients the central focus of the opinion?	○	○	○	○	
4)	Is the opinion's basis in logic/experience clearly argued?	○	○	○	○	
5)	Is the argument developed analytical?	○	○	○	○	
6)	Is there reference to the extant literature/evidence and any incongruency with it logically defended?	○	○	○	○	
7)	Is the opinion supported by peers?	○	○	○	○	

Include Undefined

Reason

Update Undo Cancel

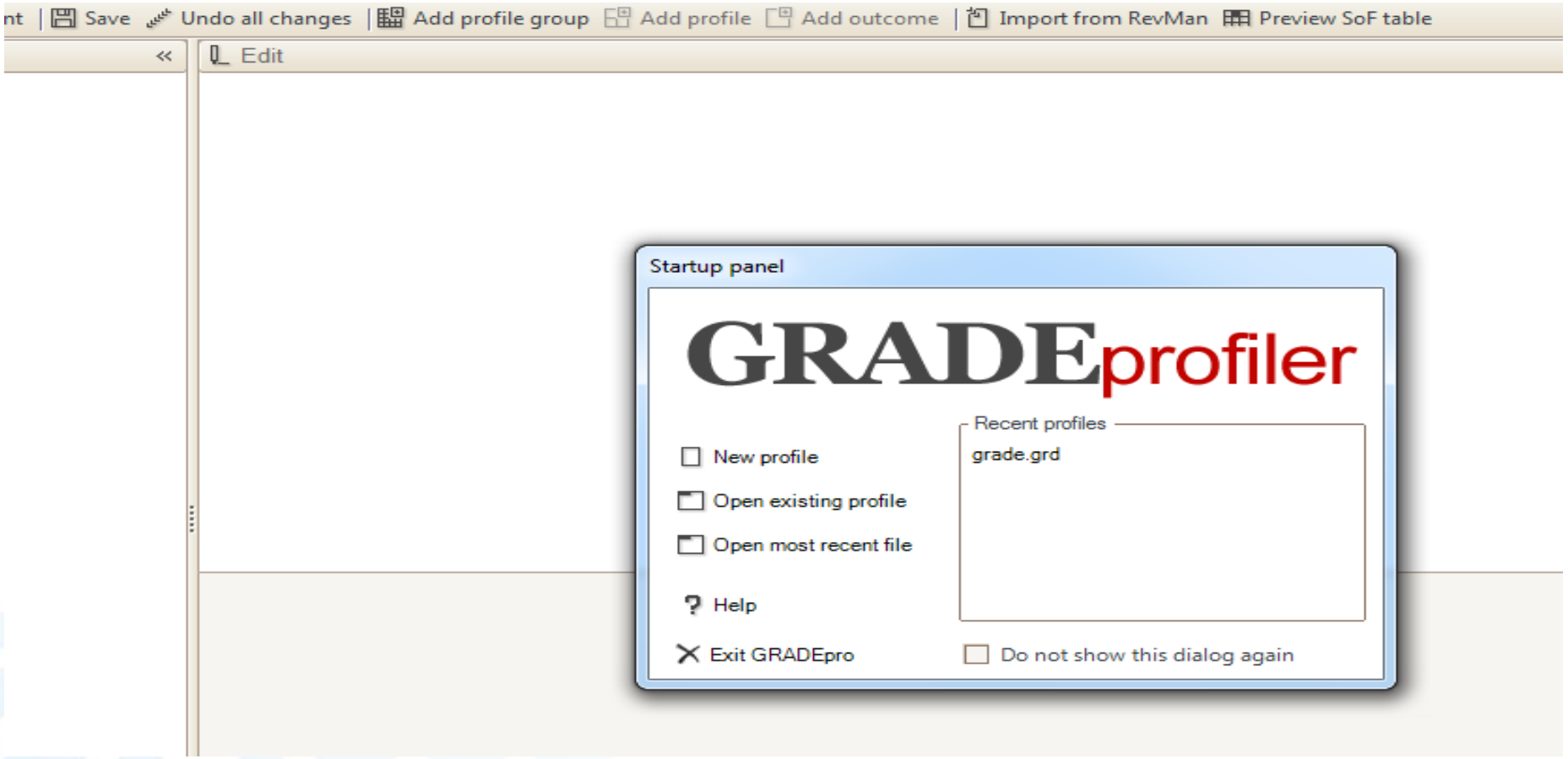
Quality of the evidence (**Dependability**)

Qualitative and text opinion

- If 4-5 of the questions are yes, the synthesized finding remains at the level it is currently.
- If 2-3 of these responses are yes, it moves down one level
  - (i.e. from High to Moderate).
- If 0-1 of these responses are yes, it moves down two levels
  - (from High to Low, or Moderate to Very Low).

Systematic reviews should be accompanied by a Summary of Findings table

Can be created using the software program GRADEPro
http://tech.cochrane.org/revman/other-resources/gradepro/download



(High; Moderate; Low ; Very Low)

Table 1: Summary of Findings Template

Title

Bibliography: (review name)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Continuous aerobic exercise	Risk difference with High intensity interval training (95% CI)
Outcome 1 - Most critical outcome (i.e. Mortality) Measurement (i.e. all-cause mortality[1]	0 (0)	⊕⊕⊖⊖ **LOW**[3,4]		**Study population**	
				See comment	-
				Moderate	
					-
Outcome 2 Measurement	i.e. 247 (4 studies) 4-16 weeks	⊕⊕⊖⊖ **LOW**[3,4]			
Outcome 3 Measurement		⊕⊕⊖⊖ **LOW**[3,4] due to risk of bias, inconsistency			

*The basis for the **assumed risk** (e.g. the median control group risk across studies) is provided in footnotes. The **corresponding risk** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR:** Risk ratio;

GRADE Working Group grades of evidence
High quality: Further research is very unlikely to change our confidence in the estimate of effect.
Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low quality: We are very uncertain about the estimate.

Example footnotes:

[1] No studies assessed mortality
[2] Change score in the control (continuous) group
[3] Methodological limitations across studies, particularly in terms of blinding.
[4] Statistical heterogeneity

Table 1: ConQual Summary of Findings Example

(High; Moderate; Low ; Very Low)

Systematic review title: The patient experience of high technology medical imaging: a systematic review of the qualitative evidence Population: Persons who had undergone high technology medical imaging Phenomena of interest: The meaningfulness of a patients experience of undergoing diagnostic imaging using high technology Context: Male and Female Adult Patients presenting to a medical imaging department					
Synthesized Finding	Type of research	Dependability	Credibility	ConQual Score	Comments
People undergoing imaging often expect a health issue to be found during their scan, which can then lead to anxiety and worry	Qualitative High	Downgrade 1 level* -1=moderate (2–3 yes)	Downgrade 1 level ** -1=Low (Credible)	Low	*Downgraded one level due to dependability of primary studies **Downgraded one level due to equivocal findings

ConQual: Type of sudy+dependability+Credebility

Grades of Recommendation

- Grades of Recommendation are used to assist healthcare professionals when implementing evidence into practice.
- The new JBI grades of recommendation has a binary system for recommendations, with only the two options:

- ‘strong’ (A)
- ‘weak’ (B)

The New JBI Levels of Evidence and Grades of Recommendation are now being used for all JBI documents as of the 1st of March 2014.

JBI Grades of Recommendation	
Grade A	A recomendação "forte" (**A**) para uma determinada estratégia/intervenção, sempre que: 1. é evidente que os efeitos desejáveis compensam os efeitos indesejáveis da estratégia/intervenção; 2. quando há evidência de qualidade adequada a apoiar a sua utilização; 3. há um benefício e nenhum impacto sobre o uso dos recursos, e 4. valores, preferências e a experiência do paciente foram tidas em conta.
Grade B	A recomendação "fraco" (**B**) para uma estratégia/intervenção sempre que: 1. efeitos desejáveis parecem compensar os efeitos indesejáveis da estratégia/intervenção, embora não seja tão claro; 2. há evidências que suportam a sua utilização, embora não sejam de alta qualidade; 3. há um benefício, sem impacto ou impacto mínimo sobre o uso dos

JBI-NOTARI

Text, Expert Opinion and Discourse as Evidence for Policy and Practice

Narrative, opinion, expertise and discourse often represent the best available evidence in areas where research is limited, or where the knowledge that is needed is generally generated through policy-making or other processes rather than through formal research

This kind of knowledge cannot be ignored as legitimate sources of evidence for policy and practice

he seven appraisal Criteria are:

1. **Is the source of the opinion clearly identified?**
   The reviewer needs to be satisfied that the author(s) is named.
2. **Does the source of the opinion have standing in the field of expertise?**
   The qualifications, current appointment and current affiliations with specific groups need to be stated in the publication and the reviewer needs to be satisfied that the author(s) has some standing within the field.
3. **Are the interests of patients the central focus of the opinion?**

Is the focus on achieving the best health outcomes or on advantaging a particular professional or other group? What is the author's purpose?
Who is the author's intended audience?

4. **Is the opinion's basis in logic/experience clearly argued?**

Questions to pose here include: What are the main points in the conclusions or recommendations? What arguments does the author use to support the main points? Is the argument logical? Have important terms been clearly defined? Do the arguments support the main points?

5. Is the Argument developed analytically

Is the opinion the result of an analytical process drawing on experience or theliterature?

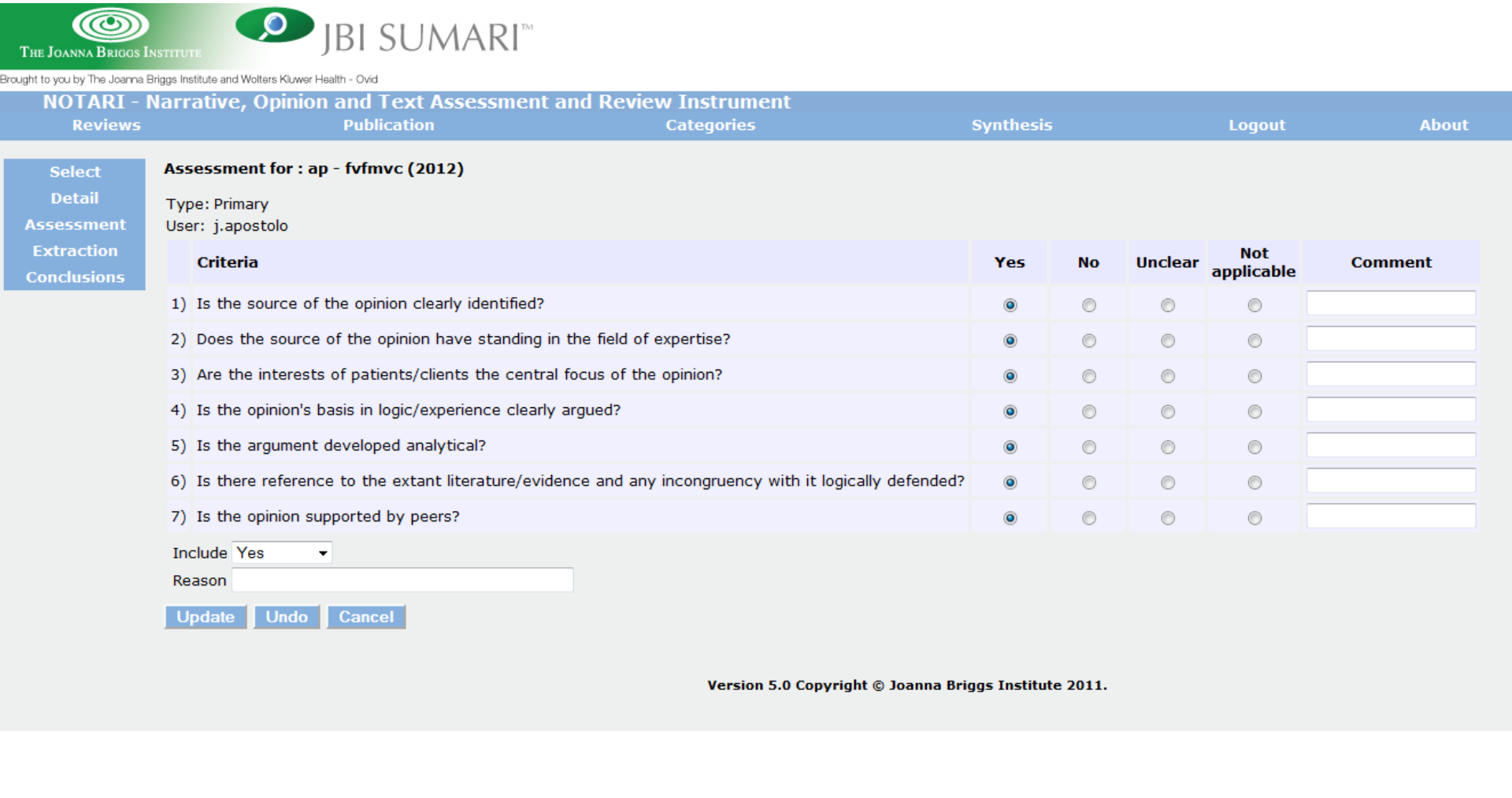
6. **Is there reference to the extant literature/evidence and any incongruency with it logically defended?**

What extant literature does the author present to support the arguments? Are incongruence addressed and justified?

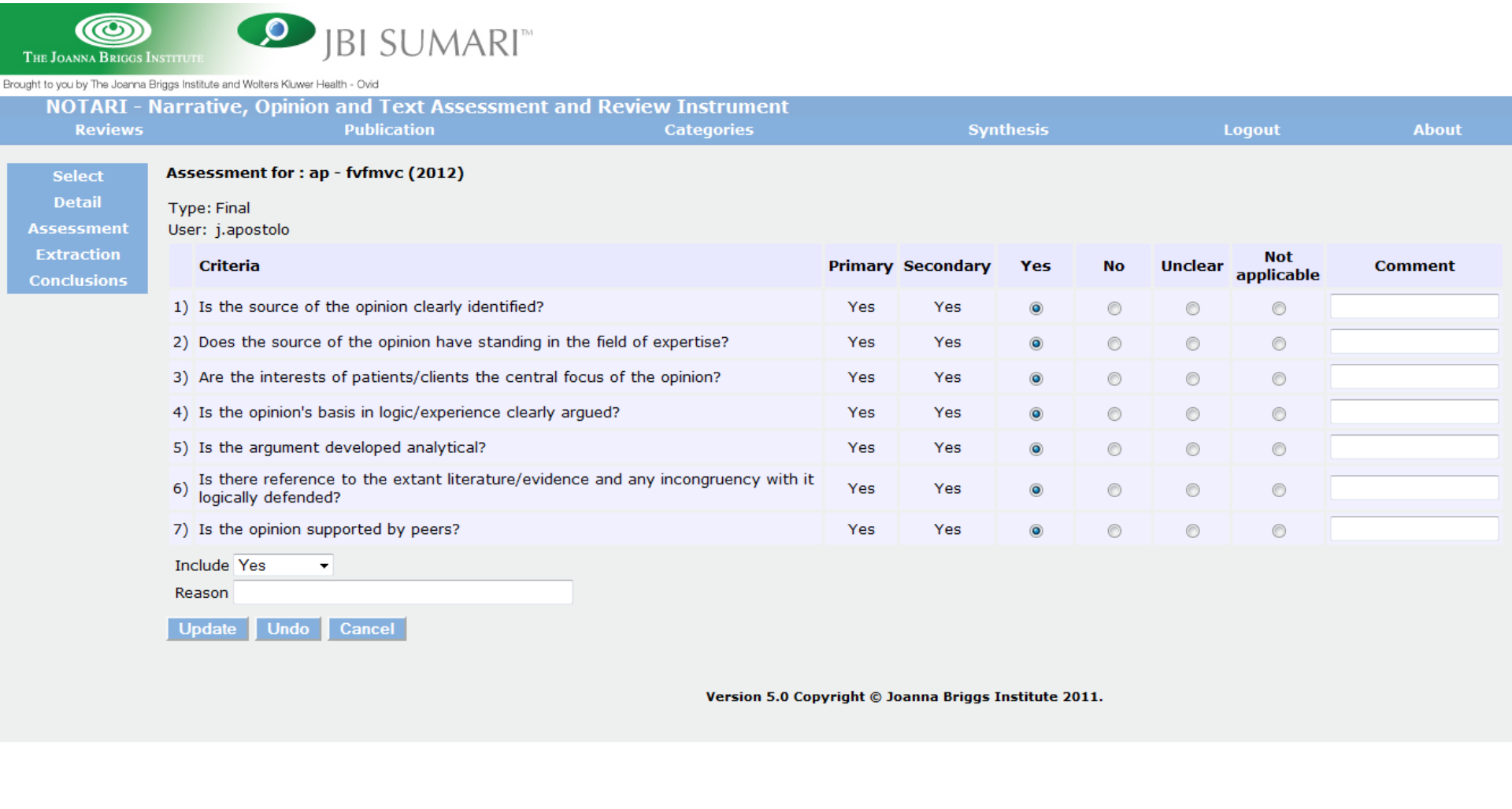
7. **Is the opinion supported by peers?**
   Does the text present and refute opposing points of view?

Based on the standard approach promoted by the Cochrane Collaboration and adopted by the Joanna Briggs Institute, two reviewers are expected to independently critically appraise data, and to then confer.

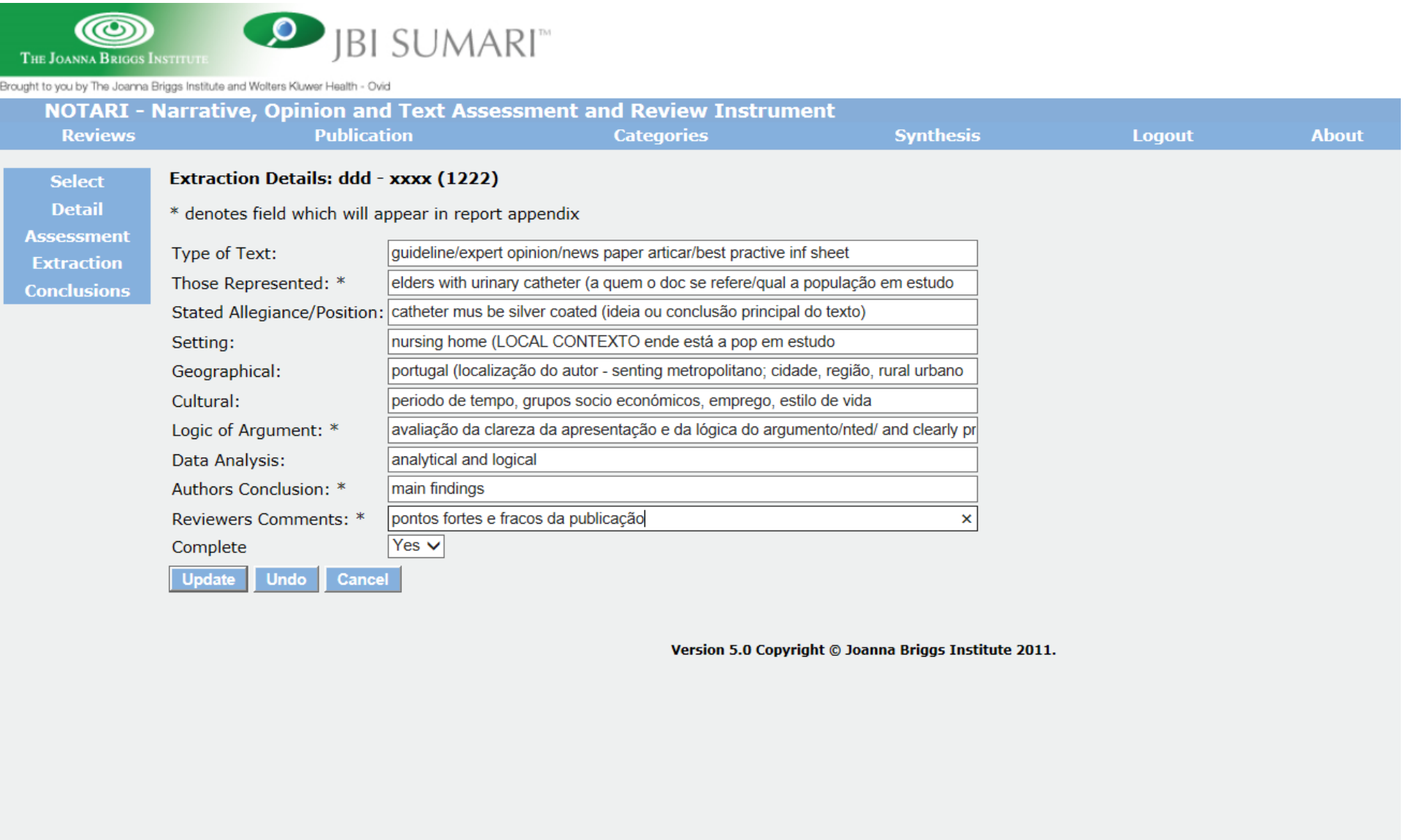
NOTARI - Assessment



NOTARI – Assessment (final)



NOTARI - Extraction



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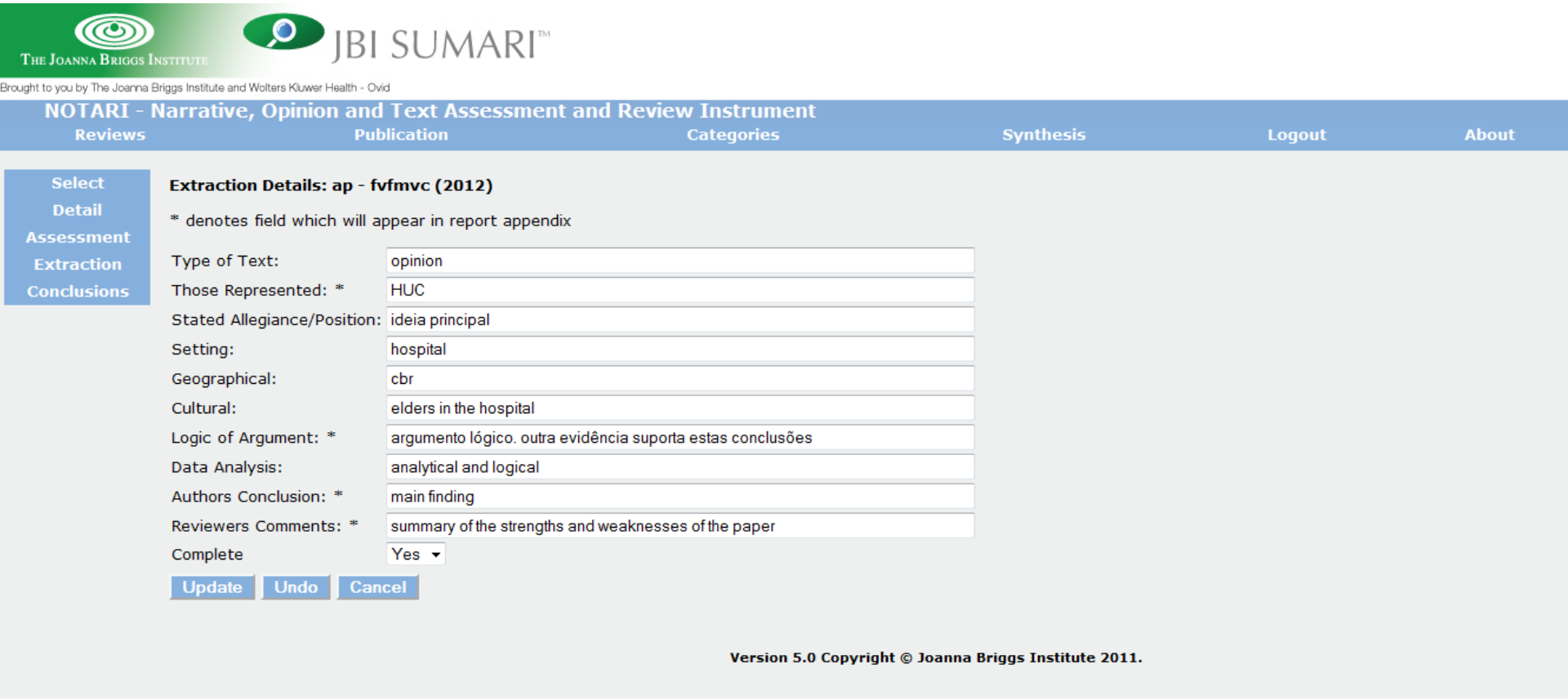
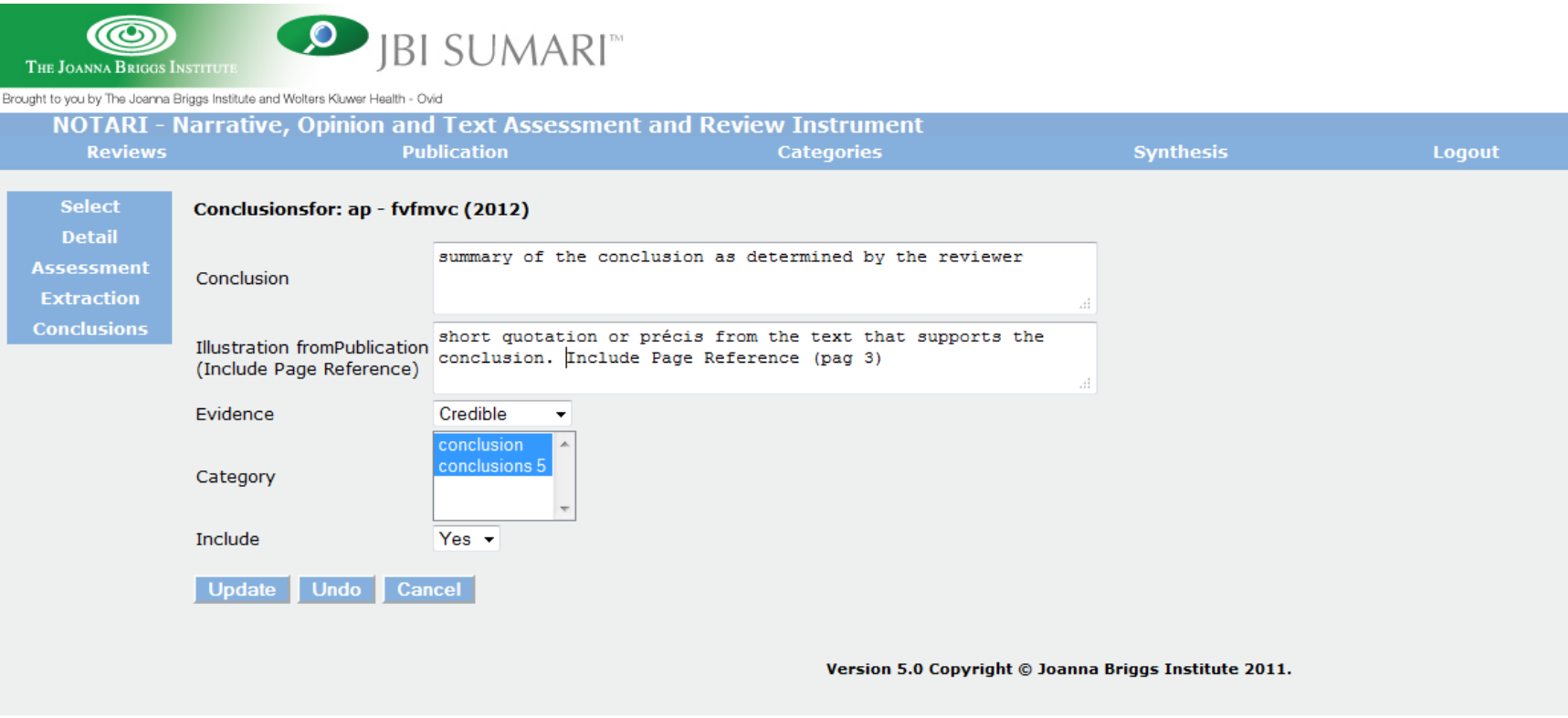
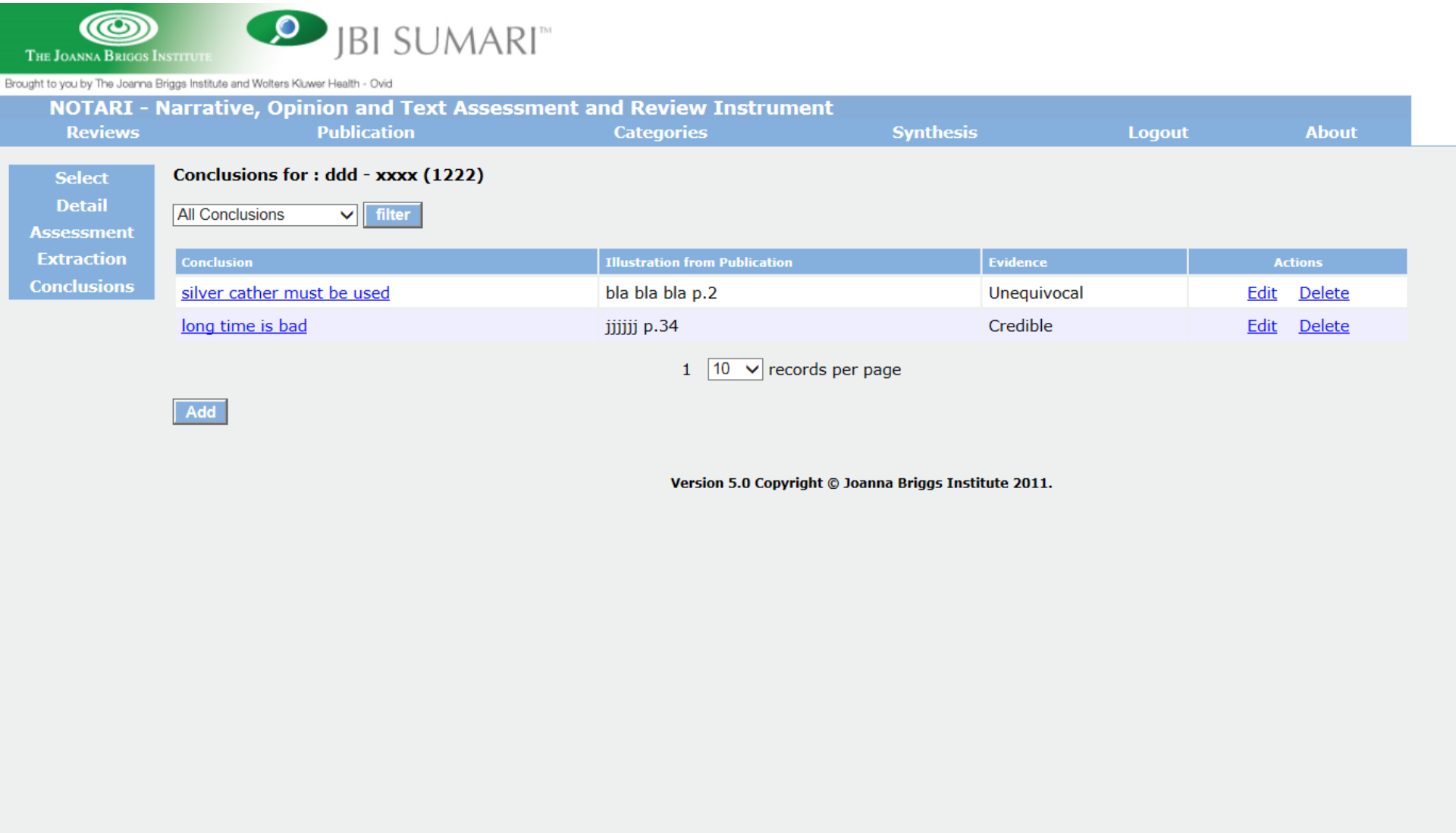


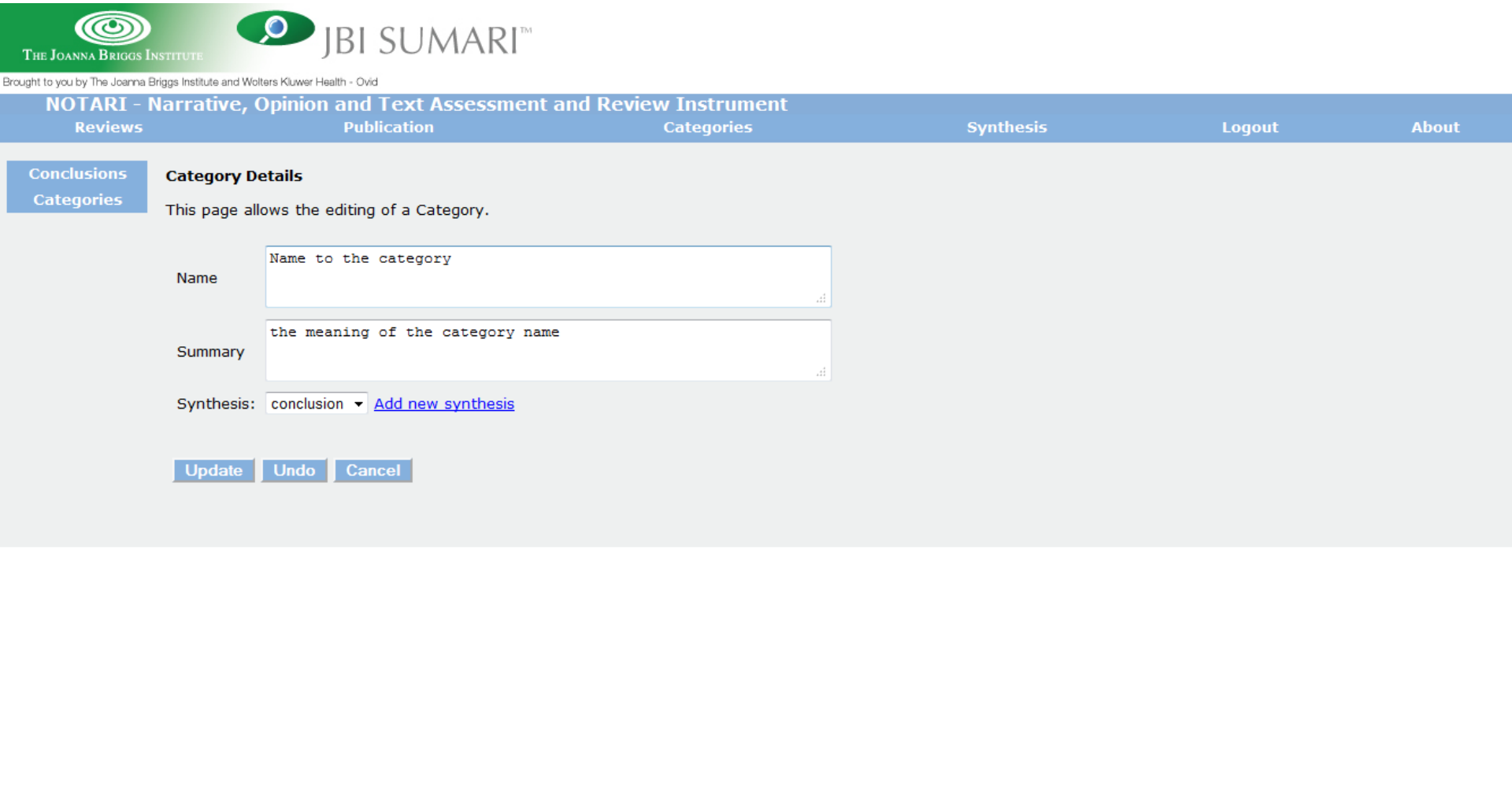
NOTARI – Extraction (Conclusions)



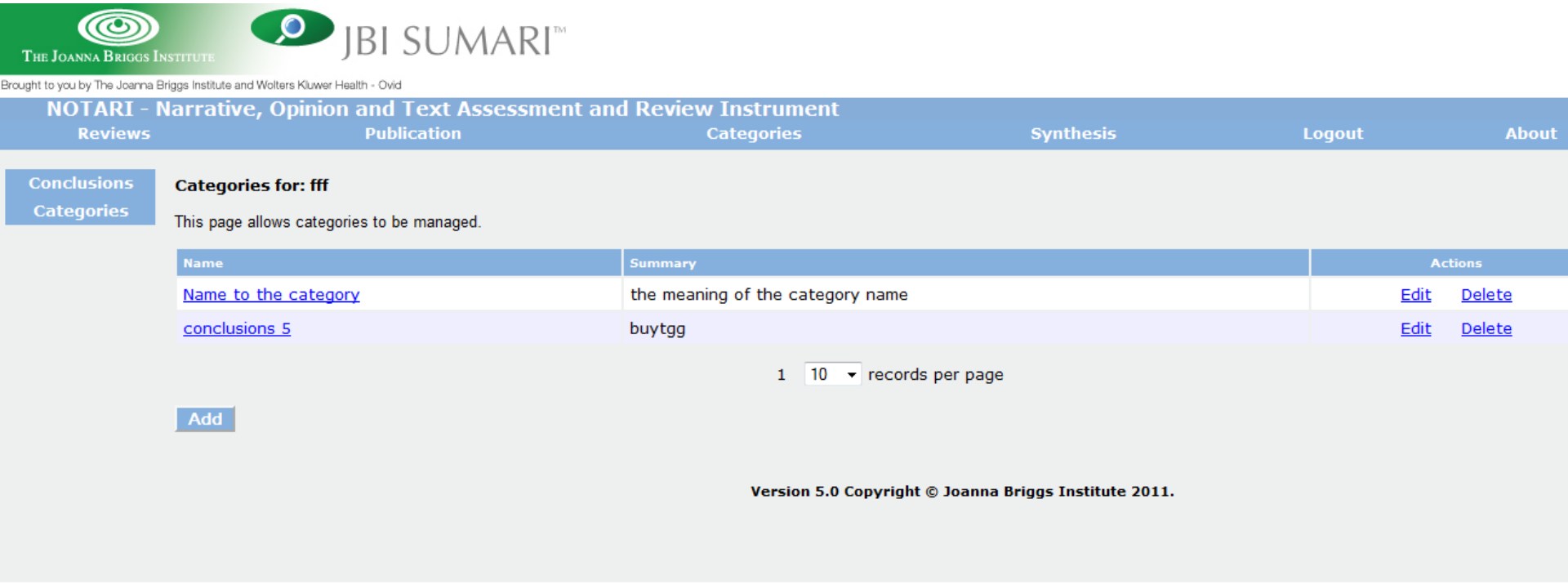
NOTARI – Extraction (Conclusions)



NOTARI – Category details



NOTARI – Categories page



NOTARI – Synthesis details

NOTARI - Narrative, Opinion and Text Assessment and Review Instrument

Reviews | Publication | Categories | Synthesis | Logout | About

Synthesis Details

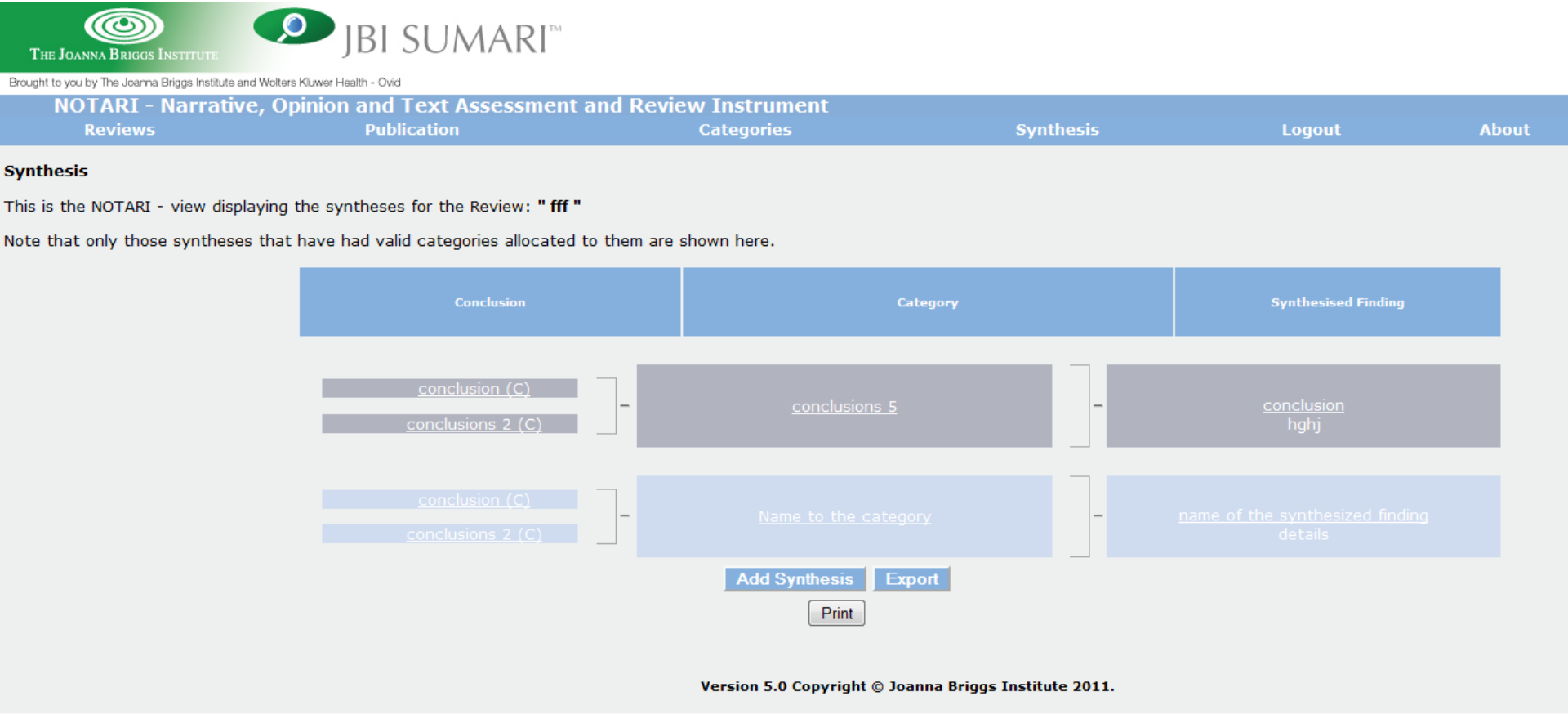
This page allows the addition of a synthesis.

Name: name of the synthesized finding

Summary: details

Insert | Undo | Cancel

NOTARI – Synthesis



JBI-ACTUARI

Types of studies

Types of studies	Costs or measures	Benefits or Consequence measures	Comments
Cost Minimization Analysis (CMA)	Costs measured in monetary units (e.g.. Dollars)	Not measured	CMA is not a form of full economic analysis, the assumption is that benefits or consequences are the same, therefore the preferred option is the cheapest
Cost Effectiveness Analysis (CEA)	Costs measured in monetary units (e.g.. Dollars)	Benefits measured in natural units (e.g.. mmHg, cholesterol levels, symptom free days, years of life saved)	Results are expressed as dollars per case or per injury averted. Different incremental summary economic measures are reported (e.g.. Incremental cost-effectiveness ratio)
Cost Utility Analysis (CUA)	Costs measured in monetary units (e.g.. Dollars)	Benefits expressed in summary measures as combined quantity and quality measures (e.g.. QALY, DALY etc)	Two dimensions of effects measured (quality and length of life); results are expressed for example as cost per QALY
Cost Benefit Analysis (CBA)	Costs measured in monetary units (e.g.. Dollars)	Benefits measured in monetary units (e.g.. Dollars)	Benefits are difficult to measure monetarily, values used are Net Present Value (NPV) and Benefit Cost Ratio (BCR)

Types of Studies

This section should flow naturally from the criteria that have been established to this point, and particularly from the objective and questions the review seeks to address. For JBI reviews of health economic evaluation evidence, there are specific study designs of interest to specific economic questions. These include:

Cost-Minimisation studies: intended to identify the least costly intervention where multiple interventions have demonstrated similar benefit

Cost-Effectiveness studies: where interventions achieve similar outcomes but have unknown or potentially different resource implications

Cost-Utility studies: seek to establish benefit as measured by quantity and quality of life (QALY's)

Cost-Benefit studies: seek to identify a specific monetary ration (gain/loss or cost/benefit) for an intervention

Source of effectiveness data extraction field

There are four options for sources of effectiveness data available in JBI ACTUARI . They refer to the original location of the information from which the effectiveness of the intervention compared to the comparator was derived: Single Study (same participants); Single Study (different participants); Multiple Studies (meta-analysis); Multiple Studies (no meta-analysis). Selection of a particular type of source document determines which data extraction fields become available in JBI ACTUARI in the next phase of extraction.

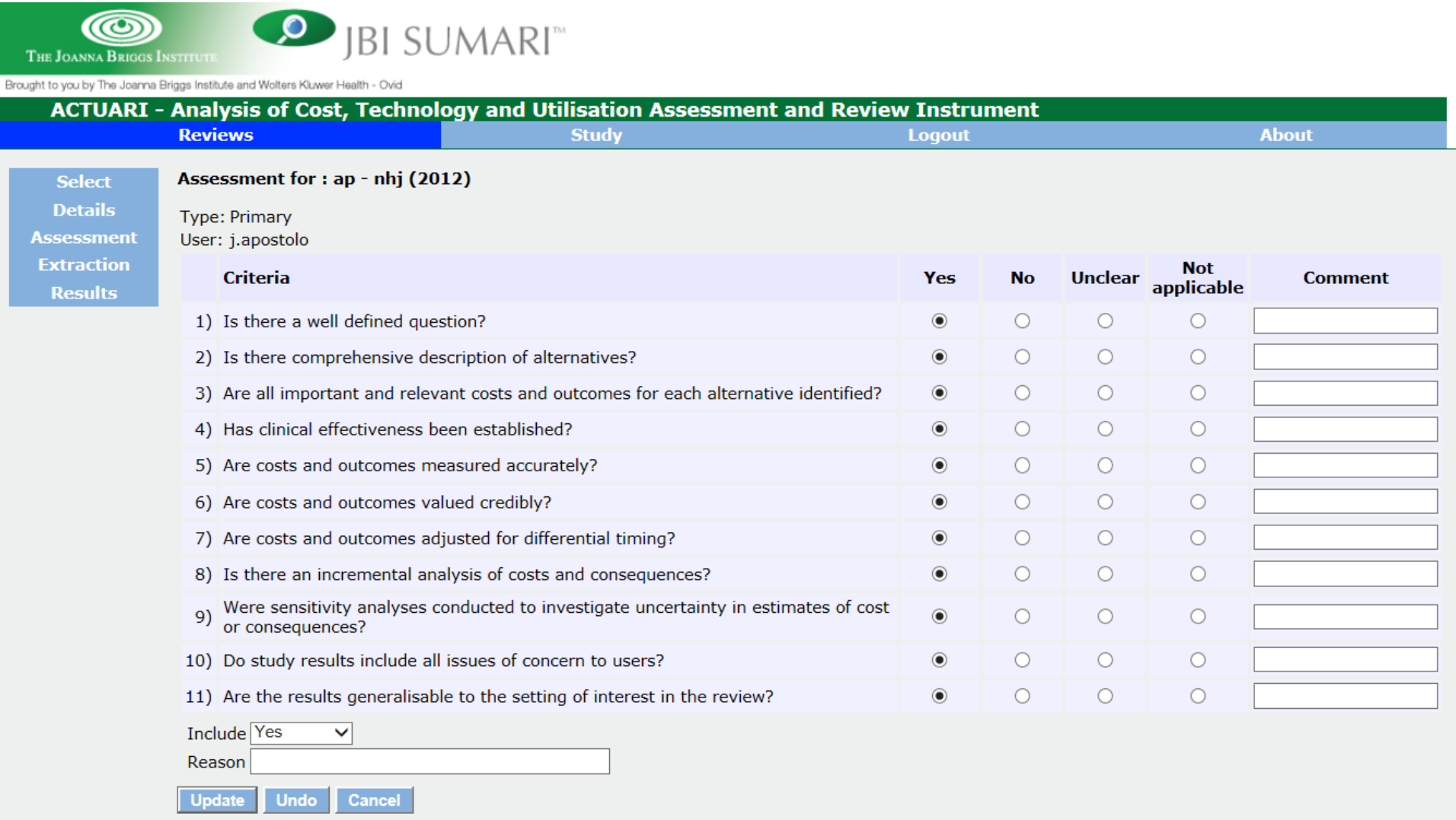
Single study (same participantes)

Parte clinica e parte económica feita aos mesmos sujeitos

Single study (different participantes)

Parte clinica e parte económica feita a sujeitos diferentes

ACTUARI - Assessment



ACTUARI – Assessment (final)

ACTUARI - Analysis of Cost, Technology and Utilisation Assessment and Review Instrument

Reviews | Study | Logout | About

Select
Details
Assessment
Extraction
Results

Assessment for : ap - nhj (2012)

Type: Final
User: j.apostolo

	Criteria	Primary	Secondary	Yes	No	Unclear	Not applicable	Comment
1)	Is there a well defined question?	Yes	Yes	◉	○	○	○	
2)	Is there comprehensive description of alternatives?	Yes	Yes	◉	○	○	○	
3)	Are all important and relevant costs and outcomes for each alternative identified?	Yes	Yes	◉	○	○	○	
4)	Has clinical effectiveness been established?	Yes	Yes	◉	○	○	○	
5)	Are costs and outcomes measured accurately?	Yes	Yes	◉	○	○	○	
6)	Are costs and outcomes valued credibly?	Yes	Yes	◉	○	○	○	
7)	Are costs and outcomes adjusted for differential timing?	Yes	Yes	◉	○	○	○	
8)	Is there an incremental analysis of costs and consequences?	Yes	Yes	◉	○	○	○	
9)	Were sensitivity analyses conducted to investigate uncertainty in estimates of cost or consequences?	Yes	Yes	◉	○	○	○	
10)	Do study results include all issues of concern to users?	Yes	Yes	◉	○	○	○	
11)	Are the results generalisable to the setting of interest in the review?	Yes	Yes	◉	○	○	○	

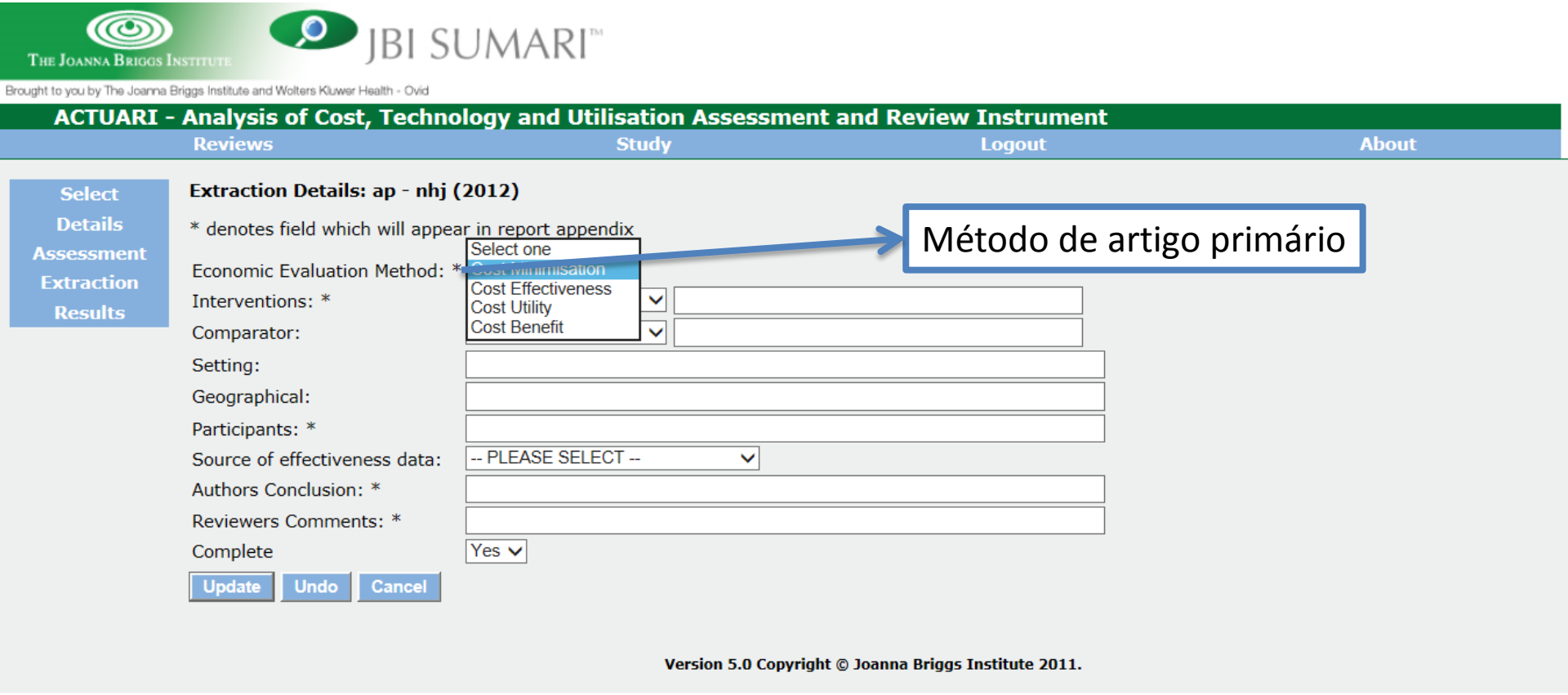
Include Yes

Reason

Update | Undo | Cancel

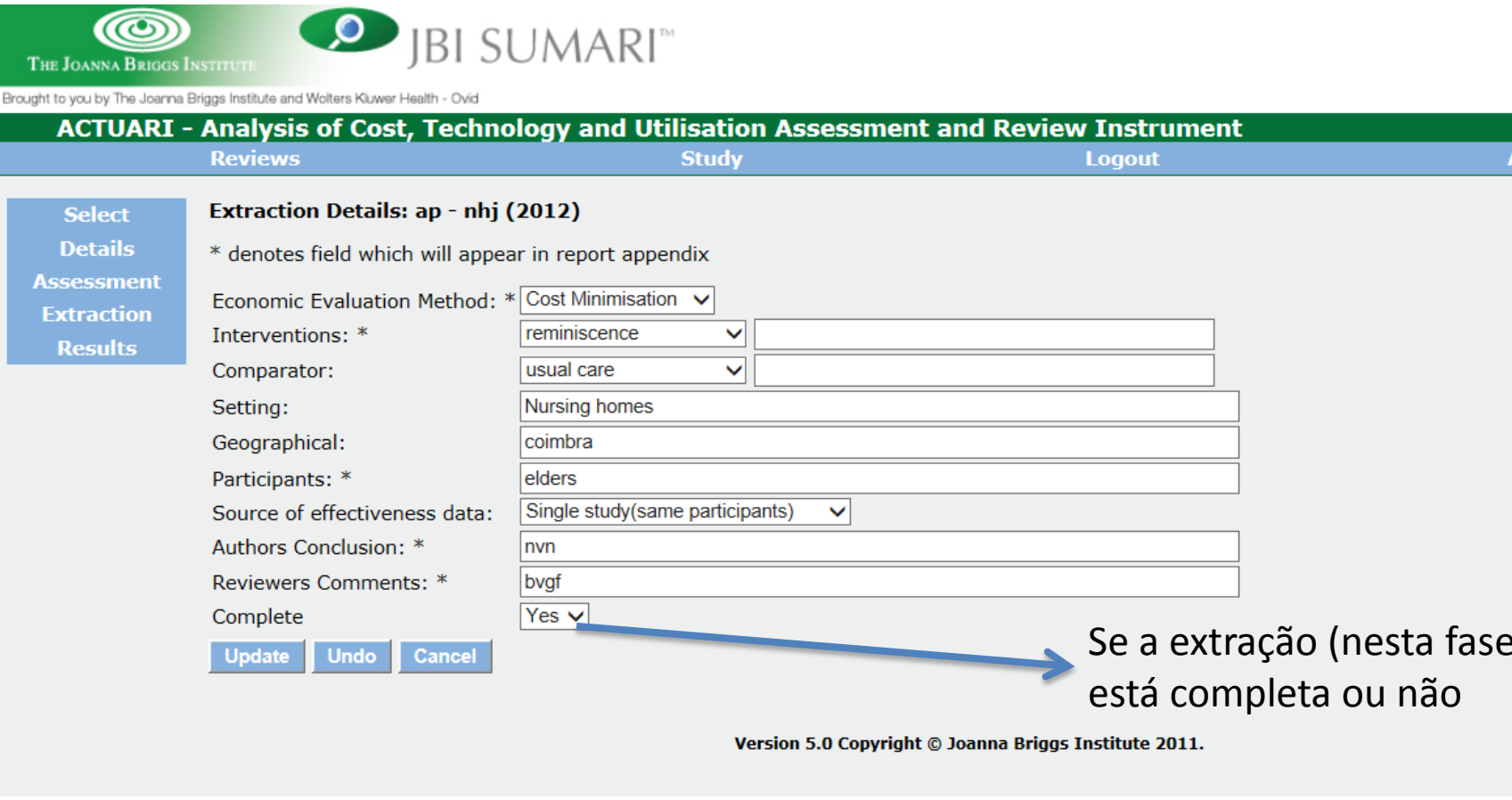
ACTUARI – Extraction

First level extraction



ACTUARI – Extraction

First level extraction



Se a extração (nesta fase) está completa ou não

ACTUARI – Extraction
First level extraction

Extraction Details: Jones - Chest (2008)

* denotes field which will appear in report appendix

Economic Evaluation Method: *	Cost Effectiveness
Interventions: *	TAD
Comparator:	Gauze
Setting:	hospital
Geographical:	USA
Participants: *	adults in tertiary care facility
Source of effectiveness data:	Single study(same participants)
Authors Conclusion: *	TAD is clinically effective
Reviewers Comments: *	TAD was as effective, but not more effective than gauze
Complete	Yes

Update Undo Cancel

the next relates to any linkages between data collected on effectiveness and cost – for example, were the effectiveness data and costs data collected on the same or different participants?

ACTUARI – Extraction
First level extraction

Source of effectiveness data

- There are four options available to select from the scroll down menu in this field. They refer to the original location of the information from which the effectiveness of the intervention compared to the comparator was derived:

1 grelha de extração

Single Study (same participants);

Single Study (different participants);

1 grelha de extração

Multiple Studies (meta-analysis);

Multiple Studies (no meta-analysis).

4 tipologias de extração diferentes na fase seguinte

- **Selection of a particular type of source document determines which data extraction fields become available in the next phase of extraction.**

ACTUARI – Extraction

Second level extraction

New Outcome for: Weeks - Chest (2009) - Edit Extraction Details

Clinical Effectiveness results

Study design:	RCT
Study date:	
Sample size:	255
Analysis used:	intention to treat / logistic regression etc
Clinical outcome results:	favours TAD

Economic Effectiveness results

Date/s of economic data:	2006
Link between effectiveness and cost data:	data collected on the same participants as the experimental trial
Measure of benefits used in economic evaluation:	dollar costs
Direct costs:	all direct costs included
Indirect costs:	all indirect costs included
Currency:	$USD
Sensitivity analysis:	not conducted
Estimated benefits used in EE:	costs compared with outcomes for the treatment and control
Cost results:	this is a summary of the economic findings of the paper
Synthesis of costs and results:	summary statement of economics and clinical impact

any sensitivity analysis conducted as part of the primary study

Outcome category

Cost \ Clinical effectiveness	+	0	-
+	A	B	C
0	D	E	F
-	G	H	I

Update outcome

Key	
Effectiveness	Cost
+ Better	Higher
0 Equal	Equal
- Poorer	Lower

A **sensitivity analysis would be conducted to determine whether the economic model and its conclusions are robust to changes in the underlying assumptions of the model.** Details of sensitivity analysis should be reported.

Clinical effectiveness results data extraction fields

This section relates to evidence on the clinical effectiveness of the intervention versus the comparator, or control group. The five fields in this section are designed for numbers and free text relating to the study design, for instance: randomised controlled study, cohort study; the study date (in years); sample size (in numbers, combining both treatment and comparator groups if relevant); type of analysis used (eg. intention to treat analysis); and the clinical outcome results (survival, survival at 1 year, survival at 5 years, stroke avoided, fracture avoided, pain intensity, frequency of vomiting, frequency of pain etc). .

Economic effectiveness results data extraction field

There are ten fields in the economic effectiveness results section. The first relates to the date (year) when the economic data were collected; the next relates to any linkages between data collected on effectiveness and cost – for example, were the effectiveness data and costs data collected on the same or different participants?

For the modelling data extraction field state the economic model used in the economic evaluation study. The 'Modelling' field can be used to describe any economic evaluation models that were part of the economic evaluation.

The third field requires a list of the measurements of benefits that were used in the economic evaluation.

The fourth, fifth and sixth data extraction fields relate to costs examined in the study: direct costs of the intervention/program being evaluated, indirect costs and the currency used to measure the costs.

For currency data extraction field quote the currency as reported in the original study, for example AUD $, US $, EUR. State whether any conversions were undertaken.

For statistical analysis of costs data extraction field report descriptive statistics methods used and results, statistical parametric tests used and results including levels of significance, statistical nonparametrical tests used, data transformation methods used.

The seventh field relates to the results of any sensitivity analysis conducted as part of the study. A sensitivity analysis would be conducted to determine whether the economic model and its conclusions are robust to changes in the underlying assumptions of the model. Details of sensitivity analysis should be reported.

The eighth field relates to listing the estimated benefits to using the intervention instead of the comparator, for example the incremental lives saved, or the incremental life-years gained, or the the incremental quality-adjusted life years gained.

The ninth field requires a summary of the cost results findings, and the tenth is a summary of the synthesis of the costs and results.

For a summary of costs report the following: total intervention cost, total comparator cost, average costs and incremental costs, results of statistical analysis of costs, results of sensitivity analysis of costs, discounted and not discounted values for costs.

For a summary of synthesis of costs and benefits report how the costs and benefits were combined, for example as cost per life saved, or cost per QALY.

Once these fields have been completed, the final step in data extraction is also the foundational step in data synthesis.

ACTUARI – Extraction

Second level extraction – Single study

Reviews | Study | Logout | About

Select
Details
Assessment
Extraction
Results

New Outcome for: ap - nhj (2012) - Edit Extraction Details

Single study(same participants)

Clinical Effectiveness results

Study design:	RCT
Study date:	2003-03-20
Sample size:	200
Analysis used:	repeated measures anova
Clinical outcome results:	depression

Economic Effectiveness results

Date/s of economic data:	
Link between effectiveness and cost data:	
Measure of benefits used in economic evaluation:	
Direct costs:	
Indirect costs:	
Currency:	
Sensitivity analysis:	
Estimated benefits used in EE:	
Cost results:	
Synthesis of costs and results:	

Outcome category

	Clinical effectiveness +	0	-
+	A	B	C
Cost 0	D	E	F
-	G	H	I

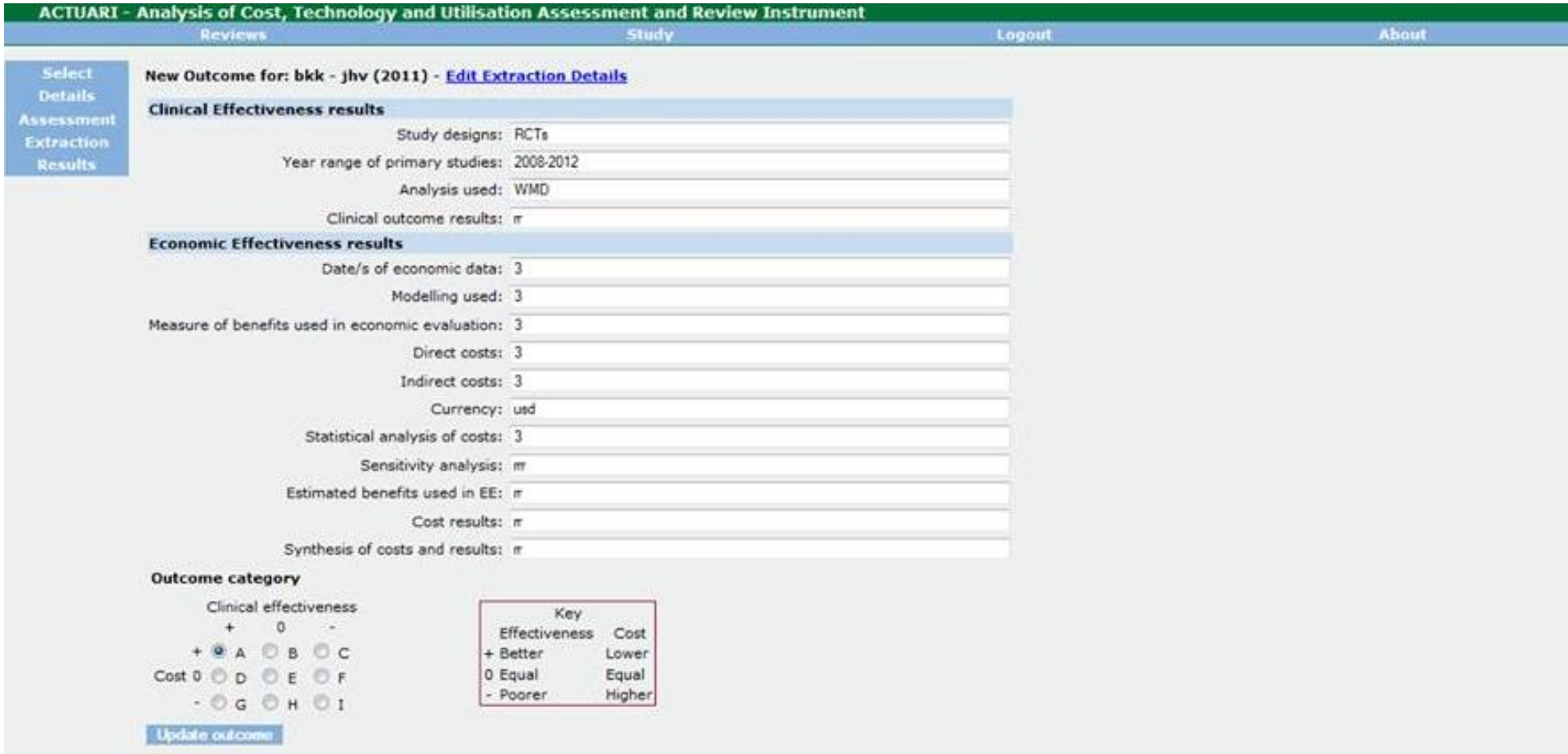
Key

	Effectiveness	Cost
+	Better	Higher
0	Equal	Equal
-	Poorer	Lower

Update outcome

ACTUARI – Extraction

Second level extraction – Multiple studies



ACTUARI – Extraction

Second level extraction – Outcome category

The outcome category is included in the detailed extraction, but is not actually an extraction of data. This is where you as a reviewer will, on the basis of your knowledge of a paper give an indication of where it sits in terms of costs and clinical effectiveness. You can come back to this screen and edit/update your decision at a later date.

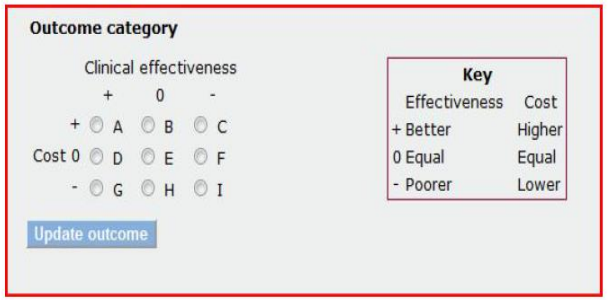
Outcome category

In comparing the clinical effectiveness of two alternatives there are three possibilities:

(i) the intervention of interest is better or more effective (ie a '+') than the comparator,

(ii) the intervention is equally effective (ie a '0') or

(iii) the intervention is less effective (ie a '-').



Similarly, in terms of cost, there are three possibilities:

(i) the intervention is more expensive (ie a '+'),

(ii) the intervention and comparator's costs are the same (ie a '0'), or

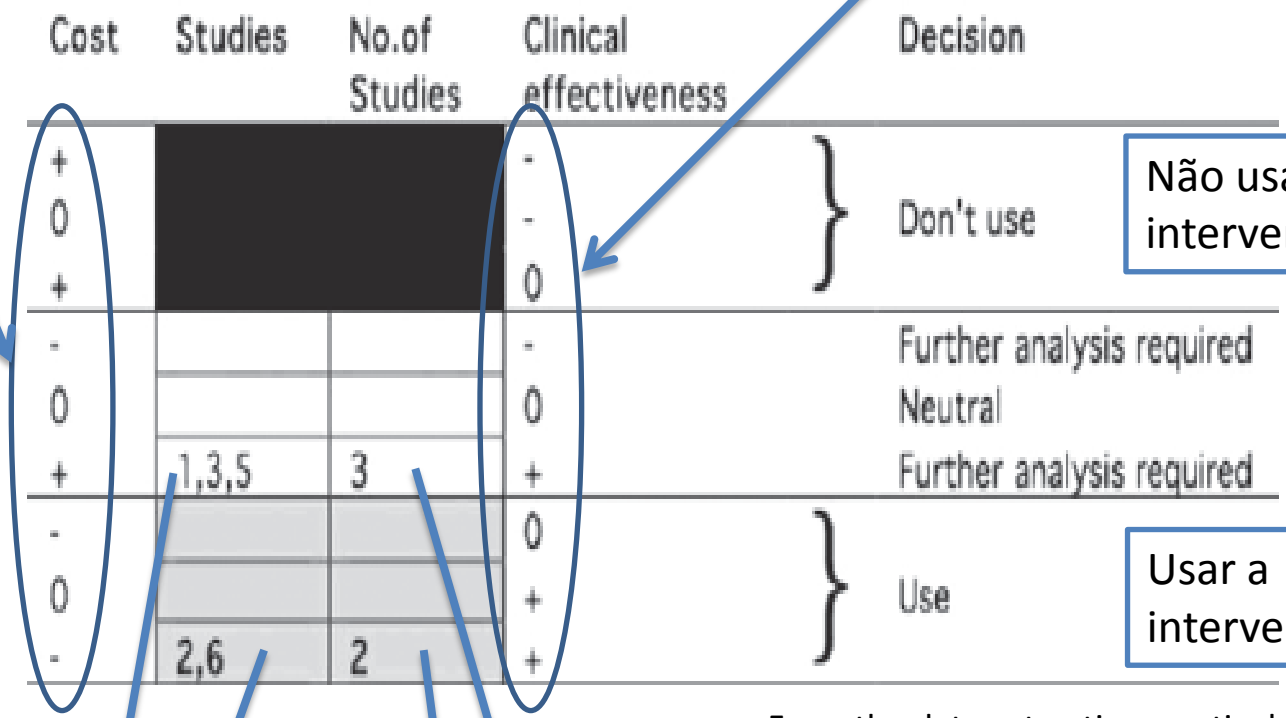
(iii) the intervention is less expensive (ie a '-').

Note that each of the comparisons between intervention and comparator can only be classed as one of nine options (A – I). For example, an intervention that was shown to be more effective and less expensive would be scored as 'G', whereas an intervention that was less effective and of equal cost would be scored as 'F'.

ACTUARI decision matrix summary of economic evidence

Relativo ao custo

Relativo à eficácia clínica



Não usar a intervenção

Necessária mais investigação

Usar a intervenção

Identificação dos estudos

Número de estudos

From the data extraction, particularly the outcome specific data per included paper, reviewers are able to generate a matrix, which lists the comparison of interest, the score from the three by three matrix for each study ('the dominance rating') and the study citation. Discuss the matrix.

FAME

- Evidence of feasibility – “the extent to which an activity is practical and practicable. Clinical feasibility is about whether or not an activity or intervention is physically, culturally or financially practical or possible within a given context”. (**Praticável /possível num contexto)**

- Evidence of appropriateness – “the extent to which an intervention or activity fits with or is apt in a situation. Clinical appropriateness is about how an activity or intervention relates to the context in which care is given.” (**Apropriada ao contexto de cuidados**)
- Evidence of meaningfulness – “the extent to which an intervention or activity is positively experienced by the patent. Meaningfulness relates to the personal experience, opinions, values, thoughts, beliefs and interpretations of patients or clients.” (**se faz sentido e positivamente experienciada por aqueles doentes**)

- Evidence of effectiveness – “is the extent to which an intervention, when used appropriately, achieves the intended effect. Clinical effectiveness is about the **relationship between an intervention and clinical or health outcomes**.” (Pearson et al 2005:210)

link http://joannabriggs.org/jbi-approach.html#tabbed-nav=Grades-of-Recommendation

Grades of Recommendation are used to assist healthcare professionals when implementing evidence into practice.

The Joanna Briggs Institute and collaborating entities currently assign a Grade of Recommendation to all recommendations made in its resources, including Evidence Summaries, Systematic Reviews and Best Practice Information Sheets. These Grades are intended to be used alongside the supporting document outlining their use.

JBI Grades of Recommendation	
Grade A	A 'strong' recommendation for a certain health management strategy where: 1. it is clear that desirable effects outweigh undesirable effects of the strategy; 2. where there is evidence of adequate quality supporting its use; 3. there is a benefit or no impact on resource use, and 4. values, preferences and the patient experience have been taken into account.
Grade B	A 'weak' recommendation for a certain health management strategy where: 1. desirable effects appear to outweigh undesirable effects of the strategy, although this is not as clear; 2. where there is evidence supporting its use, although this may not be of high quality; 3. there is a benefit, no impact or minimal impact on resource use, and 4. values, preferences and the patient experience may or may not have been taken into account.