Wolters Kluwer Health

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Joanna Briggs Institute

Evidence-Based Practice Resources

JBI實證護理資料庫

What is Joanna Briggs Institute

1. Joanna Briggs Institute (JBI)

1) 附屬於澳洲阿德雷德大學
2) 國際公認實證實務資訊權威機構之一
3) 其開發的實證基礎實務模式，被醫療照護產業視為基準指標。
4) 與全球 70 多個實證照護中心合作，提供經由研究分析、評價、專家評論編輯而成，同時兼顧研究的質與量之實證實務資訊。

2. JBI 的資源特色

1) JBI 清楚的提供醫護人員可以立即運用在臨床的作法
2) 非提供冗長的治療方式比較與研究過程。
3) 在國際間醫療單位的使用經驗上，能確實地大大提高工作上的效率與病患安全。

JBI Databases – 16主題

Aged Care 老年保健	Burns Care 燒燙傷護理
Cancer Care 癌症護理	Infection Control 感染控制
Chronic Disease 慢性症護理	Mental Health 心理健康
Diagnostic Imaging 影像診斷	Midwifery Care 助產護理
Emergency & Trauma 急診及創傷	Rehabilitation 復原照護
General Medicine 全科醫學	Surgical Services 外科服務
Health Management & Assessment 健康管理與評估	Wound Healing and Management 傷口癒合和管理
Pediatrics 兒童護理	Tropical and Infectious Disease 熱帶和傳染病護理

七大類實證文獻類型

實證摘錄

Evidence Summaries

實證式建議實務

Evidence-Based
Recommended Practices

最佳實務資訊

Best Practice Information Sheet

患者衛教單

Consumer Information Sheets

系統式評論

Systematic Reviews

系統式評論常規標準

Systematic Review Protocols

技術報告

Technical Reports

Systematic Reviews

Systematic Reviews

- 文獻的分析
  - 提出一個問題
  - 建立收錄原則
  - 建立廣泛搜索實證的策略
  - 評估每篇文章的質量
  - 擷取文章中的精華
  - 綜述各篇文章中的要點

Systematic Review Protocols

- 文獻背景資訊和進行系統化綜述的計劃

JBI Library of Systematic Reviews JBL000208 2009; 7(14):583-614

A meta-synthesis of women's perceptions and experiences of breastfeeding support

Virginia Schmied, PhD, RM [1]
Sarah Beake, MA RM RN [2]
Athena Sheehan, PhD, MN, RM, RN [3]
Christine McCourt, PhD BA [4]
Fiona Dykes, PhD, MA, RGN, RM, ADM, Cert Ed [5]

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4. Professor of Anthropology & Health, Centre for Research in Midwifery and Childbirth, Thames Valley University, London, UK and also visiting professor, NMAHP Research Unit, University of Stirling.
5. Professor of Maternal and Infant Health and Director of Maternal and Infant Nutrition and Nurture Unit (MAINN), School of Public Health and Clinical Sciences, University of Central Lancashire, England, Adjunct Professor, University of Western Sydney.

Corresponding author: Sarah Beake, Centre for Research in Midwifery and Childbirth, Thames Valley University, Paragon House, Boston Manor Road, Brentford, TW8 9GA, UK. E-mail: Sarah.Beake@tvu.ac.uk

Executive Summary

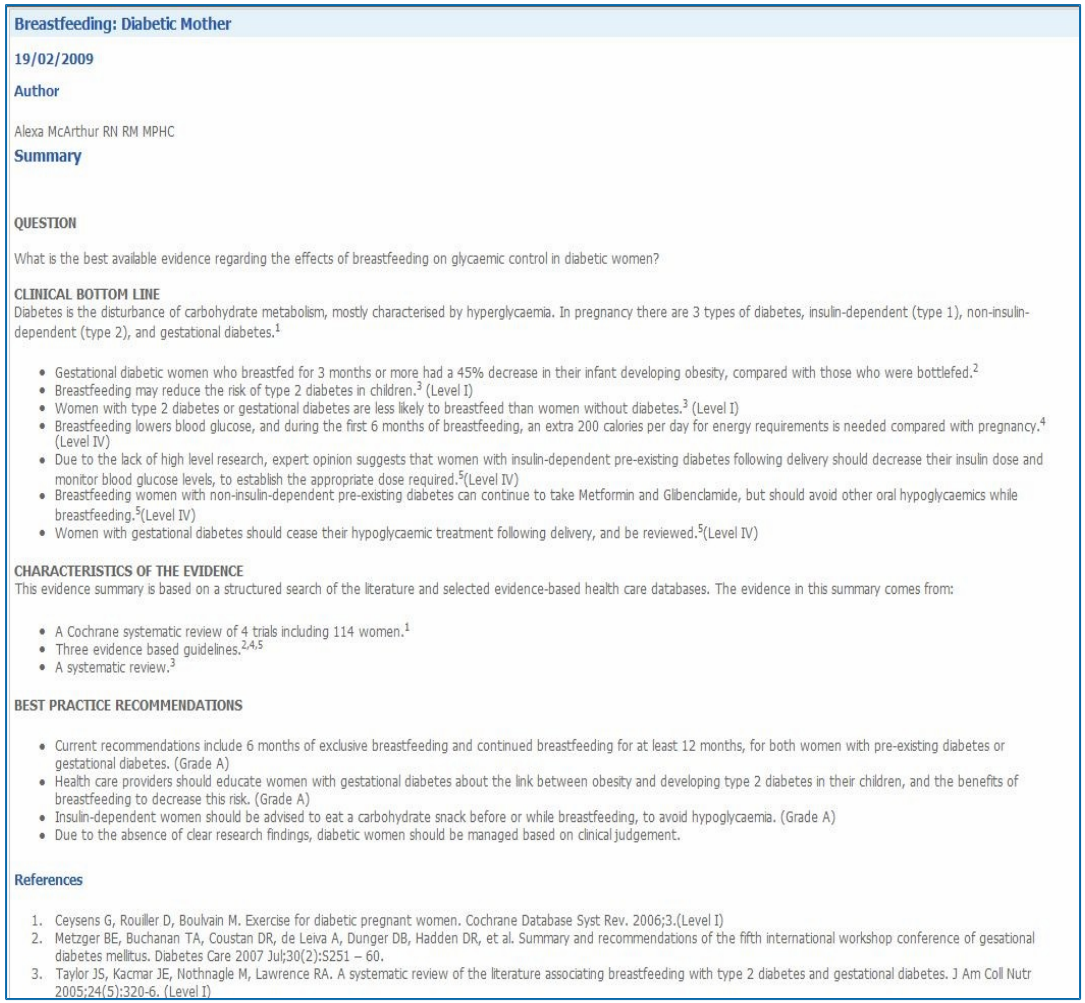
Background- Breastfeeding conveys significant health benefits to infants and mothers yet in many affluent nations breastfeeding rates continue to decline across the early months following birth. Both peer and professional support have been identified as important to the success of breastfeeding. What is not known are the key components or elements of support that are effective in increasing the duration of breastfeeding?

Objectives- The aim of this meta-synthesis was to examine women's perceptions and experiences of breastfeeding support, either professional or peer, in order to illuminate the components of support that they deem 'supportive'. A secondary aim was to describe any differences between components of Peer and Professional support.

Selection criteria- Both primiparous and multiparous women who initiated breastfeeding were included in the study. Studies that included a specific demographic sub-group, such as

Evidence Summaries

- 綜述臨床治療或過程的精煉要點、簡短摘 要
- 基於系統化的文獻檢索和權威實證醫療資料庫
- 連接研究與臨床醫療實務的重要橋樑



Breastfeeding: Diabetic Mother

19/02/2009

Author

Alexa McArthur RN RM MPHC

Summary

QUESTION

What is the best available evidence regarding the effects of breastfeeding on glycaemic control in diabetic women?

CLINICAL BOTTOM LINE

Diabetes is the disturbance of carbohydrate metabolism, mostly characterised by hyperglycaemia. In pregnancy there are 3 types of diabetes, insulin-dependent (type 1), non-insulin-dependent (type 2), and gestational diabetes.[1]

- Gestational diabetic women who breastfed for 3 months or more had a 45% decrease in their infant developing obesity, compared with those who were bottlefed.[2]
- Breastfeeding may reduce the risk of type 2 diabetes in children.[3] (Level I)
- Women with type 2 diabetes or gestational diabetes are less likely to breastfeed than women without diabetes.[3] (Level I)
- Breastfeeding lowers blood glucose, and during the first 6 months of breastfeeding, an extra 200 calories per day for energy requirements is needed compared with pregnancy.[4] (Level IV)
- Due to the lack of high level research, expert opinion suggests that women with insulin-dependent pre-existing diabetes following delivery should decrease their insulin dose and monitor blood glucose levels, to establish the appropriate dose required.[5](Level IV)
- Breastfeeding women with non-insulin-dependent pre-existing diabetes can continue to take Metformin and Glibenclamide, but should avoid other oral hypoglycaemics while breastfeeding.[5](Level IV)
- Women with gestational diabetes should cease their hypoglycaemic treatment following delivery, and be reviewed.[5](Level IV)

CHARACTERISTICS OF THE EVIDENCE

This evidence summary is based on a structured search of the literature and selected evidence-based health care databases. The evidence in this summary comes from:

- A Cochrane systematic review of 4 trials including 114 women.[1]
- Three evidence based guidelines.[2,4,5]
- A systematic review.[3]

BEST PRACTICE RECOMMENDATIONS

- Current recommendations include 6 months of exclusive breastfeeding and continued breastfeeding for at least 12 months, for both women with pre-existing diabetes or gestational diabetes. (Grade A)
- Health care providers should educate women with gestational diabetes about the link between obesity and developing type 2 diabetes in their children, and the benefits of breastfeeding to decrease this risk. (Grade A)
- Insulin-dependent women should be advised to eat a carbohydrate snack before or while breastfeeding, to avoid hypoglycaemia. (Grade A)
- Due to the absence of clear research findings, diabetic women should be managed based on clinical judgement.

References

1. Ceysens G, Rouiller D, Boulvain M. Exercise for diabetic pregnant women. Cochrane Database Syst Rev. 2006;3.(Level I)
2. Metzger BE, Buchanan TA, Coustan DR, de Leiva A, Dunger DB, Hadden DR, et al. Summary and recommendations of the fifth international workshop conference of gesational diabetes mellitus. Diabetes Care 2007 Jul;30(2):S251 – 60.
3. Taylor JS, Kacmar JE, Nothnagle M, Lawrence RA. A systematic review of the literature associating breastfeeding with type 2 diabetes and gestational diabetes. J Am Coll Nutr 2005;24(5):320-6. (Level I)

Best Practice Information Sheets

Best Practice Information Sheets

- 基於系統化評論的結果和建議
- 從大量文獻中擷取出來的關鍵議題和建議的取得方式或途徑

Technical Reports

- 獲取並綜述出最佳實務資訊

Best Practice

Volume 10
Issue 2
2006
ISSN: 1329-1874

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.

Solutions

Tap water should not be used if declared unpotable (unsuitable for drinking). Tap water should be run for 15 seconds prior to use.

1. For adults with lacerations and postoperative wounds, potable tap water may be an effective cleansing solution. However, the choice of solution should reflect patient preference and a formal economic evaluation. **(Grade B)**
2. Chronic wounds in adults may be cleansed using potable tap water if normal saline is unavailable. **(Grade B)**
3. Potable tap water may be used for cleansing simple lacerations in children. **(Grade A)**
4. Boiled and cooled water is an effective wound cleansing solution in the absence of normal saline or potable tap water. **(Grade C)**
5. ***Irrigation*** with 1% povidone-iodine is effective in reducing the infection rate in contaminated wounds. **(Grade B)** However there is no evidence of the optimal time that Povidone Iodine should be left in place. **(Grade E)**

Pressure

1. Pressures of 13 psi is effective in reducing infection and inflammation in both adults and children with lacerations and traumatic wounds. **(Grade B)**

Techniques

1. Showering patients does not impact on infection and healing rates of postoperative wounds, and may benefit patients with a feeling of well-being and health associated with cleanliness. **(Grade A)**
2. Showering for cleaning ulcers and other chronic wounds should be undertaken with caution. **(Grade C)**
3. Whirlpool therapy may reduce pain and inflammation in surgical wounds and improve the healing rate in pressure ulcers. **(Grade C)**
4. There is no research to support or refute swabbing and scrubbing to cleanse wounds.
5. Sitz bath may be used for patients following episiotomy. **(Grade E)**
6. ***Soaking*** in 1 % povidone-iodine is not effective in reducing bacterial count. **(Grade B)**

Due to a lack of research evidence, these recommendations should not be extrapolated to immuno-suppressed patients.

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).

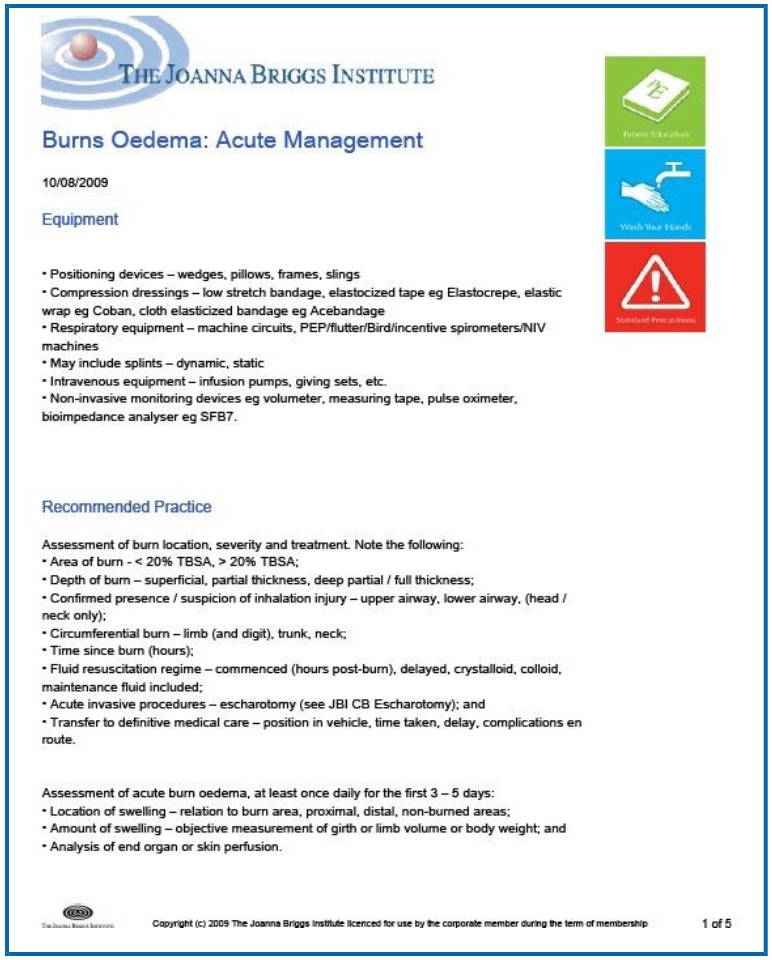
Grades of Recommendation

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 Recommended Practices

- 描述臨床實務中最佳的治療或過程:
  - 設備清單
  - 實務建議
  - 職業健康
  - 安全措施
  - 實證綜論



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Burns Oedema: Acute Management

10/08/2009

Equipment

- Positioning devices – wedges, pillows, frames, slings
- Compression dressings – low stretch bandage, elastocized tape eg Elastocrepe, elastic wrap eg Coban, cloth elasticized bandage eg Acebandage
- Respiratory equipment – machine circuits, PEP/flutter/Bird/incentive spirometers/NIV machines
- May include splints – dynamic, static
- Intravenous equipment – infusion pumps, giving sets, etc.
- Non-invasive monitoring devices eg volumeter, measuring tape, pulse oximeter, bioimpedance analyser eg SFB7.

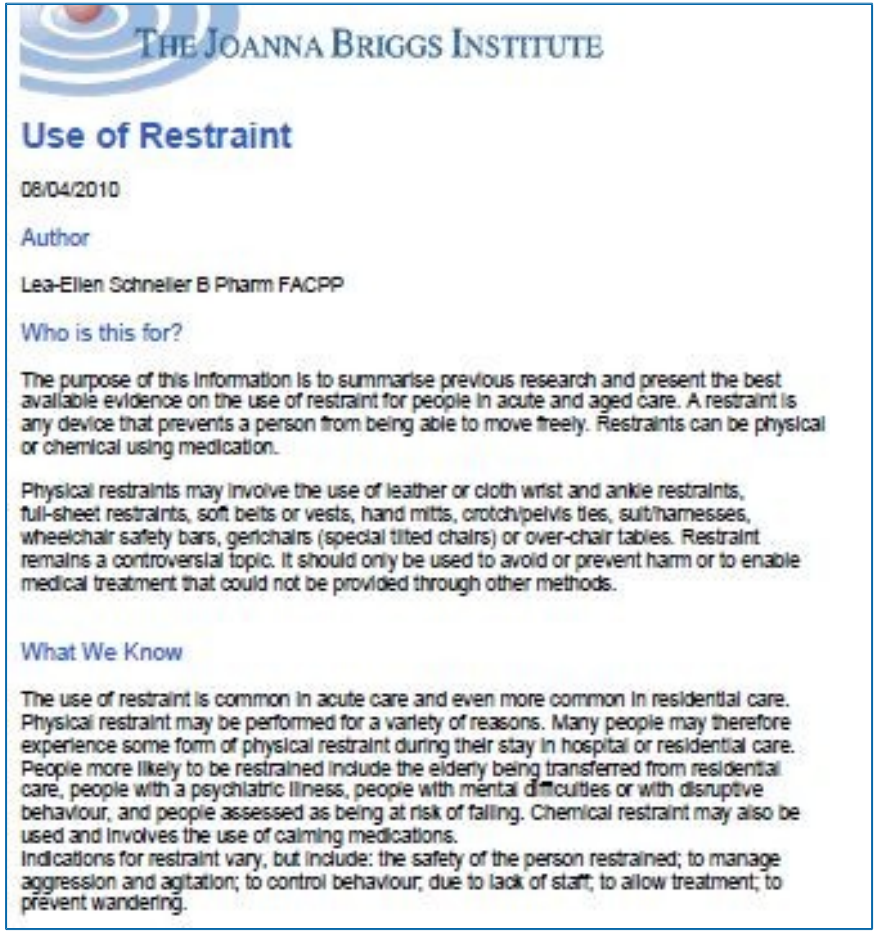
Recommended Practice

Assessment of burn location, severity and treatment. Note the following:
- Area of burn - < 20% TBSA, > 20% TBSA;
- Depth of burn – superficial, partial thickness, deep partial / full thickness;
- Confirmed presence / suspicion of inhalation injury – upper airway, lower airway, (head / neck only);
- Circumferential burn – limb (and digit), trunk, neck;
- Time since burn (hours);
- Fluid resuscitation regime – commenced (hours post-burn), delayed, crystalloid, colloid, maintenance fluid included;
- Acute invasive procedures – escharotomy (see JBI CB Escharotomy); and
- Transfer to definitive medical care – position in vehicle, time taken, delay, complications en route.

Assessment of acute burn oedema, at least once daily for the first 3 – 5 days:
- Location of swelling – relation to burn area, proximal, distal, non-burned areas;
- Amount of swelling – objective measurement of girth or limb volume or body weight; and
- Analysis of end organ or skin perfusion.

Consumer Information Sheets

- 實證資訊
- 簡單、易讀
- 指導病人、家屬



THE JOANNA BRIGGS INSTITUTE

Use of Restraint

08/04/2010

Author

Lea-Ellen Schneller B Pharm FACPP

Who is this for?

The purpose of this information is to summarise previous research and present the best available evidence on the use of restraint for people in acute and aged care. A restraint is any device that prevents a person from being able to move freely. Restraints can be physical or chemical using medication.

Physical restraints may involve the use of leather or cloth wrist and ankle restraints, full-sheet restraints, soft belts or vests, hand mitts, crotch/pelvis ties, suit/harnesses, wheelchair safety bars, gerichairs (special tilted chairs) or over-chair tables. Restraint remains a controversial topic. It should only be used to avoid or prevent harm or to enable medical treatment that could not be provided through other methods.

What We Know

The use of restraint is common in acute care and even more common in residential care. Physical restraint may be performed for a variety of reasons. Many people may therefore experience some form of physical restraint during their stay in hospital or residential care. People more likely to be restrained include the elderly being transferred from residential care, people with a psychiatric illness, people with mental difficulties or with disruptive behaviour, and people assessed as being at risk of falling. Chemical restraint may also be used and involves the use of calming medications.
Indications for restraint vary, but include: the safety of the person restrained; to manage aggression and agitation; to control behaviour; due to lack of staff; to allow treatment; to prevent wandering.

登入JBI 實證護理資料庫

醫療照護專業人士及機構殷切期盼根據最新實證研究結果、醫療照護專業及患者偏好，為患者提供最高品質的照護。

Joanna Briggs Institute (JBI) 是全球領先的實證式實務 (EBP) 機構之一，所提供的最新資源正能幫助他們達成上述目標，而現在透過 Ovid 上線了！

JBI 的實證基礎實務模式被醫療照護產業視為基準指標，鼓勵醫療照護專業人士採取有效的實證式實務方案，盡可能提供最高品質的患者照護。

檢索 JBI EBP Database:

JBI EBP Resources on Ovid

scabies 檢索

刊物種類: All

主題節點: All

實務所需資訊:

JBI 的內容資料庫涵蓋獨一無二的豐富資訊，可協助醫療照護專業人士的實證式實務工作。

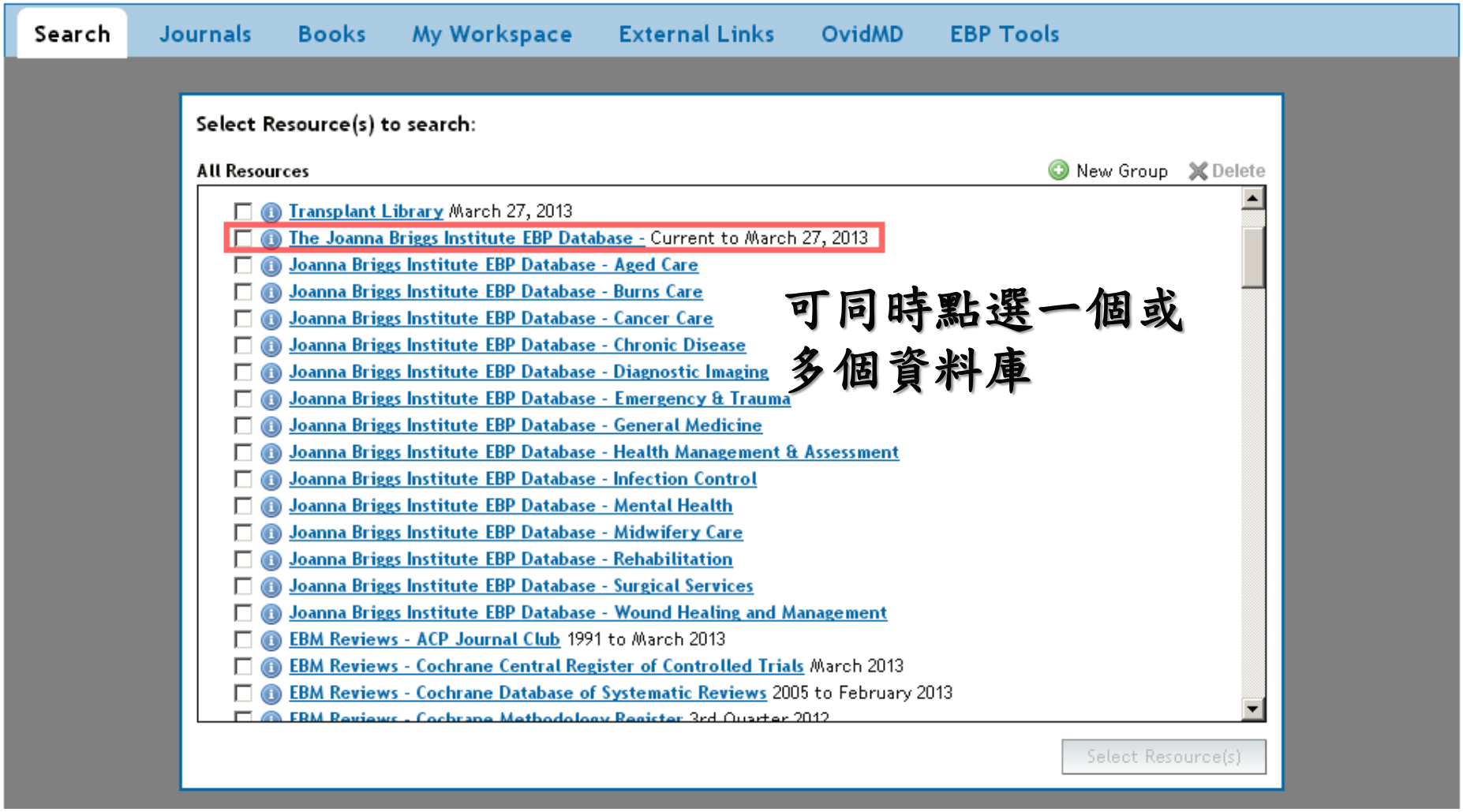
- **實證摘錄** –針對常見醫療照護干預和作業的現有國際文獻進行摘述的文獻評論
- **實證式建議實務** –以豐富實證資訊為基礎的程序資料庫，針對各種臨床主題說明和/或建議實務

專家檢索:

檢索這些題目請按此連結:

- 醫療錯誤 – 最佳處置資料單張
- 背痛復健 – 建議措施
- 團體治療 – 精神健康節點

登陸Ovid平臺，選擇JBI資料庫



Basic Search- 背傷復健的建議措施

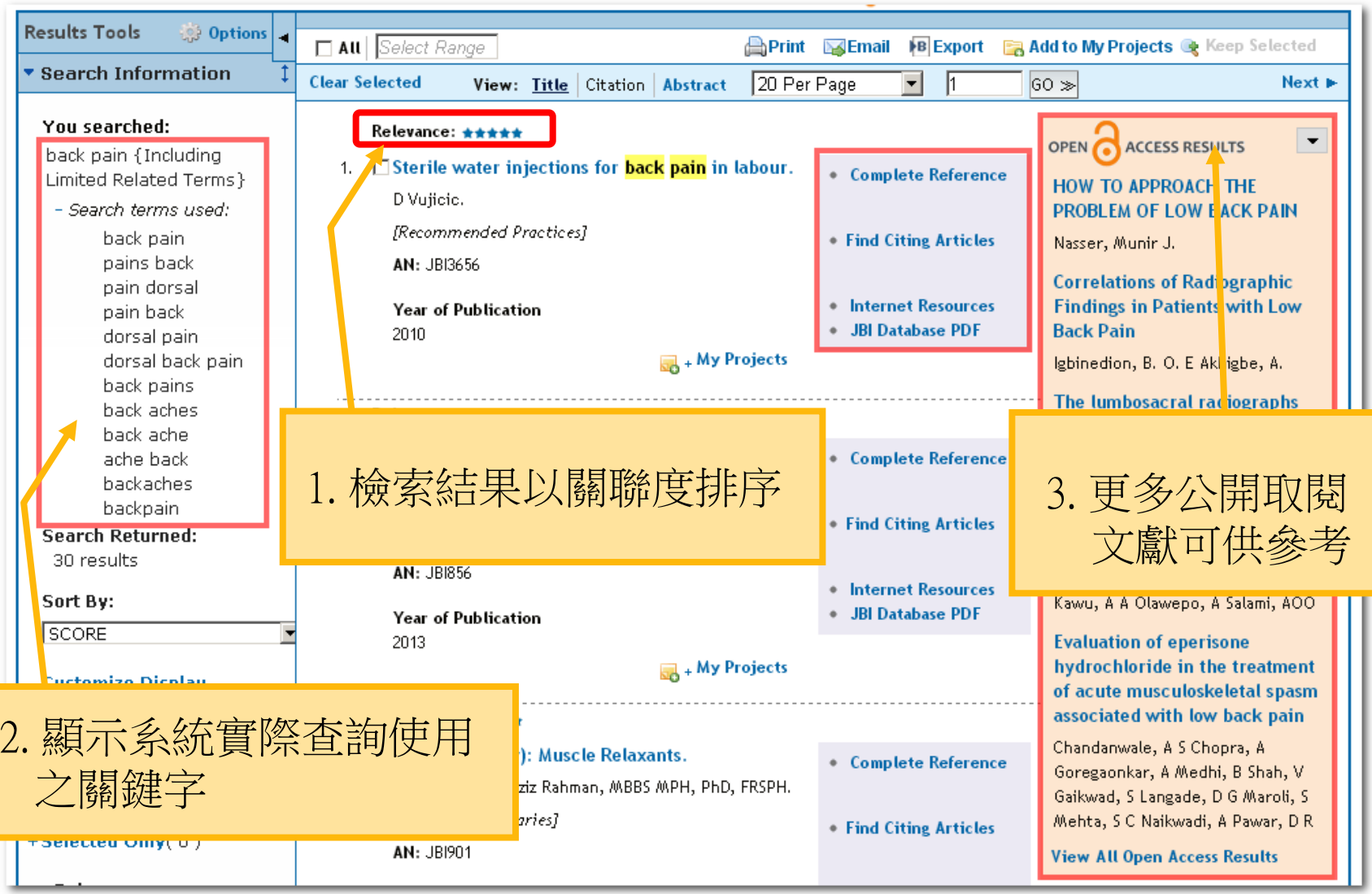
Include Related Terms

1. 同義之字/詞/片語
2. 單複數與詞性變化形
3. 英美語系之異體字
4. 專業縮寫/全寫
5. 可對應之標題詞

Limits

1. 可直接設定限制查詢的選項
2. 可依需求展開或折疊

Basic Search 檢索結果頁面:



1. 檢索結果以關聯度排序

2. 顯示系統實際查詢使用之關鍵字

3. 更多公開取閱文獻可供參考

背傷復健的建議措施: 以文獻類型做篩選

Search | Journals | Books | My Workspace | External Links | OvidMD | EBP Tools

THE JOANNA BRIGGS INSTITUTE

Chronic Low Back Pain: Exercise Therapy

27/11/2012

Author

Dr Susan Slade, BScApp (Physio), Grad Dip Manip Ther, M Musc Ther, PhD

Summary

Question

How effective is exercise therapy for treatment of chronic low back pain?

Clinical Bottom Line

Exercise therapy is the most widely used type of conservative treatment for low back pain. Systematic reviews have demonstrated that exercise therapy is effective in reducing pain and improving function in the treatment of non-specific chronic low back pain (NSCLBP). Exercise therapy might be provided as a single treatment or be part of a multimodal or multidisciplinary program and vary in type, intensity, frequency and duration.[1]

• A 2010 overview of Cochrane reviews of exercises for chronic low back pain was conducted to summarize their effectiveness. The authors reported that effects are small and

如需要更多詳細內容

JBI on OvidSP Resource Center

http://access.ovid.com/training/jbi

OvidSP Resource Center

http://resourcecenter.ovid.com/site/resources/index_ovidsp.jsp