# Evidence-Based Practice

https://www.amazon.fr/LEGO-Figurines-Collectionner-Chirurgien-Mini-Figurine/dp/B006XK808A

# Evidence-Based

- C’est quoi?
  - S’efforce de fonder, autant que possible, les décisions cliniques sur les données actuelles les plus probantes (les preuves) issues de la recherche (Pasleau, 2000).
  - En d’autres mots, c’est la pratique infirmière informée par les résulats de recherche. (Gagnon, 2011)

# Evidence-based

- Ne remplace pas le jugement clinique, elle le complète
- Vise à optimiser la qualité des soins et services offerts aux patients, sur base actuelle des connaissances probantes, scientifiques.
- « *Evidence based practice is the integration of best research evidence with clinical expertise and patient values to facilitate clinical decision making* » (DiCenso, Ciliska et Guyatt, 2005, p.4)

# L'Evidence-Based contribue à l'améloriation de certaines choses pour:

- Les soins de santé
  - Augmentation de la qualité des soins
  - Médecine intégrant les connaissances scientifiques les plus actuelles et les plus pointues  en se fondant sur les données probantes
  - Standardisation de certaines prises en charge, Guidelines
- Les prestataires
  - Mise à jour des connaissances de base
  - Perfectionnement des techniques de recherche documentaire
  - Amélioration des habitudes de lecture
- Les patients
  - Amélioration de la communication entre les cliniciens et non cliniciens

# Les inconvénients

- Besoin de temps pour l'apprentissage et la pratique de la méthode.
- Nécessité d'un minimum de matériel, de connaissances informatiques, méthodologiques et statistiques.
- Accès aux sources.
- Les articles sont bien souvent écrit en anglais
- Rend les prises en charge parfois plus complexes.
- Caractère unique de chaque patient, peut-on généraliser?
- Rapidité de l'évolution des connaissances, pléthores d'informations, parfois vite dépassées…obsolètes…

# L'histoire de Gertrude

Gertrude, 78 ans sera opérée demain. On lui posera une prothèse totale du genou. Elle a rencontré l'anesthésiste, elle lui a fait part de son anxiété, elle n'a jamais été anesthésié auparavent. Elle verbalise abondemment à l'infirmière ses craintes et son angoisse. Elle apréhende non seulement l'opération mais aussi la douleur après l'opération. L'infirmière du service discute avec une infirmière du quartier opératoire de ce qu'on pourrait proposer à Gertrude pour l'aider à gérer son anxiété pré-opératoire et éventuellement la douleur post-opératoire.

Et si les pistes de solution se trouvaient dans les données probantes???

# Et alors ??? Fondement de la décision clinique

- Face à toutes situations clinique, différentes réponses ou attitudes sont possibles:

  « on a toujours fait comme ça… »: Tradition-based: tradtition, routine

  « j'ai l'impression que… »: Confidence-based: intuition

  « j'ai déjà eu un patient qui… »: Experience-based

  « l'ordre des pharmaciens dit que… »: Obedience-based: autorité

  « la littérature scientifique dit que… »: Evidence-based: preuves

  Quelle est la meilleure attitude?

# Les 5 étapes de l'Evidence-Based

1. ÉNONCER une **question** précise: PICO
2. ACCÉDER à la meilleure **information**
3. Faire une LECTURE **critique** de l'information
4. CONCRÉTISER la preuve dans la pratique clinique
5. ÉVALUER

Sacket et al., JAMA 1994

# 2. ACCÉDER à la meilleure **information**

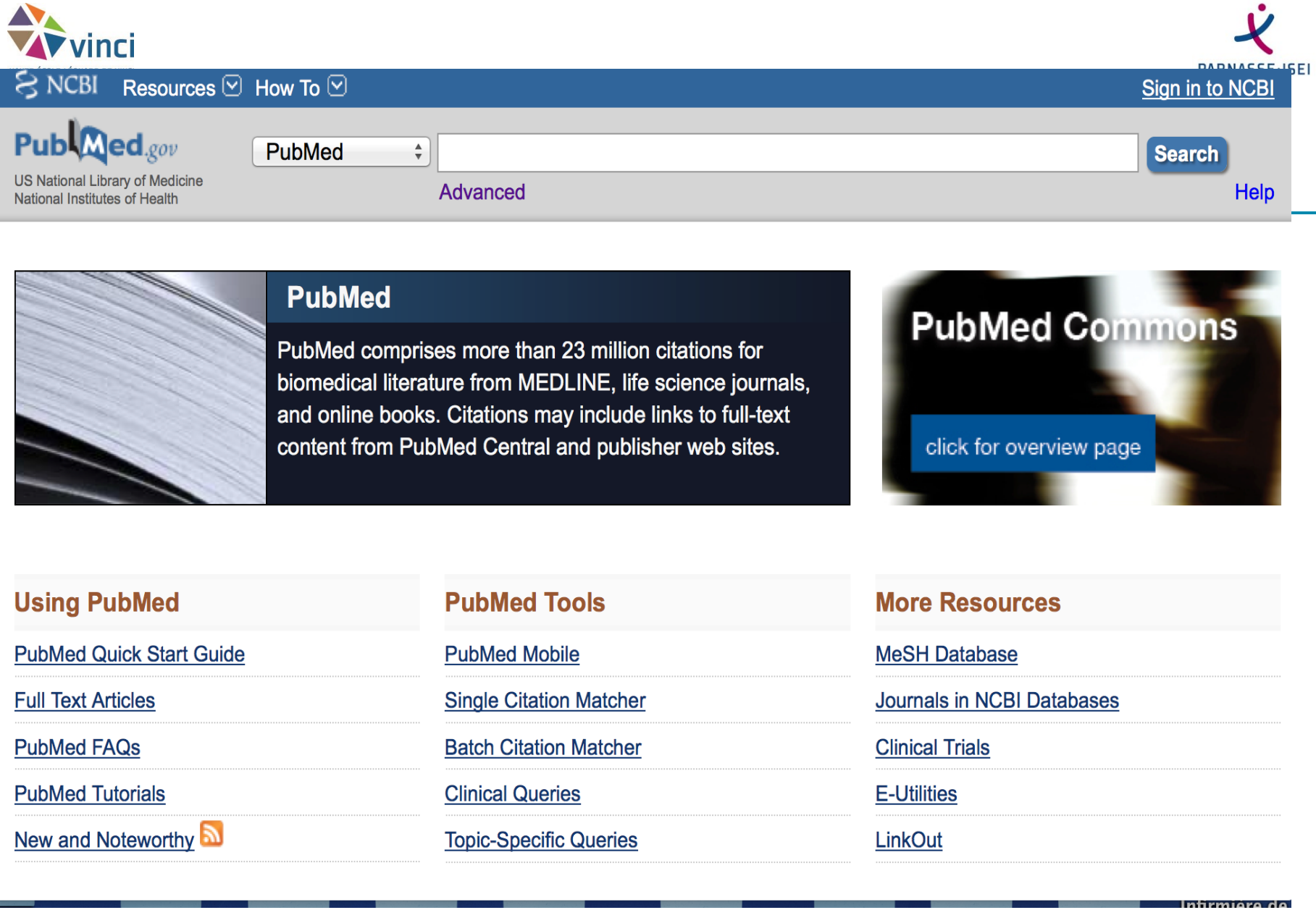
- Mots clefs,
- Mesh terms

(medical subject heading) en français:
http://mesh.inserm.fr/mesh/

HeTOP: https://www.hetop.eu

# équation de recherche

("arthroplasty, replacement, knee"[MeSH Terms] OR ("arthroplasty"[All Fields] AND "replacement"[All Fields] AND "knee"[All Fields]) OR "knee replacement arthroplasty"[All Fields] OR ("total"[All Fields] AND "knee"[All Fields] AND "arthroplasty"[All Fields]) OR "total knee arthroplasty"[All Fields]) AND ("music"[MeSH Terms] OR "music"[All Fields]) AND ("anxiety"[MeSH Terms] OR "anxiety"[All Fields])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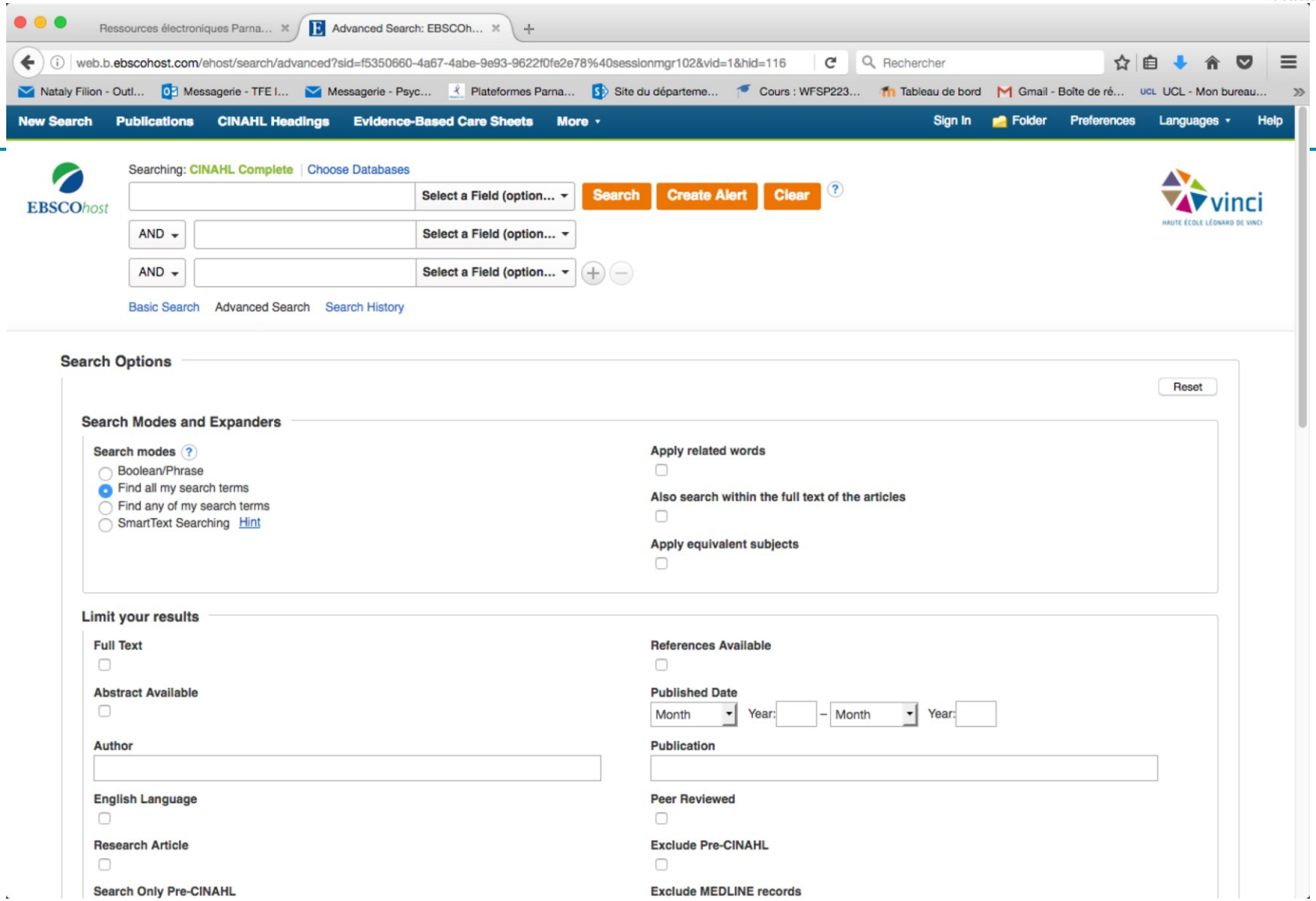
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Year:
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# Music interventions for preoperative anxiety (Review)

Bradt J, Dileo C, Shim M

# ABSTRACT

## Background

Patients awaiting surgical procedures often experience significant anxiety. Such anxiety may result in negative physiological manifestations, slower wound healing, increased risk of infection, and may complicate the induction of anaesthesia and impede postoperative recovery. To reduce patient anxiety, sedatives and anti-anxiety drugs are regularly administered before surgery. However, these often have negative side effects and may prolong patient recovery. Therefore, increasing attention is being paid to a variety of non-pharmacological interventions for reduction of preoperative anxiety such as music therapy and music medicine interventions. Interventions are categorized as 'music medicine' when passive listening to pre-recorded music is offered by medical personnel. In contrast, music therapy requires the implementation of a music intervention by a trained music therapist, the presence of a therapeutic process, and the use of personally tailored music experiences. A systematic review was needed to gauge the efficacy of both music therapy and music medicine interventions for reduction of preoperative anxiety.

## Objectives

To examine the effects of music interventions with standard care versus standard care alone on preoperative anxiety in surgical patients.

JCN Journal of Clinical Nursing

Journal of Clinical Nursing

ORIGINAL ARTICLE

# An evaluation of the effectiveness of relaxation therapy for patients receiving joint replacement surgery

Pi-Chu Lin

**Aim and objective.** To examine the effect of relaxation therapy on reducing patient anxiety and pain before and after total joint replacement.

**Background.** Despite the use of analgesics, patients may feel anxiety and pain before and after surgery, delaying their recovery.

**Design.** An experimental control group pretest–post-test quasi-experimental design was employed.

**Method.** Subjects ($n$ = 93) recruited from a medical centre in Taipei, Taiwan, from November 2006–March 2007 were randomly assigned to experimental ($n$ = 45) and control ($n$ = 48) groups. Subjects in the experimental group received relaxation therapy from the day before surgery to the third postoperative day. Researchers helped participants listen to a breath relaxation and guided imagery tape for 20 minutes daily. A pain and anxiety scale questionnaire, the State-Trait Anxiety Inventory questionnaire, blood pressure and heart rate were monitored before and after intervention.

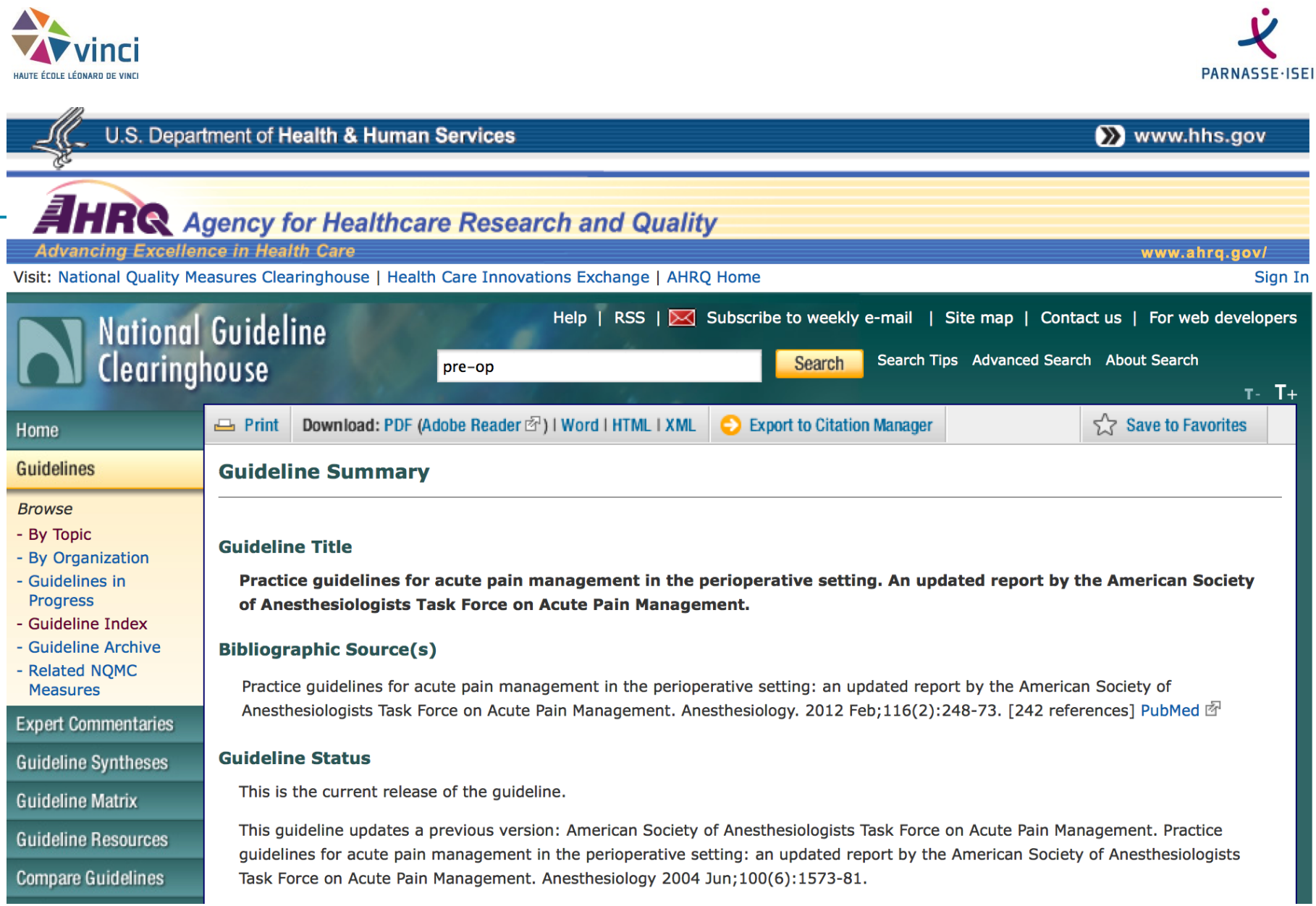
**Results.** The average age of the 93 patients was 71·0 (SD 11·1) years. The least pain severity scores in the experimental were lower than those in the control group ($p < 0{\cdot}05$) but both experienced the same level of worst or average pain ($p > 0{\cdot}05$). The mean difference in the pain score before and after intervention in the experimental group on the pre-op day ($t$ = 2·675, $p$ = 0·009) and post-op day one ($t$ = 3·059, $p$ = 0·003) was greater than that in the control group (0·48 SD 0·94 vs. 0·10 SD 0·30 and 0·93 SD 1·46 vs. 0·20 SD 0·71, respectively). The two groups differed significantly in systolic blood pressure ($F$ = 6·750, $p < 0{\cdot}05$) but not in mean blood pressure, heart rate, or State-Trait Anxiety Inventory scores ($p > 0{\cdot}05$). Patients reported that relaxation therapy helped them relax and promoted sleep.

**Conclusion.** Relaxation therapy could complement analgesics to help postoperative patients better manage pain and anxiety.

**Relevance to clinical practice.** Clinical practice should include complementary relaxation therapy to alleviate pain and anxiety in patients with joint replacement.

Key words: anxiety, nursing, pain, postoperative, recovery, relaxation therapy

Accepted for publication: 14 June 2010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Guideline Title
Practice guidelines for acute pain management in the perioperative setting. An updated report by the American Society of Anesthesiologists Task Force on Acute Pain Management.
Bibliographic Source(s)
Practice guidelines for acute pain management in the perioperative setting: an updated report by the American Society of Anesthesiologists Task Force on Acute Pain Management. Anesthesiology. 2012 Feb;116(2):248-73. [242 references] PubMed
Guideline Status
This is the current release of the guideline.
This guideline updates a previous version: American Society of Anesthesiologists Task Force on Acute Pain Management. Practice guidelines for acute pain management in the perioperative setting: an updated report by the American Society of Anesthesiologists Task Force on Acute Pain Management. Anesthesiology 2004 Jun;100(6):1573-81.

J Adv Nurs. 2013 Jul 19. doi: 10.1111/jan.12205. [Epub ahead of print]

# Perioperative anxiety and postoperative pain in children and adolescents undergoing elective surgical procedures: a quantitative systematic review.

Chieng YJ, Chan WC, Klainin-Yobas P, He HG.

Division of Nursing, National University Hospital, Singapore.

## Abstract

**AIMS:** To examine the relationship between perioperative anxiety and postoperative pain in children and adolescents undergoing elective surgical procedures and the differences in children's perioperative anxiety and postoperative pain among subgroups of demographics.

**BACKGROUND:** While anxiety and pain are regarded as two common problems experienced by children and adolescents perioperatively and the relationship between them has been reported in previous studies, there has been no review paper examining this phenomenon.

**DESIGN:** A quantitative systematic review.

**DATA SOURCES:** Nine electronic databases were searched for studies published in English from the inception date of the databases to December 2010, using various combinations of search terms of 'adolescents', 'anxiety', 'child', 'pain', 'surgery' and 'correlation/relationship'.

**REVIEW METHODS:** Using the Joanna Briggs Institute's comprehensive systematic review strategies, relevant studies were independently appraised and extracted by two reviewers using the standardized critical appraisal instruments and data extraction tool from Joanna Briggs Institute Meta Analysis of Statistics Assessment and Review Instrument.

**RESULTS:** Ten studies were included in this review from 943 studies initially retrieved. Children and adolescents who had higher level of perioperative anxiety experienced a higher level of postoperative pain. Inconclusive evidence was found regarding differences of perioperative anxiety and postoperative pain between demographic subgroups of gender, age and past surgical experience.

**CONCLUSION:** Results of this review inform healthcare providers of the role perioperative anxiety plays on children's and adolescents' postoperative pain and indicate the need to use interventions to reduce perioperative anxiety and, therefore, optimize their postoperative pain management

# 3. Faire une LECTURE **critique** de l'information

- Solidité méthodologique ?
- Fiabilité des résultats ?
- Validité ?
- Pertinence?
- Applicabilité ?
- Source d'information ?

# 4. CONCRÉTISER la preuve dans la pratique clinique

- Les résultats de l'évaluation ne sont applicables à un patient donné que pour autant qu'il ne soit pas différent des patients inclus dans l'étude.

- Il convient ensuite d'évaluer les risques et les bénéfices potentiels du traitement sur le patient en question.

(Sarasin et Gaspoz, 1997).

# 5. Évaluation

L'intervention choisie est-elle correcte ?

Est-ce la bonne décision ?

Nécessité d'adapter les consignes à la situation.

Le clinicien est responsable de ses décisions !

# Eveidence-based practice

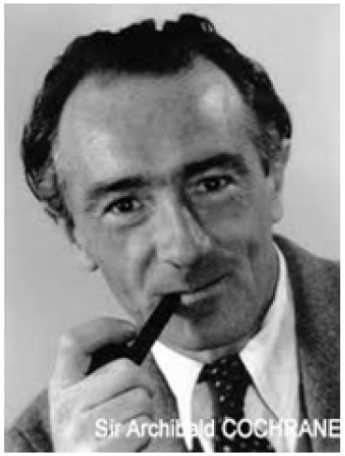
KCE REPORT 291Bs

KCE

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

**SYNTHÈSE**

## VERS UN PLAN INTÉGRÉ D'EVIDENCE - BASED PRACTICE EN BELGIQUE – PREMIÈRE PARTIE : PLAN DE GOUVERNANCE




2017 www.kce.fgov.be

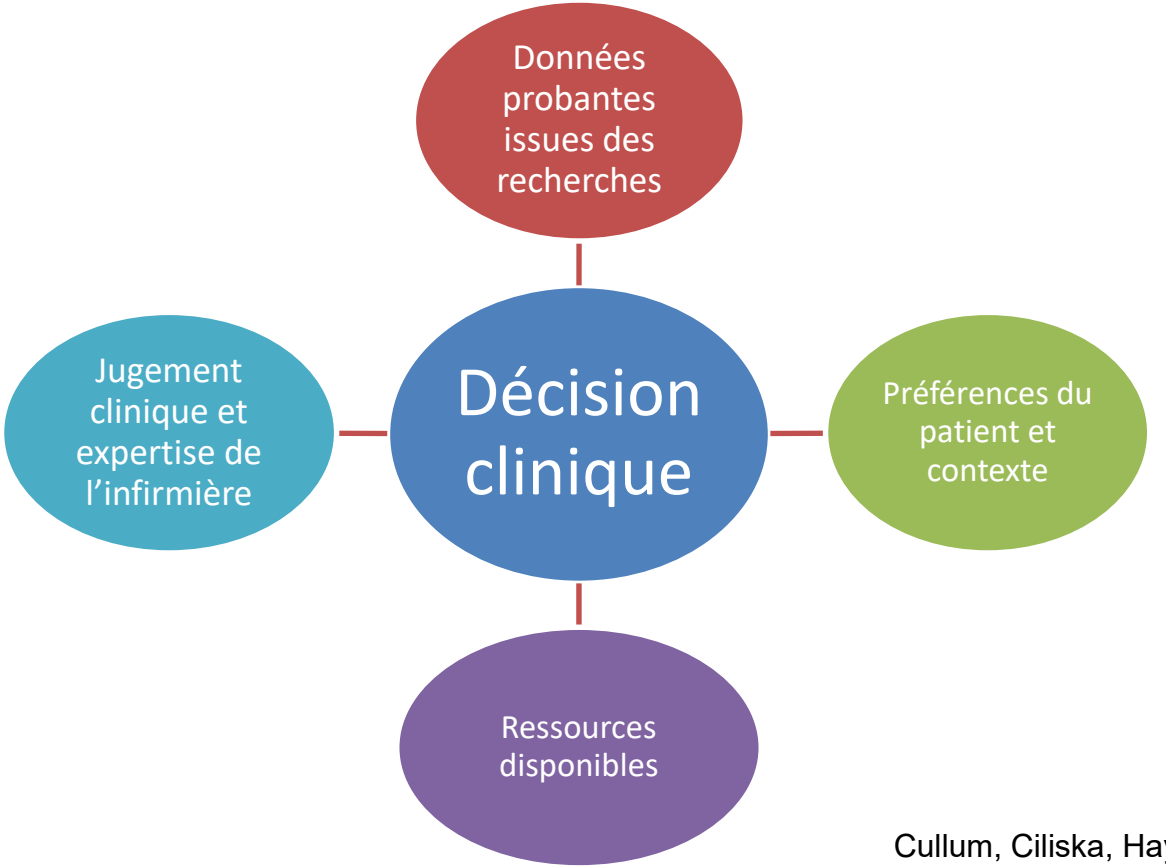
« L'utilisation consciencieuse, explicite et judicieuse des meilleures preuves scientifiques récentes lors des choix concernant les soins de patients individuels ».

Pour un soignant, pratiquer l'EBP, c'est combiner, au quotidien, trois éléments :

1. sa propre expertise clinique,
2. les « preuves » ou « données probantes » (= evidence en anglais) fournies sous forme de recommandations issues de la littérature scientifique
3. les préférences et valeurs de chaque patient individuel .
4. On y ajoute une quatrième dimension, celle des « facteurs contextuels » (tels que les coûts et la disponibilité des ressources) car il s'agit d'éléments sur lesquels on a peu de prise, mais qui peuvent affecter la force d'une recommandation et entraver sa mise en oeuvre.

KCE (2017)

# Ce qui influence la décision clinique




Cullum, Ciliska, Haynes & Marks (2008)
[traduction libre Nadine Jacquemin]

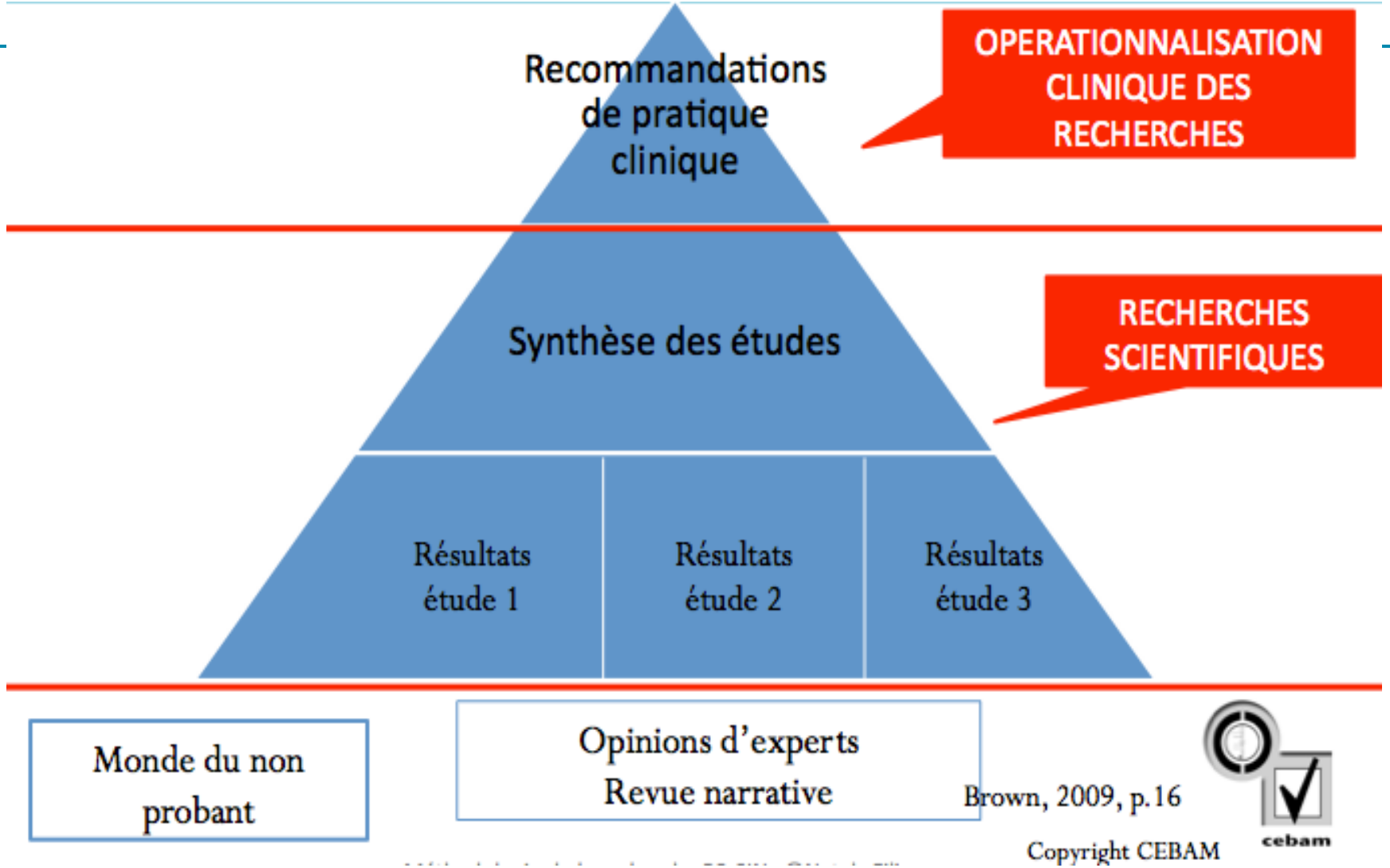
- Recommandations de bonnes pratiques (RBP)
- Guidelines
- Clinical Guidelines
- Evidence based Guidelines
- Recommandations de pratique clinique
- Ligne directrice pour la pratique clinique
- Ligne directrice sur les pratiques exemplaires

# Définitions

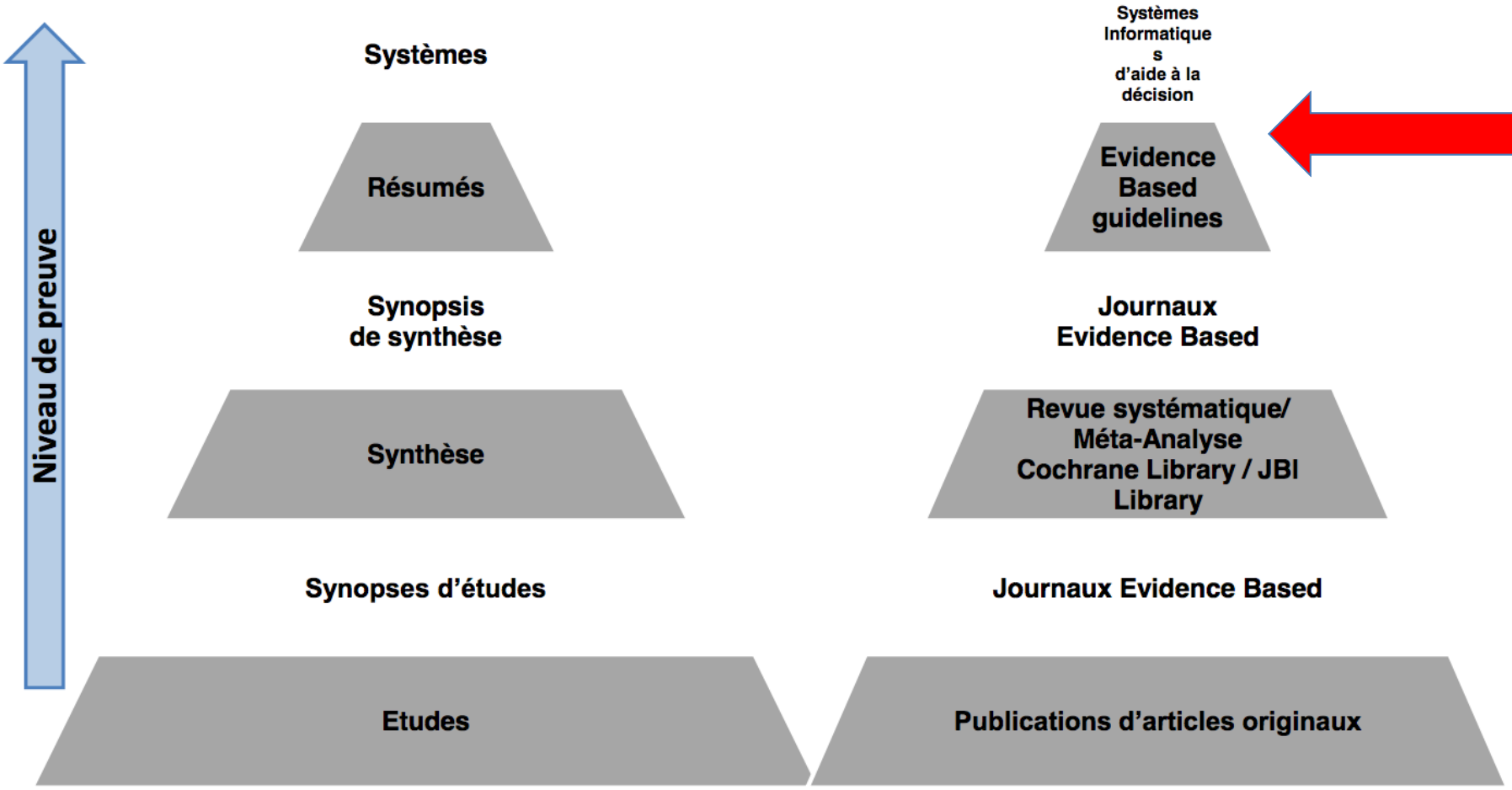
Ligne directrice pour la pratique clinique ou ligne directrice sur les pratiques exemplaires « Clinical Guidelines »:

« Déclarations élaborées d'une manière méthodique, selon les meilleures données probantes existantes, visant à faciliter les décisions du praticien et du patient concernant les soins adéquats dans certains cas cliniques»

(Field et Lohr, 1990, p. 8 cité par RNAO, 2002, p. 13).



# Hiérarchie des preuves (modèle des 6S de Haynes, 2009)




in Karam (2017): Di Censo, Bayley & Haynes 2009.

# Recommandations pour la pratique clinique (RPC)

Propositions développées méthododiquement pour aider le praticien et le patient à rechercher les soins les plus appropriés dans des circonstances cliniques données. (Woolf, Grol Hutchinson, Eccles & Grimshaw, 1999).

Ils sont conçues pour fournir aux praticiens une marche à suivre dans un domaine d'expertise (RNAO, 2002)

Leur qualité est extrêmement variable.

Ils ont des avantages et des inconvénients potentiels, tant pour les patients, les professionnels et le système de santé. . (Woolf, Grol Hutchinson, Eccles & Grimshaw, 1999).

# Guidelines

- Document avec des recommandations, avis et consignes thérapeutiques.
- En soutien à la prise de décision pour les prestataires de soins et les patients.
- S'appuyant sur des résultats fondés sur la recherche scientifique.

Guideline ≠ Protocole

# Protocole de soins

Définition:

- sélection réfléchie,
- issue des recommandations d'un guideline.
- destinées à un groupe de patients. (Grypdonck & Schoonhoven, 2003).
- Le protocole doit tenir compte :
  - des ressources organisationnelles et financières
  - des prestataires de soins
  - de l'offre de soins
  - de la disponibilité du matériel

# Protocole

**Protocole** (loco-local!)

- Doit être fondé sur des guidelines “evidence-based”
- Conduite idéale à tenir, en pratique quotidienne, dans un département/ une unité.
- Un protocole est très concrèt et spécifique, construit sur mesure pour une institution ou un département.
- = guidelines remis dans un contexte local

vinci
HAUTE ÉCOLE LÉONARD DE VINCI

NICE National Institute for Health and Care Excellence

NICE guideline

PARNASSE·ISEI

# Hypothermia: prevention and management in adults having surgery

Clinical guideline

Published: 23 April 2008
nice.org.uk/guidance/cg65

## Update information

### *December 2016*

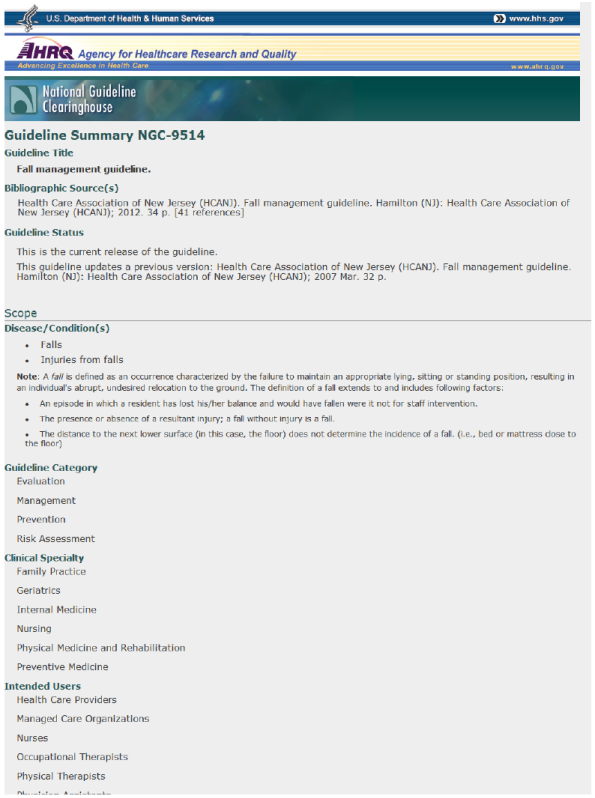
New recommendations have been added on patients with communication difficulties, measuring temperature, warming patients before induction of anaesthesia and warming patients after induction of anaesthesia. These are marked as **[new 2016]**.

Where recommendations end **[2008]**, the evidence has not been reviewed since the original guideline.

### *Amended recommendation wording (change to meaning)*

| Recommendation in 2008 guideline | Recommendation in current guideline | Reason for change |
|---|---|---|
| If the patient's temperature is below 36.0°C:<br>• forced air warming should be started preoperatively on the ward or in the emergency department (unless there is a need to expedite surgery because of clinical urgency, for example bleeding or critical limb ischaemia)<br>• forced air warming should be maintained throughout the intraoperative phase. [1.2.5] | If the patient's temperature is below 36.0°C, start active warming preoperatively on the ward or in the emergency department (unless there is a need to expedite surgery because of clinical urgency, for example bleeding or critical limb ischaemia). **[2008, amended 2016]** [1.2.3]<br>Maintain active warming throughout the intraoperative phase. **[2008, amended 2016]** [1.2.5] | 'Forced air warming' has been amended to 'active warming' to include other types of active warming.<br>The second bullet point in the 2008 recommendation has been replaced by a separate recommendation to maintain active warming throughout the intraoperative phase, which applies to all patients regardless of their temperature before they leave the ward or emergency department. |

# Contenu d'un guidelines Evidence-Based



U.S. Department of Health & Human Services www.hhs.gov

AHRQ Agency for Healthcare Research and Quality

National Guideline Clearinghouse

**Guideline Summary NGC-9514**

**Guideline Title**

**Fall management guideline.**

**Bibliographic Source(s)**

Health Care Association of New Jersey (HCANJ). Fall management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2012. 34 p. [41 references]

**Guideline Status**

This is the current release of the guideline.

This guideline updates a previous version: Health Care Association of New Jersey (HCANJ). Fall management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2007 Mar. 32 p.

Scope

**Disease/Condition(s)**

- Falls
- Injuries from falls

**Note**: A *fall* is defined as an occurrence characterized by the failure to maintain an appropriate lying, sitting or standing position, resulting in an individual's abrupt, undesired relocation to the ground. The definition of a fall extends to and includes following factors:

- An episode in which a resident has lost his/her balance and would have fallen were it not for staff intervention.
- The presence or absence of a resultant injury; a fall without injury is a fall.
- The distance to the next lower surface (in this case, the floor) does not determine the incidence of a fall. (i.e., bed or mattress close to the floor)

**Guideline Category**

Evaluation

Management

Prevention

Risk Assessment

**Clinical Specialty**

Family Practice

Geriatrics

Internal Medicine

Nursing

Physical Medicine and Rehabilitation

Preventive Medicine

**Intended Users**

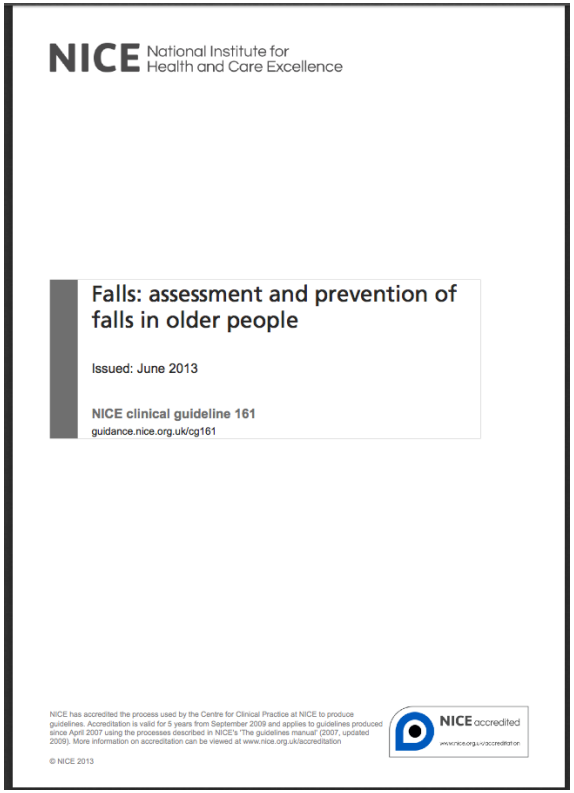
Health Care Providers

Managed Care Organizations

Nurses

Occupational Therapists

Physical Therapists

NICE National Institute for Health and Care Excellence

Falls: assessment and prevention of falls in older people

Issued: June 2013

NICE clinical guideline 161

guidance.nice.org.uk/cg161

NICE has accredited the process used by the Centre for Clinical Practice at NICE to produce guidelines. Accreditation is valid for 5 years from September 2009 and applies to guidelines produced since April 2007 using the processes described in NICE's 'The guidelines manual' (2007, updated 2009). More information on accreditation can be viewed at www.nice.org.uk/accreditation

NICE accredited

© NICE 2013

# Contenu d'un guideline

- Résumé (abstract)
- Introduction
  - Objectif, public-cible, engagement de ……., méthode, révision, responsabilité, financement
- Chapitre clinique
  - Définition, description de la maladie, épidémiologie, étiologie, physiopathologie, facteurs de risque, diagnostic, traitement suivi, prévention suivie
  - Pas seulement les recommandations mais aussi les études scientifiques sur lesquelles elles s'appuyent.
- Information, éducation, perspective patient
- (Organisation et implémentation)

# Durée de vie d'un guideline

- Durée de vie trop courte!
  - maximum 3 à 5 ans en fonction des thématiques abordées
  - Nouvelles recherches apportent de nouveaux points de vue, une nouvelle compréhension, auxquels le prestataire de soins doit s'adapter
  - La date de rédaction du guidelines doit être clairement mentionnée
  - Le moment de la révision et de l'actualisation également

# *Table of Contents*





(RNAO, 2011, p.7)

# *Summary of Recommendations*

## General Principles:

1. The client's perspective, individual desires and needs are central to the application of the guideline.
2. The over-arching principle that guides the intervention choices is the principle of maintaining the highest quality of life possible while striving for a safe environment and practices. Risk taking, autonomy, and self-determination are supported, respected, and considered in the plan of interventions.
3. Individuals, their significant other(s) and the care team engage in assessment and interventions through a collaborative process.

| | RECOMMENDATION | *LEVEL OF EVIDENCE | *GRADE OF RECOMMENDATION |
|---|---|---|---|
| **Practice Recommendations** | | | |
| Assessment | 1.0 Assess fall risk on admission.<br>1.1 Assess fall risk after a fall. | Ib<br>Ib | B<br>B |
| Intervention<br>*Tai Chi* | 2.0 Tai Chi to prevent falls in the elderly is recommended for those clients whose length of stay (LOS) is greater than four months and for those clients with no history of a fall fracture. There is insufficient evidence to recommend Tai Chi to prevent falls for clients with LOS less than four months. | Ib | B |
| *Exercise* | 2.1 Nurses can use strength training as a component of multi-factorial fall interventions; however, there is insufficient evidence to recommend it as a stand-alone intervention. | Ib | I |
| *Multi-factorial* | 2.2 Nurses, as part of the multidisciplinary team, implement multi-factorial fall prevention interventions to prevent future falls. | Ia | B |



(RNAO, 2011, p.8)

# Exemple (RNAO, 2011, pp.11-12)

Table 1: Levels of Evidence

| | |
|---|---|
| Ia | Evidence obtained from meta-analysis or systematic review of randomized controlled trials. |
| Ib | Evidence obtained from at least one randomized controlled trial. |
| IIa | Evidence obtained from at least one well-designed controlled study without randomization. |
| IIb | Evidence obtained from at least one other type of well-designed quasi-experimental study. |
| III | Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies. |
| IV | Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. |

## Table 2: Grades of Recommendation

| | |
|---|---|
| A | There is **good** evidence to recommend the clinical preventive action. |
| B | There is **fair** evidence to recommend the clinical preventive action. |
| C | The existing evidence is **conflicting** and does not allow making a recommendation for or against use of the clinical preventive action; however other factors may influence decision-making. |
| D | There is **fair** evidence to recommend against the clinical preventive action. |
| E | There is **good** evidence to recommend against the clinical preventive action. |
| I | There is **insufficient** evidence (in quantity and/or quality) to make a recommendation, however other factors may influence decision-making. |

Reference: Canadian Task Force on Preventative Health Care (CTFPHC). (1997). Quick tables by strength of evidence. Available: http://www.ctfphc.org

# Niveaux de preuve d'après le SIGN* 2008

| Niveaux | Description |
|---|---|
| 1++ | Méta-analyses de qualité élevée, revues systématiques d'essais contrôlés randomisés, ou essais contrôlés randomisés avec un risque de biais très faible. |
| 1+ | Méta-analyses bien menées, revues systématiques, ou essais contrôlés randomisés avec un risque de biais faible. |
| 1- | Méta-analyses, revues systématiques, ou essais contrôlés randomisés avec un risque de biais élevé. |
| 2++ | Revues systématiques de qualité élevée d'études cas-témoins ou d'études de cohortes.<br>Études cas-témoins ou études de cohortes avec un faible risque d'effet de facteurs de confusion ou de biais et une probabilité élevée que la relation est causale. |
| 2+ | Études cas-témoins ou études de cohortes bien menées avec un faible risque d'effet de facteurs de confusion ou de biais et une probabilité modérée que la relation est causale. |
| 2- | Études cas-témoins ou études de cohortes avec un risque élevé d'effet de facteurs de confusion ou de biais et un risque significatif que la relation ne soit pas causale. |
| 3 | Études non analytiques, par exemple séries de cas. |
| 4 | Opinion d'experts. |

** Scottish Intercollegiate Guidelines Network*

tiré de: Niveau de preuve et gradation des recommandations de bonne partique. Haute Autorité de Santé (HAS) 2013

# Grades des recommandations d'après le SIGN 2008

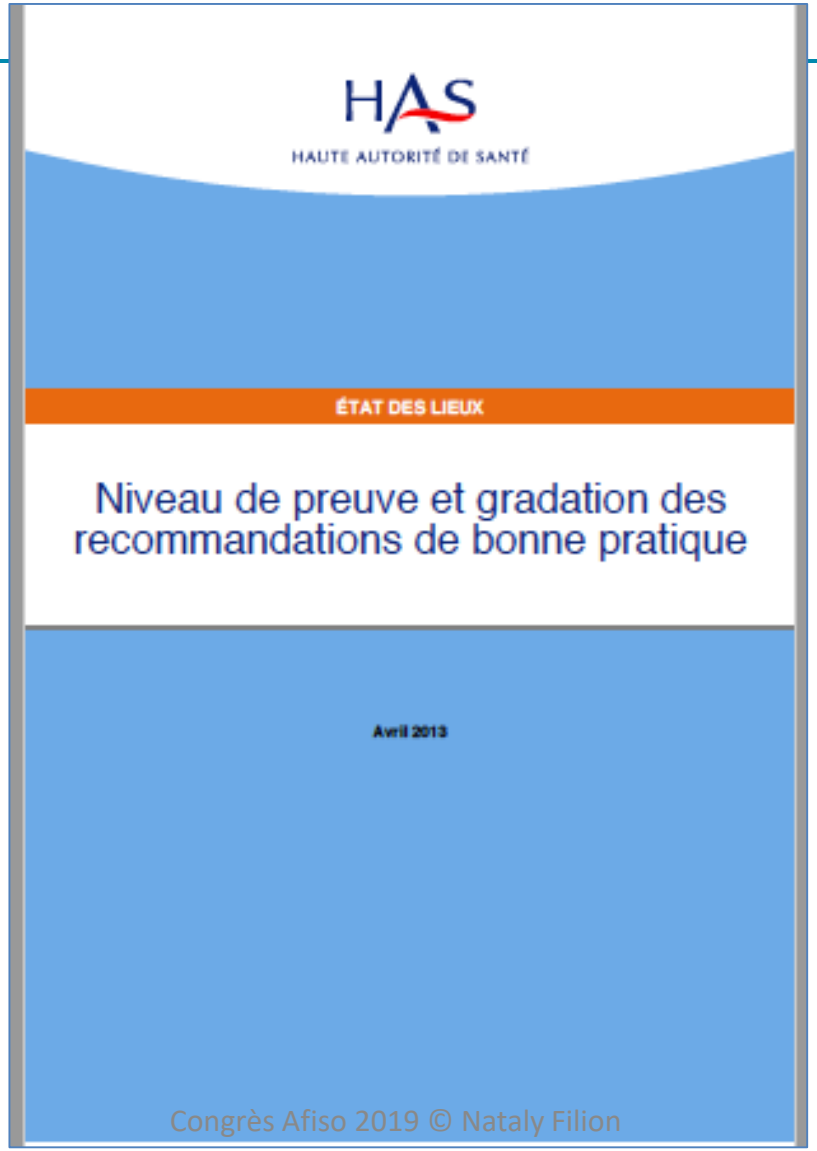
| Grade | Description |
|---|---|
| A | Au moins une méta-analyse, une revue systématique, ou un essai contrôlé randomisé coté 1++, et directement applicable à la population cible ; ou<br>un ensemble de données scientifiques composé principalement d'études cotées 1+, directement applicable à la population cible, démontrant une homogénéité globale des résultats. |
| B | Un ensemble de données scientifiques incluant des études cotées 2++, directement applicable à la population cible, et démontrant une homogénéité globale des résultats ; ou<br>données scientifiques extrapolées d'études cotées 1++ ou 1+. |
| C | Un ensemble de données scientifiques incluant des études cotées 2+, directement applicable à la population cible et démontrant une homogénéité globale des résultats ; ou<br>données scientifiques extrapolées d'études cotées 2++. |
| D | Niveau de preuve 3 ou 4 ; ou<br>données scientifiques extrapolées d'études cotées 2+. |

tiré de: Niveau de preuve et gradation des recommandations de bonne partique. Haute Autorité de Santé (HAS) 2013

# Niveau de preuve et gradation des recommandations

Plusieurs classifications existent…

- New Zealand Guidelines Group
- American academy of pediatrics
- **The Grading of Recommendations Assessment, Development and Evaluation (GRADE)**
- Scottish Intercollegiate Guidelines Network (**SIGN**)
- National Health and Medical Research Council
- National Institute for Health and Clinical Excellence (**NICE**)
- …


HAS
HAUTE AUTORITÉ DE SANTÉ
ÉTAT DES LIEUX
Niveau de preuve et gradation des recommandations de bonne pratique
Avril 2013

# Quelques sites

- https://www.nice.org.uk/
- https://www.sign.ac.uk/
- https://www.england.nhs.uk/
- https://www.ahrq.gov/
- https://health.gov/
- https://www.clinicalguidelines.gov.au/
- https://www.has-sante.fr/portail/
- https://rnao.ca/

# Limites

- Importance de faire une lecture « culturelle » des recommandations.

- Les RPC sont souvent de gros documents, on s'y perd parfois et du coup les utiliser nous semble fastidieux…

https://www.health.belgium.be/fr/eb-nursing-echelles-et-guidelines

## Bienvenue chez ebpracticenet

ebpracticenet est la plateforme de référence EBP pour les prestataires de soins belges. Elle centralise tous les guidelines et autres supports d'information EBP validés par le programme EBP.

Search...

Mon historique de recherche Recherche avancée Aide à la recherche

## Rendez-vous sur la page d'accueil de votre profession de soins de santé


Médecin Généraliste


Infirmier


Ergothérapeute


Dentiste


Diététicien


Pharmacien


Kinésithérape

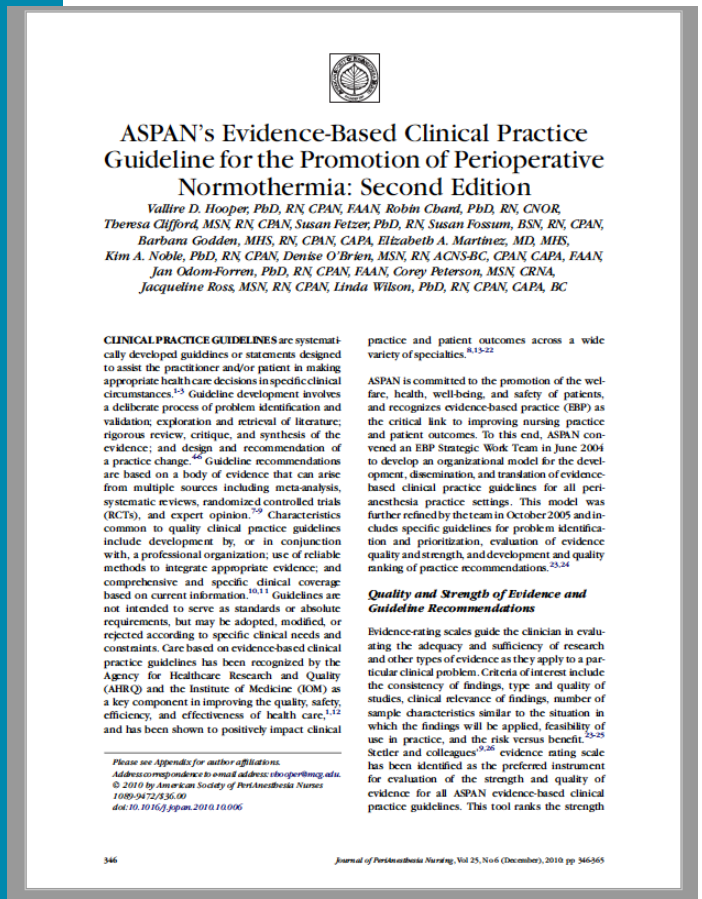

Logopède


Sage-femme


Podologue


Bureau de transfert
et d'échange de connaissances
Faculté des sciences infirmières
BTEC
COLLECTION
Les cahiers du BTEC
Approches pharmacologiques
et non pharmacologiques
les plus efficaces pour le soulagement
de la douleur lors d'une chirurgie
orthopédique (PTH et PTG)
chez les personnes âgées
Cahier 2
UNIVERSITÉ LAVAL

# Et pour la suite…



ASPAN's Evidence-Based Clinical Practice Guideline for the Promotion of Perioperative Normothermia: Second Edition

*Vallire D. Hooper, PhD, RN, CPAN, FAAN, Robin Chard, PhD, RN, CNOR, Theresa Clifford, MSN, RN, CPAN, Susan Fetzer, PhD, RN, Susan Fossum, BSN, RN, CPAN, Barbara Godden, MHS, RN, CPAN, CAPA, Elizabeth A. Martinez, MD, MHS, Kim A. Noble, PhD, RN, CPAN, Denise O'Brien, MSN, RN, ACNS-BC, CPAN, CAPA, FAAN, Jan Odom-Forren, PhD, RN, CPAN, FAAN, Corey Peterson, MSN, CRNA, Jacqueline Ross, MSN, RN, CPAN, Linda Wilson, PhD, RN, CPAN, CAPA, BC*

**CLINICAL PRACTICE GUIDELINES** are systematically developed guidelines or statements designed to assist the practitioner and/or patient in making appropriate health care decisions in specific clinical circumstances.[1-3] Guideline development involves a deliberate process of problem identification and validation; exploration and retrieval of literature; rigorous review, critique, and synthesis of the evidence; and design and recommendation of a practice change.[4-6] Guideline recommendations are based on a body of evidence that can arise from multiple sources including meta-analysis, systematic reviews, randomized controlled trials (RCTs), and expert opinion.[7-9] Characteristics common to quality clinical practice guidelines include development by, or in conjunction with, a professional organization; use of reliable methods to integrate appropriate evidence; and comprehensive and specific clinical coverage based on current information.[10,11] Guidelines are not intended to serve as standards or absolute requirements, but may be adopted, modified, or rejected according to specific clinical needs and constraints. Care based on evidence-based clinical practice guidelines has been recognized by the Agency for Healthcare Research and Quality (AHRQ) and the Institute of Medicine (IOM) as a key component in improving the quality, safety, efficiency, and effectiveness of health care,[1,12] and has been shown to positively impact clinical practice and patient outcomes across a wide variety of specialties.[8,13-22]

ASPAN is committed to the promotion of the welfare, health, well-being, and safety of patients, and recognizes evidence-based practice (EBP) as the critical link to improving nursing practice and patient outcomes. To this end, ASPAN convened an EBP Strategic Work Team in June 2004 to develop an organizational model for the development, dissemination, and translation of evidence-based clinical practice guidelines for all perianesthesia practice settings. This model was further refined by the team in October 2005 and includes specific guidelines for problem identification and prioritization, evaluation of evidence quality and strength, and development and quality ranking of practice recommendations.[23,24]

***Quality and Strength of Evidence and Guideline Recommendations***

Evidence-rating scales guide the clinician in evaluating the adequacy and sufficiency of research and other types of evidence as they apply to a particular clinical problem. Criteria of interest include the consistency of findings, type and quality of studies, clinical relevance of findings, number of sample characteristics similar to the situation in which the findings will be applied, feasibility of use in practice, and the risk versus benefit.[25-25] Stetler and colleagues[9,26] evidence rating scale has been identified as the preferred instrument for evaluation of the strength and quality of evidence for all ASPAN evidence-based clinical practice guidelines. This tool ranks the strength

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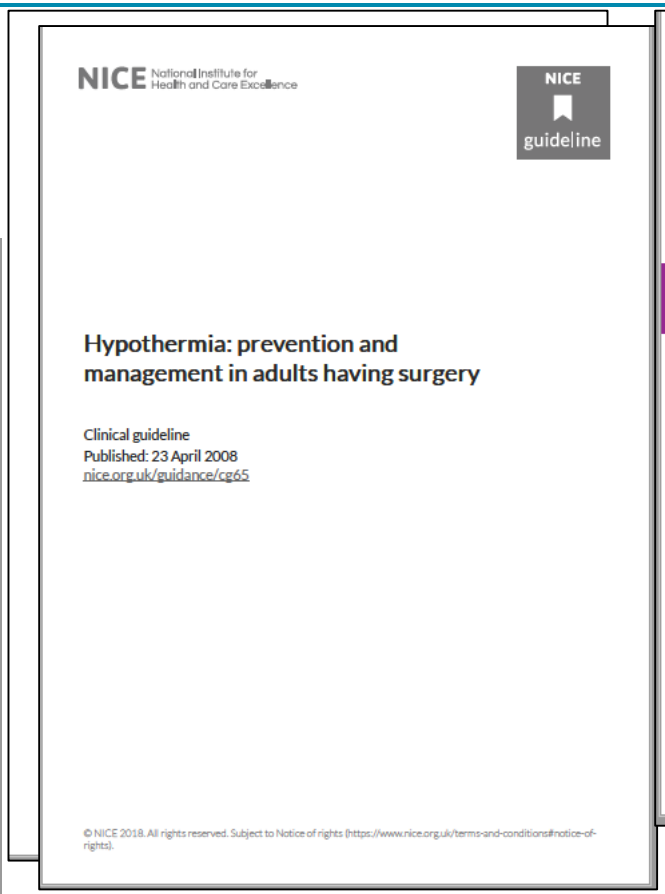
*doi:10.1016/j.jopan.2010.10.006*





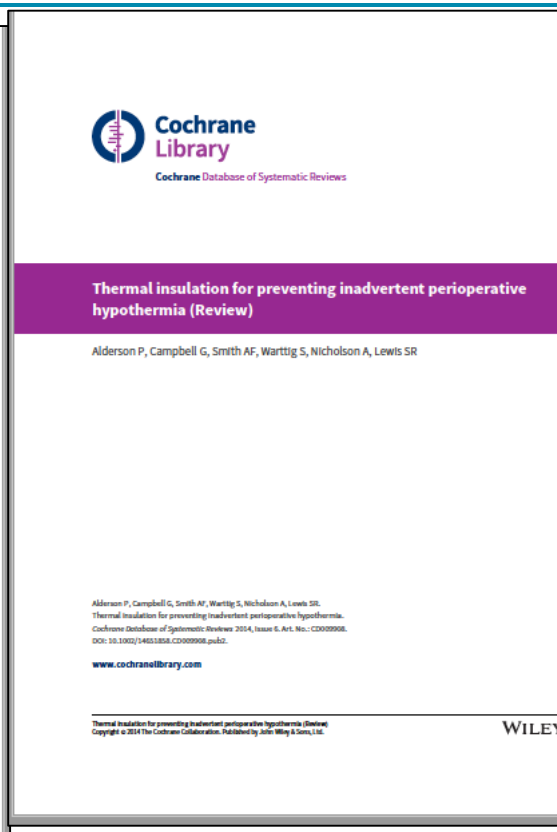
NICE National Institute for Health and Care Excellence

NICE guideline

Hypothermia: prevention and management in adults having surgery

Clinical guideline
Published: 23 April 2008
nice.org.uk/guidance/cg65





Cochrane Library
Cochrane Database of Systematic Reviews

Thermal insulation for preventing inadvertent perioperative hypothermia (Review)

Alderson P, Campbell G, Smith AF, Warttig S, Nicholson A, Lewis SR

Alderson P, Campbell G, Smith AF, Warttig S, Nicholson A, Lewis SR.
Thermal insulation for preventing inadvertent perioperative hypothermia.
*Cochrane Database of Systematic Reviews* 2014, Issue 6. Art. No.: CD009908.
DOI: 10.1002/14651858.CD009908.pub2.

www.cochranelibrary.com



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# Guideline Implementation: Preventing Hypothermia

1.0 CE www.aornjournal.org/content/cme

*MARIE A. BASHAW, DNP, RN, NEA-BC*

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## Purpose/Goal

To provide the learner with knowledge specific to implementing the AORN "Guideline for prevention of unplanned patient hypothermia."

## Objectives

1. Identify complications that may result from hypothermia.
2. Discuss factors that increase the patient's risk for unplanned intraoperative hypothermia.
3. Discuss methods for monitoring the patient's temperature.
4. Discuss considerations for choosing warming interventions.
5. Describe interventions that can be used to help prevent hypothermia.

## Accreditation

AORN is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

## Approvals

This program meets criteria for CNOR and CRNFA recertification, as well as other CE requirements.

AORN is provider-approved by the California Board of Registered Nursing, Provider Number CEP 13019. Check with your state board of nursing for acceptance of this activity for relicensure.

## Conflict-of-Interest Disclosures

Marie A. Bashaw, DNP, RN, NEA-BC, has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.

The behavioral objectives for this program were created by Liz Cowperthwaite, BA, senior managing editor, and Helen Starbuck Pashley, MA, BSN, CNOR, clinical editor, with consultation from Susan Bakewell, MS, RN-BC, director, Perioperative Education. Ms Cowperthwaite, Ms Starbuck Pashley, and Ms Bakewell have no declared affiliations that could be perceived as posing potential conflicts of interest in the publication of this article.

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http://dx.doi.org/10.1016/j.aorn.2016.01.009


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# Références bibliographiques


- Brown, S.J. (2009). *Evidence-Based Nursing. The Research-Practice Connection*. Sudbury, MA: Jones and Bartlett Publishers.
- Codeluppi, C., Da Silva, J., & Perrenoud, B. (2012). L'Evidence-Based Nursing, un levier au changement des pratiques infirmières. *Soins*, *57*(771), 31-33. https://doi.org/10.1016/j.soin.2012.10.002
- Cullum, N., Ciliska, D., Haynes, R. & Marks, S. (2008). *Evidence-based Nursing. An introduction.* Oxford, UK: Blackwell Publishing.
- Fencl, J. L., & Matthews, C. (2017). Translating Evidence Into Practice: How Advanced Practice RNs Can Guide Nurses in Challenging Established Practice to Arrive at Best Practice. *AORN Journal*, *106*(5), 378-392. https://doi.org/10.1016/j.aorn.2017.09.002
- Adriaenssens J, Eyssen M, Mertens R, Benahmed N, Paulus D, Ameye F, Bossens M, Cauwenberg C, Cools A, Doms K, Everaert E, Gheysen M, Haelterman M, Laloup M, Malonne H, Meeus P, Penninckx W, Roisin T, Walraevens M. (2017). Vers un plan intégré d'evidence - based practice en Belgique – Première partie : plan de gouvernance – Synthèse. Health Services Research (HSR). Bruxelles: Centre Fédéral d'Expertise des Soins de Santé (KCE). KCE Reports 291Bs. D/2017/10.273/55.
- Munday, J., Hines, S. J., & Chang, A. M. (2013). Evidence Utilisation Project: Management of Inadvertent Perioperative Hypothermia. The challenges of implementing best practice recommendations in the perioperative environment: *International Journal of Evidence-Based Healthcare*, *11*(4), 305-311. https://doi.org/10.1111/1744-1609.12035
- Spruce, L. (2015). Back to Basics: Implementing Evidence-Based Practice. *AORN Journal*, *101*(1), 106-114.e4. https://doi.org/10.1016/j.aorn.2014.08.009
- The AGREE Next Steps Research Consortium . (2009). *Grille d'évaluation de la qualité des recommandations pour la pratique clinique (Grille AGREE II).* Récupéré de http://www.agreetrust.org/resource-centre/agree-ii-translations/
- White, S., & Spruce, L. (2015). Perioperative Nursing Leaders Implement Clinical Practice Guidelines Using the Iowa Model of Evidence-Based Practice. *AORN Journal*, *102*(1), 50-59. https://doi.org/10.1016/j.aorn.2015.04.001