This handbook is designed for Collaborating Centre staff involved in translation of JBI materials, particularly Collaborating Centres for linguistic translation. It is designed to explain the processes involved in translating JBI materials.
Collaborating Centres focusing on Linguistic Translation

This is a new and exciting opportunity for the Joanna Briggs Collaboration to be recognised for its contribution to the JBI membership, by translating JBI websites content into a language other than English.

To participate in the development and maintenance of a Linguistic Translation node, centres will be expected to:

• Agree to translate JBI websites content into a language other than English
• Provide content for no less than one third of websites content per annum
• Maintain and update existing translated content annually
• Submit a report to the JBI Node Contact, three times per year.
• Participate in an annual teleconference with the Collaborating Centre Node Administrator and the JBI Node contact.
• Promote the Institute within the Centre’s sphere of influence.

The Joanna Briggs Institute

The JBI is a not-for-profit organisation jointly operated by the University of Adelaide and the Royal Adelaide Hospital with headquarters in Adelaide and Collaborating Centres across the world. Established in 1996, the Institute is a major international agency for evidence-based health and aged care, conceived and established in South Australia, with headquarters located on the Royal Adelaide Hospital campus.

The Institute aims to facilitate evidence-based practice globally through being a leading international organisation for the Synthesis, Transfer and Utilisation of evidence of the feasibility, appropriateness, meaningfulness and effectiveness of health and aged care practices. Its role is to improve the feasibility, appropriateness, meaningfulness and effectiveness of clinical care practices and health and aged care outcomes.

JBI Approach to Evidence Review

The JBI has as its central focus the effectiveness, appropriateness, meaningfulness and feasibility of health care practices and delivery methods. Any indication that a practice is effective, appropriate, meaningful or feasible that is derived from experience, expertise, inference, deduction or the results of rigorous inquiry is regarded as a form of evidence by the Institute. The Joanna Briggs Institute regards the results of well designed research studies grounded in any methodological position as providing more credible evidence than anecdotes or personal opinion; however, when no research evidence exists, expert opinion can be seen to represent the "best available" evidence.
The Joanna Briggs Institute has supported work that has attempted to recognise the results of non-quantitative research as legitimate evidence for health care practitioners. The international interest in evidence based practice arising largely out of the work of the Cochrane Collaboration focuses on the systematic review of evidence as a basis for the development of evidence based guidelines and their utilisation in practice. The prevailing orthodoxy in systematically reviewing evidence elevates the results of experimental research to a position of superiority in terms of quality and applicability to practice and disregards the results of non-quantifiable research - because of its interest in subjectivity and interpretation - as legitimate evidence for practice.

As well as systematic reviews, JBI also provides other evidence resources, such as evidence summaries and recommended practices.

**JBI Levels of Evidence and Grading of Recommendations**
JBI has developed its own levels of evidence and recommendation grades.

**The "FAME" Scale**

When clinicians and care staff make decisions about patient/resident/client care, they are interested in accessing different types of evidence. JBI takes the view that the evidence interests of those who deliver care to patients/residents/clients can be best summarised under the four major headings of Feasibility, Appropriateness, Meaningfulness and Effectiveness – the “FAME” scale of evidence.

**Feasibility** relates to evidence about the extent to which an activity or intervention is practical.

**Appropriateness** relates to evidence about the extent to which an activity or intervention is Ethical or culturally apt.

**Meaningfulness** relates to evidence about the personal opinions, experiences, values, thoughts, beliefs or interpretations of clients and their families or significant others.

**Effectiveness** relates to evidence about the effects of a specific intervention on specific outcomes.
### JBI Levels of Evidence

The Joanna Briggs Institute and its collaborating centres and Evidence Translation Groups currently assign a level of evidence to all conclusions drawn in JBI Systematic Reviews, evidence summaries and recommended practices. The JBI Levels of Evidence are:

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Feasibility</th>
<th>Appropriateness</th>
<th>Meaningfulness</th>
<th>Effectiveness</th>
<th>Economic Evidence</th>
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<tbody>
<tr>
<td>1.</td>
<td>Metasynthesis of research with unequivocal synthesised findings</td>
<td>Metasynthesis of research with unequivocal synthesised findings</td>
<td>Metasynthesis of research with unequivocal synthesised findings</td>
<td>Meta-analysis (with homogeneity) of experimental studies (eg RCT with concealed randomisation) OR One or more large experimental studies with narrow confidence intervals</td>
<td>Metasynthesis (with homogeneity) of evaluations of important alternative interventions comparing all clinically relevant outcomes against appropriate cost measurement, and including a clinically sensible sensitivity analysis</td>
</tr>
<tr>
<td>2.</td>
<td>Metasynthesis of research with credible synthesised findings</td>
<td>Metasynthesis of research with credible synthesised findings</td>
<td>Metasynthesis of research with credible synthesised findings</td>
<td>One or more smaller RCTs with wider confidence intervals OR Quasi-experimental studies (without randomisation)</td>
<td>Evaluations of important alternative interventions comparing all clinically relevant outcomes against appropriate cost measurement, and including a clinically sensible sensitivity analysis</td>
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</tbody>
</table>
| 3.                | a. Metasynthesis of text/opinion with credible synthesised findings  
   b. One or more single research studies of high quality | a. Metasynthesis of text/opinion with credible synthesised findings  
   b. One or more single research studies of high quality | a. Metasynthesis of text/opinion with credible synthesised findings  
   b. One or more single research studies of high quality | a. Cohort studies (with control group)  
   b. Case-controlled  
   c. Observational studies (without control group) | Evaluations of important alternative interventions comparing a limited number of appropriate cost measurement, without a clinically sensible sensitivity analysis |
| 4.                | Expert opinion | Expert opinion | Expert opinion | Expert opinion, or physiology bench research, or consensus | Expert opinion, or based on economic theory |
**JBI COnNECT+**

JBI COnNECT+ is one program of the Institute. It is an online gateway to a collection of evidence-based resources and tools designed to assist in the clinical decision-making process and to support best practice.

Based on the JBI Model of Evidence Based Healthcare, JBI COnNECT+ focuses on the following five central steps in getting evidence into practice:

1. Searching for the best available international evidence
2. Appraising the evidence
3. Embedding appraised and rated evidence in practice and organisational systems
4. Utilising the evidence
5. Evaluating the impact of evidence-based practices and policies on outcomes

And

Generating new research questions and advocating for particular research to be conducted

JBI COnNECT+ is a portal to:

- The JBI Database of evidence summaries and evidence based-practice recommended practices
- The JBI Manual Builder
- The JBI Database of Systematic Reviews
- The JBI Database of Best Practice Information Sheets
- The JBI online journal collection
- PACES
- POOL
- RAPid.

For further information on JBI COnNECT+ please refer to the user guides located in the help section of the COnNECT+ website.

**COnNECT+ Nodes**

JBI COnNECT+ contains a series of specialist sections (i.e. Aged Care, Midwifery), referred to as ‘nodes’. Each node contains the same resources and tools however information is specific to that area of health. Users of JBI COnNECT+ are able to enter the entire database or enter a specialised “COnNECT+” node. Users have the option to subscribe to one node, multiple nodes or the complete JBI COnNECT+.

Nodes are managed by JBI headquarters in South Australia or by Collaborating Centres for Evidence Transfer.
EVIDENCE SUMMARIES
Evidence summaries are short abstracts that summarise existing international evidence on common health care interventions and activities. Evidence summaries are based on structured searches of the literature and selected evidence-based health care databases. The emphasis is to write evidence summaries that are specific to a particular clinically focused information need rather than a particular profession.

EXAMPLE
Title: Deep Vein Thrombosis: Prophylaxis

Date: 11 Feb. 09

Reviewer: Dr Rasika Jayasekara RN, BA, BScN (Hons), PG Dip Edu, MNSc, PhD

QUESTION
What is the best available evidence regarding prophylaxis for deep vein thrombosis (DVT)?

CLINICAL BOTTOM LINE
Deep vein thrombosis (DVT) is the formation of a thrombus in one of the deep veins of the body; it can be any deep vein, but in 60% of cases the thrombus will form in the lower limbs.¹ DVT is the most preventable thromboembolic disorder and poses great risk to many hospitalised medical and surgical patients.¹

- A Cochrane review showed that combining compression and anticoagulants was more effective than a single preventative measure for DVT. Compared to compression alone, compression plus anticoagulant (combined prophylactic modalities) clearly decreased the incidence of DVT (from 4% to 1.6%). Compared with medication and anticoagulants alone, combined compression and medication clearly reduced the incidence of DVT (from 4.21% to 0.65%).² (Level I)
- A Cochrane review found that prolonged thromboprophylaxis with low-molecular weight heparin (LMWH) significantly reduces the risk of DVT compared to thromboprophylaxis during hospital admittance only, without increasing bleeding complications after major abdominal or pelvic surgery.³ (Level I)
- A Cochrane review of two small studies concluded that there is not enough evidence to make a definitive conclusion about the use of anticoagulant drugs (with or without mechanical devices) for DVT prophylaxis in patients undergoing abdominal aortic surgery.⁴ (Level I)
- A Cochrane review concluded that the graduated compression stockings (GCS) are effective in diminishing the risk of DVT in hospitalised patients.⁵ (Level I)
- A Cochrane review of randomised trials found that both heparins and mechanical pumping devices significantly decrease the incidence of deep vein thrombosis.⁶ (Level I)

CHARACTERISTICS OF THE EVIDENCE
This evidence summary is based on a structured search of the literature and selected evidence-based health care databases. Evidence included in the summary is from:
• A literature review.¹
• A Cochrane review of 11 studies, six of them randomised controlled trials involving 7431 patients.²
• A Cochrane review of four studies (the search exclusively detected trials evaluating prolonged thromboprophylaxis with LMWH as compared to control or placebo).³
• A Cochrane review of two studies involving 147 participants.⁴
• A Cochrane review of 16 randomised controlled trials.⁵
• A Cochrane review of 31 trials involving at least 2958 predominantly female and elderly patients.⁶

BEST PRACTICE RECOMMENDATIONS
• The use of combined modalities (compression and anticoagulants) is recommended for patients with high risk of DVT. (Grade A)
• The use of graduated compression stockings is effective in the prevention of DVT in moderate risk surgical patients. (Grade A)
• A prolonged thromboprophylaxis with low-molecular weight heparin (LMWH) is recommended after major abdominal or pelvic surgery. (Grade B)

References
3 Rasmussen Morten S, Jørgensen Lars N, Wille-Jørgensen P. Prolonged thromboprophylaxis with Low Molecular Weight heparin for abdominal or pelvic surgery. Cochrane Database Syst Rev. 2009(1). (Level I)
4 Bani-Hani M, Al-Khaffaf H, Titi Mohammad A, Jaradat I. Interventions for preventing venous thromboembolism following abdominal aortic surgery. Cochrane Database Syst Rev. 2008(1). (Level I)

Keywords: deep vein thrombosis, DVT, prophylaxis, thrombosis, thromboembolic disorders, anticoagulants, prophylactic modalities, thromboprophylaxis, low-molecular weight heparin, mechanical pumping devices, graduated compression stockings
RECOMMENDED PRACTICES
Recommended practices are processes of care that describe and/or recommend certain practices on a selected clinical topic and are based on the best available evidence. Recommended practices are designed to provide clinicians and carers with basic principles.

Example – Recommended Practice
Urethral Catheterisations: Male

EQUIPMENT:
• A disposable catheter pack or a pre-packaged catheterisation tray including:
  o Sterile drapes
  o A Foley catheter
  o Sterile lubricant
  o Sterile forceps
  o Sterile gauze / cotton balls
  o A collection bag and tubing
  o 10 ml syringe
• Normal saline as required
• 10 ml syringe lignocaine (lidocaine) gel
• A pair of disposable gloves
• Protective sheets
• Catheter support
• Sterile area towel
• Dressing trolley

RECOMMENDED PRACTICE:

PREPARATION OF PATIENTS
• Patient should shower or wash foreskin with soap and water.
• Take patient to the treatment room where available.
• Position supine and place protective sheet under perineum.

PROCEDURES
1. Explain the procedure to the patient.
2. Screen the patient’s bed or area, using curtains or a mobile screen.
3. Take the tray to the patient’s bed or area, disturbing the screens/curtains as little as possible (this will reduce the risk of airborne contamination).
4. Wipe the dressing trolley with alcohol wipes.
5. Prepare dressing pack on the top shelf of the trolley. Additional equipment is placed underneath.
6. Decontaminate hands with soap and water, or alcohol gel. Ensure hands are dried thoroughly. Don disposable gloves.
7. Set out and add extra sterile equipment. Place catheter and a pair of forceps into the receiver.
8. Saturate gauze squares (or cotton wool balls) with potable tap water. (Level I)
9. With a paper towel pick up penis and pull back foreskin if necessary.
10. Clean meatus and glans using forceps and swabs.
11. Still holding penis with paper towel, position second paper towel under penis and lower penis onto this towel. Discard first towel.
12. Position area towel leaving only cleaned part of penis exposed.
13. With the drape hold the penis vertically. Place a small amount of lubricant into the receiver then very slowly insert the remaining lignocaine gel into the urethra and hold in situ for 5 minutes. Discard syringe.
14. Using the forceps place receiver onto the drape.
15. Remove the catheter sheath. Fill syringe with required amount of sterile water, check inflation of balloon and leave syringe attached.
16. Hold the penis vertically with the drape and with forceps gently insert the lubricated catheter into the bladder (ensure urine flow).
17. Inflate the balloon and gently withdraw the catheter until resistance is felt.
18. Remove cap from drainage bag and CONNECT+ to catheter.
19. Remove area towels.
20. Wipe penis to remove all the lignocaine jelly. If foreskin has been pulled back, be sure bringing it back to its original position. Position catheter support on lower abdomen or upper thigh (clip hair if necessary) and secure catheter.
22. Dispose of all waste in the appropriate waste streams.
23. Decontaminate hands thoroughly with soap and water.
24. Chart date of insertion in patient’s medical record file and in treatment folder. Document catheter number, type and size.

Reference:

AUTHORS: Yifan Xue MBBS MPH

KEYWORDS:
Urethral catheterisation, urethral catheter, Foley catheter, Aseptic Non Touch Technique, ANTT

OHS LOGOS: (Mark an X beside the logos to be included)

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<td>X</td>
<td>Wash Your Hands</td>
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<td>Standard Precautions</td>
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<td>Maintain Electrical Safety</td>
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<td>Radiation Hazard</td>
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<td>Safety Testing</td>
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DATE: 18th DEC 2008
**Audits**

Audit criteria are developed from evidence obtained from systematic reviews, guidelines and evidence summaries. Audit criteria are uploaded into JBI PACES, the JBI online audit and feedback software. JBI PACES allows users to compare data with other organisations of similar size or setting and provides ideas on how to facilitate a process of change in relation to the use of evidence in practice on a specific activity or intervention. The criteria MUST be evidence-based.
Linguistic Translation Collaborating Centre - Quarterly Report

Name of Centre:

Date:

**Evidence Summaries, Recommended Practices and Audit Criteria**

- New

- Updates

**Node Administration**

*Teleconferences/Emails/Letters*

- 

**Materials Under Review/Development**

- 

**JBI Node Contact**

- 

**Meetings**

- 

**Other projects**

-