

The Hierarchy of Evidence



The Hierarchy of evidence is based on summaries from the National Health and Medical Research Council (2009), the Oxford Centre for Evidence-based Medicine Levels of Evidence (2011) and Melynyk and Fineout-Overholt (2011).

- I Evidence obtained from a systematic review of all relevant randomised control trials.
- II Evidence obtained from at least one well designed randomised control trial.
- III Evidence obtained from well-designed controlled trials without randomisation.
- IV Evidence obtained from well designed cohort studies, case control studies, interrupted time series with a control group, historically controlled studies, interrupted time series without a control group or with case- series
- V Evidence obtained from systematic reviews of descriptive and qualitative studies
- VI Evidence obtained from single descriptive and qualitative studies
- VII Expert opinion from clinicians, authorities and/or reports of expert committees or based on physiology

Melynyk, B. & Fineout-Overholt, E. (2011). Evidence-based practice in nursing & healthcare: A guide to best practice (2nd ed.). Philadelphia: Wolters Kluwer, Lippincott Williams & Wilkins.

National Health and Medical Research Council (2009). NHMRC levels of evidence and grades for recommendations for developers of guidelines (2009). Australian Government: NHMRC. http://www.nhmrc.gov.au/_files_nhmrc/file/guidelines/evidence_statement_form.pdf

OCEBM Levels of Evidence Working Group Oxford (2011).The Oxford 2011 Levels of Evidence. Oxford Centre for Evidence-Based Medicine. <http://www.cebm.net/index.aspx?o=1025>

Databases searched:	<input checked="" type="checkbox"/> CINAHL (Ebsco)	<input checked="" type="checkbox"/> Medline (Ebsco)	<input type="checkbox"/> Pubmed (NLM)	<input type="checkbox"/> Nursing (Ovid)	<input type="checkbox"/> Emcare (Ovid)
Keywords used:	Latex Allergy, Management of, Hospital, Nursing				
Search limits:	2015-2019				
Other search comments:					

2020 Nursing Clinical Effectiveness Committee
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Guideline Title:

Author(s):

Reference (include title, author, journal title, year of publication, volume and issue, pages)	Evidence level (I-VII)	Key findings, outcomes or recommendations
Australasian society of clinical immunology and allergy (ascia) (2006)	VII	<ul style="list-style-type: none">• ASCIA is the peak professional body of Clinical Allergists and Immunologists in Australia and New Zealand.• ASCIA Education resources (AER) information bulletins are peer reviewed by ASCIA members and represent the available published literature at the time of review.• It is important to note that information contained in this bulletin is not intended to replace professional medical advice. Any questions regarding a medical diagnosis should be directed to a medical practitioner
Association of Operating Room Nurse – Latex Guideline (2004)	VII	The AORN guideline is based on research and expert opinion and may not apply to every individual and may require modification based on specific needs of a given patient, health care provider or situation.

Commented [SR1]: Lily is there an updated resource/version of this?

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<p>Liberatore, K. (2019). Protecting Patients with Latex Allergies Strategies to reduce risk and improve patient safety. AJN, 119 (1).</p>	<p>VII</p>	<p>Latex products continue to pose a threat to patient safety and there is difficulty in ensuring a health care setting is latex free at all times. Staff must be aware there is the potential for latex containing products to be in the health setting as operating under the assumption that all products in health care are latex-free can increase risk of inadvertent exposure.</p> <p>Recommended to ask patients specifically about latex allergies before performing procedures that may involve latex products, such as urinary catheter insertion.</p> <p>Ensure that the patient’s latex allergy is documented and highlighted in handover.</p> <p>Visual reminders of the patient’s latex allergy should be utilised including ID bands and signage.</p>
<p>DE QUEIROZ, M. (2009) Latex allergy in children: modalities and Prevention. Pediatric Anesthesia 19: 313–319</p>	<p>VI</p>	<p>Identification of patients ‘at risk’ for latex allergy.</p> <p>Prevention by complete avoidance of latex ideal but difficult. Staff need to check products prior to use.</p>

<p>Samuel Malamulele Risenga (2010). Latex allergy revisited: a review. Current Allergy & Clinical Immunology. 23(1).</p>	<p>VI</p>	<p>Highlights importance of identifying risk factors and ensuring allergy status is always communicated and documented.</p> <p>Whilst management of symptoms is important, prevention of exposure to latex is crucial to prevent allergy and reaction. It is very difficult to ensure all latex products are removed in the health care setting.</p> <p>Management depends on the severity of the reaction. Remove the patient from the latex environment and treat anaphylaxis according hospital procedures.</p> <p>The most important preventive measure is education in avoidance of contact with latex and increasing awareness to check products are latex free prior to use.</p>
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<p>Hohler, S., (2017) Keeping children with latex allergies safe. Nursing2017,</p>		<p>Minimizing early exposure.</p> <p>Environmental safety – highlights the importance of minimising latex products at all times in a hospital</p> <p>Staff education regarding checking of products prior to use is critically important.</p> <p>Strong handover procedures and communication between all departments and health practitioners should include the patient’s allergy status including latex allergy.</p> <p>According to AORN Standards 2017, medication vials with rubber stoppers should be punctured only once to withdraw the medication and the medication should be administered right away. Removing rubber stoppers isn’t recommended because doing so doesn’t reduce rubber contamination of the medication.⁶ Handoff communication between all departments should include the patient’s latex allergy.</p>
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