

Bilaga 1. Mallar etc för bedömning av studiernas kvalitet

Granskningsmall

First author:

Title:

Journal:

Year:

Volume:

Issue:

First page:

Last Page:

1. Type of study

- RCT → Section A
- Controlled trial without randomization → Section B
- Observational cohort study → Section B
- Case-control study → Section C
- Cross-sectional study (exposure and outcome measured simultaneously) → Section C
- Case series
- Case report
- Ecological study
- Other:

2. Type of report

- Full paper in peer reviewed journal
- Full paper in book or other type of report
- Abbreviated paper in meeting proceedings or similar publication
- Abstract only
- Other:

3. Language

- English
- Scandinavian
- German
- French
- Other:

Section A (randomized clinical trial)

External validity

Short form answer:

- Clear external validity (0)
- Probable external validity (1)
- Uncertain external validity (3)
- External validity cannot be assessed (5)

**If uncertain, answer questions under Item 1.
Otherwise go to Internal validity (after Item 1)**

1. Accrual of study subjects

- a. Eligibility/inclusion criteria clearly stated (eg, if trial of treatment of a specified disease, is the definition acceptable)?
 - Yes = 0
 - No = 2
- b. Consecutive eligible subjects?
 - Yes = 0
 - No = 1
 - Not stated = 1
- c. Numbers and reasons for non-participation given?
 - Yes = 0
 - No = 2
- d. Exclusion criteria clearly stated and acceptable?
 - Yes = 0
 - No = 2
- e. Are numbers of excluded persons given by reason (as prescribed in the CONSORT statement)?
 - Yes = 0
 - No = 2

Total sum of section 1

0 = Clear external validity

1 = Probable external validity

2–3 = Uncertain external validity

≥4 = External validity cannot be assessed

Internal validity

Short form answer:

- Excellent internal validity (0)
- Good internal validity (1)
- Acceptable internal validity (2)
- Uncertain internal validity (4)
- Uninformative due to flawed internal validity (10)

**If uncertain, answer questions under Items 2–9.
Otherwise go to Precision (after Item 9)**

2. Treatment/exposure assignment

- a. Were details about randomization procedure given?
 - Yes = 0
 - No = 1
- b. Could the randomization be manipulated?
 - Yes (eg, tossing of coin or throwing of dice) = 1
 - No (eg, opaque envelopes, computer-generated list kept by others than investigators) = 0
- c. Did randomization lead to unpredictable treatment assignment?
 - Yes = 0
 - No, treatment could potentially be deduced in some or all = 2
- d. Were there exclusions/withdrawals after randomization?
 - Yes = 2
 - No = 0

3. Comparability of groups

- a. Was there an account of the comparability of groups with regard to all conceivable factors that might affect the outcome?
 - Yes = 0
 - No = 1
- b. Were there any important differences?
 - Yes = 2
 - No = 0
 - No data given = 0 (already scored under 3a)

- c. Were any attempts in the analysis phase to adjust for imbalances between treatment arms with regard to important determinants for the outcome (eg, through multivariate modelling)?
- Not needed (no important imbalances) = 0
 - Yes = -1 (subtract 1 if you scored 2 under 3b)
 - No, despite a need = 1

4. Blinding

- a. Were there any attempts to blind the patients/investigators to treatment allocation?
- No (open study) = 2
 - Only study subjects were blinded (single-blind) = 1
 - Blinding only of investigators who evaluated the outcome ("blind observer") = 0
 - Double-blind = 0
 - Triple-blind (breaking of the code first after completion of all analyses) = 0
- b. Was there any reason to believe that the blinding had failed (eg, due to characteristic side-effects of active treatment or dissimilarities of active and reference tablets)?
- Yes = 1
 - No = 0
- c. Was the blinding tested (eg, through asking the subjects at the end of the study what they believed they had received)?
- Yes = 0
 - No = 0

5. Compliance

- a. Was there any account of the completeness of treatment/compliance?
- Yes = 0
 - No = 2
- b. Was the completeness acceptable (>80% of the subjects receiving >80% of the prescribed treatment)?
- Yes = 0
 - No = 3
 - Completeness/compliance data not given = 0 (scored under 5a)

6. Drop-outs/losses to follow-up

- a. Was there an account of the numbers of subjects who dropped out (and the reasons for dropping out)?
- Yes = 0
 - No = 3
- b. What was the drop-out rate?
- <10% = 0
 - 10–19% = 2
 - 20–29% = 3
 - ≥30% → *study is deemed uninformative, excluded*
 - Drop-out rate not stated = 0 (scored under 6a)

7. Evaluation of outcome

- a. Was there an acceptable definition of the outcome?
- Yes = 0
 - No = 3
- b. Was the outcome clinically relevant?
- Yes = 0
 - Of questionable relevance = 2
 - Irrelevant → *study is deemed uninformative, excluded*
- c. Was the reporter of the outcome (eg, the investigator, the study subject) unaware of the treatment given?
- Yes = 0
 - No = 2
- d. Are there reasons to believe that there might have been misclassification of the outcome (eg, due to retrospective reporting over too long periods)?
- Yes = 1
 - No = 0

8. Evaluation of side-effects

- a. Was there acceptable reporting of side effects?
- Yes, with open-ended questions = 0
 - Yes, with fixed response alternatives = 0
 - Yes, response alternatives not stated = 0
 - No = 3

9. Analysis

- a. Was the main outcome variable defined in advance and was the conclusion of the study based on the analysis of this variable?
- Yes = 0
 - No (or not mentioned in the report) = 2
- b. Was there a prior hypothesis?
- Yes = 0
 - No (or not mentioned in the report) = 1
- c. Were the secondary variables defined in advance?
- Yes = 0
 - No (or not mentioned in the report) = 1
 - Not applicable, there was no secondary outcome variable = 0
- d. Were all randomized subjects included in the analysis and retained in the treatment arm to which they were initially allocated (“intention-to-treat analysis”)?
- Yes = 0
 - No = 4

Total sum of Items 2–9 (internal validity)

0–1 = Excellent internal validity

2–4 = Good internal validity

5–7 = Acceptable internal validity

8–10 = Uncertain internal validity

≥10 = Uninformative due to flawed internal validity

Precision

Short form answer:

- Premeditated and sufficient study size (0)
- Sample size of uncertain adequacy (2)
- Probably underpowered study (4)

If uncertain, answer questions under Items 10–11

10. Smallest clinically relevant effect

- a. Was the smallest clinically relevant effect defined?
- Yes = 0
 - No = 1
- b. Was the stated smallest clinically relevant effect reasonable?
- Yes = 0
 - No = 1
 - Not defined = 0 (scored under 10a)

11. Study power

- a. Were the deliberations behind the sample size decision clearly described?
- Yes = 0
 - No = 2
- b. What was the power to detect a reasonably-sized smallest clinically relevant effect?
- Not stated because there was a strong and statistically significant effect = 0
 - $\geq 90\%$ = 0
 - 80–89% = 1
 - 70–79% = 2
 - $< 70\%$ = 3
 - Not stated despite a non-significant finding = 4

Total sum of Items 10–11 (precision)

0–1 = Premeditated and sufficient study size

2–3 = Sample size of uncertain adequacy

≥ 4 = Probably underpowered study

Section B (observational cohort study or controlled clinical trial without randomization)

External validity

Short form answer:

- Clear external validity (0)
- Probable external validity (1)
- Uncertain external validity (3)
- External validity cannot be assessed (5)

**If uncertain, answer questions under Item 1,
Otherwise go to Internal validity (after Item 1)**

1. Accrual/selection of study subjects

- a. Was the studied exposure well defined (eg, if follow-up of a specified disease, is the definition of the disease acceptable)?
 - Yes = 0
 - No = 2
- b. Eligibility/inclusion criteria clearly stated?
 - Yes = 0
 - No = 1
- c. Consecutive eligible subjects included?
 - Yes = 0
 - No = 1
 - Not stated = 1
- d. Numbers and reasons for non-participation given?
 - Yes = 0
 - No = 1
- e. Exclusion criteria clearly stated and acceptable?
 - Yes = 0
 - No = 1
- f. Are numbers of excluded persons given by reason (as prescribed in the CONSORT statement)?
 - Yes = 0
 - No = 1

Total sum of section 1

0 = Clear external validity

1 = Probable external validity

2–3 = Uncertain external validity

≥4 = External validity cannot be assessed

Internal validity

Short form answer:

- Excellent internal validity (0)
- Good internal validity (1)
- Acceptable internal validity (2)
- Uncertain internal validity (4)
- Uninformative due to flawed internal validity (10)

**If uncertain, answer questions under Items 2-6.
Otherwise go to Precision (after Item 6)**

2. Exposure assessment

- a. Was the studied exposure satisfactorily measured/recorded?
 - Yes = 0
 - Yes, with minor criticism = 1
 - No = 3

- b. Were *all* in the exposed group really exposed?
 - Yes = 0
 - Yes, probably = 1
 - No, probably not = 2
 - No = 2

- c. Were *all* in the reference category really unexposed?
 - Yes = 0
 - Yes, probably = 1
 - No, probably not = 2
 - No = 2

3. Comparability of groups/selection bias/confounding

- a. Was there an account of the comparability of groups with regard to factors that might conceivably affect the outcome (potential confounding factors)? (If only one cohort was studied and compared with the background population or historical controls – was there data to support the comparability with the reference category).
- Yes = 0
 - No = 3
- b. Did the investigators consider all important potential confounding factors (potential confounding factors = factors that are independent causes of/risk factors for/protective factors against the outcome, AND not a link in the causal chain between the studied exposure and the outcome)?
- Yes = 0
 - Probably = 1
 - No = 3
 - No data given = 0 (already scored under 3a)
- c. Were the relevant confounding factors satisfactorily measured/recorded?
- Yes = 0
 - Yes, with minor criticism = 1
 - No = 3
- d. Were the potential confounding factors unevenly distributed among exposed and non-exposed/reference group (confounding arises if factors described under 3b are unevenly distributed among exposed and unexposed [ie, linked to the exposure])?
- Yes = 2
 - No = 0
 - No data given = 0 (already scored under 3a)
- e. Were attempts in the analysis to adjust for imbalances between exposure groups with regard to potential confounding factors (eg, through restriction, stratified analyses, or multivariate modelling)?
- Not needed (no important imbalances) = 0
 - Yes = -2 (subtract 2 if you scored 2 under 3d)
 - No, despite a need = 2

4. Evaluation of outcome, ascertainment/detection bias

- a. Was there an acceptable definition of the outcome?
- Yes = 0
 - No = 3

- b. Was the outcome clinically relevant?
 - Yes = 0
 - Of questionable relevance = 2
 - Irrelevant → *study is deemed uninformative, excluded*
- c. Were the evaluators of the outcome aware of exposure status of the cohort members?
 - Yes = 1
 - Probably = 1
 - No = 0
- d. Was there any reason to believe that there was important ascertainment/detection bias (eg, exposure linked to smoking, and smoking, in turn, linked to higher frequency of health care visits, and thus a more intense surveillance)?
 - Yes = 2
 - No = 0

5. Losses to follow-up

- a. Was there an account of the numbers of subjects who were lost to follow-up?
 - Yes = 0
 - No = 3
- b. What proportion was lost to follow-up?
 - <10% = 0
 - 10–19% = 1
 - 20–29% = 2
 - 30–39 = 3
 - ≥40% → *study is deemed uninformative, excluded*
 - Proportion not stated = 0 (scored under 5a)

6. Analysis

- a. Was the main outcome variable defined in advance and was the conclusion of the study based on the analysis of this variable?
 - Yes = 0
 - No (or not mentioned in the report) = 1
- b. Was there a prior hypothesis?
 - Yes = 0
 - No (or not mentioned in the report) = 1
- c. Was the statistical method adequate?
 - Yes = 0
 - No = 3

Total sum of Items 2–6 (internal validity)

0–1 = Excellent internal validity

2–3 = Good internal validity

4–6 = Acceptable internal validity

7–9 = Uncertain internal validity

≥10 = Uninformative due to flawed internal validity

Precision

Short form answer:

- Premeditated and sufficient study size (0)
- Sample size of uncertain adequacy (2)
- Probably underpowered study (4)

If uncertain, answer questions under Items 7–8

7. Smallest clinically relevant effect

- a. Was the smallest clinically relevant effect defined?
 - Yes = 0
 - No = 1

- b. Was the stated smallest clinically relevant effect reasonable?
 - Yes = 0
 - No = 1
 - Not defined = 0 (scored under 10a)

8. Study power

- a. Were the deliberations behind the sample size decision clearly described?
 - Yes = 0
 - No = 2

- b. What was the power to detect a reasonably-sized smallest clinically relevant effect?
 - Not stated because there was a strong and statistically significant effect = 0
 - ≥90% = 0
 - 80–89% = 1
 - 70–79% = 2
 - <70% = 3
 - Not stated despite a non-significant finding = 4

Total sum of Items 7–8 (precision)

0–1 = Premeditated and sufficient study size

2–3 = Sample size of uncertain adequacy

≥4 = Probably underpowered study

Section C (case-control or cross-sectional studies)

External validity

Short form answer:

- Clear external validity (0)
- Probable external validity (1)
- Uncertain external validity (3)
- External validity cannot be assessed (5)

**If uncertain, answer questions under Item 1,
Otherwise go to Internal validity (after Item 1)**

1. Type of cases studied

- a. Was there an acceptable definition of the outcome (that rendered subjects case/control status)?
 - Yes = 0
 - No = 2

- b. Did the studied cases correspond to cases in the population to which the investigators wished to generalize their findings?
 - Yes = 0
 - Yes, probably = 1
 - No, probably not = 2
 - No, definitely not = 3

Total sum of section 1

0 = Clear external validity

1 = Probable external validity

2–3 = Uncertain external validity

≥4 = External validity cannot be assessed

Internal validity

Short form answer:

- Excellent internal validity (0)
- Good internal validity (1)
- Acceptable internal validity (2)
- Uncertain internal validity (4)
- Uninformative due to flawed internal validity (10)

**If uncertain, answer questions under Items 2–6.
Otherwise go to Precision (after Item 6)**

2. Study base (NOTE, not relevant to cross-sectional studies; if so, skip 2–3)

The study base is defined as the group of people [the “virtual cohort”] who – if they developed the outcome condition – would necessarily have become cases in the study.

- a. Was the study base (the “virtual cohort” [a defined source population followed for a defined time period] that generated the cases) well defined (geographically, age-wise, gender, other characteristics)?
- Yes, quite clear (eg, an already established cohort, or definition through an existing, well-functioning population register) = 0
 - Yes, reasonably (eg, hospital-based study with strict catchment areas and no important selections of cases or controls) = 1
 - Yes, probably (eg, hospital-based study without clear catchment areas, and/or inability to rule out some less important selection among cases and/or controls; control selection via random digit dialing or through neighbourhood controls whereupon some minor mismatch [for instance socioeconomic] between cases and controls might have occurred) = 2
 - No, it is impossible to tell if the cases and controls come from the same study base and if there are important selection mechanisms for either of these categories = 4
- b. Are the cases representative of all cases in the study base?
- Yes, they represent all or virtually all new (incident) cases of the outcome that occurred in the study base = 0
 - Yes, although it is difficult to tell if they represent *all* cases, there is no reason to suspect that they are unrepresentative of all cases in the study base = 1
 - Yes, they represent prevalent cases in the study base, but there is no reason to suspect that they are unrepresentative = 1
 - No, there are reasons to suspect that they are unrepresentative of all cases in the study base = 3
 - No, definitely unrepresentative → *study is deemed uninformative, excluded*

- c. Do the control subjects come from the very same study base as the cases?
- Yes, definitely = 0
 - Yes, probably = 1
 - Uncertain = 3
 - Probably not = 4
 - No, definitely not → *study is deemed uninformative, excluded*
- d. Were the control subjects representative of the entire study base?
- Yes, they were selected randomly from a defined sampling frame (note that stratified random sampling in order to achieve frequency matching is acceptable) = 0
 - Yes, probably, but they were selected in some other way = 1
 - Uncertain = 3
 - Probably not = 4
 - No, the probability of being selected as control is linked to the subjects' exposure status → *study is deemed uninformative, excluded*

3. Non-participation

- a. Were all eligible cases occurring in the study base identified and enumerated?
- Yes = 0
 - Yes, probably = 1
 - No = 3
- b. What was the participation rate among all eligible cases?
- ≥90% = 0
 - 80–89% = 1
 - 70–79% = 2
 - 60–69% = 3
 - 50–59% = 4
 - <50% → *study is deemed uninformative, excluded*
 - Proportion not stated → *study is deemed uninformative, excluded*
- c. Was anything done to insure that major selection bias was not introduced through non-participation among cases?
- Not needed because participation among cases was >80% = 0
 - Participation ≤80%, but authors provide data about non-participants that seem to rule out important selection bias = -1 (subtract from sum)
 - Participation ≤80%, and no data is given about non-participants = 0

- d. What was the participation rate among all selected controls?
- $\geq 90\% = 0$
 - $80-89\% = 1$
 - $70-79\% = 2$
 - $60-69\% = 3$
 - $50-59\% = 4$
 - $< 50\% \rightarrow$ study is deemed uninformative, excluded
 - Proportion not stated \rightarrow study is deemed uninformative, excluded
- e. Was anything done to insure that major selection bias was not introduced through non-participation among controls?
- Not needed because participation among controls was $> 80\% = 0$
 - Participation $\leq 80\%$, but authors provide data about non-participants that seem to rule out important selection bias = -1 (subtract from sum)
 - Participation $\leq 80\%$, and no data is given about non-participants = 0

4. Participation in cross-sectional study (skip if regular case-control study)

- $\geq 90\% = 0$
- $80-89\% = 1$
- $70-79\% = 2$
- $60-69\% = 3$
- $50-59\% = 4$
- $< 50\% \rightarrow$ study is deemed uninformative, excluded
- Proportion not stated \rightarrow study is deemed uninformative, excluded

5. Exposure assessment

- a. How was exposure information collected?
- From existing databases with data obtained before cases developed outcome = 0
 - Face-to-face or telephone interviews with interviewers blinded to case/control status = 0
 - Face-to-face or telephone interviews where interviewers were aware of case/control status = 1
 - Postal questionnaire = 2
 - Other ways or not stated = 3
- b. Use of substitute responders
- No = 0
 - $\leq 20\% = 1$
 - $> 20\% = 3$

- c. Are there good reasons to suspect biased recall (ie, cases remember/report exposures systematically different compared to controls)
- No = 0
 - No, probably not = 1
 - Uncertain = 2
 - Yes, recall bias likely = 4
 - Yes, high probability of recall bias → *study is deemed uninformative, excluded*

6. Confounding

- a. Did the investigators consider all important potential confounding factors (potential confounding factors = factors that are independent causes of/risk factors for/protective factors against the outcome, AND not a link in the causal chain between the studied exposure and the outcome)?
- Yes = 0
 - Probably = 1
 - No = 3
 - No data given = 4
- b. Were the relevant confounding factors satisfactorily measured/recorded?
- Yes = 0
 - Yes, with minor criticism = 1
 - No = 3
- c. Were attempts in the study design or analysis to identify and handle confounding factors (eg, through matching, restriction, stratified analyses, or multivariate modelling)?
- Yes, adequately = 0
 - Yes, but not sufficiently = 2
 - No → *study is deemed uninformative, excluded*

7. Ascertainment/detection bias

- a. Was there any reason to believe that there was important ascertainment/detection bias (eg, exposure linked to smoking, and smoking, in turn, linked to higher frequency of health care visits, and thus a more intense surveillance)?
- Yes = 2
 - No = 0

8. Rare disease assumption

- a. Was the rare disease assumption fulfilled (the outcome affected less than 10% of the population in the study base)?
- Yes = 0
 - Unknown = 1
 - No or probably not = 3 (effects are likely exaggerated!)

9. Analysis

- a. Was there a prior hypothesis?
- Yes = 0
 - No (or not mentioned in the report) = 1
- b. Was the statistical method adequate?
- Yes = 0
 - No = 3

Total sum of Items 2–9 (internal validity) – CASE-CONTROL STUDY:

- 0–2 = Excellent internal validity
- 3–4 = Good internal validity
- 5–7 = Acceptable internal validity
- 8–10 = Uncertain internal validity
- ≥11 = Uninformative due to flawed internal validity

Total sum of Items 2–9 (internal validity) – CROSS-SECTIONAL STUDY:

- 0–1 = Excellent internal validity
- 2–3 = Good internal validity
- 4–5 = Acceptable internal validity
- 6–8 = Uncertain internal validity
- ≥9 = Uninformative due to flawed internal validity

Precision

Short form answer:

- Premeditated and sufficient study size (0)
- Sample size of uncertain adequacy (2)
- Probably underpowered study (4)

If uncertain, answer questions under Items 10–11

10. Smallest clinically relevant effect

- a. Was the smallest clinically relevant effect defined?
- Yes = 0
 - No = 1
- b. Was the stated smallest clinically relevant effect reasonable?
- Yes = 0
 - No = 1
 - Not defined = 0 (scored under 10a)

11. Study power

- a. Were the deliberations behind the sample size decision clearly described?
- Yes = 0
 - No = 2
- b. What was the power to detect a reasonably-sized smallest clinically relevant effect?
- Not stated because there was a strong and statistically significant effect = 0
 - $\geq 90\%$ = 0
 - 80–89% = 1
 - 70–79% = 2
 - $< 70\%$ = 3
 - Not stated despite a non-significant finding = 4

Total sum of Items 10–11 (precision)

0–1 = Premeditated and sufficient study size

2–3 = Sample size of uncertain adequacy

≥ 4 = Probably underpowered study

Section D (systematic reviews)

Topic/external validity

Is it an overview of the topic that you are interested in?

- Yes, completely = 0
- Yes, partly = 1
- Only to a small extent = 3
- No = 6

Is the research question clearly stated?

- Yes = 0
- Uncertain = 2
- No = 4

Internal validity

1. Literature search

Is the search strategy clearly stated?

a. Types of publications?

- Yes = 0
- No = 1

b. Years?

- Yes = 0
- No = 1

c. Languages?

- Yes = 0
- No = 1

d. Procedures?

- Yes = 0
- No = 1

Was the reproducibility of search efforts tested and reported?

- Yes = 0
- No = 1

In your opinion, did the authors succeed in capturing all of the targeted literature?

- Yes, definitely = 0
- Yes, probably = 2
- Probably not = 4
- Definitely not = 5

2. Evaluation of captured literature

Was there a defined scheme for validity assessment of captured literature?

- Yes, shown or published previously = 0
- Probably, but not shown = 1
- Probably not = 3
- Definitely not = 4

Were the criteria for accepting/rejecting papers clearly defined?

- Yes = 0
- Probably = 1
- Probably not = 3
- Definitely not = 4

Were rejected papers listed with reasons for rejection?

- Yes = 0
- No = 2

Was there any attempt to document the reproducibility of the validity assessment (eg inter- and/or intra-observer variation)?

- Yes, with acceptable reproducibility = 0
- Yes, with poor reproducibility = 2
- No = 2

3. Summary of findings

Were there any attempts to pool data or to perform a formal meta-analysis?

- Yes = 0
- No = 3

Was the choice of statistical method appropriate?

- Yes, definitely = 0
- Yes, probably = 0
- Uncertain = 1
- Probably not = 2
- Definitely not = 2
- Not applicable (no formal statistical testing) = 0

Was lack of consistency between studies evaluated (eg, tests of heterogeneity) and explained?

- Yes, satisfactorily = 0
- Yes, but poorly explained = 2
- No = 3

Were there any attempts to estimate possible publication bias (eg, through funnel plots)?

Yes = 0

No = 2

Total sum of internal validity

0–1 = Excellent validity

2–3 = Good validity

4–5 = Acceptable validity

6–8 = Uncertain validity

≥9 = Uninformative due to flawed validity

Sektion E Diagnostiska studier

VALIDATION OF DIAGNOSTIC TEST (adapted from Whiting P et al BMC Med Res Methodology 2003)

A. External validity

1. Was the spectrum of patients representative of the patients who will receive the test in practice?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

2. Were selection criteria clearly described?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

B. Internal validity

3. Is the reference standard likely to correctly classify the target condition?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

4. Is the time period between reference standard and index test short enough to be reasonably sure that the target condition did not change between the two tests?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

5. Did the whole sample or a random selection of the sample, receive verification using a reference standard?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

6. Did patients receive the same reference standard regardless of the index test result?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

7. Was the reference standard independent of the index test (i.e. the index test did not form part of the reference standard)?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

8. Was the execution of the index test described in sufficient detail to permit replication of the test?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

9. Was the execution of the reference standard described in sufficient detail to permit its replication?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

10. Were the index test results interpreted without knowledge of the results of the reference standard?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

11. Were the reference standard results interpreted without knowledge of the results of the index test?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

12. Were the same clinical data available when test results were interpreted as would be available when the test is used in practice?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

13. Were uninterpretable/intermediate test results reported?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

14. Were withdrawals from the study explained?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

C. Precision

15. Were the deliberations behind the sample size decision clearly described?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

16. Was some measure of the variability given (e.g. 95% confidence intervals)?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

17. Were the estimates reasonably precise?

- Yes = 0
- No = 1
- Not stated/Unclear = 1

SJEKKLISTE FOR Å VURDERE KVALITATIV FORSKNING

FØLGENDE FORHOLD MÅ VURDERES:

Kan vi stole på resultatene?

Hva forteller resultatene?

Kan resultatene være til hjelp i min praksis?

Under de fleste spørsmålene finner du tips som kan være til hjelp
når du skal svare på de ulike punktene.

Referanser:

1. Critical Appraisal Skills Programme. www.phru.org.uk/~casp
2. Greenhalgh T, Taylor R. Papers that go beyond numbers. *BMJ* 1997; 7110 (315)
3. Seers K. Qualitative research. In Evidence- Based Practice. A Primer for Health Care Professionals. Churchill Livingstone, Edinburgh 1999
4. Malterud K. The art and science of clinical knowledge: evidence beyond measures and numbers. *Lancet* 2001;358:397-400.

INNLEDENDE SPØRSMÅL

<p>1. Er formålet med studien tydelig?</p> <p>TIPS:</p> <ul style="list-style-type: none"> • Går det klart fram hva som blir studert? • Er dette en interessant eller relevant problemstilling? 	<p>Ja Uklart Nei</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. Er en kvalitativ tilnærming hensiktsmessig?</p> <p>TIPS:</p> <ul style="list-style-type: none"> • Har problemstillingen som mål å forstå og fortolke, eller beskrive fenomen eller subjektive erfaringer eller synspunkter? 	<p>Ja Uklart Nei</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

KAN DU STOLE PÅ RESULTATENE?

<p>3. Er det tilfredsstillende beskrevet hvordan og hvorfor utvalget ble valgt?</p> <p>TIPS:</p> <p>I strategiske utvalg er målet å dekke antatt relevante sosiale roller og perspektiver. De enhetene som skal kaste lys over disse perspektivene er vanligvis mennesker, men kan også være begivenheter, sosiale situasjoner eller dokumenter.</p> <p>Enhetene kan bli valgt fordi de er typiske eller atypiske, fordi de har bestemte forbindelser med hverandre, eller i noen tilfeller rett og slett fordi de er tilgjengelige.</p> <ul style="list-style-type: none"> • Finnes det en beskrivelse og en overbevisende legitimering av utvalget som blir gjort? • Er det gjort rede for hvem/hva som ble valgt ut og hvorfor? • Er det gjort rede for hvor mange som ble valgt og hvorfor? • Er det gjort rede for hvorfor noen valgte ikke å delta? 	<p>Kommentar:</p>
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<p>4. Var datainnsamlingen tilstrekkelig for å gi et helhetlig bilde av fenomenet?</p> <p>TIPS: Datainnsamlingen må være omfattende nok både i bredden (typen observasjoner) og i dybden (graden av observasjoner) om den skal kunne støtte og generere fortolkninger.</p> <ul style="list-style-type: none"> • Går det klart fram hvilke metoder som ble valgt for å samle data? For eksempel feltstudier (deltagende eller ikke-deltagende observasjon), intervjuer (semistrukturerte dybdeintervjuer, fokusgrupper), dokumentanalyse. • Er metoden som ble valgt den beste for å belyse problemstillingen? 	<p>Kommentar:</p>
<p>5. Ble det redegjort for bakgrunnsforhold som kan ha påvirket fortolkningen av data?</p> <p>TIPS: Forskningsresultatene blir nødvendigvis påvirket av perspektivet til forskeren. I tillegg vil konteksten som datainnsamlingen foregår innenfor påvirke resultatene.</p> <ul style="list-style-type: none"> • Har forskeren gjort rede for konteksten som datainnsamlingen foregikk innenfor? • Har forskeren gjort rede for sitt teoretiske ståsted og sin faglige bakgrunn? 	<p>Kommentar:</p>
<p>6. Går det klart fram hvordan analysen ble gjennomført? Er fortolkningen av data forståelig, tydelig og rimelig?</p> <p>TIPS: En vanlig tilnæringsmåte ved analyse av kvalitative data er såkalt innholdsanalyse, hvor mønstre i data blir identifisert og kategorisert.</p> <ul style="list-style-type: none"> • Ser du en klar sammenheng mellom innsamlede data og kategoriene som forskeren har kommet fram til? 	<p>Kommentar:</p>

<p>7. Er det blitt gjort forsøk på å underbygge data (funnene)?</p> <p>TIPS: Kategoriene eller mønstrene som ble identifisert i løpet av analysen kan styrkes ved å se om lignende mønstre blir identifisert gjennom andre kilder. For eksempel ved å diskutere foreløpige slutninger med studieobjektene, be en annen forsker gjennomgå materialet, eller å få lignende inntrykk fra andre kilder. Det er sjeldent at forskjellige kilde gir helt likt uttrykk. Imidlertid bør slike forskjeller forklares tilfredsstillende.</p> <ul style="list-style-type: none"> • Er det gjort forsøk på å trekke inn andre kilder for å vurdere eller underbygge data? 	<p>Kommentar:</p>
<p>8. Er etiske forhold vurdert ?</p> <p>TIPS:</p> <ul style="list-style-type: none"> • Ble studien forklart for deltagerne? • Ble studien forelagt Etisk komite? 	<p>Kommentar:</p>

HVA ER RESULTATENE?

<p>8. Kommer det klart fram hva som er hovedfunnene i undersøkelsen?</p> <ul style="list-style-type: none"> • Kan du oppsummere hovedfunnene? • Ble funnene diskutert i lys av det opprinnelige formålet med studien? 	<p>Kommentar:</p>
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KAN RESULTATENE BRUKES I MIN PRAKSIS?

<p>9. Hvor nyttige er funnene fra denne studien?</p> <p>TIPS: Målet med kvalitativ forskning er ikke å sannsynliggjøre at resultatene kan generaliseres til en bredere befolkning. Isteden kan resultatene gi grunnlag for modeller som kan brukes til å prøve å forstå lignende grupper eller fenomen.</p> <ul style="list-style-type: none"> • Kan resultatene hjelpe meg til bedre å forstå sammenhengen jeg arbeider i? • Drøft hvordan funnene kan utvide eksisterende kunnskap og forståelse? 	<p>Kommentar:</p>
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Bilaga 2. Sökstrategier

Triage system

PubMed April 2009

Emergency service, hospital (Me)		Triage (MeTiAb)
Emergency medical services (Me)		Emergency nursing (MeTiAb)
Emergency department (TiAb)		Emergency care (TiAb)
Emergency room (TiAb)		ATS (TiAb)
Accident and emergency (TiAb)	AND	CTAS (TiAb)
Trauma center* (TiAb)		MTS (TiAb)
		ESI (TiAb)
		CTS (TiAb)
		METTS (TiAb)

((("emergency service, hospital"[MeSH Terms] OR "emergency medical services"[MeSH Terms] OR "emergency department"[Title/Abstract] OR "emergency room"[Title/Abstract] OR "accident and emergency"[Title/Abstract] OR trauma center*[Title/Abstract]) AND ("triage"[MeSH Terms] OR "emergency nursing"[MeSH Terms] OR "emergency care"[Title/Abstract] OR "triage"[Title/Abstract] OR "emergency nursing"[Title/Abstract] OR "ats"[Title/Abstract] OR "ctas"[Title/Abstract] OR "mts"[Title/Abstract] OR "esi"[Title/Abstract] OR "cts"[Title/Abstract] OR "metts"[Title/Abstract])) NOT ("military"[Title] OR "disaster"[Title] OR "disasters"[Title])) AND ("cohort studies"[MeSH Terms] OR "evaluation studies"[Publication Type] OR "validation studies"[Publication type] OR "comparative study"[Publication Type] OR "controlled clinical trial"[Publication Type] OR "randomized controlled trial"[Publication Type] OR "controlled"[Title] OR "random"[Title] OR "randomly"[Title] OR "randomized"[Title] OR "observational"[Title] OR "longitudinal"[Title] OR "prospective"[Title] OR systematic[sb] OR "patient satisfaction"[MeSH Terms] OR "patient satisfaction"[title/abstract] OR "agreement"[title/abstract])

	Cohort studies (Me)		
	Evaluation studies (PT)		
	Validation studies (PT)		
	Comparative study (PT)		
	Controlled clinical trial (PT)		
	Randomized controlled trial (PT)		
	Controlled (Ti)		Military (Ti)
AND	Random (Ti)	NOT	Disaster (Ti)
	Randomly (Ti)		Disasters (Ti)
	Randomized (Ti)		
	Observational (Ti)		
	Longitudinal (Ti)		
	Prospective (Ti)		
	Systematic (SB)		
	Patient satisfaction (MeTiAb)		
	Agreement (TiAb)		

Emergency service (MH+)		Emergency nursing (MH+TiAb)
Emergency department (TiAb)		Triage (MHTiAb)
Emergency departments (TiAb)		Triaging (TiAb)
Emergency room (TiAb)	AND	Emergency care (TiAb)
Accident and emergency (TiAb)		ATS (TiAb)
Trauma center (TiAb)		CTAS (TiAb)
Trauma centers (TiAb)		MTS (TiAb)
		ESI (TiAb)
		CTS (TiAb)
		METTS (TiAb)

((MH "Emergency Service+") OR (TI "Emergency department") OR (TI "Emergency departments") OR (TI "emergency room") OR (TI "accident and emergency") OR (TI "trauma center") OR (TI "trauma centers") OR (AB "Emergency department") OR (AB "Emergency departments") OR (AB "emergency room") OR (AB "accident and emergency") OR (AB "trauma center") OR (AB "trauma centers"))) AND ((MH "Emergency Nursing+") OR (MH "triage") OR (TI "triage") OR (TI "triaging") OR (TI "emergency nursing") OR (TI "emergency care") OR (TI "ats") OR (TI "ctas") OR (TI "mts") OR (TI "esi") OR (TI "cts") OR (TI "metts") OR (AB "triage") OR (AB "triaging") OR (AB "emergency nursing") OR (AB "emergency care") OR (AB "ats") OR (AB "ctas") OR (AB "mts") OR (AB "esi") OR (AB "cts") OR (AB "metts"))) NOT ((TI "military") OR (TI "disaster") OR (TI "disasters"))) AND ((MH "Prospective Studies+") OR (MH "Clinical Trials+") OR (MH "Systematic Review") OR (AB "random") OR (AB "randomly") OR (TI "randomized") OR (TI "observational") OR (TI "prospective") OR (TI "cohort") OR (TI "systematic") OR (AB "systematic review") OR (AB "databases") OR (TI "longitudinal") OR (MH "Patient Satisfaction") OR (TX "patient satisfaction") OR (TX "agreement") OR (MH "Interrater Reliability")))

	Prospective studies (MH+)		
	Clinical trials (MH+)		
	Systematic review (MHAb)		
	Random (Ab)		
	Randomly (Ab)		
	Randomized (Ti)		
	Observational (Ti)		Military (Ti)
AND	Prospective (Ti)	NOT	Disaster (Ti)
	Cohort (Ti)		Disasters (Ti)
	Systematic (Ti)		
	Databases (Ab)		
	Longitudinal (Ti)		
	Patient satisfaction (MHTX)		
	Agreement (TX)		
	Interrater reliability (MH)		

Emergency health service (TiAbDe)		Emergency nursing (TiAbDe)
Emergency department (TiAb)		Triage (TiAb)
Emergency room (TiAb)		Emergency care (TiAb)
Emergency ward (TiAbDe)		ATS (TiAb)
Accident and emergency (TiAb)	AND	CTAS (TiAb)
Trauma center (TiAb)		MTS (TiAb)
Trauma centra (TiAb)		ESI (TiAb)
Trauma centers (TiAb)		CTS (TiAb)
		METTS (TiAb)

('emergency health service':ti,ab,de OR 'emergency department':ti,ab OR 'emergency room':ti,ab OR 'emergency ward':ti,ab,de OR 'accident and emergency':ti,ab OR 'trauma center':ti,ab OR 'trauma centra':ti,ab OR 'trauma centers':ti,ab) AND ('emergency nursing':ti,ab,de OR 'triage':ti,ab OR 'emergency care':ti,ab OR ats:ti,ab OR ctas:ti,ab OR mts:ti,ab OR esi:ti,ab OR cts:ti,ab OR metts:ti,ab) AND ('randomized controlled trial':de OR 'controlled clinical trial':de OR 'controlled':ti OR 'random':ti OR 'randomly':ti OR 'randomized':ti OR 'systematic review':ti,de OR 'patient satisfaction':ti,ab,de OR 'agreement':ti,ab OR 'cohort analysis':de OR 'observational study':de OR 'evaluation':ti,de OR 'comparative study':de OR 'intermethod comparison':de OR comparative:ti OR observational:ti OR longitudinal:ti OR prospective:ti) NOT (military:ti OR disaster:ti OR disasters:ti)

	Randomized controlled trial (De)		
	Controlled clinical trial (De)		
	Controlled (Ti)		
	Random (Ti)		
	Randomly (Ti)		
	Randomized (Ti)		
	Systematic review (TiDe)		
	Patient satisfaction (TiAbDe)		Military (Ti)
AND	Agreement (TiAb)	NOT	Disaster (Ti)
	Cohort analysis (De)		Disasters (Ti)
	Observational study (De)		
	Evaluation (TiDe)		
	Comparative study (De)		
	Intermethod comparison (De)		
	Comparative (Ti)		
	Observational (Ti)		
	Longitudinal (Ti)		
	Prospective (Ti)		

BNI September 2008 (OVID HOST)

Triage (TiAbDeHW)

Emergency nursing (TiAb)

Emergency care (TiAb)

ATS (TiAb)

MTS (TiAb)

CTAS (TiAb)

ESI (TiAb)

METTS (TiAb)

Emergency (TiAb)

AND Accident (TiAb)

Trauma (TiAb)

('triage'.ti,ab,de,hw OR 'emergency nursing'.ti,ab OR 'emergency care'.ti,ab OR 'ats'.ti,ab OR 'mts'.ti,ab OR 'ctas'.ti,ab OR 'esi'.ti,ab OR 'metts'.ti,ab) AND (('emergency'.ti,ab OR 'accident'.ti,ab OR 'trauma'.ti,ab) AND ('service'.ti,ab OR 'department'.ti,ab OR 'room'.ti,ab OR 'center'.ti,ab OR 'centers'.ti,ab OR 'services'.ti,ab))

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Emergency service, hospital (KW)

Emergency medical services (KW)

Emergency department (TiAb)

Emergency departments (TiAb)

Emergency ward (TiAb)

Emergency wards (TiAb)

Emergency room (TiAb)

Emergency rooms (TiAb)

Trauma center* (TiAb)

Triage (KWTi)

Emergency nursing (KWTiAb)

Emergency care (TiAb)

ATS (Ti)

AND CTAS (Ti)

MTS (Ti)

ESI (Ti)

CTS (Ti)

METTS (Ti)

((emergency service, hospital):kw OR (emergency medical services):kw OR (emergency department):ti,ab OR (emergency departments):ti,ab OR (emergency ward):ti,ab OR (emergency wards):ti,ab OR (emergency room):ti,ab OR (emergency rooms):ti,ab OR (trauma center*):ti,ab) AND ((triage):kw,ti OR (emergency nursing):kw,ti,ab OR (emergency care):ti,ab OR (ats):ti OR (ctas):ti OR (mts):ti OR (esi):ti OR (cts):ti OR (metts):ti) NOT ((military):ti OR (disaster):ti OR (disasters):ti)

AND Service (TiAb)
 Department (TiAb)
 Room (TiAb)
 Center (TiAb)
 Centers (TiAb)
 Services (TiAb)

NOT Military (Ti)
 Disaster (Ti)
 Disasters (Ti)

Triage patientflöden

PubMed April 2009

Patient flow (TiAb)

Patient turnover (TiAb)

Caseload (TiAb)

Case Load (TiAb)

Case loads (TiAb)

Caseloads (TiAb)

Workload (MeTiAb)

Work load (TiAb)

Workloads (TiAb)

Work loads (TiAb)

Department volume (TiAb)

Department volumes (TiAb)

Efficiency (Ti)

Effectiveness (Ti)

Waiting times (TiAb)

Emergency service, hospital (Me)

Emergency nursing (Me)

AND Emergency department (TiAb)

Emergency departments (TiAb)

Length of stay (Me)

OR Crowding (Me)

AND Emergency (TiAb)

("patient flow"[title/abstract] OR "patient turnover"[Title/Abstract] OR "workload"[MeSH Terms] OR "workload"[Title/Abstract] OR "caseload"[Title/Abstract] OR "work load"[Title/Abstract] OR "work loads"[Title/Abstract] OR "case load"[Title/Abstract] OR "case loads"[Title/Abstract] OR "workloads"[Title/Abstract] OR "caseloads"[Title/Abstract] OR "department volume"[Title/Abstract] OR "department volumes"[Title/Abstract] OR "clinic volume"[Title/Abstract] OR "efficiency"[Title] OR "effectiveness"[Title] OR (("length of stay"[MeSH Terms] OR "crowding"[MeSH Terms]) AND "emergency"[Title/Abstract]) OR "waiting times"[Title/Abstract]) AND ("emergency service, hospital"[MeSH Terms] OR "emergency nursing"[MeSH Terms] OR "emergency department"[Title/Abstract] OR "emergency departments"[Title/Abstract]) AND ("organization and administration"[MeSH Terms] OR "triage"[MeSH Terms] OR "triage"[Title/Abstract])

AND Organization and administration (Me)
 Triage (MeTiAb)

PubMed April 2009

Patient flow (TiAb)

Patient turnover (TiAb)

Waiting times (TiAb)

Length of stay (Me)

OR Crowding (Me)

AND Emergency (TiAb)

AND

Emergency service, hospital (Me)

Emergency nursing (Me)

Emergency department (TiAb)

Emergency departments (TiAb)

("patient flow"[title/abstract] OR "patient turnover"[Title/Abstract] OR ("length of stay"[MeSH Terms] OR "crowding"[MeSH Terms]) AND "emergency"[Title/Abstract]) OR "waiting times"[Title/Abstract] AND ("emergency service, hospital"[MeSH Terms] OR "emergency nursing"[MeSH Terms] OR "emergency department"[Title/Abstract] OR "emergency departments"[Title/Abstract]) AND ("organization and administration"[MeSH Terms] OR "efficiency"[Title] OR "effectiveness"[Title] OR "triage"[MeSH Terms] OR "triage"[Title/Abstract])

British Nursing Index (OVID HOST) September 2008

Patient flow (TiAb)

Patient turnover (TiAb)

Workload (TiAb)

Caseload (TiAb)

Department volume (TiAb)

Clinic volume (TiAb)

Efficiency (Ti)

Effectiveness (Ti)

AND

Triage (TiAbDeHw)

((patient flow or patient turnover or workload or caseload or department volume or clinic volume).ti,ab. or efficiency.ti. or effectiveness.ti) AND (triage.ti,ab,de,hw)

AND Organization and administration (Me)
 Efficiency (Ti)
 Effectiveness (Ti)
 Triage (MeTiAb)

CINAHL (EBSCO HOST) April 2009

Workload (MH)
Organizational efficiency (MH+)
Patient flow* (TiAb)
Workload* (TiAb)
Caseload* (TiAb) AND Triage (SHMHTiAb)
Department volume* (TiAb)
Clinic volume* (TiAb)
Efficiency (Ti)
Effectiveness (Ti)

(MH workload OR MH organizational efficiency+ OR TI patient flow* OR AB patient flow* OR TI workload* OR AB workload* OR TI caseload* OR AB caseload* OR TI department volume* OR AB department volume* OR TI clinic volume* OR AB clinic volume* OR TI efficiency OR TI effectiveness) AND (SH triage OR TI triage OR AB triage OR MH triage)

EMBASE April 2009

Workload (ExpTiAb)		Emergency health services (TiDe)
Patient flow (TiAb)	AND	Emergency nursing (TiDe)
Patient turnover (TiAb)		Emergency department (TiAb)
Workloads (TiAb)		Emergency departments (TiAb)
Work load (TiAb)		Emergency room (TiAb)
Work loads (TiAb)		Emergency ward (TiAbDe)
Caseload (TiAb)		
Case load (TiAb)		
Caseloads (TiAb)		
Case loads (TiAb)		
Department volume (TiAb)		
Department volumes (TiAb)		
Clinic volume (TiAb)		
Clinic volumes (TiAb)		
Efficiency (Ti)		
Effectiveness (TiAb)		
Waiting times (TiAb)		
Length of stay (TiAbDe)		
AND Crowding (TiAbDe)		
AND Emergency (TiAb)		

('workload'/exp OR 'patient flow':ti,ab OR 'patient turnover':ti,ab OR 'workload':ti,ab OR 'work load':ti,ab OR 'workloads':ti,ab OR 'case load':ti,ab OR 'caseload':ti,ab OR 'caseloads':ti,ab OR 'department volume':ti,ab OR 'department volumes':ti,ab OR 'clinic volume':ti,ab OR 'clinic volumes':ti,ab OR 'efficiency':ti OR 'effectiveness':ti OR 'waiting times':ti,ab OR (('length of stay':ti,ab,de AND 'crowding':ti,ab,de) AND 'emergency':ti,ab)) AND ('emergency health service':ti,de OR 'emergency nursing':ti,de OR 'emergency department':ti,ab OR 'emergency departments':ti,ab OR 'emergency room':ti,ab OR 'emergency ward':ti,ab,de) AND ('organization and management'/exp OR 'triage':ti,ab)

AND Organization and management (Exp)
 Triage (TiAb)

Cochrane Library April 2009

Patient flow (TiAb)		Emergency service, hospital (KW)
Patient turnover (TiAb)	AND	Emergency nursing (KW)
Waiting times (TiAb)		Emergency department (TiAb)
Workload (KWTiAb)		Emergency departments (TiAb)
Work load (TiAb)		Emergency ward (TiAb)
Caseload (TiAb)		Emergency wards (TiAb)
Caseloads (TiAb)		
Case load (TiAb)		
Department volume (TiAb)		
Department volumes (TiAb)		
Clinic volume (TiAb)		
Efficiency (Ti)		
Effectiveness (Ti)		
Length of stay (KWTiAb)		
OR Crowding (TiAb)		
AND Emergency (TiAb)		

((patient flow):ti,ab OR (patient turnover):ti,ab OR (waiting times):ti,ab OR (workload):kw,ti,ab OR (work load):ti,ab OR (caseload):ti,ab OR (caseloads):ti,ab OR (case load):ti,ab OR (department volume):ti,ab OR (department volumes):ti,ab OR (clinic volume):ti,ab OR (efficiency):ti OR (effectiveness):ti OR (((length of stay):kw,ti,ab OR (crowding):ti,ab) AND (emergency):ti,ab)) AND ((emergency service, hospital):kw OR (emergency nursing):kw OR (emergency department):ti,ab OR (emergency departments):ti,ab OR (emergency ward):ti,ab OR (emergency wards):ti,ab) AND ((organization and administration):kw OR (triage):kw,ti,ab)

AND Organization and administration (KW)
 Triage (KWTiAb)

Triage prognos vital signs

PubMed Mars 2009

Blood pressure (Me)		Predictive value of tests (Me)
Respiratory rate (TiAb)	AND	Prediction (Ti)
Heart rate (Me)		Prognosis (Ti)
Consciousness (MeTi)		Prognostic (Ti)
Glasgow coma scale (MeTi)		Predictive (Ti)
Body temperature (Me)		Accuracy (TiAb)
Oximetry (MeTi)		Validation (TiAb)
Capnography (MeTi)		Validity (TiAb)
Systolic (Ti)		
Diastolic (Ti)		
Breath rate (Ti)		
Saturation (Ti)		
Pulse (Ti)		
Exhaled carbon dioxide (Ti)		

("blood pressure"[MeSH Terms] OR "respiratory rate"[Title/Abstract] OR "heart rate"[MeSH Terms] OR "consciousness"[MeSH Terms] OR "glasgow coma scale"[MeSH Terms] OR "body temperature"[MeSH Terms] OR "oximetry"[MeSH Terms] OR "capnography"[MeSH Terms] OR "systolic"[Title] OR "diastolic"[Title] OR "breath rate"[Title] OR "saturation"[Title] OR "pulse"[Title] OR "consciousness"[Title] OR "glasgow coma scale"[Title] OR "oximetry"[Title] OR "capnography"[Title] OR "exhaled carbon dioxide"[Title]) AND ("predictive value of tests"[MeSH Terms] OR "prediction"[Title] OR "prognosis"[Title] OR "prognostic"[Title] OR "predictive"[Title] OR "accuracy"[Title/Abstract] OR "validation"[Title/Abstract] OR "validity"[Title/Abstract]) AND ("mortality"[MeSH Terms] OR "morbidity"[MeSH Terms] OR "mortality"[Title/Abstract] OR "morbidity"[Title/Abstract] OR "death"[Title/Abstract] OR "deaths"[Title/Abstract] OR "survival"[Title/Abstract])

AND Mortality (MeTiAb)
Morbidity (MeTiAb)
Death (TiAb)
Deaths (TiAb)
Survival (TiAb)

CINAHL (EBSCO HOST) Mars 2009

Blood pressure (MH+)		Predictive value of tests (MH)
Heart rate (MH)	AND	Risk assessment (MH)
Consciousness (MHTi)		Sensitivity and specificity (MH)
Glasgow coma scale (MHTi)		Prediction (Ti)
Body temperature (MH)		Prognosis (Ti)
Oral body temperature (MH)		Prognostic (Ti)
Rectal body temperature (MH)		Predictive (Ti)
Skin temperature (MH)		Accuracy (TX)
Tympanic body temperature (MH)		Validation (TX)
Oximetry (MH+Ti)		Validity (TX)
Capnography (MHTi)		Prognosis (MH+)
Systolic (Ti)		
Respiratory rate (TX)		
Diastolic (Ti)		
Breath rate (Ti)		
Saturation (Ti)		
Pulse (Ti)		
Exhaled carbon dioxide (Ti)		
Vital signs (MH+)		

Limit: Journal articles

(MH "Blood Pressure+" OR MH "Heart Rate" OR MH "consciousness" OR MH "Glasgow Coma Scale" OR MH "body temperature" OR MH "oral body temperature" OR MH "rectal body temperature" OR MH "skin temperature" OR MH "tympanic body temperature" OR MH "oximetry+" OR MH "capnography" OR TI "systolic" OR TX "respiratory rate" OR TI "diastolic" OR TI "breath rate" OR TI "saturation" OR TI "pulse" OR TI "consciousness" OR TI "glasgow coma scale" OR TI "oximetry" OR TI "capnography" OR TI "exhaled carbon dioxide" OR MH "vital signs+") AND (MH "predictive value of tests" OR MH "risk assessment" OR MH "sensitivity and specificity" OR TI "prediction" OR TI "prognosis" OR TI "prognostic" OR TI "predictive" OR TX "accuracy" OR TX "validation" OR TX "validity" OR MH "prognosis+") AND (MH "mortality+" OR MH "morbidity+" OR MH "survival" OR TX "mortality" OR TX "morbidity" OR TX "death" OR TX "deaths" OR TX "survival")

AND Mortality (MH+TX)
Morbidity (MH+TX)
Survival (MHTX)
Death (TX)
Deaths (TX)

EMBASE Mars 2009

Blood pressure (TiDe)		Predictive validity (De)
Breath rate (Ti)	AND	Prediction (Ti)
Breathing rate (TiDe)		Predictive (Ti)
Heart rate (TiDe)		Accuracy (Ti)
Pulse (Ti)		Validation (Ti)
Consciousness (TiDe)		Validity (Ti)
Glasgow coma scale (TiDe)		
Body temperature (TiDe)		
Oximetry (TiDe)		
Capnography (TiDe)		
Exhaled carbon dioxide (Ti)		

('blood pressure':ti,de OR 'breath rate':ti OR 'breathing rate':ti,de OR 'heart rate':ti,de OR 'pulse':ti OR 'consciousness':ti,de OR 'consciousness level':ti,de OR 'Glasgow coma scale':ti,de OR 'body temperature':ti,de OR 'oximetry':ti,de OR 'capnography':ti,de OR 'exhaled carbon dioxide':ti) AND ('predictive validity':de OR 'prediction':ti OR 'predictive':ti OR 'accuracy':ti OR 'validation':ti OR 'validity':ti) AND ('mortality'/exp OR 'mortality':ti OR 'death':ti OR 'deaths':ti OR 'survival':ti) NOT ((treatment:ti OR therapy:ti) NOT ('prediction':ti OR 'predictive':ti OR 'accuracy':ti OR 'validation':ti OR 'validity':ti))

Cochrane Library Mars 2009

Blood pressure (KWTiAb)		Predictive value of tests (KW)
Respiratory rate (TiAb)	AND	Prediction (Ti)
Heart rate (KWTiAb)		Predictive (Ti)
Consciousness (KWTiAb)		Prognosis (Ti)
Glasgow coma scale (KWTiAb)		Prognostic (Ti)
Body temperature (KWTiAb)		Accuracy (TiAb)
Oximetry (KWTiAb)		Validation (TiAb)
Capnography (KWTiAb)		Validity (TiAb)
Systolic (Ti)		
Diastolic (Ti)		
Breath rate (Ti)		
Saturation (Ti)		
Pulse (Ti)		
Exhaled carbon dioxide (Ti)		

((blood pressure):kw,ti,ab OR (respiratory rate):ti,ab OR (heart rate):kw,ti,ab OR (consciousness):kw,ti,ab OR (glasgow coma scale):kw,ti,ab OR (body temperature):kw,ti,ab OR (oximetry):kw,ti,ab OR (capnography):kw,ti,ab OR (systolic):ti OR (diastolic):ti OR (breath rate):ti OR (saturation):ti OR (pulse):ti OR (exhaled carbon dioxide):ti) AND ((predictive value of tests):kw OR (prediction):ti OR (predictive):ti OR (prognosis):ti OR (prognostic):ti OR (accuracy):ti,ab OR (validation):ti,ab OR (validity):ti,ab) AND ((mortality):kw,ti,ab OR (morbidity):ti,ab,kw OR (death):ti,ab OR (deaths):ti,ab OR (survival):ti,ab)

	Mortality (ExpTi)		Treatment (Ti)
	Death (Ti)	NOT	OR Therapy (Ti)
AND	Deaths (Ti)		NOT Prediction (Ti)
	Survival (Ti)		OR Predictive (Ti)
			OR Accuracy (Ti)
			OR Validation (Ti)
			OR Validity (Ti)

	Mortality (KWTiAb)
AND	Morbidity (KWTiAb)
	Death (TiAb)
	Deaths (TiAb)
	Survival (TiAb)

Triage prognos chief complaints

PubMed MARS 2009

Presenting symptom (TiAb)	AND	Emergency service, hospital (Me)
Presenting symptoms (TiAb)		Emergency medicine (Me)
Chief complaints (TiAb)		Emergency nursing (MeTiAb)
Chief complaint (TiAb)		Emergency department (TiAb)
Signs and symptoms (MJR)		Emergency medicine (TiAb)

("presenting symptom"[Title/Abstract] OR "chief complaints"[Title/Abstract] OR "chief complaint"[Title/Abstract] OR "presenting symptoms"[Title/Abstract] OR "Signs and Symptoms"[Majr]) AND ("emergency service, hospital"[MeSH Terms] OR "emergency medicine"[MeSH Terms] OR "emergency nursing"[MeSH Terms] OR "emergency department"[Title/Abstract] OR "emergency medicine"[Title/Abstract] OR "emergency nursing"[Title/Abstract]) AND ("predictive value of tests"[MeSH Terms] OR "prediction"[Title] OR "prognosis"[Title] OR "prognostic"[Title] OR "predictive"[Title] OR "accuracy"[Title/Abstract] OR "validation"[Title/Abstract] OR "validity"[Title/Abstract]) AND ("mortality"[MeSH Terms] OR "morbidity"[MeSH Terms] OR "mortality"[Title/Abstract] OR "morbidity"[Title/Abstract] OR "death"[Title/Abstract] OR "deaths"[Title/Abstract] OR "survival"[Title/Abstract])

CINAHL Mars 2009

Presenting symptom (TW)	AND	Predictive value of tests (MH)
Presenting symptoms (TW)		Risk assessment (MH)
Chief complaints (TW)		Sensitivity and specificity (MH)
Chief complaint (TW)		Prediction (Ti)
		Prognosis (Ti)
		Prognostic (Ti)
		Predictive (Ti)
		Accuracy (TW)
		Validation (TW)
		Validity (TW)
		Prognosis (MH+)

(TX "presenting symptom" OR TX "presenting symptoms" OR TX "chief complaints" OR TX "chief complaint") AND (MH "predictive value of tests" OR MH "risk assessment" OR MH "sensitivity and specificity" OR TI "prediction" OR TI "prognosis" OR TI "prognostic" OR TI "predictive" OR TX "accuracy" OR TX "validation" OR TX "validity" OR MH "prognosis+") AND (MM "mortality+" OR MM "morbidity+" OR MM "survival" OR TX "mortality" OR TI "morbidity" OR TI "death" OR TI "deaths" OR TX "survival") NOT (PT "commentary")

AND Predictive value of tests (Me)
Prediction (Ti)
Prognosis (Ti)
Prognostic (Ti)
Predictive (Ti)
Accuracy (TiAb)
Validation (TiAb)
Validity (TiAb)

AND Mortality (MeTiAb)
Morbidity (MeTiAb)
Death (TiAb)
Deaths (TiAb)
Survival (TiAb)

AND Mortality (MM+TW)
Morbidity (MM+TW)
Death (Ti)
Deaths (Ti)
Survival (TW)

NOT Commentary

EMBASE Mars 2009

Presenting symptom (TiAb)	AND	Prediction and forecasting (Exp)
Presenting symptoms (TiAb)		Diagnostic accuracy (De)
Chief complaint (TiAb)		Predictive validity (De)
Chief complaints (TiAb)		Prediction (Ti)
		Predictive (Ti)
		Prognosis (Ti)
		Prognostic (Ti)
		Accuracy (Ti)
		Validation (Ti)
		Validity (Ti)

('presenting symptom':ti,ab OR 'presenting symptoms':ti,ab OR 'chief complaint':ti,ab OR 'chief complaints':ti,ab) AND ('prediction and forecasting'/exp OR 'diagnostic accuracy':de OR 'predictive validity':de OR 'prediction':ti OR 'predictive':ti OR 'prognosis':ti OR 'prognostic':ti OR 'accuracy':ti OR 'validation':ti OR 'validity':ti) AND ('mortality'/exp OR 'mortality':ti OR 'death':ti OR 'deaths':ti OR 'morbidity':ti,de OR 'survival'/exp OR 'survival':ti)

Cochrane Library Mars 2009

Presenting symptom (TiAb)	AND	Predictive value of tests (KW)
Presenting symptoms (TiAb)		Prediction (Ti)
Chief complaint (TiAb)		Predictive (Ti)
Chief complaints (TiAb)		Prognosis (Ti)
Signs and symptoms (KW)		Prognostic (Ti)
		Accuracy (TiAb)
		Validation (TiAb)
		Validity (TiAb)

((presenting symptom):ti,ab OR (chief complaints):ti,ab OR (chief complaint):ti,ab OR (presenting symptoms):ti,ab OR (signs and symptoms):kw) AND ((predictive value of tests):kw OR (prediction):ti OR (predictive):ti OR (prognosis):ti OR (prognostic):ti OR (accuracy):ti,ab OR (validation):ti,ab OR (validity):ti,ab) AND ((mortality):kw,ti,ab OR (morbidity):ti,ab,kw OR (death):ti,ab OR (deaths):ti,ab OR (survival):ti,ab)

AND Mortality (ExpTi)
Morbidity (TiDe)
Death (Ti)
Deaths (Ti)
Survival (ExpTi)

AND Mortality (KWTiAb)
Morbidity (KWTiAb)
Death (TiAb)
Deaths (TiAb)
Survival (TiAb)

Triage hälsoekonomi patientflöden

PubMed Mars 2009

Patient flow (TiAb)	AND	Emergency service, hospital (Me)
Patient turnover (TiAb)		Emergency nursing (Me)
Workload (MeTiAb)		Emergency department (TiAb)
Caseload (TiAb)		Emergency departments (TiAb)
Case load (TiAb)		
Caseloads (TiAb)		
Case loads (TiAb)		
Work load (TiAb)		
Workloads (TiAb)		
Work loads (TiAb)		
Department volume (TiAb)		
Department volumes (TiAb)		
Clinic volume (TiAb)		
Efficiency (Ti)		
Effectiveness (Ti)		
Waiting times (TiAb)		
Length of stay (Me)		
OR Crowding (Me)		
AND Emergency (TiAb)		

("patient flow"[title/abstract] OR "patient turnover"[Title/Abstract] OR "workload"[MeSH Terms] OR "workload"[Title/Abstract] OR "caseload"[Title/Abstract] OR "work load"[Title/Abstract] OR "work loads"[Title/Abstract] OR "case load"[Title/Abstract] OR "case loads"[Title/Abstract] OR "workloads"[Title/Abstract] OR "caseloads"[Title/Abstract] OR "department volume"[Title/Abstract] OR "department volumes"[Title/Abstract] OR "clinic volume"[Title/Abstract] OR "efficiency"[Title] OR "effectiveness"[Title] OR (("length of stay"[MeSH Terms] OR "crowding"[MeSH Terms]) AND "emergency"[Title/Abstract]) OR "waiting times"[Title/Abstract]) AND ("emergency service, hospital"[MeSH Terms] OR "emergency nursing"[MeSH Terms] OR "emergency department"[Title/Abstract] OR "emergency departments"[Title/Abstract]) AND ("organization and administration"[MeSH Terms] OR "triage"[MeSH Terms] OR "triage"[Title/Abstract]) AND "costs and cost analysis"[MeSH Terms]

AND Organization and administration (Me) AND Costs and cost analysis (Me)
Triage (MeTiAb)

Triage hälsoekonomi vital signs

PubMed Mars 2009

Blood pressure (Me)		Predictive value of tests (Me)
Respiratory rate (TiAb)	AND	Prediction (Ti)
Heart rate (Me)		Prognosis (Ti)
Consciousness (MeTi)		Prognostic (Ti)
Glasgow coma scale (MeTi)		Predictive (Ti)
Body temperature (Me)		Accuracy (TiAb)
Oximetry (MeTi)		Validation (TiAb)
Capnography (MeTi)		Validity (TiAb)
Systolic (Ti)		
Diastolic (Ti)		
Breath rate (Ti)		
Saturation (Ti)		
Pulse (Ti)		
Exhaled carbon dioxide (Ti)		

("blood pressure"[MeSH Terms] OR "respiratory rate"[Title/Abstract] OR "heart rate"[MeSH Terms] OR "consciousness"[MeSH Terms] OR "glasgow coma scale"[MeSH Terms] OR "body temperature"[MeSH Terms] OR "oximetry"[MeSH Terms] OR "capnography"[MeSH Terms] OR "systolic"[Title] OR "diastolic"[Title] OR "breath rate"[Title] OR "saturation"[Title] OR "pulse"[Title] OR "consciousness"[Title] OR "glasgow coma scale"[Title] OR "oximetry"[Title] OR "capnography"[Title] OR "exhaled carbon dioxide"[Title]) AND ("predictive value of tests"[MeSH Terms] OR "prediction"[Title] OR "prognosis"[Title] OR "prognostic"[Title] OR "predictive"[Title] OR "accuracy"[Title/Abstract] OR "validation"[Title/Abstract] OR "validity"[Title/Abstract]) AND ("mortality"[MeSH Terms] OR "morbidity"[MeSH Terms] OR "mortality"[Title/Abstract] OR "morbidity"[Title/Abstract] OR "death"[Title/Abstract] OR "deaths"[Title/Abstract] OR "survival"[Title/Abstract]) AND "costs and cost analysis"[MeSH Terms]

AND Mortality (MeTiAb)
AND Morbidity (MeTiAb)
Death (TiAb)
Deaths (TiAb)
Survival (TiAb)

AND Costs and cost analysis (Me)

Triage hälsoekonomi chief complaints

PubMed Mars 2009

Presenting symptom (TiAb)	AND	Emergency service, hospital (Me)	AND
Presenting symptoms (TiAb)		Emergency medicine (Me)	
Chief complaints (TiAb)		Emergency nursing (MeTiAb)	
Chief complaint (TiAb)		Emergency department (TiAb)	
Signs and symptoms (MJR)		Emergency medicine (TiAb)	

("presenting symptom"[Title/Abstract] OR "chief complaints"[Title/Abstract] OR "chief complaint"[Title/Abstract] OR "presenting symptoms"[Title/Abstract] OR "Signs and Symptoms"[Majr]) AND ("emergency service, hospital"[MeSH Terms] OR "emergency medicine"[MeSH Terms] OR "emergency nursing"[MeSH Terms] OR "emergency department"[Title/Abstract] OR "emergency medicine"[Title/Abstract] OR "emergency nursing"[Title/Abstract]) AND ("predictive value of tests"[MeSH Terms] OR "prediction"[Title] OR "prognosis"[Title] OR "prognostic"[Title] OR "predictive"[Title] OR "accuracy"[Title/Abstract] OR "validation"[Title/Abstract] OR "validity"[Title/Abstract]) AND ("mortality"[MeSH Terms] OR "morbidity"[MeSH Terms] OR "mortality"[Title/Abstract] OR "morbidity"[Title/Abstract] OR "death"[Title/Abstract] OR "deaths"[Title/Abstract] OR "survival"[Title/Abstract]) AND "costs and cost analysis"[MeSH Terms]

Predictive value of tests (Me)	AND	Mortality (MeTiAb)	AND	Costs and cost analysis (Me)
Prediction (Ti)		Morbidity (MeTiAb)		
Prognosis (Ti)		Death (TiAb)		
Prognostic (Ti)		Deaths (TiAb)		
Predictive (Ti)		Survival (TiAb)		
Accuracy (TiAb)				
Validation (TiAb)				
Validity (TiAb)				

Triage hälsoekonomi system

PubMed Mars 2009

Emergency service, hospital (Me)		Triage (MeTiAb)
Emergency medical services (Me)		Emergency nursing (MeTiAb)
Emergency department (TiAb)	AND	Emergency care (TiAb)
Emergency room (TiAb)		ATS (TiAb)
Accident and emergency (TiAb)		CTAS (TiAb)
Trauma center* (TiAb)		MTS (TiAb)
		ESI (TiAb)
		CTS (TiAb)
		METTS (TiAb)

((("emergency service, hospital"[MeSH Terms] OR "emergency medical services"[MeSH Terms] OR "emergency department"[Title/Abstract] OR "emergency room"[Title/Abstract] OR "accident and emergency"[Title/Abstract] OR trauma center*[Title/Abstract]) AND ("triage"[MeSH Terms] OR "emergency nursing"[MeSH Terms] OR "emergency care"[Title/Abstract] OR "triage"[Title/Abstract] OR "emergency nursing"[Title/Abstract] OR "ats"[Title/Abstract] OR "ctas"[Title/Abstract] OR "mts"[Title/Abstract] OR "esi"[Title/Abstract] OR "cts"[Title/Abstract] OR "metts"[Title/Abstract])) NOT ("military"[Title] OR "disaster"[Title] OR "disasters"[Title])) AND "costs and cost analysis"[MeSH Terms]

NOT Military (Ti)
 Disaster (Ti) AND Costs and cost analysis (Me)
 Disasters (Ti)

Organisations- och managementforskning

Sökning (2008-08-19) i ProQuest ABI, Business Source Premiere, Science Direct

Science direct

(Business and economic journals only)

61 documents found

TITLE-ABSTR-KEY(triage) OR TITLE-ABSTR-KEY(emergency hospital) OR TITLE-ABSTR-KEY(patient flow) OR TITLE-ABSTR-KEY(emergency nursing) OR TITLE-ABSTR-KEY(emergency waiting time) OR TITLE-ABSTR-KEY(patient turnover)

ProQuest ABI

262 documents found for: (patient flow) OR (patient turnover)

OR (emergency hospital) OR (triage) OR (emergency nursing)

OR (emergency waiting time)

Criteria : scholarly journals

Business source premier

217 articles found for (patient flow) OR (patient turnover) OR

(emergency hospital) OR (triage) OR (emergency nursing) OR

(emergency waiting time)

Criteria : peer reviewed articles

Kompletteringssökning (2009-04-30)

Science direct, 5 additional

ABI, 26 additional

BSP, 9 additional

Bilaga 3. Arbetsblad för bedömning av vetenskapligt underlag enligt GRADE

GRADE – Arbetsblad för att sammanställa evidensstyrkan – per effektmått

Tillstånd:	
Åtgärd:	
Effektmått:	
<p>Ingående studier: Bedömning i utgångsläget:</p> <p>Hög kvalitet, ofta RCT <input type="checkbox"/> (⊕⊕⊕⊕)</p> <p>Medelhög kvalitet <input type="checkbox"/> (⊕⊕⊕○)</p> <p>Begränsad kvalitet, ofta kohortstudier t ex behandlingsstudier med kontrollgrupp <input type="checkbox"/> (⊕⊕○○)</p> <p>Antal studier: Antal pat:</p>	
<p>Studiekvalitet (Randomiseringsförfarande, blindning, uppföljning, bortfall, intention to treat, relevant confounderkontroll i kohortstudier, m m)</p> <p><input type="checkbox"/> Inga begränsningar <input type="checkbox"/> 0</p> <p><input type="checkbox"/> Vissa begränsningar (<i>men inte nog för nedgradering</i>) <input type="checkbox"/> 0?</p> <p><input type="checkbox"/> Allvarliga begränsningar (<i>minska ett steg</i>) <input type="checkbox"/> -1</p> <p><input type="checkbox"/> Mycket allvarliga begränsningar (<i>minska två steg</i>) <input type="checkbox"/> -2</p> <p>Kommentera begränsningar eller grundvalen för nedgradering:</p>	

<p>Samstämmighet och överensstämmelse (Estimat av relativa effekten lika storlek och riktning mellan studierna? Överlappande konfidensintervall?)</p> <p>Baserat på metaanalys <input type="checkbox"/> Ja <input type="checkbox"/> Nej</p> <p>Statistisk test för heterogenitet: <input type="checkbox"/> Chi-2 <input type="checkbox"/> I² <input type="checkbox"/> Inget</p> <p><input type="checkbox"/> Inga problem, stor konsistens mellan studierna</p> <p><input type="checkbox"/> Viss heterogenitet (<i>men inte nog för nedgradering</i>)</p> <p><input type="checkbox"/> Bekymmersam heterogenitet (<i>minska ett steg</i>)</p> <p>Kommentera brist på överensstämmelse eller grundvalen för nedgradering:</p>	<p><input type="checkbox"/> 0,+1</p> <p><input type="checkbox"/> 0?</p> <p><input type="checkbox"/> -1</p>
<p>Överförbarhet, relevans (Studiepopulation – extern validitet, interventionens specificitet, effektmåttets relevans, relevans av jämförelsemetod, sjukvårdsmiljö, adekvat uppföljningstid)</p> <p><input type="checkbox"/> Ingen osäkerhet</p> <p><input type="checkbox"/> Viss osäkerhet (<i>men inte nog för nedgradering</i>)</p> <p><input type="checkbox"/> Osäkerhet (<i>minska ett steg</i>)</p> <p><input type="checkbox"/> Påtaglig osäkerhet (<i>minska två steg</i>)</p> <p>Kommentera viss osäkerhet eller grundvalen för nedgradering:</p>	<p><input type="checkbox"/> 0</p> <p><input type="checkbox"/> 0?</p> <p><input type="checkbox"/> -1</p> <p><input type="checkbox"/> -2</p>
<p>Oprecisa data (Få händelser, vida konfidensintervall som infattar möjlig ogynnsam effekt)</p> <p><input type="checkbox"/> Inga problem</p> <p><input type="checkbox"/> Vissa problem med precision (<i>men inte nog för nedgradering</i>)</p> <p><input type="checkbox"/> Oprecisa data (<i>minska ett steg</i>)</p> <p>Kommentera viss osäkerhet eller grundvalen för nedgradering:</p>	<p><input type="checkbox"/> 0</p> <p><input type="checkbox"/> 0?</p> <p><input type="checkbox"/> -1</p>

<p>Risk för publikationsbias (Få och små studier från samma forskargrupp eller företag som alla visar samma sak, många kända opublicerade studier, se www.clinicaltrials.gov över påbörjade studier, "funnel plot")</p> <p><input type="checkbox"/> Inga problem</p> <p><input type="checkbox"/> Klar risk för publikationsbias (<i>minska ett steg</i>)</p> <p>Kommentera grundvalen för nedgradering</p>	<p><input type="checkbox"/> 0</p> <p><input type="checkbox"/> 0?</p> <p><input type="checkbox"/> -1</p>
<p>Effektstorlek Vid stor effekt eller mycket stor effekt kan man uppgradera evidensstyrkan</p> <p><input type="checkbox"/> Ej relevant</p> <p><input type="checkbox"/> Stor effekt (RR <0,5 eller >2) (<i>öka ett steg</i>)</p> <p><input type="checkbox"/> Mycket stor effekt (RR <0,2 eller >5) (<i>öka två steg</i>)</p> <p>Kommentera grundvalen för uppgradering</p>	<p><input type="checkbox"/> 0</p> <p><input type="checkbox"/> +1</p> <p><input type="checkbox"/> +2</p>
<p><input type="checkbox"/> Kommentera andra viktiga aspekter som ska beaktas vid kategorisering av evidensstyrka/bedömning av vetenskapligt underlag, t ex dos-respons.</p>	
<p>Räcker summan av smärre brister under flera punkter till en nedgradering med ytterligare ett helt steg?</p> <p><input type="checkbox"/> Ja</p> <p><input type="checkbox"/> Nej</p>	<p><input type="checkbox"/> -1</p> <p><input type="checkbox"/> 0</p>
<p>Slutlig evidensstyrka (införs i sammanfattande resultattabell)</p> <p><input type="checkbox"/> Starkt vetenskapligt underlag (⊕⊕⊕⊕)</p> <p><input type="checkbox"/> Måttligt starkt vetenskapligt underlag (⊕⊕⊕○)</p> <p><input type="checkbox"/> Begränsat vetenskapligt underlag (⊕⊕○○)</p> <p><input type="checkbox"/> Otillräckligt vetenskapligt underlag (⊕○○○)</p>	

Förklaringar till arbetsblad

Ett arbetsblad behövs för varje effektmått.

Ingående studier

Ange antal studier samt typ av studier (RCT, observationsstudier med kontrollgrupp etc) som ingår i bedömningen av interventionens påverkan på detta specifika effektmått. Den preliminära evidensstyrkan kan baseras på bedömd studiekvalitet eller studietyp hos inkluderade studier enligt nedan. Dessa kan eventuellt upp- eller nedgraderas när senare kriterier bedömts.

Hög (⊕⊕⊕⊕)	Underlaget bygger företrädesvis på RCT
Måttlig (⊕⊕⊕○)	Underlaget bygger företrädesvis på kvasirandomiserade studier (t ex jämna/udda datum) eller mycket välgjorda och stora kohortstudier med god ”confounder-kontroll”
Begränsad (⊕⊕○○)	Underlaget bygger företrädesvis på behandlingsstudier med kontrollgrupp eller andra kohortstudier
Mycket låg, otillräckligt (⊕○○○)	Underlaget bygger företrädesvis på fallserier utan kontrollgrupp, fallrapporter eller dylikt

Studiekvalitet

I detta steg gör man en samlad värdering av ingående studiers metodologiska kvalitet. Denna värdering har skett individuellt för varje studie med hjälp av SBU:s mallar. I första hand väger man in de traditionella faktorerna såsom randomisering (för RCT), blindning och bortfall, men även andra faktorer belysta i mallarna beaktas liksom eventuella andra ämnesspecifika metodproblem som kan identifieras med hjälp av experterna. För kohortstudier och andra observationsstudier är frågan om jämförbarhet mellan försöks- och kontrollgrupp central. Det innebär att studiernas kvalitet i hög grad beror på i vad mån man kontrollerat för förväxlingsfaktorer (”confounders”). Det sammanfattade resultatet av granskningen kan leda till att evidensstyrkan justeras. Bedömningen är arbiträr och baseras inte på en specifik poäng i granskningsmallen.

Samstämmighet och överensstämmelse

För att över huvud taget kunna bedöma samstämmigheten krävs flera inkluderade studier. Trovärdigheten kan öka om studierna gjorts av olika forskargrupper i olika länder med olika patientgrupper och studierna samstämmigt pekar i samma riktning. Studier pekar i olika riktningar och visar såväl över- som underrisker. I detta fall minskas den samlade evidensstyrkan med -1 . I vissa fall kan olikheterna förklaras med olikheter i de inkluderade studierna, t ex olika populationer. I dessa fall kan det vara mer lämpligt att undanta vissa populationer från slutsatsen än att sänka graderingen av det vetenskapliga underlaget.

Här görs även en bedömning ifall effektstorleken varierar mellan olika studier. Olika effektstorlek medför en ökad osäkerhet beträffande effektstorlek, men behöver inte medföra en sänkning av evidensstyrkan för att en effekt föreligger. Metaanalyser underlättar denna bedömning.

Överförbarhet

Hur väl stämmer studiepopulationen med den patientpopulation man ser i daglig praxis? Kort sagt, är studien rimlig ur ett kliniskt perspektiv? Här bedömer man studiepopulation, interventionens relevans, relevansen av jämförelsemetoden, sjukvårdsmiljö, adekvat uppföljningstid m m.

Oprecisa data

Det här är ett kriterium som kräver bedömningar där man både studerar konfidensintervall och antal observationer. Vid fåtal utfall bör man titta på konfidensintervallet för riskdifferensen (absoluta risken) istället för konfidensintervallet kring den relativa risken.

Publikationsbias

Det är ofta svårt att med säkerhet avgöra ifall publikationsbias föreligger, men punkten bör diskuteras i rapporten. Centrala register (www.controlled-trials.com, www.clinicaltrials.gov) över påbörjade prövningar bör undersökas. En "funnel plot"-analys bör utföras i samband med metaanalys. En "funnel plot" kan vara värdefull, men är osäker och bör tolkas med försiktighet. Vid slutsatser som bygger på små studier av låg kvalitet föreligger ofta hög risk för publikationsbias. Likaså ökar risken för publikationsbias när det är nya metoder där innovatören av den nya metoden är huvudförfattare.

Effektstorlek

Vid hög effektstorlek så ökar sannolikheten att det funna sambandet är kausalt. GRADE anger att man är beredd att höja den samlade evidensstyrkan med 2 om $RR > 5,0$ (alternativt $RR < 0,2$). Om $RR > 2,0$ (alternativt $RR < 0,5$) så kan den samlade evidensstyrkan höjas med +1

Andra viktiga aspekter, t ex dos-respons

Närvaro av dos–reponsförhållande ökar trovärdigheten för åtgärdens effekt där det är relevant.

Dos–respons kan gälla i olika situationer både när det gäller läkemedel och preventiva insatser eller inom en studie och mellan studier. Generellt är ett dos–respons samband mycket mer trovärdigt när det visats i en studie än när det visats genom jämförelser mellan olika studier. Dos–respons samband kan gälla såväl effekter som risker.

Bilaga 4. Praxisenkäten

Akutmottagningen vidsjukhus,landsting/region
Primärt upptagningsområde (befolkningsunderlag):

1. Typ av akutmottagning?

Barn Vuxen Medicin Kirurgi Ortopedi Psykiatri Övrigt:.....

2. Totala antalet besök per år.....

3. Används standardiserad F.A.S.T. (focused assessment with sonography for trauma) vid initialt handläggande av traumapatienter på akutmottagningen? Ja Nej

4. Om ja, vem/vilka utför undersökningen?

Radiolog Kirurg Akutläkare Annan:

5. Förekommer "triage" på akutmottagningen?

Nej (om Nej: enkäten avslutad, vänligen skicka tillbaka blanketten till SBU)

Ja

6. Om Ja: När infördes triagemetoden?

7. Finns det landstings-/regionbeslut om införande av triagemetod?

Nej Ja Vet ej

8. Vilken triagemetod tillämpas?

Egentillverkad (vänligen skicka med en kopia av skalan!)

MTS (*Manchester Triage Scale*)*

MTS (*annat sjukhus svensk översättning*)

Modifierad MTS (*med tillägg av vitalparametrar*)

Modifierad MTS (*med ändring/tillägg av sökorsaker*)

METTS (*Medical Emergency Triage and Treatment Scale*)

ADAPT (*Adaptiv ProcessTriage*)

CTAS (*Canadian Triage and Acuity Scale*)*

ATS (*Australasian Triage Scale*)*

ESI (*Emergency Severity Index*)*

Övrigt (vänligen beskriv antal skalsteg, användning av vitalparametrar (ja/nej) samt flödesschema (ja/nej), här kan vederbörande pm eller manual bifogas)

* Baserat på den engelska skalan men på egen översättning.

Enkät nr

9. Har triagemetoden medfört behov av organisatoriska förändringar?

Nej

Ja, med avseende på:

Personalförändring

Utbildning

Ombyggnation

Anskaffning av teknisk utrustning?

Anskaffning av övrig utrustning?

Annat:

10. Har effekterna av triagemetoden utvärderats?

Nej

Ja

Vet ej

Om ja, kommer SBU:s kansli att kontakta Er för närmare information samt beställning av material!

Bilaga 5. Diagram över antal patientbesök per år och akutmottagning i Sverige

