

Strength of Evidence by Grade

Sub-topic Section	Standard	Grade
Systems Thinking in Complex Adaptive Systems	1.0	C
	2.0	C
	3.0	C
	4.0	C
	5.0	C
	6.0	C
Positioning & Touch for the Newborn	1.0	B
	2.0	C
	3.0	C
	4.0	B
Sleep & Arousal Interventions for the Newborn	1.0	B
	2.0	B
	3.0	B
	4.0	C
	5.0	B
Skin-to-skin Contact with Intimate Family Members	1.0	B
	2.0	B
	3.0	C
	4.0	B
Reducing & Managing Pain & Stress in Newborns & Families	1.0	C
	2.0	B
Management of Feeding, Eating and Nutrition Delivery	1.0	C
	2.0	C
	3.0	D
	4.0	C
	5.0	C
	6.0	D
	7.0	B
	8.0	C
	9.0	C
	10.0	C
	11.0	C

Grades of Recommendation (1)

A	consistent level 1 and 2 studies
B	consistent level 3, 4 or 5 studies <i>or</i> extrapolations from level 1 and 2 studies
C	level 6 studies <i>or</i> extrapolations from level 3, 4, or 5 studies
D	level 7 evidence <i>or</i> troublingly inconsistent or inconclusive studies of any level

“Extrapolations” are where data is used in a situation that has potentially clinically important differences than the original study situation.

The Committee recognized that in some areas there was a plethora of evidence to support practice standards and competencies whereas in others there are still gaps. The evidence is current, within 10 years, although classic references, or relevant clinical data that support the development of practice competence and professional expertise also are included. To date, approximately 1000 references have been systematically reviewed and evaluated. To determine appropriate evidence, we used the Levels of Evidence as outlined by Melnyk and Fineout-Overholt, (2) and strength of the recommendation was based on the quality of the supporting evidence outlined in the Oxford Centre Grades of Recommendations. (1) Overall, the level of the evidence for IFCDC best practice standards and competencies is moderate to low, though the composite strength of the evidence for each published standard and competency was considered by the committee experts to be strong. There is limited evidence of experimental design, such as randomized control trials, to support clinical guidelines, practice standards, and

performance competencies. The majority of evidence is qualitative research, descriptive studies, and recommendations developed by expert panels. By consensus, the committee eliminated evidence that demonstrated a weak design, or insufficient support of the study's aim. As the evidence grows, the quality increases, best practices are evaluated, data are collected and measured, and the current standards and competencies will be refined and improved.

Reference List

1. Centre for Evidence-Based Medicine (CEBM). Oxford Centre for evidence-based Medicine-Levels of Evidence; 2009. Available from:
<https://www.cebm.net/2009/06/oxford-centre-evidence-based-medicine-levels-evidence-march-2009/>.
2. Melnyk BM, Fineout-Overholt E. Evidenced-based practice in nursing & healthcare: A guide to best practice, (2nd ed.). Philadelphia, PA: Wolters Kluwer|Lippincott Williams & Wilkins; 2011.