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What is evidence-based practice?

Simply put, EBP is practice that is supported by a clear, up-to-date rationale, taking into account the patient/client’s preferences and using your own judgement. If we practise an evidence-based approach then we are set to give the best possible care.

Sounds complicated? It’s not really, just read on…
Evidence-based practice starts with the following principle:

Have clear reasons for your practice decisions and your care

If you are a student starting out on a course in any of the health and social care professions, you are likely to be well aware of the need to be able to explain the care that you give both in practice and in the assignments you write. This is because patients and clients expect you, even as a student, to understand why you are caring for them in a particular way and to explain the reasons (or rationale) for the care you give. This becomes increasingly
important as you gain experience and become the one who is planning care and making decisions relating to care, rather than acting in a more supportive role. In fact, being able to explain a good rationale for our practice decisions and planning care is one of the things that distinguishes registered health and social care practitioners from those in assistant roles.

As a registered practitioner you may feel that you cannot always give a thorough rationale for your practice, and fear that your practice may not be as up-to-date as it could be, and this can make you feel vulnerable or under-confident. You may not have been able to access professional development opportunities or you may be about to re-start study and want to find out how to use evidence in your academic work.

If you are a practice assessor/mentor supervising learners or a practitioner who is returning to work or study after a career break, you are likely to be even more aware of this need. You may feel lacking in skills to act as a role model for best practice and lack confidence in giving reasons for your practice to others. Consider the following examples:

Examples from practice

Example 1: Imagine you are a social work student. Your current placement is with a multidisciplinary team which works in a deprived area of the country. The case load includes a lot of disadvantaged families. You visit one family in which one of the members, a 5-year-old child, has behavioural problems. The family are given advice about attending a parenting skills programme for help in managing the behaviour of the child. When you leave the family home, you ask your practice assessor/mentor why this has been advised. They explain that support provided by parenting groups can help the parents to manage the behaviour of their child and to relieve their own stress and anxiety caused by the child’s difficulties.

Example 2: Imagine you are a health visitor working in an immunization clinic. Although the health scare surrounding the MMR vaccinations has largely diminished, there are still many parents who want to know what the scare was about and whether it has been truly resolved. On one occasion you find that you have to give very specific information to allay the fears of a young mother. After you have provided a detailed rationale for why the vaccination is now considered safe, and why you are happy to give it, the mother appears reassured and agrees to the vaccination for her child.

Example 3: Now imagine you are working in a travel vaccination clinic and are consulted by a patient who is travelling far afield on a gap year. The patient asks you in a lot of detail for information about the risks and benefits of various vaccinations and you do not feel confident to answer her questions. In fact, some of her questions remind you that you are not as fully aware of
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You can see from these simple examples that as a student or registered member of staff, it is essential that you can provide a clear rationale for the care you give. You need to be able to tell the patient/client/student why an intervention or procedure is required and be able to provide a clear rationale. This is part of EBP.

But providing a rationale alone is not enough

Being able to provide a clear rationale for the care you give is essential but not quite sufficient.

An EBP approach requires that we ensure our rationale is not only clear but also up to date and based on the best available evidence.

In other words you need to be able to defend your practice and ensure that you have a good rationale for the actions you have taken. Wherever possible your rationale should be based on the best possible evidence although what we mean by ‘evidence’ is very broadly defined and is different in different cases. There are lots of different types of evidence that we can draw on to underpin practice and we will discuss these throughout this book. Often the best evidence will be research studies or, better still a review of all research studies undertaken in an area. Let’s look back to the example about the social work student on placement and the advice given to the family with the child with the behavioural problems. The multidisciplinary team knew about the provision of groups that might help the parents cope with the behaviour of the child. However this alone is not enough. Where public resources and services may be limited, we need to be as sure as we can that the support groups are likely to be useful and effective if they are to be provided for parents. We need to be aware of the evidence or rationale for the care we provide and to be sure that the evidence or rationale is robust. In this case, the social worker explained her rationale to the student. This rationale is based on a large review of many different research studies which had evaluated the impact of parenting groups for children with behavioural difficulties.
The conclusion of this review was that the provision of parenting classes was beneficial to both the subsequent behaviour of the child and the stress and anxiety of the family unit.

Defining evidence-based practice

Evidence-based practice is not just about evidence. David Sackett, founder of the NHS Research and Development Centre for Evidence-Based Medicine in Oxford, and colleagues defined EBP as follows:

**Evidence-based practice is:** ‘The conscientious and judicious use of current best evidence in conjunction with clinical expertise and patient values to guide health [and social] care decisions’. (Sackett *et al.* 2000: 71–72)

Sackett and colleagues emphasize that there is a strong link between EBP and the decisions we make in our everyday practice. Our decisions should be clearly stated and well-thought through (judicious), and use evidence sensibly and carefully. They also emphasize the role of professional judgement and patient or client preference within the idea of EBP. That is, they argue, evidence alone is not enough; it should be supplemented with the judgement of the practitioner and the wishes of the patient or client.

Dawes *et al.* (2005: 7) in the Sicily statement offer a similar, yet more holistic definition of EBP. They emphasize the role of evidence in addition to the tacit and explicit knowledge of the care givers and the views of the patient or client.

Evidence Based Practice (EBP) requires that decisions about health and social care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources.

In order to emphasize the role of professional judgement and to counteract the misunderstandings that *evidence-based practice* was just about research and that it did not value the judgement of the practitioner and the patient’s own views, the term ‘evidence-informed practice’ has emerged. This seems to be a more acceptable term for those involved in complementary and alternative medicine and those involved in work that involves interventions with more human contact and communication. Nevo and Slomin-Nevo (2011: 1) refer to the term *evidence-informed practice* (EIP) and argue that the principles of evidence and professional judgement should be central to our approach.
to patient or client care. So they think evidence-informed practice should be understood as:

excluding non-scientific prejudices and superstitions, but also as leaving ample room for clinical experience as well as the constructive and imaginative judgements of practitioners and clients who are in constant interaction and dialogue with one another.

Where do you think the balance should lie between the health and social care provider making a decision and that decision being made by those in receipt of care?

Different terminology used

We have defined EBP as we understand it. However there are many different terms that refer to the broader concept of ‘evidence-based practice’ or ‘evidence-informed practice’. These are amongst others:

- Evidence-Based Medicine
- Research-Based Practice
- Evidence-Based Nursing
- Evidence-Based Physiotherapy
- Evidence-Based Dietetics
- Evidence-Based Midwifery
- Evidence-Based Occupational Therapy.

If you were to study the exact components of each you might find slight variations in emphasis in the definitions but you would find general agreement that all definitions include use of evidence combined with professional opinion and patient or client preference. We would argue that despite differences in nuance, these terms share the same overriding philosophy and are discussed below.

Arguably, there is one approach that falls slightly outside our definitions and is referred to as ‘values-based practice’. Fulford (2010) describes the role of values-based practice as a partner to EBP, the role of which is to balance decision making within health and social care within a framework of shared values. It is beyond the scope of this book to explore this idea in detail, however there are many similarities between the approaches of ‘evidence-based practice’ and ‘values-based practice’. Given that professional opinion, patient or client preference and the use of evidence are central to the concept of EBP and VBP, it could be argued that the two frameworks are not dissimilar. Again this is a question of nuance, rather than a parallel or competing framework.
Exploring the components of evidence-based practice

The main definitions of EBP agree that there are three main components:

- Use of evidence.
- Clinical or professional judgement.
- Patient/client preference.

We will now look at each of these ideas in turn:

**Use of evidence**

We have discussed in earlier examples how evidence has been used by practitioners to justify the rationale for the care they give and how evidence is a central component of EBP. We need evidence and it must be good evidence. In Chapter 6 we will discuss how you can tell if the evidence is strong or not. What has changed in recent years is the acknowledgement that the term ‘evidence’ is quite broad and you could be looking at many diverse sources of evidence and other information to justify your practice. We will discuss the type of evidence you might come across in detail in Chapter 4 but in summary, the term ‘evidence’ does not just refer to research done in a lab under strict controlled conditions! The best evidence for our professional practice is usually some type of research evidence if it is available.

Consider how you would value the findings of a well-conducted piece of research that compared different ways of quitting smoking to an anecdotal account from one person who had tried to quit and had failed to do so.

You can usually recognize a piece of research by the way it is presented. Research is usually written up in a paper published in one of the professional journals. Professional journals, such as *Journal of Advanced Nursing* or *Addiction* are often considered to be the gold standard of professional information because the material has always been peer reviewed and checked before accepted for publication. A research study usually starts with a question – called the research question – which the researchers then seek to answer by a method which is clearly stated in the research paper, followed by the results and then discussion of what these results are likely to mean.

In an ideal situation, we would use not just one research study, but a review of studies (sometimes called a literature review or a systematic review). A
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Review of evidence provides stronger evidence than a single study because identifying the whole range of studies about a topic is more reliable than the results of just one, which might be misleading or provide an inaccurate picture.

The study referred to earlier by Furlong et al. (2012) is an example of a systematic review. The term ‘systematic’ refers to a review of the literature or evidence that has been carried out in a systematic and rigorous way and such reviews are generally high quality evidence. The most well-known systematic reviews are those produced by the Cochrane or Campbell Collaboration which we will refer to later on in this book.

If you come across a review published by either the Cochrane or Campbell Collaborations, then you have probably come across good quality evidence.

If there are no systematic reviews or literature reviews on the topic you are interested in, then the next best thing is to find a research study or several studies on your topic. The types of study you are looking for will depend on the focus or question you are trying to address and we will discuss this in Chapter 4. There are many different approaches to research and we will consider these later. It is important to emphasize that different types of research are needed for different types of situations. It is not helpful to say that one type of research is ‘better’ than another – it all depends on the aim of the research. It is however possible and necessary to make a judgement about the quality of the research and whether it has been well done or not – and we will discuss how to do this in Chapter 6.

It may sometimes be the case that there is not sufficient research evidence upon which to base practice or you find that the research evidence is inconclusive or of poor quality. There might be a lack of evidence because it is unethical to undertake research to explore the particular area you are interested in. It may also be the case that there is research but it does not directly apply to your particular area and you need to use your professional judgement as to whether the research can be applied in the context in which you are working. There will also be times when you need to draw on alternative sources of evidence other than research evidence alone.

However, it is important to note that it is research that often – but not always – provides the strongest evidence upon which we base our practice and is at the heart of EBP. However research evidence alone is not enough for your practice. This is why the definitions of EBP include referring to your professional judgement and patient or client preference. We will now address this component of EBP.
Evidence-based practice and clinical/professional judgement and intuition

There is sometimes an incorrect assumption that EBP refers to the use of research alone. You might hear people say ‘evidence-based practice is too rigid and doesn’t relate to real experiences’.

As we have already mentioned, evidence alone is not enough for EBP. Our own professional or clinical judgement is vital for assisting with providing an evidence-based approach to care. In their early discussion of EBP, Sackett and colleagues (1996) describe how evidence can inform decisions about practice, but cannot replace professional expertise and judgement. They argue that this clinical/professional expertise is used to determine whether the available evidence should be applied to the individual patient/client at all and, if so, if it should be used to inform our decision making.

It is important that all the evidence we use is professionally evaluated, because every patient or client context is unique. Tanner (2006: 204) defined clinical (or professional) judgement as:

> an interpretation or conclusion about a patient’s needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient’s response.

This definition recognizes the patients’ preferences as part of EBP and Downie and Macnaughten (2009) further describe professional judgement as ‘an assertion made with evidence or good reason in a context of uncertainty’ (p. 322).

Professional or clinical judgement may also be used alongside intuition. Intuition is often referred to as gut feeling ‘(just knowing)’.

- There appears to be a close relationship between experience and intuition.
- Intuition is grounded in both knowledge and experience in making judgements.

(Benner 1984; Benner and Tanner 1987)

Intuition can be incorporated into EBP when clinical or professional judgement is applied. Indeed this was argued by Benner and Tanner back in 1987 who described how intuitive knowledge and analytical reasoning are not opposed to each other – they can and do work together. Professional judgement can also be important if there is not sufficient evidence, or the evidence does not refer to the specific patient/client we are looking after. Therefore a judgement is needed as to the relevance of the evidence we have to the particular context, complexity and the individuality of patient or client.

Where there is no reliable research evidence, the judgement of the practitioner IS the best evidence.
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It is important to emphasize that intuition and experience are used in conjunction with an evidence-based approach. What evidence is there to support using intuition?

The importance of professional judgement and intuition was reinforced in a literature review (McGraughey et al. 2009) which gathered together the evidence about the use of checklists versus professional judgement/intuition in the nursing assessment of patients whose condition had rapidly deteriorated. The use of checklists to trigger nursing staff to refer a patient for urgent medical attention has become widely used. They are promoted as a way of standardizing the referral for urgent medical attention and, in theory at least, replace the nurses’ intuition with a more objective approach. This is in addition to the interpretation of the patient’s vital signs which checks whether or not the patient’s condition has deteriorated. The question of whether the use of these checklists has made hospital a safer place for patients whose condition deteriorates has been researched in various studies. And so, McGraughey and colleagues (2009) carried out a systematic review and compared the results of all of these studies. In their review, they found that nurses’ intuition was as reliable a trigger for seeking medical help as the use of a checklist or tool. This is maybe why some health and social care practitioners state that their professional work is an art as well as a science and it incorporates a human element which cannot be reduced to just the application of research knowledge to patient/client care. This can be described as clinical or professional judgement.

Using evidence without professional judgement can lead to formulaic care and using professional judgement without available evidence can lead to the perpetuation of outdated practice. The two should work together!

So far, we have argued that EBP requires more than ‘raw’ evidence. It requires clinical or professional judgement. This may be based on intuition and/or experience so that the evidence can be appropriately applied in practice. Now let’s look at patient/client preferences and what role they play in EBP.

Evidence-based practice and patient/client preference

There is also a third component – that the patient/client’s preference must be acknowledged and their consent sought prior to the undertaking of any intervention. If all the best evidence and clinical or professional judgement pointed towards an intervention or therapy that the patient/client did not accept, then we should not carry it out.
Find out what your professional body says about consent prior to undertaking care, or interventions.

All care delivered must be with the agreement or consent of the patient/client. Not only does the patient have a legal right to make his or her own decisions (in most countries) but in addition, there has been recent debate about the importance of shared decision making and increased patient/client involvement in the health and social care context. In the UK, this is reflected in the Department of Health (2012) consultation document entitled Liberating the NHS – No Decision About Me Without Me, which emphasizes the importance of the role of the patient or client in decision making. The consultation document is about the need to involve the public in care decisions and make information available to them in accessible formats. The document asserts that the NHS will put patients at the heart of the NHS, through an information revolution and greater choice and control, with an emphasis on shared decision making and patient access to information. (This consultation paper is available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134218.pdf).

These principles are also grounded in law. In legal terms, any care that is delivered without the patient/client’s consent may be unlawful. The exception to this is if the patient is temporarily (in an emergency) or permanently unable to consent. In these cases, care for patient/clients should be delivered that is in their best interests. Care for those who are unable to consent is determined in The Mental Capacity Act (Department of Constitutional Affairs 2005, implemented 2007, available at http://www.legislation.gov.uk/ukpga/2005/9/contents).

The Mental Capacity Act:

- Presumes capacity
- Reinforces the right of individuals to be supported to make decisions
- Reinforces the right of individuals to make eccentric or unwise decisions
- Reinforces that anything done for or on behalf of people without capacity must be done ‘in their best interests’
- Reinforces that anything done for or on behalf of people without capacity should be least restrictive of rights and freedoms.

Check that you are fully aware of the principles regarding informed consent.

There is some evidence to suggest that urgent care is sometimes delayed because practitioners are not aware that they can deliver care that is in the best interests of a patient or client who cannot consent (Variend 2012).
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Some patient/clients really want to be involved in the decisions relating to their care. Others will want to trust that the practitioner will make the best possible decision on their behalf. This is a big responsibility and we need to be well informed as to what might be the best option for our patient/clients. There are decision aids available to help patients who need to make treatment choices on the NHS direct website (http://www.nhsdirect.nhs.uk/decisionaids).

The main point to remember is that the care cannot be delivered without the consent of the patient/client and if you do not gain consent as a practitioner, you are at risk of professional misconduct and in breach of the law unless the patient or client lacks the ability to consent.

What are the consequences of not taking an evidence-based approach?

Although delivery of the best possible care is the main driver behind EBP, there are consequences for you as a practitioner if you are not able to explain your care decisions and these will now be discussed.

Example from practice

Imagine you are the patient attending the travel clinic referred to earlier. You want to seek advice about the vaccinations required before you go abroad on a tropical holiday. Unfortunately, the practitioner is not up to date with current practice and recommends a vaccine which is now rarely used and has been largely replaced by a newer vaccine which has been found, due to large scale research studies, to be far more effective. The practitioner has been administering this older vaccine for years and is unaware of the newer more effective vaccination. They are therefore not practising EBP because they are not using the best up-to-date evidence to inform their practice.

Meanwhile your friend, who is travelling with you, visits a different practitioner and is given the new vaccine. You experience some unpleasant side effects and when you read up about the vaccine, you discover that your friend is better protected than you are against the disease in question – and did not experience any side effects! You feel angry and your trust in the practitioner who had not given you the most up-to-date and best available healthcare is broken.

Accountability

In the example above, you might feel like making a complaint against the practitioner who gave you the out-of-date vaccine, especially if it caused you
to have unpleasant side effects or reduced your enjoyment of the holiday because you feared that you were not fully protected by the vaccination. If you did make a complaint, the practitioner would then have to justify why this out-of-date vaccine was given. This would be difficult to do if all the evidence pointed towards the newer vaccine.

As a health or social care practitioner, you are **accountable** to your manager or university (if you are a student), your professional organization and to the law.

This means that you must be able to justify and give a clear account of and rationale for your practice. Failure to do this can result in professional misconduct.

- Students are accountable to their higher education institution and when in practice should be supervised by a registered practitioner.
- Registered practitioners are accountable to their professional body and their employers.
- We are all accountable to the law.

If there was a standard or policy document in his or her place of work that recommended the newer vaccine, then the practitioner would find it difficult to justify administering the old vaccine. Even if no such documentation existed, the practitioner would still find it difficult to justify why an outdated vaccine was administered when a more effective vaccine with fewer side effects was available.

We can see that when you are called to account for your practice, you will only be able to do so if you have administered care that is based on the best available evidence. You will not be able to account for care that is based on old or weak evidence.

Find out what your **professional body, college or association** says about your accountability and evidence-based practice.

In the United Kingdom these are as follows:

For **allied health professions and social workers** including: occupational therapists, physiotherapists, operating department practitioners, dieticians, paramedics, radiographers, speech and language therapists, art therapists, chiropodists/podiatrists, clinical scientists, orthoptists, prosthetists and orthotists
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They state that ‘you must keep your professional knowledge and skills up to date’ (HCPC 2012: 10).


The Code requires all practitioners to deliver evidence-based care. Practitioners are required to ‘deliver care based on the best available evidence or best practice’ (NMC 2008: 7). The Code declares that nurses and midwives are accountable for the care they deliver.

Therefore, if you are called upon to account for your practice, you must be able to provide a sound rationale for why you acted as you did. If you are only able to say ‘I was told to do this’ or ‘I’ve always done it this way’, your practice will look very poor indeed! Students are expected to work towards these standards in order to obtain registration and failure to do so may affect progression towards qualification.

Individual colleges or associations may also be involved in setting professional guidance and you should access their websites to see what relates to your own profession.

Do you think the practitioner referred to earlier would be found guilty of professional misconduct because of the decision to administer a vaccine which had been superseded by a more effective vaccine?

Would that verdict have been reached if he/she had used an evidence-based approach to the selection of the appropriate vaccine?

Clinical governance

In addition to accountability through the professional governing bodies, in the UK, health and social care practitioners are also accountable to the organization in which they work through the concept of clinical governance. Whilst the mechanisms of clinical governance are liable to change, the concept of clinical governance is that of accountability of the individual practitioner to the institution in which he or she is employed (http://www.dh.gov.uk/health/2011/09/clinical-governance/).

The purpose of clinical governance is to ensure that the institution – in addition to the individual practitioner – is accountable for the care that its service provides.
The government website (http://www.dh.gov.uk/health/2011/09/clinical-governance/) on clinical governance explains that:

Clinical governance’ describes the structures, processes and culture needed to ensure that healthcare organisations – and all individuals within them – can assure the quality of the care they provide and are continuously seeking to improve it.

The Kings Fund offers a directory of the monitoring and quality organizations including the Quality Care Commission (http://www.kingsfund.org.uk/topics/governance_regulation_and_accountability/index.html).

Part of this governance is ensuring staff are educated and trained and that they are using up-to-date interventions.

In addition, the Essence of Care benchmarking statements have been designed to contribute to the introduction of clinical governance at local level. The benchmarking process outlined in ‘The essence of care’ statements ‘helps practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best practice and to develop action plans to remedy poor practice’ (DH 2010). (These documents are available at: http://www.dh.gov.uk/en/Publication sandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119969).

Standards and quality assurance initiatives will be present in non-NHS organizations too.

Legal considerations

Finally, in addition to accountability to the relevant professional body and employing institution, as registered practitioners you are accountable to the law. The main area of law in the UK that is likely to be of relevance to those working within health and social care is the tort of negligence. Being able to justify the care that you give may protect you or your organization from a claim in negligence. There is a developing culture of litigation and claims against health and social care organizations. Patients or clients who are unhappy about the care they receive can make a claim in negligence if they have suffered harm as a result of that care. There is a National Health Service Litigation Authority (NHSLA, http://www.nhsla.com/home.htm) that handles negligence claims and works to improve risk management practices in the NHS. Clinical governance, discussed earlier, includes several measures to ensure we provide safe and effective care.

Let’s return to the example about the administration of an outdated travel vaccination. Let’s say that the worst does happen and you contract a serious tropical disease whilst you are away, the disease against which you had been vaccinated (with the less effective vaccine). Your travelling companion does not contract the disease. You become very ill and lose sight in one eye and are unable to work. In order to seek compensation you make a claim of negligence against the healthcare provider who did not use the best available evidence when selecting your travel vaccinations.
To make a successful claim in negligence against a health and social care provider, the patient/client has to demonstrate that the healthcare provider failed in their duty to provide care and that this failure led to harm. The courts have consistently ruled that such a failure occurs if the health or social care provider has provided care that is not evidence based. In this case, the administration of an outdated vaccine that is less effective than its newer version led to a greater likelihood of your contracting the disease and might lead to a claim of negligence. Under the current system, you can only make a claim in negligence if you have suffered harm. Therefore, you would not be able to claim in negligence just because you had received the less effective vaccine; you would only be able to make a claim if you did contract the disease or suffered some other harm.

Let’s then say that unfortunately your friend also contracts the disease, despite receiving the newer vaccine – (no vaccination is ever 100 per cent effective). If (s)he then attempts to bring a case in negligence against the health and social care provider, (s)he is less likely to be able to succeed because the practitioner in this case used the most up-to-date evidence to select the appropriate vaccine and hence did not fail in the duty owed to the patient/client.

Being able to provide a good rationale or explanation for your practice is an essential component of the concept ‘evidence-based practice’ and might even prevent you from becoming involved in any legal proceedings.

Therefore, you can see that you are less likely to make errors or give the wrong information to your service users if you follow recommendations for best practice and have a sound rationale for what you do.

What does evidence-based practice mean to me?

So far in this chapter we have introduced the concept of EBP and why we feel it is so important. We have used examples from professional health and social care practice to illustrate this and the likely implications that can arise from following a ‘non evidence-based’ approach.

Throughout this book, we will look in more detail at how you might achieve an evidence-based approach. The following approach (adapted from Thompson et al. 2005) provides an illustration of how an evidence-based approach may be used in professional practice and we identify where in this book we discuss the stages of using an evidence-based approach.

1 **Identify what you need to find out:** this may be information or evidence about the best care for an individual patient or client or at a wider public health level. In this chapter we have identified examples where
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Practitioners needed to find specific evidence to enable them to provide the best evidence-based care.

1. Search for the most appropriate evidence: this is usually research evidence but could be other forms of evidence as we will discuss in Chapter 5.

2. Try to work out if the evidence you find is any good: we refer to this process as critical appraisal of the evidence and we will discuss how we assess evidence in Chapter 6.

3. Incorporate the evidence into a strategy for action: if the evidence is good enough, remember to refer to your professional judgement and patient or client preference. We will discuss this further in Chapter 7.

4. Evaluate the effects of any decisions and action taken: this will be discussed further in Chapter 7.

Examples from practice

Example 1: Let’s imagine you have noticed that several practitioners carry out an intervention differently. You wonder why this is and when you ask questions in your professional practice, you get different answers!

Example 2: Alternatively, let’s imagine you have been asked to write an essay or discuss a case study on a given scenario discussing what you did and why you did it.

For both of the examples above you would need to take an evidence-based approach and ask the question: What is the evidence for the way the care was undertaken?

To answer this question you would first need to search for and locate the appropriate evidence. You might find a wide range of different research studies, case studies, guidelines, literature reviews or opinion articles. You would then need to judge the quality of the evidence you find and whether it is relevant to your problem or issue. You would probably consider any research that you find to be of more value than someone’s personal view. This evidence should then be applied to the care of the patient/client, whose needs initiated the question, taking into account their preference and your clinical or professional judgement. The resources available may also need to be considered at this point. You may then want to evaluate the effectiveness of your intervention in that situation with that patient/client.

We will cover how to ask the right question, how to search for the evidence, and how to judge the value and quality of different types of evidence in more detail later in this book.

This is evidence-based practice in practice!

It is important to find the right evidence to underpin your practice and this book will show you how best to do that. You can see that carrying out an
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intervention or approach because it has ‘always been done’ or acting because something is expected of you is not enough. You need to ensure that there are stronger reasons and evidence than acting out of a sense of tradition or ritual. This is not to say that traditional practices are necessarily outdated or to be avoided at all costs. Nor is experience alone to be disregarded. It is just that nowadays, as practitioners, we have a wealth of research available to us which can inform how we should proceed in practice, also considering professional judgement and patient or client preference. Given that we have this opportunity, we need to ensure that we use it for the best outcomes for our patients and clients.

In summary

In this chapter we have discussed the meaning of the term evidence-based practice. We hope that you are now thinking that there is a good logical argument for health and social care to be evidence based. After all, who would want to receive outdated care from a practitioner who could not account for it, in preference to care that is based on the best available evidence combined with professional judgement and patient/client involvement?

In the remainder of this book we will consider why practice needs evidence and what we mean by evidence. We will then consider different research approaches that you might encounter. We will discuss how to search for evidence and then consider how to determine whether it is any good or not. Before that we will consider in more detail why EBP has become so important in our practice today.

Key points

1 There are several reasons why we need to adopt EBP:
   i to ensure best practice
   ii for our professional accountability
   iii to avoid litigation/negligence claims.
2 EBP incorporates using best available evidence, clinical or professional judgement and patient/client preference in our decision making.
3 EBP does not replace using intuition or experience in our practice but can be used alongside them.