Critical Appraisal of an Evidence Based Nursing Guideline

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Nursing is one of the crucial healthcare professions because nurses play the role of front liners in taking care of the patients according to the standards. According to the research, evidence-based practice and continuous learning are the keys to honing the skills of the nursing cohort in a medical setup. Evidence-based practice is one of the progressive approaches that is used in devising the strategy for obtaining clinical knowledge and practice. The study of clinical expertise in light of the previous cases and evidence has been fruitful. Now, evidence-based learning is considered at the heart of medical practices, as experiential-based studies have proven that they can bring advanced skills to nurses. Three significant elements that contribute to the decision-making for evidence-based practice are the personal preferences of the patients, external devices, and acquired clinical knowledge (Melnyk and Fineout-Overholt, 2015). The essay focuses on the analysis of an evidence-based guideline and its critical appraisal.

The essay focuses on the evidence-based practice guidelines concerning the issue of depression among older adults availing of assisted living. Depression is now emerging as a common but underrecognized problem, and if not treated well, it will second the cardiovascular diseases for causing the most fatalities.

Who were the guideline Developers?

The guideline was elaborated on and composed by “Marianne Smith”, an Assistant Professor, and “Christine Haedtke”, a doctoral student from the “University of Iowa”. This study was supported by a financial grant from “The University of Iowa College of Nursing John A. Hartford Center for Geriatric Nursing Excellence”. The IMPACT Coordinating Center generously allowed researchers to include IMPACT information for treating depression (Melnyk and Fineout-Overholt, 2015).

Were the developers of the guideline representative of key stakeholders in this speciality (inter-disciplinary)?

Yes, the developers of the model were the stakeholders of the nursing profession, having years of experience at the University of Iowa: College of Nursing. The speciality in the field helped the developers better understand the feasibility of the process and evaluate the loopholes of contemporary practices. One of the primary purposes of conducting this study was to assess

stakeholder perceptions of implementing a blended model of late-life depression care in elderly patients. Moreover, it focused on essential features of evidence-based collaborative care to be used in AL settings.

Who funded the guideline development?

The University of Iowa professors carried out the research, so the funds for the project, along with access to the resources, were provided by the university itself. So without external intervention, “The University of Iowa College of Nursing John A. Hartford Center for Geriatric Nursing Excellence” provided the funding for researchers. Moreover, IMPACT trusted their information regarding the late-life depression treatment model to be used by the researchers. So finances were granted by the University of Iowa, while organizations like IMPACT provided help with the resources from guideline development.

Were any of the guideline developers funded researchers of the reviewed studies?

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Did the team have a valid development strategy?

The team had developed a goal-oriented strategy that, in my opinion, was an apt technique as the guidelines were to be used as an implementation plan in medical practices. The implementation stage of the change is more arduous than the planning stage. If carefully designed and complied with, then the guidelines can be easily implemented in any hospital setup. In my opinion, the University of Iowa had a proper development strategy as they developed the guidelines, keeping their objectives in keen view. The guideline development strategy by the University of Iowa revolved around achieving three goals, namely, obtaining a clear distinction between the prior practices and the new suggestions and reviewing the patterns in the statistics obtained. Moreover, the researchers researched to figure out the solution to the three standard procedures in depression control carried out in our hospitals; these were:

- diagnosing depression
- communicating with the patients about their anxiety and depression,
- modifying the contemporary approaches to the functionality of the procedure and reducing depression-related problem rate

Thus, in my opinion, the research was well conducted as it was goal-oriented and brought many factors under discussion. The team was particular about their goal; all the objectives and features of the research are explained in the provided guide.

Was an explicit (how decisions were made), sensible, and impartial process used to identify, select, and combine evidence?

In our case, it is easy to relate to whether the decision was explicit or not because the single organization was in charge of making the decision and leading the research. In multi-faced spectrum research, it is often difficult to make an unbiased judgment about the explicitness of the process, as in those researchers, many organizations are playing the decision-making role. Fortunately, in our case, the UNIVERSITY OF IOWA was only the decision-making organization, so the situation facilitates making the implication that the choices were taken alone by the UNIVERSITY OF IOWA. The other organizations involved were the funding and affiliated organizations. So, all the options and results deduced from the research were made solely by the leading organization. However, the reports mention that the university illustrated what the part of the companion organizations in the study was. Well elaborated reports of the financial and technical assistance of the sponsors were available. Moreover, study equipment and tools were also available from the affiliated institutes. Thus, the reports and the omniscience of the single researcher in charge fortify the explicit and impersonal nature of the UNIVERSITY OF IOWA strategy.

Did its developers carry out a comprehensive, reproducible literature review within the past 12 months of its publication/revision?

Yes, the research was understandable and well compiled, addressing all the contemporary issues; the guide is well elaborative and presents an innovative approach to solving late-life depression; not only did the researchers focus on the contemporary issues and problem statements by carrying out an extensive literature review but also take the suggestions from the nursing institutes and kept in view their stance on the depression study guidance.

Were all the crucial options and outcomes considered?

Yes, the guideline covered all the main aspects and results with regard to depression recognition and

control. These characteristics of the study covered cognitive problems, social issues, financial problems, and even psychological problems, thus making sure that the guidelines are well suited to implement the DT-AL model. Therefore, in my opinion, the team put the effort into taking into account all the possible options and outcomes to make the guideline well elaborative yet comprehensive.

Is each recommendation in the guideline tagged by the level/strength of evidence upon which it is based and linked to the scientific evidence?

The limitations and the recommendations in the guideline were more factual, such as the availability of resources, staff, and time. So, the recommendations suggested by the authors are more concerned with the factual basis rather than scientific evidence. The offers have not been tagged by strength level as all the recommendations will depend upon the condition and finances of the hospital that intends to implement the model, so the strength of the evidence could not be predicted in general.

Do the guidelines make explicit recommendations (reflecting value judgments about the outcomes)?

Yes, the guidelines successfully gave explicit recommendations. For instance, the guidelines about the model explicitly explained the limitations of the DT-AL model and, for each restriction, offered further recommendations. The study recruited late-life depression patients, but the limiting factor was that all the adults could verbally tell about their depression state; they were well aware that they were suffering from some depression. However, the authors suggest that for those elderly patients who cannot talk about their depression, further research and study will be needed to make the improvised version of the DT-AL model.

Has the guideline been subjected to peer review and testing?

Yes, the DT-AL model has been clinically tested, taking into consideration the objectives. The principal investigator of the problem statement and graduate research assistant developed an evaluation tool and conducted well-elaborative assessments to review the feasibility of the model suggested. The study was approved by “Iowa University’s Institutional Review Board”, as the university was providing the funding and resources for the research.

Is the intent of use provided (i.e., national, regional, local)?

Yes, the purpose of the guideline and the directions to use were given. Although the scope of the use was not explicitly mentioned in the policy, depending upon the mode of research, data acquired, and the inferences obtained, a reader can understand that the guidelines could be used at the national level across the United States. The information provided in the guideline is well indicated, and the approach could be linked to other sources to further build on the knowledge acquired by this study. Thus, at the local or regional levels, the hospitals could implement this model, keeping in view their resources, the stakeholders of the model, and the limitations factors. The guidelines contain well-elaborated tabulated data regarding the liaisons, resources, and staff requirements for the implementation of the model. In my opinion, any medical setup in the United States can implement the DT-AL model by bringing in a few changes because the model design and the results have been drawn from the US clinical setup data. At the national level, almost similar practices govern the prevention of disease.

Are the recommendations clinically relevant?

The authors have taken in assistance from the “Hartford Center for Geriatric Nursing Excellence” and taken into account the clinical practices and the treatment protocols, so the guidelines and the further recommendations made by the team are feasible to achieve and are also clinically relevant. The DT-AL model, as proposed by the group, recommended that in hospital setups, the AL nurses and the medical caregivers should be both well aware of the receptive assistance techniques for depression treatment (Smith, M., & Haedtke, C, 2013). Furthermore, the guidelines encouraged the use of standardized monitoring setups; thus, in light of the above discussion, the recommendation that was made was relevant and feasible according to the clinic’s practices.

Will the recommendations help me in caring for my patients?

Implementation of the DT-AL model in cooperation with the primary care providers, primarily the nurses, will promote optimal outcomes for patients in their depression treatment. The result of the research showed that the role of nurses in depression care is bi-faceted and beneficial in terms of both resident care and resource providence.

Are the recommendations reasonable/possible? Are resources (people and equipment) available?

Yes, the model incorporates the resources that are mainly present in the hospital setups. Thus, the model proposed in the guideline exhibits considerable potential in relieving patients of late-life depression. However, the model research had a few practical restrictions, not much in the context of resources but in the context of staff availability and dedication level, as the research incorporated volunteer participation and facilitation. So, the incorporation of hospital setup must take into account the staff availability, the time they could spare, and the equipment (Zakiya, Q. B., 2008).

Are the recommendations a significant variation from current practice? Can the outcomes be measured through standard care?

The model proposed by the research elaborates on an innovative approach for handling late-life depression in AL settings. Thus, it is different from the conventional systems. DT-AL model presents the idea of the enhanced care manager who is specifically trained to improve the acceptability of old patients suffering from late-life depression; the model on various grounds is different from the previously used collaborative depression care management. The clinically acquired results from the implementation of the DT-AL model signified a considerable decrease in anxiety and distress symptoms among the resident patients.

Analyzing this evidence-based guideline, the significance of rational understanding and evidence-based practice in the nursing profession can easily be understood. The decision-making power of the nurses can be greatly improved by such practices; the in-time, rightly taken decisions surely increase the credibility of the healthcare standards.

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