

Using Evidence-Based Practice In Implementing Depression Treatment Model

Posted on July 27, 2022

Introduction

The number of medical errors has reduced significantly with the application of evidence-based knowledge and practice in the healthcare sector, which has relatively improved the services provided to patients by healthcare professionals. Therefore, the integration of [evidence-based practice](#) is essential to effectively address the problems and needs of patients in the clinical environment for an appropriate intervention with efficient decision-making. This integration is achieved through various resources such as skills and knowledge from healthcare instructions, traditions, and rituals, along with personal choices. Therefore, according to Melnyk & Fineout-Overholt (2015), the incorporation of skills and knowledge is necessary for nurses to deploy effective decision-making to achieve exceptional clinical outcomes.

The implementation of evidence-based practice (EBP) includes an individual's clinical expertise, expectations of the patients on the basis of their individual preferences, and external evidence and values. In this regard, the following paper describes the different steps toward the integration of evidence-based practice into the clinical settings for the implementation of the depression treatment model (DTM), potential barriers to this implementation, and effective strategies to optimize the outcomes by overcoming these barriers. The second section of the paper highlights the six sources of internal evidence that are extensively used to provide data for the demonstration of improvement in different outcomes.

Integration of EBP into the Clinical Environment

Eight Steps of Integration

Clinical care nursing practice can be easily enhanced by integrating EBP, which also improves the outcomes and satisfaction of healthcare providers, families, and patients by reducing the operational costs and risks associated with different tests and procedures. Therefore, the steps included in the implementation of EBP must be incorporated into the daily activities of healthcare. In this regard, the first step is the formation of an organizational culture that makes it easier for nurses to utilize BHP effectively. This further results in the high quality of patient care and a significant decrease in the treatment cost due to lesser stay and consequently reduced risk of infections usually acquired in hospitals, e.g. CLABSI and (CAUTI) etc.

The second step towards the integration of EBP is the development of PICOT, i.e. population, intervention, comparison, outcome, and time question to facilitate the healthcare professionals in identifying the clinical problem, which has a direct impact on the accuracy of the implemented approach. In the current case, the sample population consists of 30 participants, including 3 RN leaders, 12 residents, and 15 additional staff to analyze the perceptions of the primary components of the DT, i.e. onsite depression care management, AL nurses as staff resources, and liaisons to healthcare providers and activities for staff development (Smith & Haedtke, 2013).

The third step is the literature review, which is utilized to investigate the accuracy, application, and reliability of the existing research studies in the intervention, i.e. depression treatment. The main purpose of this step is to gather reliable and accurate data based on high-quality evidence with respect to the intended intervention, as described by Lehane et al. (2019). In this regard, each resource is assigned to a specific accuracy level, which helps identify sturdy EBP and strong teamwork. The degree of accuracy thus obtained provides the assessment of expected potential outcomes when evidence-based practice is applied in the clinical environment.

The fourth step involves determining different means to incorporate recommendations and findings into practice, which is directly dependent on the ability of the EBP team to evaluate the integrating strength of treatment during the intervention. For this, a grading measurement scale is used to help the team implement the recommendations from the different sources collected and analyzed previously. Therefore, such a grading system must be created to support standardization among different healthcare professionals in analyzing the effectiveness of EBP and ensuring the reliability of the evidence by promoting its accuracy.

The fifth step incorporates the evidence obtained from the clinical experts in light of their experiences. The evidence is further aligned with the preferences and values of patients as indicated by their socioeconomic and epidemiologic as well as biological issues observed in a specific individual's case. The main objective of focusing on the respective preferences of patients is to deploy patient-centred care and treatment measures.

The sixth step involves the implementation of the evidence, which is collected, measured, and evaluated to successfully apply in the clinical environment by considering the critical appraisal of the parameters related to any issue in the patient population. Thus, a complete assessment of the strengths and weaknesses of the respective evidence is made in the following step, along with uncovering the missed mistakes and evaluating them before moving forward to the next step.

The seventh step is the evaluation process for the implemented practice, in which specific outcomes of the practice are analyzed, and the experiences of patients are gathered. In this way, the effectiveness of the applied strategy in patient care is examined in the light of results obtained from the tests and experiences, which consequently measures the effects of implementing EBP in the clinical setting. In the following case, as narrated by Smith & Haedtke (2013), "Satisfaction with work (staff) or living in AL (residents) was rated on a 10 points scale with anchors of 1=very dissatisfied to

10=very satisfied”.

Finally, in the eighth step, the results are distributed among all departments of the organization through different means, such as posters, conferences, podiums, or presentations, depending on communication strategies used in the organization to disseminate information to their healthcare professionals. In this regard, the role of appropriate leadership is very critical to encouraging positive reception and successful implementation of evidence-based practice into the clinical environment.

Barriers to Implementing DTP (Depression Treatment Model) By Integrating EBP and Relevant Strategies to Overcome Them

There are many challenges and barriers involved in implementing evidence-based practice as it changes the overall setting of the healthcare practice. One such potential barrier is the resistance faced by the staff, who are reluctant to implement the suggested changes in the existing clinical environment. There are many factors that can lead to this reluctance and unwillingness of the staff to adopt certain changes. For example, some staff members might not comprehend the importance and effectiveness of implementing evidence-based practice, which can result in their resistance. The lack of dedicated leadership can also contribute to the ineffective integration of the EBP.

With respect to the implementation of the depression treatment model, the primary issues involved with the change of care practices include the recognition of depression, conversation with older patients about their depression, and adjustment of daily healthcare approaches, methods, and interventions to enhance function and mitigate the problems associated with depression which are mistakenly conceived as the result of high age (Smith & Haedtke, 2013). So, in order to achieve superior outcomes consistently, it is important that healthcare providers discuss clearly different aspects of depression and the preferences of older patients and their treatment (Smith & Haedtke, 2013). This can be achieved by providing the necessary education to staff members about the potential benefits of EBP and how to interact with older patients.

Patients’ reluctance to respond positively to the depression treatment model is another hurdle during the implementation of EBP. Therefore, proper initiatives should be taken by the staff members to educate patients as well as to develop prior awareness of the process at the time of admission.

Lastly, time and resource constraints can potentially influence the whole process of integrating EBP. For instance, an RN (registered nurse) leader in the AL residence, on the one hand, serves as a depression resource person while, on the other hand, a liaison to the patients’ key care provider to help assisted living (AL) nurses build necessary skills related to depression. Therefore, Smith & Haedtke (2013) found that five RN participants showed concerns about time constraints in their responses. Thus, in the case of the implementation of a depression treatment model using evidence-based practice, residents’ concerns related to the time constraints for staff members and service costs are a few potential barriers that can only be overcome by deploying more resources.

Outcome Improvement Using Six Sources of Internal Evidence

Internal evidence refers to the data obtained through various sources within the organization, for example, quality aspects, client satisfaction, safety measures, content, clinical experts, and patient experiences (Melnik & Fineout-Overholt, 2015). The role of the quality management department is to evaluate the quality of care that patients are subjected to in the organization. For this inspection, the quality experts gather data on different aspects of quality, such as incident reports and new [hospital-acquired infections](#). Moreover, to maintain the standard of healthcare, they initiate different training sessions to educate the staff members about different aspects of the quality after examining the collected data.

Clinical experts have a great role in the successful implementation of EBP because of their knowledge, specified experience, and relationships with the patients and other staff members as a whole. Therefore, their input is a critical tool to compare the information with the clinical data available. More importantly, they are easily accessible in case of any clarification or further information. However, their input is very subjective and dependent on their personal experiences, which can change with time as they perform their duties on a daily basis. Client satisfaction and patient experiences are other important sources for investigating the outcome, which is an indicator of the effectiveness of the evidence-based model. In this regard, the record of previous clients and patients and their responses to a specifically designed survey can be compared to analyze the changes the implantation of EBH has brought.

Conclusion

After reviewing the implementation of the depression treatment model by integrating evidence-based practice, it can be concluded that the model has significant potential to eliminate distress, costs of late-life depression, and disability, while some potential barriers in this regard are concentrated on residents' concerns about time constraints for staff and service costs. Further, it can be assessed that scientific knowledge and skills can be enhanced by using evidence-based practice, and therefore, it should be practised by all healthcare professionals to improve patient care delivery, satisfaction, and outcomes and reduce the costs of treatment. In this regard, the potential barriers must be considered beforehand by the skilful leadership to effectively integrate the EBP while making its implementation more acceptable among both staff members and patients.

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