

Appriseating evidence based practise

[Law](#), [Evidence](#)



This paper will explore four key pieces of evidence with regards to experiences of people with intellectual disabilities through appreciating evidence for practice. The research cuts across social exclusion in people with intellectual disabilities, substance misuse, personal independence and family involvement. It also looks at the definition for evidence based practice in nursing, evaluating qualitative and quantitative evidence as well as service audit and evaluation in support to Gary Mitchell's case study.

Evidence Based Practice Evidence based practice is an avenue that ensures best care is given to patients and service users, ensuring that the care that suits their needs is administered based on positive result and practice with regards to feedback from patients/ service users that would reflect in an effective nursing practice (Barker, 2013; Pape, 2003). This definition drives across three components which are research evidence, Clinical expertise as well as “ patient involvement”.

Barker, 2013 indicated that nurses should base their practice on evidence in order to improve patient's safety and the quality of care and be able to make clear and reasonable link between theory and practice. Jolley (2009) article shows that evidence may be limited and may contradict each other and as a result, informed decision and judgment must be made. Quantitative research evidence is a method of inquiry that makes use of post positive claims towards acquiring knowledge for practice (Creswell, 2003).

It is said to be objective as it is used to gain understanding into underlying thoughts, it is also used to quantify evidential problems by way of numerically generating data or data types that are transformed into useable

statistics (Bruce, Pope and Stanistreet, 2008) Qualitative research evidence is said to be focused on the thoughts of people, thereby making it to be subjective (Seidman, 2006). It provides insights into the problem as they focus more on the problem.

They often take the form of “ what is what has” (Ploeg, 1999). The data collection methods varies as it makes use of unstructured or semi structural methods for data collection.

2. 1 Importance of Evidence Based Practice

Evidence based practice in nursing has helped to minimise risk, it has also ensures that patient receive care based on adequate research, eradicating doubts and worries as the evidence would have been tested prior to its publication (Sackett, 2002).

Due to the fact that new evidences and technologies keep emerging, there is need to collate old and current evidence together for effective clinical decision making (Gabby & le May, 2004). Department of Health(2004) indicated that evidence based practice in now part of job description and a gateway to advancement.

2. 2 Locating Evidences

While locating materials and evidences for this paper, several methods and approaches were applied.

Such approach was including wildcard characters (*) which were either placed before or after a catch word, like * intellectual disabilities *, *substance misuse *, family involvement and intellectual disabilities*, *social exclusion in people with intellectual disabilities *, *substance misuse & intellectual disabilities, * patient involvement & intellectual disabilities*. An online database such as CINAHL, British Nursing journal was used as it will help to gain access to more recent materials and a bench mark was set with

the date so as to get access to most recent materials (Courtney and McCutcheon, 2009) except in cases where there

are no recent materials. Although in some aspect of the search, only limited materials were found that involved intellectual disabilities but disabilities in general. 3 Social Exclusion and People with Intellectual Disabilities (ID) A quantitative systematic report by L. Nicholson & S. A. Cooper, 2013 focused on social exclusion and people with intellectual disabilities, which was a rural – urban comparison.

They carried out their research using a quantitative methodology with their study aimed at comparing indicators of social exclusion of adults with ID living in rural areas compared with urban areas to test if there is a double disadvantage. Their research cut across several journals, research materials and books to support their work. Their participants were recruited from a range of settings, both in the urban and rural with people with ID, not considering a particular age, gender or level of disabilities and their consent was obtained, which is in line with NMC regulation (NMC, 2012).

Both results were statically analysed using statistical package for the social sciences and outliers removed to ascertain their result. It was concluded that social exclusion was more in the urban area than the rural area. The research by L. Nicholson & S. A. Cooper is quite a recent evidence and it can be used to represent to settings, which are urban and rural settings and people with Intellectual disabilities do reside in both type of settings and reaction for different settings on people does differ from one another.

Kenyon et al, 2002 saw social exclusion as ‘ The unique interplay of a number of factors, whose consequence is the denial of access, to an individual or group, to the opportunity to participate in the social and political life of the community, resulting not only in diminished material and non-material quality of life, but also in tempered life chances, choices and reduced citizenship’ (Kenyon et al, 2002). World Health Organisation defined intellectual disabilities as ‘ a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence).

This results in a reduced ability to cope independently (impaired social functioning), and begins before adulthood, with a lasting effect on development’ (WHO, 2012). Social exclusion was also noted in the aspect were employers attitude may also affect the likelihood of a person with intellectual disability to obtain and retain employment, it was also noted that people with disabilities are more likely to have restricted social networks, looser ties with their local community, experience bulling and being victim of crime (NCB, 2007, ILCDP, 2004).

These definitions does emphasise on most major aspect of social exclusion on Intellectual disabilities as they have been excluded from some aspect of activities because people thought that they lack the ability to make informed decision. 3. 1 Substance Use and Misuse Research has shown that most people with Intellectual disabilities or disabilities, sometime result to substance use / misuse in the community by trying to engage in similar life style with other non-disable persons and that substances could also be used

as a coping mechanism from stress encountered during their day to day living in the community (Sturmey et al.

, 2003, Stavrakaki, 2002). They could also use substances as a means to fit into the community, whereby socialising and making new friends in the community (Degenhardt, 2000). Research has shown that substance use does not equate to misuse but in some cases, it has lead to abuse / misuse of substances. Slayter (2010), quantitative review of Medicaid healthcare billing claims, it was concluded that 2. 6% of all people with ID had a diagnosable substance abuse disorder. Sturmey et al.

, (2003) also indicated that the use of illicit substances in people with ID can be associated to their local community, its availability and the individual themselves. 3. 2 Independence / Choice Most people with Intellectual disabilities complain of not being given the choice in decision making over some certain issues. In a research carried out on choices by Growing older with an intellectual disability in Ireland, (2011), it was indicated that three quarters 75. 4% reported having no choice in relation to where they lived and 85.

5% regarding where they lived and whom they lived with. Just as the position of Gary Mitchell in his case study where he indicated that he would have loved to live close to his sister if given the choice. The research by IDS-TILDA, 2011, only based their research on 240 participants. It did not base its research on gender which made it acceptable for generality of people with Intellectual disabilities. McClimens & Hyde, (2012), in the issue of choice noted that if choice does not give optimal result for non-intellectual disable people then

its sufficiency as a vehicle for optimising the rights of people with ID is highly questionable. In another development, it was noted that some people with Intellectual disabilities can not take or make informed decision in the area of choice that would improve their quality of life (Schelly, 2008). 4 Family Involvement in Care Most people with ID find family support in their care very handy, in a research by IDS-TILDA (2011), it was noted that people with ID living with family indicated that that they had fewer difficulties as family members helped to manage some area of their life that they had difficulty.

Families also play fundamental roles in development and inclusion in the society (Council of Europe 2006). Another research indicated that all disable children should live with their own family, which is seen as the natural development for growth and wellbeing of a child (people with disability), unless there are circumstances that prevent it (Council of Europe 2006). Most people with ID would have loved to be quite close to or live with a family member that they felt happy together so as to get some support and assistance from them to make their life happy as was discussed in a case study by Gary Mitchell.

AHRQ (2012) quantitative research indicated that family involvement and participation in patients care could lead to better patient experiences and outcomes as the best and appropriate care with improved safety and support would be given to the patient. The research also noted that family involvement in patient's care can improve communication and help to facilitate a better understanding between the patient and its care. 5 Conclusion It is obvious that without evidence based practice in nursing,

quality care would not be provided to service users because of the lack of qualitative and quantitative research to make reference to.

Several researches show that people with intellectual disabilities have been socially excluded in the community in one way or the other by people with no disabilities, community and government in some cases. According to Sturmey et al (2003) and Stavrakaki (2002), victims of ID tend to get involved in substance use / misuse due to their experiences and pressure from the community which eventually lead to substance addiction and or abuse in some cases. However, there is positive impact on ID victims when they interact with people with no disabilities as they cope easier and manage stress more effectively (Hartman, 2004).

The research in this article has shown that everyone would like to have some choice and control over their lives and activities as it does help to add some quality over daily living. However, would everyone with ID be able to make informed decision for their day to day living? That is a question that should be addressed for autonomous power of choice to be handed out. The impact of family members is of great importance in the rehabilitation of ID victims and helps in reducing the risk of substance use / misuse (AHRQ, 2012) thereby creating room for quick recovery.

It can be recommended to base our care on the most recent, up to date evidence based practice with the evaluation of evidences for its weaknesses and strengths. Research has also found that there could be some setback to evidence based practice due to a lack of understanding of the material, lack of adequate time to spend reviewing the materials and unable to effect a

change and peoples attitude towards accepting a change or skills (Glazious and Haynes, 2005).