Preventing self-harm: mental health nursing

ASSIGN BUSTER

The area of self-harm has been subject to extensive research since the 70s when professionals first noted the occurrence of the behaviour in psychiatric inpatients (Iwata et al, 1994). Since then the occurrence of self-harm has continued to increase. Each year approximately 220, 000 people present to A&E after self-harming and it accounts for the most common reason for medical admission in females and the second most common cause for admission in males (Hawton et al, 2007). The prevention and minimisation of Self-harm within an acute inpatient setting will be the focus of this dissertation not only because of the high prevalence but because of an interest that has developed from my past clinical experiences.

The first chapter of the dissertation will review the relevant literature to explain the issues pertinent to self-harm. Research suggests that for the correct treatment and interventions to be proposed, knowledge of self-harm as an aspect of mental health nursing needs to be understood (Chapman et al, 2006; Klonsky and Glenn, 2008). In addition chapter one will explore the link between self-harm and a diagnosable mental disorder and the prevalence of the behaviour within an inpatient setting.

At the centre of mental health nursing is the one-to-one therapeutic relationship that nurses develop with their patients (Dooher, 2008). The concept of the therapeutic nurse-patient relationship evolved from the work of Hildegard Peplau in the 1950’s (Forchuk and Reynolds, 1998). Therefore, Peplau’s (1997) Theory of Interpersonal Relationships will provide the backdrop for the dissertation. Chapter two will critically discuss the importance of the therapeutic relationship when working with an individual who self-harms with the focus predominantly on the working phase of the

nurse patient relationship. The working phase of the relationship consists of identification and exploitation, chapter two will focus on collaboratively working with the patient to identify what they would like to achieve from the nurse-patient relationship.

Chapter 3 will discuss the exploitation phase and the helping approaches used to minimise or prevent self-harm, currently there are only a few evidence based approaches devised specifically for self-harm (Nock, 2010). Harm reduction will be critically analysed given that self-harm is often the only coping strategy an individual has and removing this coping mechanism suddenly can lead to withdrawal from the therapeutic relationship (Pengelly et al, 2008). Furthermore, ‘ enhanced nursing observation’ is the most commonly used nursing intervention to manage self-harm in an inpatient setting (Bowers et al, 2000). However, much criticism surrounds the use of nursing observations. Therefore, the literature will be reviewed and critically analysed to determine if it does reduce self-harm through therapeutic engagement.

Naturally all therapeutic relationships come to end. A therapeutic relationship can end for a number of reasons including, disengagement from the client, the nurse may be transferred to a different position or even death. Nevertheless the ending of the relationship is difficult (Sreevani, 2007). Chapter 4 will critically discuss the issues that may arise and the discharge planning process when transferring care to a community mental health team.

Chapter One

Introduction to self-harm as an aspect of mental health nursing

This chapter will explore the issues pertinent to self-harm. Self-harm will be defined and the behaviour will be explored to determine why and how individuals may self-harm.

A single definition of self-harm, as well as the vocabulary used to describe the behaviour, has been difficult for researchers and clinicians to identify because there is no generally accepted terminology and therefore various terms have been used in the literature (Ross & Heath, 2002). The term self-harm has often been used interchangeably with self-mutilation, deliberate self-harm, self-injurious behaviours, parasuicide and self-wounding. Weber (2002) identifies that the terms used often, such as self-injury, Para-suicide and self-destructive behaviour, reflect the theoretical standpoint of the clinician using them rather than the client who is harming. Furthermore the term used to describe the self-harm can imply a different meaning of the act, for example self-abuse suggests a psychodynamic understanding of the motivation for the behaviour whereas direct self-harm conveys the person has chosen to act in this way and that it is a behaviour rather than an illness. Onacki (2005) defines self-harm as a deliberate, repetitive, impulsive, and non-lethal harming of one’s body. Whereas the National Institute for Clinical Excellence (NICE) guidelines for the short-term management of self-harm define self-harm as ‘ self poising or self-injury, irrespective of the apparent purpose of the act’ (NICE, 2004, p7) The term ‘ deliberate’ has been removed from their definition, in acknowledgement that some people may self-harm

in a dissociative state and that intent varies from individual to individual and on each occasion that someone harms themselves. Their broad scoping definition aims to ensure people presenting with a wide range of self-harm will be offered access to a psychosocial assessment and appropriate support and follow-up.

Research has categorized self-harm and there is a general agreement based on the severity of the behaviour and the act itself. The most recent theoretical classification discussed in the literature is proposed by Favazza (1998). In this classification system, self-harming behaviour has been classified in to three observable categories, including major, stereotypic, and superficial/moderate based upon tissue destruction and the rate and pattern of the behaviour. According to Favazza (1998), major self-harm consists of rare acts in which a major amount of body tissue is destroyed for example a limb may be amputated in the act and stereotypic self-harm includes acts of moderate behaviours such as head banging, hitting, throat and eye gouging, and self-biting and are primarily rhythmic and repetitive. Superficial or moderate self-harm is the most common and varied type of self-harming behaviour and it comprises of acts of low lethality that occurs both sporadically and repetitively (Rao, et al 2008).

Whalen (2006) identifies superficial or moderate self-harm (herein referred to as self-harm) as the most common type of self-harm among the psychiatric inpatient population. Self-harm can take many forms including self-injury and self-poisoning. The most common form of self-injury is skin cutting with a variety of implements targeting areas of the body that can be covered by clothing and most likely the lower arm (Beer, 2010; Mannion,

2009). There is some evidence that cutting is more repetitive than other forms of self-injury (Lilley et al, 2008). Other forms include burning, scratching banging or hitting body parts and interfering with wound healing (Klonsky, 2007a). Self-poisoning is the intentional use of more than prescribed or recommended doses of any drug and includes poisoning by non-ingestible substances, overdoses of recreational drugs and severe alcohol intoxication where this seems to be intended as an act of self-harm. Furthermore, Substance misuse, physical risk-taking, sexual risk-taking and self-neglect are sometimes labelled as indirect self-harm (Royal College of Psychiatrists, 2010). In addition, when people who repeatedly harm themselves through cutting or taking overdoses are helped to overcome these behaviours, eating disorders or other self-damaging problems may emerge. With research suggesting that the prevalence of self-harm among patients with an eating disorder is 25% (Sansone et al, 2003). For the purposes of this dissertation the discussion will be predominantly focused on self-injury because research has identified this as the most common type of self-harm within an inpatient setting (e. g. James et al, 2012; Beer et al, 2010).

Self-harm has been identified as a key risk factor for suicide with approximately 50% of people who commit suicide having previously self-harmed (Cooper et al, 2005); this strong correlation may suggest why some researchers feel self-harm only exists when the intent is to kill oneself (Klonsky et al, 2003; Ross & Heath, 2002). However, Conaghan & Davidson (2002) are of the opposite view and suggest self-harm is a behavior with the outcome being not to kill oneself. This view is supported by Favazza (1998)

who suggests that self-harm is a ‘ morbid’ form of self-help that is opposing to suicide. Furthermore, Suyemoto’s (1998) ‘ anti-suicide’ model focuses on self-harm as an active coping mechanism to avoid suicide. Thus suggesting that suicide and self-harm are two very different phenomena and therefore in this dissertation self-harm will continue to be discussed without suicide intent.

Self-harm can occur because of a wide range of psychiatric, psychological and social problems. Meltzer et al (2001) found that individuals with current symptoms of a mental disorder are up to 20 times more likely to have self-harmed in the past. However, self-harm does not currently fulfil the criteria for an independent category of mental or behavioural disorder in the DSM-IV-TR (Diagnostic and Statistical Manual 4, Text Revision, American Psychiatric Association, 2000) or the ICD-10 (International Classification of Diseases, World Health Organisation, 1992). In both classificatory systems, the DSM-IV and the ICD-10, self-harm is only referred to as a symptom of Borderline Personality Disorder. Conversely, Klonsky et al (2003) discussed that self-harm is also commonly found in clients with a number of mental disorders. Haw et al (2001), for example, found that 92% of individuals receiving inpatient treatment for self-harm were also suffering from psychiatric disorders, with the most common being depression and anxiety disorders. The vast research that illustrates self-harm co-occurs with a variety of diagnoses, and not just Borderline Personality Disorder, has lead to a proposal for the DSM-V to include a new diagnosis specific to non-suicidal self-injury (Shaffer and Jacobson, 2009). Signifying that self-harm is an issue in itself irrespective of the co-occurring diagnoses.

Some of the other psychological or social problems stem from early childhood experiences and may include: sexual abuse, neglect, emotional and physical abuse, loss or separation and parental mental health problems (Skegg, 2005). Current psychological or social experiences, aside from a mental health diagnosis, rape, domestic violence and substance misuse have been found to increase the risk (Tuisku et al, 2009). The risk factors identified could have a significant impact on everyone, and even more so if someone has a mental health diagnoses, however not everyone predisposed to these experiences and/or with a mental health diagnosis self-harms. Therefore, these contributing factors alone do not control the behaviour. More recently, both academics and professionals have recognised that until there is an evidence base indicating why people self-harm, it is unlikely that the correct treatments and interventions will be proposed (Klonsky and Glenn, 2008). Fortunately, the functions of self-harm have been subject to increased research in recent years (Klonsky, 2007b).

Research has identified multiple functions of self-harm (Hanley et al, 2003). Converging evidence suggests self-harm occurs with a primary intent to alleviate negative emotions and to release tension (Klonsky, 2009). Utilising self-harm to reduce tension does seem to result in an immediate release and Crowe & Bunclarck (2000) have found biological evidence to suggest that a physiological stress reduction after an episode may last up to 24hrs. These findings emphasise the risk of repetition and further more why self-harm is a very complex behaviour to treat which will be discussed further in Chapter Three. Another prominent function is reported by Machoian (2001), who describes self-harm as a means to communicate the degree of pain that is

being felt. It seems that those who self-harm feel that no one can offer emotional support or show they understand (Magnall, 2008). These beliefs suggest the importance of a therapeutic collaborative relationship because if self-harm is being used to communicate, the skills of a nurse should be adapted to overcome this. Although these functions are commonly identified to explain why someone may self-harm they are not inclusive thus emphasising the importance of a comprehensive assessment (both of these points will be discussed further in Chapter Two). Nevertheless self-harm is a maladaptive coping strategy (Linehan, 1993).

The demographics of individuals who self-harm, age, gender and ethnicity, may also give insight in to why people self-harm or at least help to identify who is more at risk. Self-harm can occur at any age but it is most prevalent in adolescents and younger adults. Martin et al (2010) found that self-harm typically begins in early adolescence around fourteen years of age and the disorder seems to peak between the ages of sixteen and twenty-five. Furthermore, studies which have specifically looked at self-harm within an adult acute in-patient setting have found an age range between 20 to 37 years old (e. g. Bowers et al, 2003; Chengappa et al, 1999). More recently, Beer et al (2010) identified that 69% of patients were under the age of 35 supporting that self-harm can indeed occur at any age but it is more predominantly seen in younger adults. In addition, whether an individual is male or female has been captured in research studies and until recently much of the research suggested that females are more likely to self-harm. For example Fox and Hawton (2004) indicated that females are four times more likely to self-harm whereas, Beer et al (2010) found there to be no

specific gender prevalence. The variation in the findings suggests there is no specific relationship between gender and self-harm. However, gender is an important factor as it may determine the method used to self-harm. Females are most like to cut themselves and males are more likely to burn or hit themselves (Claes et al, 2007). Findings in relation to the ethnicity of people who self-harm are somewhat inconsistent; Bhardwarj (2001) discussed that Asian women are two to three times more likely to self-harm compared to other ethnic groups. Whereas Beer et al (2010) found the prevalence of self-harm to be disproportionately high in white ethnic groups. Conversely other research has identified no correlation between self-harm and gender (for e. g. Bowers et al, 2003). Thus, suggesting that ethnicity cannot always indicate if someone is likely to self-harm.

Additionally the prevalence of self-harm is much higher in in-patient settings, with up to 80% of a psychiatric inpatient sample self-harming (Nock and Prinstein, 2004) compared to a prevalence rate of 15-20% in the community (Heath et al, 2009). Of late, James et al (2012) reviewed the self-harm incident reports from adult psychiatric wards during 2009. The review established that 14, 271 self-harm incidents were reported and self-injury in the form of cutting was the method used most. Acute services reported the highest amount of incidents (65%) with forensic services reporting 29%. However, acute services have a higher quantity of beds compared to forensics and therefore there are significantly more reports of self-harm from forensic settings (James et al, 2012). Nevertheless the high rate of self-harm occurring within psychiatric inpatient settings suggests that all nurses will experience someone who self-harms at some point during their career.

Nijman et al (2005) estimated that during a year period 84% of mental health nurses will witness mild self-harm and 57% severe self-harm.

To summarise, self-harm is a maladaptive coping mechanism which predominantly starts in adolescents usually at age 14 and peaks at 16 through to the age of 25. However, within an adult acute inpatient setting the age range increases to 35 with self-injury in the form of cutting the lower harm being the most likely form of self-harm. Finally, the varied causes and functions that self-harm serves highlight the importance of in-depth therapeutic assessment which will be discussed in the next chapter.

Chapter Two

Critical Discussion of the therapeutic relationship and assessment tools used within self-harm.

Therapeutic relationships provide the foundations for mental health nursing practice with people who are experiencing threats to their physical and mental health (Reynolds, 2009, p. 313). An effective therapeutic alliance is one of the key factors that help patients to develop alternative modes of coping with intolerable affects when habitual self-harm has become common (Walsh, 2007).

The concept of the therapeutic nurse-patient relationship evolved from the work of Hildegard Peplau in the 1950's (Forchuk and Reynolds, 1998). Peplau (1988) held the view that whilst relationships may contribute to dysfunctional behaviour, people can also heal within relationships. Peplau's interpersonal relationship theory of nursing focuses on the evolving therapeutic relationship between the nurse and client. Peplau (1997)

identifies overlapping phases. Firstly, the orientation phase, in which parameters of the relationship are established and the initial trust develops. Secondly, the working phase, which includes problem identification and exploitation (making full use of the services of the nurse) and finally, the resolution phase, within which the nurse prepares the patient for termination of the therapeutic relationship (Forchuk, 1995). The current health care environment, including shortage of nurses, economic constraints and advances in pharmacology, has led some to question the relevance of Peplau's model in current nursing practice (Ziegler, 2005). For example, Hagerty and Patusky (2003) discuss that the long-term relationship development is no longer useful in most health care settings. Conversely, Gastman (1998) argues that the fundamental concepts found in the interpersonal relations theory are still useful.

Development of a therapeutic relationship has been identified as being particularly complicated where self-harm is involved. It is not unusual that self-injurers encounter professionals that respond ineptly to their behaviour. Many authors (e. g., Simeon and Hollander, 2001; Walsh, 2006) have discussed negative reactions, such as shock, disgust, fear and anxiety, that self-injurers experience when they first encounter professionals such as nurses. This may lead to individuals who self-harm being ‘ sceptical’ of the continuity and longevity of the therapeutic relationship (Walsh and Rosen, 1988). Although these preconceptions exist both for the nurse and client, a therapeutic relationship is vital. The guidelines provided by the National Institute for Clinical Excellence (NICE, 2004) for the management of self-harm, suggest that a therapeutic relationship is often more important than

the treatment. Furthermore although a positive therapeutic relationship is not the solution to self-injury, it provides a context in which problem solving and behaviour change can take place (Nafisi and Stanley, 2007). Therefore it is essential that the skills used in the orientation phase to develop trust are continued and expanded upon throughout the relationship. Shiner (2008) identifies it is important to maintain a non-judgemental, empathetic, open-minded and respectful attitude with the focus kept on the person and not on their self-harm behaviour. These underlying principles are congruent with the much earlier work of Peplau (1952) and Rogers (1957). The use of empathy has been identified as a key component when working with an individual who self-harms, the ability to communicate an understanding of what they are going through may alter the individuals' perception of adults and their previous experiences (Davies & Huws-Thomas, 2007).

For problem solving and behaviour changes to take place collaborative care is important to identify the needs individual to the patient. Collaborative working ensures that both the nurse and patient influence the decision making process (Ellis, 2009, p. 145). Hence, Nurses should deal with the ' persons' description of their own immediate needs, this is something The Tidal Model recognises. The Tidal Model advocates an essentially curious and broad-minded stance towards people's problems. The model incorporates elements of alliance, whereby, the nurse is aware the patient already has the acquired skills and abilities to move forward and helps the patient to recognise and develop these through achievable therapeutic goals, which is essentially collaborative care (Barker and Buchanan-Barker, 2005). The philosophical underpinning of this model draws upon the earlier work of

Peplau (1952) which further supports the relevance of Peplau's model in today's practice. A recent study by Cook et al (2005) illustrates the interpersonal transactions displayed when The Tidal Model is implemented, as being positive for recovery. This emphasizes the use of this model when mental health nursing is fundamentally aiding someone on their journey to recovery (Shepherd et al, 2008).

The working phase of Peplau's model is initially concerned with identification. During this phase of the therapeutic relationship the nurse in partnership with the client carries out an assessment to identify problems that require working on within the relationship (Peplau, 1988). Unfortunately, relatively little has been written on the formal assessment of self-harm. This absence is unfortunate because any effective treatment of self-injury must begin with a thorough and accurate assessment to identify needs and problems (Walsh, 2007). Nevertheless, a mental health assessment is a legal requirement under the Mental Health (Wales) Measure 2010 (MHM).

The MHM is primary legislation that was passed by the National Assembly for Wales in 2010. It recognises that the majority of people with mental health problems rarely need to be treated compulsorily under the Mental Health Act 2007 and voluntarily seek treatment (Welsh Assembly Government, WAG, 2010a). The Measure is different to the Mental Health Act as it does not provide for compulsory admission and treatment of people. The measure ensures that people are able to access appropriate mental health services and receive care that is co-ordinated by a named person. Part 2 of the Measure places duties on service providers, Local Health Boards and local authorities in Wales, to act in a co-ordinated manner to improve the

effectiveness of services provided to an individual. The WAG (2010b) identified that clients often require help with aspects of their lives in addition to care and treatment, such as education and their physical health. This places demands on services that one discipline cannot meet alone, and it is therefore a requirement to have an integrated system of effective assessment, planning delivery and review, so that collaborative care can be provided to benefit the client. The framework for this integrated system is the Care Programme Approach (CPA).

Fundamentally, the CPA is a problem solving process designed to facilitate effective and efficient clinical management of a client from admission in to services through to discharge (Kingdom, 1994). In essence the CPA introduced no major changes in to psychiatric care and should have merely formalised good care. However many have found this not to be the case and the CPA has been subject to major criticism with it being unevenly implemented (Social Services Inspectorate, 1999) and clients have reported it to be ‘ invisible’ and ineffectual (Webb et al, 2000; Rose, 2001). These findings may suggest that the use of the CPA is ineffective however the principles of the framework are now legitimate requirements under the Measure which should eradicate any criticism and negative preconception in the future. Furthermore Part 2 of the Measure, which applies to secondary services, does not prescribe a particular assessment process (WAG, 2012). Therefore, the CPA framework still has an existence if used in conjunction with the Measure’s care and treatment planning documentation.

Assessment is the first stage of the CPA framework which needs to be personalised to suit the individual who is self-harming. A psychosocial

assessment following self-harm, as outlined in the NICE (2004) guidance, is a necessary starting point for preventive interventions (Hawton et al, 1998). To carry out a psychosocial assessment means to recognise the importance of, and interrelationships between, psychological and social domains of the client's life. A recent study carried out by Bergen et al (2010) found a psychosocial assessment following self-harm was associated with a 53% decreased risk of a repeat self-harm episode in individuals without a mental health diagnose and a 26% decreased risk in those with a mental health diagnoses. These findings, although lower if an individual has a mental health diagnosis, support the importance of a psychosocial assessment. More importantly these findings identify that such assessment can reduce repetition of self-harm. However, the findings may be limited because some diagnostic factors, including previous or current mental health diagnoses, were not available. Nonetheless, the large sample may override this deficit and therefore the findings could be generalised to represent the wider population. Furthermore, previous studies (e. g. Hickey et al., 2001; Kapur et al., 2002) have also highlighted that psychosocial assessment appears to reduce repetition by 50%, which offers reliability to the more recent findings.

Although a psychosocial assessment has been proven to reduce the risk of repetition there are a high proportion of individuals who will continue to self-harm after an assessment (Hawton et al, 2003), with one percent of individuals going on to commit suicide in the 12 months following the assessment (Hawton and Fagg, 1988). Therefore, before formulating a care and treatment plan, a risk assessment to identify risk-factors for future self-harm is a nursing priority. Risk assessment is integral to the management of

individuals with a mental disorder and a vital part of the CPA framework (Phull, 2012). Risk has been defined as the likelihood of an event happening with potentially harmful or beneficial outcomes for the self and or others (Morgan, 2000). In mental health nursing it is not uncommon for the ‘ event’ to be referred to as behaviours resulting in suicide, self-harm, neglect and violence. Because of the high risk of death associated with these behaviours it may explain why until recently there has been little or no consideration of the positive potentials of risk taking. However, risks may need to be tolerated and managed, for longer-term positive gains (Morgan, 2004), in relation to self-harm this may be interpreted as allowing the patient to self-harm ‘ safely’ initially which will be discussed further in the next chapter. The Best Practice in Managing Risk (Department of Health, DoH, 2007) identifies that positive risk taking aids recovery and by avoiding all possible risks it may be counterproductive creating more problems for the patient in the long term. Therefore positive risk management is essential and can be achieved by using a collaborative approach.

The ability to assess risk effectively is an essential skill for mental health staff working with patients who harm themselves. The assessment should include identification of the main clinical and demographic features known to be associated with the risk of further self-harm and or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent (NICE, 2004). The means of collecting this information includes using past clinical notes, information gathered from the psychosocial assessment, actuarial

assessment tools and clinical judgement, as well as working closely with the patient to anticipate their future behaviour (Doyle 1999, Morgan 2004).

In clinical practice there are a number of risk assessment tools which provide practitioners with prompts to ensure that all aspects of the risk assessment are considered. Self-harm has been identified as a main predictor of suicide therefore risk assessment tools to help identify suicidal ideation would aid the nurse. The Becks Hopelessness Scale (Beck et al, 1974) has been recognised as a useful tool to predict repetition of self-harm and suicide (DoH, 2007). If repetition of self-harm is identified as being likely, the Functional Assessment of Self-Mutilation (Lloyd et al, 1997) assessment tool may be used to determine what type of self-harming behaviour may prevail. The incorporation of specific risk assessment tools has been described by some as creating the ‘ ideal’ assessment (Brown et al, 2004). However, the usefulness of such tools has been questioned because such tools tend to focus on common behaviours and more often than not they have primarily been developed for research purposes (Walsh, 2007). Because of these limitations the use of risk assessment tools alone would not ensure a valid risk assessment and should be used to aid clinical judgement only.

Once a comprehensive psychosocial risk assessment has been completed, a care and treatment plan needs to be formulated and although this is a fundamental part of the CPA framework it is now a legal requirement under Part Two of the Mental Health (Wales) Measure 2010. Furthermore under the measure it is now a statutory requirement that a care coordinator is allocated to the patient as soon as possible. A care coordinator is responsible for developing, reviewing and revising the care and treatment plan and

coordinating the care which is delivered by both themselves and others (WAG, 2010a). Qualified mental health professionals including nurses are eligible to be care coordinators. The new standardised care plan consists of eight domains, recognising that there are a number of aspects that collectively contribute to an individual's mental well being. These include accommodation, education and training, finance and money and medical and other forms of treatment, including psychological interventions (WAG, 2012). Although all domains are of importance, for the purpose of the next chapter, the interventions will be based on the aspect of ' medical and other forms of treatment, including psychological interventions'.

To summarise, therapeutic engagement consisting of a non-judgemental, open minded, empathetic approach is essential to develop a therapeutic relationship with a patient who self-harms. A therapeutic relationship provides the essential platform needed for collaborative care to take place which will encourage behaviour changes. Furthermore, research has identified that a psychosocial assessment reduces the risk of future self-harm, suggesting the assessment is a therapeutic intervention in its self. Additionally for a care and treatment plan to be effective a risk assessment is essential, not only to help minimise future risks such as suicide and neglect but to enable the patient to incorporate positive risks in to the plan to promote recovery. Finally with a care and treatment plan established and agreed the interventions incorporated can be initiated to minimise and reduce the self-harming behaviour which will be the focus of the next chapter.

Chapter 3

Critical discussion of the Helping Approaches used within a inpatient setting to prevent and or minimise self-harm

Currently, there are few evidence based interventions or prevention programmes specifically devised to reduce and minimise self-harm (Nock, 2010). Nevertheless any intervention or helping approach needs to be based on the best evidence available (Zauszniewski, 2012). Evidence based practice is the systematic use of current best evidence to make clinical decisions for patient care