**Week 2: Levels of Evidence**

There are seven levels of evidence as identified in the table below:

|  |  |  |
| --- | --- | --- |
| **Level of Evidence** | **Description** | **Practice Change** |
| **Level I** | The evidence is obtained through systematic reviews and meta-analysis of all relevant randomized controlled trials (RCTs) or evidence based practice guidelines of systematic reviews or three or more good quality RCTs with similar results | Clinicians follow the strong recommendations unless they have a compelling g rationale supported by evidence for an alternative approach |
| **Level II** | Evidence is obtained from at least one well designed RCT | Clinicians follow recommendations but also remain alert for any new information and preferences of the patient |
| **Level III** | Evidence is obtained from well designed controlled trials without randomization (quasi experiments) | Clinicians are flexible in decision making regarding the practice. They set bounds on alternatives but patients preferences have substantial influencing roles |
| **Level IV** | Evidence is obtained through cohort studies or case controls | Clinicians are flexible in decision making regarding the practice. They set bounds on alternatives but patients preferences have substantial influencing roles |
| **Level V** | Evidence is from systematic reviews of qualitative studies and descriptive studies | In practice clinicians consider all the options in decision making. They are also alert of any new information published as evidence clarifying the benefits vs harm of certain practices. Patience preferences is crucial in decision making |
| **Level VI** | Evidence is from a single qualitative or descriptive study | Clinicians consider all options and keep alert for any new information or evidence related to practice. Patient preferences are highly considered as part of decision making |
| **Level VII** | Evidence is from opinion of reports or those of expert committees | Clinicians consider all options and keep alert for any new information or evidence related to practice. Patient preferences are highly considered as part of decision making |
|  |  |  |

**Articles**

1. Campbell, E. T., Franks, A. T., & Joseph, P. V. (2019). Adolescent obesity in the past decade: A systematic review of genetics and determinants of food choice. *Journal of the American Association of Nurse Practitioners*, *31*(6), 344. <https://doi.org/10.1097%2FJXX.0000000000000154>

Level I – The level of evidence of the article is Level I since it is a systematic review. It is based on clearly formulates research questions and identifies relevant high quality studies summarizing their evidence using explicit methodology

1. Bell, L. K., Schammer, C., Devenish, G., Ha, D., Thomson, M. W., Spencer, J. A., ... & Golley, R. K. (2019). Dietary patterns and risk of obesity and early childhood caries in Australian toddlers: findings from an Australian cohort study. *Nutrients*, *11*(11), 2828. <https://doi.org/10.3390/nu11112828>

Level IV- The article is level five since it is a cohort study and follows research participants over a period of time to determine a particular aspect of the study participants. Data on the food intake of participants is collected over a period of time to determine common characteristics amongst the population. Participants for the study are chosen based on particular characteristics such as their age.

**References**

Titler, M. G. (2008). The evidence for evidence-based practice implementation. *Patient safety and quality: An evidence-based handbook for nurses*.