Influences on clinical decision-making during a community placement: reflections of a student nurse

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ABSTRACT

High quality care is dependent on good clinical judgement and often-complex decision making. Nurses need to be able to justify and defend their clinical decisions. In this article, a third-year nursing student reflects on an incident from a community placement involving a collaborative clinical decision. Carper's (1978) four fundamental patterns of knowing are used to analyse the decision-making process. It is shown that influences on decision-making include prior knowledge and expertise, law and accountability, and ethical principles such as respect for autonomy and beneficence. Good communication, interpersonal skills and a person-centred approach have a bearing on decision-making. It is argued that intuition also has a place and may be increasingly used with experience.

KEY WORDS

◆ Decision-making ◆ Patterns of knowing ◆ Accountability ◆ Informed consent

A nurse's ability to provide high quality care is dependent on using effective clinical judgement (Royal College of Nursing, 2014). Decision-making is acting on clinical judgement by choosing the best available option and applying it to practice (Thompson and Dowding, 2003). In nursing, that decision is often made with a degree of uncertainty about the outcome and involves weighing up the potential risks and benefits of each option (Baron, 2008). However, nursing practice needs to be safe and effective; it needs to be well-reasoned, evidence-based and justifiable (Tilley et Watson, 2004). Student nurses need to understand influences on decision-making to develop good clinical judgement.

Understanding the decision-making process and how it can be improved can lead to better quality patient care and outcomes (Thompson et al, 2013). This article discusses the decision-making process using a scenario from a third-year student placement and reflects upon influences that affect such decisions. Names have been changed to maintain confidentiality (Nursing and Midwifery Council, 2015).

Scenario

Hazel had been under the care of the community nursing team for several months and was being treated for chronic leg ulcers that had repeatedly become infected. She had taken several courses of antibiotics and various dressings had been trialled with little improvement. Hazel had recently been assessed by a tissue viability specialist nurse (TVSN), who recommended that she should be admitted to hospital for a course of intravenous antibiotics. Hazel expressed a wish not to be admitted, therefore a joint visit was arranged with a community nurse (Sarah) and a GP to decide the best way forward in light of the TVSN's opinion and the patient's wishes.

A collaborative decision is a joint decision made between two or more people for the purpose of reaching an agreed aim, with each party sharing responsibility for the decision (Standing, 2014). In this example, the nurse, GP and patient are involved in making the decision. There are three elements to the decision-making process (Standing, 2014): consultation, where opinions on what needs to be done are expressed; negotiation, where a solution that is acceptable to all parties is identified; and co-operation, where participants work towards shared aims.

Various factors influence this process, since the individuals involved may have different priorities. However, for effective decision-making, a consensus must be achieved. Importantly, the patient's own priorities should be identified to ensure better patient-centred outcomes (Coulter and Ellins, 2007).

The decision-making process

In learning how to make a decision, it is useful to reflect on a decision made in practice. There are several models and theories that can support this reflection. In this instance, how Sarah and the GP reached their care decision is analysed using Carper's (1978) four fundamental patterns of knowing

in nursing (*Table 1*).

In making decisions, nurses gather information from a variety of sources, ranging from patient observations to research studies. Also taken into account are patient preferences, colleagues' opinions, and policies and procedures that ensure care is of a high standard (Standing, 2014). The 'hypothetico-deductive' model (Elstein et al, 1978) suggests that the practitioner seeks out cues from the presenting situation, builds up hypotheses and then looks for further cues or gathers more information to confirm or refute hypotheses before drawing a conclusion. In the current scenario, both Sarah and the GP initially gather information by assessing the wound, asking Hazel what her priorities were, and by using prior knowledge and experience to create hypotheses. They then discuss their understandings until reaching a consensus.

Empirical knowing

Sarah's empirical knowledge encompasses evidence- and practice-based knowledge, wound care guidelines, her knowledge of dressings and experience (seeing similar wounds treated successfully). She may have also sought advice from other colleagues. Gillespie et al (2015) found that nurses making decisions about wound care tended to source information that was more readily accessible, often preferring to seek the advice of colleagues, which may not be current best practice.

Sarah, the GP and Hazel decided not to admit Hazel to hospital but to prescribe high-dose oral antibiotics and use a new dressing that Sarah had heard about. It was decided not to follow the advice of the TVSN perhaps because, when taking Hazel's wishes into consideration, they recognised the need for a more amenable solution. Sarah's information source for the new dressing was a drug company representative; in recommending this dressing she would have needed to consider the scientific evidence and the potential for bias in that information (Gillespie et al, 2015).

Ethical knowing

Carper's (1978) ethical pattern of knowing is about applying moral values to practice. It is about knowing the right thing to do and about duties and obligations. According to Caulfield (2005) there are four pillars of accountability: professional, ethical, legal and employment. In reaching a decision regarding Hazel, Sarah would need to consider her accountability. Sarah is accountable to her employer through her contract of employment. Her employer will expect her to carry out her duties with due care and skill (Griffith and Tengnah, 2017). For safe practice, Sarah is duty-bound to abide by the professional code of conduct set out by the regulatory body of her profession, the Nursing and Midwifery Council (2015).

In decision-making, Sarah needs to be aware of how the law impacts upon her practice. The law recognises a patient's right to give informed consent to treatment (Husted et al, 2015). For informed consent, the patient must be given sufficient information about the advantages and disadvantages of an intervention, and alternative suggestions. Providing this information is a legal requirement and failing to do so can result in action for negligence if the patient comes to harm

Table 1. The four fundamental patterns of knowing (Carper, 1978)

Empirical—the science of nursing	Personal—an awareness of self and others
Ethical—applying moral values and working in the best interests of the patient	Aesthetics—the art of nursing

(Royal College of Nursing, 2017). To give informed consent, the patient must have capacity, have sufficient information, and consent must be given freely (Wheeler, 2012). The Mental Capacity Act 2005 requires the health professional to determine that the patient is mentally competent to make descisions about their care (Wheeler, 2012). For example, Sarah would need to consider if Hazel was showing signs of confusion, whether due to the infection or other causes. Accountability means all registered nurses are legally and professionally answerable for their actions and omissions, irrespective of whether they are acting on their own initiative or following the instructions of another health professional (Griffith and Tengnah, 2017). Sarah therefore needs to be able to justify the decision taken against the advice of the TVSN. Legal and professional accountability can lead to defensive practice where the perceived safest option is always chosen (Caulfield, 2005). In taking into account Hazel's wishes and providing patient-centred care, Sarah and the GP did not take this approach and admit Hazel to hospital, despite the potentially greater likelihood of success.

Ethical accountability in decision making relates to applying ethical principles or rules that may be set by society or the nurse's own moral values to nursing practice (Caulfield, 2005). Beauchamp and Childress (2009) identified four ethical principles: respect for autonomy, non-maleficence, beneficence and justice.

Non-maleficence means that the nurse should do no harm. For instance, withholding intravenous antibiotics could be considered harmful to Hazel, particularly if alternative treatment is unsuccessful. On the other hand, giving intravenous antibiotics could be considered harmful, if judged not to be in the patient's best interests when everything is taken into consideration. Risk management therefore influences the decision. Sarah has a duty of care towards Hazel but needs to respect, as Dimond (2003) suggests, that an individual has the capacity to give consent and the right to determine what she allows to be done to her own body. In so doing the ethical principle of justice is upheld since this respects an individual's rights to make an autonomous decision.

Respect for autonomy means the nurse needs to uphold the patient's freedom of choice and dignity, but also enable informed consent. The consequences or possible consequences of each treatment action, or inaction, need to be explained to the patient to enable him or her to provide informed consent. The resulting decision does not have to be correct or optimal from a clinical point of view if it respects autonomy; however, the patient needs to be suitably informed to make that decision (Griffith and Tengnah, 2017). There can be tension between respecting someone's autonomy and providing the

best possible care (Standing, 2014).However, the nurse has a duty to explain the risks and benefits relating to the decision in a comprehensible way and can thereby influence the decision (Griffith and Tengnah, 2017). Good communication is essential, as the patient may not always disclose his or her concerns (Dowding and Thompson, 2009). Sarah may believe that intravenous therapy to be the most appropriate treatment, but needs to consider patient preference and ensure Hazel fully understands her options.

A person-centred approach is necessary to enable a patient to exercise his or her autonomy in a situation that may be restrictive or oppressive in making assumptions about the patient's needs and wishes (Jasper, 2013), leading to an imbalance of power (Gulbrandsen et al, 2016). Health professionals can possess an undesirable degree of power over patients (Husted et al, 2015). Thinking of a patient as an autonomous being, however, may lead to an underestimation of their vulnerability and their reduced ability to make decisions may go unrecognised (Gulbrandsen et al, 2016). A balance is therefore needed. In this case, Hazel is reliant on Sarah and the GP for care, and may perceive them as experts exerting undue influence in the decision-making process. In addition to recognising this, Sarah also needs to consider Hazel's vulnerability and be aware that the principle of non-maleficence also applies to psychological harm. For example, Hazel may not want to upset family members by expressing differing opinions from them. Both situations could be distressing for Hazel. Nurses must be certain that the patient's decision is not coerced (Wheeler, 2012). Sarah may need to advocate for the patient in this situation. She should consider the situation holistically to determine the best possible outcome for Hazel.

Personal knowing

Personal knowledge involves an awareness of the self and others in a relationship. It means being aware of views and values that could influence your responses and also interfere with objectivity in decision-making (Jasper, 2013). Sarah needs to explore any prejudices she holds that could cloud her judgement. For example, if Sarah's views are affected by ageism, it could cause her to be paternalistic and lean towards taking the decision out of Hazel's hands and making it for her. Paternalism can therefore conflict with the principle of autonomy (Caulfield, 2005). Sarah's personal knowledge should enable her to explore her emotional attachment to Hazel and consider whether this could impair the decision-making process (Dowding and Thompson, 2009).

Aesthetic knowing

Carper's aesthetic pattern of knowing involves perceiving the nature of the clinical situation and understanding what it means for the patient (Johns, 1995). Chronic ulceration of the leg is described as a miserable, painful and socially-isolating condition (Ousey and McIntosh, 2008). In order to provide person-centred care, Sarah needs to understand what living with a leg ulcer means for Hazel based on the information Hazel provides. Understanding the lived experience and the patient's perspective is a key principle of person-centred care, and in so doing upholds the principle of beneficence (Buckley et al, 2018). Carper (1978) identifies empathy as a core skill in aesthetic knowing and Johns (1995) likens this to intuition, which he relates to the difference between recognition and perception.

Intuition has been the subject of debate and controversy (Holland and Roberts, 2013). It is not based on empirical facts, but relies more on the individual's perception of the situation (Pearson, 2013), and perception is prone to bias (Standing, 2014). Intuition has been described as understanding without any rational reasoning (Benner and Tanner, 1987). The NHS puts great importance on evidence-based practice, which is underpinned by empirical facts, but intuition is increasingly becoming an acceptable way of knowing in clinical decision-making (Dowding and Thompson, 2009). Seminal work by Benner (1984) suggested that practitioners moved through five stages from novice to expert. Intuition develops as the nurse becomes expert (Benner, 1984) and so may be increasingly used with experience. Jasper (2013) renames intuition as professional expertise. Experts use a rapid, automatic process of pattern recognition that draws on past experiences, which could be considered a cognitive skill rather than perception (Pearson, 2013).

Schön (1983) suggests that intuitive practice is a way in which professionals can move from rule-bound behaviour to seeing things more holistically. Sarah's intuition may have played a part in aspects of decision-making, for example in assessing the wound, recommending a dressing or determining the congruence of Hazel's words and behaviour to understand what living with an ulcer was like for her. However, Greenhalgh (2002) believes intuition is not unscientific and that it is fundamental in hypothesis generation in science; therefore, intuition may play a part in hypothetico-deductive reasoning. Nurses make clinical decisions using their clinical expertise, the best available research evidence, and patient preferences (Thompson, 2003). If intuition is an aspect of clinical expertise, it can be argued that it legitimately has a place in clinical decision-making and evidence-based practice. The aesthetic pattern of knowing allows for evidence that is not apparently underpinned by research to be incorporated into decision-making (Pearson, 2013).

KEY POINTS

- Involving patients in decision-making is essential to providing high quality care
- Student nurses need to be equipped to justify and defend clinical decision-making
- The clinical decision-making process involves consultation, negotiation and cooperation
- Patients are vulnerable and health professionals can possess an undesirable degree of power over patients
- Respect for autonomy means upholding a patients' freedom of choice and dignity while enabling informed consent

Conclusion

The example analysed in this article demonstrates that there are many influences on the decision-making process. Carper provides a useful framework for reflecting on decision making, identifying the different ways of thinking and knowing that can be brought to bear on a situation; none of these are sufficient on their own but none are mutually exclusive. No specific model of reflection was used when reviewing Hazel's case, however this article reflects deeply on a decision made in practice and learning from it may influence future decisions. It is essential that nurses develop their decision-making skills. One way of doing this is by reflecting on decisions to better understand how to incorporate theory, experience, self-knowledge, ethics and intuition into the decision-making process to improve outcomes for patients. ***BJCN***

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CPD REFLECTIVE QUESTIONS

- Can you identify an example of collaborative decision-making from your practice?
- What are the three elements of the decision-making process?
- What influences your decision making (prior knowledge and expertise, law and accountability, and ethical principles)?
- How can you aid a patient in making an informed decision about his or her care?
- How can you encourage and uphold the autonomy of your patients?

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