

Is it me? Or is there something in the water? Client decision making in nursing

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KEY WORDS

Client, decision making, chronic care, rural, nursing.

ABSTRACT

Objective

This paper aims to retrospectively explore client decision making via two case studies prompting us as nurses to reflect on the factors that lead to this. Clients do not always act in 'their own best interests' as 'defined by health professionals'. Our response and understanding of this is key if we are to support and devise strategies encouraging more appropriate decisions and improved outcomes.

Setting

Sole nurse practitioner in community health practice in isolated rural Australia.

Primary Argument

In the rush of daily chronic care caseload management, factors affecting client decision making are often overlooked. Client decisions around care often result in poor outcomes for isolated rural clients. Improved client outcomes can be gained if nurses, (aware of these decision making factors), are able to assist clients to overcome their decision making barriers.

Conclusion

In rural nursing practice client decision making is multifactorial. By reflecting on clients decisions and addressing barriers in this context, short term and long term strategies can be implemented to improve the decision making process resulting in improved outcomes for isolated rural clients.

INTRODUCTION

Chronic care is in the process of becoming a central feature of primary care and in the rural Australian context is also on the increase (Dennis et al 2008; Couper 2007). With an epidemic of chronic disease, increasing comorbidities, coupled with seemingly poor decision making and client non-adherence poor health outcomes are seen. Following up on clients who have not been able to take personal responsibility for aspects of their own health care, nurses debriefing sessions and case reviews have frequently resulted with the reflection of rural health professionals and this nurse practitioner (NP) asking 'Is it me? Or is there something in the water?'

The literature abounds both internationally and in Australia that there is an increase of clients within the community living with chronic illness (Dennis et al 2008). Chronic illnesses are defined as 'health problems that require ongoing management over a period of years or decades...and are not self limiting' including hypertension, diabetes, chronic obstructive airways diseases and cardiovascular diseases (Couper 2007). Those clients with chronic illness living in rural Australia suffer the added burden of poor access to health practitioners, services and programs that may assist them to self care reducing their choice of action and is reflected in their decision making (Dennis et al 2008; Woolf et al 2005; FitzGerald et al 2001).

NP's in community health and rural primary health care settings are scarce in number, with only 20% of the approximately 143 Australian NPs practising outside the metropolitan areas (Gardner et al 2009). A large percentage of the rural NP client load includes management of chronic care clients. For the NP the lack of resources, fewer services, low staffing levels and resistance from existing rural general practitioners (GP) can result in difficulties establishing collaborative care and maintaining client centred care (FitzGerald 2001; Wagner 2000; Couper 2007). Additionally for this NP, blurring of area health service

boundaries across two area health services increases the difficulty of collaboration, management care planning, and timely communication. Understanding decision making factors and improving professional communication, collaboration and networks can have a positive client outcome through improved decision making leading to adherence to treatment (Montgomery et al 2001; Barry 2002; Ganzini et al 2003; Woolf et al 2005).

Frequently an 'absence of chronic disease self management' and delayed decision making on seeking care, result in poorer outcomes for the client (due to non-adherence to treatment/medication) and frustration for their health practitioners (Adams et al 2001; Barry 2002; Ganzini et al 2003; Montgomery et al 2001; Woolf et al 2005). However when client decision making factors (see table 1) are analysed, strategies and reasons become apparent. These decision making factors include client depression, cognition, education, sources of information, physical condition, emotions, stressors, social supports, access to services, treatment preferences, communication styles, understanding and client nurse rapport/relationships (Adams et al 2001; Barry 2002; Bechara 2004; Cooper et al 2003; DiMatteo 2004; Donovan 1995; Edwards and Elwyn 2001; Ganzini et al 2003; Montgomery et al 2001; Pierce and Hicks 2001; Saba et al 2006; Vermeire et al 2001; Wagner 2000; Wahl et al 2005; Woolf et al 2005). In the rural context rural independence and stoicism are added factors (Dixon and Welch 2000; Strasser 2003).

This paper aims to retrospectively explore client decision making via two case studies with the aim of prompting us as health professionals to reflect on the factors that lead to client decisions. By understanding the reasons why clients do not act in 'their own best interests' we are better equipped to support and devise strategies to support self management and appropriate use of health care thus achieving improved outcomes.

Table 1: Factors affecting client decision making.

Factor (references)	Meaning
Rapport/ Relationship with health care team	Shared decision making has been a shift away from the paternalistic (health practitioner directed) care towards a more consumer (client directed) care. Studies have shown that patients are more likely to engage in decision making when they felt listened too and understood, had trust, could express their own difference of opinion and could negotiate. (Cooper et al 2003; Edwards and Elwyn 2001; Ganzini et al 2003; Woolf et al 2005).
Educational background	Formal education of the client has been identified by a number of studies as important factor for decision making ability. (Benbassat et al 1998; Ende et al 1989; Woolf et al 2005).
Health care team	A health care team is a multidisciplinary team of health professionals who communicate regularly about the care of the client of interest. Most successful management of chronic health conditions is via a team (Wagner 2000).
Information sources	Clients have an enormous ability to access information via their health care team, family, friends, brochures and the advent of the internet, however not all information is appropriate (Brodie et al 2000; Impicciatore et al 1997).
Client time	The client needs to have the time to communicate with their health practitioner effectively. This includes time to listen to advice and act accordingly following consultation (Edwards and Elwyn 2001; Ganzini et al 2003).
Health care professional time	The attitude and behaviour of the health professional has been shown to profoundly influence the decisions of clients (Woolf et al 2005).
Clients physical condition	Studies have shown that clients who refuse care in emergency situations frequently have disorientation, inappropriate behaviour, and a deterioration in chronic health conditions (Alicandro et al 1995).
Client emotions	Anger/aggression and happiness reflect in decision making (Bechara 2004).
Client stressors	Include lack of family support, transport, financial situation, rurality and property concerns - this can include 'who will feed the animals if client attends hospital' (Adams et al 2001)
Clients social support	What social support does the client have - this may include family, friends, or in the case of one client "the men at the pub" (Adams and Drake 2006; Adams et al 2001; Cooper et al 2003; DiMatteo 2004).
Clients depression	Depressive illness in the client hinders all decision making processes, and communication (Ganzini et al 2003).
Clients cognitive ability	Clients need a thorough understanding of 'what' a health practitioner needs decisions on. Both memory and cognition are equally important to aid in decision making. A client may have the ability to decide in one aspect of their life however it may be completely inappropriate for them to do so in other areas (Cooper et al 2003; Ganzini et al 2003; Weber and Johnson 2009).
Personal values/ preference	Client preferences in chronic illness and self care are reflected in their decision making, determining improved or poorer outcomes (Adams et al 2001; Montgomery et al 2001).
Decision aids	Decision aids vary and need to be used as educational adjuncts to personal interactions with health professionals to assist in choice. Type of aid used should depend on context, decision to be made and other relevant client decision making factors (education, social/financial support) (Barry 2002).

Case Studies

All identifiable client information has been removed from the case studies.

Case Study One

Gordon initially presented to clinic feeling unwell and requested blood pressure monitoring. It revealed hypertension and he was assisted to access a GP within the local area. Following consultation, continued monitoring, and education of risk factors, Gordon was advised to commence antihypertensive

medications. Gordon returned to discuss with the NP alternative treatment as he didn't want to take medication. This resulted in six months of collaborative care within a multidisciplinary team including the NP, GP, dietician, and Gordon. Gordon reduced his risk factors by changing his diet, reducing his weight, increasing his activity by daily exercise (bike riding) and reducing his salt intake. Gordon agreed to commence on minimal medication six months after presentation after reducing all possible

risk factors. He is now self caring and monitoring his own blood pressure and has maintained this within normal limits for over 12 months.

Case Study Two

Todd lives alone on an isolated rural farm. He was previously known to the service after refusing admission to hospital for dangerous hypertension because "he had to get home". The NP had discussed the ongoing monitoring and care planning for his hypertension however he stated "I'll be right". He explained that his usual GP was 600 kilometres away. Local medical and health professionals were very concerned about an ischaemic ulcer on his foot and his uncontrolled diabetes. He was again refusing admission to hospital despite being unable to walk due to pain. He agreed to meet the NP on his way home from town and "have a chat". He again refused admission to hospital stating "I have to get home, there is no-one to feed the animals. They can't fix this anyway because my mate at the pub told me they haven't been able to fix his!" Two days later he agreed to a follow up home visit. Refusing an ambulance he agreed the NP could drive him to hospital (after the menagerie of animals had been fed). Following a diagnosis of untreated type 2 diabetes with comorbidities of cardiovascular disease, renal failure, peripheral vascular disease, and hypertension, Todd required transfer to the state capital for extensive treatment (some of which he refused). When asked why he had avoided doctors and hospital for his 69 years he stated "Drs bury their mistakes" and hospitals "once you get in there you never get out". When asked why he got into the NP car and came to hospital with her for admission he stated "you were [the NP] so up on your high horse I thought it was the only way I would get any peace" he then smiled and added, "the Dr said later that I would have died if I had not come with you" [the NP].

DISCUSSION

Factors affecting client decision making are multifactorial as noted in table 1. In the rural context, themes of financial stressors, social and geographical isolation, and low health literacy levels impeded

by lack of access to services and resources are significant barriers for rural clients decision making and chronic illness self care (Wong et al 2009).

Limited education and understanding of his medical condition, inaccurate sources of information, a deteriorating physical condition, the stressors of activities of daily living and farming without social/emotional support and financial strains were all reflected in Todds' decision making. Additionally, rapport with the NP was difficult and contentious due to the intermittent crisis contact, Todds' abrupt communication style, and the NP direct communication style. In comparison, Gordon's education and understanding of his medical condition developed over time as he gained information from his health care providers improving his physical condition. His social/emotional support was gained from his family and wife. Without stressors of daily living Gordon maintained a collaborative 'all on the same page' relationship towards a goal with his team and the NP used a collaborative style of communication. Jallinoja et al (2007) note some health care professionals' lack of communication skills results in impersonal counselling focusing on irrelevant factual material and failure to engage the client which can block client lifestyle changes. In contrast, other health professionals believed clients were unable to act 'in their own best interests' even though the client was 'responsible for their lifestyle change' (Jallinoja et al 2007). On reflection, the above statement was certainly the NPs communication style when crisis managing Todd's case. Without an optimal trusting rapport/relationship between Todd and the NP, the challenge of addressing acute medical needs within a timely fashion required a direct factorial communication style. In this climate non-optimal client decision making resulted.

Gordon functioned actively in the community and self managed his medical conditions suggesting normal cognition. For Todd, the concerns of repeated refusal of ambulance transfer and hospital admission had the NP questioning his cognition and decision making. Ganzini et al (2003) warns health professionals of the risks of assuming clients are unable to make their own

decisions that lead to poorer outcomes and notes that health professionals 'used higher standards to assess [client] capacity if refusal of treatment increased risk [to the client]. The literature also demonstrates that clients may be incapable of decision making in one area of their life and be quite capable of making decisions in another area of their life (Ganzini et al 2003). Essential for appropriate client decision making, is the clients ability to communicate a choice and to understand and appreciate the consequences of decisions (Ganzini et al 2003). Again on reflection, the NP identified with Ganzini et al (2003) findings within Todds' ability to make business for the farm, and yet presenting as unable to understand and appreciate the consequences of his medically related decisions.

Both Todd and Gordon experienced partial teamwork from a fragmented team. Gordons' involvement and simpler case management resulted in his successful outcome. In contrast, Todds' care and complex requirements required rapid teamwork and extensive communications between nurses and a local GP. This was necessary to facilitate his admission first to the local hospital and transfers onto the state capital. Todds' decision making delayed the timeliness of his care with less than optimal outcomes. Todds' story also demonstrates the difficulty in trying to maintain relationships with a GP across area health service and distance boundaries. GP interaction and the difficulties experienced in maintaining a multidisciplinary team approach in rural areas is well documented in the literature (Wagner 2000; Heisler et al 2002). In this NPs experience, dependent on health professionals availability, multidisciplinary teamwork occurs and they all want to work together for the best client outcome, despite the 'team' being difficult to identify. In cases where multidisciplinary teamwork is nonexistent it is generally because there is lack of practitioners rather than health professionals not wanting to work together.

Information sources are important in the clients' education and with the advent of the internet, wider information access is possible. Incorrect information is impacting further on some chronic clients self

care. As noted in Todd's case, where he neglected to continue and follow up with his wound care because information gained 'at the pub' overruled the decision making information given to him by health care providers. Gordon accessed the internet for information from sites that supported the information given to him by the health care team. Incorrect health information is evidenced on the internet and well documented in the literature (Brodie et al 2000; Impicciatore et al 1997).

The increasing workload of health care professionals and reduction in staffing and clients daily responsibilities often affect the amount of time available for service provision and self-care respectively. Time restraints were evident for Todd, Gordon, and the NP and therefore reflected in Todds' decision making, the NPs' communication style, and ability to further assist Todd as previously mentioned.

Deteriorating physical conditions and increasing co-morbidities increase the difficulty of self management and decision making. Todds' chronic illnesses had progressed to a stage where he had severe co morbidities while Gordons' chronic illness was simpler to manage.

Socially and emotionally Gordon was much happier and healthier than Todd, whose angry and aggressive manner interfered with the NP/client rapport. As noted in the literature, Todds' lack of social supports and increased daily stressors, managing activities of daily living and minimal financial resources are reflected in his decision making with poor self caring outcomes. In contrast, Gordons improved outcomes, resulted from his reduced stressors and socially supported, decision making (Adams and Drake 2006; Adams et al 2001; Bechara 2004; Cooper et al 2003; DiMatteo 2004; Ganzini et al 2003).

Initial review suggests Todds' case abounds with poorly understood decisions (as judged by the NP and extended medical, nursing, allied health team). When viewed with reference to the themes in table 1, it is not surprising that he was resistant to treatment. His extensive co-morbidities and episodes of verbal

aggression resulted in the NP communication style moving between collaborative and encouraging to direct, depending on personal risk and medical urgency. Multidisciplinary team collaboration was further fragmented by unpredictable decisions, waiting lists, health professionals being in four different communities across two health areas services and three divisions of general practice.

CONCLUSION

Decision making is an inter-relationship between the nurse and the client, and is definitely multifaceted. So in asking; 'Is it me? Or is there something in the water?' a significant part was the NP and with added knowledge and understanding of the barriers affecting client decision making, short-term and long-term strategies can then be implemented to improve client care. In the context of the rural client with chronic illness, awareness of communication styles and improved communication techniques, psychosocial emotional and practical support will improve their decision making capacity. Rural health professionals need to adapt their practice to the clients' context to assist in achieving optimal outcomes. There is nothing in the water and it is quite safe to drink.

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