A view from the outside: nurses' clinical decision making in the twenty first century

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ABSTRACT

Objective
The purpose of this paper is to highlight some observations of clinical decision making processes made by culturally and linguistically diverse nurses (CALD), in relation to elderly patients in particular. It will explore some of the potentially serious professional and legal implications for nurses when there is an over reliance on experiential knowledge and routine tasks without mindful application of evidence and consideration of the ethico-legal imperatives.

Setting
The CALD nurses in the study were enrolled in competency based assessment programs (CBAP) in two universities in Melbourne, Victoria between 2005 and 2006 in preparation for their professional registration in Australia.

Participants
Following ethical approval from the relevant universities and participating hospitals, a purposive sample was chosen followed by theoretical sampling. Fourteen CALD nurses and three teachers, who were directly involved in the clinical supervision of the nurses during their placement took part.

Primary Argument
Using some *in vivo* quotes to highlight what appear to be less than optimal decision making process by nurses, it will be argued that sound decision making in clinical practice is ideally based on a combination of factors; amongst them professional judgement and a sound knowledge base, supported by principles of physical/psychological assessment and ethical principlism.

Conclusion
The views of nurses who are new to the system can foster reflection on practices that have become routine, potentially lacking in application of scientific knowledge, and therefore a potential threat to patient safety with associated legal implications for the nurse.

INTRODUCTION

Clinical decision making is an integral part of nurses work and vital to health outcomes for patients. If based on reliable decision making criteria it can constitute a legally defensible position for the nurse in the event of a malpractice accusation. However, when handling large volumes of rapidly changing clinical information, coupled with organisational imperatives, nurses need to consider a range of factors to guide and support decision making processes.

Using the findings from a small qualitative study on the experiences of a culturally and linguistically diverse (CALD) group of nurses enrolled in competency based assessment programs (CBAP) in Melbourne; this paper will highlight some observations of clinical decision making processes made by CALD nurses, in relation to elderly patients in particular. It will explore the professional and legal implications for nurses when there is an over reliance on experiential knowledge and routine tasks without mindful application of evidence and consideration of ethico-legal imperatives. A brief overview of the study will be presented with a view to explaining the background and context of the argument.

This will be followed by a brief review of the literature aimed at providing an overview of nurse migration and professional expectation in the host nation, clinical decision making and ethical principlism. Some *in vivo* quotes will be used in appropriate sections of the literature review to highlight links between the concerns expressed by CALD nurses and published views regarding clinical decision making. It will be argued that sound decision making in clinical practice is ideally based on a combination of factors; amongst them professional judgement, a sound knowledge base supported by principles of physical/psychological assessment and ethical practice.

The terms clinical reasoning and clinical decision making will be used interchangeably in this work.

COMPETENCY BASED ASSESSMENT PROGRAMS

Competency based assessment programs for CALD nurses consist of theoretical and clinical components designed to enable them to demonstrate the Australian Nursing and Midwifery Council (ANMC) National Competency Standards.

METHODOLOGY

Design
The study was conducted using a modified grounded theory approach. Grounded theory is a useful approach to explain relatively unknown situations (Taylor et al 2006).

Setting
The CALD nurses in the study were enrolled in competency based assessment programs in two universities in Melbourne, Victoria between 2005 and 2006. The programs consisted of theoretical and clinical components. The clinical component consisted of approximately forty days at an acute care clinical venue.

Sample Selection
Following ethical approval from the relevant universities and participating hospitals, a purposive sample was chosen followed by theoretical sampling. Fourteen CALD nurses, and three teachers, who were directly involved in the clinical supervision of the nurses during their placement took part (*n*=17). No payment or other inducements were offered to the volunteers. Written consent was required from all participants prior to interview and observation. All participants were assigned a pseudonym for the purpose of the study.

Data Generation

Data were collected using semi-structured in-depth audio taped interviews, member checks and observation in the clinical environment. Data collection, sampling, and analysis took place simultaneously as the study progressed. Interviews were arranged by mutual agreement. An *Aide Memoire* was used to help guide conversations, and participants were asked to expand on their responses and to check the information for accuracy (Berg 2004).

Data Analysis

The constant comparative method of open coding, axial coding and selective coding were used as an organising framework for data analysis (Miles and Huberman 1994).

Descriptive Results

Fourteen CALD nurses and three of their clinical educators participated *n* = 17. The nurses came from diverse cultural and linguistic backgrounds namely: India, China, Philippines, El Salvador and The Czechoslovakia Socialist Republic. They ranged in age from twenty five to forty five years. The clinical educators ranged in age from 35-55. The CALD nurses fell into three groups in terms of their previous professional experience regardless of their country of origin. These were:

- Specialists
- Experienced generalists
- Inexperienced generalists

The specialist group (n = 5) had practised in clinical specialities such as operating rooms and intensive care units for extended periods up to ten years. The experienced generalists (n = 6) had practiced in a variety of acute care settings, for example medical-surgical units and emergency. The inexperienced generalists (n = 3) were nurses who had graduated in the previous three years and had nursed in one or two clinical areas, such as coronary care and surgical units. The CALD nurses accounts (where presented) are presented as spoken and therefore reflect evidence of the use of English as a second language.

LITERATURE REVIEW

Nurse Migration

International nurse migration is an established feature of the global market (Brush and Sochalski, 2007). Williams and Balaz (2008 p.1925) point out there are well structured and asymmetrical channels for mobility that bring health care workers from 'less' to 'more' developed health care systems; amongst them discourses about the location of advanced knowledge. This according to these authors strongly mediates resulting knowledge transactions with those arriving in developed health systems seen as coming to learn rather than co-learn. However, according to Williams et al (2008) the transfer of knowledge via mobility is not an unfettered learning and knowledge transaction; but, is mediated by a range of factors including institutions and practices.

Examples of this as it applies to CALD nurses have been found in international and Australian literature; for example Obrey and Shillingford 2011; O'Brien and Ackroyd 2011; Nichols and Campbell 2010; Deegan and Simkin 2010; Deegan 2008; Hancock 2008; Allan 2007; O'Brien 2007; found that although CALD nurses recruited are highly trained and proficient in knowledge and technical skills, organisational and attitudinal barriers exist that marginalise the nurses and devalue their skills, leading to disempowerment and dissatisfaction with nursing in host nations where they have little if any input in clinical decision making processes (Smith et al 2011).

Clinical Reasoning

A nurses' ability to recognise changes in the patient's physical condition is crucial as they have meaningful interactions with patients, frequently and for longer than any other health professional; and are therefore, likely to be the first link in the causal chain between the recognition of complications and the commencement of corrective interventions (Gregory 2011; Levett-Jones et al 2010). Cue collection is the fundamental basis for clinical reasoning. That is, available patient information e.g. hand-over reports, patient history, charts, results of investigations, previous nursing and medical assessments, current clinical assessment data psychological and physical; and, knowledge recall i.e. understanding of physiology, pathophysiology, pharmacology, context of care, ethics and law. However, prejudices, stereotypes, assumptions and routines, particularly in relation to elderly patients with multiple co-morbidities and frequent admissions can impact on the type and range of cues collected. In exploring the influence of different care environments on nurses decision making Armstrong et al (1989); McCarthy (2003) and Higgins et al (2007) found that, nurses' perspectives on health and ageing ultimately shaped their reasoning pathway and how they dealt with the elderly in clinical situations; with acute care settings being least conducive to effective reasoning by nurses in relation to the elderly. The following quote from an experienced Indian nurse sheds some light on her concerns regarding the apparent clinical reasoning associated with the imposition of the hygiene routine on an elderly patient in an acute care setting:

> *Showering the patient most of them before they make any other assessment [sic], like if the hands are very warm and bluish or very cold and bluish, and the patient say I don't want to have a shower; they say, you will feel better when you have a shower. They will insist on taking the patient to the shower without assessing why the patient is complaining, or if the patient had the same yesterday. Yesterday she may be ready for a shower and today she may be more-weak [sic]. Angeline, PG10 Ln2*

It is noted by Thompson (2003) that reliance on the phenomenon of hind-sight bias can lead clinicians to change the relative importance of influences that their judgement tells them are responsible for an event. In other words, when confronted with a priori knowledge they attempt to make sense of what they know has happened in the past, rather than working with objective data at a given time. It may be that this phenomenon could; in part at least, be responsible for the argument 'you'll feel better after you have a shower', as distinct from basing the decision for action on definitive physiological parameters in order to recognise deviations that should be addressed promptly to promote optimal patient outcomes, and avoid the potential for ethico-legal implications associated with duty of care.

According to Rytterstrom et al (2010 p.3513) routine can be viewed as a cultural activity. In a study involving qualified pool nurses Rytterstrom et al (2010) found that routines are experienced by new staff as: pragmatic, obstructive and meaningful. Pragmatic routines ensure that daily working life works, based on rational arguments and obvious intentions. Obstructive routines however, had negative consequences and were described as "nursing losing its' humanity and violating patients integrity". Examples of such routines were cited as routines associated with washing and dressing patients, and when other forms of care took place without reflection, this was viewed as potentially dangerous lacking in purpose and offensive to patients.

Meaningful routines on the other hand, involved nurses becoming one with the routine, when it felt right and meaningful to adapt to it. For example routines that did not involve direct patient care, but were helpful in terms of organising work. For regular ward staff obstructive routines were often unconscious. However, for new staff obstructive routines lead to an inner conflict between doing the right thing; i.e. "following routine and ignoring the suffering patient, under the protection of the routine" (Rytterstrom et al 2010 p.3519). Rytterstrom et al note that organisational routines are not developed from a caring perspective. Rather they are frequently focused on task completion.

The following comments were provided by nurses from the Philippines and China:

> *The time for patient management is different because nurses are worried to finish their showering and their bed-making these things can be done by a nurses' aid, and sometimes the quality of care was [sic] being at stake because you have to do the beds and the showering everything.* Leesa, PG5: Ln3

Some CALD nurses expressed concern about not being able to contribute to decision making as they would like to as evidenced from the following quote from a nurse from the Czechoslovakia Socialist Republic:

> *Sometimes you think it's not right, and you get the feeling as a nurse that you would do that different, but still haven't got your registration so....* Deanne, PG4: Ln 6

Ethical Principlism

Ethical Principles are general standards of conduct that make up an ethical system i.e. a behaviour guide. The principles most commonly used are those of beneficience, non-malificence, autonomy and justice (Johnstone 2004 p.37). In this case it appears that the ethical principal of autonomy was violated in terms of the right to refuse intervention. This according to Johnstone (2004 p.38) "requires the nurse to respect patients as dignified human beings capable of deciding wh at is in their best interest".

The potential for harm in this case appears be the nurse's failure to carry out a clinical assessment on the patient to ascertain her fitness to undergo the hygiene routine; an omission that could lead to serious consequences in terms of health outcomes for the individual patient. Angeline's concern then, with enforcement of the shower routine has potentially two significant implications for professional practice. Firstly, professional judgement based on clinical evidence or, duty of care, (Staunton and Chiarella 2003); and secondly, it seems two elements of ethical principlism were called into question: autonomy and non-maleficence. Whilst the nurse's assurance that 'you will feel better after a shower' may well have an air of beneficence (Staunton and Chiarella 2003 p.29) point out that the duty to do no harm is greater than the duty to do good.

DISCUSSION AND IMPLICATIONS

Clinical reasoning is an essential component of competence, and since the 1980s various attempts have been made to organise nurses' work in a way that promotes a professional patient relationship rather than the model of the assembly line associated with task allocation (Procter 1989 p.181). Consequently, the current position in nursing practice and education appears to favour a distance from "ritual" on the basis that it is irrational and unscientific (Philpin 2002 p.114). Nonetheless, it is appears that some strong elements of routine and ritual remain embedded in the action that Angeline describes.

Some CALD nurses in the study reported in this paper expressed concerns regarding what they perceived as questionable processes around the clinical decision making utilised by local nurses, and their own lack of autonomy to influence clinical decisions. In part the concerns expressed by CALD nurses may arise from divergent views of what constitutes the role of the registered nurse and how that role is executed in the acute care clinical environment. Such views are grounded in their professional culture and shape their expectations on the transferability of their knowledge and skills to clinical practice in Australia. However, many practices that CALD nurses encounter on clinical placement in Australia, are in fact cultural (McAllister et al 2007); and, culture patterns rely on unquestioned recipes, that have to be followed although they may not be fully understood (Rytterstrom et al 2010). Many examples of why nurses resort to routines in practice are evident in professional literature with the practice being viewed as both useful and obstructive. However, one of the more alarming reasons cited by Rytterstrom et al (2010) and Philpin (2002) is the routine as a protective mechanism for nurses in situations of perceived difficulty. Examples of such difficulty were found by Rytterstrom

et al with a participant indicating that to finish the routine work often removed the need to stop and see what the patient really wants, instead blaming the need to complete routine tasks. The decision was however, viewed as a matter of conscience with routines that violated the patients integrity viewed as wrong.

It is acknowledged that expert nurses may appear to carry out interventions in a way that is almost automatic and instinctive and sometimes find it difficult to explain the congnitive processes involved (Levett-Jones et al 2010). However, nurses need to make explicit their decision making processes particularly when supervising students or less experienced staff, as there is more to education than making people aware of routines and rituals (Rytterstrom et al 2010), and explaining an action can assist nurses to reflect on their own practice.

This is important in the case of CALD nurses in particular, as they will be unfamiliar with the context of care and may have difficulty interpreting cultural cues. As noted by Rytterstrom et al (2010) routine is meaningful only when nurses recognise a cultural pattern that is in harmony with their own interpretation scheme. Since many international nurses are accustomed to more automomous roles in community based health services in their countries of origin (Smith et al 2011) adapting to, what seems to them, unreflected routine is difficult. Finally, it is noted by Henderson et al (2011 p.26) the provision of quality care is sustained through systematic continuous teaching and learning integrated with care delivery and supervison of CALD nurses providing an ideal platform for nurses to share knowledge and ideas; to co-learn, as knowledge sharing, problem-solving and reflection have been found to validate and extend practice and enhance patient care (Henderson et al 2011).

RECOMMENDATIONS

- Education that is focused on the maintenance and development of clinical knowledge should be a regular feature of staff development in all health care organisations with a particular focus on clinical assessment to support decision making.

- This could be enhanced through collaborative processes between large public health care providers and the private sector within geographical clusters to maximise the use of educational resources such as simulated learning and expert facilitation of learning activities.

LIMITATIONS

This paper was inspired by concerns expressed by a small group of CALD nurses, and is therefore not sufficient to draw generalisations around how widespread routine practices are in the health system more generally. Similarly, there is not sufficient understanding of all the contextual factors, and processes that may have impacted on the specific care decisions mentioned. Nonetheless, it can serve to remind nurses of the importance of basing clinical decisions on accurate and up-to-date clinical data and ethical principlism rather than routine imperatives. Furthermore, it could possibly serve as a basis for research into the phenomenon of ritual and the factors that drive and sustain it in the working lives of nurses, particularly in relation to clinical decision making.

CONCLUSION

The views of nurses from other systems can provide a point of discussion and reflection around the basis for current clinical decision making processes in Australia. This is because when nurses evaluate a routine as useful they are evaluating their own reason for thinking it is good or bad. In situations where all nurses are expected to act in accordance with an established cultural pattern a more reflective approach to clinical practice is called for, because competent professional practice requires complex thinking processes and rigorous application of knowledge and skill.

Whilst some routines are useful for the purpose of organising work, routines that compromise patient safety and autonomy are to be discouraged, and replaced with individual assessment, and the use of professional knowledge and judgement to recognise deviations in the patient's clinical status and balance the concepts of beneficence and non-maleficence to guide appropriate nursing interventions.

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