Reflective essay on clinical decision making

Clinical decision making in nursing involves applying critical thinking skills to select the best available evidence based option to control risks and address patients' needs in the provision of high quality care that nurses are accountable for. – Standing, M. (2011)

Nurses are accountable for the quality, safety and effectiveness of their clinical decision making. We are accountable to the patients, clients and service users to whom we owe a duty of care. According to Standing, M. (2011), accountability in decision making is being answerable to patients, the public, employers, NMC and the law for the consequences of our actions and having to explain, justify, and defend our decisions.

The Nursing and Midwifery Council (NMC, 2008) states that nurses are personally accountable for their actions during practice and therefore they must be able to justify their decisions at all time. Nurses have to balance a number of elements before they make a decision, however the patient's best interest is their main priority.

Decision making involves assessing available options and their effectiveness. It applies judgement regarding our reasons for doing or not doing things. As nurses, we use different information sources to support our judgement and decision making.

Nursing is the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life whatever their disease or disability, until death. (Royal College of Nursing, 2003)

Decision making requires thinking skills to exercise judgement in assessing the benefits of available options and choosing a preferred option that is then acted upon. Judgement is not decision making but is closely related. Decision making links judgement to practice by acting on it in choosing from the options available. There are different models of decision making in nursing developed to help nurses make their decision on all aspects of nursing care and I decided to focus on risk analysis and management and evidence based decision making.

Clinical practice is often concerned with risk reduction and with the developing trend in healthcare litigation, there is a big emphasis on risk management for both the patients and health care staffs. Clinical risk management will fundamentally happen through the interpretation and application of agreed individual care plans. The development of a comprehensive and individualised care plan will relate to the broad range of effective treatment, rehabilitation and support services provided at the current level of clinical knowledge (Morgan, S., 1998).

Risk assessment is a process of identifying and investigating factors associated with the increased probability of specified risk occurring. It is an examination of the context and details of past risk incidents in the light of current circumstances. It is also concerned with the patterns of circumstances in which these factors may arise.

A nurse may assess a patient as at risk of developing pressure sores, and then implement measures to try and reduced the likelihood of this event occurring by providing equipment such as specialist mattress.

Risk assessment is a continuous process in which nurses gather information from multiple sources and other health care professionals with the focus of identifying the factors that is associated with the increased probability of risk happening. It is the foundation on which decisions are made and risks plans are then formulated through available national and local policies and procedures (Morgan, S., 1998). According to Lipsedge (1995), good practice in risk assessment requires nurses to translate their knowledge into a clearly distinct formulation of the risks. The formulation should ideally reflect aspects of each individual, context and systems that may influence the potential for risks.

The primary aim of pressure ulcer risk assessment tool is to help nurses identify individuals at risk of pressure ulcers and determine the degree of risk (Shakespeare 1994). Formal pressure ulcer risk assessment involves the use of a tool that assists in identifying those patients likely to develop a pressure ulcer.

According to Guy, H. (2007), risk assessment on pressure ulcer requires multifactorial consideration. Risk-assessment tools are a useful signpost to risk factors but must not be used in isolation to identify risk. It is important to carry out a care plan once the patient is identified to be at risk of developing a pressure sore so that occurrence of pressure damage can be prevented.

Most nurses are familiar with the use of pressure sore risk assessment tools such as the Braden or Waterlow scales. These tools collect data regarding various factors thought to be associated with the development of pressure sores. There is normally some form of scoring system which shows the

probability of the pressure sore occurring. For example, if a patient scores 15 or over on the Waterlow scale, the individual may be considered at risk of developing pressure sores and therefore the nurses will have to maintain a pressure ulcer prevention (PUP) bundle in order to keep track of the patient's condition. According to Waterlow (1985), recommended care interventions are available with each recommendation corresponding to the risk score parameters of the Waterlow scale.

The Waterlow scale is mostly used in adult field of nursing. It can also be used with hospitalised mental health and learning disability patients. However, the Waterlow scale is specifically designed for adults and therefore it is not appropriate to be use on children. Paediatrics use a different pressure ulcer risk assessment tool called the Glamorgan scale (Willock, J. et al, 2007).

No risk assessment tool can be 100% accurate. The key issue in examining risk assessment tools is how good they are at distinguishing those at risk from those who are not and if they are better or more accurate than simply relying on professional judgement (Thompson, C. & Dowding, D., 2002). When considering risk assessment and risk reduction, it is important that the initial assessment of risk is accurate.

Evidence refers to information that is used to support particular beliefs, decisions and actions. Evidence-based decision making is a prescriptive approach to making choices based on ideas of how research and theory can be used to improve decision making in regards to delivery and quality of patient care. According to Nursing and Midwifery Council (2008a, p. 7),

nurses are now required to use evidence based practice. For example, nurses must deliver care based on the best available evidence or practice and must ensure any advice given to patients are evidence based.

Sackett el al (1996) defines evidence base practice as “ the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient by incorporating individual clinical expertise with the best available external clinical evidence from a systematic research.” This means that one solution will not be the same for all clinical scenarios and it is the nurse’s role to identify the research that best fits the clinical situation.

According to McKibbon (1998):

“ Evidence based practice is an approach to health care wherein health professionals use the best evidence possible, i. e. the most appropriate information available to make clinical decisions for individual patients. Evidence based practice values, enhances and builds on clinical expertise, knowledge of disease mechanisms, and pathophysiology. It involves complex and conscientious decision making based not only on the available evidence but also on patient characteristics, situations and preferences. It recognises that health care is individualised and ever changing and involves uncertainties and probabilities. Ultimately, Evidence base practice is the formalisation of the care process that the best clinicians have practiced for generations.”

McKibbon (1998) recognises the importance of the patient when making decisions about their own care. According to Reigle, Steven, Belcher et al

(2008) and Talsma, Grady, Feetham, et al (2008), the reason why evidence based practice is consistently implemented is because it leads to the highest quality of care and best patient outcomes. It involves combining the knowledge of an expert, patient preferences and research evidence within the context of available resources. Also, studies by McGuinty and Anderson (2008) and Williams (2004) showed that evidence based practice has reduced healthcare costs and geographic variation in delivery of care.

“ Integrating research evidence into decision making involves forming a focused clinical question in response to a recognised information need, searching for the most appropriate evidence to meet that need, critically appraising the retrieved evidence, incorporating the evidence into a strategy for action, and evaluating the effects of any decisions and actions taken.” – Thompson et al (2004)

One of the tools used in evidence based practice is the use of the early warning score system (EWS). EWS were developed to assist health care professionals detect if patients are deteriorating. It is based on physiological parameters taken when recording patient observation e. g. the patient’s heart rate, respiratory rate, temperature, oxygen saturations and systolic blood pressure. The EWS is designed for adults and can also be use with mental health and learning disability patients. However, due to children and adults different physiological responses, EWS is inappropriate to use on children. Alternatively, Paediatric Early Warning Scores (PEWS) is use for children, to record observations and is use to assess the child’s condition i. e. If the child’s score is high then this means he/she is at risk of deteriorating, this gives nurses an early indication that an action has to be done.

The use of early warning score (EWS) is the best practice for clinical observations (Department of Health, 2000), and this is backed up by NCEPOD (2005) who emphasised that every in-patient should have a EWS recorded. Accurate and timely observations and adherence to EWS is essential in order to recognise patients who are at risk of deterioration.

According to NICE (2007), nurses caring for patients in acute hospital settings should be skilled in monitoring, measuring, and interpreting data and have prompt response to the acutely ill patient and they should be assessed in order to demonstrate their competency. Early intervention can help prevent patient’s condition from deteriorating which then helps avoid the need to transfer the patient to a higher level of care.

However, despite the good outcome of using evidence based practice in decision making with regards to patient care, there are issues such as nurses do not always make their decision based on available evidence due to lack of skills i. e. poor IT skills, lack of research skills and literature. There are also misconceptions that traditional ways is the best way, or that gathering evidence is too difficult and time consuming. Becoming skilled in clinical decision making requires the application of a range of evidence regarding patient concern, physical and human resources within healthcare contexts, understanding health and illnesses, developing expertise in applying therapeutic approaches, a commitment to enhance the wellbeing of those in your care and fulfilling the requirements of the relevant professional body.

Overall, as nurses, it is important to have a basis when we make a decision regarding patient care. Risk is integral to nursing and the assessment of risk

is one of the most common judgements nurses make. Each decision making model requires certain set of skills in order to be put on proper use and get the right results. Nurses are expected to use valid evidence to support their decisions when deciding what care to provide each patient. It is also important that nurses use their resources cost effectively by ensuring that resources and equipment are used correctly by the patient. Sometimes it is difficult for the nurse to come to a decision that will satisfy clients and co-workers and they also may be challenged at any time, however the important thing is that the nurse takes full responsibility and is able to justify his/her decision. Making the wrong clinical decision is not only harmful to patients but can also damage a nurse’s career. Learning about developing and applying effective clinical decision making skills is vital for the wellbeing of patients and nurses’ capacity to demonstrate that decisions are justified.