



ROLE OF SHARED DECISION MAKING AND CDM ABILITY AMONG NURSES CHOICES FOR ELECTIVE SURGICAL CARE: A STUDY

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Abstract

Shared decision making (SDM), an integrative patient-provider communication process emphasizing discussion of scientific evidence and patient/family values, may improve quality care delivery, promote evidence-based practice, and reduce overuse of surgical care. Little is known, however, regarding SDM in elective surgical practice. Clinical decision-making (CDM) is a process used by nurses on a regular basis when making decisions on patient care and management problems. When nurses become more seasoned as care professionals, the decision-making process becomes more intricate. CDM is a dynamic practise that needs health care practitioners to be informed about the relevant aspects of nursing, to have access to reliable information sources and sufficient networks for patient care, and to operate in a supportive setting. The purpose of this systematic study is to synthesize findings of studies evaluating use and outcomes of SDM and CDM ability among nurses in selected Delhi hospitals in elective surgery.

1. OVERVIEW

The SDM process offers patients an opportunity to take more advantage of patient values and prospects, so they feel as if they are the best choice of treatment, whether conservative or surgical. The SDM process is the best method of treatment. The apparent benefits of SDM are summarized in this research.SDM means a mechanism of contact with the provider that shares all applicable risk, benefits, and alternative therapies. The patient has all the desires and beliefs concerning his/her choices. In combination with the use of patient action supports, SDM is widely used.

Quality patient decision-making aids are intended to give the patient information so that they can understand their decisions, understand the costs, benefits and alternatives to the care recommended, and encourage them to make a decision compatible with their beliefs and desires in consultation with their provider.



Informed Consent vs. Serious Decision-making

The informed process of consent entails discussion of risks, benefits, and alternatives. Many surgeons create their discussion points to explain the specific risks of surgery for the pre-op visit, including written content, or, indeed, digital media, for education and incorporate the complications to illustrate surgery and post-op recovery. In general, legal guidelines for doctors require a “reasonably cautious physician” to accept reporting risks, advantages, and alternatives under the same or similar circumstances. Informed consent should include “fair patient” knowledge in similar cases from the patient’s viewpoint.

However, in many cases, informed consent is a signature on a meaningless small print booklet rather than a real educational process. How often does a doctor ever mention carpal tunnel death as a possible risk? However, the default consent form for the operating theater also lists death. In comparison, SDM goes beyond passive information sharing to set up a bidirectional information exchange mechanism. SDM was declared the pinnacle of treatment as a resource for patient-centric care[1,2].

The provider offers information about the costs, benefits, and alternatives to planned care to the patient in the same way as informed consent. It goes beyond eliciting the patient’s beliefs and desires.

Implementing SDM in Surgical Practice

SDM has the most significant impact on care sensitive to preference. Choices include conservatory options for surgery, such as coronary artery bypass grafting or early-stage breast and localized prostate cancer treatment[3]. Increased patient participation in the process of decision-making led to greater satisfaction with the outcomes of these procedures.

The cost-effectiveness of phone support with qualified health professionals participating in the project was cost-effective [4]. After receiving the decision aid, a health trainer was provided with studies on hip and knee arthritis, which indicated that the operation patients used this office visit more efficiently.

A primary-care study, including back pain decision aids and orthopedic procedures, found patients receptive to intermediate-level providers to provide decision-making assistance. Just 35% of radiation oncologists and urologists in prostate cancer say that decision aid is used to address this. The provision of a structured SDM in the primary care services office or after an operation has been performed may improve office efficiency by giving the patient decision-making support during a visit.



SDM as a Tool to Lower Liability Risk

The maxime ‘nobody ever speaks to a patient’ has been known by most surgeons. A patient who feels “conversed” about the procedure is far less willing to undergo surgery, with a poor result. Classic doctor’s documentation on risks, benefits, and alternatives for treatment and surgery was informed consent. The improvements in SDM provide a better understanding of risks and benefits for the patient and thereby decrease frustration with adverse effects.

The therapeutic alliance is strengthened and protected in the medical, legal context by using the patients ‘ personal preferences to harmonize these values and preferences with treatment decisions[5]. Bad provisional communication and inadequate patient awareness is also a precursor to assertions of professional liability. The results of a structured SDM ligation procedure have been studied.

Risk Factors for Ischaemic Heart Disease

- Obesity
- Hyperlipidaemia
- Hypertension
- Diabetes
- Smoking

Physical Examination

Assessment concentrates on detecting signs of: heart failure (raised jugular venous pressure, cardiomegaly, gallop rhythm, basal lung crepitations, hepatomegaly and dependent oedema); significant murmurs, especially those of aortic stenosis and mitral stenosis or regurgitation; hypertension; arrhythmias and conduction defects; and carotid artery stenosis.

2. SHARED DECISION MAKING AND CHOICE FOR ELECTIVE SURGICAL CARE

Shared decision-making (SDM) is a collective mechanism in which patients and suppliers work together to find a care plan that is mutually agreed upon. By encouraging the participation of patients in their own treatment, SDM can decrease the indiscriminate use of medical interventions and unnecessary variation in care[6].

Primary components of the SDM process include the creation and expression of patients ‘ personal beliefs as well as care priorities and expectations, the exchange of clinical context and medical evidence information by the clinicians, and a shared dialogue to make a collective decision based on evidence and consistent with best practises. The practise can be streamlined



by the use of decision-making aid, which is a method (e.g. video-disc, booklet) that educates patients, enhances their comprehension of the risks and advantages of treatment choices, and offers proof of their condition factors. Many decision aids often provide some kind of explanation of patient values, which is one of the features that differentiates these devices from traditional educational materials[7].

While SDM's objectives are widely applicable across health conditions, SDM may be an especially important strategy for elective treatment decisions[8], or 'preference-sensitive.' A preference-sensitive decision is one in which there is a lack of strong empirical evidence that indicates one treatment 's superiority, and treatment options differ in ways that may be important to patients. In such cases, surgery may be prescribed, rather than patient expectations, according to local guidelines or practise trends, leading to overuse or improper surgical use[9]. It has been demonstrated that SDM decreases these patient reactions[10]. In turn, contributors to unwarranted variance, such as surgeon choice, financial rewards, and local practise trends, can be addressed by applying SDM and consciously engaging patients in the decision by eliciting their expectations and values, and the standard of care can be enhanced. SDM is seen as a possible option for improving the quality of treatment[11] and surgical care guideline-based practice. SDM has also been celebrated and adopted around the world into health policy and clinical practise programmes. The Patient Safety and Affordable Care Act alone in the United States identifies and recommends SDM as one tool by the newly formed Center for Medicare and Medicaid Innovation[12] to reform health care delivery and payment. In addition, through legislation, pilot programmes, or incorporation into requirements set by alternative payment mechanisms (e.g. accountable care organizations)[13], some states have incorporated SDM and decision support tools into policy.

3. A STUDY FROM DELHI HOSPITALS

This Figure 1 and survey research explain the Standard decision-making SDM processes using better decision aid, 58 respondents strongly agree, 71 respondents are agree, 39 respondents are disagree and 32 respondents are strongly disagree.

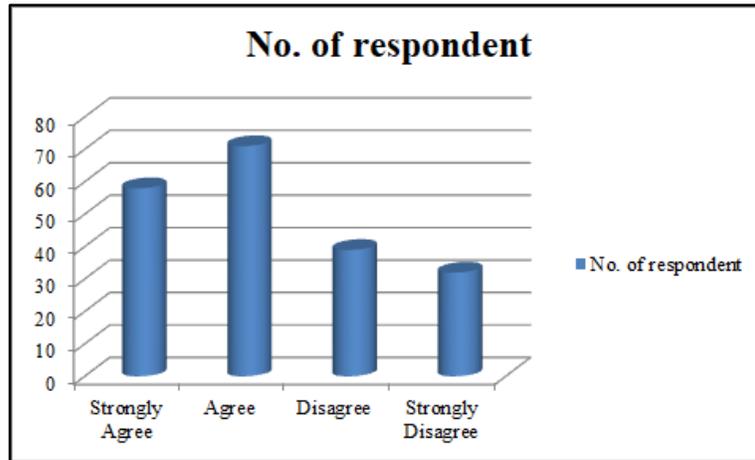


Figure 1: Standard Decision-Making SDM Process Using Decision Aid

This Figure 2 and survey research explain about that who have a good knowledge (e.g; Male and female doctors 42 respondents strongly agree, 51 respondents are agree, 58 respondents are disagree and 49 respondents are strongly disagree.

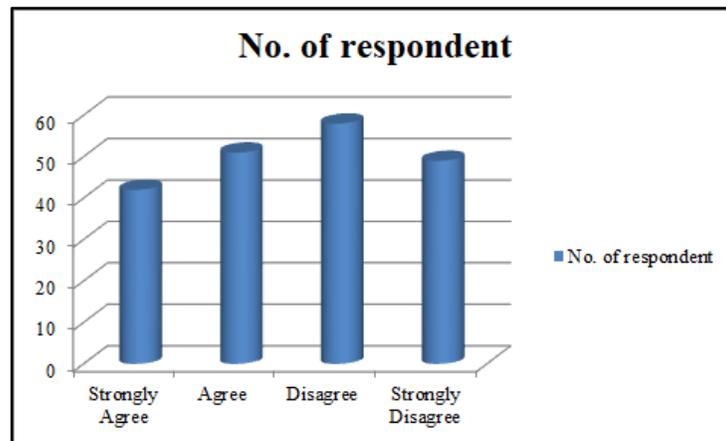


Figure 2: Male Gives Good Decision Maker Rather Than Female Doctors

This Figure 3 and survey research explain the Consuming Effort To Improve The Patient Decision-Making Process 53 respondents strongly agree, 64 respondents are agree, 45 respondents are disagree and 38 respondents are strongly disagree.

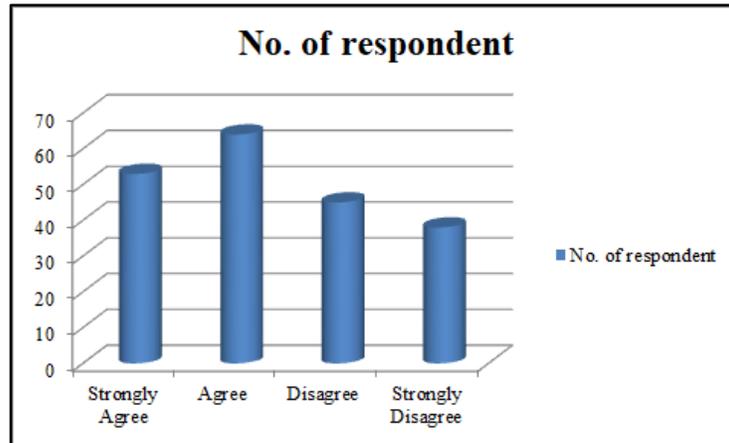


Figure 3: As a Process, It Was Seen As a Time-Consuming Effort to Improve the Patient Decision-Making Process

This Figure 4 and survey research explain the Increased patient participation in the process of decision-making led to greater satisfaction with the outcomes of these procedures, 57 respondents strongly agree, 68 respondents are agree, 41 respondents are disagree and 34 respondents are strongly disagree.

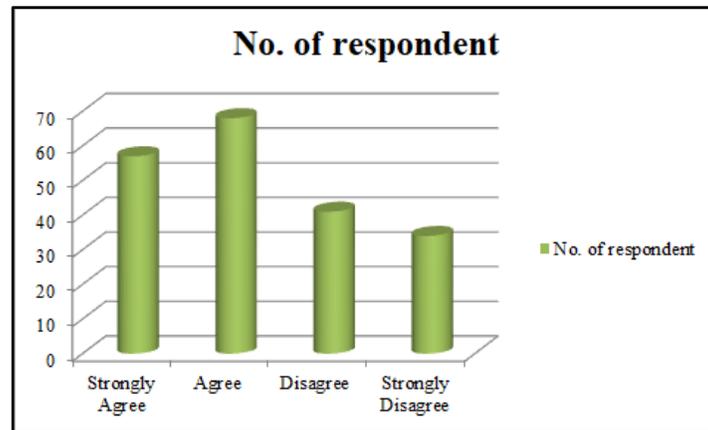


Figure 4: Increased patient participation in the process of decision-making led to greater satisfaction with the outcomes of these procedures

This Figure 5 and survey research explain the improvements in SDM provide a better understanding of risks and benefits for the patient, 56 respondents strongly agree, 67 respondents are agree, 41 respondents are disagree and 36 respondents are strongly disagree.

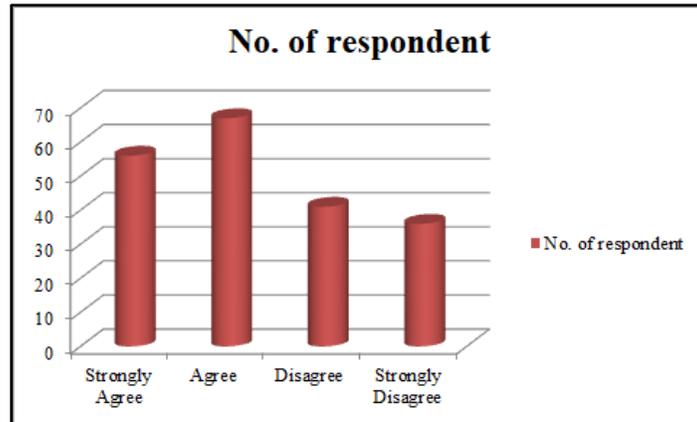


Figure 5: The improvements in SDM provide a better understanding of risks and benefits for the patient

4. CDM ABILITY AMONG NURSES

It refers to awareness and skills among nurses implementing CDMR-POPM in practise in this report. It is calculated by integrating information and ability scores, calculated by reflection of case studies, to classify the signs, judgments, decisions and assessments. Nurses are also observed specifically during pain management while providing care to post-operative patients.

When nurses become more seasoned as care professionals, the decision-making process becomes more intricate. CDM is a dynamic practise that needs health care practitioners to be informed about the relevant aspects of nursing, to have access to reliable information sources and sufficient networks for patient care, and to operate in a supportive setting. The abilities of the nurse as independent clinical decision makers are decided by the education and training programmes that concentrate and educate the graduating nurse on the analytical and cognitive skills to process complex information and make decisions.

As a part of clinical practise, nurses have to arrive at decisions by gathering data, evaluating information, judge and execute strategies and evaluate for resolution of issue. Clinical judgement and cognitive psychology has shown that just recall from experience, as the sole basis for clinical decisionmaking which adversely affects outcomes of judgement. A successful CDM should be from an evidence based viewpoint, which requires technical experience, available resources, patient's values and research knowledge.

Changes in the provision of health care and care have challenged nurse educators to develop strategies to train nurses for advanced nursing practise alongside academically diverse health care practitioners. Given the increased complexities of health care, CDM skills are critical to



safe client care. The evidence-based culture embarking on the health care scenario has made the creation of a research-driven workforce mandatory for nursing. Therefore, nurses have to be reliable decision-makers with technical accountability and field specialisation requirements. Since clinical decision-making in nursing is important in all areas, a nurse must gain first-hand CDM expertise in the respective fields in which she works, such as cancer, pain, surgery, critical care disease, emergency and advanced nursing, etc.

One such arena for surgery is pain management, where nurses need to play a key role in making pain recognition decisions and delivering decisive treatments. Pain includes a dynamic phenomenon involving interconnecting physical, psychological, social, cultural, and environmental variables that influence how pain is experienced, handled, and assessed.

In pain management, nurses recognise common clinical decisions related to pain, challenges to providing optimal pain relief and ethical/professional disputes. Popular pain-related decisions are the severity of pain, when drugs should be given, and the choice of analgesics.

For patients and health practitioners, pain is a personal experience and is affected by the context in which it happens. The context includes type and nature of pain, root cause, coordination of treatment, prioritisation of work tasks, time constraints and demands during a working shift and incorporation of knowledge to make professional decisions on how to treat pain all influence such contact.

5. CONCLUSION

In hospitals, a large proportion of the antibiotics administered are for surgical patients. Inappropriate prescription of antibiotics in surgery is widely reported, with patients at risk of receiving prolonged antibiotic durations for prophylactic and therapeutic indications. In addition, one of the most common and expensive hospital-acquired infections remains postoperative infections and is associated with significant morbidity and mortality. The prescription of antibiotics in hospitals remains suboptimal, despite various interventions.

Antibiotic prescribing research in surgical teams aims to concentrate mainly on strengthening operating room (OR) surgical prophylaxis and reducing surgical site infections (SSI). Unlike primary care, where clinical intervention happens primarily within 1: 1 patient-physician appointments, many teams of healthcare practitioners conduct most of the clinical procedures for a patient in secondary care.

There is also a need for our teachers to be trained with decision-making skills to develop the abilities of students in order to close this void. In the field of nurses' CDM, there is a large literature that indicates a broad gap. But there is a lack of evidence to suggest that a specific technique can be used to improve decision-making capacity. Therefore, all careers are haunted



by new technologies and challenges, particularly health care providers, which include nurses and nurse educators. Researchers who have explored the decision-making of nurses have found that decision-making is a acquired ability that educators must teach.

This ‘joint decision-making’ inside and across teams can lead to practise gaps and reveal areas of communication vulnerability. Surgical checklists such as the Surgical Safety Checklist of the World Health Organization have been introduced to ensure that key care elements are not missed, including prescribing antibiotic prophylaxis. Recent researches on the application of the WHO checklist, however, have shown that the use of this simple intervention is suboptimal. Although interventions have been developed to improve the efficacy of surgical teams and their use of tools to improve quality and safety, there is still a research gap.

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