Clinical decision making amongst domiciliary community matrons: an observational study

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Objectives of the Study

• To map level descriptors for DCMs decision making against five levels of expertise namely; novice, advanced beginner, competent, proficient and expert

• To identify the levels at which DCMs operate within different clinical contexts

• To compare and contrast variations in decision making levels amongst DCMs

• To identify factors that facilitate DCMs in operating at the expert practitioner level

• To identify barriers that prevent DCMs from operating at the expert practitioner level
Background

- The NHS improvement plan (DH, 2004) introduced the community matron as a new type of practitioner who is highly skilled and a specialist in community care and inter-agency working.

- Role designed to support new ways of working with the aim of reducing unplanned hospital admissions and supporting vulnerable people, particularly those with long term conditions within communities.

- CM's are highly experienced senior nurses who work to provide, plan and organise care for patients who have long term or complex conditions. These are often conditions which cannot be cured but can be managed via the appropriate care from the CM. CM intervention, which involves advanced nursing practice, normally takes place within a domiciliary setting allowing patients to stay independent and preventing unnecessary hospital admissions.

- In the study Primary Care Trust (PCT) there are two categories of matrons:
  - DCMs
  - Care homes

- 34 DCMs working in the PCT
- the activities that DCMs engage in are guided by a service specification but little known about the clinical decision making processes that they use in the course of their work.
- Assumed that DCMs perform at an expert level, but limited evidence available to confirm this assumption.

- The study set out to uncover the level of expertise at which DCMs are operating when making clinical decisions and to outline factors which facilitate and hinder DCMs in performing at an expert level.
Methodology

• A structured observation of DCMs whilst they engaged patient related activities.
• The level of decision making graded against pre-defined descriptors and a generic scoring system, following Benner’s novice to expert continuum.
• Semi structured interview following each episode to explore basis of decisions
• Approval was gained from NHS research ethics committee and from the PCT R&D to undertake the study.
<table>
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<tr>
<th>Activity</th>
<th>Definition</th>
<th>Novice</th>
<th>Advanced Beginner</th>
<th>Competent</th>
<th>Proficient</th>
<th>Expert</th>
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<td>Urgent Intervention</td>
<td>Urgent interventions are those necessary in episodes that are immediately detrimental to the patient’s health and well being. They include acute clinical deteriorations which require the application of communication, clinical and professional skills to expedite urgent management or appropriate referral.</td>
<td>Recognises and orchestrates urgent referral using protocols and procedures to validate decision. Relies on seniors or members of the MDT for further advice and guidance. Initiates call to emergency services for immediate hospital transfer if required.</td>
<td>Able to apply support interventions and is able to anticipate likely sequelae of condition. Rapidly involves seniors or other MDT members to confirm that correct decisions have been made and correct information given. Initiates call to emergency services for immediate hospital transfer if required.</td>
<td>Operates within the appropriate protocols and procedures. Able to initiate immediate supportive interventions to stabilise the patient’s condition. Evaluates effectiveness of interventions. Involves seniors/other members of MDT only when has cause for concern. Initiates call to emergency services for immediate hospital transfer if required, providing detailed handover documentation.</td>
<td>Very experienced, knowledgeable, reflective practitioner operating within appropriate protocols and procedures. Responds to complexity and instability based upon experience knowledge and evidence. Initiates call to emergency services for immediate hospital transfer if required, providing detailed handover documentation.</td>
<td>Independently orchestrates and manages all elements of urgent interventions. Operates autonomously at a level commensurate with an advanced practitioner.</td>
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Recruitment

- Contact details of 26 DCMs passed on to research team
- Aim to recruit 12
- Of the 26 approached only 7 were willing to participate.
Data Collection and Analysis

- Field notes were produced as a written document and scores assigned based on the activity descriptors.
- Interviews were transcribed verbatim.
- Data analysis involved a framework analysis Approach (Ritchie and Spencer 1994).
- A five stage process
  - familiarisation with the data
  - generation of a thematic framework,
  - indexing of all transcripts
  - charting data and mapping data extracts to the framework,
  - followed by a process of interpretation.
Results

• 18 episodes of observation were completed with 7 DCMs
• 6 DCMs had all been in post for four years or more, 1 for 9 months
• Had been qualified as nurses for between 13 years and 42 years
• All had completed a post graduate programme of study relevant to their role
• All but 1 held a prescribing qualification, 1 was currently studying towards this.
• Of the 18 episodes of care that were observed, DCMs were rated as ‘expert’ practitioners on 12 occasions and ‘proficient’ practitioners on 6 occasions.
• Two main themes relating to decision making emerged from the data, each characterised by a number of distinctive categories
Figure 1: Category Tree

- **Decision Making**
  - Individual Factors
    - Disease Complexity
    - Patient & Family
    - Family Support
    - Empowerment
    - Understanding
    - Concordance
  - Organisational Factors
    - Primary Care
    - Secondary Care
    - Teamwork
    - Evidence base
    - Community Matron
    - Confidence
    - Clinical Skills
    - Medicine Management & Prescribing

- Avoidance of Admissions

Individual Factors - patients and family

- Complexity of disease
  - He’s also in stage four renal failure and that complicates medication and things….so we had to reduce his ACE inhibitors (DCM 4 interview)

- Compliance and concordance
  - The other big thing is that she’s taking her medication and that she’s complying with her medication because she does do her own thing and she either overdoses on stuff and takes stuff every hour or she doesn’t take it at all........She does things like she’ll take 10 Senokot and then wonder why she doesn’t feel well (DCM 7 interview)
  - We’ve had some concerns about her renal functions but she’s actually added in Voltarol herself over the counter and that could be the problem (DCM 2 interview)

- Understanding of condition

- Empowerment
  - ...the Community Matron allowed the patient to express his fears and to explore options available to him. Agreements on hospice care and end of life decisions were made by the patient and not for the patient (DCM 3 field notes)

- Family

- Therapeutic relationship
  - I think because I actually know her so well, You know I’ve known her for over a year now, I know when she’s deteriorating and when she’s not deteriorating, when she’s stable because I’ve got that experience (DCM 10 interview)
Individual Factors: DCMs

• Knowledge of Evidence base
  – Right you use, the NICE guidelines, the COPD guidelines, the GOLD guidelines the BNF is my bible you know it’s a wonderful book isn’t it? (DCM 2 interview)
  – The advice did follow national guidelines for the management of asthmas, however when discussing this with community matron after the consultation the matron seemed somewhat vague as to the evidence base underpinning her practice. (DCM 7 field notes).

• Documentation
  – But we’ve not actually got any documentation for that. We’ve got clinical assessment forms but we’ve got, we’ve not got telephone consultation documents so I think that’s something for us to bring up with our managers(DCM 2 interview)
Individual Factors: DCMs

• Medicines Management
  – The matron has a good clinical knowledge and made appropriate
decisions to alter dose of diuretics and check other medication
including steroids, analgesics and NSAIDs (DCM 2 field notes).

• Confidence
  – On exploring why the matron felt she could not increase the
medication during this intervention she specified that she would
feel more confident with a more cautious approach. An expert in
this field may have prescribed an increase in the diuretic therapy
and ordered a chest x-ray (DCM 7 field notes)
  – The DCM was evidently able to deal with the patient’s care
competently and she was confident in her decision making.
    DCM 1 field notes)
Organisational Factors

• Primary Care
  – Establishing networks
    • Well you can have disagreements with any GP but on the whole I get on really well with the GPs, I go to the meetings, I discuss my caseload with the GPs, I’ll run through what’s been happening with the patients in the last week or two, I try to go to (name of doctor) surgery on a Friday lunchtime (DCM 4 interview)
  – Multidisciplinary working
    • What we will quite often do is, they (social workers) will suggest doing a joint visit, and I do joint visits with them (DCM 2 interview)
  – Clinical Supervision
Organisational Factors: Secondary Care

- **Lines of communication**
  - Now we do to a certain extent we’ve got Dr (Name) in the (Hospital name) that we can ring ... and he’s fantastic (DCM 2 interview)

- **Collaborative decision making**
  - I’ve done dommie (domiciliary) visits with Dr (name) but they’re very different, they have to be organised cause he’s really busy isn’t he in clinics so they can take so long to organise and your patient can deteriorate in the meantime can’t they (DCM 2 interview)
  - They don’t know who you are, what your background is. I went to a clinic with a patient once and the doctor spoke to me as if I was Health Care Assistant even though I’d introduced myself as a Community Matron. (DCM 5 interview)

- **Avoidance of Admissions**
  - Over 1 year she had been admitted for over 180 days... and the then next one it was 150 and then it was about 139 so it worked out on average about 150 days a year which is 5 months isn’t it? So since February she’s been in hospital ...once with her chest when she needed to go on theophylline( DCM 7 Interview)
  - Really so we’re just looking at symptom control and meeting what his priorities are really, which is always to stay at home, he doesn’t want to go to hospital, he’s always said that, so that’s my priority really and that’s why my decision making today. (DCM 5 interview)
Conclusions

• Recruitment Disappointing
  – low participation rate and the demographic profile means that some care needs to be taken in generalising the results of this study to the whole workforce.
• Expert/Proficient practitioners
• Patient centred approach to care
• Evidence based practice
• Multidisciplinary working
• DCMs provide a service that meets the needs of patients and fulfils the majority of the aims set by the DoH (2005) when introducing the role of community matron.
  – a command of an expert knowledge base of physical, psychosocial, clinical and pharmacology,
  – the ability to provide a holistic generalist overview and care co-ordination for patients with multiple long term conditions,
  – the ability to make complex clinical decisions using expert clinical judgment.