



Power and decision making on acute wards

Key points

- Recent research by the Values MIN provides evidence that neither service users, carers or healthcare workers feel there is currently shared decision making on the acute wards.
- The current ward round structure is not fit for practice.

Implications for practice

- There is a need to be more transparent about the real power differences influencing decision making.
- We need to restructure decision making to allow for patients to be informed, involved, influential and in-control of decisions.

Shared decision making on acute wards.

The importance of shared decision making (SDM) within all healthcare settings has become increasingly prominent within Department of Health policy¹ and is regularly summed up by the phrase “No decision about me without me”. Placing the user of services at the heart of decision making is seen as central to providing high quality care, yet we rarely stop and analyse in detail to what extent this is actually happening. Therefore the Values Managed Innovation Network (MIN), a research group made of local clinicians and academics with an interest in the values of mental healthcare, have recently conducted a study² in an attempt to answer the following questions:

1. What extent are decisions about patient’s care on acute wards perceived to be shared.
2. What extent do participants feel their views were listened to and contributed to the final outcome in decision making on the acute wards.

To try and answer these questions the Values MIN conducted seven focus groups with: service users; carers; occupational therapists; nurses; peer-support workers; psychiatrists and social workers, all of whom had experience of inpatient units within the last two years. Within each focus group participants were asked a series of questions about decision making on the wards and their perceptions of it. From this information the research group identified certain themes within and across the groups. When these themes had been identified the research group tried to understand how they might relate to the different interests and levels of power individuals and groups have.

What was discovered?

Service users experienced ward reviews as oppressive and being subjected to a decision making process which left them disempowered and having their freedom, choices and rights removed against their will. Whilst at times they understood the need to be “looked after” they felt that even at these times they were treated poorly. Many other participants (OT’s; carer’s; social workers; peer-support workers) felt that they were outside rather than part of the decision making process. This may well reflect the real lack of power that these staff have in the ward round. Additionally, it may also be that at times staff are more comfortable feeling that they are not centrally involved in decisions which can be unpleasant, difficult and carry high levels of risk. Whilst many groups spoke of feeling like outsiders in the process, the psychiatrists spoke about how they felt responsible for any decisions made. They also spoke about how they at times wanted to bring others into the decision making process but did not always feel

confident in other staff to follow tasks through properly. Whilst they wanted others to be involved in the decision making process it appeared that overall they did not want fully shared decision making. This may be because it would threaten the influence and power psychiatry currently has within the system. Nurses in turn spoke of waiting for decisions to be made and then implementing or enforcing these. Whilst noting the interests of services users, all groups focused largely on their own interests and concerns. Furthermore, other than psychiatrists, all groups felt they had very little influence in the decision making process on acute inpatient wards. Overall, the findings from the study can be summarised in the following two points.

1. The goal of shared decision making is a long way from being met. All focus groups felt the voice of the service user was marginalised and that decisions were not shared.
2. The ward round as the main forum for shared decision making is not fit for purpose.

Where do we go from here?

The first step in the process of improving shared decision making on the wards may well be to start to acknowledge the obvious power differences and interests at play. Many patients on acute wards are there against their will and under sections of the Mental Health Act. It is not a democracy³. The patient's level of power is vastly different from the professionals around them, and even within the different professions there is not a level playing field of power and status. The differences in terms of power and interest in turn influence how much the voices of each group are heard, prioritised and acted upon. Acknowledging this is a key part in starting to think about how we might maximise shared decision making on wards but it also raises some difficult questions. How much are the more powerful professions willing to give up an element of power and influence? How willing are staff groups who currently do not feel part of the decision making process willing to challenge more powerful colleagues and take on greater levels of responsibility? How do we maximise patients power within the decision making process whilst operating under the constraints of the Mental Health Act?

Whilst these are difficult questions, if we as individuals, professions and services are committed to shared decision making, we have a responsibility to consider them. We should not be obscuring marked differences in power through claiming to offer shared decision making. Rather we need to acknowledge the differences in power which currently exist and then work on how we can enhance patients' power to the maximum it can possibly be. In this regard it may be helpful to tease apart the various aspects of shared decision making and aspire to patients on acute wards being: *Informed of*; *Involved in*; *Influencing*; and ultimately *In-control* of decisions. It may be that at different times that not all of these "four I's" are possible, but much like guidance around capacity, we should assume they are possible until there is evidence to the contrary.

There may also be very practical changes which can be made to the decision making process. The ward round is not seen as fit for purpose. We therefore have an obligation, no matter how difficult this may be, to try to design and implement different models of decision making on wards (something that the Values research group will be trying to address in future action research). These then need to be evaluated as to how much they increase the power of the patient to be involved in and where possible in-control of the decision making process. If successful this will inevitably mean that many of us will have to give-up some of our power and claims to expertise that we currently have, and it is this which may ultimately prove the biggest challenge.

REFERENCES

1. Department of Health. (2012). *No decision about me without me: Liberating the NHS*. HMSO. London
2. Stacey, G; Felton, A; Morgan, A; Stickley, T; Willis, M; Diamond, B; Houghton, P; Johnson, B; Dumenya, J: (In Press): *A critical narrative analysis of shared decision-making in acute, inpatient mental health care*.
3. Houghton, P. (2008). *Values Based Practice*. Clinical Psychology Bite-Size

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