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Canadian hospital nurses' roles in communication and decision-making about goals of care: An interpretive description of critical incidents

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ABSTRACT

Background: Nurses in acute medical units are uniquely positioned to support goals of care communication. Further understanding of nurse and physician perceptions about hospital nurses' actual and possible roles was required to improve goals of care communication.

Objective: To critically examine nurse and physician perceptions of the nurse's role in communication with seriously ill patients and their families.

Design: We focus on the qualitative component of a mixed method study. We employed an interpretive descriptive approach informed by Flanagan's critical incident technique.

Settings: Participants were recruited from the acute medical units at three tertiary care hospitals in three Canadian provinces.

Participants: Thirty participants provided interviews (10 from each site): 12 nurses, 9 staff physicians and 9 medical resident physicians.

Methods: Participants' described "critical incidents" they considered as "excellent" or "poor" or "usual" practice. Interviews, were audiotaped and transcribed. Team-based analysis used constant comparison and triangulation to identify healthcare team members' roles in goals of care communication.

Results: We identified two major themes from 120 critical incidents: 1) the ambiguous nature of the nurse's role in formal, physician-led, decision-making communication, and 2) *embedded in care* serious illness communication. Physicians understood nurses' supportive role in relation to their own communication practices that culminated in decisions about care; nurses' reported their roles were determined by unit routines, physician practices and preferences, and their self-confidence in supporting decision-making. Nurses described their unique role in facilitating informal and spontaneous communication with patients and families that was critical background work to physician-led goals of care communication.

Conclusions: Nurses and physicians had different understandings, practices and beliefs about goals of care communication The value of nurses *embedded in care* work is key to supporting the interprofessional team's work during formal goals of care communication.

What is already known about this topic?

- The Registered Nurse's scope of practice includes initiating and engaging in goals of care discussions and supporting decision-making processes with seriously ill patients and their families.
- Hospital Nurses act as information brokers, advocates and supporters for patients and families in the end-of-life decision-making process.
- Multiple issues create conditions that impede nurses' engagement in end-of-life communication; these include nurses' lack of confidence, implicit understandings of existing hierarchical structures in health care teams, and social historical constructions of nurse-physician

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relationships.

What does this study add?

- Nurses' goal of care communication is *embedded in care* and thus occurs informally with patients and families on acute medical units. Such communication is often unrecognized, since it is embedded in-the-moment work that arises spontaneously during care and occurs asynchronously and outside of the most often researched, physician-led, formal, and planned decision-making processes (i.e., patient consultations and family conferences). We unpack these hidden practices as a way of foregrounding nurses' important roles in communication with seriously ill patients and their families.
- Hospital nurses' hesitancy to claim their role in goals of care communication and decision-making with seriously ill patients is dynamically influenced by uncertainties about their own relational skills, what is perceived as physician preference for nurses' participation, and normalized routines on the medical teaching unit that can position nurses as outsiders to these conversations.
- Physicians' practice experiences, assumptions and understandings about the value of nurses' roles in goals of care discussions influenced their intentional inclusion of nurses in these discussions. Understanding these contextual dynamics is essential to inform efforts that support nurses' active involvement and to optimize their participation to their full scope of practice in both informal and formal goals of care communication.

1. Introduction

Seriously ill patients at high risk of decline and death and their families have identified effective communication and shared decision making as crucial to their end-of-life care (Virdun, Luckett, Davidson, & Phillips, 2015). By listening carefully to hospitalized patients and their families, healthcare professionals can illuminate what might be important to accomplish with care, which is also referred to as “goals of care”, and then consider the range of treatment decisions that are salient for an individual. Goals of care communication refer to the process of discussion that ideally informs and occurs prior to shared decision-making processes about end-of-life care options (Sinuff et al., 2015). Shared decision-making is an approach to decision-making where the healthcare team listens to and actively engages seriously ill patients and their families throughout the process from identifying opportunities where choice exists to implementing care and assessing how it meets their needs (Kryworuchko, Stacey, Peterson, Heyland, & Graham, 2012). Serious illness communication refers to communication between health care professionals and patients and/or their families, within the context of a serious and life-threatening illness. It may include advance care planning, goals of care discussions and shared decision-making regarding end-of-life care options (Bernacki, Block, and for the American College of Physicians High Value Task Force, 2014).

As essential caregivers at the point of care, nurses in acute care settings are uniquely positioned to support communication with seriously ill patients and their families (Adams, Bailey Jr, Anderson, & Docherty, 2011). Internationally, professional nursing standards and position statements highlight the crucial role for nurses in serious illness discussions identifying patient-centered goals of care and salient health decisions (American Nurses Association Professional Issues Panel, 2017; Canadian Nurses Association, 2014; College of Nurses of Ontario, 2009), yet nurses continue to experience challenges enacting their role amidst the complexities of the acute care setting. A review and synthesis of best practices in communicating about goals of care and decision-making in serious illness has drawn attention to the need for the development of communication expertise amongst all clinicians on interprofessional teams working with seriously ill patients (Bernacki, Block for the American College of Physicians High Value Task Force, 2014). Importantly, developing nursing communication expertise within interprofessional teams must attend to power differentials that affect relational practice and to the contextual nature of nursing practice in acute care settings with patients at the end-of-life (Hartrick Doane, Stadjuhar, Causton, Bidgood, & Cox, 2012).

Within a broad research program, we undertook a mixed methods study (DECIsion-making about goals of care for hospitalized meDical patiEnts:[DECIDE]) to understand factors important to optimal goals of care discussions and decision-making with seriously ill hospitalized patients on acute medical units in Canada, from the perspective of physicians and nurses involved in those discussions (You et al., 2015). Results from the multi-center (quantitative) survey component of this study involving 13 medical units in teaching hospitals across Canada (512 nurses, 484 residents, 260 staff physicians) indicated that a staff physician was the preferred clinician in any final decision about goals of care and the use of life-sustaining technology. Nurses viewed it as acceptable that nurses initiate goals of care discussions, exchange related information with patients and families, act as a decision coach and make a final decision with patients and/or their families. Medical residents and staff physicians generally concurred with this view, however they for nurses to make a final decision with patients and families (You et al., 2015).

Qualitative data about practice experiences were collected alongside this survey data via interviews conducted with 30 physicians and nurses at three hospitals in three Canadian provinces. A culture of death avoidance pervaded across study contexts, and goals of care discussions and decisions about the use of life-sustaining technology were delayed until days or hours prior to death (Nouvet, Strachan, Kryworuchko, Downar, & You, 2016). Overall findings from these interviews identified a number of factors that contributed to goals of care discussions and decision-making going well, or less well, in the eyes of physicians and nurses (Kryworuchko, Strachan, Nouvet, Downar, & You, 2016). A major theme amongst these was *how physicians and nurses conducted professional work within teams.* Communication was led most often by a physician, with nurses working in the background *behind the scenes* (Kryworuchko et al., 2016: 7). In this paper we will present a more in-depth analysis of nurse's goals of care communication work within the acute medical context.

1.1. Aim

The aim of this paper is to critically examine nurse and physician perceptions of the nurse's role in goals of care discussions and decision-making with patients experiencing serious illness and their families.

2. Methods

2.1. Methodological orientation and theory

The qualitative methodology for the DECIDE mixed methods study employed an interpretive descriptive approach (Thorne, 2008) using Flanagan's critical incident technique (Flanagan, 1954). Our methods were previously reported in detail (Kryworuchko et al., 2016) and are summarized here.

2.2. Participants and setting

Participants were recruited from three selected hospital sites (Alberta, Ontario, Quebec) of the 13 hospitals involved in the quantitative study component. This was done to offer a diversity of geography (three provinces) and language (English and French) from the Canadian perspective. The units from which participants were recruited were acute medical units in a tertiary care teaching hospital. Medical resident physicians routinely rotated through these units. Units had 35–45 beds with nurse patient ratios of 1:4–1:8 depending on the medical complexity of non-surgical patients. Patients had complex, potentially life-threatening conditions and or organ failure including