

Shared Decision Making in Residential Aged Care: A Framework Synthesis

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Abstract

Very little is known about shared decision making (SDM) in residential aged care, despite world-wide policy and imperatives that encourage resident choice and autonomy. This paper provides a framework synthesis of SDM in residential aged care (RAC) and potential barriers and enablers to implement SDM utilising a theoretical framework of implementation. A review of the literature on SDM in RAC from 2005 to 2016 was undertaken, using MEDLINE (Ovid), CINAHL, PsychINFO and Scopus. The articles were synthesised by utilising an implementation theory framework to better understand what may facilitate or hinder the introduction of SDM. Eighteen studies were identified and analysed to determine barriers and enablers to SDM in RAC from the perspectives of staff, residents and relatives. A workplace culture of person-centred care and judicious use of research evidence are enablers of SDM. There is a potential need for additional resources, such as education for staff and families to enable implementation of SDM. Implementation of any health care intervention, including SDM, relies on many complex factors but these are predominantly related to capacity. Determining current uptake and readiness of RAC organisations, residents and their families to adopt SDM is an essential starting point.

Keywords

Narrative Synthesis, Shared Decision Making, Residential Aged Care, Implementation

1. Introduction

Shared decision making (SDM) brings clinicians and patients together about making shared decisions on patient's care, as opposed to clinicians making decisions on behalf of the patient [1]. SDM is considered the pinnacle of Person

Centred Care (PCC) [2]. SDM integrates patient values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment to achieve an option which is acceptable to both the patient and the clinician [3]. SDM is based on important moral, ethical and legal principles, and is recognised as important in developing a genuinely patient-centred health system [4]. The core of SDM is that individual self-determination and autonomy are desirable goals for patients [2].

There are no existing definitions of SDM specific to differing health care settings. In general, Coulter and Collins [5] describe three essential components of SDM:

- The patient is provided with current, unbiased evidence based information about potential treatment, care or support clarifying outcomes or uncertainties
- There is decision support counselling with a clinician to clarify options and patient preferences
- There is a robust system to record patient preferences, to communicate them to others and to execute the preferred choice.

SDM is poorly understood by clinicians [6] who, in addition, may not have a sufficient level of research literacy to fully understand evidence based findings from the literature [7], let alone translate those findings in a meaningful way in a patient encounter. Current research in SDM has been limited to measuring processes used by clinicians in patient/clinician dyads as well as focusing on patient perspectives of their involvement and satisfaction with the decision making process, or clinicians' opinions on SDM effectiveness [8].

Very little is known about SDM in residential aged care (RAC) settings, despite increasing emphasis on resident choice and autonomy in aged care reforms internationally [9] [10] [11]. Likewise knowledge specific to the implementation steps required successfully achieving SDM in the context of RAC is unknown. This is problematic given that the World Health Organization (WHO) advocates for a human rights approach for health and ageing including the right of a person to actively participate in decision making about their health care, as a basis for quality of care [12]. SDM is increasingly advocated in clinical guidelines and health care policy [3] [13] [14]-an imperative that health care providers cannot achieve without a greater understanding of the enablers and barriers to implementation.

2. Design

We synthesised the literature for current practices and processes for potential implementation of SDM in RAC from the perspective of staff, residents and resident's families. A narrative synthesis approach was utilised as opposed to a rigid systematic review. A systematic review uses strict criteria to summarize the evidence of studies and focuses on the effectiveness of an intervention. On the other hand, a narrative synthesis employs a textual approach to examine the heterogeneity of studies and population groups, while incorporating principles of a

systematic review. Application of the strict criteria of a systematic review would have excluded relevant studies concerned with implementation of the phenomena under review. Hence, a narrative synthesis was better suited to describe the scope of the existing SDM concepts to describe implementation in practice.

Narrative synthesis enabled the interpretation of isolated research findings which used different research approaches. We used framework synthesis, described by Richie and Spencer [15], based on existing conceptual framework to identify *a priori* themes [16].

2.1. Conceptual Framework

Two frameworks were utilised for this review. Previously identified terms and the taxonomy and mapping of concepts [17] was utilised for the search strategy. The studies are described using this conceptual framework to show the relationship to SDM. The findings from this search are then synthesized using May's theory of implementation [18], to explain how the findings relate to clinical practice.

Embedding SDM as a new healthcare intervention within the usual clinical practice may be challenging. May [18] proposes implementation of a new intervention as a social process of collective action as it never refers to a single 'thing' that is to be implemented but rather a complex bundle of material and cognitive practices to be introduced into a social system. It follows that a process as complex as SDM needs substantial support and planning before and during widespread implementation into clinical areas to enable its success [19]. A theoretical framework of implementation characterises the elements of context and agency within a social system, that enable capacity to implement change [18]. May's [18] framework provides a template to understand health care contexts and the elements involved which act as barriers or enablers to implementation of new interventions. The key components of May's framework include potential, capacity, capability and contribution to implementation in practice.

A conceptual framework is an essential component for undertaking framework synthesis [20]. A framework guides decisions regarding analysis and assists in the interpretation of findings [21].

2.2. Search Strategy

The first author extensively reviewed the literature from August to December in 2015 and updated the search in November 2016. An anticipated complexity of the literature search was the multiple terms used independently and interchangeably for SDM. The heterogeneity of the concepts, definitions and terms used in relation to SDM has been described by other authors [22]. Makoul and Clayman [23], found in a review of 418 papers devoted to SDM that the terms "patient preference" and "options" were terms used in more than half. Policy documents frequently refer to "patient choices" [24] and "consumer participation" [25]. Cooper [26] supports incorporating the broadest conceptual definitions possible.

Subsequently the search strategy was based on previously identified terms and concepts developed in a taxonomy and mapping of SDM [17]. Additional terms used to describe RAC internationally and traditionally were added (such as long term care and nursing homes). Because the focus was clinical practice, clinicians were defined by terms used internationally in the literature (care staff, nurses, allied health and medical staff). The search was adapted to each bibliographic database and Medical Subject Headings (MeSH) used where possible.

Search terms used for SDM and related concepts were;

“Shared decision making” OR “decision-making” OR “patient preference” OR “patient option” OR “patient choices” OR “consumer participation” OR “Consent” OR “guardianship” OR “advocacy” OR “proxy” OR “next of kin” OR “advance care plans” OR “patient centred care” OR “patient autonomy” OR “evidence based practice” OR “variations in care” OR “training” OR “education” OR “health literacy” OR “decision aids”.

To capture the relevant literature in residential aged care settings, SDM search terms were combined with AND for: “residential aged care” OR “nursing home” OR “long term care” OR “care staff” OR “medical staff” OR “allied health” OR “nurses”.

Bibliographic data bases searched included MEDLINE (Ovid), CINAHL, PsychINFO and Scopus.

2.3. Inclusion/Exclusion Criteria

Articles related to governance and occupational health and safety were excluded since the aim was to explore practice and processes relevant to SDM implementation in RAC. Studies conducted in settings other than RAC, such as community or transitional care, were excluded. Studies prior to 2005 were excluded to give a contemporary account of existing models and processes. Studies reported in languages other than English were also excluded. Qualitative and quantitative, or mixed methods research approaches were included, plus one case study due to its relevance to the topic under consideration. Systematic reviews were excluded but the reference lists were searched.

2.4. Screening

Quality appraisal of the methodology of the studies and risk of bias was not a central focus. Studies were critically appraised by the first author using the Critical Appraisal Skills Program (CASP) tool [27], to determine validity of the aims and methodological quality.

The search yielded 374 articles, Medline-153, PsychINFO-105, Scopus-47, CINAHL-44, Pubmed-27. Experts in the field of SDM were also contacted to provide other sources of potential studies, which provided three additional articles. The total was reduced to 300 when 76 duplicates were removed. Of the 300 remaining articles, 211 were excluded after reading the abstracts because they were not studies related to the search for models or processes of SDM in

aged care, but focused on tool development or discussion or alternative settings. Eighty nine full text articles were screened and a further 62 excluded for being irrelevant to the research question. Of the 27 remaining articles, nine screened negatively to the two initial screening questions of the CASP and so were eliminated. The final 18 articles are described using the conceptual framework and synthesized using May’s theory of implementation. A flow chart shows the selection process in **Figure 1**.

3. Findings from the Literature Search

Seventeen of the articles were published peer reviewed research articles and one a research report. The study designs, year of publication, country or origin, intervention, concept related to SDM and major findings are listed in **Table 1**. In addition, **Table 1** shows the target population, whether the study was conducted with staff, residents or families or a combination. Ten of the studies included

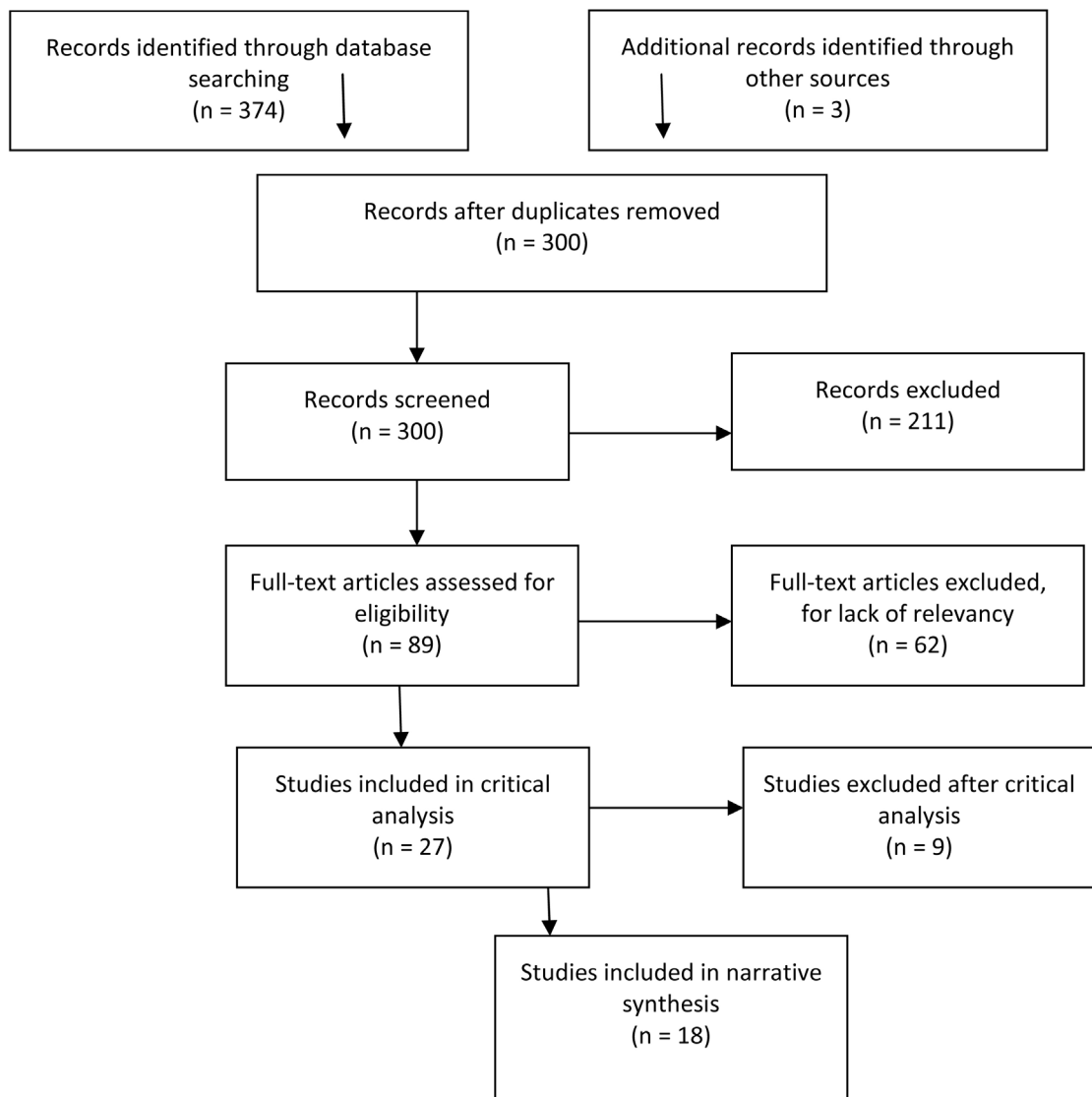


Figure 1. Process of article selection.

Table 1. Summary of included studies related to SDM in residential aged care.

Author-title	Study participants	Study aim	Country	Method	Primary concept/s related to SDM	Finding-potential barriers or enablers to SDM implementation
Qualitative						
Abrahamson, K., Bernard, B., Magnabosco, L., Nazir, A., & Unroe, K. The experiences of family members in the nursing home to hospital transfer decision. (2016) [28]	Relatives	The experiences of family members in the nursing home to hospital transfer decision making process	USA	Interviews	Readiness Evidence based information	Barrier Information on the risks of hospitalisation may assist family members to make decisions. Family roles are variable depending on readiness to make decisions.
Arendts, G., Popescu, A., Howting, D., Quine, S., & Howard, K. “They never talked to me about...” Perspectives on aged care resident transfer to emergency departments. (2013) [29]	Residents, relatives and staff	To explore perspectives concerning decisions to transfer residents to emergency departments	Australia	Interviews	Readiness	Barrier SDM rarely occurred, staff were paternalistic and denied stakeholders choice. Relatives expressed both unpreparedness to make decisions and had conflicting opinions to staff.
Fetherstonhaugh, D., Tarzia, L., Bauer, M., Nay, R. & Beattie, E. “The red dress or the blue?” How do staff perceive that they support decision making for people with dementia living in residential aged care facilities. (2014) [30]	Staff	Staff perceptions of supported decision making for residents with dementia	Australia	Interviews and focus groups	PCC	Enabler Existing culture of PCC. Staff awareness of strategies to support resident decision making. Informed consent apparent in staff ensuring information was understood.

Continued

Gjerberg, E., Lillemoen, L., Forde, R., & Pedersen, R. End-of-life care communications and shared decision making in Norwegian nursing homes-experiences and perspectives of patients and relatives. (2015) [31]	Residents and families	Perceptions of SDM in end of life care	Norway	Interviews and focus groups	Readiness	<p>Enabler Explored readiness for residents and families in SDM for end-of life care. Found that health care professionals should take responsibility for initiating conversations and involve families with consent. SDM should be individualised and iterative.</p> <p>Barrier Some residents and families expressed unpreparedness for SDM. Differences between residents in desire for SDM. Most relatives wanted to be involved in decisions but entrusted staff to make final decisions.</p>
Iden, K., Hjørleifsson, S., & Ruths, S. Treatment decisions on antidepressants in nursing homes: A qualitative study. (2011) [32]	Staff	Explores decision making about treatment with antidepressants	Norway	Interviews and focus groups	Evidence based information	<p>Barrier Lack of EBP and resident/family involvement SDM in antidepressant prescription.</p>
Mann, E., Goff, S., Colon-Cartagena, W., Bellantonio, S., & Rothberg, M. Do-not-hospitalize orders for individuals with advanced dementia: Healthcare proxies perspectives. (2013) [33]	Families	Explores health care proxies understanding of do-not-hospitalize orders and why they may or may not initiate them	USA	Interviews	Evidence based information Readiness	<p>Barrier No collaboration with families to improve capacity to make informed decisions that reflect individual values and wishes.</p>
Norheim, A., & Vinsnes, A. Factors that influence patient involvement in nursing homes: staff experiences. (2012) [34]	Staff	Explores staff experience of factors influencing patient involvement	Norway	Focus groups	PCC Education	<p>Enabler Staff education in PCC. Staff stressed the importance of patient-centred attitudes for resident involvement in decision making.</p> <p>Barrier Time pressure was a key limiting factor to PCC.</p>

Continued

O'Shea, F., Weathers, E., & McCarthy, G. Family care experiences in nursing home facilities. (2014) [35]	Families	Explore relatives involvement in the care of older people admitted to RACF's	Ireland	Interviews	PCC	Barrier Families excluded from participating in decision making. Staff task oriented not PCC. Interventions that engage residents and their families in care required.
Sims-Gould, J., McKay, H., Feldman, F., Scott, V., & Ribonovitch, S. Autonomy, choice, patient-centred care and hip protectors: The experience of residents and staff in long term care. (2013) [36]	Residents and staff	Examine perceptions of staff and residents on the decision to use hip protectors and factors which influence decisions	Canada	Focus group (Part of a larger mixed methods study)	Evidence based information	Barrier Evidence based research took precedence over resident choice. Insistence on EBP even when explicitly declined by the resident.
Tarzia, L., Fetherstonhaugh, D., Bauer, M., Beattie, E & Nay, R. "We have to work within the system!" Staff perceptions of organizational barriers to decision making for older adults with dementia in Australian aged care facilities. (2015) [37]	Staff	The perceptions of staff regarding organizational barriers that prevent facilitating decision making for residents with dementia	Australia	Semi-structured interviews and Focus groups.	PCC	Barrier Staff perceived there was not enough time to facilitate decision making and that education and training is required for the skills as a facilitator. Policies and procedures needed to support practice in facilitated decision making.
Quantitative						
Ampe, S., Sevenants, A., Smets, T., Declercq, A & Van Audenhove, C. Advance care planning for nursing home residents with dementia: policy vs. practice. (2015) [38]	Staff	Evaluate advance care planning policy for people with dementia, and family involvement in advance care planning in practice	Belgium	Audit, self developed ACP questionnaire and OPTION scale	ACP	Barrier Staff failed to discuss the risks and benefits of treatment options with residents or their families. Strategies are required to translate ACP policy into practice. Staff training is required and greater family involvement recommended. Enabler Resident and family readiness for SDM was assessed on admission.

Continued

Eloranta, S., Arve, S., Isoaha, H., Aro, I., Kalam-Saliminen, L. & Routasalod, P. Finnish nurses' perceptions of care of older patients. (2013) [39]	Staff	Explores how far nurses' perceptions of care take into account preferences of older patients and their families	Finland	Questionnaire (25 item purpose-designed from gerontological nursing literature)	PCC	Barrier Staff reluctance and difficulty in practicing SDM, due to perceived expertise of staff. One third of nurses make decisions on patient care themselves. Staff asked the views of patients less frequently than those of family members.
Hanson, L., Carey, T., Caprio, A., Lee, T., Ersek, M., Garrett, J., Jackman, A., Gilliam, R., Wessell, K., & Mitchell, S. Improving decision-making for feeding options in advanced dementia: A randomised, controlled trial. (2011) [40]	Residents and families	Testing quality of decision making about feeding options using a decision aid	USA	RCT-Questionnaire (Decisional conflict scale administered at 1 and 3 months)	Evidence based information Education	Enabler Evidenced based research, utilising decision aids reduced decisional conflict for families and increased knowledge and communication with care providers about feeding options.
Helgesen, A., Athlin, E., & Larsson, M. Relatives' participation in everyday care in special care units for persons with dementia. (2015) [41]	Families	To determine relatives participation in everyday care for persons living in dementia specific facilities and factors which influence it	Norway	Questionnaire (Study specific-derived from 2 previous studies by same researcher)	PCC	Barrier Lack of PCC and SDM. Families seldom participated in decisions about everyday care though half perceived their participation was crucial for PCC.
Werner, P. Perceptions regarding the use of physical restraints with elderly persons: comparison of Israeli health care nurses and social workers. (2005) [42]	Staff	To explore the perceptions of health care workers and social workers on the use of physical restraints with elderly people	Israel	Questionnaire (Perception of restraint use questionnaire)	Evidence based information	Enabler Decision support role for mediation between residents and their families and staff member. Both groups perceived EBPs to be important, but decision support role could be strengthened. Barrier Evidence abrogated SDM. Moral dilemmas for staff.

Continued

Mixed methods						
Bauer, M., Nay, R., Bathgate, T., Fetherstonhaugh, D., Winbolt, M., & McAuliffe, L. Constructive staff/family relationships in residential aged care. (2009) [43]	Staff and families	To identify and address barriers to constructive staff-family relationships	Australia	Interview & 2 Questionnaires (34 item adapted version of previously developed British survey tools)	Education	<p>Enabler Staff and family education in PCC, information exchange and communication to facilitate improvements in staff-family relationships.</p> <p>Barrier Differences in staff and family perceptions about information exchange and communication (SDM).</p>
Blackford, J., Strickland, E & Morris, B. Advanced care planning in residential aged care facilities. (2007) [44]	Staff	To describe lessons learned in implementing an advanced care planning program	Australia	Case studies Interviews Questionnaire (unspecified) Informal feedback	ACP Education Documentation, communication and enacting	<p>Enabler Collaborative decision making was facilitated by introduction of advanced care planning.</p> <p>Barrier Sustainability depended on governance structures, educational processes, resident documentation, quality audits and communication. Varying success of sustainability over time. Resources and continued staff education are required over a long time period.</p>
Case study						
Jeong, S., Higgins, I & McMillan, M. Advance care planning (ACP): The nurse as “broker” in residential aged care facilities. (2007) [45]	Residents, families and staff	To describe how advanced care planning is implemented and the role of a clinical nurse consultant	Australia	Case studies in 3 RACF’s.	ACP Enacting	<p>Enabler Decision support and education for staff and families. Additional staff performed roles of mediation, assessment, intervention, coordination, communication and education in advanced care planning.</p>

were published since 2013 and of the remaining eight only four are older than 2009.

Two of the studies retrieved explored SDM in RAC in the context of advance care planning. The other models focused on person-centred care, evidenced based care and models of advance care planning with perceptions of the con-

cepts of decision making or shared decision making within each model, from the perspective of staff, residents and families. One of the studies aimed to measure the process of SDM as a primary outcome. The term “shared decision making” was only found in two of the studies.

The target populations of staff, residents and families was represented across the retrieved articles, providing perspectives of all groups about decision making processes, which helped to reduce bias of the findings collectively.

Eight of the studies are explicitly related to decision making in RAC, though only one described the process of SDM as described by Coulter and Collins [5]. All other studies are implicitly related and concerned with relevant concepts related to SDM, such as person centred care, evidence based practice and knowledge or education. Nine of the studies illustrate potential barriers to SDM implementation, three studies provide examples of potential enablers and the remaining six studies have elements of both barriers and enablers related to SDM implementation in RAC.

4. Application of the Conceptual Framework of SDM

4.1. Person-Centred Care

PCC is a dimension of quality care which is individualised to consider both the patient and their family as integral components of health care decision making and delivery of care [46]. As the essential component, or crux, of SDM [47] models of PCC are an important consideration in RAC. Six of the studies analysed concepts related to PCC [30] [34] [35] [41] [43]. These studies used qualitative [30] [34], quantitative research methods [41] and mixed methods [43] to provide the perspective of residents and families [35] [41] and staff [30] [34] or both groups [43] to illustrate the opinions of all stakeholders. Time pressure and a task oriented focus of care was a key limiting factor in providing PCC. Families were excluded from the decision making process when a PCC workplace culture was absent, though the families viewed their participation as crucial. Staff propose that an existing workplace culture of PCC is an enabler to supported decision making and family involvement [30] [34]. Importantly, the perceptions of staff and families differed about the level of communication and information exchange that was taking place, with staff perceiving higher levels of PCC than families [43].

Additional studies [29] [36] [39] included in the analysis illustrate that non PCC models of care result in a lack of SDM. A consistent finding was that paternalistic, task focused and evidence focused workplace cultures denied residents and families choice, from the perspectives of staff, residents and families [29] [36] [39].

If SDM is to be successfully implemented in RAC it requires a workplace culture of PCC, but evidence suggests that social norms in RAC may not align with PCC, and that residents, families and staff have differing opinions about the workability of PCC.

4.2. Evidenced-Based Practice

Evidence is utilised in SDM to ensure that patients understand all the risks and benefits of associated care and treatment (informed consent) and to help them reach a decision based on their preferences [48] [49]. Like PCC, it is an essential component of the SDM process and utilisation of high quality research evidence demonstrates capacity for the implementation of SDM by workability.

Studies that utilised either qualitative [36] [42] or quantitative [40] designs as an intervention in RAC demonstrated contrasting results about potential SDM implementation. Perspectives of residents and families [40], residents and staff [36] or staff alone [37] [42] are reported in each of these studies. A top down approach to utilising evidence [36] [42], where staff held the knowledge of best practice, denied residents choice and autonomy, while a bottom up approach [40], where families were provided with evidence of treatment risks and benefits increased family members knowledge and facilitated SDM with staff. Staff as reported in Sims-Gould *et al.* study [36] perceived that evidence based practice should take precedence over resident choice, while staff in Werner's study [42] expressed moral and ethical issues about utilising evidence that is known to abrogate resident autonomy. In another study by Hanson *et al.* [40], there is no knowledge of staff opinions of a bottom up approach to utilising evidence. Without staff perspectives of a bottom up approach, understanding of potential implementation is limited.

Four articles focused on advance care planning (ACP) or end-of-life care, two quantitatively measured [38] [44] staff perspectives, one case study [45] described perspectives of all stakeholders and three qualitative methodological approaches [31] [33] focused on residents and families. None of the articles describe utilising evidence to help residents or their families decide on treatment options. Two studies found a lack of provision of information to residents and their families, and reported that staff rarely discussed the risks and benefits of treatment options [28] [38]. Some families indicated that there was a lack of information provided to them to assist in decision making [33]. This suggests that poor knowledge may result in some families deferring decision making to staff, though other families expressed a desire to be part of the decision making process. Staff perceived it was unfair to expect families to make decisions without knowledge of the risks and benefits of the treatment option, and so believed that their expert knowledge justified them as decision makers [29].

4.3. Readiness of Residents, Staff and Organisations

There is evidence that some patients prefer not to be involved and to leave decisions about treatment to clinicians [19] [50]. The reasons for this are multi-factorial, but an important consideration. Additionally, clinician and organisation readiness for the process of SDM is vital to implementation. Readiness to participate in SDM was highlighted in five of the studies regarding ACP and end-of-life care [31] [33] [38] [44] [45], the study methodology and stakeholder perspectives having already been described but which includes a mixture of qua-

litative and quantitative methodologies plus a case study involving all stakeholder perspectives.

There are differences in the level of involvement residents and families wish to have in decision making in ACP and end-of-life care. Resident and family readiness to participate was shown to be a significant factor in the process of collaborative decision making. Perspectives of residents and families willingness to be involved in decision making varied within and across studies. Residents and families often give staff an imprimatur to make decisions on the resident's behalf, rather than being involved [29] [31]. Importantly, some families were stressed and uncertain if expected to make a decision, but postulated that this may be a result of poor knowledge of the consequences of their decision [29]. Alternatively, some family members expressed dissatisfaction with being excluded from the decision making process [29] [31]. The study by Ampe *et al.* [38] demonstrated that readiness of families to be involved in SDM was assessed by inquiring about their preferred approach to receiving information to assist in SDM.

Staff and organisation readiness is paramount to effective SDM [29] [32] [34] [35] [36] [39] [41]. A lack of PCC was the limiting factor in staff and organisation readiness for SDM. Staff unpreparedness for SDM was highlighted in two of the studies [36] [39], while organisational unpreparedness was perceived as a barrier in two [39]. Frequently, the unpreparedness or lack of readiness could be attributed to both staff and organisational factors [29] [32] [35] [41]. Organisational readiness was also identified as having policies to support SDM in practice by two studies [37] [38].

There can be multiple factors contributing to staff and organisation readiness [32] which requires a huge organisation cultural shift [43]. Education was identified as paramount in staff, family and organisational readiness for implementing change.

4.4. Education

Much of the broader literature on SDM, focuses on education for clinicians on how to execute the process of SDM [51] [52], what SDM is [53] [54] and why it is important [6]. Education in SDM was not a focus of any of the articles retrieved, however, many of them utilised education to execute and embed models of care [30] [43] or enact organisational change to adopt new processes [44] [45] and are thus particularly relevant to SDM in RAC if it is to be implemented. Education in SDM was recommended in two studies, [28] [38] particularly about the importance of family involvement. The articles analysed which utilised an educational intervention were predominantly quantitative approaches [40] [43] [44]. Hanson *et al.* [40] differed by providing education to families not staff, while Bauer *et al.* [43] provided education to staff and families concurrently. All of the studies concerned with education excluded the perceptions of residents and focused on staff and families.

Staff and family education in collaborating together is illustrated as the corner

stone for successful implementation of new interventions [43]. It is also important to seek staff opinion on factors which mitigate against collaborating with families [34] [43]. Discussion with family members on treatment options is crucial to SDM [28] [38] [40]. Education can be resource intensive, particularly if it focuses on embedding long term, sustained adoption of change [44] [45].

4.5. Documentation, Communication and Enactment

The third component of Coulter and Collins SDM process [5] is documentation of the decision reached, communication between stakeholders and enactment of the treatment choice. Without this final component, the previous components have no validity in the process of SDM. Documenting and communicating residents preferences so that they can be enacted are the operational phase of SDM.

There were six articles concerned with the components of documentation, communication and execution of care in RAC settings, three articles used a quantitative research design [29] [33] [44], a case study [45], and three used qualitative methodology [29]. Arendts *et al.* [29] provides perspectives of staff, residents and families, while the other articles focus on staff [34] [44] or families [33] alone, or is purely descriptive [45].

A support worker (facilitator or broker) was perceived as the key to implementation of Advance Care Planning (ACP) [44] [45]. The support workers role is to educate staff and families about process and act as a mediator. The support worker initiates discussion with all stakeholders and facilitates the implementation of goals and plans. Involvement of residents and relatives in understanding the process of an intervention is central to successful implementation. The importance of information exchange and communication between stakeholders is emphasized [34]. Barriers to execution of wishes include a lack of documented resident preferences [33], or inadequate planning and communication [29]. Systematic operationalization of an intervention requires regular and ongoing education of all stakeholders [44] as well as auditing of existing processes, policies and strategic planning about organisational changes that may be required for success [28] [37]. High staff turn-over and changes to management of RAC is a threat to sustainability of interventions [44]. Blackford *et al.* [44] describe a system-wide approach to documentation, communication and dissemination of a residents wishes as paramount to success.

5. Narrative Synthesis Procedure Utilising an Implementation Framework

The perceptions of the population groups (stakeholders) regarding the components of SDM (person-centredness, evidence, education and documentation and communication of decisions) are important in illustrating the extent to which each component can serve as a potential barrier or enabler to implementation in practice in a RAC setting. The final part of this synthesis aimed to determine how the components of SDM relate to implementation in practice.

May's theoretical framework of implementation [18] was utilised to under-

stand how the essential components of SDM potentially facilitated or abrogated the process of SDM. An important step in the analysis was to compare and contrast the perceptions of the different populations (staff, residents and families) both within each study and across studies. In light of the predominantly qualitative methodologies of the extant literature, the analysis used a framework synthesis approach to bring together the current evidence [55] and reach conclusions.

Although there are a plethora of implementation frameworks [56] [57], May’s framework specifically relates to the complex hierarchical structures of health care settings and potential complex interventions that may be introduced. May’s framework recognises that implementation is not simplistic.

How the theoretical framework of implementation [18] was applied to the components of SDM is shown in **Figure 2**. The subject of the “social system” [18] for implementation in this analysis is residential aged care. The “element of context” [18] is the capacity and potential of RAC to implement SDM.

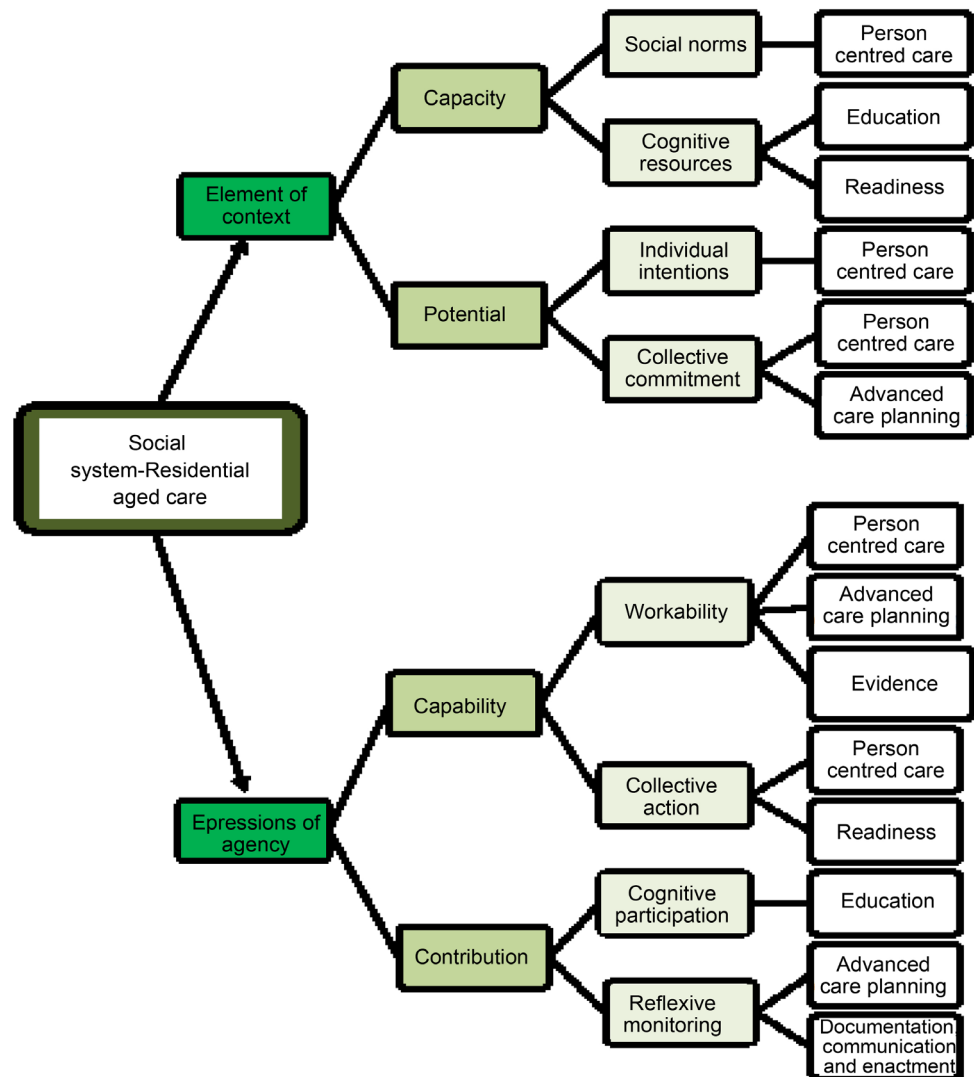


Figure 2. Application of theoretical framework of implementation [18] to the components of SDM.

Potential for implementation relies on organisational readiness, shown through individual intention and shared commitment. Implementation theory describes individual intentions and shared commitment as agents (clinicians, residents and families) motivation to translate beliefs and attitudes into behaviours that align with the social system. Capacity for implementation is dependent on material (access to resources needed for operationalization) and cognitive resources (knowledge, information and evidence) as well as social norms (institutionally sanctioned rules within the social system).

“Expressions of agency” [18] in this analysis are identified by capability and contribution of stakeholders to implement SDM. Capability for implementation relates to workability-social practices the agents perform in enacting or operationalizing an intervention. Contribution in the implementation framework relates to cognitive participation and collective action (how agents enrol themselves or mobilise skills to enact interventions) and reflexive monitoring (appraisal of the intervention).

6. Discussion

The initial literature search aimed to review current practices of SDM concepts in RAC and the synthesis to describe potential implementation of SDM in RAC using implementation theory framework. It is evident that SDM, as described by Coulter and Collins [5] has not been implemented fully in aged care settings. There is also evidence that the full concept of SDM is rarely implemented in any health care settings [52], even when clinicians have been trained in the process. This suggests that clinician training on cognitive resources is only one of the many factors required and that implementation of SDM in practice is complex.

6.1. Capacity

Capacity, in terms of RAC, is bound up in the social norms that govern behaviour within it. Paternalistic attitudes are a common social norm in RAC [29] [36] [39] [58] and the antithesis of SDM-there is an imbalance of power between clinicians and patients created by law and specialist knowledge [59]. Paternalism is frequently driven by clinician’s belief that they know what is best for patients. There is a tension between strong commitment by staff to keeping residents safe and violating their right to choice and autonomy [36] [39]. For SDM to be effective clinicians must relinquish their role as the single, paternalistic authority and train to become more effective coaches or partners [2]. The greatest challenge is turning the rhetoric into reality, changing workplace culture requires a huge shift in the common social norms of many RAC facilities [43]. Respect for a person’s right to make choices and participate in decision making is generally viewed as central to quality of life and well-being [30], however existing social norms in residential aged care potentially prevents SDM implementation [37].

A culture of person centred care is fundamental to SDM, and a recurring theme in the articles reviewed [30] [31] [34] [35] [41] [43]. PCC is a required social norm for implementation of SDM and SDM is viewed as a strategy that in-

corporates PCC principles into standards of care [60]. An audit tool has been developed to measure PCC in RAC settings, which aims to minimise staff bias of their perception of providing PCC [61]. Auditing PCC, as an essential component of SDM, is paramount to determine capacity for implementation. Implementation involves interaction with other agents, processes and contexts [18]. A workplace culture of PCC indicates capacity for SDM implementation, one factor of readiness. As well as organisational readiness, readiness of residents and their families is an essential component of capacity to implement SDM.

Material resources within a social system including their distribution and allocation are also a dimension of capacity. Similarly, shared commitment requires that participants are induced to participate, and Implementation Theory recognises that coercion, rather than motivation may be a strategy used to constrain others. SDM utilises evidence to inform the patient of the risks and benefits of various treatment options, to support their decisions [51] [62], not to coerce patients into practices or treatments that conflict with their preferences and values. Patient preference is a warranted variation to best practice initiatives [63].

Evidence can be utilised through the provision of patient decision aids. Although decision aids do not guarantee that decision making will be shared [64] [65] they offer a structured way to provide detailed information about treatment choices [1]. Decision aids are valuable for patients with low literacy levels [65] and so provide real hope for facilitating SDM with various population groups. Although decision aids have demonstrated effectiveness about increasing patient knowledge and risk perception, SDM is not dependent on them [6]. While increasingly available, a decision aid, or quality evidence may not necessarily exist for the condition under consideration, or the evidence may be rapidly changing. Clinicians must be able to access up-to-date evidence, evaluate quality and ensure that they are appropriate for the patient and their condition [66], skills the clinician may not possess. Utilising decision aids is not straight forward [6]. The implementation theory framework suggests that agent's capacity relies upon cognitive and material resources [18]. Knowledge of how to access, interpret and apply evidence will be crucial to successful implementation of SDM.

The provision of resources to both educate staff and families [34] [42] [43] [44] [45], and promote sustainability increases capacity to implement SDM in RAC. The provision of education in SDM is widely supported [28] [37] [67] [68]. Paradoxically, the resources necessary to implement SDM, such as increased time, support workers and overall governance, may also be a barrier. RAC settings are typically busy, time poor environments [30]. Time constraints are a limiting factor for practicing PCC [34], and also found to be true for SDM [37] [38]. Additional resources and dedicated funding are required to embed SDM practice within RAC facilities.

6.2. Potential

Lack of resident and family readiness for SDM is a barrier to potential implementation [29] [31]. Resident and family readiness relates to individual inten-

tion. Clinicians must first assess the patients preferred level of involvement in decision making [67] [69]. Previous authors of SDM studies [67] emphasize the importance of flexibility and warn that strict adherence to the principles of SDM risks another form of paternalism. Some patients prefer not to be involved and to leave decisions about treatment to clinicians [31]. It is recommended [68] that for SDM to become embedded requires a bottom up approach, where patients have an expectation that decision making will be negotiated together. The current regulatory pressures in many countries [54] to adopt SDM ignores that flexibility must be maintained, and that patient autonomy begins with the preferred level of involvement. Non participation in the decision making process, is in itself SDM, provided that risks and benefits of treatment options are clearly articulated and understood. Individual intention and collective commitment to SDM demonstrate potential to implement it. The object of an implementation process may be a modified way of thinking, where the agent intentionally makes things happen by action.

6.3. Contribution and Capability

Like capacity, much of contribution and capability relate to PCC. SDM includes collaboration (collective action) with families as appropriate and emotional and physical support [70]. Contribution includes cognitive participation and reflexive monitoring. Joint action, such as sharing of information, unites two or more individuals towards a shared end. Documentation and dissemination of resident choices are essential to operationalize SDM [44]. Capability is concerned with the dimension of workability-operationalizing the intervention. Communication between all stakeholders is necessary for dissemination of information but there is evidence that clinicians and residents/families do not communicate well [59]. There is also evidence that enhanced communication can be achieved through a process of education of staff and families on how to collaborate more effectively [43]. To successfully implement and embed SDM will require RAC facilities to undertake reflexive monitoring or appraisal of the effects of SDM to ensure that property is shared, not a single entity. Reflexive monitoring frames how participants collect and utilise information about the effects of the intervention.

7. Conclusion

The most important finding of the synthesis is that the implementation of SDM in RAC, hinges on a person centred culture of care. Paternalistic practices of staff hinder person-centred care and capacity to implement SDM in RAC. Operationalization of SDM practice may be dependent on additional resources in the facilities. As well as a person-centred culture of care, cognitive and material resources such as education of staff and residents/families are important enablers to implementation of SDM. Readiness or preparedness of residents and families to be involved in SDM should be ascertained as part of the process. Importantly this synthesis highlights the caution that must be exercised in introducing research based evidence into practice to ensure that it is utilised to assist in deci-

sion making but balanced with residents' preferences and values. Additionally, evidence needs to be provided in simple, easily understood formats (such as decision aids) to facilitate knowledge and understanding of the information provided and increase workability.

8. Recommendations

Implementation of any health care intervention, including SDM, relies on many complex factors but these are predominantly related to multi-dimensional aspects of capacity. If there is to be effective implementation of SDM, auditing capacity within the system of RAC is required. The synthesis indicates that capacity relies on workplace culture and organisational support for resources such as support workers and education for staff and residents to increase readiness.

To date, little research has been undertaken in RAC to determine staff knowledge, or previous training in SDM. Additionally, little is known about the uptake of SDM in RAC. The absence of studies may not reflect current practice. Aged care quality standards emphasise resident choice, so processes which support this must exist to meet minimum requirements. How regulatory agencies assess this is unclear and not the subject of peer reviewed publications.

As a starting point, rigorous evaluation is required to measure readiness of organisations and residents and families for implementation of SDM processes. This will provide a baseline for future SDM intervention studies.

Ethical Approval

Not applicable, no human research was involved.

Competing Interests

The authors declare they have no competing interests.

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