Exploring clinical decision making in learning disability nursing

Clinical decision making is a fundamental role of the nurse. Standing (2020a) placed clinical judgement and decision-making skills at the forefront of nurses’ professional identity, and proposed that comparing the judgments and decisions of different health professionals allows their distinctive contribution to patient care to be identified (Wilson and Abraham, 2020).

Health professionals use clinical judgement when delivering care to enable people to improve, maintain or recover health, cope with health problems, and achieve the best possible quality of life whatever their disease or disability until death (Atkinson and Moulster, 2015).

Clinical decision making is a huge responsibility for everyone in healthcare as it can affect whether a person survives or dies from their illness or injury (Ellis, 2020). The Nursing and Midwifery Council’s (NMC) (2018) Code states that nurses are personally accountable for their actions and omissions in their practice, and must always be able to justify the decisions they make. Decision making will always bring risk, as things can, and will, go wrong and patients are sometimes harmed, no matter how dedicated and professional health workers are (NHS Improvement, 2018).

This article examines clinical decision making in learning disability nursing, using the example of enteral tube feeding for patients with malnutrition, to help both post-registration and student nurses understand the decision-making process and the issues faced when making such decisions.

Keywords
Clinical decision making/ Learning disability/Assisted feeding

In this article...
- Decisions for learning disability nurses around assisted feeding
- What influences the decision-making process
- Moral, ethical and legal dilemmas encountered by nurses

Key points
- Clinical decision making requires cognitive skills to manage complex information and make judgements
- Student nurses need support to maximise their clinical decision-making skills when making the transition to becoming qualified staff
- Decision making can be enhanced through improved understanding of capacity and consent
- Decision-making models offer analytical tools that can be combined to provide useful insights into decisions made in clinical practice

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Abstract
Clinical decision making is a key role of nurses. To develop nurses as autonomous clinical decision makers, student education and training programmes need to support the development of the intellectual and cognitive skills needed to manage complex information and make judgements. Student nurses also need extra support through their transition to becoming qualified staff to maximise their clinical decision-making skills. This article examines clinical decision making in learning disability nursing, using the example of enteral tube feeding for patients with malnutrition, to help both post-registration and student nurses understand the decision-making process and the issues faced when making such decisions.

Citation
Clinical Practice

Discussion

Box 1. Enteral feeding

Percutaneous endoscopic gastrostomy (PEG) is when food, fluids or medication are passed through a tube directly into the stomach (National Institute for Health and Care Excellence (NICE), 2006). For patients with swallowing limitations, enteral nutrition is commonly the first choice if their bowel function is still intact (NICE, 2006). Kitzinger and Kitzinger (2018) demonstrated there were no significant differences between various tube-feeding techniques in terms of mortality rate and complications, but proposed that PEG feeding was superior to nasogastric feeding in terms of quality-of-life outcomes. PEG feeding can be undertaken during periods of prolonged illness when food or fluid refusal may be the presenting clinical picture (NICE, 2006).

Barriers to the withdrawal of artificial feeding in patients in a vegetative and minimally conscious state include families:

- Not accepting the implications of the diagnosis, believing “any life is better than none”
- Having ethical or religious objections to possibly ending life
- Believing that “withdrawal is ethically equivalent to euthanasia” (Kitzinger and Kitzinger, 2018).

Health needs may be nutritionally vulnerable for various reasons, including social isolation, limited nutritional knowledge and a reduced ability to understand and apply health messages (Lay, 2015).

Inadequate oral intake can result in people becoming malnourished – whereby a deficiency of nutrients, such as protein, vitamins and minerals, can have measurable adverse effects on the body composition and function – increasing the risk of ill health and vulnerability to disease (NICE, 2006). Patients who are malnourished can cope poorly with modern medical and surgical interventions; the average length of hospital stay for these patients is around five days longer than that for patients who do not have malnutrition, resulting in care costs that are approximately 50% higher (Elia, 2015).

The cost of malnutrition in the UK has been estimated at £23.5bn, with health and social care costs for a single malnourished patient totalling £7,408 annually (BAPEN, 2018), so small fractional cost savings could convert to significant savings.

Respiratory conditions

The NHS (2020) reported that respiratory conditions remain the most prominent causes of premature mortality for people with LD and that, after bacterial pneumonia, aspiration pneumonia is a leading cause of premature death in people with an LD, accounting for 17% and 3% of adult and child deaths respectively.

A review of people with LD who died from aspiration pneumonia showed gaps in service provision that may have been contributing factors including lack of training and knowledge around dysphagia, as well as the need for clarity over care plans, particularly in relation to feeding (NHS, 2020).

Tube feeding

Percutaneous endoscopic gastrostomy (PEG) feeding (Box 1), also known as tube feeding, is a widely used method for long- and short-term enteral feeding for some patients with a general indication of dysphagia or an inability to take sufficient food by mouth (BAPEN, 2016). NICE (2006) stated that decisions on nutritional support should be considered for anyone who has “eaten little or nothing for more than five days and/or is likely to eat little or nothing for the next five days or longer”.

In patients with LD, one of the most common reasons for PEG feeding is aspiration pneumonia linked to dysphagia.

Decision-making tools and models

Assessment tools such as BAPEN’s Malnutrition Universal Screening Tool (MUST) and the nursing process can help nurses make decisions about care for patients at risk of malnutrition (Box 2). Decision-making models also offer analytical tools that can be combined to provide useful insights (Ellis, 2020).

Among the criteria for selecting a tool is the ability to give a true measure of a patient’s degree of risk and consistent results, which Ellis (2020) stated provides validity and reliability. Models, such as the information processing model, use a scientific or hypothetico-deductive approach to help the reasoning and decision making that is essential to medical diagnosis (Ju and Choi, 2018). This involves testing a hypothesis by determining whether the consequences are consistent with observed data.

Analytical decision-making models have been used to help describe nurses’ ability to diagnostically reason. Ju and Choi (2018) explained that these models help clinical decision-makers’ thought processes to follow realistic logic that can be explored until a decision has been made. However, Karlsen et al (2020) suggest the hypothetico-deductive approach can be affected by several cognitive biases. One of these is anchoring, in which decision-makers tend to favour their initial hypothesis despite incoming conflicting evidence.

The experience of the decision maker and the ability to recognise situations that impact on the decision-making process are also key components of analytical models (Ellis et al, 2020).

The focus of an intuitive humanist model is intuition and the relationship between nursing experience, the knowledge gained from this, and how it enhances the clinical decision-making process as nurses progress along their professional journey. Ju and Choi (2018) associated intuition with three forms of heuristics or subjective probability judgements that form the basis of intuitive reasoning:

- Availability heuristics – using examples that come to mind immediately;
- Anchoring and adjustment – starting off with an initial idea then adjusting beliefs accordingly;
- Representative heuristics – basing a decision on its similarity to something else, or stereotyping.

They described these as mental shortcuts that help speed up the process of finding a satisfactory solution. However, Karlsen et al (2020) argued that this can lead to uncertainty as it is based on predictions rather than scientific reasoning, which fail when a person is overconfident or their background knowledge is unreliable.

Ethical dilemmas

The fitting of a PEG tube creates complex legal and ethical issues, and should be performed only if the benefits clearly outweigh the risks. Some patients lack the capacity to...
consent or withhold consent to treatment so a professional must make on their behalf treatment decisions that are in the patient’s best interests (Bird, 2000). The Mental Capacity Act (MCA) 2005 advises that whoever is providing the treatment will be the decision maker. This can sometimes involve a range of professionals, including speech and language therapists and dietitians, when several decisions need to be made.

Lasting power of attorney (LPA) for health and welfare allows capable individuals to appoint a person to make healthcare decisions on their behalf (Griffith, 2018). However, an attorney cannot decide on behalf of someone without capacity to withdraw artificial nutrition and hydration, unless the person has specifically given authority for this in the LPA (Bird, 2000).

If a conflict about care persists, it may be resolved by the Court of Protection. In such a case, treatment regarded as life sustaining or necessary to prevent serious deterioration in the patient would continue (Bird, 2000). Before an LPA becomes effective, it must be registered with the Office of the Public Guardian (Griffith, 2018).

There has been controversy around PEG feeds due to the ethical issues of keeping someone artificially alive, especially if patients lack the capacity to consent, or their wishes are unknown (Banks, 2004). In a study by Kitzinger and Kitzinger (2018), most people reported that they would not want to be kept in a permanent vegetative or minimally conscious state; however, legal disputes have also occurred with patients fighting for the right to live through artificial nutrition if they lost the capacity to communicate. The Office of the Official Solicitor and Public Trustee (OSPT) (2010) highlighted a case that illustrates some of the difficulties: the family of a patient, who had been unconscious for four years and was diagnosed as being in a persistent vegetative state, wished for him to have the right to die through withdrawal of artificial nutrition and hydration but, before any decisions were made, the patient regained consciousness and was able to sit up.

PEG feeding enables health professionals to prolong the life of those who would otherwise die of malnutrition (NICE, 2006). However, decisions around PEG feeding will always present health professionals with moral, ethical and legal dilemmas. Quality of life is individual and PEG feeding may simply prolong death in some patients, requiring health professionals to consider the patient’s emotional, physical and mental health when making any decision (Kitzinger and Kitzinger, 2018).

Statutory provisions place a legal duty on the NHS to involve and consult with patients, families and carers in making decisions that may affect them (Wilson and Abraham, 2020). This is re-emphasised by the NMC’s (2018) Code, which states that nurses must collaborate with and listen to the people in their care, while also responding to their concerns and preferences. The handbook to the NHS Constitution pledges to make sure everyone is given:

- The opportunity to participate in decision making about their care;
- Information in a form that is appropriate to their understanding and level of development for this to happen (Department of Health and Social Care and Public Health England 2015).

**Reliable decision making**

Most health professionals rely heavily on experience when making decisions under conditions of uncertainty (Atherton and Derry, 2015). This raises complications that may not be a sufficient basis for reliable clinical decision making, as Standing (2020a) pointed out. Errors or poor decisions may be caused by a lack of the skills necessary to access information effectively or a lack of the critical appraisal skills to interpret research findings for validity, applicability and clinical importance, which Standing (2020b) argued are key to evidence-based practice.

Decisions are often made unconsciously and influenced by:

- Our need for stability, certainty and familiarity;
- Feelings of urgency;
- Risk relevance and external pressures.

Available choices are often constrained by social, practical, business, safety and environmental requirements and objectives (Wilson and Abraham, 2020). Cognitive, emotional, reflective and social capabilities also affect the decision-making process (Standing, 2020), and the interaction between context and decision-making is complex (Atherton and Derry, 2015).

Social and emotional intelligence is important for decision making as it affects how we understand and relate to people, with key skills being self-awareness, self-regulation, self-motivation and social awareness. The influence of contextual factors – such as clinical pathways, policies, protocols and system definitions of acceptable practice – may be reliant on the features of the decision being made.

Importance has been placed on clinical decision making as a collaborative process, involving shared and comparable choices with patients and health professionals (Ellis et al, 2020). The collaborative nature also requires consideration of factors influencing team and patient decision making (Atherton and Derry, 2015). Wilson and Abraham (2020) suggested decision making is a balance of experience, awareness, knowledge and information gathering, guided by appropriate assessment tools, colleagues and evidence-based practice.

**Advice for student nurses**

Student nurses must be prepared for the unexpected, open to experiential learning and interpreting changes during transitions in fast-paced, open-ended environments (Mooney, 2007). When they go into the advanced beginner stage as newly qualified nurses, there may be questions about their confidence in making and committing to decisions. Many newly qualified nurses like to think carefully, researching everything before applying themselves to an area of work; this may feel like a weakness, although Benner (2001) believed it to be a unique strength that enabled nurses to formulate useful ideas. It is also a valuable approach in identifying a goal and resolving individual or group problems when used with experienced team members. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) stated that the approach can be an excellent basis for critical appraisal of the decisions they make and what is – or is not – being accomplished through their management of care delivery.

To develop nurses as autonomous clinical decision makers, Burden et al (2018) recommended that student education and training programmes incorporate an educational framework that supports development of the intellectual and cognitive skills for managing complex information and
making judgements. Mooney (2007) sug-
gested nearly qualified nurses need increased support through their transition
to becoming qualified staff to maximise
their clinical decision-making skills.

Although student nurses in their final
year of education will have functioned close
to the level of a staff nurse, many will not
have engaged fully in administrative or
managerial tasks, despite having studied
the principles and practices related to these
roles. The main change for newly graduated
nurses is that they have full legal and profes-
sional responsibility (NMC, 2018). This new
level of responsibility and entitlement brings
changes in how nurses experience them-

selves and the practice environment. They
may no longer feel that they can always look
to other nurses to tell them what to do or bear
their responsibility (Burden et al, 2018).

Choosing the best decision and the
timing of it can be difficult for students
(Mooney, 2007). This can leave them with a
sense of self-doubt or feeling uncertain or
lacking in confidence. As such, it is impor-
tant that students can identify the kinds of
questions health professionals ask about
alternative interpretations, potential solu-
tions and their consequences.

Students also need to guard against
unhelpful assumptions. Wilson and
Abraham (2020) suggested there are prob-
lems with health professionals making poor
decisions about patients due to confirma-
tion bias – for example, patients may be
labelled or expected to show troublesome
behaviour, which can lead to discrimination
and unsafe practice. It is important that
health professionals deliver care with
empathy, compassion and objectivity.

Student nurses may fear saying the
wrong thing, causing them to appear unen-
thusiastic or even make the wrong choices,
so it is important that they develop critical
thinking and problem-solving skills. Aca-
demic development throughout pre-regis-
tration education focuses on the develop-
ment of critical thinking skills, but clinical
decision-making skills are generally devel-
oped in the workplace under the guidance
of mentors/practice facilitators, using
structured reflection techniques.

Research suggests effective, ongoing
training in the NHS creates a safe, cost-effec-
tive learning environment that supports the
dynamic changes in health services (NHS
Improvement, 2018). Health Education Eng-
land (2019) reported that patient safety is
everyone’s responsibility, and, without up-
to-date training to meet the ever-changing
needs of service provision, patient safety and
service costs will be negatively affected.

Wilson and Abraham (2020) cited insti-
tutional barriers to students’ development –
such as inadequate time to teach or evalu-
ate activities to promote critical thinking –
as issues. They suggested resources do not
always support the infusion of activities;
for example, clinical simulation may not
happen because of a lack of money or equip-
ment. Clinical supervision can be an oppor-
tunity to overcome these barriers, enabling
the development of professional knowledge
and skills (Lay and Atkinson, 2015).

Conclusion
Nurses’ skills in decision making can be
enhanced by improving their understand-
ning of capacity, consent, ethical and
legal dilemmas, and how to make safe
decisions, as shown in the example of arti-
ficial feeding for people with LD who have
malnutrition. Difficulties in the decision-

making process can also be clarified,
helping nurses to feel more confident in
analyzing information, and assessing and
coping with difficult decisions.

A need for greater understanding and
awareness among decision makers treating
patients with LD and malnutri-
tion is needed and, given the high annual
cost of malnutrition, could result in sig-
nificant savings. Efficient recognition and
treatment of malnutrition and continuity of
care are key to achieving such goals.

Developing student nurses into autono-
mous clinical decision makers requires an
educational framework that supports
developing the intellectual and cognitive
skills needed to manage complex informa-
tion and make judgements. Trainee nurses
also need support in their transition to
becoming qualified staff to maximise
their clinical decision-making skills. NT

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For more articles on learning disability nursing, go to
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