

*Consumer participation in acute care settings: An Australian experience*

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### **Abstract**

Consumer partnerships have been embraced as an important component of building high quality health care services. While nurses have the greatest contact with clients in hospital, little is known of their views about consumer participation or how they facilitate that participation at the bedside. Using focus group interviews and participant observation methods, this project explored nurses' approaches to working with consumers to support their participation in health care delivery. Findings indicate a sharp contrast between the ideas that nurses expressed and the actions observed in practice. It was clear from the interviews that nurses had adopted the rhetoric surrounding consumer participation, yet observational data revealed nursing practices that excluded active participation by consumers. Factors influencing nurses' facilitation of consumer participation were identified as the division of nursing labour in the setting, limited communication between nurses and patients and environmental constraints.

**Key words:** acute care services, consumer participation, focus groups, nursing practice, observation.

### **INTRODUCTION**

Health policy-makers in Australia have made consumer participation a key focus for health and social policy.<sup>1</sup> Consumer participation implies the involvement of consumers in sharing information and opinion and, more particularly, sharing decision-making power.<sup>2</sup> Acute health care service providers have embraced the idea of consumer participation as being central to the quality of their services. However, pathways for engaging consumers actively in these services remain unclear. Consumer participation has been studied in commercial and political arenas<sup>3,4</sup> but there has been scant work undertaken to explore the application of this knowledge to human services industries.<sup>5</sup>

The idea of consumer participation in health services is not new, nor has its adoption been without problems.<sup>6</sup> At a macro level, there has been considerable development of and investment in consumer participation in health policy development and public health initiatives, yet there is little evidence of the successful implementation of these policies at the coalface. The mental health sector is often credited with having developed successful consumer partnerships in care<sup>7</sup>, but as Kent and Read suggested, levels of consumer involvement might not be as high as previously reported in the literature.<sup>8</sup> They argued that professionals operating from a social model of health are more able to incorporate consumers as partners, whereas those working from a biomedical approach are less accepting of high consumer participation in treatment decisions.

There are two major themes in the existing body of work related to consumer participation in health care services. The first is participation in medical treatment decisions which has received the greatest attention,<sup>9-11</sup> particularly among people experiencing high-profile illness (for example, Human Immunodeficiency Virus or breast cancer). Younger, well-educated consumers have been identified in the literature as being more willing and prepared to participate in treatment decisions.<sup>11</sup>

The second theme explores a broader level of consumer participation in health care including levels of involvement of consumers in nursing care and daily disease management. Consumer physical fitness and knowledge as well as the structure of the service-providing organization have been identified as factors that influence consumer-nurse collaboration.<sup>12,13</sup> Issues of power, specifically the level of control that professionals have over their practice, have been shown to affect the level of active consumer participation in service delivery.<sup>14,15</sup> Predominantly, research examining consumer participation in health care has developed from the provider's view of what consumers need,<sup>9,11,16</sup> illustrating what Brownlea referred to as scant evidence that consumer participation is little more than tokenism.<sup>6</sup>

Our previous work clearly identified consumers' dissatisfaction with the limited opportunities available to them to be partners in their own health care. A number of consumers with chronic illness suggested that some health care workers do have a vision for partnership, but frequently lack the resources or skills required to actualize that vision in practice.<sup>17-20</sup> Clearly, there is a need for health care organizations to support their staff to meet the challenge of working in partnership with consumers. We are working in partnership with major acute health care service organizations (representing the non-profit sector and the public sector) to develop strategies for increasing consumer partnerships in the delivery of health care services. This study formed the first stage of a multistage study investigating consumer participation in complex health care environments. Given the paucity of literature relating to nurses and consumers in acute care health service delivery, this study focused on exploring current nurse practices and perceptions of working in partnership with people who experience an episode of acute illness.

## **METHODS**

This study employed a qualitative interpretive design to develop an understanding of how nurses in acute care environments interact with patients to support their participation in health care planning and delivery. By using triangulation of methods, focus group interviews<sup>21,22</sup> and modified participant observation techniques<sup>23,24</sup> to collect data, we were able to draw contrasts between nurse perceptions of practice and actual practices relating to consumer participation in care.

Nurses working in a public sector acute care hospital were invited to participate in focus group interviews to discuss what consumer partnership meant to them in practice. Three focus groups were held for registered nurses (RNs). Separate focus groups were conducted for nurses according to their work classification. Six nurses in their first year of practice formed one focus group (RN Grade 1), eight nurses who had more than one year of experience but no management or leadership responsibilities formed a second group (RN Grade 2) and six nurses who had roles as team leaders and associate nurse unit managers formed a third group (RN Grade 3). Participating nurses represented a broad range of practice settings in the hospital. Each of the focus groups participated in a 1-h interview in which participants were asked what consumer participation in care meant to them. The focus groups, conducted by two of the research team, were audiotaped and subsequently

transcribed verbatim. Data were analysed thematically using a modified approach for focus group data.<sup>25,26</sup>

Subsequent to the focus groups, a registered nurse employed at the study hospital was trained to conduct observation of practice following the general guidelines of Marshall and Rossman.<sup>27</sup> Events and behaviours observed between nurses and consumers in a cardiovascular medical unit were systematically noted and recorded by this clinician-observer. The cardiovascular medical unit had a staffing mix that was representative of the three levels of nurses who participated in the focus group interviews. The observer was familiar with the unit, but was not one of the unit's staff. She was located in one four-bed room in the unit for 2-h periods at various times of the day covering both day and evening shifts. The aim was to observe interactions between nurses and patients, and to identify ways in which nurses adopted consumer participation as part of their clinical practice; for example, by offering choices to patients and including them in care planning. Field notes were made by the clinician-observer documenting these interactions and included notations on the environment and observed practices, as well as records of segments of conversations. In total, 18 h of observation was undertaken.

Members of the research team met the clinician observer three times during the data collection period for debriefing and to refine the direction of observations. Frequent debriefing of the clinician-observer was required in this study because of the unanticipated emotional impact of what was observed and the challenges of maintaining the role of researcher during observation periods. Observational data were analysed thematically, with each member of the research team developing her own schema of identified themes through reading and rereading the data. Subsequently, members of the team shared their findings and noted similarities and differences in their analyses. Areas of disagreement required a re-examination of the data as a team and further discussion until agreement on analysis was reached.

Ethics approval was gained for the study both from the university and hospital human research ethics committees. Informed consent was gained from each of the focus group participants prior to the commencement of the interviews. Before the study commenced, global consent was sought from all relevant staff in the unit where observations were undertaken.

## RESULTS

In each focus group, nurses of all levels of experience articulated the value of consumer participation in their own practice. All participants were aware of the value placed by their organization on supporting consumer participation in the planning and delivery of care, and expressed a commitment to working towards this model. As one nurse commented:

*... acceptance (of consumer participation) from nurses because we're also used to being in charge, now that things are changing the patients do want to be independent ...*

Another nurse suggested consumer participation was:

*... an interactive relationship. So that we're also helping them plan their care, much more of a teamwork approach, rather than I suppose accepting what we do.*

However, there were differences between nurses at different levels of appointment in their expressed understanding of what consumer participation meant and how they could incorporate it in their own practice. Nurses with more experience and a broader range of responsibilities demonstrated greater understanding of the issues and were

more positive about the benefits of increasing consumer participation in care. The most senior staff (Grade 3 RN) were the most supportive of the implementation of a consumer participation model of care. The following comments by these Grade 3 nurses indicated their interpretation of patient participation:

*My idea of patient participation is that they are fully informed.*

*... it's the ability to question and also looking at what treatment options they'd like to take and explore and all of that, and also taking control, I guess ... planning their own discharge in some way.*

A core theme of the focus group data related to issues of control. Despite supporting the rhetoric of consumer participation, nurses in each focus group simultaneously reported that they made an effort to maintain some level of control over patient care interactions. Less experienced nurses attempted to justify this behaviour, as evidenced in this typical comment:

*They (patients) may not have as much choice, because it has to be done and I have to do it, it has to fit into my time.*

Nurses with broader patient care experience recognized that nurses actively maintained control of care. One Grade 3 nurse stated that:

*Patients are not treated as individuals because we have our rules ... we have to obey others' rules which restricts what we do for patients.*

Grade 3 nurses used phrases such as 'subtle manipulation', 'we're still in control of them' and 'we decide what's pertinent', which clearly demonstrated that the balance of power was retained by the nurses. These findings from the focus groups contrasted strongly with the observational data, which showed little facilitation of consumer participation in care. Three main themes were identified in the observational phase of the study: the division of labour, communication and environmental constraints. Each of these themes is explored in turn.

### **Division of labour**

The provision of bedside care was largely delivered by junior staff—Grade 1 and Grade 2 RNs and second level nurses (enrolled nurses). The focus of observed practice was on doing tasks. Observational data revealed that Grade 3 RNs did not engage in bedside care, nor did they accompany other health professionals who attended the patients at the bedside during the period of observation.

Nurses spent time with patients only when there was a task to perform. Such tasks included the administration of medications, assessing vital signs, dressing wounds and assisting people in and out of bed and with personal hygiene. Nurses initiated and controlled interactions with patients and determined when care would be delivered. Few situations were observed when patients were given any choice about when and how nursing care would be provided. When choices were offered, these appeared to be token choices, with no real alternatives being given.

Higher order planning of care was not observed at the bedside, implying that this activity took place in other areas of the unit. Those making decisions about care (Grade 3 RNs and other health professionals) were doing so away from the bedside and apparently without consultation with patients. It appeared that patients were not directly included in the planning of their care.

### **Communication issues**

Limited communication was observed between nurses and patients. The time nurses spent with patients was devoted to performing tasks related to patient care and little

dialogue was observed. Again, this finding contrasted with the focus group interviews, where participants spoke of needing time to be with patients to communicate. These nurses stated that they wanted to be able to deliver 'hands on care', and indicated a belief that it was important that nurses and not lower levels of staff (that is, patient care assistants) delivered basic care. The participants had argued that this time was vital for communicating with patients. However, the observed nurses did not use the limited time they had with patients to communicate. For example, the observer reported a nurse tuning the radio to her preferred station and listening to it while washing a patient.

At the bedside, nurses did not appear to be responsive to cues from the patients to communicate, build relationships, ask questions or just talk. Nurses did not appear to recognize when patients wanted to talk, nor did they create opportunities for initiating communication with patients. There was frequent use of closed questions by nurses when conversing with patients. Medical staff, however, were observed using the time they had with patients to explain the planned treatment and engage in dialogue with patients.

### **Environmental constraints**

Factors in the unit environment were also identified as limiting consumer participation in care. Structural factors that had an impact on the patient's experience of hospitalization, but over which the patient had little or no control, were identified.

To maximize bed occupancy, the hospital had adopted a policy of mixed gender bed allocation within rooms. Throughout the study, both male and female patients occupied the four-bed room where observations took place. Some patients adopted the strategy of keeping the curtains drawn between beds to maintain privacy. This resulted in reduced visibility of both patients and nurses, and few opportunities to engage in communication about aspects of care.

Shared rooms also presented difficulties for patients wanting to have private conversations, particularly when shared by males and females. The four-bed room was very noisy when radios and televisions were on. Staff often controlled the volume and channel selection of televisions and radios for their own interests, and were observed tuning televisions to music video channels without consulting patients. This was a deterrent to open conversation and meant that communication about personal matters was not private as only loud speech could be heard over the environmental noise.

Nurses also controlled the level of lighting in the room. Room lights were turned on and off as required by staff with no consultation with patients. In one instance, a Grade 2 RN closed the blinds mid-morning to darken the room while she tested a patient's pupil reactivity to light. There was no information about why she was doing this, nor did she reopen the blind when she exited the room.

These results demonstrate a contrast between the espoused ideas nurses had of consumer participation and the ways in which these ideas were incorporated into the observed practices. There appear to be factors in the practice context which influence the level of participation attained.

### **DISCUSSION**

The findings of this study demonstrate that in this particular study setting, the involvement and participation of consumers was difficult to achieve at the most basic level of service delivery. This suggests that developing models for consumer participation should not be limited to a question of shared clinical decisions. There is

a more fundamental issue that needs to be considered, that of general engagement with people in the everyday aspects of being in hospital space. There seem to be a number of complex factors that limit the involvement of consumers in hospital care. In this study, these factors were related to professional practice and environmental constraints.

The desire by RNs to maintain control over patient interactions was evident both in interview and observational data. The contradiction between the expressed desire for partnerships with patients in care and the expressed desire to maintain control was marked and reinforces the findings of others who have noted the difficulties that health care professionals have in relinquishing power.<sup>14,15</sup> The findings of our study illustrate some of the implications of the current division of labour in the Australian acute health care sector. For example, there were few opportunities for junior RNs in the study setting to observe alternative ways of working in partnership with patients. The fact that senior RNs were not seen at the bedside in this study environment suggests that they were not available to model advanced ways of communicating and facilitating nurse-patient partnership activities, and challenges the current models of care selected for use in the acute ward setting. These preliminary findings suggest that current models of care in the study setting failed to support experienced nurses in working with patients at the bedside, and role modelling and mentoring less experienced staff. Despite the educational philosophy of patient-focused care, practice—as recorded by the observer—was predominantly task-oriented. This further suggests that there is a mismatch between the educational sector's expectations of the practice environment and the realities of the clinical setting.

The communication style most commonly in use in the unit during the period of observation demonstrated that the maintenance of professional control was given priority over the type and frequency of interactions. These findings reinforce Brownlea's identification of barriers to consumer participation as being associated with inadequate resources and skills among health professionals to facilitate the needed organizational culture change.<sup>6</sup> Problematic communication styles of nurses working within environmental constraints limit patient privacy and have also been noted by Wellard<sup>18</sup> and Wellard and Rushton<sup>19</sup> as influencing levels of collaboration between health care professionals and people with spinal cord injury.

This study was novel in its use of participant observation in exploring how nurses support consumer participation in practice. There appears to be merit in undertaking observational studies to answer this type of research question because observational studies enable researchers to uncover the realities of practice and the differences between what nurses say and what they do. However, this observational methodology needs more refinement and further testing in clinical environments.

## **CONCLUSION**

Clearly, a demonstrable level of patient participation in care in this study setting was not observed. The environmental and division of labour factors could be partially addressed by management-led organizational change. However, they are also influenced by the period of intense fiscal constraint confronting health services and the significant shortage of registered nurses, both in Australia and globally. The increasing casualization of the workforce reinforces the current division of labour and, therefore, innovative strategies for enhancing staff development within this context are needed. Communication problems remain an important issue in the development of relevant nurse practice. If genuine consumer participation is to become a feature of future health services delivery, then it is imperative that health care management begin to understand and resolve communication barriers. As Cahill reflected, no conclusions can be drawn about the desirability of patient participation, but 'the effort

to treat patients as individuals and genuine human beings ought to be axiomatic to a profession widely understood to have interpersonal relationships at heart'.<sup>28</sup> There are many challenges to overcome before the practice matches the rhetoric.

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