



MSc Social Policy and Social Intervention

What still stands in our way? A study exploring the conditions necessary for long-term care professionals to successfully implement shared-decision making with elderly multimorbid patients.

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Abstract

BACKGROUND: Characterised by demographic and epidemiological transitions, the healthcare requirements of the world's population are rapidly changing. Greater longevity and medical advances have given rise to a growing number of individuals, particularly towards later life, experiencing multiple chronic conditions. Confronted with such burden, shared-decision making (SDM), a practice centred in patient-oriented care, supports the call for increased patient participation to ensure the care sector's future sustainability. Nevertheless, its application, further complicated by the presence of multimorbidity in old age, still remains limited. **AIM:** The research aimed to identify the conditions necessary for long-term care (LTC) professionals to successfully implement SDM with their elderly multimorbid patients. **METHOD:** A mixed method sequential design was utilised to first acquire a broad understanding of the practice within the LTC setting, and after expand on and interpret the collected quantitative information by means of individual interviews. **RESULTS:** LTC professionals working with the study's target group experience very similar barriers and facilitators to those active within the acute care setting. However, the predominant application obstacles lie neither with the limited understanding of SDM nor with individuals' attitudes towards it. Instead, the social and organisational environments encountered by LTC professionals appear to overwhelmingly predict the practice's routine usage. **CONCLUSION:** Findings point towards a current faulty conclusion in which it is assumed all healthcare professionals require identical support in order to successfully implement SDM. Alternatively, compared to those working in acute care, LTC professionals appear more positive regarding the practice, hence adjustments of implementation strategies focused towards the social and organisational contexts in which SDM presents are essential to improve its application with elderly multimorbid patients.

Keywords: long-term care, multimorbidity, old people, shared-decision making

1. Introduction

In a time characterised by demographic and epidemiological transitions, the health of older people and their requirements for health and social care are rapidly increasing in significance (Bastiaens et al, 2007). Brought on by a rising number of individuals suffering from multiple chronic conditions, otherwise known as multimorbidity, the Dutch Ministry of Health (2014) highlighted the forthcoming social and economic challenges the sector, particularly the sector of long-term care (LTC), is prone to encounter without revision. Both nationally and internationally modern healthcare hence has directed its attention towards promoting patient-centred values in an attempt to enhance the quality of care provided at a reduced cost. Thought to decrease the previously existing power asymmetry between professionals and patients, the resulting individualised form of care demonstrates the importance of effective patient participation in accomplishing said task (Barry & Edgman-Levitan, 2012).

Shared-decision making (SDM) is an approach whereby patients' values, preferences and perspectives are disclosed and integrated with the best scientific evidence available (Elwyn et al, 2000). Patients are supported to deliberate about different treatment options in order for, rather than a unilateral decision, a collective agreement between involved stakeholders to emerge. In 2011, a Cochrane review of 80 studies on the benefits of SDM was published. The mutual knowledge exchange revealed to stimulate greater awareness of treatment opportunities, which led to a more accurate risk perception, greater comfort with decisions and consequently increased the adherence to prescribed care (Stacey et al, 2011). Additionally, the involvement in the decision process has been found to improve patients' self-management skills, thereby minimising long-term costs and hence endorsing the principles of the Dutch participation society (Verhoeven & Tonkens, 2013). Outlining similar advantages, Shafir and Rosenthal (2012) conclude that the practice of making shared-decisions is fundamental to the safe and effective supply of care. The implementation of SDM with elderly people suffering from multimorbidity, due to their familiarity with many of the above issues (Bastiaens et al, 2007), could carry both enormous individual and societal benefits (Belcher et al, 2006; Wittenberg, 2015).

“No decision about me without me” presents the call for more patient-oriented healthcare systems that advocate shared-decision making. Nevertheless, despite its numerous positive contributions and the increasing academic interest – no publications in 1980 to 542 in 2012 (Ouwens et al, 2012) – examinations of European behaviour suggest the practice is only applied in approximately 10% of suitable situations (Godolphin, 2009). Existing studies on the implementation of SDM are frequently distinguished by their focus on the acute care

sector. However, considering the growing importance of the long-term care setting in the light of a growing, aging and increasingly multimorbid population, the research scarcity into this area is both surprising and alarming. Whilst a small number of publications have previously identified utilisation factors relevant to the participation of elderly people suffering a multiplicity of chronic conditions, the literature on the experience of different LTC professionals working with the forgoing, regardless of the distinct challenges encountered, remains limited.

Gravel et al (2006) suggest that should shared-decision making be desirable, more research needs to be conducted in an attempt to better understand the practice's barriers and facilitators in order to improve the implementation across all healthcare situations. The following exploratory study aims to analyse the experience of Dutch long-term care professionals working with elderly people, defined as those aged above 65 (WHO, 2016), suffering from multimorbidity to understand the conditions necessary for successful making of shared-decisions. The results of the paper will contribute to fill an existing knowledge gap as well as improve SDM's future implementation in the LTC sector.

2. Theoretical Exploration

2.1 Background

The continuous shift in the world's demographic structure requires drastic adjustments in terms of the populations' health care needs. Greater longevity and the growing ability to manage disease, a combination that has led to an increasing number of people experiencing multiple chronic conditions, pose significant challenges to the 21st century healthcare systems (Nolte & McKee, 2009). In 2014, a forecasting report published by the Dutch Ministry of Health estimated over seven million citizens will suffer from a multiplicity of chronic illnesses by 2030. Multimorbidity, the prevalence of which sharply rises with age, is associated with both disability as well as care dependence; hence, unless preventative measures are taken, the demand on long-term care will exponentially grow in the near future. Additionally, research demonstrates that affected individuals often experience an inferior care quality whilst simultaneously requiring greater healthcare resources than their healthier counterparts (Wittenberg, 2015). Thus, in the light of recent austerity measures, Koller et al (2014) question the impending sustainability of the aforementioned care setting. In response to the changing conditions, many countries have adapted their health and social policy in an attempt to enhance the quality of care provided under a shrinking budget (Wittenberg, 2015).

In 2013, Dutch King Willem-Alexander called for a cost-effective solution to many modern welfare struggles: the participation society. The underlying idea rests upon a bottom-up notion of responsible citizens – patients in the context of health care – and the ethos of active support for self-management, which subsequently encourages active aging at a lower cost. In order to achieve successful patient participation, support from healthcare providers to individualise care and inform patients to become self-sufficient is necessary (Nolte & McKee, 2009).

Autonomy refers to the independent exercise of individual choices free from the controlling interference by others. Over the past decades, a movement away from the patronising “the doctor knows best” attitudes has been noted and instead patient-centred practices that promote self-determination have gained popularity. Shared-decision making, the process in which professionals and patients aim to reach a joint decision regarding future healthcare provisions, is seen as a tool for balancing the wishes, preferences and goals of patients against the best scientific evidence available (Elwyn et al, 2000). Consultations examine the available treatment options, as well as assess the risks and benefits associated with each, in order to reach a medically appropriate solution that is also congruent with the patients’ perspective. Therefore, on the patient engagement continuum, SDM presents a middle ground between the traditional paternalistic model and informed patient choice (Desroches, 2006). The practice is encouraged by its potential to stimulate knowledge about different treatment opportunities, which in turn has shown to create a more accurate risk perception as well as greater comfort with final decisions made. Ultimately, the practice then increases the adherence to recommended care (Stacey et al, 2011). Through its focus on information, decision and implementation sharing, SDM not only improves patients’ self-management behaviour and self-efficacy measures but also it significantly reduces the healthcare costs and waste encountered (Bulsink, 2012). Whilst some studies articulate concerns regarding the practice producing inequalities due to patients’ varying levels of health literacy, Durand et al (2014) found evidence suggesting joint decision-making interventions actually improve outcomes for disadvantaged patients. Studies demonstrate the patient empowerment achieved enhances both the physical and mental health of patients, and by extension the quality of care provided (Evetts, 2012). By reasons of the forgoing, the promotion of SDM with elderly multimorbid individuals, who account for a large majority of both health service users as well as annual medical spending (Wittenberg, 2015), appears particularly promising. Having achieved longevity, Stacey et al (2011) show elderly individuals suffering from a multiplicity of chronic conditions often display an altered

mindset in which they prioritise quality of life (e.g. comfort) over quantity. Hence, encouraging joint decisions between said patients and professionals may reduce unwanted interventions and increase the adherence to prescribed care, both of which contribute to avoid wasteful behaviour whilst stimulating well-being and the quality of care perceived (Belcher et al, 2006; Bastiaens et al, 2007).

Reviews by both Légaré et al (2008) and Godolphin (2009) revealed that the utilisation of shared-decision making, despite its various benefits, still remains rather limited with little known about effective strategies to increase its uptake. Hence, immediate efforts need to be made to improve the understanding of factors involved in its successful implementation.

2.2. Theoretical Framework

Over the last decade there has been a mounting interest in the use of theory, models and frameworks to gain insight and evaluate the mechanisms necessary for the successful application of different interventions. Implementation science, which helps clarify how and why utilisation thrives or fails, emerged out of the desire to address difficulties associated with the use of research to achieve more evidence-based practice (Nilsen, 2015). Academic literature on the implementation of shared-decision making has boomed during the past decades. However, research to a great extent has been concerned with identifying barriers and facilitators as experienced by patients and/or doctors within the acute care setting (Stiggelbout et al, 2012). In contrast, much less attention has been directed at the practice's implementation within the long-term care sector that, fuelled by the rapid increase in longevity and multimorbidity, is quickly growing in significance (Deusdad, 2016). A possible explanation for this phenomenon is an underlying assumption that all healthcare experts, regardless of their profession, require identical support to implement the practice routinely.

For its successful application in daily practice, a strategy focused on overcoming encountered barriers and identifying facilitators within different domains influencing the shared-decision making is needed. In order to analyse the factors that hinder and support an intervention such as SDM, Grol and Wensing (2004) developed a framework that aims to identify necessary determinants to subsequently improve intervention strategies. Based on several theoretical reflections, the constructed model consists of six categories, each equally relevant to success. The idea of implementation as a multilevel phenomenon is also in line with many other established frameworks (Nilsen, 2015). To improve the applicability of the

model to the practice of SDM, each of the following divisions were supplemented with existing knowledge acquired from the relevant acute care sector literature. A full taxonomy of the information presented below can be found in Appendix A.

Category 1: Intervention – Shared-Decision Making

The initial level of implementation outlined within Grol and Wensing's model (2004) aims to assess the situational feasibility, credibility and accessibility of a questioned intervention. A majority of relevant research exploring the barriers and facilitators to shared-decision making highlights the perceived complexity of the practice both in terms of the involved process as well as the types of decisions made (Joseph-Williams et al, 2014). Professionals' cloudy understanding of the practice, demonstrated by comparable experts struggling to communicate identical actions involved in the process, further adds to SDM's complexity (Evetts, 2012). Another hurdle frequently described in the published work is the alleged mismatch between physicians' actions and goals, for instance the treatment of patients as 'numbers' rather than individual human beings (Bulsink, 2012), and the principles underlying shared-decisions. Finally, authors such as Elwyn et al (2000) quote the practice's limited application flexibility as a considerable barrier. In the light of multimorbidity for example, single-disease focused guidelines considerably complicate its implementation for professionals.

Category 2: Individual Professional

Professionals are individuals that each display a distinct set of knowledge, attitudes and behaviours that help predict the level of interventions' success (Grol & Wensing, 2004). As mentioned previously, a large amount of research into the acute care setting shows professionals often lack the awareness of and familiarity with the subject in order to correctly implement SDM (Godolphin, 2009, Joseph-Williams et al, 2014). Moreover, the attitudes held both regarding the associated benefits of the practice but also concerning the patients are highly relevant. According to Wittenberg (2015), ageism, the stereotyping and discrimination of individuals based on their age, is a common problem within the acute care sector. The expectation of older people's inability to partake in decisions is further intensified by the presence of multimorbidity. Mishler (1984) notes that doctors tend to act on hidden assumptions related to their own cultural beliefs, biases about treatment options and/or economic consideration, which can distort the information presented. He speculates this may be a subconscious strategy by experts to maintain their dominance. Therefore, physicians' behaviours can also present a significant hurdle to the successful implementation

of shared-decision making. Relevant literature highlights the idea that healthcare experts may lack the motivation and/or confidence to discuss treatment options and limitations with patients, particularly when they present complex, coexisting and chronic conditions (Joseph-Williams et al, 2014; Williams et al, 2014). Finally, existing research demonstrates many established healthcare professionals commonly struggle to break established routines, and behaviour changes are of slow nature (Godolphin, 2009). Speculations can be made that similar barriers will prove true for long-term care professionals also.

Category 3: Patient

Similarly to the forgoing section, the focus within this category is directed at the knowledge, attitudes and behaviours associated with patients. Studies published commonly focus on the age-related participation gap that sees younger, healthier and more educated individuals more willing to partake in decisions. Older multimorbid individuals that grew up under a more paternalistic healthcare model in contrast are much less inclined to request participation as they often underestimate the relevance of their own expertise (Belcher et al, 2006; Gravel et al, 2006). Additionally, a study by Joseph-Williams et al (2014) revealed elderly patients fear suboptimal treatment due to being perceived a 'difficult patient' when voicing opinions. Along the lines of the social breakdown theory, explanatory thoughts about societal tendencies to devalue and negatively label the elderly as incompetent, thereby triggering self-fulfilling prophecies have been expressed (Durand et al, 2014). Nevertheless, a growing number of publications highlight the importance of patient participation as it encourages active aging (Belcher et al 2006). Elderly multimorbid individuals typically display complex care needs that may render them incapable of making decisions as their functional, social and/or psychological domain are affected. In said cases, the informal network often becomes an essential advocate for the patient (Joseph-Williams et al, 2014).

Category 4: Social Context

Seen as essential to the successful application of SDM is the specific context in which an intervention is placed (Grol & Wensing, 2004). Researchers including Barry and Edgman-Levitan (2012) have repeatedly pointed towards the significance of professionals' work environment in order to explain the level of implementation success. The close connection and collaboration with colleagues is highlighted in the relevant literature as a significant predictor of SDM's successful implementation (Godolphin, 2009). Furthermore, the networks' culture, namely the norms and values present, have a large impact on the implementation of the practice. Leadership and social learning, for instance through

reinforcement by role models, are two highly relevant concepts that also factor into the outcomes of the process (Bulsink, 2012). Furthermore, Godolphin (2009) found that young physicians frequently lack role models as their more established mentors often are doubtful of the practice. This in turn then can promote a negative trickle-down effect onto the newly qualified individuals.

Category 5: Organisational Context

According to the research, organisational settings that encourage education and continuous learning are more successful at regularly utilising shared-decisions (Bulsink, 2012). SDM is about choosing and respecting patients' preferences, however, during the early education of professionals emphasis is frequently placed on the perspective of evidence-based care and therefore a 'correct' treatment from the healthcare perspective. Only recently has shared-decision making been included in aspects of professionals' initial education. Barry and Edgman-Levitan (2012) found established healthcare experts that attended regular training sessions while simultaneously engaged in the labour market were more open to and engaged more often in SDM than those that did not receive continuous learning opportunities. Furthermore, a large barrier outlined within the existing implementation literature is the limited availability of resources such as staff, time and support offered (Elwyn et al, 2012).

Category 6: Political Context

The political support expressed is thought highly significant for interventions' success. Political encouragement by means of compensation and financial incentive will increase the appeal of interventions such as shared-decision making (Grol & Wensing, 2004). The political ideal of a Dutch participation society, which aims to promote societal inclusion of all individuals to enhance successful aging and reduce the reliance on health-related services hence should support the practice. Concrete and focused efforts to promote SDM within the Netherlands began in 2015 when Minister Schippers, referencing crucial evidence, published a cabin letter urging the immediate political encouragement of the practice. Simultaneously, the growing call for increased transparency within the healthcare system, supported also by various citizen initiatives, has led to the organisation of a first meeting regarding political subsidies for the regular practice of shared-decisions in July 2016.

2.3 Research Question

After consideration of the forgoing, exploring and understanding differences in factors that hinder and facilitate long-term care professionals, in opposition to those working within the

acute care setting, to promote SDM with older individuals suffering from multimorbidity appeared a pressing issue in modern society. Due to the limited information available on the subject, an exploratory research was conducted centred around the question: *What conditions are necessary for long-term care professionals to successfully implement shared-decision making with elderly people suffering from multimorbidity?*

3. Research Design

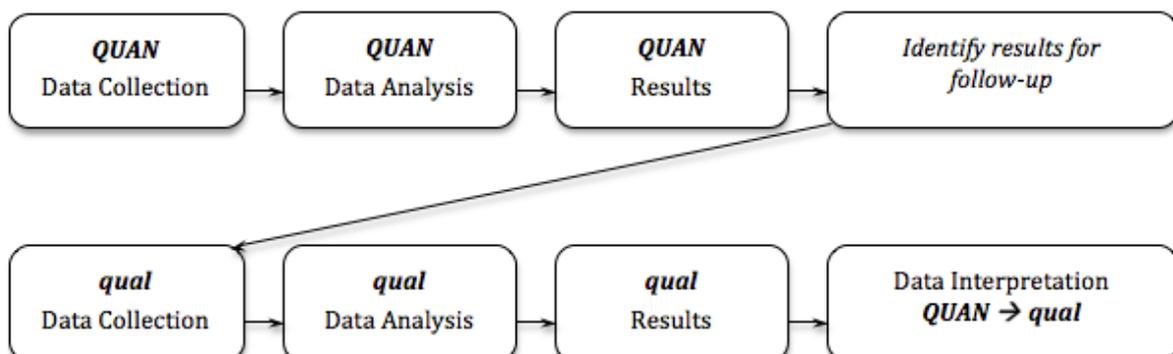
The posed research question was evaluated utilising a mixed method sequential design composed of two individual but related stages of inquiry (*Figure 1*). The initial data, collected exclusively in the Netherlands, was generated via a quantitative study and expanded on through consecutive qualitative methods. The chosen design allowed the research to gain both depth and breadth as the two approaches served to complement one another’s findings whilst simultaneously offsetting encountered weaknesses. Additionally, the use of a sequential arrangement enabled a more structured collection and documentation of final results (Malina et al, 2011).

3.1. Study 1: Quantitative Research

Justification of Research Method

The initial stage of the research consisted of a quantitative questionnaire that sought to enable a broad, descriptive and context-specific understanding of both the barriers and facilitators to shared-decision making with elderly multimorbid individuals as experienced by different long-term care professionals. The utilisation of a survey allowed for a large sample of participants to arguably produce more objective data, which then revealed informative trends suited for demographic comparison

Figure 1: *Visualisation of Methods*



Development of Questionnaire

The self-reported survey was developed on the basis of Van de Wees et al's "*Developing a questionnaire to identify perceived barriers for implementing the Dutch physical therapy COPD clinical practice guideline*" (2013). The decision to utilise the particular questionnaire was based on the similarity in research aims as well as the mutual understanding, fuelled by the 2004 work of Grol and Wensing, of implementation as a multi-levelled process. Assessment of the forgoing tool indicated both great validity and reliability (Cronbach's alpha= 0.9). The survey developed for the research at hand used 36 out of 46 rephrased questions (e.g. "My colleagues and I collaborate in adopting the COPD" into "My colleagues and I collaborate in making shared-decisions"). In order to avoid patterned response, statements were adjusted to randomly alter between positive (e.g. "Shared-decision making is a clear process") and negative (e.g. "Shared-decision making does not line up with my professional activities/goals") phrasing. As the questions aimed to measure latent constructs such as attitudes and opinions, a 5-point Likert scale (1= strongly disagree, 5=strongly agree) was used. Two of the included questions required the same scale but instead involved percentile measures (1= 0%, 5= 100%). Further two statements merely required a binary yes/no response. All inquiries included were organised according to the established taxonomy (*Appendix A*) in order to structure the responses. Four additional questions regarding the demographic information of participants were added to the beginning of the questionnaire to allow for a later group comparison of the collected data.

Participants

Due to the very particular nature of the study question, the units of analysis were exclusively comprised of long-term care professionals working with multimorbid individuals above the age of 65. The recruitment process occurred via two distinct channels, namely various online platforms operated by Vilans (Vilans.nl; ZorgVoorBeter.nl; BeterOud.nl) and a conference on the topic of shared-decision making in long-term care. Both the enlistment and execution of the questionnaire took place in the months of March and April 2016.

Data Analysis

The anonymous questionnaire received a total of 134 responses, 42 of which were excluded due to large sets of missing data. The remaining 93 responses registered a range of long-term care occupations including nurses, carers, physiotherapists and occupational therapists. Prior to the analysis of the collected data, all negatively phrased statements were recoded in a positive direction in order to yield comparable results. Evaluation, due to the unexplored

nature of the topic was accomplished by means of descriptive analyses with frequency tables via SPSS 23.0. As some questions, particularly those related to the context in which shared-decision making occurs, revealed even responses across the response continuum, cross tabulations were run to improve the interpretation of data.

3.2 Study 2: Qualitative Research

Justification of Research Method

The second stage of the research consisted of in-depth, semi-structured interviews with open-ended questions that aimed to ratify and expand on the quantitative information gathered. The use of qualitative methods forced respondents to engage and reflect more critically upon the previously revealed trends, which proved essential to the exploration of this under-researched area.

Development of Topic List

The queries of the qualitative research were based on the knowledge exposed by the forgoing method. Hence, lead questions of the topic list (*Table 1*), which were adjusted and added as part of a helical process throughout the interviews, aimed to discuss, deepen and expand on the quantitative trends found in order to further explore the reasons behind barriers and facilitators to SDM with elderly multimorbid individuals. Participants were offered a copy of the topic list prior to their interview in order to make interview sessions more productive.

Participants

Although the survey was anonymous, respondents were presented with the opportunity to

Table 1: Interview Guide/Topic list

<i>Qs regarding personal experience</i>	<ol style="list-style-type: none"> 1) Please tell me a little more about you professionally and your work setting? 2) In your opinion what does SDM entail? Please share an example of a decision you regularly share with your elderly multimorbid patients. 3) Are you aware that you might subconsciously influence the treatment options presented?
<i>Qs expanding on quantitative results</i>	<ol style="list-style-type: none"> 4) What patient group do you treat and what role do informal caregivers in SDM 5) Why do you think there are differences in utilisation of SDM regarding: <ol style="list-style-type: none"> a) Duration worked in profession? b) Profession? c) Work environment? 6) What influence does your social and organisational environment have on your use of SDM? 7) What improvements do you think are necessary for SDM to be implemented more regularly: <ol style="list-style-type: none"> a) In your own profession? b) In the wider long-term care setting?

enter contact information should they wish to partake in follow-up interviews. Hence, the population of interviews solely consisted of volunteers recruited via the previous quantitative study. The self-selection process ensured a high level of both motivation and engagement during questioning, thereby producing more well-rounded, critical and detailed responses. Subjects were excluded if they were unable to interview in English. Due to distance, Skype/telephone interviews of 30 minutes each were conducted with seven eligible participants that covered a wide range of occupations, work environments and durations worked. Prior to giving verbal consent, interviewees were made fully aware of the research project, confidentiality and their ability to drop out. Telephone numbers were deleted directly after the interview and participants were reimbursed for their efforts with a €20 voucher.

Data Analysis

As English was not the participant's primary language, interview transcripts were sent to each interviewee for them to reflect and confirm the correctness of the written text prior to its analysis. Transcripts then underwent a qualitative content analysis using the software MaxQda 12. Data was analysed using an inter-coder agreement in which two autonomous researchers were involved in the coding of information. No conflict of interest was declared by either of the involved analysts. An initial coding tree with nodes based on the first transcript was established, however, the possibility of discovering unanticipated nuances and themes in the later interviews was acknowledged. The two researchers independently coded one transcript at a time, discussing conflicts and adjusting the coding tree accordingly. This process continued until all interviews were analysed and saturation was reached – that is until no new codes emerged. Codes included barriers such as professionals' attitudes and behaviours with sub-codes labelled 'limited preparedness to deal with multiple chronic conditions' or 'limited interaction and value attached to patients'. Coded transcripts were reread to confirm all relevant data was coded and included for analysis. A final version of the coding tree can be found in Appendix B.

4. Results

Demographic Information

Survey. The questionnaire received a total of 134 responses, 93 of which, following the removal of surveys with incomplete and large missing data sets (at least 5 missing answers), proved eligible for inclusion in the information analysis. Surveys were also excluded if the

respondent did not (yet) have any practical experience within the professional (e.g. student, medical administrators). Table 2 presents an overview of the remaining participants' characteristics.

Individual Interviews. Seven of the 93 respondents, representing a mix of LTC experts, were interviewed. Interviewees had been active in their professions for varying amounts of time and covered all of the work environments included in the study.

4.1 Quantitative Data

Examination of the posed 55 survey questions helped uncover long-term care professionals' attitudes towards shared-decision making, whilst simultaneously highlighting perceived barriers and facilitators to the practice with elderly multimorbid individuals. Tendencies based on individuals' profession, work environment and duration worked were noted.

Table 2: Demographic Information Participants (n=93)

Characteristics	Frequencies	Percentage
Professions		
Nurse	21	22,5%
Carer	42	45,2%
Occupational Therapist	6	6,5%
Physiotherapist	24	25,8%
Education		
Higher Scientific Education (WO)	9	9,7%
Higher Professional Education (HBO)	43	46,2%
Secondary Vocational Education (MBO)	41	44,1%
Duration in Profession (in years)		
1-5	27	29%
6-10	14	15,1%
11-15	15	16,1%
16-20	4	4,3%
21-25	8	8,6%
25 and over	25	26,9%
Work Environment		
Nursing Home	44	47,3%
Home Care	31	33,3%
Private Practice	14	15,1%
Hospital	4	4,3%

Descriptive statistics and intercorrelations

To achieve an overview of all responses given, descriptive analyses with frequency tables were run for each of the questionnaire's statements. The most informative results that emerged from the evaluation of survey categories demonstrated the principles underlying shared-decision making are much clearer and applicable to LTC professionals (M=3.8; SD=1.1). More than 80% of participants (n=75) believed they understood what the practice entails and possess the necessary competencies – clear communication and confidence – to successfully implement it with their patients. Nevertheless, 82 professionals (88.2%) indicated that their elderly patients frequently are unaware of the possibility to partake in

decisions. Variations regarding the desired and actual involvement of the target group could be noted with significantly lower numbers of participation than requested by patients (M=1.8; SD=1.6). Similarly the quantitative data showed a negative perception of a majority of respondents (n=64; 69%) who believed not every patient is equally qualified to participate in decisions. The support received by the social and organisational environment, for instance through colleagues and management, presents crucial to the successful implementation of SDM. While 65 of the participants (69.8%) indicated SDM to be in line with their work norms, less than half the respondents (n=43; 46.2%) reported experiencing support to routinely apply the practice. Moreover, nearly 49% of respondents (n=45) indicated to feel discouraged within their work environment to pursue SDM due to resource scarcities, for instance a lack of time. Lastly, opinions recorded regarding the governmental support for the practice were evenly split with equal numbers of participants stating support and no support. Overall, 79% of participants agreed that the investment in shared-decision making in LTC would be a good idea whilst 15% reported no opinion on the matter.

Due to some data discrepancies largely regarding the social and organisational environment, group difference tests were run in order to explain the trend variation. Cross tabulations revealed noticeable differences in regards to a) profession, b) duration worked within the profession, and c) the work environment. For instance, analysis showed newly qualified professionals that spend more time with their elderly multimorbid patients such as carers (M=3.8; SD= 0.9) are much more likely to utilise SDM than established nurses that commonly experience time pressure at work (M=3.1; S=1.4). Similarly, those working within a presumably hectic environment, such as large-scale companies, indicated that they felt less encouraged by their management (M=2.1; SD=0.5) than professionals employed within smaller institutions (M=3.5; SD=1.0).

4.2 Qualitative Data

The analysis of qualitative information validated and further gave insight into many of the previously identified factors relevant to the successful implementation of SDM with elderly multimorbid individuals. From the coded interviews, four common topics, some with sub-themes, emerged that were equally applicable as both barriers and facilitators (Table 3).

Table 3: Themes identified in Interviews

Barriers/Facilitators to SDM

- 1: Professionals: Behaviour & Attitudes**
 - 1i: Education**
- 2: Patients: Behaviour & Attitudes**
- 3: Social Environment**
- 4: Organisational Environment**
 - 4i: Resource**

Barriers to Shared-Decision Making

When referencing barriers, all interviewees focused on patient characteristics such as their willingness to contribute, which can be burdened with increasing age and a growing severity of conditions present. Both the demanding process of encouraging older individuals to participate, as well as the sheer complexity multimorbidity presents in the light of single-disease focused guidelines further complicate the practice. Two newly qualified nurses also commented on the limited communication both with patients but also other healthcare professionals that presents a hurdle to SDM. Although all participants seemingly promoted SDM, subconsciously several interviewees revealed paternalistic attitudes: *“It’s nice to think that at every stage of your life you are able to make decisions but really is that realistic?”* Similarly an established physiotherapist admitted herself that it is a difficult process in which it is easy to unconsciously overrule older patients, particularly when they are indecisive or do not clearly voice their opinions.

Hand-in-hand with the previous attitudes, interviewees confirmed the quantitative findings that elderly patients are often unaware of their role and still show a paternalistic reliance on the LTC experts. In turn, this complicates the process of patients opening up, trusting and expressing their wishes. Additional barriers not previously considered in the survey included communication issues due to various auditory and cognitive impairments that may render individuals incapable of partaking in healthcare decisions. Thus, additional stakeholders such as informal caregivers are introduced that further complicate the process of SDM. Interviews highlight the importance of informal caregivers, however, professionals also acknowledge the downsides of their involvement. For instance, selfish behaviour as well as strong opinions displayed by said carers are problematic. The breakdown of family relations and demographic freedom were referenced to complicate this further.

The social environment in which SDM presents can work to prevent its application. Limited collaboration within a team of experts that was facilitated by the disengagement of higher management emerged as a significant barrier. Particularly prominent during the questioning was also the connection between professionals’ work duration and the implementation of the practice. Participants that only recently joined the workforce repeatedly point towards the conservative attitudes of many role models that hinder shared-decisions. A young physiotherapist noted, due to the still existing hierarchy, he did not feel confident telling his more experienced co-workers how to handle their patients. Similarly, all newly qualified interviewees expressed concerns about the longevity of their actions within the current environment. *“I am afraid I will also follow them and soon give up trying”*.

One of the less experienced nurses explained: “We were taught to use SDM during our training but I think it is unreasonable to expect it to happen over a long-term under the current conditions”. Shared-decision making has repeatedly been shown to be a very time-consuming practice, especially when undertaken with older patients suffering from multiple chronic conditions. If not supported by their organisational environment, interviewees highlighted issues such as staff shortages, high staff turnovers and limited-time appointments can seriously hinder the usage of SDM. Particularly within hectic work environments, all questioned nurses outlined the limitation of heavy workloads and limited interdisciplinary collaboration. “*We get told off for spending too much time with the patient when we could be doing something else*”. Additionally, the constant need to make quick decisions under pressure was referenced to lead professionals to display a dismissive style of communication in which older people are prematurely classed as incapable of decisions.

Facilitators to Shared-Decision Making

“*Shared-decision making is probably the most important part of my job*”. The personal tendencies held towards fellow human beings both in the interviewees’ private and professional lives emerged as highly significant to the application of SDM. Furthermore, characteristics such as empathy and patience appeared to promote trust and speed up the process of engaging elderly patients, thereby allowing the questioned experts to provide care based on mutual respect and dignity. “*I always imagine when I grow old what would I want to be treated like*”, stated one individual. Moreover, qualities highlighted by recently qualified professionals such as the desire to please people facilitated shared-decisions. However, at the same time it appeared important that professional could also stand up for themselves and hence minimise the patients’ over-reliance on them. “*They cannot hold on to me for their comfort*”.

Contrary to the existing literature findings, the majority of participants interviewed communicated older patients do wish to be involved and are not afraid to voice their opinions once they trust the professional. The period in which you can tell people what to do has long passed and “*it is their energy that is needed for the therapy to succeed*”. Nevertheless, in order to be involved they have to have the capacity to understand. The informal caregivers can be a facilitator to SDM in such cases. Although various professionals indicate that the involvement of the patients’ informal network complicates the practice, they do acknowledge the significance of different perspectives introduced through the involvement. Considering additional stakeholders when the patient is incapable makes

the decision *“more realistic because if I recommend a person stays at home but the family lives hours away than that will be difficult and not good for the old person”*.

The involvement of the social environment in the promotion of the practice is essential. One interviewee said: *“Everyone is emotionally involved in the jobs and we love what we do. It does not feel like work”*. From the interviews it became clear that SDM is applied more routinely if individuals within a team feel fully engaged in their profession. The recently employed nurses interviewed particularly reported their enthusiasm about the practice and the importance to engage in it on a regular basis as part of a larger team. One in particular indicated difficulties imagining the different options available hence she outlined the usefulness of interdisciplinary meetings – *“talking about it with other professionals helps me ‘visualise’ what is going on”*.

Finally, the organisational environment in which SDM happens emerged as highly significant to the success of its implementation. The emphasis the company prescribes to shared-decision making is highly relevant. *“I feel very pushed to take time and find the best decision with a patient or in other cases their family”*. A nurse that had worked in both a hospice and hospital compares her experiences and demonstrates how the different environments had very different emphases. Whilst the newly qualified individuals referenced mainly their initial education as a facilitator, some long-term employed professionals highlighted the periodic training they received to increase their awareness and improve their communication skills. Furthermore, comfortable physical environments appear to help facilitate the practice in the eyes of many interviewees. Comfortable and quiet rooms that offer little distraction were mentioned by long-term employed carers to improve the practice’s application with elderly individuals. Additionally, a lower staff-patient ratio was highlighted as a predictor for more regular application of SDM. Similarly, the time given to professionals to work with patients is also relevant to shared-decisions. One of the physiotherapists interviewed said: *“We have 30mins and come back two to three times a week. If it isn’t working today I can just come back and try again tomorrow”*.

Suggestions for Improvement

Before concluding the interviews, participants were asked to offer suggestions for the improved application of shared-decision making with elderly multimorbid individuals. Four themes, namely training to enhance understanding and communication skills, the presentation of supportive evidence, increased organisational resources, and a more flexible approach to the practice emerged from the interviews. The necessity of an adequate initial education, which highlights the values underlying healthcare occupations, and further is

supported by continuous training throughout the professionals' careers, was communicated. One newly qualified therapist suggested displaying evidence of SDM's success particularly to more conservative professionals in order to convince them of the usefulness of the practice. Furthermore, interviewees said organisations must upgrade their resources, such as qualified staff, in order to address time barriers experienced by almost all professionals of both parts of the study. Additional staff could lift work related pressure and thereby make the work environment more pleasant and suitable for shared-decision. Particularly when working with elderly multimorbid individuals the two aforementioned are of the essence. Moreover, the combination of sufficient education on the topic and more organisational resource may decrease the presence of implicit paternalistic attitudes by professionals. Finally, persistence but also flexibility in the approach is vital to the success of SDM. One of the established physiotherapists suggested close collaboration with or possibly a referral to another healthcare professional that may be better equipped to deal with the patients' needs could improve the practice. Particularly in the case of multimorbidity in which individuals often adhere to multiple professionals the collaboration between them is essential for the success of therapies.

5. Discussion

The research conducted revealed that, in the long-term care context, healthcare professionals experience several barrier and facilitators to the promotion of shared-decision making with elderly multimorbid patients. After careful consideration of both the quantitative and qualitative data a number of factors, similar to those experienced by individuals working within acute care, were revealed. It appears the majority of research participants understood the importance of shared-decision making within their line of work and hence generally displayed positive attitudes towards its promotion. Thus, rather than at the baseline stages identified by Grol and Wensing's model (2004) the obstacles for long-term care professional, which vary in their significance demographically, more commonly lie within the wider context in which the practice is promoted. Across all demographic groups the importance of the perceived barriers in regards to both the social and organisational environment were overwhelming. Similarly, Elwyn et al (2012) and Evetts (2012) indicated that the implementation of shared-decisions with patients required other individuals crucial to the process, including colleagues and employers, to support the approach. Among the questioned carers and physiotherapist encouragement by employers as well as the working

team recorded positively in both the quantitative and qualitative data. In contrast, regardless of the length of employment, nurses, particularly those active within hectic work environments, communicated a severe lack of (interdisciplinary) team contact. Time pressure across all demographic characteristics recorded presented a considerable barrier to the application of shared-decision making. Hence for SDM to be successful in a particular profession and work environment it seems barriers are more commonly outside the individuals' immediate control. The finding of hurdles uncontrollable to the individual professionals also resonates with many published studies in the area of person-centred care (Nolte & McKee, 2009; Wittenberg, 2015). Thus, additional measures need to be taken in order to improve and encourage tailored strategies to emerge. For instance, more time offered to professionals by means of lower patient-staff ratios would be beneficial. Additionally, a close collaboration between interdisciplinary teams should be encouraged by the management in order to not only engage all involved experts critically but also allow newly qualified professionals to 'visualise' different perspectives. Furthermore, all healthcare professionals reported major barriers to the engagement in SDM related to a lack of resources provided by their organisations, which also in the existing literature is the most widely reported barrier (Légaré et al, 2008). A seemingly common staff shortage across almost all work settings included in this study further present a limit to organisations' resources. High staff turnover was perceived as another barrier as it may produce conflict and affect team cohesion and communication and is likely to directly impact the quality of the professional. The addition of newly qualified staff members, which generally appear very supportive towards shared-decision making, is hampered by the aforementioned conditions. Particularly striking during the interviews was the fear articulated by various newly qualified professionals to soon follow the more conservative footsteps of their role models, thereby slowly fading out the principles of SDM. This perspective has not yet been explored in the existing implementation literature on the topic.

As also outlined by interviewees, various reasonable adjustments are necessary in order to effectively address the majority of current hurdles to the practice and thereby allowing welfare saving policy approaches such as the Dutch participation society to succeed. Education and continuous training in particular are essential, as they would serve to provide a universal understanding and awareness of the practice across the healthcare sector. The differences in implementation strategies needed based on profession and work environment call for individually tailored improvements in order to enhance the routine application. Légaré et al (2013) reached a similar conclusion when examining physicians in

different healthcare settings. This study has shown that in fact the underlying assumption, based on the one sided research into the implementation of the practice, that all healthcare professionals require the same support to implement SDM is incorrect. In order to improve the application of shared-decision making in long-term care it is therefore of great importance that further research is conducted into the conditions necessary for individual professions and possibly their work environments in order to effectively support patient-oriented healthcare. For instance, studies could focus on different professionals within the hospital setting in order to realise the adjustments of strategies required.

5.1 Limitations

Although insightful results emerged, it should be noted that for various reasons the data collected might hold bias. First, survey participation was not rewarded by any means thus it is reasonable to assume respondents had a personal interest in the exploration of the research topic. Additionally, the self-selection process associated with the qualitative procedure saw only volunteers, which are likely to display (un)favourable attitudes towards the study subject, partake. Hence, both the methods' samples may not be representative of all long-term care professionals. Due to time constraints, another limitation was that the survey used was not validated but only modelled on a valid questionnaire. Furthermore, an existing language barrier, affecting both the researcher as well as the participants, may have impacted the depth of information collected and its later interpretation. Nevertheless, the linguistic bias produced was thought minimal due to the preventative measures, such as the screening of transcripts by participants prior to their analysis, taken. Lastly, despite not being the goals of exploratory research, the study had a small sample size that was not evenly spread across the recorded demographics and hence final results were limited in their reliability and generalisability. Both of the foregoing limitations could have been refrained from by a larger, more representative response. Similarly, the random selection of interviewees from the quantitative sample could have minimised biases encountered. Finally, further research may choose to employ either native researchers or professional translators to overcome the aforementioned language limitations.

6. Conclusion

Shared-decision making presents a great opportunity to improve the quality of healthcare provided for elderly multimorbid individuals, whilst simultaneously decreasing the

associated social and economic burden. Hence, at the heart of current political initiatives, the eradication of hurdles and instead promotion of the practice is essential. Long-term care professionals appear aware of SDM's value and supportive notions towards the practice have been noted. Nevertheless, making shared-decision with elderly individuals suffering from a multiplicity of chronic conditions within long-term care still appears a very demanding process that requires adjustments to optimise its implementation. Modifications especially are necessary in the social and organisational environments in which the practice presents. The current lack of support and encouragement by colleagues and the higher management, in combination with resource strains, was referenced to severely hinder the successful routine application of shared-decisions. Differences in the emphasis put on individual barriers and facilitators could be observed between each group of professionals working in different environments for varying amounts of time. The present literature gap in regards to the implementation of the practice outside the acute care sector results in a faulty assumption in which all healthcare experts require the same conditions to improve SDM's application. Instead, it seems distinctive developments are necessary for specific groups of individuals to promote the practice successfully.

6.1 Future Research

Future studies should focus on identifying the conditions necessary for individual groups of professionals working within specific environments to successfully implement the practice of shared-decisions with their patients – particularly those at risk of lower quality care. Potentially this could reveal new tailored strategies for professionals to receive sufficient support to apply SDM and thereby encourage current policy goals.

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Appendix A

Attachment: Taxonomy based on the framework by Grol and Wensing (2004) and supplemented with relevant literature on the implementation of SDM in the acute care sector.

A. Innovation: SDM

- i. Complexity (process/decision)
- ii. Lack of flexibility
- iii. Lack of compatibility

B. Individual Professional

- a. Knowledge
 - i. Lack of awareness
 - ii. Lack of familiarity
- b. Attitude
 - i. Failure to interpret evidence
 - 1. Lack of applicability
 - 2. Lack of the perception of benefits
 - ii. Lack of expectations
 - 1. Patient outcomes
 - 3. Lack of self-efficacy
 - a. Degree of confidence in own skills
 - iii. Lack of motivation
- c. Behaviour
 - i. Behavioural routines
 - ii. Difficulties breaking old habits

C. Patient

- a. Demographic Characteristics
 - i. Age
 - ii. Social economic status
 - iii. Severity of condition(s)
 - 1. Informal carers
- b. Knowledge
 - i. Lack of awareness to participate
 - ii. Health literacy
- c. Attitude
 - i. Paternalistic tendencies
- d. Behaviour
 - i. Power Imbalance
 - 1. Fearful behaviour

D. Social Context

- a. View of colleagues
 - i. Degree of contact between colleagues
 - ii. Disagreements between colleagues
 - iii. Hierarchical structure of professionals
- b. Collaboration
 - i. Degree of cooperation and response between colleagues
- c. Culture of the network
 - i. Social norms and values
- d. Leadership and Social Learning
 - i. Support from management
 - 1. Incentives
 - 2. Feedback
 - 3. Reinforcement
 - 4. Observed behaviour of role models

5. Supportive resources

E. Organisational context

- a. Organisational characteristics
- b. Organisational constraints
 - i. Lack of resources
 - 1. Staff
 - 2. Time (Workload)
 - 3. Support services
- c. Capacities
 - i. Arrangements for continuous learning

F. Political context

- a. Policy

Appendix B

Attachment: Coding Tree

	Definition SDM
D1	- Collaboration with patient/family
D2	- Collaboration with team
	Barriers
B1	- Behaviour/Attitudes: Professionals
B1.1	- Limited preparedness to deal with multiple chronic conditions
B1.2	- Limited interaction and value attached to patients
B1.3	- Limited interaction with (interdisciplinary) team
B1.1.1	- Education
B2	- Behaviour/Attitudes: Patients
B2.1	- Impairment/Severity of condition
B2.2	- Paternalistic attitudes
B2.3	- Selfish/Careless contribution of informal caregivers
B3	- Social Environment
B3.1	- Limited contact with (interdisciplinary) team
B3.2	- Limited support from employer
B4	- Organisation Environment
B4.1	- Limited support from management
B4.1.1	- Limited resources (time, staff, conditions)
	Facilitators
F1	- Behaviour/Attitudes: Professionals
F1.1	- Individual value placed on independence
F1.1.2	- Perceived value of and attachment to patient
F1.1.3	- Perceived personal responsibility as patient advocate
F1.a	- Education
F2	- Behaviour/Attitudes: Patients
F2.1	- Willingness to participate/Engagement of patient
F2.2	- Informal caregivers
F3	- Social Environment
F3.1	- Collaboration with team
F3.2	- Engagement of team in SDM
F4	- Organisational Environment
F4.1	- Importance of SDM to management
F4.a	- Resources (time, staff conditions)
	Suggestions for Improvement
I1	- Education/training
I2	- Resources (time, staff, conditions)
I3	- Flexibility in approach
I4	- Evidence
I5	- Communication
	Necessity of SDM in LTC
N1	- Yes
N2	- Maybe
N3	- No