MEASURING DECISION QUALITY IN A CLINICAL SETTING

A tentative success

The MAGIC (Making Good decisions In Collaboration) programme is a project to learn how best to implement shared decision making.

Background
We are developing tools to measure decision quality. Sepucha et al. have studied the best ways to measure decision quality in breast cancer patients using the Decision Quality Instrument (DQI): these tools explore patients’ decision-specific knowledge and the concordance between their preferences and the choice of treatment.

Aims
• To adapt the DQI (with permission) for use in two NHS breast clinics in the UK: Cardiff & Newcastle.
• To understand how the breast care nursing teams would use these measures in routine practice.

Methods
The applicability of the DQI was considered in Cardiff and Newcastle teams. The DQI was adapted during an iterative process of consultation and revision with two breast care teams, using quality improvement ‘Plan, Do, Study, Act (PDSA)’ test cycles. Knowledge questions were matched against Bresdex, the patient decision support used. Treatment preference questions were assessed in relation to different clinical care pathways. Observations and PDSA cycles were used in the Cardiff team to understand how the breast care nurses were using the adapted DQI.

Results
Scale adaption
Many aspects of the DQI required local adaption. Knowledge questions were changed to reflect information provided in Bresdex. Preference questions were adapted to elicit the importance patients placed on specific consequences of surgery options the clinical teams felt were relevant. Deliberation process was assessed using a new scale (DelibeRATE). Consultation with the breast care teams led to further revisions to the order and wording of questions, and an overall reduction in the length of the measure. The adapted instrument is known as the Decision Quality Measure (DQM).

Scale use
Initially, there was some resistance to the idea of measuring patient knowledge and preference. This was due to ethical implications of asking patients tough questions at a time when they were coping with bad news. The nurses were involved in the adaption of the instrument to their local setting and they tested this approach in clinic using PDSA cycles. PDSA documents and observations indicate that the nurses are now using the DQM routinely as a diagnostic tool.

In Cardiff, the tool is completed by the patient twice: at the diagnostic consultation (DQM1), prior to information provision, and at a follow-up home visit (DQM2), after patient and family have been given access to decision support. The DQM is being used in the following ways:
1. Nurses examine DQM1 knowledge scores and use this to inform the follow-up home visit (guides information provision)
2. Nurses use DQM2 to check patients understanding of the information and the alignment between the patients preferences and choice of treatment
3. Nurses are interested in using the comparative data from DQM1 & DQM2 to provide evidence for the value of their role and the home visit

Data is presented for DQM1 (n=20) and DQM2 (n=13) in Figures 1-6.

Conclusion
Despite initial resistance, the new measure has been adopted by one of the clinical teams: it helps inform their clinical practice and allows them to assess whether their patients are making a decision that is “right for them”. The DQM has crossed the boundary from being perceived as a research instrument to a measure that is used to guide the clinical encounter.

Knowledge
DelibeRATE
Intention