## Qualitative Analysis of Perceptions of the Cataract Decision Aid for Shared Decision Making

**Qualitative Analysis for Involve-CAT**

**A feasibility randomised controlled trial of a Cataract Decision Aid**

**Cardiff** **Qualitative Report for Involve-CAT**

**A feasibility randomised controlled trial of a Cataract Decision Aid**

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**REPORT PURPOSE**

This element of the programme will explore the feasibility of establishing a randomised controlled trial (RCT) using the Cataract Decision Aid (CDA) as an intervention. Embedded within the trial will be qualitative and cost elements and an exercise to validate the benefits prediction model developed earlier in the research programme. This report relates to Question 6 of the overarching Cataract Programme, outlined in the main study protocol:

Q6. Implementation: how do patient decision support tools influence preoperative shared decision making; what are the implementation costs and potential savings; how feasible is a full-scale decision support RCT; how accurate is the benefits and prediction model; why unexplained poor outcomes?

A6. A feasibility trial of a Cataract Decision Aid (CDA) with embedded qualitative assessments for a possible future fully powered RCT; evaluation of prediction model validity; qualitative investigations to include outcome mismatches (a continuation of qualitative aim commenced in WP3).

The report outlines the results and analyses that the Cardiff University team have completed with regard to WP4 (Involve-CAT). Specifically, this report outlines the qualitative elements of WP4:

* How does a decision aid influence preoperative shared decision making?
* How do patients and clinicians perceive the CDA in the context of routine care?

**Executive Summary of Qualitative findings from Involve-Cat: a feasibility randomised controlled trial (RCT) of a cataract decision aid (CDA)**

**Background**

Using a mixed-methods approach, we conducted qualitative and quantitative analysis of the decision aid. This included quantitatively scoring consultations using the OPTION 5 Observer instrument, comparing appointments with (CDA) and without the aid (Standard Care). We listened to recordings of the appointments and scored each of them in relation to shared decision making. Also, we analysed the ‘used a framework’ approach to qualitatively analyse the consultations. Additionally, we conducted interviews with patients and clinicians and qualitatively analysed their perceptions of the appointments and the decision aid.

We found that the Cataract Decision Aid (CDA) does have an effect on the quality and quantity of Shared Decision Making (SDM) that takes place during cataract consultations. We also found that the CDA was acceptable and perceived as helpful by both patients and clinicians and the CDA has the potential to be integrated into routine clinical settings.

However, several key issues arose that would likely impact on the effectiveness of the CDA and the extent to which it could be easily integrated. We highlight these key findings and outline recommendations for improving how and when the CDA is delivered within routine cataract care pathways, and as part of a future full-scale RCT.

**Key Findings**

* Observer OPTION5 scores revealed that there was a significant difference in mean total scores between the CDA and the Standard Care (SC) arm. We also found that there was a significant difference in OPTION5 scores at the item level, with all five items scoring higher on average in the CDA consultations compared to the SC consultations. These results suggest that when clinicians use the CDA with patients, more SDM behaviours are present, and they are carried out to a greater extent.
* The consultation observations and the OPTION5 analyses revealed that the key SDM tasks of introducing the choice and eliciting patient’s preferences were not always carried out, regardless of whether the CDA was used.
* Consultants did not consistently perceive the choices of ‘surgery, delay or decline’ as useful or even legitimate and therefore some did not agree with the presentation of choices in the decision aid. For some consultants who believed that there was a choice available to patients, declining surgery was generally not perceived as an ‘equal’ choice. For other consultants, the options were to have surgery or delay surgery, but not to decline the surgery. This view was also reflected by some patients, with several patients stating that they felt the only route was to have the surgery and ‘doing nothing was not an option’.
* For many of the patients, they had strong prior preferences and had already decided that they wanted the surgery. Thus, it would be difficult to re-introduce the choice talk at the consultation stage. This indicates that the shared decision making discussion around having or declining cataract surgery might be better placed earlier in the clinical care pathway or at least initiated earlier, before patients had formed strong prior preferences of what they wanted.
* The CDA was very effective at providing information to patients about their options, including their personalised risk, but it did little in the way of supporting the introduction of choice or the elicitation of patients’ preferences, partly because of the patients’ prior preferences.
* A number of approaches could help to rebalance the process towards SDM including: more work could be done in the consultation to re-introduce the concept of choice, emphasising that surgery is not a foregone conclusion, and providing a clear rationale for patient involvement in the decision making process; or, the introduction of choice could be initiated earlier in the care pathway (e.g. with an optician).

**Recommendations**

Overall, clinicians felt that the CDA could be integrated into routine clinical settings, and delivered as part of a larger RCT. However, changes would need to be made to the way in which the CDA is delivered so that it is feasible, including:

* The CDA should be used as part of a two-stage process. First, the CDA should be introduced to patients before the consultation, ideally being sent to patients with appointment letters. They will be asked to focus on using Section A (FAQs) and Section B (what matters to me) before the appointment, and they will be told that Section C (personalised risks) will be completed during the appointment. Then, the CDA will be used as a collaborative tool during the consultation.
* Possibly introduce the CDA at an earlier point in the care pathway. Generic elements of the CDA (Section A and Section B) would be better delivered prior to the referral to the consultant (e.g. with an optician), leaving the personalised element for the detailed discussion with the consultant after referral.
* Provide more consistent and adequate clinician training in SDM to the clinicians and the wider team who will be delivering the CDA. The skills training would help to ensure ‘coherence’ of the concept of SDM amongst the team members and it will explain how SDM is different to existing processes (e.g. informed consent). It will ensure that the way in which the CDA is introduced and delivered by the clinician maximises the potential effectiveness of the CDA.
* To improve future feasibility, the risk calculators should be better integrated into the local clinical systems, or a process should be put in place to pre-populate as much of the information as possible prior to the consultation.