Introduction of the ‘talk’ model of shared decision making into dental consultation.

Sanober Maknojia
Royal College of Surgeons in Ireland

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Introduction of the ‘talk’ model of shared decision making into dental consultation

Sanober Maknojia

A Dissertation submitted in part-fulfilment of the degree of MSc Healthcare Management, Institute of Leadership, Royal College of Surgeons in Ireland

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Declaration:

“I hereby certify that this material, which I now submit for assessment for the Project Dissertation Module on the MSc in Healthcare Management is entirely my own work and has not been submitted as an exercise for assessment at this or any other University.”

Student’s Signature(s):

Date: 12/05/2016

Student Number: 14110181
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Abstract

Background: In current dental consultations, collaborations and treatment plans may not always be based on the best practice of shared decision making, but rather rest on the traditional paternalistic style of decision making.

Aim: The planned organisational development project aims to improve shared decision making by introducing the ‘talk’ model into dental consultation.

Rationale: The paternalistic style of decision making can lead to dissatisfaction, compromised consent, and poor patient-centred care. The literature identified shared decision making as central to patient engagement, effective communication and quality of care.

Change Process Plan: The Health Service Executive Change Model was utilized as a framework for the systematic planning and future implementation of the planned project. The four stages included are: initiation, planning, implementation, and mainstreaming. This change model is coupled with a consideration of risk management, a supported financial case, a communication plan and a project management plan, so as to ensure a thorough foundation for successful change.

Evaluation: Project evaluation included a mixed method approach of informal interviews, questionnaires, and observations. Kirkpatrick’s model of evaluation was employed to evaluate educational aspects of the project.

Conclusion: Leading the planning for an organisational development project in healthcare is complex and challenging. The proposed implementation and evaluation of this planned project will enhance the dentist-patient relationship. For the project plan to be successful, it is important to understand the organisation’s vision, culture, and its stakeholders. Finally reflecting and learning strengths and limitations, both at an organisational and individual level are crucial.
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<tr>
<td>DCS</td>
<td>Decisional Conflict Scale</td>
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<td>DTSS</td>
<td>Dental Treatment Services Scheme</td>
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<td>GDC</td>
<td>General Dental Council</td>
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<td>HIQA</td>
<td>Health Information and Quality Authority</td>
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<td>Health Service Executive</td>
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Chapter 1

1 Introduction

1.1 Introduction

Direct involvement of patients in their care, with individualization of their dental treatment is central to a high-quality of healthcare services, improved health outcomes, and enhanced care experience. Dental treatment naturally involves a multitude of invasive procedures in the oral cavity, e.g. restorative and surgical procedures, and the majority of treatment decisions involve several options, including that of no action. To recommend a patient preferred, individualized, evidence-based dental treatment plan, an environment of effective communication between the dentist and the patient is required, thus leading to Shared Decision Making (SDM).

SDM is a philosophy and a process that leads to a higher quality of care while protecting the patients’ right to receive the appropriate care; no less than they require and no more than they want (Da Silva, 2012). SDM involves a healthcare professional and a patient working together and sharing information about treatment options, with the primary aim of fostering an informed decision, agreed upon by both parties (Coulter & Collins, 2011). In contrast, the status quo maintains a paternalistic style of decision-making, which leaves the health care professional to make decisions on behalf of the patient. Research suggests this paternalistic style may lead to unsuitable decisions (Charles et al., 1997) (Emanuel & Emanuel, 1992) as information the patient has, and the patient’s preferences are not considered, or equally valued, as part of the consultation. Roing & Holmstrom (2012) suggest that the paternalistic style is still practiced by healthcare professionals, including dentists. This style is deeply rooted in a plethora of reasons which include: insufficient time for
consultation, a lack of training in understanding of patient preferences and delivering information (Legare & Witteman, 2013), and the potential of healthcare professionals providing patients with information limited to what they consider to be the ‘best’ treatment (Röing & Holmström, 2012). It is apparent that healthcare professionals assume patient preferences based on the patients’ information and background, such as literacy, socioeconomic status, etc. (Stevenson et al., 2000). This is further supported by the finding that dentists prefer low-cost treatment options for patients with low socioeconomic status and more decayed teeth (Brennan & Spencer, 2005).

Evidently, there is a common issue where healthcare professionals tend to match certain treatment plans to specific patient groups, based on their preconceived notions.

To successfully achieve SDM, healthcare professionals should ensure that patients are informed about options, and supported to deliberate about those options. The ‘talk’ model of SDM (Elwyn et al., 2013) (Appendix 1), describes ‘team talk’, ‘option talk’, ‘patient preference’, and ‘decision talk’ as fundamental steps in the process to establish SDM in dental consultation. First, ‘team talk’ is about creating a partnership and explaining the need to deliberate about decisions. Second, ‘option talk’ is about informing and providing information about the available options. Third, ‘patient preference’ is about listening to the patients’ preferences about treatment and outcome goals, and eliciting their priorities, concerns, and expectations. Finally, ‘decision talk’ is about integrating informed preferences into a decision-making process (Elwyn et al., 2013).

The Institute of Medicine defines patient-centred care as care provision that respects individual patient preference, needs, and values to guide all clinical decisions (Bailes, 2007). SDM and effective healthcare professional-patient communication are
crucial components of patient-centred care (Epstein & Street, 2007). The purpose of the organisational development (OD) project is to promote this patient-centred care, through the training of healthcare professionals working in a private dental practice, by engaging patients in their dental treatment decisions through the introduction of the ‘talk’ model for SDM.

1.2 Organisational Context

The writer is a practising dentist working in Ireland’s largest private provider of dental care. The organisation has 20 dental practices nationwide, employs over 150 dentists and treats more than 100,000 patients per annum. The aim of the organisation is to provide exceptional patient-centred care while making the patients’ dental care experience stress free and enjoyable. The organisation supports and endorses this OD project as it is in line with the organisation’s goal to deliver patient-centred care. It is anticipated that with this project in place, patients and dentists will collaborate for improved health outcomes. However, it is important to note that practices, attitudes, and behaviours of some healthcare professionals should change for the complete success of this project.

This project will also support the Irish Society for Quality and Safety in Healthcare (ISQSH). The ISQSH has carried out and published research measuring patients’ perceptions of their experience in general healthcare. To date, ISQSH has not conducted research into the perceptions of patients with their dental treatment and this dissertation will assist ISQSH in the creation of a framework for a patients’ dental experience. It is proposed that the literature review in chapter two will provide an evidence base for further search strategies, specifically about dental practice.
1.3 Rationale for carrying out the project

The provision of patient-centred services through patient engagement is now at the top of the agenda for many healthcare regulators in Ireland and worldwide. The regulatory requirements of the Health Information and Quality Authority (HIQA) in the National Standards for Safer Better Healthcare (2012) state that:

(a) Service users should be empowered to engage in making informed decisions about their care

(b) Service users’ informed consent to treatment should be acquired in accordance with regulation and best existing evidence

(c) Service users’ privacy, autonomy, and dignity should be valued and promoted (HIQA, 2012).

The Minister for Health envisages that these national standards will be the basis for the licencing of all public healthcare organisations in the future, including dental practices. Practicing SDM in the dental consultation is also a current requirement of the Irish Dental Council (IDC). The Council’s Professional Behaviour and Ethical Code of Practice (2012) describe how dentists, must give their patients enough information about the treatment options along with associated risks and benefits, before starting any treatment so that patients can make informed decisions about their healthcare. (Code of Practice, 2012). While this is a regulatory code and more importantly, it is the most appropriate way to treat and work with patients, it is not always standard practice in dental consultation. A 2015 report of a confidential clinical audit review revealed that dentists do not discuss treatment plans in detail with patients. Moreover, research evidence indicates that SDM is neither widely practised nor well conducted universally (Oshima Lee & Emanuel, 2013) (Couët et
al., 2013), despite the fact that healthcare professionals believe that they do involve patients in their treatment decisions (Da Silva, 2012).

The introduction of this ‘talk’ model will not only bring a vast improvement in dental consultations, by engaging patients in their treatment decisions and promoting patient-centred care but will also serve as a framework for dentists to know the extent of patient involvement in clinical decision-making, to achieve SDM. Overall, reasons for introducing SDM are:

1. A regulatory imperative (HIQA national standards)
2. An ethical obligation (IDC’s code of practice)
3. Aid to achieving an aim of the writer’s organisation (high-quality dental care experience)
4. The right thing to do (patient-centred care)
5. Wanted by patients (patient empowerment).

In line with the established regulatory ethos for healthcare professionals, it is critical that dentists, while reflecting on their practices, should be mindful of their decision-making approach and should provide evidence of such in each patient chart. Through this, should the need to revisit a decision or treatment arise, the decision-making process will be documented. Moreover, this adds value and incentive for healthcare professionals to practice and benefit from SDM.

1.4 Aim and Objectives

1.4.1 Aim

To improve SDM by introducing the ‘talk’ model into dental consultation.
1.4.2 Objectives

1. Six dentists will be 100% competent in SDM skills through training to carry out the ‘talk’ model in their consultation by 2nd September 2016.

2. To achieve an 80% compliance rate of participating dentists in three-month pilot project towards the adoption of the ‘talk’ model by the end of 31st December 2016.

3. To achieve a 60% return rate of patients who indicated they would return six months post consultation from 1st April 2017 to 30th June 2017.

4. To measure the ‘talk’ model efficacy in dental consultation during the pilot period i.e. from 1st October 2016 to 31st December 2016 and six months post consultation from 1st April 2017 to 30th June 2017.

1.5 Role of the student in the organisation and project

The writer is a practicing dentist in the organisation with responsibilities including, but not limited to, patient consultations and treatments. The specific roles and responsibilities in this voluntary change initiative will include:

1. To research and identify an evidence-based model for SDM.

2. To obtain formal approval for this pilot project from the senior management in the organisation.

3. To obtain permission from senior management to implement the project in full at a later date.

4. To apply to the IDC for verifiable CPD points for SDM training session.

5. To employ effective communication strategies to facilitate stakeholders participation.

6. To facilitate dentists in their SDM training.

7. To pilot the project with six dentists in an existing clinical practice.
8. To measure the effectiveness of project by completing initial and final developmental evaluations.

9. To analyse data and produce findings for business case presentation.

1.6 Summary and Conclusion

Although the practice of SDM into the clinical consultation is challenging, the adoption of a patient-centred strategy, the ‘talk’ model, by dentists, will empower patients to participate in treatment decision making and will shift the healthcare professional-patient relationship from paternalistic towards mutualistic. It will also provide an opportunity for the patient to discuss their treatment priorities and concerns, hence expanding the skills and role of the dentist. SDM is a vital factor in ensuring that the health-care professional is making an adequate contribution to the patients’ well-being and fulfilling their responsibilities. Moreover, if decision making improves, then the patient satisfaction of their care experience will increase, and accordingly there will be an increased return rate of patients, thus impacting positively on the organisation and its revenue.

These benefits and a more detailed analysis of the aforementioned SDM in clinical consultations will be explored in the following chapters of this dissertation. Chapter two examines the themes of the existing literature in this field. The systematic review provides a critique of the literature and further verifies the rationale for this project. Chapter three provides an overview of the OD methodology and methods to be used in the planned implementation. This chapter further incorporates a detailed project management plan, an assessment of potential risks, and a financial ‘income and expenditure’ outline for the pilot project. Chapter four details how the writer proposes to evaluate the planned OD. Finally, chapter five critiques the planning process was
undertaken, identifies shortcomings and suggests recommendations. Chapter five ends with a discussion of the potential organisational impact of this project.
Chapter 2

2 Literature Review

2.1 Introduction
A systematic literature review has been completed to identify, analyse, and critique the need for the proposed OD plan. The review aims to inform and provide background on current thinking, previous research evaluation methods, findings, and to learn from strengths and limitations in the selected area. The selected articles from the literature review will be presented under different theme headings.

2.2 Search Strategy
A variety of databases were chosen as the main research tools for articles. These were comprised of CINAHL, PUBMED, Science Direct and Emerald; the review yielded a comprehensive list of associated and relevant literature. In addition, Google Scholar was used to supporting arguments and explore varying and unique perspectives about the themes. The initial search was restricted to articles written after January 2010. However, it was found that this information is limited in the context of dental care, and therefore the search was expanded to articles published between January 2000 and January 2016. For a thorough analysis, references listed within articles were further reviewed and assessed to identify seminal articles on that particular topic. The search terms and keywords used include: ‘patient engagement’, ‘shared decision making’, ‘dentist-patient relationship’, ‘clinician communication’, ‘treatment decisions’, ‘quality in dentistry’, ‘patient -centred care’. The inclusion criteria for this review consisted of systematic reviews, randomised controlled trials, and peer reviews. Literature published in Europe, the United States (US), Australia and Canada was assessed to understand standards of care and best practices. 60 articles were included in the review, of these 35 articles were used to provide
evidence to support the rationale for the proposed change. Four themes emerged from the review of the literature as (1) patient engagement, (2) communication, (3) shared decision-making and (4) quality in dentistry. The following literature review comprehends and evaluates the transition to a high quality of patient-centred care.

2.3 Review Themes

The themes are discussed as follows:

(1) Patient engagement
(2) Communication
(3) Shared decision-making
(4) Quality in dentistry

2.3.1 Patient Engagement

Patient engagement is described in the literature ‘as a cognitive or a relational (i.e., the quality of healthcare professional-patient encounters) factor which influences patient’s emotional experience with healthcare delivery and fosters patient alliance with healthcare professional’ (Barello et al., 2012) (p. 5). The current emphasis on this theme highlights that patients have an active role to play in their healthcare, which includes health literacy by understanding health information, SDM by sharing information, and quality improvement by giving feedback (Coulter, 2012).

Additionally, engaging the patients in their health matters is now widely accepted as a critical component for high-quality healthcare systems (Barello et al., 2012). A practical, effective way to ensure sustainability of health systems is proposed in (Coulter, 2006a) whereby people are encouraged to engage in their health care and take responsibility for managing their health.
Furthermore, patient engagement encourages patient-centred care which is fundamental to improving outcomes and the overall quality of care (Luxford et al., 2011). Simmons et al. (2014), in their review, demonstrated the positive correlation between the interventions focussing on increasing patient engagement and improving health outcomes. In contrast, other literature identified the lack of scientific evidence and the lack of relevance of patient engagement to excellence in clinical care (Coulter & Ellins, 2007). These differing perspectives of healthcare professionals and their misalignment on patient engagement and the more broadly defined patient centred approach create a conflict on the horizon of patient participation.

Whilst patient engagement is at the forefront of the research and theory on quality healthcare, the application of its fundamental principles to practice do not seem to be successful in many cases (Crawford et al., 2002). An international study by Picker Institute revealed that while the United Kingdom (UK) is committed to patient-centred care, healthcare is delivered in a more paternalistic fashion and patients seem to receive less support from healthcare professionals for their engagement in healthcare as compared to other countries in that study group (Coulter, 2006a). Clearly, patient engagement depends on the attitude of the healthcare professionals and their approach towards patient care. Considering the similarities between the UK and Irish healthcare systems, these findings were of increased importance given that there is a substantial lack of evidence on patient engagement in Ireland.

Various interrelated barriers to patient engagement and patient-centred care are discussed in the literature, i.e., structural, healthcare professional, and patient-related barriers. A further breakdown of these barriers identifies the power imbalance between patients and healthcare professionals, patient unwillingness, and lack of
health literacy (Gluyas, 2015), leading to suboptimal outcomes and wasted resources (Gruman et al., 2010). Therefore, it is important to understand that there is no absolute approach to patient engagement, rather, it varies with the healthcare professionals’ attitudes and the complexities of patient-related barriers.

For increased and meaningful patient engagement, the role of the healthcare professional is vital. Healthcare professionals need to offer respect i.e. listen to the patient and provide personalised information while considering the patients’ knowledge about their care and situation. Eldh et al. (2006) suggest that this can be achieved through effective communication in clinical consultations. The prospect of patient engagement not only increases the likelihood of better outcomes but most importantly, enables patients to understand the treatment they are receiving from their healthcare professionals. The next theme discusses the healthcare professional and patient communication in clinical consultation.

2.3.2 Communication

Communication plays an essential role in engaging patients and promoting patient-centred care (Epstein & Street, 2007). Effective communication is crucial for successful clinical consultations, and it requires both the patient and the healthcare professional to communicate their understandings of the ailment and align them, to achieve an agreeable therapeutic goal. One specific aspect of patient-centred care involves healthcare professionals’ communicating their concern, care, and interest by empowering patients to engage actively in their healthcare (Haidet et al., 2005), and as such, patients feel valued.

Effective healthcare professional-patient communication is fundamental for the construction of a therapeutic healthcare professional-patient relationship (Ha &
Longnecker, 2010). There are three core aims of healthcare professional-patient communication: (1) to build a good interpersonal relationship, (2) to enable the interchange of information, and (3) to engage patients in clinical decision making (Arora, 2003). The patient’s perception of service quality and their intention-to-return to the practice is influenced by their interaction with the healthcare professional (Chang et al., 2013).

A survey of the Canadian population on their views towards oral care professionals found that dentists are not communicating effectively enough with their patients (Ipsos Reid, 2010) (Mazurat et al., 2012). Today, patients want the dentist to listen, consider their concerns, address their expectations, and to treat them as individuals, not cases. These patient expectations are echoed by those listed in “Standards for the Dental Team” issued by the General Dental Council (GDC) in the UK. In its 2013 standards document, the GDC cautions dentists of their body language and tone of voice, which patients are acutely aware of and influenced by (GDC, 2013).

Moreover, patients regard healthcare professional’s communication skills and trust as important in determining a healthcare professional’s performance (Sloan et al., 2014) and quality in dental care (Campbell & Tickle, 2013). A national survey in England of the public’s views on quality in dental care found that good interpersonal communication was among the key positive factors provided in the positive responses. This survey has a large sample size with over 500 people interviewed as part of the study (Tickle et al., 2015).

Excellent communication in clinical consultations is critical for an appropriate and supportive patient experience (Burt et al., 2014), and can lead to improved care outcomes in both general (Hagihara & Tarumi, 2006) and dental healthcare (Carey et al., 2010).
Effective communication benefits both the patient and the healthcare professional by creating a positive impact on patient satisfaction and enabling patients to give informed consent for their treatment; a regulatory requirement for healthcare professionals (Code of Practice, 2012). To ensure the efficacy of communication with patients, it is essential that dentists receive training in communication skills (Schouten et al., 2003). Furthermore, effective communication has been found to reduce patient anxiety, increase patient adherence to treatments and decrease the risk of clinical malpractice litigations (Hottel & Hardigan, 2005) (Wener et al., 2011).

Many patients are nervous about dental care visits, so it is important that a dental professional concentrates on establishing trust and report in their initial consultation. This can be acquired through appropriate communication skills, addressing patient queries, while encouraging them to participate and engage.

Interpersonal skills based on basic communication are not sufficient in establishing a therapeutic partnership which also includes multiple perspectives, approaches to problems, treatment goals, and psychosocial support (Duffy et al., 2004). According to the IDC’s Code of Practice (2012), maintaining good communication is essential to allowing a patient to understand the diagnosis, treatment plan, possible outcomes, and costs involved. Miscommunication decreases patient satisfaction and hinders a patient’s understanding, treatment expectations, and engagement in treatment planning (Ha & Longnecker, 2010).

Ethical, moral, and professional principles and values guide healthcare professionals to communicate effectively with their patients. Above research evidence suggests that patients value a trustworthy relationship with their care provider, and that patients are concerned and aware of the health care professionals’ communication
skills and attitudes towards collaboration in the decision-making process. The subsequent theme explores SDM in clinical consultation.

### 2.3.3 Shared Decision Making

The literature relevant to the theme of SDM has been divided into three subtopics which are considered as follows: (1) SDM Overview, (2) healthcare professional challenges and enablers to participating in SDM, and (3) patient challenges and enablers to participating in SDM.

1) SDM Overview

Healthcare professionals are beginning to accept the new model of patient involvement in healthcare decision making by taking the patient’s views and ideas into account. This model is in contrast with the traditional, paternalistic model, in which healthcare professionals make treatment decisions on behalf of the patient while the patient is a passive recipient of their care (Longtin et al., 2010). Engaging patients in decision making requires professionals to have a set of indispensable and basic competencies, i.e., knowledge, skills and abilities (Elwyn et al., 2000). Dentists are trained in the relevant knowledge and technical skills areas as part of their university education. However, dentists in training are not classically taught the communication skills necessary for SDM. Elwyn et al. (2012) evidence that attests to the importance of the development of such skills, as without them, healthcare professionals only partially fulfil the components of SDM (sharing information, deliberating, and decision making).

Most healthcare professionals consider SDM in selecting a treatment option, however, only a minority of healthcare professionals comprehensively assess the different treatment options together with patients (Bouma et al., 2014). Today, an
abundance of medical information is available on the internet, and patients can search options for treatments and procedures with ease. It is of ever increasing important for healthcare professionals to discuss each option with the patient, including its pros and cons, to help the patient identify the right treatment. Where variable treatment options exist, and outcomes are unclear, informed consent becomes an invaluable part of the SDM process. Understanding choices, risks, and benefits, along with costs involved in clinical decisions, leads to more successful patient treatment outcomes (Bauer et al., 2005).

Towle et al. (1999) argue that the responsibility of SDM rests on the healthcare professional-patient partnership rather than solely with healthcare professionals, and as well, the patient needs to bring certain abilities for decision making. A patient’s ability to play an active role in their treatment decision has been described as decisional control (Adams & Drake, 2006). Ghane et al. (2014) argue that decisional control can predict improved patient outcomes, but to increase a patient’s degree of decisional control, healthcare professionals need to show competence by engaging the patient at all stages of decision making. In this manner, the patient can identify their preferences and choose the most suitable treatment option. Of note, a healthcare professional’s advice can sway patient’s decisions away from their preferentially selected treatment option, and this may result in a less satisfied patient overall (Mendel et al., 2012). Patient awareness and a mutual acceptance of an equal healthcare professional–patient partnership, is directly linked to improved satisfaction for both parties (Légaré & Thompson-Leduc, 2014). The above studies are based on general medical and surgical practitioners’ consultations. However, the conclusions drawn are quite relevant to the field of dentistry, which by nature, is both
diagnostic and surgical and as well, dental consultation addresses both these aspects while simultaneously arriving at decisions.

2) Healthcare Professional’ challenges and enablers to participating in SDM

Frosch et al. (2012) reported that healthcare professionals perceive that they are reasonably good at diagnosing a patient’s choice and consider it in decision-making (Mulley et al., 2012). However, these perceptions may not be accurate: Lee et al. (2011) compared healthcare professionals’ and patients’ viewpoints on what was important to patients regarding choices around breast cancer treatment options and found that patients’ and professionals’ perspectives were quite varied. It is vital that healthcare professionals, take the patient’s view into account and do not rely on their perception of the patient’s view. Lee et al. (2011) concluded that overall, healthcare professionals are ill equipped towards assessing what the patient wants, as there were significant discrepancies in perception between the patient and the professional.

Healthcare professionals do not consider patient preference diagnosis, as crucial as clinical diagnosis, which in essence, renders a silent misdiagnosis (Mulley et al., 2012). It is critical to understand that each patient is an individual even if the cases and diagnoses are similar. The SDM process will allow a patient's perspective to be included while planning the treatment, so as to keep each case personal and individualized.

According to healthcare professionals, lack of time with each patient is a limiting factor to the practice of SDM (Bouma et al., 2014). However, Towle et al. (1999) maintain that well-developed communication skills may allow for time saving and establishment of decision-making within 10 minutes. Should the communication
process take longer, it may be more effective because of improved health outcomes. The healthcare professionals’ failure to adopt SDM into clinical practice may be due to their lack of understanding of all aspects of SDM, or that they consider the mandatory informed consent process the same as SDM (Légaré & Thompson-Leduc, 2014).

Légaré et al. (2008) reported on both the barriers and facilitators to the introduction of SDM, as perceived by healthcare professionals, and found that the most perceived barriers for SDM are: lack of time, lack of patient ability, and unsuitable clinical situations. The most often reported facilitators were healthcare professionals’ motivation and positive influence on the clinical process and patient outcomes.

3) Patient’s challenges and enablers to participating in SDM

Almost all patients express their desire for information about their health (Kiesler & Auerbach, 2006). However, the patient’s choice for engagement in healthcare decisions varies by individual and by illness (Adams & Drake, 2006). The fine-tuning of patient abilities and ways to ensure competency are major challenges for effective implementation of SDM (Towle et al., 1999). On the other hand, when it comes to patient preferences for engagement in decision-making, people vary considerably. Healthcare professionals should not assume that all patients desire to engage, rather, they should assess individual patient’s wishes and act accordingly, as a fraction of patients does refuse to engage in decision making. A US population-based study demonstrated that 96% of patients preferred to be presented with treatment options and to be asked their views. 52% of those preferred leaving concluding decisions to their healthcare professional, and 44% preferred to rely on the healthcare professionals clinical knowledge, rather searching for information themselves (Levinson et al., 2005). This study challenges the notion that the patient
alone can make the right choice by choosing the best evidence-based treatment option (Gilmore et al., 2006) and proving the myth that in SDM, patients are left alone to make decisions (Légaré & Thompson-Leduc, 2014). Evidently, healthcare professionals’ attitude towards patients can easily influence their priorities in decision making, and therefore, healthcare professionals should be cautious not to influence patient preferences.

Chapple et al. (2003) explored patients’ preferred and perceived roles in dental treatment decision-making and found that a collaborative decisional role was most common. However, in practice, patients found to perceive themselves in a passive decisional role in treatment decisions and the reasons reported were a lack of knowledge and trust in the dentist. Conversely, the patients with a more active decisional role were found to be of consumerist attitude.

SDM requires a trusting healthcare professional-patient relationship (Kraetshmer et al., 2004). Therefore, it is imperative to have a therapeutic partnership between patient and healthcare professional. This partnership serves a two-fold purpose: building trust and empowering patients to make their treatment decisions.

Patient participation in SDM is also based on certain situations; in decisions based on health literacy or knowledge, patients tend to participate less than in the decisions related to cost and outcome (Longtin et al., 2010). For example, many patients would not be able to determine whether a radiograph reveals a dental decay or not, and thus would hardly participate in decisions about radiographs. However, in the decision-making situations that require an exploration of the treatment costs and its potential care outcomes, the patient tends to participate actively, especially with high-cost health care intervention, e.g. dental implants. For treatments where patients pay the cost themselves, the related decision-making process would be
closer to an informed, SDM model rather than a paternalistic one (Vernazza et al., 2015).

Regardless of patient willingness to participate in decision making, they may be reluctant to do so because they feel dependent on the goodwill of their healthcare provider for their high-quality care; their participation might be perceived as a challenge to the healthcare professional’s authority (Frosch et al., 2012).

In short, the evidence base implies that the application of SDM in clinical practice is a challenge, and the intervention to promote SDM should focus on overcoming the barriers from both the patient and the healthcare professional’s perspective; patient education is as significant as a healthcare professional’s attitude. It is essential that healthcare professionals maintain their positive attitude towards SDM by developing appropriate skills and boost the patients’ confidence by providing enough knowledge to participate them in making quality decisions. The following theme explains the quality in dentistry

2.3.4 Quality in Dentistry

Most literature defining quality in primary care applies to general medical practice. Campbell & Tickle (2013) cautions of assuming the application of quality measures developed for primary medical care in dentistry. In the absence of quality frameworks in dentistry, they proposed a conceptual model for quality in dentistry based on the relevant areas: patient care experience, patient safety, clinical effectiveness, and access to treatments. These four domains are explored as follows:

First, patient-centred experience in the context of quality, according to the US Institute of Medicine can be assessed in two ways: patient satisfaction and self-confidence (Da Silva, 2012), Patients who participate in decisions are more likely to
be satisfied with the care provided. A systematic review of over 100 international studies found that SDM is associated with improved patient satisfaction (Scheibler et al., 2003). Taking a shared approach fosters an improved decision quality, leading to improved health outcomes, whilst having a significant positive impact on patient self-confidence (Coulter, 2006b). Patients are usually found to be more self-confident in decisions in which they perceived more involvement, irrespective of their preference for involvement (Burton et al., 2010).

SDM also improves self-efficacy, increases self-confidence and makes patients feel empowered (Joosten et al., 2011). Mills et al. 2014, reviewed the quality in dentistry and concluded that there is a lack of understanding of patient- centred care in general dental practice. They also suggested the need for further research with patients’ opinions central to the research. A national survey interviewing over 500 people in England on their perception of quality in dental care indicated access, technical quality, good interpersonal communication, and value for money as the issues of greatest importance (Tickle et al., 2015).

In dentistry, where quality is intertwined with value for money, SDM practice would have a positive impact on patient’s dental care experience (Vernazza et al., 2015). Sbaraini et al. (2012) examined the patient dental care experience in Australia and suggested that the patient values, having a caring dentist who listens to their concerns and educates them.

Second, patient safety can be enhanced by maximising the likelihood of desired health outcomes and undertaking appropriate patient centred decisions whilst minimising the opportunity for undesired consequences (Coulter, 2006b).
Third, clinical effectiveness is the application of best evidence-based practices to achieve ideal processes and outcomes of patient care. SDM was found to increase patient adherence to treatment and improve the quality of life (Desroches et al., 2011) (Wilson et al., 2010). In contrast, a randomised controlled trial of SDM trained GPs, found no impact on health outcomes at a one-month patient follow-up (Edwards et al., 2004). The one month follow-up time frame can be argued as too short.

The ideologies of SDM are well documented in the literature, but there is a lack of direction about how to achieve the approach in routine clinical consultations (Elwyn et al., 2012). Several models are found to have similar core concepts: equipoise, knowledge transfer, information exchange, preference expression, deliberation and decision making (Stacy et al., 2010). Elwyn et al. (2012) translated the existing conceptual description into a three-step clinical practice model based on choice, option, and decision talk. The ‘talk’ model is a revised version with emphasis on building partnerships and eliciting patient preference (Elwyn et al., 2013).

Fourth, the point of access to dentistry in Ireland comes from the Pay Related Social Insurance Scheme (PRSI) or the Dental Treatment Services Scheme (DTSS). Both allow for a free dental examination, and the DTSS further allows for minimal treatment. However, for the majority of treatments patients pay privately, and as the cost bearer, there is an expectation of higher quality. This has direct implications for patients understanding of treatment options and their outcomes, as well as their level of engagement.

Perspectives about the quality of healthcare vary between individual stakeholders. For health professionals, it could be standards of professional practice, for
managers, it could be efficiency and outcomes of care, and for patients, it could be communication skills and continuity of care (Campbell & Tickle, 2013). Therefore, by considering all stakeholders’ perspectives, the practice of SDM in dental consultation can positively impact the quality of dental care by having it as a standard for practice and a link to effective communication and clinical outcomes.

Research suggests that incorporating SDM into clinical practice can have a positive impact on multiple domains of a quality framework in dentistry. Literature shows the positive impact of SDM on increasing patient satisfaction by improving their care experience. It suggests an indirect link to patient safety by increasing the likelihood of better outcomes by undertaking patient centred decisions. In contrast, there is less evidence in the literature on the direct impact of SDM on clinical outcomes. There is a lack of research on quality that directly measures access, which does not rule out the beneficial impact, rather, implies that more research is recommended and required in this direction.

2.4 Implications for the project

The literature review provided an informed overview of patient-centred care with a large focus on SDM, which further confirmed the rationale behind this OD project. In the writer's view, the literature is considerably more in favour of patient-centred care, which encompasses patient engagement, communication, SDM and quality are noticeably linked and together lead to better outcomes. It is apparent from the review that research in the field of quality in dentistry is at an initial stage and is only beginning. SDM in the context of dentistry is increasingly emergent, relative to its contemporary medical counterpart, where it is established. Further to this pattern, it is noted that practicing SDM in clinical consultations is a real challenge. While reviews are in agreement that effective communication with patients is necessary for
improved decision making and care outcomes, there appears to be a lack of consistency in both delivery and assessment. Literature cited that SDM led to an improvement in patient engagement particularly in decision making but failed to empower patients for decisions about their healthcare.

Reflecting on this literature review and its implications for the proposed OD project, the writer contends that although most of the studies are based on medical practice, they can be applied to dental care because of the highly similar nature of clinical consultations.

The introduction of an evidence-based ‘talk’ model for SDM in dental consultation will help dentists improve their communication skills, attitudes and competencies to establish collaboration and a shared approach towards decision making. It will enable dentists to educate and empower patients to participate actively in decision making which in turn will result in greater patient satisfaction. The identified barriers to patient engagement and SDM will be taken into account while planning the project, to increase the likelihood of dentists’ adoption of the ‘talk’ model and to improve the quality of dental care by establishing the core aspect of patient-centred care. The writer considered the evaluation methods used in relevant research articles and was especially interested in the comprehensive survey and the questions asked by Tickle et al. (2015).

2.5 Summary and Conclusion

A literature review of patient-centred care identified patient engagement, patient-professional communication, SDM, and quality in dentistry as the main review themes. The findings from the literature are in favour of SDM initiatives promoting patient-centred care, resulting in better quality and outcomes. The review not only
informed and highlighted the integral aspects of patient care which need to be addressed for the success of the project, but also revealed a lack of understanding of patient-centred care within dentistry, and general dental practice in particular.

Chapter three provides an overview of the methodologies for the OD and discusses the proposed change process in detail using the HSE change model of organisational change.
Chapter 3

3 Organisational Development Planning Process

3.1 Introduction

"Change is inevitable . . . adapting to change is unavoidable, it's how you do it that sets you together or apart." William Ngwako Maphoto.

Change is considered a sign of progress and improvement (Lewis, 2011). Health services around the world are undertaking substantial changes driven by increased public expectations, changes in legislation, and technological advancements. Change is requisite either to necessity or in response to problems, and whatever the drive, there must be a need for an internal desire for change, with a sense of urgency (Gittins & Standish, 2010). It is the first and main step in laying the foundation for change, as seen in Kotter’s model, which found that over 50% of companies fail this step (Kotter, 1995).

Research suggests that organisational change initiatives fail from one-third to as high as two-third (Beer & Nohria, 2000) (Kotter & Schlesinger, 2008) (Sirkin et al., 2005), and is still not improving (Jacobs et al., 2013).

Such failures may be due to the absence of a dedicated framework to guide the implementation process (Leeman et al., 2007). Burnes and Jackson (2011) argue that reasons for failures lie beyond improper planning and an absence of commitment, according to them, the fundamental cause is a clash of beliefs between the organisation and its type and approach of change. Sirkin et al. (2005) noted that ‘soft factors’ such as leadership, motivation, and culture, are vital to successful change. However, they advocate a close consideration of ‘hard factors’ as well: project duration, integrity or competency of project teams, the level of staff commitment, and employee effort, for impact on outcomes of any change project.
This chapter provides a brief discussion of approaches and models to OD and change, selection of an appropriate OD model to propose the planned development project, and the rationale behind its selection. Additionally, a comprehensive and detailed plan of the proposed project is described using the selected model, which is followed by a summary.

3.2 Critical Review of Approaches to Organisational Development:

The fundamentals of organisational change have remained intact since Lewin’s (1949) innovative change model; a planned approach to change with processes of unfreezing, moving and refreezing (Lewin, 1989). Critics maintain that the model assumed that organisations operate in a stable state, that it failed to reflect on the role of organisational politics and power, and that the approach was mainly top-down and management-driven; despite these limitations, support does exist. Burnes (2004) supports Lewin’s approach by stating its relevance to the modern world. With the increased criticism of the planned approach as not applicable to circumstances that require quick and transformational change (Senior, 2002), emergent approach gained popularity.

The emergent approach to change is bottom up driven and emphasizes that change is a constant process of adaptation to changing environments. The emergent model is appropriate for all organisations, at all times and in all circumstances (Burnes, 1996). Kotter’s eight step model is an example of the emergent approach, and all organisations can use it to evade failures in employing change and improve the probability of their successes (Kotter, 1996). Hughes (2015) critically assessed Kotter’s model and identified seven shortcomings. These include, but are not limited to, power, ethics, illustrating employees as resistors, overemphasis upon a sequence of linear steps, and under emphasis on unique cultural context.
Further, (Dunphy & Stace, 1993) argue that a situational model based on a contingency approach is one that can differ change strategies to attain an optimum fit with the changing situation (p. 905). Burnes (1996) criticizes that an organisation does not have to inevitably adapt to the exterior environment, and supports an approach of choice.

3.3 Rationale for selecting HSE Change Model

According to Cohen et al. (2005), the best change interventions also require a model to integrate change into practice. Literature yields many models from which to choose for OD implementation, some of which are discussed below.

The Coghlan & Brannick (2014) model has four distinct steps in its methodology: constructing, planning action, taking action, and evaluating action. As this is an action dependent change model, it is not suitable for this planned OD project.

The Senior and Swailes (2010) OD model of change approaches ‘soft problems’ which involve human factors and emotions. While this OD model is advantageous in creating a learning organisation to achieve both personal and organisational goals, this model has its limits, specifically with the public sector. However, whatever the organisation, the model focuses particularly on the change agent as central to drive the change forward and as directly responsible for its successes and failures. Although the role of the change agent in bringing change is fundamental, the complex nature of healthcare cannot be ignored where most of the changes are externally driven i.e. legislations, health policies, etc.

A valid framework for organisational change is required for the success of change projects (Rafferty et al., 2013). The HSE change model is proposed for this change for following reasons:
(a) The Irish context and the dynamic nature (cyclical, continuous and adaptive) of the model. Organisations are different in their contexts and their problems, and change initiatives require a context-specific approach (Boonstra, 2004).

(b) This project has similar aims to the aims of developing this model which are supporting teamwork and engaging and empowering both service providers and users.

(c) This soft system organisational model is inclusive and gives particular consideration to the people and cultural aspects of change i.e. managing uncertainty, reactions, and supporting people while accounting for any resistance. The organisational culture needs to be considered carefully for the success of change, irrespective of how well the change is planned. (Werkman, 2009).

In contrast to other models, this model is comprehensive and less complex, with more clarity and guidance on each stage through its well-defined subcategories. It takes into account almost all critical aspects of this project and therefore, it is the best suitable model for planning and implementing this OD project.

3.4 OD Model – HSE Change Model

The Health Service Executive Model (2008) consists of four main elements: initiation, planning, implementation, and mainstreaming. Though the elements describe a chronological pattern, it is clear in the model that change is a continuous process, with all elements interrelated, and that it is acceptable to move between stages with fluidity.
Overview:

The change project under consideration is an organisational convergent (fine-tuning) change project, concerned with promoting patient-centered care in dental consultations, by introducing the ‘talk’ model for SDM (Appendix 1). As part of the project planning, essential areas of interest have been determined, based on the writer’s clinical experience. These areas will steer the anticipated successes while appropriately considering expected challenges and overall outcomes.

Ethical Consideration:

The change project is in line with the dentists’ regulatory obligation to ensure that patients have been given enough information about treatment options and associated risks to make informed decisions (Code of Practice, 2012). As this OD project will be in collaboration with the dentists in their professional role, ethical approval should not be a requirement. However, ethical issues can arise when undertaking any change project and will be addressed accordingly. There would be
no individual identifying information to maintain confidentiality. The data obtained from the questionnaires would only be used for the purpose disclosed and would only be accessible to the participating dentists and the writer. The circulation of the report will be restricted, and the data will be shredded after the report is prepared. Furthermore, informed consent would be obtained for voluntary participation after providing patients with information on nature, purpose, and risks and benefits of the project.

3.4.1 Initiation

The purpose of this first step is to prepare a solid foundation for successful change and gather support by creating readiness and a sense of shared responsibility across the organisation (HSE, 2008). At initiation, it is apparent that a clear purpose and vision are essential. In the context of this planned change, the vision is patient-centred care, and the purpose is to improve patient engagement through SDM.

3.4.1.1 Preparing the Lead

In preparing to lead the change, the HSE change model makes reference to the following areas which require attention.

(a) Identifying the drivers of the need for change and the degree of urgency:

The force field analysis by Lewin (1951) (Appendix 2) assesses and outlines the drivers and resistors of the proposed change. Senior and Swailes (2010) suggest the need for drivers to overshadow resistors. The key drivers, HIQA standards of respecting patient autonomy, organisation’s codes of professional conduct, and HSE mandate of patient-centered care, are integral for integration of the ‘talk’ model into dental consultation. Clear communication of drivers for change and a presentation to
dentists and administrative staff on the relevant literature around SDM will increase buy-in from stakeholders and strengthen the degree of urgency.

For a successful change, it is equally important to lessen the burden of the resistors (Health Service Executive, 2008). The effect of resistors will be reduced by putting a substantial focus on dentists' participation in the planning stages. Weisbord and Janoff (2010) promote the idea of participation and note that exploring issues involving people releases creative energy, leading to projects that are considered noteworthy and could not otherwise be accomplished alone. It is necessary for improvement in healthcare delivery that managers engage and interact with healthcare professionals in organisational change, as both have different professional identities and mindsets, which can hinder change (Bååthe & Norbäck, 2013).

(b) Key Influencers and Stakeholders:

Using the interest power grid, a stakeholder analysis by Borgoyne (1994) (Appendix 3) was completed to identify key individuals to gain their support and to develop strategies to manage any stakeholders who may be barriers to change. While leading the change, it is critical to acknowledge any potential obstacles and to draft strategies for managing them (MacPhee, 2007). One of the key stakeholders identified are the dentists with strong influence yet mediocre interest. It is crucial to encourage them through open discussion and feedback using the monthly clinical meeting forum. Kotter stresses the importance of constantly reiterating the vision to gain support (Kotter, 1995).
(c) Assessing Readiness and Capacity for Change:

Organisational readiness towards change is described as the organisational individuals’ self-efficacy and change commitment and to implement change in organisation (Weiner, 2009) (p. 68). To assess readiness, key influencers’ attitudes of, willingness, aims, and intentions, need to be analysed. A strong commitment, and positive attitude to change are the core outcomes of readiness to change (Rafferty et al., 2013). Capacity involves ensuring the staffs have appropriate knowledge and skills to carry out change related actions. The assessment of readiness and capability to change by Beckhard and Harris (1987) (Appendix 4) proved useful to list and assess individuals or groups who are fundamental to the change initiative. Moreover, this analysis helped focus on increasing capabilities required for the proposed change to occur, such as dentists’ knowledge and skill training.

(d) Organisational Politics:

Incorporation of the ‘talk’ model into dental consultation will require dentists’ time and communication skills. This adoption is practically and realistically possible for dentists as they can be trained or accustomed to SDM in a structured fashion. It is potentially effective for both dentists (increased trust and loyalty; decreased dental litigation) and patients (increased satisfaction).

With the provision of high quality, patient-centered care in dental practice, it is anticipated that the implication of mentioning the use of the ‘talk’ model within the patient’s notes, will be of great importance in adding weight to the dentists’ political will to adapt to this procedure. Additionally, documenting in the patient’s notes will make this ‘talk’ model real and practical for other dentists who may review the notes.
(e) Identifying Leverage Points and Opportunities for Change:

A SWOT analysis is a strategic tool to identify the strengths, weaknesses, threats, and opportunities in a change process (MacPhee, 2007). The SWOT analysis (Appendix 5) identified the strength of the alliance with IDC for the success of this project. Research highlights the great variability in SDM training programmes and illustrates the need for an internationally agreed upon criteria for certifying programmes, including Continuing Professional Development (CPD) (Legare et al., 2012). In the absence of evidence-based SDM training programmes, the IDC will be consulted for certification of SDM training. By constructing an external alliance with the IDC, the project will be supported by dentists and the benefit of CPD points will further aid in increasing dentists’ willingness for training.

Finally, threat management is an integral aspect of SWOT. A lack of dentists’ motivation is found to be a potential threat to the project, which needs to be managed using motivational inspiration tactics to ‘pull’ rather than ‘push’ dentists towards this project. Change leaders are change agents as well as agents of continuity (Jacobs et al., 2013). All involved dentists will have an individual leadership role in the implementation of this project, in contrast with the traditional view of one leader. According to Doyle (2001), the idea of a single mandated change agent is obsolete; organisations need a variety of individuals to be trained and to be able to manage change proactively.

(f) An Initial Assessment of the Impact of the Change:

The initial generalized analysis of impact is a powerful way to gain insight into required engagement, planning, and resources (HSE, 2008). A project impact statement (Appendix 6) is used to assess the project influence by identifying issues
around structural, personal, behavioural, and cultural, thus comparing the present situation with the anticipated situation by the end of the project.

(g) Outlining the Initial Objectives and Outcomes of the change:

The early communication of the sense of change objectives and intended outcomes to staff will increase project credibility and gain required support for the change effort. With this in mind, the writer used the SMART (Specific, Measurable, Attainable, Realistic and Time-bound) objectives mentioned in chapter one from the early stage to communicate the change to stakeholders.

(h) Agreeing Initial Resource Requirements:

The need for adequate resources is evident for successful change. The most substantial resource required in this project is dentists’ additional time for carrying out SDM in their patient consultations. Through the rational persuasion tactic, additional time spent by dentists, is justified by the inevitable benefits for the dentist: improved patient trust, loyalty, increased patient return and reduced dental litigations. To manage financial resources (Table 1), the writer proposes a breakeven financial model.

<table>
<thead>
<tr>
<th>Income</th>
<th>Euro</th>
<th>Expenditure</th>
<th>Euro</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Training contribution of €100 each from six dentists</td>
<td>600</td>
<td>• Cost of printing patient leaflets, surveys, and questionnaires</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cost of speaker for training</td>
<td>500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>600</td>
<td><strong>Total</strong></td>
<td>600</td>
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Table 1: Financial projections for pilot project
The anticipated resistance of dentists towards time and money investment in training is managed by offering CPD accredited training out of practice hours to improve their communication skills as a whole, and the SDM skill in particular. After encountering this initial resistance, the writer deemed it prudent to carry out a risk assessment plan (Appendix 7). Eight further risks are detected and evaluated, with control measures identified.

(j) Outlining the initial business case for change:

The above description in this initiation will serve as the business case (Project Initiation Document - PID). This report will then be used to acquire senior management approval for the proposed change. Upon completion of initiation, a review is essential to reflect the early analysis to highlight the issues of resources (time & cost), risks (anticipated resistance), and communication. The stakeholders’ involvement in the learning phase will increase their commitment and decrease their resistance to the change process (Waddell & Sohal, 1998). Good communication with stakeholders throughout the change process is vital for their continuous engagement.

3.4.2 Planning

3.4.2.1 Building Commitment

This step of the project involves bringing key stakeholders together to present a business case and communicate change. The steps necessary to build commitment according to the HSE change model include:

(a) Build a shared vision:

Providing substantial information to the stakeholders and an opportunity for them to give feedback is vital for building a shared vision for change (Fernandez & Rainey,
2006). For the proposed change, it can be achieved by educating dentists and discussing the importance of SDM in healthcare, particularly in dental care. A stepwise explanation of the ‘talk’ model will illustrate clear advantages of putting this model in place and will aid in generating commitment.

(b) Communicating the vision and business case for change:

Kotter (1996) emphasized the need for effective communication for successful change projects. Relentless communication, both internal and external, is critical to successful change (HSE, 2008). Therefore, by developing a project communications plan (Appendix 8) at an early stage both external communication (IDC application form-Appendix 9 and patient leaflet-Appendix 10) and internal communication (dentists, staff, and management) will prove fruitful. The communication plan will help to discuss what they already know, how to integrate change, when to take actions, and provide feedback, using appropriate forums with respect to a target audience e.g. dentists’ clinical meeting for communicating the project to dentists.

(c) Increase readiness and the capacity for change:

Awareness of the rationale behind the change and drivers for the change will encourage the dentists to adopt the ‘talk’ model in their consultation.

(d) Demonstrate that change is underway:

The use of the ‘talk’ model will give structure to dental consultation and is highly unlikely to affect other activities surrounding the consultation. Despite this, meetings for tracking project progress, reviews, and feedback, could be possible resistors to the change and need to be managed carefully in the implementation stage.
3.4.2.2 Determining the detail of the change

The focus of this step is on increasing the momentum for change, which can be done by analyzing the present condition against the future vision for change and providing this feedback to key stakeholders (HSE, 2008).

(a) Assess the current situation against the future vision for change

An initial assessment of the existing situation in contrast to the future vision for change can be carried out by interviewing and observing dentists, to establish the need for practicing SDM in dental consultation. However, a detailed assessment using pilot dentists and monitoring of adoption of SDM in their practice is required. This gap analysis will help in gaining support from dentists for the future vision and identifying the areas of improvement. Methodologies for this gap analysis will include, observations, interviews, questionnaires, and surveys, discussed in detail in chapter four.

(b) Feedback this analysis to key stakeholders

Providing accurate and meaningful feedback on the analysis, without overloading information to key stakeholders, senior management, and dentists, will provide a stimulus for action, problem-solving, and enhanced ownership of the project.

3.4.2.3 Developing the implementation plan

This step is about preparing the organisation for implementation. It provides the details of specific changes (organisational, service, and cultural) required to achieve the vision. The organisational change itself would be the introduction of the ‘talk’ model, acting as the organisation’s patient engagement strategy; service change would be SDM, and culture change would be the adoption of the ‘talk’ model in clinical practice. A GANTT chart is used to produce the project implementation and
management plan (Appendix 11) by illustrating the project schedules and activities (tasks or events) against time.

The following are the four components of developing the implementation plan:

(a) Design the detail of the future state

While designing the detail of the future state, it is vital to have both strategic and operational knowledge to integrate it into current practices (HSE, 2008). In the context of this project, dentists will have the competency of skills through training provided and will adopt the ‘talk’ model into consultation. The use of SDM will be recorded in patient notes, which is significant from both a dentist and management perspective, for future reference should the need arise.

(c) Assess the impact of the detailed design

To assess the impact of the detailed design pilot testing will be carried out. It will not only assess the change impact on consultations and treatment decisions but will also increase buy-in from stakeholders and further refine the design before launching a full organisational roll out.

(d) Outline and agree on the plan for implementation

Learnings from the pilot will help outline the plan for implementation. The plan outline will include sequencing actions within timeframes, highlighting crucial milestones such as the adoption of SDM by dentists, establishing performance indicators in place to measure outcomes (marking of patients as ‘new patients’), and ways to communicate feedback either through one on one interview or focus group discussion.
(e) Complete the detailed implementation/project plan

The project plan (Appendix 11) needs to be communicated to all related stakeholders once it is agreed and signed off. Moreover, it is important to reconsider the plan at a specific interval to check the need for renewal of commitment or reprioritization of certain aspects of the plan and if required, to take appropriate actions to prevent drift. Possibly, the need for renegotiation with dentists may occur while implementing this project.

3.4.3 Implementation

The execution step of the HSE change model focuses on implementing the agreed actions and sustaining the change.

(a) Implementing change:

While implementing the change, it is fundamental to have clarity on start dates and sufficient communication with staff and service users. Appropriate communication and regular meetings with staff facilitate implementing change (van et al., 2013). The writer will ensure that the actual implementation is communicated to the relevant key stakeholders (dentists, managers, and staff) during the monthly meeting.

According to Nielsen and Randall, (2009) even the most promising change initiatives have been unsuccessful as a result of poor implementation and managers should be available to assist in change and create a supportive environment. For project management and demonstrating support, the writer will be physically present in the clinic for one month to closely monitor the impact of the ‘talk’ model on service delivery to patients and its adoption by the dentists involved. Additionally, daily feedback from practicing dentists will be taken into account to adjust and refine the
plan accordingly. A focus group for review will be held weekly to evaluate the success of the change.

(b) Sustaining momentum:

Change takes time, and it is crucial to plan to maintain the momentum. The weekly focus group discussions with the dentists involved provide a platform for shared learning and problem solving. To support the new behaviour (adoption of the ‘talk’ model) continual communication is required, and a WhatsApp group will be used to promote such interaction. Technology has a strategic role in assisting change and embedding it into organisational culture (Bayerl et al., 2013).

3.4.4 Mainstreaming

It is the final step of the HSE change model that focuses on the success of change and incorporating and sustaining new behaviours of working. It also focuses on methods for assessment and continuous improvement.

3.4.4.1 Making it “The Way We Do Our Business”

Celebrating short-term wins is essential in preventing the loss of momentum and encouraging participants to remain actively involved in change process (Kotter, 1995). The introduction of the ‘talk’ model into dental consultation is very much dependent on its adoption by participating dentists, so it is essential to boost their morale through appreciation. Staff involvement and attitude towards the change are important factors in sustaining change (Doyle et al., 2013).

To ensure old habits do not return and the change remains, planning around process monitoring and data reviewing is required (Nelson et al., 2011). The ‘talk’ model should be an integrated part of dental consultation rather an ‘add on’. To make it routine for dentists, regular communication and active engagement with concerned
dentists is vital to acknowledge their feedback, which will assist with assimilation of the ‘talk’ model into dental consultation.

3.4.4.2 Evaluating and Learning

Evaluation is a final and essential step in the change process which allows service users view to be heard, thus enabling the organisation to understand the outcomes of the change project and further progression of change (Hodges, 2008). According to the HSE change model (2008), this step is about, building a system for refinement and continuous improvement, learning from the change process and establishing best practices, and reviewing the temporary change support structures, systems, and roles. Evaluating and learning from planning and implementing change project, can have a real impact on capacity and willingness of the organisation to continue change.

Continuous feedback from dentists and patient satisfaction surveys will be valuable in improving the service delivery and establishing best practice. To embed change, lessons learned from change and dissemination of best practice are crucial (Shigayeva & Coker, 2015). The detailed discussion on project evaluation follows in the next chapter.

3.5 Summary and Conclusion

The aim of this change project is to improve patient engagement, quality of decisions and increased patient satisfaction through the introduction of a patient-centred service in dental practice. Various change models were reviewed before selecting the HSE change model for the proposed change. In reviewing the HSE change model, its comprehensive framework provides a solid foundation for planning the proposed change. The data gathered from the use of various analytical tools such as
Force Field, Stakeholder, and SWOT analysis will align content, people, and processes for proposed change. Such proper alignment will lead to successful change (Anderson & Ackerman, 2001). The core principles of the change model are grounded in improving patient care services, staff engagement in change (getting feedback and reflections), and a steady approach to change. These are integral to ensure the success of the ‘talk’ model in practice and are evident in each step of the model. In detailing the model, it has been useful in identifying the areas where resistance can occur and developing the appropriate strategies to overcome it. The next chapter four examines the crucial aspects of evaluation to support the study of this proposed change.
Chapter 4

4 Evaluation

4.1 Introduction

Evaluation is a process which constantly occurs, in the background, without thinking i.e. judging the value of something. It is a relative assessment of the value of an intervention using systematically gathered and analysed data, to resolve action (Øvretveit, 1998). For this planned change project, it is vital to determine whether the project will be a success before deploying it on a considerable scale. However, factors determinant of the change project’s successes or failures are equally important. As Feuerstein (1986) (p.7) contends, “Knowing why a programme succeeds or fails is even more important than knowing that it does.” As discussed, this planned project will be piloted in one dental practice and if successful will be considered for the whole organisation.

This chapter discusses the significance of evaluation in healthcare and this project in particular. In addition, it provides models of evaluation and the proposed methods for evaluating the objectives of this planned OD project, as outlined in chapter one of the dissertation.

4.2 Significance of Healthcare Evaluation

Healthcare evaluation is a broad field involving a multitude of interventions (treatments, policies, services and changes to organisations) which are evaluated to help patients make informed choices, for better professional and management decisions, for the best use of scarce resources, and to improve services (Øvretveit, 1998).
On healthcare improvement, the evaluation needs to consider the full path of intervention, from engaging patients to the expected changes in processes and outcomes (Parry et al., 2013). Therefore, the measuring tools for evaluation should be in place at every stage in the change process (HSE, 2008).

Evaluation is critical for all health care initiatives and must be designed early in the process of healthcare planning as it is central to report successes, failures, strengths, and weaknesses (Øvretveit, 1998). Clearly, there is an ethical obligation to confirm that interventions cause no damage, directly on individuals or indirectly, by wasting limited resources on ineffective interventions (Green and South, 2006). Green and South (2006) describe the following reasons for evaluation:

1. To establish whether or not interventions have worked.
2. To improve health programme implementation.
3. To provide accountability to funders.
4. To increase support for sustaining or expanding an intervention.
5. To contribute to the scientific base for interventions.
6. To impact policy decisions.

4.3 Evaluation

Lazenbatt (2002) defines evaluation as “a method of measuring the extent to which an intervention achieves its stated objectives”. Evaluation models are developed to measure the effectiveness of interventions. However, the evaluation model is secondary to other factors in influencing the evaluation such as the context of the evaluation, staff involvement, resources available, and expertise (McNamara et al., 2010). Evaluation experts have reached a consensus on selecting the model that best suits the requirements of the process being evaluated, as no one model suits all
situations (Stufflebeam, 2007). Multiple evaluation models were reviewed to find the best and most correct method for evaluating the proposed change.

Evaluation Models:

The Stufflebeam or CIPP (Context, Input, Process, and Product) model was developed by Daniel Stufflebeam in the 1970's as a means of programme improvement rather than focussing on outcomes (Frye & Hemmer, 2012). It's non-linear and flexible framework facilitates examination of different aspects of the change process. It is labour intensive, requires careful planning, and multiple data collection methods, to carry out evaluation efficiently (Légaré et al., 2012).

Considering the nature of the project, the use of the CIPP model seems time-consuming. Conversely, Jacobs’ ten stage model considers the complexities of evaluation and allows for unexpected alterations and modifications throughout the change process (McNamara et al., 2010). However, due to its apparent complexity and lengthy stepwise layout, it is unsuitable for this objective focused evaluation.

Comparatively, the Kirkpatrick model is a robust, easy to understand, and very outcome-focused model. It can be used for planning the training by flipping it upside down to serve as a tool to do backward planning with the end in mind (Clark, 2008). The writer finds this model most appropriate for planning and evaluating the skill-based training for dentists.

4.3.1 Aims

The aim of the evaluation methods in this project will be to determine whether the outcomes would successfully be linked to the objectives outlined in chapter one. Moreover, it will help the writer understand the practicality and effectiveness of the project for further expansion.
4.3.2 Methods and Measures

Donabedian (1966) completed a seminal work on assessment in which he approached evaluation through three components: structure, process, and outcome. Applied to this project, evaluation components; structure relates to the training of dentist’s skills for using the ‘talk’ model in dental consultation, process relates to SDM adoption by dentists in care delivery, and outcome relates to patient satisfaction through decision quality.

**Objective 1:** Six dentists will be 100% competent in SDM skills through training to carry out the ‘talk’ model in their consultations by 2nd September 2016.

Kirkpatrick’s four-level evaluation model remains the standard for educational evaluation models through its clear focus on learner behaviour in the context of the training they received (Frye & Hemmer, 2012). It was developed to evaluate learning outcomes in training programmes (Kirkpatrick, 1959).

![Kirkpatrick's Model (1959)](image-url)

*Figure 2: Kirkpatrick’s Model (1959)*
Level 1: Reaction

This level of Kirkpatrick’s model is about quantifying the participants’ reactions. In evaluating how dentists feel about the teaching and the introduction of the ‘talk’ model into consultations, informal interviews are suggested. Informal interviews can also be highly valuable as, “social cues, such as voice, intonation, body language, etc. of the interviewee can give the interviewer a lot of extra information” (Opendakker, 2006) (p.1). The basic questions to discover dentists’ reaction after the training would be:

1. Did the session clearly explain the ‘talk’ model?
2. Am I comfortable carrying out the ‘talk model’ in my consultations?
3. Am I more likely to use this procedure in my consultations?

Level 2: Learning

Dentists’ knowledge will be assessed using questionnaires (from MAGIC programme of The Health Foundation, UK) on the basic evaluation design of before (pre-training questionnaire - Appendix 12) and after training (post-training questionnaire - Appendix 13). Skill competencies that were covered in training will be assessed through a post-training skills checklist: the OPTION-the education feedback version (Appendix 14).

Level 3: Behaviour

Behaviour evaluation is the magnitude to which the learnings are practiced at work. It can be undertaken by dentist’s consultation observations using the OPTION 12 item scale (Appendix 15). According to (Robson, 2002), observations are relatively straight forward compared to interviews. Robson (2002) states that “you simply
“watch what they do and listen to what they say.” (p.191) Behavioural change is the key to cultural change and change sustainability.

**Level 4: Result**

This level is to measure the quantifiable aspects of dentists’ performance and would be completed by a clinical note audit to track the use of the ‘talk’ model by dentists in their consultations, being recorded in patient notes.

**Objective 2: To achieve 80% compliance of participating dentists in three-month pilot project towards the adoption of talk model by the end of 31st December 2016.**

Questionnaires are an objective means of gathering data about individual's beliefs, knowledge, attitudes, and behaviours (Oppenheim, 1992). Boynton & Greenhalgh (2004) recommends using a previously validated questionnaire. Keeping this in mind, the writer reviewed the literature for evidence-based, reliable, and valid questionnaires.

The main obstacle for measuring SDM is that no gold standard exists and as such establishing validity proves difficult. Despite this, there are multiple reliable scales available to assess different aspects of SDM and dentist’s adoption of the ‘talk’ model in particular, including process and outcome measure (Sepucha & Scholl, 2014). A precise OPTION 5 Item scale was developed using the ‘talk’ model as a framework. However, this proposed version needs to be evaluated for its use in clinical practice (Elwyn et al., 2013). Therefore, the observer OPTION 12 item scale (Appendix 15) will be used to assess the decision-making process. It is the first validated instrument specifically designed to measure the extent and quality of SDM by healthcare professionals, by rating observed consultation (Elwyn et al., 2005).
This scale has been tested worldwide, from a primary care setting to a speciality setting. It has proved to be a practical and applicable instrument (Couët et al., 2013), despite the relative lack of attention to the elicitation of patient preferences, which is found to be the weakness of the measure (Elwyn et al., 2013).

Current studies have found inconsistencies in SDM ratings from the observer, healthcare professional and patient perspectives (Wunderlich et al., 2011) (Scholl et al., 2015) and no study to date has resolved this issue. Therefore, it is imperative to include all three perspectives in evaluating SDM quality, to ensure the reliability of results. The 9-item SDM questionnaires, with both patient (Appendix 16), and healthcare professional versions (Appendix 17), are suggested to obtain their perspectives. Both these versions have been found to be acceptable, reliable, and valid (Kriston et al., 2010) (Scholl et al., 2012). In contrast, in the UK, the Decisional Conflict Scale (DCS) has been used for measuring SDM primarily from the patient perspective (Department of Health, 2012), which comprises of 16 items in its original version (O’Connor, 1995). The 9-item SDM questionnaire patient version is brief in comparison. Both the aforementioned scales are available in multiple languages, which might benefit patients for whom English is not their first language.

Considering the limited time frame of routine consultation, the SURE Test (Sure of myself, Understand information, Risk-benefit ratio, Encouragement) (Appendix 18), the clinical practice version of DCS is advisable to use as a routine practice for evaluating SDM after the end of this project. According to Legare et al. (2010) the SURE Test is an acceptable and validated measure of decisional conflict. With its efficiency and simplicity, it is easy for healthcare professional to use.
Objective 3: To achieve 60% return rate of the patients who signified they would return six-month post consultation during 1st April 2017 to 30th June 2017.

The potential of increased patient return will be a review at six-month recall marker. It can be done by putting, the new patient, to the patients visiting the clinic for first time consultation for whom ‘talk’ model was used. This cohort could be reviewed to see whether they returned and the driver was SDM.

Objective 4: To measure the ‘talk’ model efficacy in dental consultation during pilot period i.e. from 1st October 2016 to 31st December 2016 and six-month post consultation from 1st April 2017 to 30th June 2017.

For measuring the ‘talk’ model efficacy through patient satisfaction, a post-consultation patient survey (adapted from the MAGIC programme of The Health Foundation, UK - Appendix 19) regarding the quality of SDM process in the dental consultation is suggested. The Decision Regret Scale (Appendix 20) is suggested to evaluate the decision quality after six months of initial consultation as it has demonstrated strong internal consistency and correlation with decision satisfaction (Brehaut et al., 2003). Donabedian (1996) suggested that patient satisfaction is an essential desired outcome of care. Federman et al. (2001) suggested that the healthcare professional-patient relationship can sway patients’ decisions not to follow care. In this study, it was found that 6% of patients were unwilling to return to their usual health care professional, due to dissatisfaction with the length of consultation and their perceptions of the healthcare professional’s inadequate attention to their concerns.
The Decision Quality Instruments have strong content, adequate reliability, and are feasible to implement, but are not recommended for this project as they are decision specific and lack generalizability across the topics (Sepucha et al., 2004) (Sepucha et al., 2011). In the absence of research on the appropriate timing of the assessment (Sepucha & Scholl, 2014), the writer determined that six month time wait to assess decisional regret for dental decisions would be most appropriate, and questionnaire will be administered to patients on their six-month return.

From a project stance, reception staff involvement and their familiarity to the questionnaires is vital to facilitate patients to complete questionnaires post consultation and at six-month recall.

4.3.3 Result

As this is a planned project, there is no current hard data from evaluation measures. Notwithstanding this, the writer assessed two main aspects of the evaluation. First, the administration of the questionnaires, and second, the utilization of Plan Do Study Act (PDSA) cycle within the context of this project.

Questionnaires:

It is hopeful that the suggested questionnaires will yield critical information for the evaluation of the project. Their administration and management are critical with consideration and careful attention regarding data protection. Further, staff engagement will be crucial for facilitation and collection of questionnaires.

Plan Do Study Act (PDSA) Cycle:

Using the PDSA provides an opportunity to build evidence for change (Taylor et al., 2013). Its use within the context of this project is to justify the anticipated and expected outcomes. However, there needs to be caution during the planning stage,
as a failure in applying appropriate rigour and discipline, will result in a much longer overall improvement process (Feeney & Murphy, 2014). It is evident that, after the pilot (small scale) implementation of the project, a reliable approach to data collection (validated questionnaires) and analysis of data will compare predictions. If the results do not justify the expected outcomes, then the PDSA should be stopped and restarted with a different plan. Conversely, if the results justify the adoption of the ‘talk’ model, then there should be a continuation of this improvement cycle and implementation as a new practice. Finally, continually monitoring and reviewing are equally important, to ensure that change is sustained.

4.3.4 Dissemination Plan:
This project will first be implemented as a pilot scheme in one dental practice and will involve: dentists, managers, and staff from the same practice, for three months. Assuming that the results are positive and, actions are administered for the learnings from the PDSA cycle, the revised project version will be scaled up and disseminated to other dental practices within the organisation. The real-time data from the pilot scheme will be used in communicating to and encouraging other dentists towards this project.

Dissemination Aim:
The dissemination aims are to enhance further patient and dentist awareness to SDM and to achieve dentist’s adoption of the ‘talk’ model, which will lead to an increased patient contribution in decision making and change the current practices in the organisation while ensuring best evidence-based practice.

Target Audience:
To achieve the aim, the data will firstly be disseminated to the senior management within the organisation and IDC. Once their “buy-in” is confirmed, the remainder of the target audience can be considered, in this case, the dentists, managers, and patients.

The vital communication to stakeholders (senior management and dentists), to encourage them towards the project will include the project’s positive impact; this will be conveyed through the real-time results from the pilot project about patient satisfaction and care. The organisation currently operates 20 dental practices in Ireland; hence, the dissemination of change to all dental practices would require a change champion for its more practical roll out, and to increase the chances of project sustainability. A change champion will be recruited from the pilot programme’s dentist team to work closely with the writer to ensure that the ‘talk’ model is implemented. Various means of communication will be employed to ensure the transfer of data is effective. The organisation’s monthly email update will be used as a medium to disseminate the successes of the project to dentists and managers alike. This communication will enhance their understanding of the project and prepare them for future roll-outs led by a change champion. Leaflets will be designed and circulated for patient awareness about the provision of patient-centred service.

For wider stakeholder acceptance of this improvement initiative, it is vital to demonstrate its considerable impact regarding patient satisfaction towards decision-making process in consultation and six-month patient return rate.

### 4.4 Summary and Conclusion

The writer proposed a mixed methodology, both qualitative and quantitative (use of validated questionnaires), to evaluate the project, which according to (Denscombe, 2010), can provide the evaluator with multiple methodologies on data collection and
will foster accuracy, validity, and reliability of data. The writer believes that the proposed evaluation measures will demonstrate an improvement, with its benefit to the patient, healthcare professional, and management. The final chapter five discusses the findings and suggests further recommendations.
Chapter 5

5 Discussion & Conclusion

5.1 Introduction
During the 20th century, clinical decision making shifted from a paternalistic approach to a shared one. Now, in the 21st century, health professionals worldwide are increasingly practicing and incorporating SDM. The introduction of the ‘talk’ model as an approach to improving decision making in the dental consultation is a step up towards engaging patients in decision making, respecting patient autonomy, and promoting patient-centred care.

This chapter critically discusses the planning process of this OD project and illustrates findings that will support its implementation. Implications for stakeholders and the related strengths and limitations of the project are also discussed. This section also identifies learning points for the writer, as well as thinking and ideas around planning and change and their related challenges. The chapter also highlights areas for improvement and presents recommendations that will facilitate the success of the OD project.

5.2 Project Impact
The successful delivery of the project will have a short and long term impact for stakeholders, both in theory and in practice. The impact is explored in the sections below.

5.2.1 Stakeholders
Smith (2002) identified the main factors affecting successful change as: “visible and sustained sponsorship, addressing the needs of employees, and having strong
resources dedicated to the change” (p. 81). All these change enablers can be achieved by engaging all stakeholders

Senior management:

From the management’s perspective, the benefits of SDM using the ‘talk’ model are explained in chapter four. The documented proof in patients’ notes about dentist’s use of ‘talk’ model, and the patient return rate, will be verifiable safeguards of patient autonomy, with regards to their decisions. Use of the ‘talk’ model in consultation will add value to the patient care experience and will be potential evidence to satisfy any expected requirement of providing patient-centred services. In the longer term, feedback from the evaluation of the SDM process and quality of shared decisions, from patient perspectives, will better inform the organisation’s goals to increase patient numbers and improve patient care.

Dentists:

While practicing SDM in clinical practice is an ethical requirement of regulatory bodies, the literature review in chapter two suggests that it will reward dentists in several ways including: effective consultations, clearer risk communication, better quality decisions, fewer unwanted treatments, increased trust, less litigation, and better health outcomes. All these benefits can easily outweigh the need for additional time in consultation for carrying out SDM. The record keeping of SDM will have significant positive implications, particularly in care services where patients may later have issues with the standard of care received (Shaw, 2007).

Support Staff:

With this project in place, staff will be tasked with administrative responsibilities, such as collecting data for evaluation. Staff will play a crucial role in providing feedback for
refinement of the project. Administrative staff specifically, constantly communicate with patients on a daily basis regarding patient issues, and their participation in the project will enhance their level of confidence in dealing with such issues.

Patients:

In healthcare, there is no single right decision, as in most of the cases, treatment choices are available. It is anticipated, and confirmed by the literature review in chapter two, that when patients engage in SDM, they get the opportunity to give their opinions, weigh different treatment options according to their needs and priorities, and make informed decisions that are right for them. In this way, they will feel respected, empowered, and more knowledgeable with regards to their conditions. Feedback from patients will better inform the writer of the patients’ care related experiences and satisfaction.

Irish Dental Council:

Approval from the IDC to award CPD points for SDM related training is an important step. Respect for patient autonomy and the promotion of SDM in dental care is rarely practiced in dentistry so an understanding and the application of SDM will benefit the IDC in the longer term, should more registered dentists in Ireland practice SDM in their consultations.

Irish Society for Quality and Safety in Healthcare:

The Society, which proposes to undertake a dental patient perception survey in the future, will benefit from the literature review undertaken for the purpose of this project.
The writer:

The entire OD planning process encountered many challenges, but overall, it was a valuable learning experience. The writer is now much more competent in setting SMART objectives, reviewing and critiquing literature, carrying out risk assessments, preparing project timelines and financial projections, and composing formal reports. The writer understands more, the importance of measuring and evaluating against objectives. The writer’s leadership skills have improved as part of the planning process, and the writer looks forward to leading the implementation of the project.

5.2.2 Practice

The primary aim of this planned change is to improve SDM by introducing the ‘talk’ model into dental consultation. The project requires a cultural change to the clinical practices of dentists. As mentioned in chapter one, a clinical audit undertaken by the organisation in 2015 revealed gaps in current practices regarding treatment planning i.e. treatment plans are not discussed with patients in detail, and that leads to a loss of the patient’s trust in dentists. The implementation of the change project will improve and develop clinical practice by adding value to the patient journey and improving the patient experience. The introduction of the ‘talk’ model will improve the communication and engagement between dentist and patient, thus increasing their trust and adherence to the treatment plans and improving health outcomes. It will also influence a change in the current culture of dental practice through changing the process in which dentists and patients engage. The SDM also encourages improved collaboration and note-taking of the patient, emphasizing its use. It can have implications for marketing the provision of dental consultation under its use.
5.2.3 Theory

Before planning the change project, the writer reviewed the literature with a primary focus on patient-centred care and SDM in particular. The rationale for the change was further substantiated with the review, and an evidence-based ‘talk’ model was identified for introducing SDM into dental consultation. The information gathered through the literature review detailed in chapter two encouraged the planning of this project, highlighting the advantages and obstacles to SDM practice. The review also helped the writer determine the change methodologies that are discussed in chapter three.

The theory behind SDM (its notion, adoption in clinical practice, evaluation, and review) has been important in clarifying and explaining the vision of patient-centred care. Initial meetings with the main stakeholders have proved useful in informing the writer to be certain of its successful implementation.

Together, the evidence from the literature review, the drivers for the change and the writer’s clinical experience, suggest the possibility of improvement in the dental decision-making process, using the ‘talk’ model. The timeline for completion of the pilot project is short, so it is not possible to say with certainty that the behavioural changes will be embedded within the organisation within the time frame. However, the impact of the process within the organisation should be evident from the evaluation results.

5.3 Strengths of the project

The main strengths of the project are that it is patient-centred with an aim of promoting SDM. Relevant literature on the successful practice of SDM in the field of medicine provides a reference for its use in dentistry. The literature also provides
evidence to influence dentists and management towards improvement. The ‘talk’ model is an evidence-based conceptual model of practising SDM.

Another strength is that the project is based on the HSE change model (2008) to managing change in the health services. This best practice guide incorporates project management and focuses on the importance of engaging stakeholders.

5.4 Limitations of the project
A risk assessment (Appendix 7) was undertaken as part of the project plan, and this outlined many of the risks that could affect the successful implementation of the OD project. The project’s successful implementation is dependent on the dentists’ availability for training and thereafter, their compliance with the adoption of the ‘talk’ model. The objective regarding dentists’ compliance will be evaluated via observation, and there is a potential for bias towards dentist’s skills competency, as the observer would be a colleague of the participants. Further, time could be a limitation to measuring project sustainability, as change requires time to be properly embedded into existing culture. The introduction of SDM in busy months could put pressure on both dentists and administrative staff, who are key to the project success. The busy dental practices could reduce the likelihood of its adoption by dentists and creates a possibility of compromised project evaluation, due to the strain on staff resources. The patients will be invited to participate in patient surveys, and uncooperative patients’ attitudes toward filling out the questionnaire could limit the results of evaluation as well.

5.5 Recommendations
While planning this project and, following consideration of the project limitations, the writer suggests that other recommendations for the project could be considered.
Specifically, an information session for participating staff will benefit the project as
the use of the ‘talk’ model for the SDM process, and associated evaluation measures
will be new to them. The project is more inclined in establishing the need and the
dentists’ role in SDM. A discussion will take place with the dentists who will be part
of the project, to establish if the dental nurse who assists the dentist can take up the
role of observing the consultation and recording the use of SDM.

The patients’ role is equally important for the success of the project. It is
recommended to assess patient readiness for SDM interventions, increasing patient
knowledge and use of decision aids. The writer is aware of the popularity of decision
aids and the contribution they can provide to the decision-making process. Decision
aids not only significantly increase patient knowledge of options and related
outcomes, with accurate perceptions of risk, but also reduce the number of passive
and undecided patients, and the feeling of uninformed and unclear personal values
(Stacy et al., 2014). However, Elwyn et al. (2006) caution that decision aids are
envisioned to supplement rather swap the healthcare professional and patient
collaboration. Also, their use in decision making requires enthused healthcare
professionals, who are motivated to adopt SDM in clinical consultation (Légaré et al.,
2008).

It is recommended that planning for the implementation of this project focusses on
the healthcare professionals’ adoption of SDM and that the next step would target
both healthcare professionals and patients using decision aids to promote SDM
further. Finally, with the successful results of the project, the ‘talk’ model for SDM will
be disseminated to all dentists in the pilot practice, other general dentist practices,
and specialist consultations within the wider organisation.
Keeping in mind the importance of culture in managing change, the writer suggests that a study based on the Irish population, examining the dental care experience in the themes mentioned in chapter two, would further substantiate the rationale of the project.

Whenever another opportunity arises for planning and implementation of a change initiative, the writer will choose the HSE change model (2008) as a guide for planning and implementing.

5.6 Summary and Conclusion

This report presents a business case for the introduction of the ‘talk’ model into dental consultation, promoting patient-centred care through patient engagement in dental decision making. The short and long-term benefits for the organisation, staff, and patient are described. Four SMART objectives were set, which will be used to measure and evaluate the success of the project. The literature review of previous research was used by the writer to inform the OD project, and the HSE change model was chosen to guide the planning for the project initiation, planning, implementation and mainstreaming. The pilot implementation and evaluation, along with overall feedback from stakeholders, will indicate the effectiveness of change and will inform its future direction.

Leading the planning for an OD project in healthcare is complex and challenging. For the project plan to be successful is it important to understand the organisation’s vision, culture, and stakeholders. The use of a best practice guide to steer the project, and having knowledge of project management, risk management, and change management tools, are also important factors. Finally, reflecting and
learning, both at an organisational and individual level, is paramount to the success of such a project.
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Appendix 1 - The ‘talk’ model of shared decision making (Elwyn et al., 2013)

Key to the talk model of shared decision making
• **Justify**: explain the need to deliberate about a decision, create a partnership to support the work – ‘team talk’.
• **Inform**: two-way exchange of high quality information and opinions – ‘options talk’.
• **Elicit**: listen to patient’s preferences about treatment and outcome goals, concerns, and priorities.
• **Integrate**: ‘diagnose preferences’, make recommendations, seek patient’s views, and make or defer decisions – ‘decision talk’.

Steps to achieve shared decision making in dental consultation
1) **Justify**:  
   a) The work of deliberation: the dentist draws attentions to a problem where alternate treatment or management option exist and that required the decision making  
   b) The work of deliberation as a team: the dentist reassures the patient to become informed. The dentist will support the need to deliberate about the options.  
2) **Inform, describe options and exchange views**:  
   The dentist gives information and checks understanding, about options that are considered reasonable (including taking ‘no action’) to support the patient in understanding and comparing the pros and cons.  
3) **Elicit preferences**:  
   The dentist supports the patient to examine voice (concerns and priorities) and explore his/her personal preferences about treatment and outcome goals in response to the options that have been described.  
4) **Integrate preferences**:  
   The dentist make recommendations, seek patient’s views, and make an effort to integrate the patient preferences as decisions are either made by the patient or arrived at by a process of collaboration or defer decisions.
Appendix 2 - Force Field Analysis
Adapted from Lewin (1951)

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<thead>
<tr>
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<tbody>
<tr>
<td>5</td>
<td>Experience in the UK</td>
</tr>
<tr>
<td>5</td>
<td>Ethical implication</td>
</tr>
<tr>
<td>5</td>
<td>Regulatory implication</td>
</tr>
<tr>
<td>3</td>
<td>Revenue potential</td>
</tr>
<tr>
<td>4</td>
<td>Reduce clinical litigation</td>
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</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Forces AGAINST Change</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Introduction of the talk model of shared decision making in dental consultation</td>
</tr>
<tr>
<td>1</td>
<td>Patient interest</td>
</tr>
<tr>
<td>4</td>
<td>Lack of time</td>
</tr>
<tr>
<td>3</td>
<td>Culture</td>
</tr>
<tr>
<td>2</td>
<td>Conflicting projects</td>
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<td>Skill deficit</td>
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## Appendix 3 - Stakeholder Analysis

Adapted from Borgoyne (1994)

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<th>Senior management, Irish Dental Council</th>
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<tbody>
<tr>
<td>HIGH</td>
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<td></td>
</tr>
<tr>
<td>MEDIUM</td>
<td>Practice Manager</td>
<td>Pilot Dentists</td>
</tr>
<tr>
<td>LOW</td>
<td>Staff</td>
<td>Patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th>REACTION TO CHANGE</th>
<th>No commitment</th>
<th>On the fence</th>
<th>Committed</th>
</tr>
</thead>
</table>

No commitment: On the fence: Committed
## Appendix 4 - Assessment of readiness and capability to change

Adapted from Backhard and Harris (1987)

<table>
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<th>Capability for change</th>
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<td>Medium</td>
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<td>Practice Manager</td>
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<td>Staff</td>
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## Appendix 5 - S.W.O.T. Analysis

<table>
<thead>
<tr>
<th>INTERNAL</th>
<th>WEAKNESSES</th>
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<tr>
<td>STRENGTHS</td>
<td>TRAINING REQUIRED</td>
</tr>
<tr>
<td>• Organisation aim to promote patient-centred care</td>
<td>• Dentist resistance to change</td>
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<tr>
<td>• Regulatory obligation (HIQA Standards)</td>
<td>• Time constraints</td>
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<tr>
<td>• Professional Code of Practice (Irish Dental Council)</td>
<td>• Culture</td>
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<td>• Senior management sponsorship</td>
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<table>
<thead>
<tr>
<th>EXTERNAL</th>
<th>THREATS</th>
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<tr>
<td>OPPORTUNITIES</td>
<td>SUSTAINABILITY</td>
</tr>
<tr>
<td>• Setting standards in dental consultations</td>
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<tr>
<td>• To network with Irish Dental Council</td>
<td>• Patient resistance</td>
</tr>
<tr>
<td>• Enhance company reputation with the introduction of patient-centred care</td>
<td>• Dentists and support staff turnover</td>
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</table>
# Appendix 6 - Project Impact Statement

## Evaluating the impact of OD project

<table>
<thead>
<tr>
<th>Describe here how things are now in relation to the issue</th>
<th>Describe here how things should (ideally) be when the issue has been addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioural:</strong> describe current patterns of behaviour/attitudes of the key people involved with the issue</td>
<td>Behavioural: what sort of behaviours would (ideally) be evident when the issue has been addressed?</td>
</tr>
<tr>
<td>- Paternalistic style decision making.</td>
<td>- Partnership-style of decision making.</td>
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<tr>
<td>- Partially compliant to SDM process.</td>
<td>- Fully compliant to the ‘talk’ model of SDM.</td>
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<tr>
<td>- Improper compliance with National Standards &amp; Code of Practice.</td>
<td>- Proper compliance with National Standards and Code of Practice.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Structural:</strong> describe the way roles and responsibilities are currently organised</th>
<th>Structural: describe how roles/responsibilities would be organised once this issue has been addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Clinical decision making is healthcare professional’s responsibility.</td>
<td>- Clinical decision making is shared responsibility of health care professional and patient.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Personal:</strong> describe how you participate in and contribute to the current reality</th>
<th>Personal: describe how you will participate in and contribute to the new reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Lack of skills for carrying out SDM in the clinical consultation.</td>
<td>- Competent with skills to carry out SDM effectively in the clinical consultation</td>
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<tr>
<td>- Time pressure in consultations.</td>
<td>- Managing time efficiently.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cultural:</strong> describe “how things are done around here” now, e.g. accepted ways of doing things, implicit understandings</th>
<th>Cultural: what will be “the way things are done around here” when the issue has been addressed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Patient approval consent for carrying out treatment in notes.</td>
<td>- Patient participation in decision making and informed decisions in notes.</td>
</tr>
<tr>
<td>- Dentists’ knowledge influences decision making.</td>
<td>- Patient priorities will be taken in account and equal partnership in decision making.</td>
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<tr>
<td>- Patients are not empowered.</td>
<td>- Patients will be empowered and informed.</td>
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</tbody>
</table>
## Appendix 7 - Risk Assessment Plan

<table>
<thead>
<tr>
<th>Risk #</th>
<th>Risk to project success</th>
<th>Impact to project</th>
<th>Likelihood it will occur</th>
<th>Action to proactively control risk</th>
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<tbody>
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<td></td>
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<td>Low</td>
<td>Medium</td>
<td>High</td>
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<td>1</td>
<td>Lack of senior management engagement</td>
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<td>2.</td>
<td>Lack of dentists engagement</td>
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<td>3.</td>
<td>Lack of patient engagement</td>
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<td>4.</td>
<td>Financial risks of Project over spend</td>
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<td>5.</td>
<td>Administration staff will not show commitment to questionnaire administration</td>
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<td>6.</td>
<td>Unavailability of external observer</td>
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<td>7.</td>
<td>The pilot project will not be completed on time</td>
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<td>8.</td>
<td>Ineffective patient SDM awareness leaflet</td>
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</tbody>
</table>
## Appendix 8 - Project communications plan

<table>
<thead>
<tr>
<th>Stakeholders (Who)</th>
<th>Information Required (What)</th>
<th>Information Provider</th>
<th>Frequency (When)</th>
<th>Method of Communication (How)</th>
<th>Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Management</td>
<td>- Project Proposal&lt;br&gt;- Detailed project plan&lt;br&gt;- Project update</td>
<td>SM</td>
<td>- Start of pilot implementation&lt;br&gt;- Monthly meetings</td>
<td>- Presenting business case&lt;br&gt;- Meeting personally</td>
<td>- PowerPoint presentation&lt;br&gt;- GANTT chart</td>
</tr>
<tr>
<td>Irish Dental Council</td>
<td>- Application for CPD points&lt;br&gt;- Follow-up</td>
<td>AR</td>
<td>- June 2016</td>
<td>- Submission of application form</td>
<td>- By post&lt;br&gt;- Email</td>
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<tr>
<td>Dentists</td>
<td>- Aims, rationale and&lt;br&gt;- Project details&lt;br&gt;- Feedback</td>
<td>SM</td>
<td>- Start of pilot implementation&lt;br&gt;Weekly</td>
<td>- One on one meeting.&lt;br&gt;- Clinical meeting forum&lt;br&gt;- WhatsApp group</td>
<td>- GANTT chart</td>
</tr>
<tr>
<td>Staff</td>
<td>- Project need and importance of their role</td>
<td>SM</td>
<td>- Start of pilot implementation&lt;br&gt;Weekly</td>
<td>- Email&lt;br&gt;- Dental practice group meeting</td>
<td>- Notice board presentation of pilot project with specified roles of support staff</td>
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<tr>
<td>Patients</td>
<td>- SDM awareness and benefits of SDM</td>
<td>PM</td>
<td>- Every day during the three-month pilot project</td>
<td>- Verbal and written education of SDM and their role in SDM</td>
<td>- Patient SDM awareness paper leaflets</td>
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# Appendix 9 - Irish Dental Council application form for verifiable CPD points

## APPLICATION FORM FOR VERIFIABLE CPD POINTS

To be completed by Course Organiser

<table>
<thead>
<tr>
<th>Organising Group</th>
<th>Course Organiser</th>
<th>Location</th>
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<tbody>
<tr>
<td>S. Dental</td>
<td>SM</td>
<td>Dundrum</td>
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</table>

<table>
<thead>
<tr>
<th>Subject Matter</th>
<th>Date</th>
<th>Duration (in hours)</th>
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<tbody>
<tr>
<td>Shared Decision Making in Dental Consultation</td>
<td>2nd September 2016</td>
<td>Lectures (in hours) 2 hours</td>
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<td>Hands-on (in hours) 1 hour</td>
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### Lecturers / Course Presenters

Presenter: et to co

### Concise Educational Aims / Objectives

- To gain a clear overview of the nature of Shared Decision Making (SDM),
- To explore dentists’ attitudes to SDM and some of the reasons why doing it even better might be important
- To understand and practice a number of core skills in SDM:
  - Inviting participation and exploring options
  - Balancing good quality information of the risks, benefits and consequences of these options
  - Exploring what matters to the patient
  - Arriving at a shared decision that is ‘right’ for the patient
- To have a better idea of the next steps in embedding SDM in dentists’ own practice and, where appropriate, in their organisation.

### Anticipated Outcomes

Dentists will be knowledgeably & skilfully trained to carry out proper SDM in their consultations.

### Quality Controls (outline opportunities for Dentists to provide feedback)

Dentist will get an opportunity to hands on with the skills learned in workshop for 40 mins and then education feedback questionnaire will be provided to welcome their feedback on skill learning. Overall, training will three 10 min slots for dentist to provide feedback.

### Details of proof of attendance/participation provided to attendees

Certificate of competency in consultation communication skills will be provided to participants.

### Office use only

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<tr>
<th>F&amp;GP</th>
<th>Decision</th>
<th>Points</th>
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For Course Organiser’s

Only activities approved in advance by the Dental Council can be regarded as verifiable CPD activities. Attendance at verifiable activities will be recorded (including the dentists name and registration number) by the course organiser and forwarded to the Dental Council, similar to the procedure operated previously by the Post Graduate Medical and Dental Board. Course organisers are required to apply to the Dental Council at least three months in advance of the activity occurring for approval. To count as verifiable CPD an activity must have:

- Concise educational aims and objectives
- Clear anticipated outcomes
- Quality controls (i.e. there must be an opportunity for dentists to provide feedback)
- Documentary proof of attendance/participation from the course organiser

In signing this form I affirm that to the best if my knowledge this course meets the requirements for Verifiable CPD set down by the Dental Council.

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<th>Name</th>
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<tbody>
<tr>
<td>Contact Address</td>
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<td>Contact phone number</td>
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<td>Contact e-mail</td>
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<td>Signature</td>
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<td>Date</td>
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</table>
Appendix 10 - Patient leaflet

Adapted from MAGIC programme of The Health Foundation, UK

Ask 3 Questions

Sometimes there will be choices to make about your healthcare. If you are asked to make a choice, make sure you get the answers to these 3 questions:

What are my options?

What are the possible benefits and risks?

How can we make a decision together that is right for me?

www.making-good-decisions.org
## Appendix 11 - GANTT chart of project management plan

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<td>Senior management sponsorship for planning the project</td>
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<td>Pre-planning initiation</td>
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<td>Creating sense of urgency (Force Field Analysis)</td>
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<td>Literature search &amp; review</td>
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<td>Stakeholder analysis, SWOT, Impact evaluation</td>
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<td>Dentist communication (one to one meeting followed up by email)</td>
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<td>9.1</td>
<td>Pilot evaluation</td>
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<td>9.1.1</td>
<td>Questionnaires administration &amp; collection</td>
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<td>Data Analysis &amp; feedback</td>
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<td>9.1.3</td>
<td>PDSA</td>
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<td>Result Communication to Stakeholders</td>
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<td>11</td>
<td>Scale up &amp; spread</td>
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</tr>
</tbody>
</table>
Appendix 12 – Pre-training questionnaire
Adapted from MAGIC Programme of The Health Foundation, UK

Self-Assessment of Shared Decision Making knowledge and skills:
please complete prior to the SDM Advanced Skills Training

This self-assessment survey will be used to help to understand how knowledge, belief and skills in shared decision making change over time. Thank you for completing the survey.

Please indicate in the table below your self-assessed skill/knowledge level for each competency listed. A description of each skill level is provided here:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaware</td>
<td>1 At this stage you think that Shared Decision Making (SDM) skills/techniques might be useful to you, but you don’t know anything about them.</td>
</tr>
<tr>
<td>Aware</td>
<td>2 At this point you are learning about SDM skills/techniques, perhaps by going on a training course, reading a book or informally from your supervisor or colleagues.</td>
</tr>
<tr>
<td>Informed</td>
<td>3 Now you are ready to look for suitable opportunities to put SDM into practice, but it will take conscious effort to use the new skills/techniques.</td>
</tr>
<tr>
<td>Capable</td>
<td>4 You are now using SDM skills/techniques routinely, and are consciously aiming to improve by other methods.</td>
</tr>
<tr>
<td>Recognised</td>
<td>5 People around you recognise the change in skill level and you are now so practised that the skill has moved from your conscious to subconscious level.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skill or knowledge</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand the structure of a shared decision making consultation</td>
<td></td>
</tr>
<tr>
<td>I am able to introduce a preference sensitive decision in a consultation</td>
<td></td>
</tr>
<tr>
<td>I am able to explain why there is more than one treatment option</td>
<td></td>
</tr>
<tr>
<td>I am able to portray the options and check for understanding</td>
<td></td>
</tr>
<tr>
<td>I am able to elicit the patient’s personal preferences</td>
<td></td>
</tr>
<tr>
<td>I am able to put into practice the skills I learned at the workshop</td>
<td></td>
</tr>
</tbody>
</table>

NOW PLEASE TURN OVER AND COMPLETE PAGE 2
1. I think involving patients in decisions about treatment and care is not a good idea
   - **Tick one box**: □
   - I think involving patients in decisions about treatment and care is probably a good idea
     - **Tick one box**: □
   - I think involving patients in decisions about treatment and care is definitely a good idea
     - **Tick one box**: □

2. I do not have any of the skills to involve patients in decisions about treatment and care
   - **Tick one box**: □
   - I have some of the skills to involve patients in decisions about treatment and care
     - **Tick one box**: □
   - I have all of the skills to involve patients in decisions about treatment and care
     - **Tick one box**: □

3. At present I do not involve patients in making decisions about treatment and care
   - **Tick one box**: □
   - At present I sometimes involve patients in making decisions about treatment and care
     - **Tick one box**: □
   - At present I routinely involve patients in making decisions about treatment and care
     - **Tick one box**: □

4. In future I do not wish to involve patients in making decisions about treatment and care
   - **Tick one box**: □
   - In future I would like to involve patients more in making decisions about treatment and care
     - **Tick one box**: □
   - In future I would like to feel my practice was based on fully involving patients in decisions about treatment and care
     - **Tick one box**: □

Have you had any previous information about or training in shared decision making skills?

**Yes/No/Details:**
Appendix 13 - Post-training questionnaire
Adapted from MAGIC programme of The Health Foundation, UK

Post-training self-assessment of skills and knowledge in Shared Decision Making (SDM)

Please enter date of training (MM/YYYY) ______/_______

Please indicate in the table below your self-assessed skill/knowledge level for each competency listed. A description of each skill level is provided here:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaware</td>
<td>1 At this stage you think that Shared Decision Making (SDM) skills/techniques might be useful to you, but you don't know anything about them.</td>
</tr>
<tr>
<td>Aware</td>
<td>2 At this point you are learning about SDM skills/techniques.</td>
</tr>
<tr>
<td>Informed</td>
<td>3 Now you are ready to look for suitable opportunities to put SDM into practice, but it will take conscious effort to use the new skills/techniques.</td>
</tr>
<tr>
<td>Capable</td>
<td>4 You are now using SDM skills/techniques routinely, and are consciously aiming to improve by other methods.</td>
</tr>
<tr>
<td>Recognised</td>
<td>5 People around you recognise the change in skill level and you are now so practised that the skill has moved from your conscious to subconscious level.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skill or knowledge</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand the structure of a shared decision making consultation</td>
<td></td>
</tr>
<tr>
<td>I am able to introduce a preference sensitive decision in a consultation</td>
<td></td>
</tr>
<tr>
<td>I am able to explain why there is more than one treatment option</td>
<td></td>
</tr>
<tr>
<td>I am able to portray the options and check for understanding</td>
<td></td>
</tr>
<tr>
<td>I am able to elicit the patient’s personal preferences</td>
<td></td>
</tr>
<tr>
<td>I am able to put into practice the skills I learned at the workshop</td>
<td></td>
</tr>
</tbody>
</table>

Please tell us what you consider to be the Most Significant Change in your consulting behaviour since attending the advanced skills training:

Please tell us what you consider to be the Most Significant Change within your team since team members attended the advanced skills training:

NOW PLEASE TURN OVER AND COMPLETE PAGE 2
### Post training self-assessment of Shared Decision Making knowledge, beliefs and skills

<table>
<thead>
<tr>
<th></th>
<th>I think involving patients in decisions about treatment and care is not a good idea</th>
<th>I think involving patients in decisions about treatment and care is probably a good idea</th>
<th>I think involving patients in decisions about treatment and care is definitely a good idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2</td>
<td>I have all of the skills to involve patients in decisions about treatment and care</td>
<td>I have some of the skills to involve patients in decisions about treatment and care</td>
<td>I do not have any of the skills to involve patients in decisions about treatment and care</td>
</tr>
<tr>
<td>3</td>
<td>At present I routinely involve patients in making decisions about treatment and care</td>
<td>At present I sometimes involve patients in making decisions about treatment and care</td>
<td>At present I do not involve patients in making decisions about treatment and care</td>
</tr>
<tr>
<td>4</td>
<td>In future I would like to feel my practice was based on fully involving patients in decisions about treatment and care</td>
<td>In future I would like to involve patients more in making decisions about treatment and care</td>
<td>In future I do not wish to involve patients in making decisions about treatment and care</td>
</tr>
</tbody>
</table>

Tick one box
## Appendix 14 - Post-training skills checklist

### OPTION Observing patient involvement (Educational Feedback Version)

© June 2004 elwyn@cardiff.ac.uk

<table>
<thead>
<tr>
<th>Rater Name</th>
<th>Clinician Code</th>
<th>Date of rating</th>
<th>DD</th>
<th>MM</th>
<th>YY</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Description of index problem</th>
<th></th>
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</tr>
</thead>
</table>

1. The clinician draws attention to an identified problem as one that requires a decision making process.  
   - Yes 1  
   - No 0

2. The clinician states that there is more than one way to deal with the identified problem (‘equipoise’).  
   - Yes 1  
   - No 0

3. The clinician assesses the patient’s preferred approach to receiving information to assist decision making (e.g., discussion, reading printed material, assessing graphical data, using videotapes or other media).  
   - Yes 1  
   - No 0

4. The clinician lists ‘options’, which can include the choice of ‘no action’.  
   - Yes 1  
   - No 0

5. The clinician explains the pros and cons of options to the patient (taking ‘no action’ is an option).  
   - Yes 1  
   - No 0

6. The clinician explores the patient’s expectations (or ideas) about how the problem(s) are to be managed.  
   - Yes 1  
   - No 0

7. The clinician explores the patient’s concerns (fears) about how problem(s) are to be managed.  
   - Yes 1  
   - No 0

8. The clinician checks that the patient has understood the information.  
   - Yes 1  
   - No 0

9. The clinician offers the patient explicit opportunities to ask questions during the decision making process.  
   - Yes 1  
   - No 0

10. The clinician elicits the patient’s preferred level of involvement in decision-making.  
    - Yes 1  
    - No 0

11. The clinician indicates the need for a decision making (or deferring) stage.  
    - Yes 1  
    - No 0

12. The clinician indicates the need to review the decision (or deferral).  
    - Yes 1  
    - No 0
# Appendix 15 - Observer OPTION 12 item scale

**OPTION Observing patient involvement**

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<table>
<thead>
<tr>
<th>Rater Name</th>
<th>Clinician Code</th>
<th>Date of rating</th>
<th>DD</th>
<th>MM</th>
<th>YY</th>
<th>Age</th>
<th>Sex</th>
<th>Age</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation number</td>
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<td>Consultation duration [m, s]</td>
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<td>Practitioner (M = 1, F = 2)</td>
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<tr>
<td>Patient (M = 1, F = 2)</td>
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<tr>
<td>New Consultation</td>
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<td>Review Consultation</td>
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<td>Composite Consultation</td>
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</tr>
</tbody>
</table>

**Description of index problem**

1. The clinician draws attention to an identified problem as one that requires a decision making process.

2. The clinician states that there is more than one way to deal with the identified problem ('equipoise').

3. The clinician assesses the patient's preferred approach to receiving information to assist decision making (e.g. discussion, reading printed material, assessing graphical data, using videotapes or other media).

4. The clinician lists 'options', which can include the choice of 'no action'.

5. The clinician explains the pros and cons of options to the patient (taking 'no action' is an option).

6. The clinician explores the patient’s expectations (or ideas) about how the problem(s) are to be managed.

7. The clinician explores the patient's concerns (fears) about how problem(s) are to be managed.

8. The clinician checks that the patient has understood the information.

9. The clinician offers the patient explicit opportunities to ask questions during the decision making process.

10. The clinician elicits the patient’s preferred level of involvement in decision-making.

11. The clinician indicates the need for a decision making (or deferring) stage.

12. The clinician indicates the need to review the decision (or deferment).

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>The behaviour is not observed.</td>
</tr>
<tr>
<td>1</td>
<td>A minimal attempt is made to exhibit the behaviour.</td>
</tr>
<tr>
<td>2</td>
<td>The behaviour is observed and a minimum skill level achieved.</td>
</tr>
<tr>
<td>3</td>
<td>The behaviour is exhibited to a good standard.</td>
</tr>
<tr>
<td>4</td>
<td>The behaviour is exhibited to a very high standard.</td>
</tr>
</tbody>
</table>
The 9-item Shared Decision Making Questionnaire (SDM-Q-9)

**Example:** Please indicate which health complaint/problem/illness the consultation was about:

**Example:** Please indicate which decision was made:

Nine statements related to the decision-making in your consultation are listed below. For each statement please indicate how much you agree or disagree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Completely disagree</th>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
<th>Completely agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My doctor made clear that a decision needs to be made.</td>
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<td></td>
</tr>
<tr>
<td>2. My doctor wanted to know exactly how I want to be involved in making the decision.</td>
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</tr>
<tr>
<td>3. My doctor told me that there are different options for treating my medical condition.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. My doctor precisely explained the advantages and disadvantages of the treatment options.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. My doctor helped me understand all the information.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. My doctor asked me which treatment option I prefer.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. My doctor and I thoroughly weighed the different treatment options.</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. My doctor and I selected a treatment option together.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. My doctor and I reached an agreement on how to proceed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reference:
Appendix 17 - Healthcare professional questionnaire

The 9-item Shared Decision Making Questionnaire (SDM-Q-Doc, physician version)

[Example] Please indicate which health complaint/problem/illness the consultation was about:

[Example] Please indicate which decision was made:

Nine statements related to the decision-making in the above mentioned consultation are listed below. For each statement please indicate how much you agree or disagree.

1. I made clear to my patient that a decision needs to be made.
   - completely disagree
   - strongly disagree
   - somewhat disagree
   - somewhat agree
   - strongly agree
   - completely agree

2. I wanted to know exactly from my patient how he/she wants to be involved in making the decision.
   - completely disagree
   - strongly disagree
   - somewhat disagree
   - somewhat agree
   - strongly agree
   - completely agree

3. I told my patient that there are different options for treating his/her medical condition.
   - completely disagree
   - strongly disagree
   - somewhat disagree
   - somewhat agree
   - strongly agree
   - completely agree

4. I precisely explained the advantages and disadvantages of the treatment options to my patient.
   - completely disagree
   - strongly disagree
   - somewhat disagree
   - somewhat agree
   - strongly agree
   - completely agree

5. I helped my patient understand all the information.
   - completely disagree
   - strongly disagree
   - somewhat disagree
   - somewhat agree
   - strongly agree
   - completely agree

6. I asked my patient which treatment option he/she prefers.
   - completely disagree
   - strongly disagree
   - somewhat disagree
   - somewhat agree
   - strongly agree
   - completely agree

7. My patient and I thoroughly weighed the different treatment options.
   - completely disagree
   - strongly disagree
   - somewhat disagree
   - somewhat agree
   - strongly agree
   - completely agree

8. My patient and I selected a treatment option together.
   - completely disagree
   - strongly disagree
   - somewhat disagree
   - somewhat agree
   - strongly agree
   - completely agree

9. My patient and I reached an agreement on how to proceed.
   - completely disagree
   - strongly disagree
   - somewhat disagree
   - somewhat agree
   - strongly agree
   - completely agree

Reference:
Appendix 18 - SURE Test

SURE Test version for clinical practice

Yes equals 1 point
No equals 0 points
If the total score is less than 4, the patient is experiencing decisional conflict.

<table>
<thead>
<tr>
<th></th>
<th>Yes [1]</th>
<th>No [0]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sure of myself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel SURE about the best choice for you?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Understand information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you know the benefits and risks of each option?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Risk-benefit ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you clear about which benefits and risks matter most to you?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Encouragement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have enough support and advice to make a choice?</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

The SURE Test © O’Connor and Légaré, 2008.
Appendix 19 - Post consultation patient survey form

Adapted from MAGIC programme of The Health Foundation, UK

Making a GOOD shared healthcare decision means you:
- Know the options available to you.
- Know the benefits, risks and consequences of the options and the chances of these happening.
- Are asked about what is important to you in making a decision.
- Are as involved in the discussion as much as you want to be.

If there was no decision to make today please tick here □ and do not fill in the rest of the survey – thanks!

If there was a decision to make today:

Please circle a number below to tell us what you think about the quality of the shared decision making in your consultation today.

Very poor shared decision making 1 2 3 4 5 6 7 8 9 10 Very good shared decision making

Thank you for completing this survey
Please post back in the ‘MAGIC’ box at reception
Appendix 20 - Decision Regret Scale

**Definition**
The 'Decision Regret Scale' measures “distress or remorse after a (health care) decision” [1].

**Sample Tool**

<table>
<thead>
<tr>
<th>Decision Regret Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please think about the decision you made about [doctor, surgeon, nurse, health professional, etc.] after talking to your [doctor, surgeon, nurse, health professional, etc.]. Please show how you feel about these statements by circling a number from 1 (strongly agree) to 5 (strongly disagree).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. It was the right decision</th>
<th>1 Strongly Agree</th>
<th>2 Agree</th>
<th>3 Neither Agree Nor Disagree</th>
<th>4 Disagree</th>
<th>5 Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. I regret the choice that was made</td>
<td>1 Strongly Agree</td>
<td>2 Agree</td>
<td>3 Neither Agree Nor Disagree</td>
<td>4 Disagree</td>
<td>5 Strongly Disagree</td>
</tr>
<tr>
<td>3. I would go for the same choice if I had to do it over again</td>
<td>1 Strongly Agree</td>
<td>2 Agree</td>
<td>3 Neither Agree Nor Disagree</td>
<td>4 Disagree</td>
<td>5 Strongly Disagree</td>
</tr>
<tr>
<td>4. The choice did me a lot of harm</td>
<td>1 Strongly Agree</td>
<td>2 Agree</td>
<td>3 Neither Agree Nor Disagree</td>
<td>4 Disagree</td>
<td>5 Strongly Disagree</td>
</tr>
<tr>
<td>5. The decision was a wise one</td>
<td>1 Strongly Agree</td>
<td>2 Agree</td>
<td>3 Neither Agree Nor Disagree</td>
<td>4 Disagree</td>
<td>5 Strongly Disagree</td>
</tr>
</tbody>
</table>

*Decision Regret Scale © AM O’Connor 1996*