CLINICAL COMMUNICATION SKILLS THEME

STAGE/LEVEL 3: 2011-2012

COMMUNICATING BEYOND THE PATIENT

" And as soon as he's on the mend,we'll get the physiotherapist in here with a ball of twine."

FACILITATORS' PACK V.6 (02/09/2011)

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Introduction

For the standard course students the Communicating Beyond the Patient session will take place at the start of Stage 3 during students' SSC component. For the CGC students this session will take place in Level 3 when doing either the Medicine or Surgery block.

This is one of several Clinical Communication Skills courses specifically designed to prepare students to work effectively as FY1 doctors. This session is only one component of a coordinated series of opportunities for students to learn about team working in stage/level 3. Here we concentrate on communication beyond the patient: relatives, other doctors and other health professionals.

Format of the stage/level 3 team-working curriculum

The session is part of a curriculum of team-working events in stage/level 3:

1. Day in Addenbrooke's simulator centre (high tech unit which simulates acute emergencies):
The standard course students will attend their simulator session in their Acute Care block. The CGC students will have their session in the Cambridge Medicine & Surgery block. The simulator session will address team-working and leadership as vital non-technical skills needed in an emergency situation. *There will be some overlap here with the role plays in this session - we have discussed this with the simulator team who think this duplication is in fact useful. Observation of the simulator session has shown that some students find it very helpful in identifying possible problems they may have with communicating under stress, but that they do not have enough time to practice other approaches.*

2. Team-working portfolio assignment:
This assignment, which students have to complete before the end of February, requires students to analyse how teams function, the importance of communication to effective team-working and to reflect on both the professional and personal issues that relate to team-working. Specifically students have to:

a ***analyse one of the clinical teams they have been attached to***

"During Stage 3 you will become a member of several teams. Please undertake an in-depth analysis of one of the teams you have been attached to and use this to consider how teams function and what makes for an effective team"

b ***interview a member of the inter-professional team***

"Select a patient from your current attachment. Identify a key member from the inter-professional team who appears to be leading the non medical decision making process about this patient's care. Arrange a meeting with this person to discuss:

- *how they view their role in the team and what they see as their responsibilities with this patient*
- *how they see their role interacting with other team members involved with this patient*
- *the clinical expertise and values this team member contributes to the patients care*

c ***write a 1500 words reflective portfolio essay***

"This assignment requires you to step back and reflect on the teams you are working within. The intention is to enable you to demonstrate that you are aware of and understand personal and professional factors that influence a team's effectiveness and that you can reflect on how these issues may influence your future practice as a qualified doctor"

3. This session on communication beyond the patient
This session concentrates on experiential small group work. It looks at a complex scenario involving responding to a colleague's request, telephoning a senior for help, talking to a relative and handling a

complaint. **In the students pack they are directed to look at the hand-out and practise using SBAR prior to the session.**

Background information for facilitators about the principles of teamwork - not necessarily to be transmitted to the students:

In the stage/level 3 curriculum students will have true responsibility for a small number of patients and therefore will have to engage as team members. Before teaching the course, facilitators need to have an effective knowledge of the subject matter. To help us all here we have compiled the following notes:

How this fits into the Calgary Cambridge Guide
All the skills needed for effective communication with patients are equally useful when communicating with others; but **relationship building** and **structuring** the communication are of particular importance. Clear introductions are an efficient basis for building relationships. Equally, structuring communication, so that it is clear when we give a message or handover information about a patient, is vital. How do we highlight the key information and check understanding? Use of signposting and summarising are crucial skills we use on a day to day basis.

We can emphasise the parallel between the structure and skills of the medical interview and that of any inter-personal interaction. 'Identifying the reasons for the consultation' in this situation becomes 'identifying the issues to be discussed' and has a strong element of setting objectives and negotiating an agenda. The 'illness' here is the other person's feelings and concerns.

Of course, in the medical interview it is clearly the doctor who is structuring the interview and who has the implicit power. In discussions with colleagues, it is not clear who has responsibility for structuring the session, nor is it clear who is interviewing who and who is giving the information.

What is needed for effective team working?
- clearly defined roles
- a clear sense of purpose and direction
- team members feeling collectively accountable
- openness – feeling able to express oneself
- welcoming and acknowledging contributions from team members
- a strong learning culture that enables team members to share insights with each other
- good support through effective leadership
- effective use of all resources
- delegation

Barriers to effective team-working
- competing demands both personal and professional
- the system
- workload
- poor communication
- status
- historical problems: 'doing what we've always done' and adopting inappropriate role models
- attitude

e.g. the assumption of a professional hierarchy that does not allow for equal contribution of the skills and knowledge of team members from other professions, or overly defensive protection of professional boundaries

EXPERIENTIAL SMALL GROUP WORK: EITHER 9.00-12.00 or 14.00-17.00

The students will be divided into groups of six/seven each with a facilitator, simulated patient and ideally an FY doctor, depending on availability ***It is very clear that the involvement of FYs in this session is very valuable.***

Aims

- to explore skills required for effective communication with relatives
- to explore skills required for effective clinical communication with colleagues on the telephone
- to explore the skills of acknowledgement and assertiveness
- to explore responding to a complaint
- to highlight that many of the skills from the CC guide which we use to communicate effectively with patients apply equally to communication with others.

Please note that student packs now contain the following information:
Facilitators have been asked to adhere to strict timekeeping for all CCS sessions. Therefore, you can expect this session to start and finish on time. Please ensure that you arrive at least 5 minutes before the start of the session as students arriving after the initial group introductions may not be allowed to join the group.

Verbal feedback is provided to individual students throughout the session. Students wanting to discuss/request further feedback may wish to speak to the facilitator privately. Similarly, if the facilitator has additional feedback for individuals they may request a meeting at the end of the session. Facilitators will aim to finish with ten minutes to spare to allow time for this and student evaluation/feedback.

Introductions: 20 mins

- Welcome, introduce yourself, ask the simulated patient and FY Ask each student in turn to think for a minute about 1 situation related to 1:1 communication with other health professionals including doctors and nurses and 1 working with relatives that they have found difficult or witnessed others finding difficult: try to remember a particular incident
- Ask each to talk briefly about the situations, who was involved, where it occurred, or a particular type of situation that regularly occurs that they find tricky.
- Flipchart responses and draw out common themes
- Explain that we can try to explore some of these as we go through the scenarios or look for generic strategies that might help derived from what we do this afternoon

9.20/2.20 Complex Situation

Facilitators: there will not be time to do a lot of theory and this would be unhelpful – focus predominantly on the experiential learning and give handouts to summarise and enable them to think later. However, a brief amount of theory with each section is helpful
Try to progress the unfolding scenario throughout the afternoon with different students taking turns

9.20/2.20 What is different about telephone communication? 10mins

You are going to speak on the telephone to a nurse and a senior about a patient. Before we do this,

- why is telephone communication different?
- what makes for an effective telephone call?

- what causes difficulties?
- which skills from the CC guide do you have to use with more clarity, depth and sensitivity?

It's important here to get the students to think of this from both perspectives of both people on the call.
Draw out and teach on the handout included in this pack called "how to make your telephone communication effective" (The handout should be given out at the end of this section)
Experience and some literature on triage and telephone communication suggest the points in the handout are key to successful telephone communication. Remember it is different depending on who rings who. If you are ringing somebody, thinking about structuring can help you prepare and consider what you want to achieve. If somebody is ringing you, it is normally unexpected without preparation time and in medicine, often the person ringing you is anxious: you need to think carefully about relationship building in the absence of most non-verbal cues: also if someone rings you additional caution should be employed re 'who they are.'

9.30/2.30 Responding to a colleague's request for help. 30 min

Here the simulated patient plays the part of the nurse and the students work out how to tackle this phone call and take turns on the telephone. Please use mobile phones as props for telephones and place the participants back to back when making the phone call.

The Scenario
You are the FY1 on call, its 10.00 pm and your bleep goes off for the 6th time in 15 minutes. You are busy (useful to briefly review list of tasks to help students get in role - see student handout 1). You recognise the extension of Ward 6. You don't have any of your own patients on that ward but you are the doctor covering it. Please ring the Ward.
They do not know who they are going to speak to but in fact they are being bleeped by a bank staff nurse about Mr Lees a patient they have not met before.

Distribute role C part A information to the group:
Practice with the simulated patient

Possible points to be raised from responding to a colleagues request for help

How to get the key information you need to establish your priorities when someone is ringing you for help and clearly very anxious.

Issues to debrief:

1) *What exactly is the staff nurse asking of you?*
   - *need to find out what 'checking' means*
2) *How are you going to establish how urgent this call is?*
   - *Clinical need, ask nursing staff details of clinical scenario,*
   - *Need to know severity of COPD*
   - *Specifics re vital signs, MEWS score may be helpful (see p21)*
   - *need to know what's been done already,*
   - *how urgently you need to attend*
3) *What can you get staff nurse to do till you get there?*
4) *What does the nurse need from you?*
   - *To know that the doctor has appreciated the difficult situation she is in.*
   - *That help is coming*

10.00/3.00 Telephoning a senior colleague to ask for help. 45 min

Following the phone call you go to the ward to assess the patient and the patient does not seem so bad and you think the nurse is panicking. The temperature is 37.5 and the pulse 90, and his RR is back to 26. You increase the oxygen to 4 litres, calm the nurse down and ask her to ring you if the patient deteriorates. You hear nothing more and get on with your work.
It's 6 o'clock in the morning now and the nurse rings again saying he is no better on the oxygen and she is still worried. You agree to see him and quickly realise if this patient is to remain safe they need urgent attention which you do not feel competent to provide. His wife is sitting on a chair beside him. You explain that you are going to seek help and that you will come back and explain what is happening. You are working beyond your limitations and need help. You will need to be assertive.

Distribute role C part B information to the group: group discussion about the difficulties of the situation and how to handle it. Discuss how using SBAR may help reduce some of these difficulties, give out hand-out and ask students to think about how they will use SBAR in the call.

Practice with simulated SpRs. This is easiest played by either the FY1 or facilitator

These are possible discussion points to be raised and areas to cover concerning telephoning a senior to request help - but please remember that the experiential element is the most important here - you do not have to do all of these

How to communicate quickly and effectively to a senior member of staff in an urgent situation. Here it is useful to consider the value of using a model to structure their handover to another colleague e.g. SBAR (Leonard, Graham and Bonacum 2004) and or to work out what questions you want to ask when a colleague rings you.

SBAR = situation, background, assessment and recommendation.

One example:

Situation – Who is the patient and what is going on?

Mr X is currently having difficulty breathing

Background – what is the clinical background or context?

He's 65 yr old man with chronic lung disease who has been improving following an acute infection but has now got suddenly much worse.

Assessment

I don't hear any breath sounds on the right side – I think he has a pneumothorax

Recommendation

Can you come and see him right now - I think he needs a chest drain.

In this situation it is also important to discuss the importance of team members speaking up – not hinting and hoping – importance of stating the problem politely and persistently until they get an answer, get person's attention, express concern, state problem, propose action, reach decision.

Draw out:

- *confidence: once you make the call be confident, remember you are the one who has seen the patient*
- *introduce yourself and check who you're speaking to*
- *clarity: be clear about your level of concern, why you are so concerned, what it is you want, , what questions you want addressed,*
- *important to state why you are ringing and what you need early on in the telephone call*
- *think how to convey to someone on the end of the phone that you are concerned the patient may be about to rapidly deteriorate.*
- *be sure to have the information you need to hand*
- *remember the only communication they have is your tone of voice and what you say. So tell them what's worrying you, explain why you think that's the problem and ask them what they think.*
- *assertiveness: make requirements known with necessary level of assertiveness (see below)*
- *negotiate reasonably while trying to convey/explain why your case is urgent – share what's worrying you with them and ask what they think. But if you're really concerned don't let them talk you out of it*
- *stay calm and be courteous at all times*
- *respect your colleagues who have pressures of their own*
- *be prepared to admit you may be wrong and recognise the importance of admitting to error and the role of the apology*
- *document the conversation*

Being Assertive

Get the students to think about why some people struggle to assert themselves within a perceived hierarchy and how their behaviour can enable or disable. The point is that if someone is struggling to convey their message, this will make their job as a doctor more difficult.

What is assertiveness?

What words do you associate with assertiveness?
Who have you seen who you think is assertive?
What do people do when they are not being assertive?
What is the difference between this and aggression?

People often think of assertiveness as a personal trait when in fact assertiveness is a way of behaving. Write up responses on a flip chart and use this brainstorm to bring this difference out.

Defining assertiveness

Look at a couple of definitions of assertiveness
(See handout)
Facilitators:
It's important to unpack these definitions in a way that is meaningful for a medical student and in the situations they find themselves - in other words this is about recognising that you have needs that you are allowed to express, that others may see things from a different perspective, that they are allowed to express their needs as well and may also be working under pressures.

It is also important to try to get the students to make the distinction between assertiveness and other behaviours. At certain times most people find it difficult to communicate honestly, directly and openly with other people. The idea here is to draw out the main responses which are passive, aggressive and assertive; what makes for assertive behaviour and how, depending on the response, one can slip from one to the other. ***(See handout)***

Components of assertive communication

- *being clear about what you feel, what you need and how it can be achieved*
- *saying "yes" when you want to and "no" when you mean "no"*
- *ask, if you are unsure about something*
- *if the other person tries to create a diversion, point this out calmly and repeat your message*
- *being able to talk openly about yourself and being able to listen to others*
- *being able to give and receive positive and negative feedback*
- *having a positive, optimistic outlook*
- *always respect the rights and point of view of the other person*
- *be happy to stick to your objectives even if it does get a negative response*
- *be confident about handling conflict if it occurs*

Emphasise that body language is vital here. Having confident, open body language and eye contact is the beginning of being assertive.

Clear communication is an important part of assertiveness. This is where you show:

- *knowledge – you are able to understand and summarise the situation*
- *feelings – you can explain your feelings about the situation*
- *needs – you are able to explain clearly what you want or need, giving your reasons and any benefits to the other party*

If you meet objections, keep repeating your message whilst also listening to the other's point of view. Try to offer alternative solutions if you can.

10.45/3.45 Tea **15 mins**

11.00/4.00 Talking to the relative	**10 mins**

Before the registrar comes, on his advice, you get a chest x-ray and blood gases which show the following results

Blood gases – pO2 5.7, CO2 4.3, pH 7.37, lactate 1.9 (these are not good! suggesting a possible respiratory acidosis)
CXR: poor inspiration, old right-sided pneumonia, partially resolved

The registrar then comes to see the patient and arranges a bed for him in HDU. He tells you he thinks the patient has a DVT and possibly a PE and he doesn't think it's a pneumothorax. You realise you didn't check his legs and didn't think about that possible diagnosis. You have told his wife/husband and the nursing staff that having spoken to your registrar you will come and

The student needs to realise that there is a possibility that they may have made an error although this is far from certain. The relative will be played by the simulated patient. It will be straightforward, without too much emotion, just concern, although the simulated patient will say at some point, "he will be all right won't he?"

This role play should be kept short and done by only one student

Communicating to a relative that a patient has deteriorated - areas that you might want to see the students cover:

- ***What does the relative know already***
- ***He is not very well and his condition is giving some cause for concern***
- ***Have discussed with SpR***
- ***Agreed he needs closer monitoring***
- ***He will be moved to HDU***
- ***A nurse will show you where this is***
- ***We need to do some more tests to confirm the diagnosis***
- ***We will keep in close contact with you – very important to emphasise that the doctor is communicating on behalf of the team.***

See role D, part A

11.10/4.10 Responding to a potential complaint **45 mins**

One week later, the patient has been discharged from HDU back onto your ward and your care, having been very ill with multiple pulmonary emboli. The wife/husband asks the ward nurse if she/he can see you.

She opens with quite a well considered, calm and reasoned complaint about what happened on the ward last time. She is not aggressive, and in the back of her mind, she has wanted to make sure that this doesn't happen to other people in the future. The substance of her concern is that she had noticed him becoming more breathless and confused over the previous 24 hours and it didn't seem like the way he had been before with his chest infections. He was panting much more and looked unwell. She had mentioned this to the nurses and asked them to draw this to the attention of the doctors. But nothing happened. She knows that the doctor saw him earlier in the evening and felt there was little wrong and then all of a sudden at 6 AM, he had to be admitted to HDU where he was found to have multiple pulmonary emboli.. She is now unhappy about him coming back to this ward. He received exemplary care in HDU.

See role D, part B

Practice with the simulated patient

Points to be raised from dealing with a complaint

What to do when a patient complains

If a patient raises concerns about his or her treatment or care, the correct thing to do is to listen to them, explore what their concerns are, take their concerns seriously, use acknowledging and empathetic statements, and answer any questions you can. This may provide sufficient reassurance, in which case you should inform the senior responsible clinician and document the discussion in the clinical notes. If the patient wishes to make a formal complaint, you should advise them to complain to the complaints manager in the relevant NHS trust at the earliest opportunity. Complainants will often be extremely angry as well as experiencing fear and lack of trust. Their anger may focus on individual healthcare practitioners, including you and/or your colleagues. It is important to acknowledge the complainant's anger and to try to understand the underlying causes. It may also help to be aware of the effect that the complainant's anger will be having on you. Many doctors take this anger very personally, when often the cause of the anger is the adverse outcome. There may be significant inaccuracies in the complainant's perception of the situation. Try to be supportive of colleagues if you can.

The Medical Defence Union (MDU), encourages members to tell patients if something has gone wrong and to apologise. It is 'a bit of an urban myth' that doctors don't say sorry, says Dr Emma Cuzner, an MDU medico-legal adviser. Section 2 of the Compensation Act 2006 states: 'An apology, offer of treatment or other redress shall not of itself amount to an omission of negligence or breach of statutory duty.' She explains that, if something goes wrong, patients are entitled to a prompt and truthful account of what has happened, which should be accompanied by an explanation by the clinician of what they propose to do to put the matter right and an apology where appropriate. This is also stated in the General Medical Council's Good Medical Practice guidelines, published in 2006.
'We always say at the outset that a lot of people just want an apology and an explanation, and if you do that the complaint is not likely to run on,' Dr Cuzner explains.

Principles and skills for an effective apology
Firstly decide if you are making an expression of consolation or a true apology.
Expression of consolation An expression of consolation is appropriate after an unfortunate but recognised complication of a procedure—for example, a haematoma after operation. Use a phrase such as "I am so sorry for what has happened." It is helpful to empathise ("It looks very swollen. Is it painful to move your arm?") and to offer any practical support available ("Would you like some stronger painkillers?"), but it is not necessary to accept blame.
True apology A true apology is necessary when you wish to acknowledge responsibility and to express remorse—for example, when an incorrect drug dose has been given. The following approach is helpful.
Step 1—Acknowledge and identify the details and consequences. Confirm that the offence was unacceptable—for example, "I need to apologise. I prescribed you 10 mg of warfarin last night instead of 1 mg. I am very sorry—this shouldn't have happened. Your blood is a little too thin today. It shouldn't be dangerous because we are monitoring it, but you are going to need extra blood tests and possibly an injection to reverse the warfarin."
Step 2—Explain how it happened—for example, "I was in a hurry because there was a patient with chest pain waiting in casualty, and I didn't look up your latest results on the computer."
Step 3—Express a commitment not to repeat what happened, for example, "I am sorry to have made such a simple mistake. I will ask for help if I am feeling overworked." It may help to empathise with the patient, showing your awareness of how the mistake made he or she feel.

	Degree of importance accorded by patients		
	Very important	Important	Not important
Admit a mistake when it has occurred	84	7	2
Explain how the incident could have happened	65	14	9
Offer an apology	41	22	24
Show sympathy for what I went through	38	21	29
Make an effort to recover our relationship	15	17	53

Facilitator to emphasise that ideally, if it was clear and that there was forewarning that this was a potential complaint, this meeting would not be the FY alone. Also to highlight the importance of keeping their senior staff informed. Importance of reading the background information, notes and possibly involving PALS.

If the students are very able and wish to practice discussing a clinical error use the scenario on the BMJ article "I prescribed you 10mg of warfarin last night instead of 1mg.

12.15 /17.15 **Finish**

- Brief round of how the students are feeling and what they have learnt
- Facilitator sums up and relates to the literature and to the Calgary-Cambridge guides.
- Make sure you return to the overall aims (on page 2). Emphasise that the main themes which we have covered in communicating with colleagues are:
    - Communicating with relatives
    - Communicating across disciplines

- Communicating with seniors
- Face-to-face versus telephone communication
- Assertiveness
- Complaints

Distribute handouts and feedback sheets

12.20/17.20	**Evaluation and Feedback**

References

See additional materials

BACK, K. & BACK, K. (1999) *Assertiveness at work: a practical guide to handling awkward situations,* London, McGraw-Hill

MALES, T. (2007) *Telephone consultations in primary care: a practical guide,* London, Royal College of General Practitioners.

Role A: BANK STAFF NURSE
Name: John/Jane Anderson **Age: your own**

Please note that this session must NOT be about students needing to deal with stroppy people. It's how you work best with colleagues who are feeling stretched and who may become easily frustrated.

This is a telephone conversation with the on-call FY1 doctor.

You are a newly qualified staff nurse working on the bank until a permanent job comes up. You are finding it hard constantly changing wards. As a person, you have always lacked confidence and you sometimes ring others to ask for help without thinking through what you want to say. You have so many things to keep track of and you do get quite stressed and find it hard to think clearly when you're on the telephone.

Tonight you are on night duty on a medical ward, Ward 6, at Hinchingbrooke Hospital. After the hand over with the previous staff nurse you find yourself in charge. You have given a student nurse the task of keeping an eye on Mr Lees (among others). It's really busy and you're trying to get an IV (intravenous) done before the next patient arrives for admission. Then your student nurse reports that you should 'come and look at Mr Lees'. You are immediately worried. You don't like what you see and you note that the patient's respiratory rate has increased from 26 to 30 in an hour and his sats (saturation levels) have dropped from 96% to 94% on oxygen.

You bleep the on-call FY1 doctor who you don't know. When he/she rings back you are pleased he/she has answered quickly. Start by saying: "Ward 6 – John/Jane Anderson." Then simply explain that you are very worried about Mr Lees. "It's Mr Lees, I am very worried about him - please will you check him?."

If FY1 asks for more information, give the following: "I don't like the look of him. He's a 65-year old man with acute COPD (Chronic Obstructive Pulmonary Disease). He was admitted 3 days ago for IV antibiotics. His respiratory rate has increased from 26 to 30 and his sats are 94% on oxygen." [You didn't check his temperature or pulse before calling the doctor – an error you now realise!]

When the doctor asks you if you know his temperature or pulse be really apologetic but emphasise that you really don't like the look of him. If the doctor asks you to take the patient's temperature and pulse be very willing and say you'll make sure they are done by the time the doctor gets to the ward but can they please come soon!

Behaviour: slightly panicky (as feeling overwhelmed and out of depth) but react to FY doctor and become more focused in response to clear questioning.

Role B: SPECIALIST REGISTRAR

Name: Dr Pamela/Gareth Hughes **Age: your own**

A follow on telephone consultation

You are a specialist registrar (SpR). You have had a busy day. Before work you were trying to study for your forthcoming Consultants exams and since arriving at work you haven't stopped.

You tried to grab a coffee at 3 a.m. and your bleep went off four times. Two of these really irritated you - if they'd only bothered to gather all the information available and think before reaching straight away for the phone they'd have realised they were perfectly able to manage. This seems to be a recurring pattern with your current junior staff and it's making your life difficult.

However you're quite good at disarming junior staff and you can usually block their attempts to involve you in routine work although if juniors are clear about what they want you can be persuaded to listen. You're not normally a good listener.

At 6 a.m. you are still dealing with two acutely unwell patients – one who you are waiting to transfer to Intensive Care and the other who you expect to be finished with in the next 20 minutes. Then you have promised yourself a coffee.

At 6.15 you are just finishing in the medical ward when your bleep goes off. Start by assuming this is another junior who should be able to cope while you go and grab that break you've promised yourself. You're answering your bleep start with a clipped Gareth/Pamela Hughes. When they start off quickly ask what the problem is and then interrupt saying "Oh I know Mr Lees. He's always in and out." And then your aim is to block further discussion and you should do this with sighs and silence or minimal response. You could question why they've rung you if they don't volunteer that they rang the SHO (Senior House Officer) but he doesn't answer his bleep, so then they rang you.

The junior doctor may tell you that on examination he/she has found: respiratory rate is 30, sats 90% on oxygen. They are finding it very difficult to hear any breath sounds on the right side (interrupt with: "Yes you're right – his chest isn't easy to examine.") The junior may continue with something about being unsure of their findings but things are not what they were like before. Unless they've given you Pulse, Temp, Resps, Sats and how they've changed reply with "What are the changes in all the obs?"

Your reaction will depend upon the student and how assertive they are. If still wishy-washy then "I'll just finish this patient (and think to yourself and grab that coffee I've promised myself); should take me 30 to 40 minutes and then I'll pop over and see what's up – ok?"

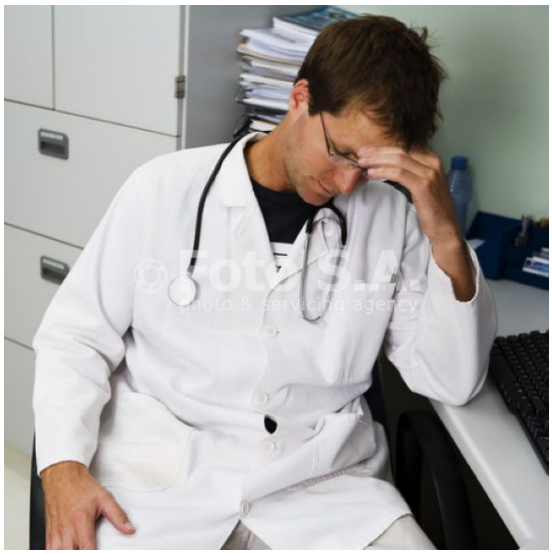
If the junior is clear and confident (with a hint of assertiveness) then respond with "Thanks for contacting me; you've down the right thing. I'll be along as quickly as possible. If he deteriorates, then get back to me. In the meantime, please could you do some more obs for me to look at when I get there and organise a blood gas and portable chest X-ray.

Student Handout 1:
Role C: FY1 DOCTOR

Part A

The Scenario

You are the FY1 on call, its 10.00 pm. You have just reviewed your list of outstanding jobs..



1. Rewrite drug chart for patient.
2. Pre-dose gentamicin levels for a patient to be taken.
3. Cannula for fluids.
4. 70 year old Gentleman with a bladder scan of 999ml 1 day surgery post TURP complaining of abdominal pain.
5. A discharge letter that needs to be done.
6. A 75 year old lady who has had 3 previous heart attacks has shortness of breath, SATs 85, RR 36.
7. A gentleman aged 60 admitted with pneumonia has had enough of the hospital and wants to self - discharge- will you come and talk to him?

You are pretty busy. Think for a few minutes about this list of jobs and how you might feel when your bleep goes off again for the 6th time in 15 minutes.

You recognise the extension of Ward 6. You don't have any of your own patients on that ward but you are the doctor covering it. Please ring the Ward It feels like it's going to be a long night…..

Student Handout 2:
Role C: FY1 DOCTOR
Part B

You are the FY1 seeing Mr Lees, a patient who is in Ward 6. At 6 am you received a call from the nurses to say the patient's condition is deteriorating again and could you see him again. You are now on the ward. You met Mr Lees last night at 10 pm.

Mr Lees is a 65 yr old married man who was admitted following exacerbation of COPD. He was diagnosed 4 yrs ago and is under the care of Dr Jones at Hinchingbrooke. He has been gradually deteriorating for the last 12 months having required several courses of IV antibiotics. Three days ago, he began to feel acutely unwell and drove straight to the Emergency Dept at Hinchingbrooke. On admission he had a high temperature and felt worse than he had ever felt before. He was finding it difficult to get his breath. His temp was 38.4, pulse 120 and RR 30. He was started on IV antibiotics for a presumed infective exacerbation of his COPD. He was gradually getting better until tonight

On examination you find: he is unwell, respiratory rate 30, sats 90% on 4 litres oxygen, P 120 reg. You find it very difficult to hear any breath sounds on the R side but are not sure about your findings or what they were like before – you wonder if perhaps they have always been like this – you check the notes but they don't really help. Next you ring the SHO but he doesn't answer his bleep.

You do not know what to do. You do not feel confident in this situation. You want to ask your senior to come and see the patient because you are very worried that he may have a pneumothorax. You have only ever seen one before. You feel you need someone to come and assess this patient as soon as possible. However you know that recently one of your colleagues called the SpR for advice and was really put down for not knowing what to do. You also know that the SpR is tied up with several acutely ill patients.

Task: You are the FY1 doctor and need to telephone the SpR, Dr Hughes, to explain that the patient's condition is deteriorating and ask them to come and assess the patient. You don't know this SpR well, but you do know he is fairly senior and has a bit of a reputation.

The MEWS (modified early warning score) is often used by the nursing staff to assess a patient's likelihood of needing urgent attention and very careful monitoring. A score of 4 or more is cause for concern. This patient has a MEWS score of 6.

MEWS (MODIFIED EARLY WARNING SCORING)

Score	3	2	1	0	1	2	3
Resp rate (/min)		<8		9-14	15-20	21-29	>30
Pulse (/min)		<40	41-50	51-100	101-110	111-130	>130
Temp (oC)		<35		35-38.4	>38.5		
CNS				Alert	Voice	Pain	Unresponsive
Urine (ml/hr)	Nil	<30	<60		>150		

Role D: The wife
Part A

You are the wife of Dennis Lee, a 65-year-old man who was admitted three days ago with an acute exacerbation of his chronic bronchitis. He was diagnosed four years ago and is under the care of one of the consultants at Hinchingbrooke Hospital.

Your husband is a quantity surveyor and you work as a volunteer in the Citizens Advice Bureau, mostly helping people get the financial help they need when they are in difficulties. You are a fairly calm person.

In the last 12 months, your husband has had several admissions with infections and three days ago he began to feel really unwell and he drove himself straight to the emergency department at Hinchingbrooke. You weren't around at the time as you were at work. He said he felt worse than he had ever been before and you were really worried about him. He had a high temperature and was very short of breath.

He now has had three days of antibiotics and the nursing staff told you he was gradually getting better. However, you were not so sure. You stayed at the hospital last night because you had noticed he was becoming more breathless and confused over the last 24 hours and it didn't seem like the way he had been before with his chest infections. He was panting more and to you he looked unwell. You had mentioned this to the nurses and asked them to draw this to the attention of the doctors. But nothing happened until tonight. You saw the FY at 6am when he came to reassess Dennis and he told you that Dennis was not very well and that he wanted to speak to his senior colleague and then he would come back and talk to you as soon as he knew what the plan was.

In fact, what he's going to tell you is that he needs to be transferred to a high dependency bed and might even need ventilation.

Don't get too emotional in this role-play. You are fairly calm and decide not to mention your previous concerns at this point. You were just pleased that they are taking his condition seriously and hope for the best. However, you like to know how things stand and some way into the interview, you say “He will be all right won't he?". Working at the Citizens Advice Bureau has made you realise that lots of difficult things happen to people, and you have been thinking through over the last few months what will happen if your husband does die. So it's not a great shock to you that he is so unwell.

Role D: The wife
Part B

It is one week later and your husband has been discharged back from HDU onto the same ward he started in. While he was there, he was diagnosed with having several clots on the lungs which apparently came from a thrombosis in his leg. These were what were making him so unwell. He was very ill for a few days but is now making headway again.

You have asked the ward nurse if you could see the particular doctor who was looking after him before he was admitted to HDU.

You open with quite a well considered, calm and reasoned complaint about what happened on the ward last time. You are not aggressive, and in the back of your mind, you just want to make sure that this doesn't happen to other people in the future. You are not really seeking to make a formal complaint.

The substance of your concern is that you had noticed him becoming more breathless and confused over the previous 24 hours and it didn't seem like the way he had been before with his chest infections. He was panting much more and looked unwell. You had mentioned this to the nurses and asked them to draw this to the attention of the doctors. But nothing happened. You understand that the junior doctor saw him earlier in the evening and felt there was little wrong and then all of a sudden at 6 AM, he had to be admitted to HDU where he was found to have these clots.

You are now a little unhappy about him coming back to this ward. He received exemplary care in HDU.

You are certainly not going to be in any way aggressive to this junior doctor. He is after all the same age as your children and clearly his work is both stressful and difficult. But then again, why didn't anybody listen to you when you said that he wasn't actually well? Your complaint is not so much against this particular doctor, but the system whereby relatives are not taken into account and there views acknowledged. It's almost impossible to see one of the medical staff if you do want to discuss things, you always have to see a nurse and they don't necessarily know what is going on. Everybody says they will pass messages on but nobody does.

So be reasonably considered about this. Start with "I'm sorry to have to bring this to your attention but I want to talk to you about what happened to my husband before he was admitted to the HDU - I am concerned about the way he was treated"

This opening will give the student the opportunity to get the wrong end of the stick and assume that the complaint is about himself. Whereas in reality, it is about the system. Your work and the Citizens Advice Bureau makes you irritated with systems that don't listen to their clients.

Later on, you can say that you understand the doctor didn't pick up the problem the first time round, but that anyone can make a mistake and you don't hold it against him/her. But don't say this until quite late on in the conversation or at least until the doctor says something about his own involvement.

If the doctor apologises on behalf of himself or the system, you are quite happy, but you want some assurances that what you are saying is passed on appropriately. If you are offered to speak to PALS, who deal with complaints, you are happy to do that.

Student Handout 3:

Handout
How to make your telephone communication effective

Preparation when you are making a phone call:

- ask yourself is telephone the best way to deal with this situation?
- prepare what you want to say before you ring
- what do you need to achieve or discover?
- how will you word what you want to say?
- be calm before you pick up the phone
- have pen and paper to hand
- check the name of the person you are going to call
- give the call your concentration (not multi-tasking with email, signing scripts etc.)

Making or receiving the call

- think about your body language – adopt a relaxed posture
- be careful with tone of voice
- volume – keep the voice well modulated
- remember on the telephone it is much more difficult to hear intonation; even more so by mobile
- stay calm
- concentrate
- check who you are speaking to
- say who you are and your role
- rapport building: if making the call "I know you must be really busy. I need your help.."; if receiving a call such as "please could you come straightaway doctor" say "that sounds a real problem, of course I'll help, could you just tell me a little bit more about the situation" - this defuses the emotion and enables you to understand the problem - so easy to get rapport building wrong with little nonverbal communication
- if receiving a call, ask the information you need but signpost why: "I just need to know a few more things about her shortness of breath"
- if making a call
    - signpost info " I'm ringing because I'm concerned about a patient on D1"
    - give your rationale for your concern
    - carefully structure and share that structure with the person at the other end of the phone. This is particularly true with closing a call. If you think about a telephone call with a friend you go through a whole series of checks before you say your final goodbye. If a call finished badly it's often because those checks and turn taking didn't happen.
    - give your information clearly
- summarise what you've agreed

After the call

- document – almost all phone calls require documentation

Student Handout 4:

Handout
Getting help from senior colleagues

Getting the help you want can sometimes be a difficult business. Senior colleagues may be busy and distracted. You may not know them very well and feel quite intimidated. They may not know you.

There are several useful principles to remember when requesting senior help:

Be assertive
Say what you want and why you want it. Assertiveness is about being direct, appropriate and taking responsibility. If you are not happy with the response you get, say so –diplomatically.

First say what assistance you want: e.g. do you want them to come or to give advice.
If you wish the senior colleague to come and see the patient, say so at the beginning.

Have all the information to hand
Have the notes, charts and results in front of you – you won't have to go away back to the bedside to get the vital signs chart!

Be concise
Think about what you are going to say before you pick up the phone – a coherent, concise request is much more likely to get you what you want.

Repeat the request if necessary
None of us take in every part of what we are told – the same goes for senior colleagues – repeat the request if necessary.

DON'T DELAY
If you think you might need senior help –get it NOW.

Handout
SBAR = situation, background, assessment and recommendation

SBAR: situation, background, assessment & recommendation

One example:

Situation – who is the patient and what is going on?

Mr X is currently having difficulty breathing

Background – what is the clinical background or context?

He's 65 yr old man with chronic lung disease who has been improving following an acute infection but has now got suddenly much worse.

Assessment

I don't hear any breath sounds on the right side – I think he has a pneumothorax

Recommendation

Can you come and see him right now - I think he needs a chest drain.

SBAR (Leonard, Graham and Bonacum 2004): a model to structure handover to another colleague

Student Handout 5:

SBAR HANDOUT

Before calling

-Assess the patient
-Read the most recent notes
-Have the patient's charts/notes to hand

Date _____Time_____

SITUATION

I am _____from _____ _____
(ward/location)
I am calling about_____(patients name)
The reason I am calling is_____
_____

BACKGROUND

The patient is in hospital because_____
The relevant medical history is_____

Summary of treatment to date _____
Surgery_____Procedures_____
Lab results_____Medication_____
Allergies_____

ASSESSMENT

Vital Signs
HR_____RR_____Saturations_____BP_____T___
MEWS_____GCS_____
I think the problem is_____
_____***or***
I am not sure what the problem is but the patient is deteriorating (delete as appropriate)
I have done_____

RECOMMENDATION

I would like you to come and see the patient _____(time) ***or***
I would like your advice on _____ (delete as appropriate)

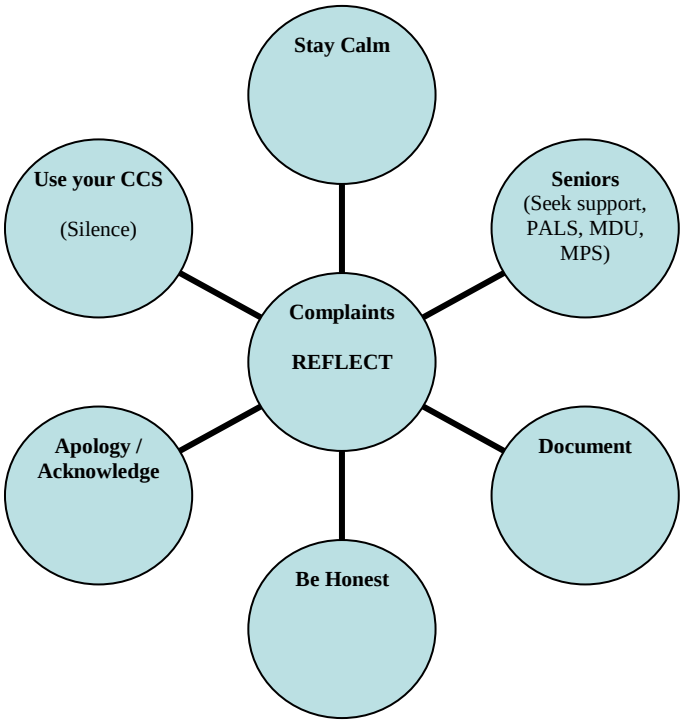
Do you need me to do anything now?

Person contacted _____Grade_____
Bleep number_____

Please remember to file this form in the notes.

Student Handout 6:

Key points to consider when faced with a complaint



Use your CCS

Listen
Stop what you are doing, and give your undivided attention to the patient. If you are on the phone, make appropriate responses so the patient knows you are listening. Remain calm and do not argue with the patient or interrupt with explanations. Listen without attributing fault.

Empathize
Place yourself in the patient's place. Offer a statement of empathy (e.g., "I'm sorry that ...," or "I understand that ..."). Do so without agreeing to guilt on your part or on behalf of the team. Extend understanding without agreement.

Gather information
Gain as much information as you can about the problem. This will help you decide the best way to handle the complaint. Be sure the patient knows you take his or her concern seriously.

Act
Suggest solutions you can perform. Get the patient's approval on the recommended action (e.g., "I will contact ... and ask her to get back to you"). If no immediate action is apparent, assure the patient that an appropriate manager will be informed and that he or she can expect a response. The patient should be given details of PALS.

Conclude
Thank the patient for taking time to notify you of the complaint. Stress that patient satisfaction is a critical component of quality patient care in your practice.

Document
Give any patient and/or family member with a complaint an opportunity to document it. Create a simple form that contains the patient's name and date of the complaint, the patient's statement of the problem, the staff member's statement or response, a description of the action taken, and the staff member's signature with a date.

Adapted from the TMA's *Medical Office Policy and Procedure Manual*, 2nd Edition 200

Student Handout 7:

Responding to a relatives concerns

You need to:

- **be willing/open to hear their concern. (**It may have taken a lot of courage for the person to mention their concern in the first place).
-
- **find out are they wanting:**
    - to express dissatisfaction?
    - to seek an explanation?
    - to clarify accountability?
    - an apology or expression of regret?
    - Compensation?

- **Stay calm**
- **listen –** assess the concern by gathering information
- **identify and acknowledge the specific problem**
- show understanding and empathy
- apologise
- offer solutions
- check if solutions are acceptable
- be prepared to come to a mutual agreement about outcome
- thank the person for taking the time to notify you
- **record the discussion**

Remember that:
You do not have to deal with this on your own seek support from your seniors.
It is unhelpful to see this as an attack on your personal commitment or competence.
Approx only 4% of people who express dissatisfaction will lodge a complaint.
By reflecting on our mistakes we improve the safety and quality of healthcare.

Assertiveness

Definitions of assertiveness

Assertiveness is an interpersonal behaviour that is defined as:
"that which attends to and informs others of one's own needs and feelings and sends the message to the other in such a way that neither person is belittled, put down or blamed'' (Poritt 1990, p. 98)

Assertive behaviour is described as "a person giving expression to his/her rights, thoughts, and feelings without denying the rights of others" (Alberti and Emmons, 1986).

Passivity

When someone doesn't know how to express themselves assertively, they tend to resort to passive modes of communication, sometimes in an attempt to punish or undermine the other person without them knowing the real cause of the behaviour. They may play games, use sarcasm, give in resentfully, or remain silent to their own cost.

Aggression

This involves bottling up feelings which eventually explode, leaving no room for communication.

Assertion

Assertive behaviour does not involve aggression. Assertiveness involves clear, calm thinking and respectful negotiation within a space where each person is entitled to their opinion. It is polite, respectful and willing to negotiate - it is not aggressive, impolite and intransigent.
While some people think that being assertive is about being selfish, it is in fact the opposite. Assertiveness is about acknowledging all opinions as important. An assertive attitude says "I matter and you do too".

Why people might respond in different ways.

- view of themselves as not important
- a feeling that being assertive may not be compatible with being liked
- tiredness
- lack of confidence
- stress
- choice

ALBERTI, R. E. & EMMONS, M. L. (1986) *The professional edition of your perfect right: a manual for assertiveness trainers,* San Luis Obispo, California, Impact

PORRITT L (1990) *Interaction strategies. An introduction for health professionals.* 2nd Ed. Churchill Livingstone, London

Student Handout 8:

When to use Assertion

- Always use the minimum degree of assertion for achieving your aim.
- If you use strong assertion too early, you will undoubtedly come across to some people as being aggressive.
- It is far too tiring to be assertive all the time!

Type	Definition	Examples
Basic	A straight forward statement that stands up for your rights by making clear your needs, wants, beliefs or feelings	"I need to be away by 5.30 at the latest" "I am so glad we are able to sort out that difficult situation"
Empathetic	A statement that contains both an empathic statement and a statement of your needs	"I appreciate you're busy however I need to ask you to check Mr Kings urine the next time he uses the toilet"
Discrepancy	A statement that points out the difference between what was previously agreed and what's happening now.	"When we spoke last week you agreed that you would stop putting my bleep number on the blood forms but I found another one today."
Negative feelings	A statement that clearly indicates to the other person the effect their behaviour is having on you	"When you go off at 4pm to study for your exam I am left with all the bloods to check and that makes me feel very stressed. I'd really appreciate it if you didn't do that".
Responsive	A behaviour that seeks to find out the needs, opinions, feelings of the other person	"What are you thinking Steve" "What would you like to see happen"
Consequence	A statement that clearly highlights to the other person the consequences for them of not changing their behaviour. It also gives the person a chance to change their behaviour.	"If you won't test Mr King's urine, I am left with no option but to go to the ward Sr and ask her to find someone who will. I'd prefer not to." "If this happens again I'm left with no alternative. I will have to complete an incident form"

Adapted from:
KEN AND KATE BACK (2005) *Assertiveness at Work: a practical guide to handling awkward situations,* McGraw-Hill, London