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A Peer Reviewed International Journal for the Advancement of Clinical Skills
- *'docendo ac discendo' - 'by teaching and learning'*



In this issue:

.....
Studying living anatomy: the use of portable ultrasound

Clinical reasoning and interactive board-games

Inter-professional simulation

Communicating with confused elderly patients

The African Working Time Directive

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The International Journal of Clinical Skills looks forward to contributing positively towards the training of all members of the healthcare profession.

Contents

The Executive Board Members	69
Acknowledgements	69
The Editorial Board	70
Foreword	
- Dr Elaine Gill	71

Editorial

Studying living anatomy: the use of portable ultrasound in the undergraduate medical curriculum	
- Debra Patten	72

Original Research

Skills days are superior to experiential learning for the development of core procedural skills for foundation trainees	
- Simon Lambden	78
Learning diagnostic and clinical reasoning strategies through an interactive board-game	
- Keith Taylor	86
Use of a secondary task paradigm to measure medical student's mental workload during a simulated consultation	
- Michael Oliver	92
Inter-professional simulation: the experience of occupational therapy and child branch nursing students participating in a simulation and problem based learning activity	
- Jane Davies	96
Communicating with confused elderly patients: development and evaluation of an innovative teaching session for medical students	
- Muna Al-Jawad	101
Perforator based soft tissue flaps for lower limb soft tissue defect cover – evaluation of a novel training model	
- Duncan Avis	106
Blood pressure measurement and clinical preparation: BSc nursing students' perspectives	
- Liz Kingston	110
The African Working Time Directive: a comparison of logbooks	
- Saqib Noor	116
Development of inter-professional simulation in the acute paediatric clinical setting	
- Karen Tomlinson	120
Consultants' feedback on medical graduates' performance: Universiti Kebangsaan Malaysia experience	
- Abdus Salam	126

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Clinical Skills Notice Board

	130
	131

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Foreword

Head of Clinical Communication King's College London



Since its inception, the International Journal of Clinical Skills (IJOCS) has provided a unique platform for the teaching and learning of clinical skills in a variety of healthcare disciplines. It has become a well established peer reviewed Journal publishing a diverse range of clinical skills articles.

The Editorial Board consists of people active in the field of clinical skills teaching and this is reflected in the journals philosophy to encourage sharing of ideas and practice. Pertinent contributions aim to meet the current needs of researchers and practitioners.

Clinical skills teaching is going through a definite 'growth spurt' at present with increasingly responsive models, manikins and e-learning programmes - not dismissing financial investment that comes along with this. High quality clinical simulation is becoming more sophisticated as a teaching and learning methodology. The need to equip health professionals with the skills and competencies to improve patient-safety is one of the drivers behind this growth. However, alongside the purchase of the 'Sim'-men/women/babies and linked e-learning, let's not forget the importance of personal

interactions through faculty support, i.e. experienced clinical teachers. In addition, simulated patients and the delivery of interprofessional sessions, bring clinical simulation closer to the realms of reality and validity, for both undergraduate and postgraduate health professionals.

The use of simulated patients, relatives and carers is well established in clinical communication education. More recently, additional interesting and innovative approaches to clinical communication teaching are in various stages of substantive core curricula and special study activity across medical schools in the UK.

The IJOCS is now established in the world of clinical skills publications by providing a niche specific arena that welcomes quality research, thereby promoting excellence in healthcare internationally. The wide range of papers covering research, discourse and reflection in clinical education and practice, plus the inclusivity of interprofessional approaches in one publication, raises the validity of this journal. There remains room for research based evidence to support teaching and practice of patient-centred clinical learning. The IJOCS welcomes additions to the literature that encourage critical debate.

Without doubt, the International Journal of Clinical Skills has continued to exceed its original ambitions and I wish it growing success.

A handwritten signature in black ink that reads "Elaine Gill".

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Communicating with confused elderly patients: development and evaluation of an innovative teaching session for medical students

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Abstract

Clinical communication skills are an essential part of medical practice. It is widely accepted that teaching communication skills to health practitioners improves patient health outcomes. Approximately half of general hospital inpatients aged 65 or over have dementia, delirium or both. Communication with confused elderly patients may be challenging, however, it is possible and worthwhile.

This article describes a new teaching session, with objectives to help medical students identify and use complex communication skills with confused, elderly patients. The session was developed according to the principles of constructivism and experiential learning. It used group discussion, analysis of video clips and tasks on the ward with feedback to develop skills. After piloting, it was evaluated with 146 medical students in the first, second and fourth year.

A questionnaire was completed by students before and after the session. This included ratings of their confidence in aspects of communication with confused patients as well as qualitative analysis of their comments about the session and what had been learnt.

Wilcoxon signed-rank test showed a significant increase in median confidence after the session. This increase was most marked in the fourth year medical students. Students' comments showed that their learning had followed the objectives of the session and feedback was overwhelmingly positive.

This is an important new approach to teaching about communication with confused, elderly patients and has the potential to be useful in teaching geriatric medicine in undergraduate, postgraduate and inter-disciplinary settings.

Introduction

Confused elderly patients are commonly encountered in hospitals. Of general hospital inpatients, approximately 30 - 50% aged over 65 years will have either dementia or delirium or a combination of both [1, 2, 3]. The prevalence of cognitive impairment is much higher in general hospitals than in the community, yet there is little training on the wards for students or hospital staff in dealing with elderly patients with dementia and delirium [4]. It is also unclear which interventions bring about real change in practice. One approach is to foster understanding of the "personhood" of elderly, confused patients [5]. This concept was developed as a social-psychological theory of dementia care, which recognises social as well as individual aspects of well-being. This understanding requires two-way communication. Communication with confused patients is challenging, but is possible and worthwhile [6].

Research at Yale School of Medicine examined medical students and trainees perceived needs for education in geriatric medicine. The study identified a perceived deficit in communication skills

at all levels of training, particularly when communicating with patients with cognitive impairment [7]. Recent British Geriatrics Society guidelines on the management of delirium in hospital stress the importance of education for trainees in recognition of cognitive impairment in the elderly [8]. The idea that there should be specific competencies for medical students, related to caring for older people, is also gaining favour [9]. In the UK, the General Medical Council (GMC) stresses that the undergraduate curriculum must include training in clinical communication to prepare students to communicate with patients who may have a sensory impairment, or suffer with mental illness or a physical disability. The need to help vulnerable people is also recognised [10].

It is widely accepted that although doctors may have varying degrees of innate ability in talking, listening and empathy, clinical communication skills can be learnt. This is reflected in their emergence as a core part of the undergraduate medical curriculum in the UK [11]. A 2005 study showed that doctors who had not undertaken communication skills training were less able to demonstrate some basic communication skills, even 10 years after registration to practice [12]. Another study showed that medical students who had received training had a rich conceptualisation of communication and felt that training had helped them understand the needs of their patients [13]. There is evidence that explicit teaching of communication skills improves patient health outcomes [14].

A programme to train Nursing Assistants to communicate with residents with dementia was proven to increase effectiveness of communication, have a positive impact on symptoms of depression in residents and reduce staff turnover rates [15]. Geriatric nursing has also turned its attention to the area of communication [16]. Although there is training available for doctors which focuses on the diagnosis and treatment of delirium and dementia [17], there are no published sessions for medical students which deal specifically with clinical communication skills with confused, elderly patients.

The primary aim of this work is to develop an effective teaching session for medical students, focusing on complex communication skills with confused, elderly patients on general hospital wards in order to increase the efficacy of the medical interview for both patient and student.

Developing the teaching session

In this section development of the session will be discussed in terms of educational goals, theoretical basis of session design, practical issues and piloting. Methods of evaluating the session are then described. Ethical advice was sought from St George's NHS Trust Ethics Committee and the study proceeded accordingly.

The educational objectives of the session were to allow students to:

1. Describe principles of communication with patients with delirium and dementia
2. Identify appropriate skills to use when communicating with patients with delirium and dementia including rapport building and empathy

3. Understand the significance of touch and non-verbal communication for patients with delirium and dementia
4. Demonstrate appropriate skills and attitudes in practice on the geriatric wards

The initial session was developed in consultation with senior physicians in geriatric medicine and experienced communication skills teachers. An explanation of the principles behind the components of the sessions follows; details of the session itself are shown in Summary Box 1.

Summary Box 1: Outline of the teaching session

Preparation

- Introduction; brainstorm why communication with confused patients is important and relevant.
- Discuss students' experiences of talking to people with dementia or delirium; generate principles of communication with confused patients.
- Watch video clips from the film 'Iris' (Directed by Richard Eyre, Miramax Films, 2001); discuss and generate more principles.
- Focus discussion on non-verbal communication and appropriate use of touch in those with cognitive impairment.
- Show students "rough and ready guide" (after Goldsmith [6]) to communicating with confused patients.
- Stress importance of protection for vulnerable patients during task.

Practice

Explain task is to pair up and talk to a patient with delirium or dementia on a hospital geriatric ward:

- Introduce yourselves
- Find out what name the patient likes to be called by
- Find out how the patient is feeling today
- Find out what brought the patient into hospital
- Get the patient to lift their arms into the air and shut their eyes (testing for pronator drift)
- Close the interview

Feedback

- Feedback on talking to patients; reflections on what was challenging, surprising, easy or upsetting; brainstorm strategies for overcoming barriers.
- Conclusion: how will this session change communication practice?

The design of the teaching session uses a predominantly behaviourist, experiential approach to communication skills, with attitudinal issues addressed as they arise in discussion [18]. The introduction to the session uses evidence from real clinical practice to highlight the importance of learning these skills to students and to establish authenticity. The initial discussion of group members' own experiences as a resource for thinking about good practice and challenges in communication is based on the constructivist idea that all learning is founded on what learners already know. This methodology essentially raises the prior knowledge of students and prepares them to add new knowledge and skills to this.

Watching and critiquing communication skills from a film encourages the students to think specifically about their own and other's practice. Explicit guidance on things to consider when communicating with confused patients (adapted from Goldsmith's work [6]) is given to students. Practising with real patients in a controlled environment aided by constructive feedback (with a facilitator overseeing them) aims to allow experiential learning to take place [19]. Peers are also able to help "scaffold" each other's learning [20].

The sessions were carried out with groups of 10 - 12 students in a seminar room, then with practice in pairs on the geriatric medicine wards. The session facilitators were senior geriatricians who had experience of teaching communication skills. Issues of consent and protection for vulnerable patients were recognised. The patients involved in this teaching session often did not have capacity to directly consent to talking to medical students. In order to gain learning from these sessions however, the opportunity to talk to a real patient with dementia or delirium was felt to be essential. Patients were selected by the clinician in charge or their care and consent sought where possible. If the patient was unable to consent, they were included only if the clinician and other carers felt no harm or distress would be caused to the patient by talking to the students. The students were informed that if a patient were to become distressed or upset, the students should inform the facilitator or a member of staff immediately.

The session was piloted with 11 medical students and showed positive results and feedback from students. This was presented as a Poster Presentation at the Association for Study of Medical Education (ASME) Annual Scientific Meeting, Edinburgh, UK, 2009.

Over a six month period, groups of first, second and fourth year medical students participated in the session as part of their clinical attachment to the geriatric medicine wards. A questionnaire was completed by students before and after the session. This included evaluating their own confidence in history-taking and examination of confused patients, as well as helping an agitated patient. Confidence was rated according to a 5-point Likert scale (1 = not at all confident, 5 = very confident).

Data analysis was conducted using SPSS 17. Students' confidence ratings before and after training were compared using Wilcoxon signed-rank test. Participants' post-training confidence ratings were subtracted from their pre-training ratings to determine the number of participants who had a decrease in confidence following training, no change in confidence, a small increase in confidence (one point on scale) or a large increase in confidence (two or more points on the scale). Chi-square analysis was conducted to compare student year groups on change in confidence. In order to have adequate numbers of people in each group the 'decrease in confidence' and 'no change in confidence' groups were combined for this analysis.

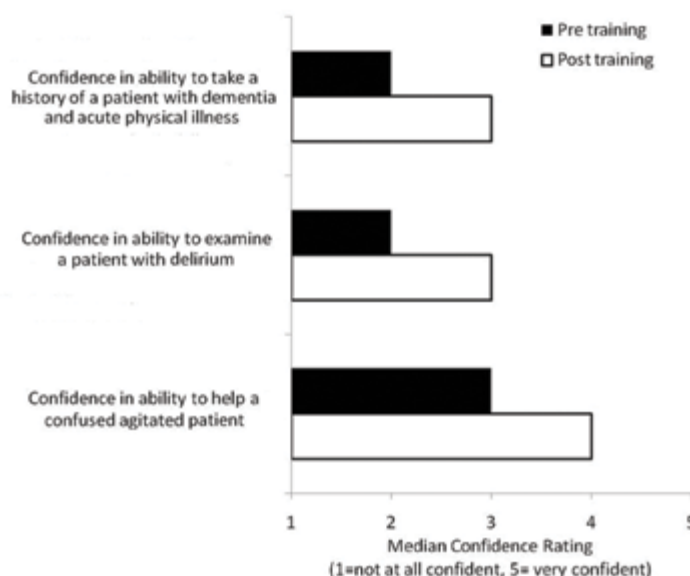
Qualitative data was also collected with two free-response questions on the questionnaire asking students to identify the three most important things they had learnt and what they thought of the session overall. This data was analysed thematically using a framework approach [21].

Evaluation

146 medical students participated in the training session and all completed the pre- and post-training questionnaires; 47 first year, 60 second year and 39 fourth year students.

Figure 1 shows students' median reported confidence levels before and after the training session. Students reported an increase in their confidence in taking the history of an elderly patient with dementia and acute physical illness ($Z = 9.73$, $p < 0.001$), in examining a patient with delirium ($Z = 9.36$, $p < 0.001$) and in helping a confused agitated patient on the wards ($Z = 8.48$, $p < 0.001$) following training.

Figure 1: Increase in median confidence ratings following the training session



All year groups had the same median pre-training confidence rating (history taking = 2, examining = 2, helping = 3). Table 1 shows the number and percentage of students from each year group reporting a large increase in confidence, a small increase in confidence or no change / a decrease in confidence following the training session.

For all items, fourth year students were the least likely to report a decrease / no change in confidence and the most likely to report a large increase in confidence. This difference between year groups was significant for confidence in ability to take a history of a patient with dementia (χ^2 (4, $N=146$) = 12.7, $p = 0.013$) and approached significance for confidence in ability to help a confused agitated patient (χ^2 (4, $N=146$) = 8.90, $p = 0.064$).

Table 1: Impact of training on students' confidence rating across year groups

Questionnaire Item	Year	Students with each type of confidence change Number and percentage (%)					
		Less confident or no change		Small increase in confidence (one point on scale)		Large increase in confidence (two or more points on scale)	
		Number	%	Number	%	Number	%
History taking	1st	10	21.28	26	55.32	11	23.40
	2nd	14	23.33	35	58.33	11	18.33
	4th	3	7.69	17	43.59	19	48.72
Examining	1st	14	29.79	28	59.57	5	10.64
	2nd	17	28.33	27	45.00	16	26.67
	4th	7	17.95	19	48.72	13	33.33
Helping	1st	20	42.55	20	42.55	7	14.89
	2nd	20	33.33	27	45.00	13	21.67
	4th	10	25.64	13	33.33	16	41.03

142 out of 146 medical students wrote comments in the free-response section of the questionnaire. Students gave a range of answers when asked to identify the three most important things learnt in the session. These were analysed thematically and a framework was developed which grouped comments into verbal and non-verbal communication; use of pauses and time; attitudes to patients and carers; other things learnt. The most frequent comments were about non-verbal communication and attitudes to patients. There were no negative attitudes expressed on the questionnaires and the comments reflected the educational objectives of the session.

Students' views of the session were grouped according to the following themes: generally positive; generally negative; about the structure of the session; about future practice. The answers were mostly positive with only 2 negative comments. The structure of the session was useful to students and they were able to relate the session to their future practice.

Table 2 shows some of the qualitative data collected, with examples from each theme.

Table 2: Examples of students' comments. Answers have been grouped by theme; repeated or very similar comments have not been included.

Theme	Question: Identify the three most important things you learnt
Verbal communication	Use short, clear, closed questions Ask the question again, using exactly the same words
Non-verbal communication	Same level, sitting down Use gestures to reflect what you are saying Touch when appropriate Appear calm and reassuring To confused people how you say something is often more important than what you say
Time	Perseverance Allow time, wait for an answer Can come back another time
Attitudes to confused patients	Connect on a personal level, adapt to each patient's situation Don't dismiss patients as being too confused to talk without trying Not to be daunted by patients with confusion Don't be scared, don't be distressed if a patient is agitated Don't be patronising
Attitudes to carers	Consider the carer as well, acknowledge the role of helpers Collateral information is important
Other	Make sure that its only the dementia/delirium that causes the problems with communication (i.e. that it's not actually deafness, blindness or a language barrier)
Theme	Question: What did you think of the session?
Positive	Excellent There should be more of these sessions Really enjoyable and exciting
Negative	Still think it would be hard to get any amount of detail from my patient Not enough time with patients
Structure	Allowed me to practise some of the skills on actual patients I really liked the session – great introduction, group work and use of various mediums to improve understanding
Future practice	Necessary to strengthen skills required for later clinical practice Learnt about different methods I may not have thought of using myself Very practical with tips I will definitely use

Discussion

The primary aim was to develop a new teaching session with objectives to help students identify and use complex communication skills with confused, elderly patients. The development and theoretical basis of the session have been described. The data presented shows that medical students have a significant increase in confidence in history-taking from, examination of, and helping confused elderly patients after the teaching intervention. The comments about what they have learnt fit with the educational objectives and, in fact, go beyond them, with more emphasis on attitudinal aspects of learning than expected. The initial student evaluation of this session is overwhelmingly positive and included some evidence that the skills taught were relevant and might be carried over into future practice.

The optimum stage of training, based on these participant groups, seems to be later in the undergraduate curriculum. This is perhaps because the more experienced students have had some exposure to clinical practice and realise the challenges faced, or that these communication skills are of a higher order than those practised in earlier years.

The fact that previous clinical experience made the session more effective may suggest that the session would be even more valuable at a later stage of training, perhaps in the early postgraduate years. It could be used in conjunction with other educational interventions which have been shown to improve patient outcomes, reducing levels of delirium and length of stay in hospital for confused patients [22, 23].

Conclusion

Overall this innovative teaching session has shown evidence of student satisfaction, increase in confidence and learning. Given the high numbers of confused, elderly patients on general hospital wards, and the known impact of communication skills teaching on patient outcomes, the authors would suggest this type of teaching session is a useful part of undergraduate training in geriatric medicine.

In the wider setting of geriatric medicine, a modified version of this teaching may also have an impact at postgraduate level, and may be of benefit to team members from other professions involved in frontline geriatric care.

Declarations

The authors have no financial or other interests to declare in relation to this paper.

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References

- Royal College of Psychiatrists. (2005). Who cares wins: improving the outcome for older people admitted to the general hospital. Report of a working group for the Faculty of Old Age Psychiatry. London, Royal College of Psychiatrists. Available at: <http://www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf>
- Joray S, Wietlisbach V, Büla C J. (2004). Cognitive impairment in elderly medical inpatients: detection and associated six-month outcomes. *The American Journal of Geriatric Psychiatry*. **12**(6):639-647.
- Sampson E L, Blanchard M R, Jones L, Tookman A, King M. (2009). Dementia in the acute hospital: prospective cohort study of prevalence and mortality. *The British Journal of Psychiatry*. **195**(1):61-66.
- Teodorczuk A, Welfare M, Corbett S, Mukaetova-Ladinska E. (2009). Education, hospital staff and the confused older patient. *Age and Ageing*. **38**(3):252-253.
- Kitwood T, Bredin K. (1992). Towards a theory of dementia care: personhood and well-being. *Ageing Society*. **12**:269-287.
- Goldsmith M. (1996). Hearing the voice of people with dementia: opportunities and obstacles. London, Jessica Kingsley Publishers.
- Drickamer M A, Levy B, Irwin K S, Rohrbaugh R M. (2006). Perceived needs for geriatric education by medical students, internal medicine residents and faculty. *Journal of General Internal Medicine*. **21**(12):1230-1234.
- British Geriatrics Society (2006). The prevention, diagnosis and management of delirium in older people. London, Royal College of Physicians.
- Leipzig R M, Granville L, Simpson D, Anderson M B, Sauvigné K, Soriano R P. (2009). Keeping granny safe on July 1: a consensus on minimum geriatrics competencies for graduating medical students. *Academic Medicine*. **84**(5):604-610.
- General Medical Council. (2002). Tomorrow's Doctors: recommendations on undergraduate medical education. London, General Medical Council (GMC).
- Brown J. (2008). How clinical communication has become a core part of medical education in the UK. *Medical Education*. **42**(3):271-278.
- Aspegren K, Lønberg-Madsen P. (2005). Which basic communication skills in medicine are learnt spontaneously and which need to be taught and trained? *Medical Teacher*. **27**(6):539-543.
- Willis S C, Jones A, O'Neill P A. (2003). Can undergraduate education have an effect on the ways in which pre-registration house officers conceptualise communication? *Medical Education*. **37**(7):603-608.
- Stewart M A. (1995). Effective physician-patient communication and health outcomes: a review. *Canadian Medical Association Journal*. **152**(9):1423-1433.
- McCallion P, Toseland R W, Lacey D, Banks S. (1999). Educating nursing assistants to communicate more effectively with nursing home residents with dementia. *Gerontologist*. **39**(5):546-558.
- Miller C A. (2008). Communication difficulties in hospitalized older adults with dementia. *American Journal of Nursing*. **108**(3):58-66.
- Bagri A S, Flacker J M. (2009). Care of the hospitalized aging medical patient: delirium module. *Journal of the American Geriatrics Society*. **57**(7):1268-1269.
- Silverman J, Kurtz S, Draper J. (2005). Skills for communicating with patients. 2nd Edition. Oxford, Radcliffe Publishing.
- Maguire P, Pitceathly C. (2002). Key communication skills and how to acquire them. *British Medical Journal*. **325**(7366):697-700.
- Wood D, Bruner J S, Ross G. (1976). The role of tutoring in problem solving. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*. **17**(2):89-100.
- Pope C, Ziebland S, Mays N. (2000). Qualitative research in health care: Analysing qualitative data. *British Medical Journal*. **320**(7227):114-116.
- Tabet N, Hudson S, Sweeney V, Sauer J, Bryant C, Macdonald A, Howard R. (2005). An educational intervention can prevent delirium on acute medical wards. *Age and Ageing*. **34**(2):152-156.
- Naughton B J, Saltzman S, Ramadan F, Chadha N, Priore R, Mylotte J M. (2005). A multifactorial intervention to reduce prevalence of delirium and shorten hospital length of stay. *Journal of the American Geriatrics Society*. **53**(1):18-23.

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