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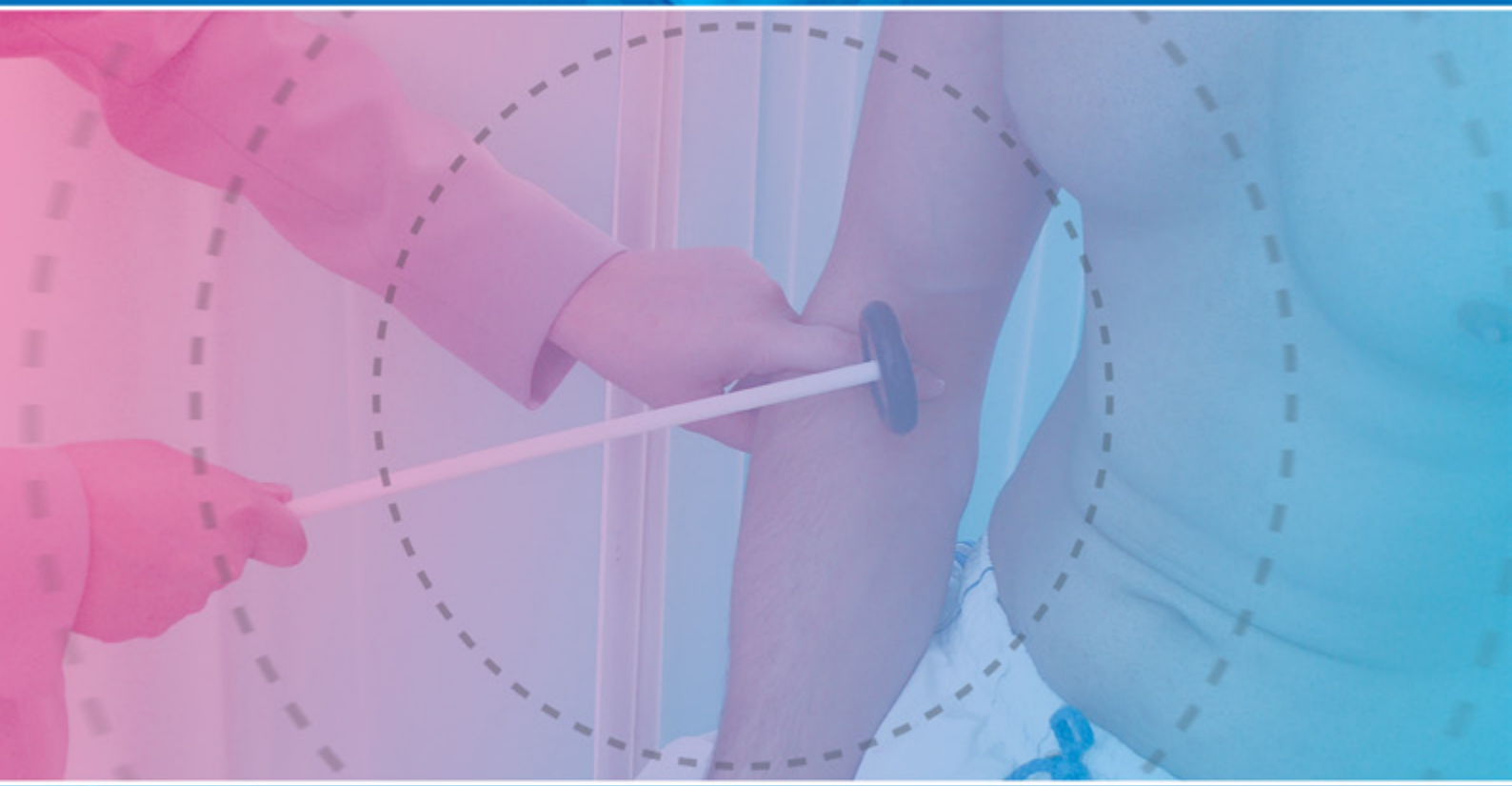

A Peer Reviewed International Journal for the Advancement of Clinical Skills

- 'docendo ac discendo' - 'by teaching and learning'

In this issue:

With proceedings from

The 8th International ePortfolio Conference

Clinical Training Associates & Pelvic Examinations
WHO 'Five Moments for Hand Hygiene'
Holistic approach to resuscitation
Cranial nerve examination

EIfEL
Building a Learning Europe

Executive Board

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Congratulations to Mr Ronak Ved of Cardiff Medical School (UK) on successfully winning The IJOCS Award 2010 - presented for creativity and excellence in the field of Clinical Skills.

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

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Foreword

We want raw ePortfolio data, and we want the data now

Patients trust that healthcare professionals will possess the clinical skills to provide safe and effective treatment. Serious failures of medical care, through the actions of individuals and the inaction of organisations, have shaken that trust and led to a re-examination of the process of registration. In many countries and disciplines, continued registration now depends on the documentation of continuing professional development. Some jurisdictions, such as the UK, have gone further and are planning more comprehensive evaluation of clinical performance for revalidation. In all cases, assessment is based on some form of ePortfolio.

"An e-portfolio is a purposeful aggregation of digital items – ideas, evidence, reflections, feedback etc, which 'presents' a selected audience with evidence of a person's learning and/or ability." Sutherland and Powell (2007)

Presenters in the healthcare ePortfolio track at the 8th International ePortfolio Conference, London (July 2010) described a wide range of ePortfolios being used or being developed for allied health, dental surgeons, surgeons, physicians, nurses, medical education, foundation medical graduates. ePortfolios are used by students to evidence acquisition of clinical skills for initial registration, by new graduates to collect evidence of competence for credentialing and by trained staff for evidence of consistent expert performance. As Stuart Cable from the Royal College of Nursing (UK) explained:

"[the ePortfolio] enables nurses to demonstrate their competence in different areas of nursing practice. They are able to capture 'just-in-time' reflections on their practice or a learning experience and then re-present this evidence for different purposes, for example, personal development planning, competence demonstration and educational accreditation of prior learning." (Stuart Cable, Proceedings of the ePortfolio Conference, Maastricht, 2007)

The need for repurposing the same set of collected data across time was confirmed by many of the International ePortfolio Conference presenters: as their careers develop, healthcare professionals will be required to transition across several ePortfolio systems, from those used during initial training, continuing professional development, quality assurance procedures and, at regular intervals, to support reaccreditation processes.

To support evidence of informed and reflective practice, healthcare professionals collect evidence from a variety of sources and data systems, such as patient personal health records, laboratory test analysis, clinical diaries, feedback from peers and patients. Unfortunately, all these different pieces of information are usually stored in independent information silos, making the work of ePortfolio construction and assessment more difficult, notwithstanding that silos make data errors more likely to occur and less likely to be corrected. As most individual ePortfolios also create their own data silos, it reduces the ability to share relevant and critical information across a profession to advance professional practice.

While the initial idea of repurposing ePortfolio data rests on the editing work of an individual compiling a new document, there is an alternative and more radical way of exploiting ePortfolio data: data freedom, i.e. allowing a wide range of online services to exploit raw ePortfolio data.

Imagine a world in which all data created by a healthcare professional when interacting with patients, teachers, colleagues and organisations is securely stored in a Personal Data Store (PDS), creating a 'life log'. Imagine that patients in the healthcare ecosystem have their own personal data stores and can share the contents, under their control, with the people and services they trust. Imagine a world where everyone would be able to choose any health ePortfolio services while being fully interoperable with those used by various institutions with which healthcare professionals interact.

Imagine a world where the performance of students at several medical schools could be confidentially mined to identify best practice for teaching clinical skills. Imagine a service collecting data from the personal data stores of all the staff of a hospital to conduct audit procedures. Imagine another service identifying the need for training and linking it to workshops on particular topics at a conference or a review in a journal. Imagine a service mining anonymous healthcare data collected in personal data stores by a patient's support group. What Amazon® and Google® can do with their global data stores to identify patterns and trends and target advertising, we can do, with personal data stores for the benefit of healthcare, professional education, patient safety and society in general.

Such a world is possible. It was presented by ElfEL at the launch of the Internet of Subjects (www.iosf.org) during the 8th International ePortfolio Conference. The Internet of Subjects supports the programme that Sir Tim Berners-Lee, the inventor of the Internet, called for: *"we want the data raw, and we want the data now!"* To achieve that goal, which is to facilitate reuse, repurposing and exchange of data, we need to achieve the separation of data from the applications and services producing and exploiting it; applications and online services must remain the servants, not the masters, of our personal data.

In the near future institutions will not have to select the ePortfolio platform for their students or professionals; it will be an individual choice. On the other hand, educational institutions, professional communities and public healthcare authorities will have the opportunity to develop a number of innovative services, based on the exploitation of the raw data contained in personal data stores. For example, with an Internet of Subjects, data collected by students and trainees for assessment of progress or by trained staff for revalidation could be used, with permission, for other useful purposes such as quality assurance, needs analysis and career planning.

By providing access to raw data in personal data stores (anonymised and under the full control of individuals) to the services of their choice, healthcare professionals and communities would have the foundations to support the development of lively learning communities, for the benefits of their members, patients and society at large. Data collected whilst compiling an ePortfolio is too rich to be limited to a unique usage. We want raw ePortfolio data, we want it now, to contribute amongst other things, to the improvement of the continuing education of healthcare professionals.

Professor Harry Owen
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Flinders University
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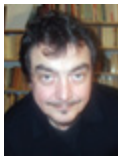

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Holistic approach to resuscitation: required skills beyond advanced life support

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Keywords:
Resuscitation
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Abstract

Introduction: Resuscitation can have long term unwanted effects on the patient's family members, as well as the healthcare professionals involved, especially if it does not meet the targeted outcome. In view of this, health care professionals have to ensure strategies are in place to minimize unwanted effects.

Case Study: A 20 month old male was brought to the Emergency Department at Universiti Kebangsaan Malaysia Medical Centre (UKMMC) in a collapsed state due to foreign body airway obstruction. Despite resuscitation efforts, the child did not survive.

Conclusion: The holistic approach to resuscitation requires communication and management skills beyond that of advanced life support. In particular, specific skills in breaking bad news, management of family members, as well as healthcare professionals' post-resuscitation self-care skills, are essential in delivering holistic care.

Introduction

Resuscitation is an event that most healthcare professionals (HCPs) find extremely challenging. The resuscitation team deals not only with the patient, but also the distressed family members. When the resuscitation efforts do not meet the targeted outcome, the HCPs may feel that they 'should have done more' or 'performed better'. Informing family members regarding progress or outcome of resuscitation, is one of the most difficult communication skill scenarios between HCPs and relatives; if inappropriately performed, it can have tremendous long-term unwanted effects. This paper presents a resuscitation case study and discusses the additional skills beyond advanced life support, that are required to minimize any unwanted consequences and allow delivery of holistic care to the patient and family members.

Case Study

A 20 month old male was brought in to the emergency department (ED) by his father in a collapsed state. The patient was triaged to the resuscitation zone immediately. He appeared pale, cyanosed, had no spontaneous breathing and no palpable pulse - cardiopulmonary resuscitation (CPR) was commenced. Initial rhythm check showed asystole. His pupils were fixed and dilated.

On further history from the father the patient was described to be choking, whilst he had been playing with his sibling, approximately one hour prior to presentation. His father had noticed that the patient 'turned blue' and rushed him to hospital, suspecting that his son may have had a foreign body airway obstruction, but was unsure what the foreign body might be. The child was previously well with no significant past medical history.

CPR continued for 40 minutes, but despite all resuscitation efforts, the child did not survive. During extubation a small screw came out together with the endotracheal tube. His father, who had not been present in the resuscitation room, was

informed regarding the death of his son in the 'Family Room' and was allowed to see his son shortly after. The staff involved in the resuscitation attempt took a few minutes to gather themselves together, then continued to perform their normal duties till the end of their shift.

Discussion

When resuscitation does not meet the targeted outcome, resuscitation team members may have feelings of inadequacy and may even question their own capabilities. They can identify with the grieving relatives as most of them have families themselves [1].

Informing family members about the death of their loved ones can be a very difficult task for inexperienced professionals, especially since the reaction of the family members can be unpredictable. There may be extreme feelings of helplessness and guilt. Most family members are probably aware that they may lose their loved ones despite the resuscitation effort and may feel a very real need to be present with the patient during the resuscitation effort. Others may fall into a state of denial and some may even feel the need to find someone to blame. It is a very difficult time for any family member to try to comprehend the reality of the situation and the limitations faced by HCPs. They, as any of us would, just want everything humanly possible, to be done to save their loved ones.

Post-resuscitation self-care skills

HCPs may deal with dying patients on a daily basis. If the emotional consequences of caring for dying patients and their surviving family members are not acknowledged, post traumatic stress disorder may develop. Post traumatic stress disorder is a disorder whereby people repeatedly re-experience the ordeal or trauma in the form of memories, nightmares or frightening thoughts, resulting in emotional detachment, irritability, depression and outbursts of anger. Studies have shown that in the effort to escape the necessity of coping with death, many ED staff experience career disillusionment and some even leave the ED field of work altogether [1]. An additional stress factor is that HCPs are expected to continue working throughout the rest of the shift as if nothing had affected them. Consequently 'switching off emotions' may allow staff to perform their duties, however, this can eventually take its toll. Inability to 'switch off' can affect decision making processes and this may have deleterious effects on other patients [1], which of course is unacceptable. Therefore, how are HCPs expected to cope? What mechanisms are in place to ensure that they are coping and able to function optimally for the benefit of all patients?

At the conclusion of any resuscitation attempt, a debriefing session should be held for the resuscitation team members, including pre-hospital health care professionals [1, 2]. Due to lack of time or staff shortages, some Emergency Departments are unable to do this for all resuscitation cases. One strategy to help this problem is to have the debriefing session at the end of the relevant shift, instead of right after the resuscitation attempt. One objective of such debriefing sessions is to identify any areas of change or possible improvement. Continuous improvement is essential to maintain high standards of resuscitation care. However, debriefing sessions also serve another important purpose which is to provide emotional support and some form of closure to HCPs after their involvement in these difficult cases. It provides the perfect opportunity to tackle the question of 'could we, or should we, have done more?' The session should be held in a comfortable but private and confidential environment, where team members feel safe to explore questions without fear of judgment or any repercussion [1].

Educators, be it at undergraduate or postgraduate level, should emphasize the importance of the emotional well being of HCPs and acknowledge these feelings as a normal part of 'working experience'. The ability to confide in others during debriefing sessions should be regarded as a basic skill to ensure self-care of the HCPs, who are then able to continue to deliver standardised high quality patient care [2].

Breaking bad news

Bad news is defined as "any information which adversely and seriously affects an individual's view of his or her future" [3]. It includes news of chronic disease, poor prognosis, terminal illness or death of a loved one. Understandably, breaking bad news is never easy, however, informing parents of their child's death can be one of the most difficult communication skills scenarios between HCPs and family members. If not done appropriately, it can have tremendous long term psychological effects on the family members concerned. It may even open up the resuscitation team to medico-legal litigation. Many strategies are available to aid HCPs in breaking bad news such as the ABCDE approach to breaking bad news and the SPIKES protocol [3, 4]. Table 1 (next page) illustrates the SPIKES six-step protocol for delivering bad news [3].

Breaking bad news should be conducted in a private and comfortable area with space to accommodate all persons. Apart from ensuring the infrastructure is adequate for breaking bad news, the person delivering the news should have also undergone specific communication training, in view of the possible long term effects (including any medico-legal consequences) of this sensitive but crucial communication scenario. This is especially true when the news involves the death of a child; having inexperienced staff informing parents about the death of their child is not only unpredictable, but some may deem it to be unethical [5].

The use of simulation training is nothing new in the emergency medicine field to teach resuscitation skills. Simulated patients for communication skills training, though not commonly used in the emergency medicine field, is very commonly used in other areas of medicine and proves to be one of the most effective methods in training for difficult communication scenarios. Simulated patient communication skills training can exemplify real life situations accurately and provides the closest experience to an actual patient encounter. Using simulated patients also provides the unique opportunity to allow feedback in order to improve communication skills [5]. This method of training is becoming increasingly important as surviving family members have voiced that the most important part of communicating bad news is the attitude of the news giver, the clarity of the information, privacy and the ability of the news giver to answer questions. There is also a growing body of evidence that the HCPs themselves will benefit, if they are better prepared for this difficult task [4].

Table 1: A Six-Step Protocol for Delivering Bad News (Adapted with permission from Baile W F et al [3])

	Steps	Examples
S	Setting-up the interview	• Arrange for some privacy • Involve significant others • Sit down • Make connection with patient • Manage time constraints and interruptions
P	Assessing the patient's / relative's perception	• What have they been told? • What is their understanding? • What are their hopes? • Need to correct any misperceptions
I	Obtaining the patient's / relative's invitation	• Discuss the amount of information the patient / relative would like to know or can handle • Offer to answer any questions in the future should the patient / relative decide they do not want full disclosure now • Document all discussions
K	Giving knowledge & information to the patient / relative	• Inform the patient / relative that you have some bad news • Give the medical facts at the level of comprehension and vocabulary of the patient / relative • Avoid excessive bluntness
E	Address the patient's / relative's emotions with empathic response	• Use of verbal and non-verbal empathic response • Use of appropriate exploratory and validating responses
S	Strategy & summary	• Explain clearly what is to be expected from here • Discuss treatment options • Explain appropriately the prognosis of the patient • Identify and understand the patient's / relative's goals

Family presence during resuscitation

Family presence during resuscitation is not a well practiced phenomenon. In fact a study in the USA (2002) found that the majority of HCPs surveyed did not support family presence during resuscitation [6]. This disapproval stems from a variety of reasons among which are the fears of psychological trauma to the family, distraction and performance anxiety among the resuscitation team members, as well as medico-legal issues [6, 7, 8].

However, Foote Hospital in Jackson, Michigan (USA) initiated a change in this customary policy [9]. Family members were given the option of being involved in the resuscitation efforts, not just as spectators, but as participants. They were encouraged to talk to the patient informing of their presence and to say farewell if appropriate. Their presence places the patient in a social network and profoundly alters the resuscitation experience for resuscitation team members [9, 10].

Many argue that patients may feel their confidentiality was compromised or that they may want to be remembered as they were and not their last dying moments. An interview with patients who survived resuscitation revealed that they felt content and supported by family presence and none felt their confidentiality or dignity was compromised [6, 7, 10]. Should the resuscitation effort end negatively, many fear the psychological trauma to the surviving family members. However, family members do not share this concern as it provides the opportunity for closure [10]. Small published studies revealed no adverse psychological effects were experienced by family members [6]. HCPs who have had experiences with family presence during resuscitation seemed to be more accepting of this policy [11].

Family presence was advocated in the American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation. To address the concerns put forward by HCPs regarding fear of psychological trauma to the family and distraction among the resuscitation team members, Foote Hospital ensured that a dedicated member of staff was present with family throughout the resuscitation [7, 9]. The AHA do not describe a particular time that would be most suitable for family members to enter the resuscitation area, however, many believe that the HCPs would be more accepting of family members after invasive procedures have been completed, as this provides a more controlled atmosphere for the resuscitation team [6].

It would be interesting to further evaluate the success of incorporating family presence into the resuscitation efforts at Foote Hospital and compare the feasibility of applying the same system elsewhere. Several areas need to be considered, for example, the expectations and level of education of the local population compared to other localities, as well as the support systems available, such as presence of dedicated staff with the family throughout the resuscitation attempt. The dedicated staff do not need to be HCPs; a specially trained public relations officer or even a religious representative can play the role equally well. There are many issues to be considered prior to initiating any policies regarding family presence during resuscitation. A '5-step guide' by Blaire P (2004) addresses these issues, including seeking the opinion of HCPs involved, as well as the ideas and comments from family members [8].

Conclusion

Resuscitation is an event that is physically, mentally and emotionally demanding for both the family members and HCPs. Holistic approach to resuscitation requires skills beyond that of advanced life support. Training in post-resuscitation self-care skills and breaking bad news are interventions that can be done to address the health care professionals' needs. Clear policies on family presence during resuscitation should be in place as this profoundly affects the experience and healing processes for relatives. Health care professionals need to embrace their role not only in saving lives, but also in aiding a dignified death.

References

1. Knazik S R, Gausche-Hill M, Dietrich A M, Gold C, Johnson R W, Mace S E, Sochor M R. (2003). The death of a child in the emergency department. Annals of Emergency Medicine. **42**(4):519-529.
2. Serwint J R. (2004). One method of coping: Resident debriefing after the death of a patient. The Journal of Pediatrics. **145**(2):229-234.
3. Baile W F, Buckman R, Lenzi R, Glober G, Beale E A, Kudelka A P. (2000). SPIKES – A six step protocol for delivering bad news: Application to the patient with cancer. The Oncologist. **5**(4):302-311.
4. VandeKieft G K. (2001). Breaking Bad News. American Family Physician. **64**(12):1975-1978.
5. Greenberg L W, Ochsenschlager D, O'Donnell R, Mastruserio J, Cohen G J. (1999). Communicating bad news: A pediatric department's evaluation of a simulated intervention. Pediatrics. **103**(6 Pt 1):1210-1217.
6. McClenathan B M, Torrington K G, Uyehara C F. (2002). Family member presence during cardiopulmonary resuscitation: A survey of US and international critical care professionals. Chest. **122**(6):2204-2211.
7. Bowden V R, Greenberg C S. (2009). Should family members be present when their child is being resuscitated? Paediatric Nursing. **35**(4):254-256.
8. Blair P. (2004). Is family presence practical during emergency resuscitation? Nursing Management. **35**(6):20-23.
9. Timmermans S. (1998). Resuscitation technology in the emergency department: Towards a dignified death. Sociology of health and illness. **20**(2):144-167.
10. Fell O P S. (2009). Family presence during resuscitation efforts. Nursing Forum. **44**(2):144-150.
11. Sacchetti A, Carraccio C, Leva E, Harris R H, Lichenstein R. (2000). Acceptance of family member presence during pediatric resuscitations in the emergency department: Effects of personal experience. Pediatric Emergency Care. **16**(2):85-87.

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