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

C.O.M.E.T. – A novel educational method in clinical skills

From simulation to reality
Shibboleths of incompetence
Development of a clinical skills bus: making simulation mobile
"See one, do one, teach one!" – the uphill struggle for clinical skills acquisition

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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 1
Acknowledgements 1
The Editorial Board 2
Mission Statement 2
Foreword
– **Professor The Lord McColl CBE** 3

Editorials

Developing the continuum of clinical skills teaching and learning; from simulation to reality
– **Patsy Stark** 4
Medico-legal consequences in surgery due to inadequate training in anatomy
– **Harold Ellis** 8
Development of clinical skills bus: making simulation mobile
– **Maggie Nicol** 10
Clinical communication: the emergence of a clinical discipline
– **Elaine Gill** 14
See one, do one, teach one – the uphill struggle for clinical skills acquisition
– **Raina Nazar** 17
Feedback to enhance student learning: facilitating interactive feedback on clinical skills
– **Faith Hill** 21

Original Research

COMET: Clinically Observed Medical Education Tutorial – A novel educational method in clinical skills
– **Rajiv Nair** 25
Preparing for practice – use of simulation to identify sub-optimal levels of care with junior medical students
– **Jean Ker** 30
Assessment of final year medical students in a simulated ward: developing content validity for an assessment instrument
– **Louis McIlwaine** 33
The use of medium fidelity simulation to develop technical and non-technical acute care skills early in the undergraduate curriculum
– **Lucy Ambrose** 36
Reducing errors in laboratory test requests
– **Lysa Owen** 38

Reviews

Shibboleths of incompetence
– **Dason Evans** 41
Patient safety skills
– **Rick Johnson** 43
Face to face: a training DVD-rom to develop skills to diagnose patients presenting with mental health problems
– **Lisetta Lovett** 47
Interview with Kuldip Birdi, author of 'Clinical Skills for OSCEs'
– **Wing Mok** 49

Correspondence 51

Clinical Skills Notice Board 52

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Mission Statement

The clinical skills arena is an ever expanding field with an increasing wealth of knowledge; however there is no central resource for the sharing of evidence based research and information. The International Journal of Clinical Skills (IJOCS) is a peer reviewed International Journal, which will promote the sharing of information and evidence based research, as well as bringing together the clinical skills community.

The Journal aims to develop and maintain standards in research and practice, lay a platform for discussion and debate, and provide opportunity to present evidence based medicine and critical appraisal of research. Provision of this much needed resource for both students, teachers and healthcare professionals, will ultimately enhance patient care.

The IJOCS will be a regular publication, three times a year in the first instance, both online and in print. The implementation of the IJOCS website will provide a continual resource for daily use. Also, in conjunction with the 'Clinical Skills Lab', the IJOCS will allow access to an online database on over 200 clinical skills – launching in 2008.

A diverse range of reviewers support the Editorial Board, all of whom are leaders in their respective fields and the IJOCS prides itself on the quality of content. Contribution of original ideas, research, audit, policy, reviews, case reports and 'Letters to the Editor' are welcome from all those involved in this multidisciplinary field. Submissions are not limited to these specific publication types and your novel suggestions will be considered.

I wish to thank all those involved in the development of this unique venture – a Journal whose remit is highly significant to today's needs.

Dr Humayun Ayub
Editor-in-Chief
International Journal of Clinical Skills

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Foreword

International Journal of Clinical Skills – An exciting forum for clinical skills

There has been an explosion in the volume of medical information related to clinical skills, which are essential in our efforts to maintain optimal patient care. The International Journal of Clinical Skills (IJOCS) aims to disseminate this knowledge in an easily accessible form. This will not only enhance our attempts to provide a quality health service, possibly with some standardisation, but also provide a vehicle for teaching and learning, hence the Journal's motto – 'docendo ac discendo' (by teaching and by learning).

The IJOCS will not only serve as an avenue for publication of research papers, but will also act as a means of communication between clinical skills professionals at an international level. Consequently, those involved in the clinical skills field, can keep those in other countries informed of their activities, as well as offering best practice guidance.

Alongside this valuable publication, a continually evolving online database ('Clinical Skills Lab') will become available for students and teachers to access – this will hold extensive information on over 200 clinical skills. The Clinical Skills Lab will be regularly updated by all those involved in this field and provide a platform for discussion and debate.

The IJOCS also aims to present comment on items of specialist interest. For example, the current issue contains a paper by Professor Harold Ellis CBE, on 'Medico-legal consequences in surgery due to inadequate training in anatomy', and explores the potential niche for anatomical clinical skills training within the newly developed medical Foundation Years (F1 & F2). It is hoped readers will make use of the Journal to comment on matters such as this – and on others relating to the subject of clinical skills – by means of 'Letters to the Editor', research based evidence and shared practice.

In order for IJOCS to become an exciting forum for clinical skills, the Journal welcomes submission of innovative research, papers, reviews and case reports. Of course, submissions are not only limited to these specific publication types and your innovative ideas would be greatly welcome by the Editor.

I am confident that IJOCS will be appreciated by a variety of health care professionals, at an international level. It promises to be representative of an ever expanding field, and with the support of all those able to contribute, it will, without doubt become increasingly influential.

I wish those responsible for the production of the International Journal of Clinical Skills, the success which their initiative deserves.

Professor The Lord McColl of Dulwich CBE
September 2007

Patient Safety Skills

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TRM, team resource management
aviation

Over the last few years the world has become increasingly intolerant of medical error. The increasing litigious nature of society, consumerism and the improved ability to gather data are all contributing factors. People seem no longer prepared to accept that sometimes things go wrong. Commercials on American TV offer the services of 'no-win-no-fee' lawyers but rather than the usual work-based personal injury theme, these were directed at those who had experienced an adverse event in hospital. The British experience is not so extreme but, given the way we have followed the USA in terms of personal injury claims, I wonder how long it will be before British lawyers follow suit.

The UK has put resources into organisations such as the National Patient Safety Agency (NPSA) and its National Reporting and Learning System (NRLS) in an attempt to gather data from which it can institute change to stem the flow of adverse events. The recent formation of the National Patient Safety Forum and Sir Liam Donaldson's "Safety First" document, which called for Trust boards to be more accountable for patient safety, are steps in the right direction. Time will tell how these translate to the front line.

Statistics abound such as 98 000 avoidable deaths per year, 850 000 adverse events per year, 1:10 in-patient adverse events or outstanding negligence liability in the region of £8 billion.

Interestingly there has yet to be a study which determines whether these are meaningful figures or just inevitable white noise given the very risky nature of healthcare. For example, aviation recognised some time ago that, given the explosion in air traffic (excuse the pun) about to take place over the next decade, error and subsequent crash rates would increase to approximately 1 every 5 days. Clearly this would be unacceptable but ashamedly one suspects not because of the loss of human life but rather the business would not survive financially. There appears to be little evidence to determine what the acceptable level of error should be in healthcare. One could of course assume that given the ever-increasing demands on healthcare systems worldwide, errors are bound to increase and that unless we address it now it is likely to get out of hand. That said flawless healthcare is unrealistic since we are human and therefore by definition fatally flawed.

The culture is key to the development of high reliability organisations. If the culture is focussed on safety all other safety processes will flourish. If not they will struggle. Learning from reported errors is laudable but requires a culture of reporting to support it. The NPSA includes building a safety culture as one of its Seven Steps but how this is to be achieved is unclear.

Reporting systems are successful based on three key criteria.

Data must be:

1. Gathered
2. Processed
3. Acted upon / Fed back

If there is a poor safety culture the data will not be gathered in the first place and then clearly processing and action become impossible.

The target for the NHS should be to foster a strong safety culture. This cannot be achieved unless safety becomes the prime goal, "Do No Harm". In aviation the front line, whilst under immense pressure from many external factors including customer service, competition, terrorism, profits and shareholders, still regard safety as their prime directive.

The key question is how do we achieve this?

Firstly, management and governing bodies need to visibly promote and encourage progress in this domain. All the major institutions of the NHS are 'for' patient safety (who could be 'against' it?) but how do the pieces fit together? As a surgeon, I have an active interest in patient safety but still find the responsibilities of the NPSA, Healthcare Commission, GMC, Royal Colleges and other agencies in this field complex and confusing. This lack of clarity sends out an unconvincing message to front line clinicians who often feel unsupported, have to deal directly with the consequence of safety failures and may face court action. Even at local level I wonder how many CEOs of acute trusts will prioritise Patient Safety over waiting time or other targets?

Secondly, staff must be trained in Patient Safety. Aviation used Crew Resource Management (CRM) as its vehicle to provide two things. One was the opportunity to offer skills training in managing human fallibility (Human Factors – HF) and teamworking, areas which had not been addressed before. Secondly, and probably more importantly, it provided a forum in which all elements of safety could be discussed and brought to life. Safety and the initiatives to support it, such as reporting incidents and near misses, were placed in plain sight. It showed a genuine commitment from the organisation that safety was paramount. In healthcare we have seen the same idea in the translation of CRM into Team Resource Management (TRM). This is a solution which is provided for the front line and so TRM fosters a safety culture.

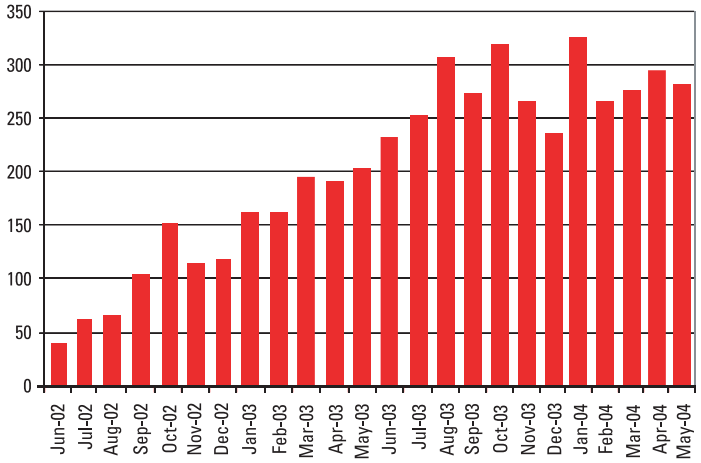
The two industries are very different and many of the pressures are incomparable but there are obvious areas of experience that will stop healthcare from having to reinvent the wheel. Culture is big, complex and very difficult to measure. It is informed by geographical, territorial, social, and professional factors. It can be seen as a reflection of the 'stories, which groups tell about themselves' but is almost impossible to measure. Climate is used as a proxy and the analogy would be the weather climate. There may be short-term variations (as with our variable weather) but the general picture has identifiable characteristics, which can be measured or assessed.

The Safety Climate Survey developed by Professor Bryan Sexton and others at the University of Texas is a tool used in Healthcare and it measures the percentage of people who score positively in terms of safety climate.

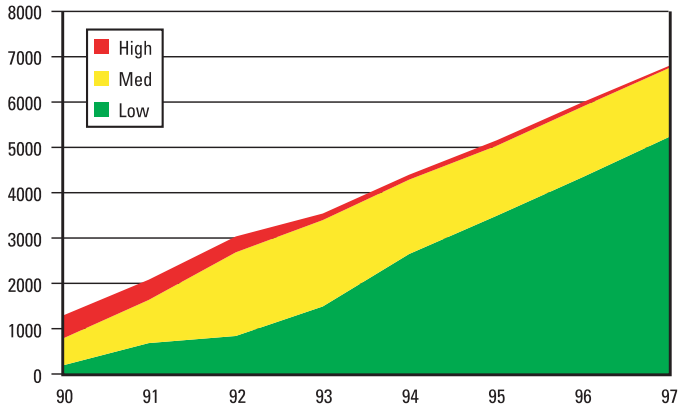
At Ashford and St Peters NHS Trust, TRM (Team Resource Management) training as a singular intervention successfully increased the number of people who scored positively. Perhaps, more importantly was the force multiplier effect that TRM training had on other tools. Other initiatives were measured in isolation using the same methods and generated only a very small increase in safety climate scoring. However, when combined with TRM the scoring increased dramatically (from approx. 35% to 60%), suggesting that TRM unlocked the safety aspects of tools such as the widely publicised SBAR (Situation, Background, Assessment, Recommendation), a structured briefing tool developed by the Institute for Healthcare Improvement.

Increased reporting is another positive move towards a safety culture and University Hospitals Coventry and Warwickshire NHS Trust also invested in TRM education to help motivate staff towards a safer environment and engage in their clinical governance agenda. The graph illustrates the absolute increase seen over a period of time and so suggests a corresponding increase in the safety culture.

Clinical Adverse Events by Month - Trust



The often displayed graph which was plucked from aviation (data below is from a leading international airline) shows how over time and as people become more confident in the reporting culture, they start to report near misses (green) and as this number increases the number of serious reports (red) decreases. This is because we can now act on the near miss and so put a barrier in place before encountering the real catastrophe.



The NHS has focused on systems reform as the secret to its success. Blame it says must be stamped out and replaced with a just culture. This cannot be achieved unless a balanced approach is taken. Systems must be addressed but as said by Sir Liam Donaldson,

"Modern health care is delivered in a highly complex, pressurised environment often involving the care of vulnerable seriously ill patients. More than almost any other industry in which risks occur healthcare is reliant on people more often than machines, to make decisions, exercise judgement and execute the techniques which will determine the outcome for a patient." *Making Amends, Chief Medical Officer DoH, June 2003.*

It is proven that increased error is strongly linked to poor teamworking or human factors skills. This, according to Professor Helen Muir at Cranfield University, is not industry specific and healthcare suffers from many of the same problems as other high risk industries i.e. approximately 75% of errors involve human factors. This is reinforced through the research paper "Team

Working and Effectiveness in Health Care" by M West and C Borril at Aston University, which shows a direct link between teamwork and mortality and morbidity rates.

These skills are vital in any walk of life if people are to be proactive in their ability to prevent error. Reporting systems in their early stages are by their very nature reactive methods of control i.e. something needs to go wrong before it is reported and then acted upon to try to prevent it from happening again. This results in an "Organisation with a Memory" as described by the Chief Medical Officer's report of the same name.

Team Resource Management provides additional skills, which have not previously been included in medical training. It offers another defence against the chance of error developing but instead of relying on the system it relies on humans. If we assume that 75% of errors involve human factors then we should obviously report on them when we see them go wrong. But how can we report on something we don't understand? Examples such as leading questions, confirmation bias and inappropriate behaviour are all human factors red flags that can act as precursors to catastrophe.

Safety in aviation has advanced through the eras. From 1900 – 1960 it experienced the "Hero Age", handlebar moustaches etc. Pilots were gods! This moved into the "Technical Age" 1960 – 1980 as advances in technology dramatically improved safety e.g. jets, simulation and radar. Finally came the "Human Age", which is where they are currently focused. Healthcare has yet to move properly into the Human Age but possibly because technology advances at such a rate that this appears to be the better investment.

People must be trained to think 'safety'. Professor James Reason (emeritus Professor at Manchester University) once described looking out of his window and gazing at a squirrel. It occurred to him that the squirrel has no natural predator yet is permanently vigilant. It has a quality of feral alertness and is always looking for danger. It is this quality that NHS staff need to acquire if a safety culture is to exist. This constant vigilance can be developed using TRM training. It is a skill.

Safety needs to be included at all levels of training and continually reinforced. It is not enough for senior doctors just to teach technical skills to their juniors, as technical proficiency alone will not guard against error.

Trust boards need to invest in the culture of their staff. Learning from mistakes is vital and the local Trust reporting systems hold the key to this but it is the culture which they foster which will drive the data. Training programmes can provide skills and support. The resulting staff engagement with the whole Clinical Governance process will regenerate the culture as long as the information feedback loops are closed and reporting is seen to drive safety benefits.

The culture is changing in small pockets across the country but there needs to be policy support and perhaps legislation to force its spread nationally. The recently formed Clinical Human Factors Group may provide the necessary lobbying to assist with this agenda. With more than a million employees in the NHS support from the top is crucial but change also grows from the ground upwards. With appropriate training, we can start with individual doctors leading safety culture in their teams. ■

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The Clinical Skills Lab database will comprise information on over 200 clinical skills, broadly separated into:

- History taking skills
- Communication skills
- Clinical examination/interpretation skills
- Practical skills

Not only will this valuable resource provide material to students as a learning tool and revision aid, for example, OSCEs, it will also offer educational materials for teachers from all disciplines, allowing some standardisation of practice. The Clinical Skills community will also be encouraged to contribute, making this database interactive.

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