

Please see chapter 3 for notes on the meeting to introduce Pack 3.

4.5 Observation and reflection tasks Phase 1: Discovery (Tasks 9-13)

Note: Please include the header in all tasks, to credit the author and acknowledge source

Communication Awareness Tools Series – Created by Ane Haaland
Observation tasks: Patient centred care, managing anxiety, and research

KEMRI-Wellcome Trust – Kilifi County Hospital

Communicating with awareness and emotional competence Process training for health providers March 2019 – Nov 2019

Preparation Pack 3: A series of self-observation and reflection tasks on Patient Centred Care, Communicating Anxiety, Research, and story of change

Introduction

We hope you are finding the observation tasks useful, and that you are all discovering and learning important things about how you communicate with patients and colleagues (and perhaps family and friends). Feedback from your many observations will be a very important part of the intensive communication skills course **August 12th – 16th**, together with the information from the baselines. Thank you very much for all the hard work, and the many good examples!

Over the past 10 weeks, you have observed your basic communication skills (listening, asking questions, hindering and facilitating good communication), how you deal with anger and irritation, and how these emotions influence how you communicate with patients and colleagues. In this last set of tasks before the first workshop, you can use all your previous learning and practice to observe **“Patient Centred Care” (PCC): You can observe how you put the term into practice** in your everyday work, how you **Take care of patients’ fears**, and **how you communicate when patients – or you yourself - are scared**.

Please note that the observations are a **compulsory** part of the preparations for the course.

Guidelines for reflection on Patient Centred Care (PCC)

“Patient Centred Care” is a term which is increasingly used in medical care. Please discuss with colleagues – what does this term mean for you in your everyday work as a health professional? Do you put the term into practice, and if yes - how? Share some examples of what you do when you provide **“Patient Centred Care”**, to get a better grasp of the meaning of the concept. To help your discussion, please read the article about Patient Centred Care, below.

What Does Patient-Centered Care Mean?

There have been many attempts to define the attributes of patient-centered care (PCC). However, there are gray areas even in the most comprehensive of definitions. The following is from NRC Picker, the company specializing in tracking patient experiences:

1. Respect for patient's values, preferences and expressed needs. This dimension is best expressed through the phrase, "Through the Patient's Eyes" and the book of the same title, and leads to shared responsibility and decision-making.
2. Coordination and integration of care. This dimension addresses team medicine and giving patients support as they move through different care settings for prevention as well as treatment.
3. Information, communication and education. This includes advances in information and social technologies that support patients and providers, as well as the cultural shifts needed for healthy relationships.
4. Physical comfort. This dimension addresses individual, institutional and system design (i.e. pain management, hospital design, and type and accessibility of services).
5. Emotional support. Empathy and emotional well-being are as important as evidence-based medicine in a holistic approach.
6. Involvement of family and friends. Care giving includes more than patients and health professionals so that the larger community of caregivers are considered.
7. Transition and continuity. Delivery systems provide for caring hand-offs between different providers and phases of care.

All of this seems praiseworthy, but what does it mean in practice? How would you know if the care you received was truly patient-centered? How would providers know if they were delivering patient-centered care? How would system managers know? What indicators best reflect patient-centeredness? PCC is in some ways in the eye of the beholder. Providers might think they are delivering PCC but their patients might disagree. Different aspects of PCC will be more relevant to some patients than others.

The purpose of this paper is to explore PCC in practical terms and propose some possible indicators and measures that would support transparent performance reporting on its achievement. The aim is to make PCC more concrete, so that it is a living concept meaningful to those who receive, deliver, and organize care, and who make policy. Ultimately, PCC is as much about the culture of the system as specific approaches and behaviors. The challenge is translating it into understandable, consistent and valid terms and indicators.

A. The Fundamentals of PCC

A basic foundation of PCC is the notion of service. Many think of contemporary health care as a combination of science and technology deployed by professionals to address health problems. This is of course true, but PCC is based on a simpler premise: health care is a *service* industry. This may sound like mere common sense, but if truly embraced and built into the health care system, it is a transformative idea. In important ways health care is unlike commercial services like hair salons and hardware stores. Sick people are not shoppers and their relationship with providers is qualitatively different from their relationship with sales clerks. But one concept fundamental to the commercial world is relevant to health care: the customer is always right.

Technically, of course, the customer is not always right – customers are just as fallible as businesses. But a dissatisfied customer is a customer whose needs have not been met, and the essential insight is to recognize this as a failure. Successful businesses view an unsatisfied

customer as evidence of their own failures. That ethos lies behind no-questions-asked return policies, ironclad warranties, and personal communication to resolve problems. Businesses adopt this attitude because it is a key ingredient to their survival and success. Publicly funded health care does not face the grim prospect of collapse due to the loss of customers. It can, and does keep the customers it fails because there is no other place to go. Most of the failures are not catastrophic (although many are and the death and morbidity tolls are high). They are rather the failures of disrespect, inconvenience, poor communication, and fragmentation. Put most simply, the system has been designed for the providers more than for the users of services, and it shows.

It is important to distinguish PCC from consumer-driven health care. The latter uses the language of the market and increased patient control as a purchaser of services, and more informed choice about where to receive care. PCC experts emphasize that while the two concepts may overlap, PCC begins with the premise that people vary in their capacity and inclination to engage in their own decision-making. Some are confident and able to direct their own care, while others are less so. PCC makes no assumptions

The Change Foundation in Ontario has done a lot of work on PCC. A major literature review confirmed that there is very little research that examines health care integration from the patient perspective. The Foundation conducted a series of focus groups to get a better understanding of the patient experience. Many implicit definitions of the elements of PCC emerged, among which were:

1. Comprehensive care – all of their needs, not just some, should be addressed
2. Coordination of care – someone is in charge, there is someone to go to who knows you and will help you navigate the system
3. Timeliness – they should get care when they need it and where a sequence of services is required, the intervals should be short
4. Functioning e-health – provide information once, ensure that it is accessible to those who need it, give patients access to the records and the opportunity to add
5. Clear and reliable communication – listen, explain, clarify, ensure that the provider team members are on the same page, consistency of messages, access to phone or internet consultations
6. Convenience – minimize the need to go to different physical locations for services; open access, same day scheduling; no unnecessary barriers or steps to getting to the right provider
7. Respect – for their time, intelligence; for the validity of their stories; for their feedback about quality and effectiveness; for their environment and family care giving partners
8. Empathy and understanding – for their circumstances, fears, hopes, psychological state
9. Time – to express needs and be heard effectively
10. Continuity and stability – to know and be known, minimize the number of different care providers
11. Fairness – amount and timeliness of service commensurate with need.

Different initiatives and attributes are required to meet all of these needs. Some are structural: how well the system is integrated, where services are located, the nature and use of an EHR. Some are organizational: how are appointments made, how staff is deployed, are there processes for pro-active rather than reactive communication. And many are attitudinal and behavioral: whose needs come first, do providers listen, do they treat patients as equals and partners, do they welcome feedback.

C. Provider Attributes That Promote PCC

Achieving genuine PCC requires a cultural adjustment. Provider attitudes and behaviors can accelerate or thwart PCC. Among the provider attributes essential to transformation are:

1. Recognition that health care is an integrated service industry designed to respond to people's needs
2. A commitment to organizational effectiveness and collective responsibility for the processes and outcomes of care, with special focus on handoffs, communications, and follow-up
3. Willingness to participate in non-hierarchical teams to ensure that patients get comprehensive, well-integrated care from the most appropriate caregiver
4. Willingness to adopt an incentive structure that encourages spending adequate time with patients with complex needs
5. Trust in and encouragement of those patients who want to be actively engaged in the management of their own health
6. Commitment to organizing the system to provide timely care and adoption of tools and techniques that prioritize patient access over provider convenience
7. Willingness to own the failures on any of the main PCC indicators and dimensions and vigorously pursue remedies
8. Embrace of e-health and other technologies that expedite communication, flow, and efficiency.

All of these attributes come down to attitude and primarily deal with the non-technical aspects of their work. Many of the problems PCC aims to address involve fragmentation – the parts of the system don't work together. Some fragmentation arises because for over a century, professionals have put clinical autonomy at the centre of professional identity. While the exercise of clinical judgment is fundamental to quality, absolute clinical autonomy is anathema to an integrated system that delivers PCC. Because health care is not a market good, there are no "natural" market forces to drive PCC, quality and efficiency. Many values compete for priority status in any health care organization: PCC, clinical autonomy, organizational loyalty, or any number of others. The core value cannot be all of these, and if PCC is to be paramount, the others have to be modified accordingly. Either the sun revolves around the earth, or the earth revolves around the sun. Patients can orbit their providers, or providers can orbit their patients.

4.5.1 Observation task 9: Linking Patient Centred Care to practice in your daily care**June 12th - 18th**

After reading the article, observe how you practice PCC in your work at the moment. Decide on a day you will observe yourself and keep the concept with you in your mind. Observe each encounter with a patient, and reflect after each encounter:

- What did I do which was patient centred?
- What about my behaviour made it patient centred (i.e. was it *what* I did, *how* I did it, or both?)
- What was/were the reaction(s) of the patient?
- How did I feel myself?

Reflect on:

- What were the needs of the patient, physically/medically, and mentally/emotionally, and on how you met these needs, using PCC;
- Is there anything you could/should do to make your interaction more patient centred? What could be the effect on the patient if you did this, and the effect on you?

Continue to observe for some more days, whenever possible, how you practice PCC, and how it works for you and for your patients. Are there any cultural (and/or automatic) reactions which work *against* you practicing PCC? Any that work *for* you practicing PCC? Anything you have discovered, which needs to change?

4.5.2 Observation task 10: Stepping into the shoes of a patient, or caregiver: How does PCC feel?

June 19th - 24th:

This week we ask you to reflect on situations where you have been a patient yourself or have accompanied a patient (e.g. a family member, or friend) to a health care facility. We invite you to **step into the shoes of a patient** or a caretaker to a patient, and try to imagine what it would be like to be in those shoes: Observe (in action) and reflect on how it may feel to be a patient/caregiver/relative to a patient, and what you wish(ed) for, from the health provider. If you have not recently had this experience yourself – you can talk with a friend or relative who has had this experience and ask about his/her experience of being a patient.

The following questions can guide your reflections:

- What happened/what was the situation/what was the context?
- How did you feel to be patient/caregiver?
- What were your/his/her needs?
- What did the health care provider do (and not do)?
- Did you feel the provider tried to see the situation and understand your need, from your own perspective as a patient or caregiver? (what could be the reasons s/he did, or did not?)
- Did you feel the provider saw you as a person, or as “just another patient/caretaker”?
- What do you wish s/he could have done differently to take better care of you, or your patient (re medical needs, information, emotional needs, etc)?
- What would have been the effect on you, if you/your patient got the care you wished for?

Please reflect on your experience(s), and on what “Patient centred care” means to you as a Patient. Compare this to your observations and reflections from last week and discuss with your colleagues.

Task: From your observations these two weeks, please **pick one example**/situation where you practiced PCC, or where you experienced PCC as a patient or caregiver. Please write your example/story, your insights and reflections, and send/hand in to us, by **25th June**.

4.5.3 Observation task 11: Your methods to take care of fear and anxiety in patients and parents

June 26th – July 1st

We know that being a patient or caretaker is often very difficult, and patients are afraid or anxious for a large number of reasons, all of which are “good” or “reasonable” - from their perspective: They are in a new place, full of technical instruments and sick people. They don’t know what is wrong with themselves, or their child. They don’t know how long they have to stay in the hospital, and if

someone will take care of their family at home. They don't know what it will cost. They may have been met by an unfriendly nurse who told them things and used words they did not understand. They may have travelled for several hours to get to the hospital. They may have waited long, and are exhausted, hungry, etc. And so on. ***Their anxiety and fears are well founded.***

How do you take care of this fear, and make the patient feel safe and in good, competent hands?

This week we invite you to observe what it is you do to take care of patients' and caretakers' anxiety and fears: how do you communicate verbally and nonverbally in these situations, and how do you know it "works"/have the effect that you intend. You may also reflect on whether your intention is conscious – whether you decide what it is you want to achieve with this patient or caretaker, and how you need to act to achieve what you have decided. In other words – observe how you are using emotional intelligence skills.

Does their fear "infect" you sometimes? Fear is a very strong emotion, and it has many faces, and many effects. We ask you to explore more systematically what these "faces" are, how you respond, and what are the effects of your responses, on the patient or caretaker. Fear can also be contagious, and it is easy to "pick up" some of the feeling and let it affect you: Are there signs that tell you their fear is "getting under your skin"? How do you react when you are also feeling the fear?

This observation is linked to and builds on the observations in Pack 2, on anger and irritation. It is connected to the first three skills of practicing emotional intelligence.

Task 11: How do you take care of fear and anxiety?

a) Observing patients' reactions:

Please observe the following during your interactions with patients and parents:

- How do you ***sense that a patient is anxious or afraid?*** What are the "different faces of anxiety", or signs, which you observe or sense when interacting with a patient? How do you decide or "know" that anxiety or fear is actually "the problem"?
- What do you do ***to respond to the signs, in different situations?*** Note for yourself what you do, and how you communicate – including use of non-verbal methods, and emotions.
- Do you have ***many different ways to respond?*** ***How do you choose*** your method of response – is this ***automatic***, or do you "take a step back" to ***assess*** what this particular patient needs before you respond? And if so – how do you know what she needs?
- Do you ***follow up*** patients who are anxious? If yes – how?

Day	Situation	What did the patient do? How do you know s/he was anxious or afraid?	How did you respond to the patient's emotion?	What do you think were his/her needs?	How did you feel? (when taking care of the patient fears/anxiety?)	How do you think the patient felt?
1						
2						
3						
4						
5						
6						

NOTE: Please make much more space in this table – make it in landscape format, with ample space.

Please describe an example from your observations. Reflect on your learning and note what you want to learn more about – on your own, as well as in the workshop.

Remember – observation is more effective (i.e. you learn more) when you focus on a small part of your communication habit to pay attention to

Note: This task is related to all four Emotional Intelligence skills.

4.5.4 Observation task 12: Special task for providers working with research projects

To get people to agree to take part in studies requires good communication skills and respect for people's right to say no. You can assume that people whom you ask are scared or anxious, as they are usually quite sick (or have a sick child/relative with them), and they usually do not know what will happen in the hospital. How do you manage this careful balance of giving clear information which is being understood in a difficult/stressed situation for the patient, with making sure you get your work (as a researcher, or recruiter for a research project) done?

Communicating about research and procedures (e.g. an operation) will be the topic for observations after the intensive workshop. However, some of you may want to pay special attention to how you carry out this work now, in relation to your observations on how you handle anxious patients. We will have a session on research in the workshop, where you can ask questions related to research.

4.5.5 Voluntary task: Communicating with friends and family members

Over the past months, you have reported on how your communication has changed with colleagues and patients. Has your observation and reflection also affected your communication with friends and family members (including children)? We invite you to observe during this period as you continue to interact with your friends and family. You could for example observe:

- How do you listen these days?
- How do you ask questions?
- How do you deal with emotions (anger, irritation, others)?

Has anything changed in the way you interact with your family and friends? If yes – what has changed, and how? What is the effect of these changes on your relationship(s)?

If you feel like it – you can also ask if your family and friends have noticed any changes in the way you relate with each other, and use this to discuss communication in the family.

4.5.6 Observation and reflection task 13: The Most Significant Change, and Defining your learning needs

July 1-6th

We are asking you to hand in **one important example** from this set of tasks. This should be an example that shows **your learning and reflections** during these weeks. It can be something you do, which has changed in an important way. It can be something which has made you realize why your present practice is effective or achieves the goal you have intended - an example which you can share, and maybe show to others.

Please also tell why these changes are important to you.

The workshop should be a place where we discuss our problems and learn from each other how to handle them better. It should also be a place where we share our “successes”, and learn from what each of us does well in our practice.

Define your learning needs: At the end of your Most Significant Change/Best Practice example(s), please answer the following question: **What do you now feel you need to learn about communication skills and management of emotions, from doing these observations for 3 months?**

Important Deadline: July 6th – to enable us to read, understand and use your examples, and to analyse and respond to your learning needs!

Best regards,
(name/course leader) and the training team

4.6 Observation and reflection tasks for trainee doctors - Cardiff training

These sets of tasks were used to train trainee doctors in Wales in 2016 and 2017. We include these tasks here, as many of these were developed to directly observe use of skills related to emotional intelligence and resilience.

We do not include the first two packs here (Pack 1: Basic communication skills (1-4), and Pack 2: What makes you react emotionally – anger and irritation(5-8)), as these were in large parts the same as those described above. We have commented on the changes used in Cardiff, in the original packs 1 and 2, above.

We include here the tasks we developed especially for the Cardiff setting, **NEW tasks 9-16 that have not been used anywhere else**. These are pack 3 (positive emotions, values and vulnerability, kindness to yourself and MSC), pack 4 (criticism of self, and others), and pack 5 (on the influence of (other) professional cultures on your emotions, communication and behaviour). We maintain the numbers on the tasks as we used them in Cardiff, and hope they will not cause confusion with the tasks with same numbers, above. **All additional tasks for the entire course are included here – for the 7 months the course process was run.**

The title of the programme is included only for task 9 – it remained the same for the two courses, each of which lasted 7 months. Some of the tasks were developed for the last course, only, as this course had six half day workshops, and the first course only four.

All tasks are developed by Ane Haaland, some of them with inputs from Debbie Cohen, and in the second year – with inputs from the two trainee doctors who assisted in organising and teaching the course – Thomas Kitchen and Isra Hassan.

Please include reference to the original source when using the tasks:

Communication Awareness Tools Series – Created by Ane Haaland

Observation tasks: Positive emotions, values and vulnerability, kindness to yourself, and MSC
