Year 2 Consultation skills

Revision

Student handbook

2024

This has been written using resources from consultation skills handbooks from the MBBS course and my thanks goes to the team for allowing me to use their work.

With thanks to; Toni Alderton.

Try to have the role plays timed to 8 minutes (this is how long you get in a PA OSCE). An OSCE is a performance and therefore is a skill to learn. You may be a fantastic communicator but you also have to learn to be able to demonstrate this to show an OSCE examiner

GATHERING INFORMATION

PROCESS

Initiating the Session
- *Establish initial rapport;*
- *Identify reason(s) for the consultation*

Gathering Information
- *Explore patient's problems;*
- *Understand the patient's perspective*
- *Use open to closed cone;*
- *Clarify statements*

Providing Structure to the Consultation
- *Make organisation overt (signposting, summarising; screening);*
- *Attend to flow*

Building the Relationship
- *Use appropriate non-verbal behaviour;*
- *pick up verbal and non-verbal cues*
- *Develop rapport (use empathy, recognises, acknowledges, validates);*
- *Involve the patient*

Closing the Session
- *Summarise session briefly;*
- *agree next steps*

CONTENT

Disease Perspective
Narrative sequence of events including:
- *presenting complaint;*
- *history of presenting complaint;*
- *exploration of associated symptoms*

Illness Perspective
- *Ideas, concerns, expectations,*
- *effects on life, feelings*

Essential Background Information
- *Past Medical History,*
- *Drug History & Allergies,*
- *Family History,*
- *Social History,e.g. smoking, Alcohol & Drugs*

Systems Review (SR)
- Otherwise well?
- Systems review

Information Giving	**Providing the correct type and amount of information**	○ **Asking patients if they have any questions** Identifies any underlying reasons for question. Clarifies any concerns What information would be helpful to them?
		○ **Assessing patient's starting point** What does the patient already know or understand?
	Aiding accurate recall and understanding	○ **Using explicit categorisation or signposting** e.g. There are 3 main things we need to discuss today
		○ **Organising explanations using a logical sequence** and relates information to patients own ideas, concerns and expectations **(ICE)**
		○ **Chunking and checking** Chunks of information are discussed and then patient is invited to ask questions or clarify further before moving onto next section
		○ **Using repetition and summarising** Key points both at beginning and end of discussion, paraphrasing main information to take away
		○ **Using concise, easily understood language** Avoiding jargon or medical terminology
		○ **Using visual methods of conveying information**
		○ **Checking patient's understanding** e.g. inviting patient to say in their own words what they understand from conversation (consider alternative ways of phrasing)
		○ **Inviting further questions** Is there something else you would like to ask me about that?
		○

Shared decision making

Step 1- Relationship building

Attention needs to be paid to initiating the session and building the relationship in order for the patient to feel able to fully engage in an open and honest discussion about their preferences for care. If the patient does not feel

respected or that their opinion is not important they are unlikely to engage. Encourage students to use skills developed in module 1 of consultation skills teaching.

Step 2 –Invitation to choice talk

The doctor needs to be explicit that there are choices to be made and 'invite' the patient to work collaboratively with them on making the best decision for the patient. This invitation is important as many patients assume that they will just be told what to do. Remember that SDM is in sharp contrast to the traditional approach to clinical decision-making – still prevalent in the NHS – in which clinicians are seen as the only competent decision-makers, with an expectation that they will make decisions *for* rather than *with* patients.

Individual patients may want more or less involvement in the decision making process so check for reaction to invitation.

Step 3- Explanation- Option talk

Involves applying all the skills of information giving covered in module 2.

Use patient decision aids or option grids during the discussion if available.

Decision aids are different from more traditional patient information materials because they do not tell people what to do. Instead they set out the facts & help people to deliberate about the options. Patients may not be aware of these aids and may want to defer their appointment to have time to consider them. There are now a large number of patient decision aids available and many of them are listed on the following Making decisions about your care | NICE and the public | NICE Communities | About | NICE

Step 4- Deliberation

Support the patient in discussion of the options as part of step 3 and step 4. What questions do they have so far? Is there one or more of the options that they would like to discuss in more detail?

Describe the pros and cons of each choice.

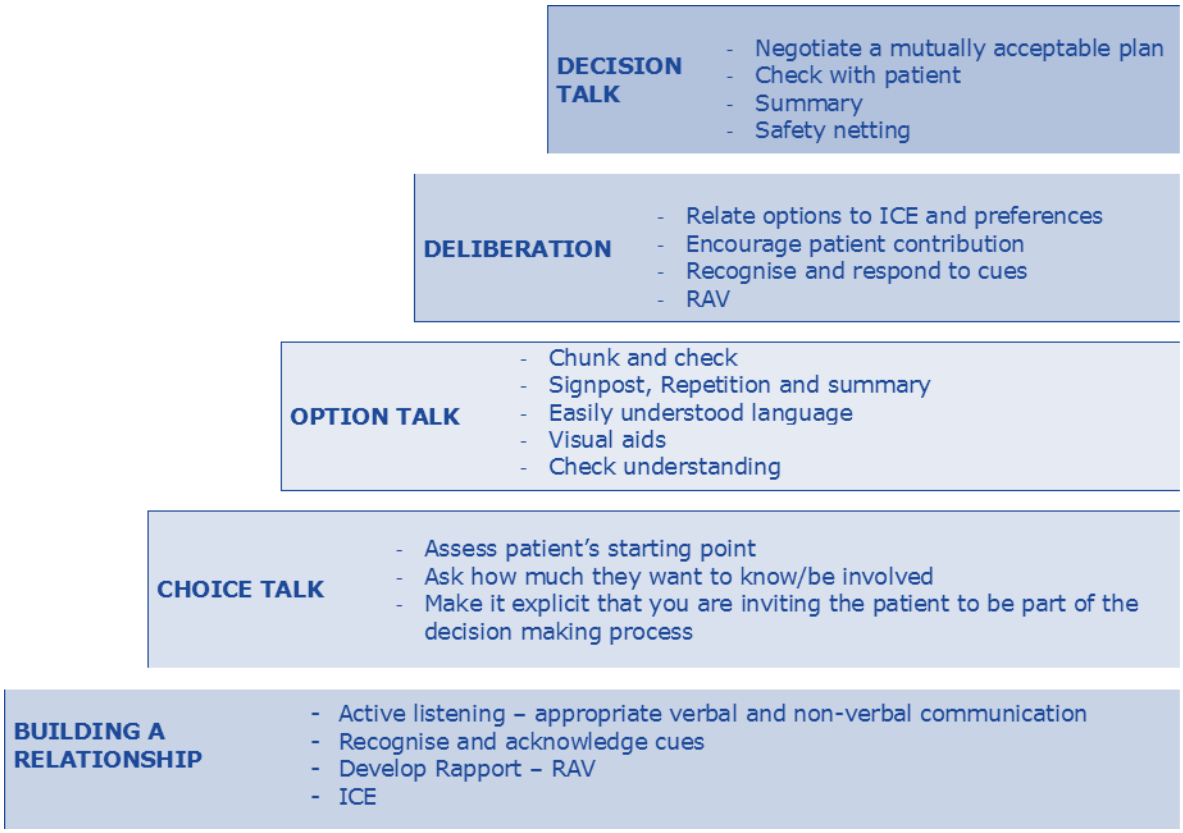
Step 5- Decision talk

Negotiate a mutually acceptable plan. Check whether concerns have been addressed.

Agree or defer the decision dependent on the patient's expressed views and preferences. Utilise the skills associated with this part of the consultation such as summarising an agreed plan and 'safety netting' – who the patient should contact if they have further questions or if the situation changes.

Step 6-Review

Agree if review is required. If yes, who will reconsider the decision or outcome and timescale for doing so.



BBN - SPIKES

Settings	Privacy, Involve signif. others, Look attentive and calm, Listening mode, Availability
Perception	"Before you tell, ask!" – What is the patient's perception/starting point?
Invitation	"How much information would you like?"
Knowledge	Warning shot – Avoid technical language – "Chunk and Check" – Adjust speed
Empathy	Identify emotions and their origins – Validate
Strategy	Summarize, check for understanding – Agree a shared management plan

Anger

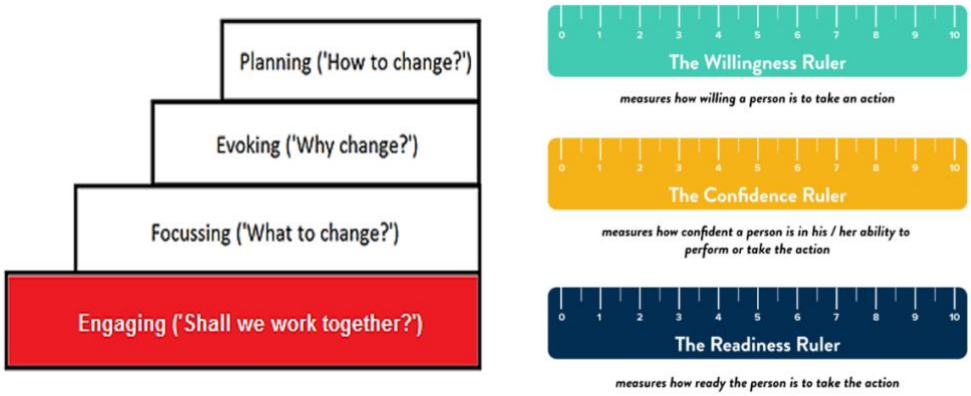
RAGE (Recognise, Acknowledge/Apologise, Gather information, Empathise and Explore)

LEAPS (Listen, Empathise, Ask, Paraphrase and Summarise)

Motivational interviewing

The steps diagram relates to the recognised steps or tasks integral to MI.

The scales you can see below are most often used in Steps Three or Four.



Scales are frequently used to get a sense of the patients 'starting position' e.g how important it is for them to make a change to their lifestyle or how ready they are to make a change and improve their health going forward.

The aims of using scales in MI is to encourage the patient to state for themselves all the reasons why they might change, rather than being told by the doctor.

Sexual history

1.Sexual history and orientation

a. When was last sexual intercourse?
b. Was this with a casual or regular partner?
c. Was this with someone known or a casual acquaintance?
d. Male or female?
e. Has partner mentioned any genital symptoms?
f. What contraception used?
g. Was a condom used and If condom used did it split?
h. When was the last time you had sex with someone other than this partner?
i. Have you had any other sexual partners in last three months?
j. Have you had any sexual contact with partners from abroad, which countries?

Sexual practice Ask the patient what form intercourse takes

- penetrative sex
- vaginal intercourse
- anal intercourse: which way round (receptive or active intercourse? Receptive intercourse more risky; therefore important to ask) or both?
- oral sex: which way round (do you go down on him) or both?
- mutual masturbation
- use of condoms or dental dam

2. HIV exposure concern

a. previous partners HIV positive?
b. high risk groups – e.g IV drug users?
c. previous HIV test?
d. Hep B vaccination?

Taken from the BASHH guidance, this is the minimum sexual history needed for a symptomatic female attending for STI testing.

- Symptoms/reason for attendance
- Date of LSC, partners gender, anatomic sites exposure, condom use, suspected infection, infection risk or symptoms in this partner
- Previous sexual partner details, if in last 3 months & note of total no. partners if>2
- Previous STI's
- LMP, menstrual pattern, contraceptive and cervical cytology history
- Pregnancy and gynaecological history
- Blood-borne virus risk assessment & vaccination history for those at risk
- PMH
- DH, allergies, SH
- Agree method of giving results
- Establish competency, safeguarding children/vulnerable adults
- (alcohol & recreational drug history, recognition of gender-based violence/intimate partner violence)

SBARD

Situation - I am (name), (X) nurse on ward (X) I am calling about (patient X) I am calling because I am concerned that... (e.g. BP is low/high, pulse is XX, temperature is XX, Early Warning Score is XX

Background - Patient (X) was admitted on (XX date) with... (e.g. MI/chest infection) They have had (X operation/procedure/investigation) Patient (X)'s condition has changed in the last (XX mins) Their last set of obs were (XX) Patient (X)'s normal condition is... (e.g. alert/drowsy/confused, pain free)

Assessment - think the problem is (XXX) And I have... (e.g. given O2 /analgesia, stopped the infusion) OR I am not sure what the problem is but patient (X) is deteriorating OR I don't know what's wrong but I am really worried

Recommendation - I need you to... Come to see the patient in the next (XX mins) AND Is there anything I need to do in the mean time? (e.g. stop the fluid/repeat the obs)

Decision - repeat key information to ensure understanding

Scenarios

1) History taking

2) Information giving

3)Shared decision making

4)Breaking bad news

5)Angry patient

6)Motivational interviewing

7)Sexual history

8)Telephone

In order to complete all 8 of the scenarios, it will be necessary to limit the time spent on each to 20 minutes.

I have included history taking and information giving for completeness but know that you are more practised at these types of consultations. I therefore suggest perhaps leaving these scenarios until last, if you wish to concentrate on some of the more challenging consultations, to ensure you don't run out of time.

Scenario 1: History taking

Name, Age, occupation and appearance: Mr Leslie Jones, aged 49 (DOB: 02/02/1971) delivery driver, normal appearance, not in pain or distressed

Main Complaint:

You have been having abdominal pain on and off for the last three months.

If asked:

Epigastric pain – mid upper abdomen,

Intermittent, lasts an hour or two

Burning in nature

4 out of 10 if asked

Radiating to your back

Worse after eating, especially spicy/fatty food

Initially relieved by antacids (Gaviscon or Rennies, and some other tablets you bought for acid, now they only give temporary relief)

You feel a little nauseous occasionally; you do not have any vomiting

Bowels working normally, stools normal colour

Urine normal

You do not think you have lost weight

You have no difficulty swallowing

No problems with your heart, no sweating, no palpitations

Not noticed any yellow colour of your skin

Your diet is not very good, you live alone and work as a driver, so eat a lot of take-aways and coffee, make yourself sandwiches or toast

Past Medical History: Not seeing GP for anything. Never had any blood tests. No abdominal complaints or surgery.

Drug History: No prescribed drugs. Takes ibuprofen for chronic knee pain from old injury, ibuprofen 2 tabs when you need, usually once or twice a day, driving makes the knee pain worse

Family History: No family history of abdominal complaints or cancer, parents died aged 65 in car crash

Social History: Non smoker (never smoked)

Drinks 2 beers every night, 4-5 on Sat and Sunday

Lives alone, eats a lot of takeaways, toast, sandwiches

Ideas: Thinks he needs stronger medication

Concerns: Worried it may be serious as not responding to the over-the- counter medication, does not want to be off work

Expectations: Medication to get rid of it

Students:

Mr Smith is having a consultation in the GP surgery for his abdominal pain.

Your task;

Take a focussed history from Mr Smith about his pain.

Students:

Mr Smith is having a consultation in the GP surgery for his abdominal pain.

Your task;

Take a focussed history from Mr Smith about his pain.

CONTENT – History of Presenting Complaint
Epigastric pain, burning, now radiating to back
Intermittent, lasts one to two hours
Worse after eating, especially spicy/fatty food
Initially relieved by OTC antacids, now not really
Nausea, no vomiting
Bowels normal, stools normal colour
No loss of weight, no difficulty swallowing
Diet – takeaways, coffee, sandwiches
CONTENT – Past History and Drug History
Previously well, no abdominal surgery
No prescribed medication
OTC ibuprofen for old knee injury, 2 tabs once or twice a day PRN
CONTENT - Family and social history
Divorced, lives alone, delivery driver
No family history abdo problems/cancer
Drinks 2 beers a day in the week, 4 at weekends, Non smoker
PROCESS - Building the Relationship
Encourages patient to tell story from beginning to present, and establishes dates/timeline without interruption
Uses open and closed questions appropriately
Demonstrates attentive listening and picks up verbal / non-verbal cues
Clarifies statements that are vague or need more details
PROCESS -– the patient perspective
Elicits patient's ideas, concerns and expectations (1 = all done, 2 = all done well)
Acknowledges patient's views AND validates patients' feelings
PROCESS - Structuring the Consultation
Initiates the consultation (introduction, explanation, consent) (1 = all done, 2 = all done well)
Progresses logically from one section to next using sign-posting
Summarises at intervals to clarify

Closes the session appropriately

Scenario 2: Information Giving

Information for role player:

Name: Katie Simmonds **Age:** 63 **Occupation:** Salesperson – double glazing

Setting: GP surgery. You are waiting to see your GP Dr Brant for a follow up appointment having recently started treatment for angina.

Clinical details and recent medical history: You were diagnosed with angina a month ago after an emergency admission to hospital when you developed chest pain during a new exercise regime you had just started. Luckily you live with your daughter Emma and she phoned 999 for an ambulance.
You had noticed for about a week before you had a bit of a slight tightness in the chest when you went for a brisk walk. It settled quickly when you stopped walking so you didn't think any more about it. Then on the evening you were admitted you had felt tight chested (like someone was sitting on your chest) and a little faint. This time it didn't go away.

When you were in hospital you had a spray under your tongue and some aspirin which helped your pain, and they did quite a few tests – blood tests and heart tracings. Following these you were diagnosed with angina and discharged home with some aspirin tablets (which you have now finished) and a spray to use, whilst awaiting further investigations.

Past Medical History: You do not have any other medical conditions, although your GP has been keeping an eye on your blood pressure, which has been raised on a couple of occasions.

Medication: The spray that you were given in the hospital, you are not exactly sure of the name unless the student prompts you. Aspirin.
You do not have any allergies that you know of.

Family history: Several members of your family have suffered from high blood pressure and also angina, you recently discovered a great Uncle died from a heart attack.

Social History: You live with your daughter Emma in a small house. You have smoked since age 23 and have several times tried to give up and have cut down to less than 10 a day (usually). You only drink alcohol occasionally on a night out with friends.
If the student asks *"are you otherwise well?"* Yes apart from your angina you are feeling fine and have not had any changes in weight, despite trying to lose some by starting on a new diet, no problems with breathing apart from being short of breath

when you exercise, no issues with appetite, indigestion or bowels, urinary symptoms or problems with fits, faints, blackouts, or numbness.

Ideas: You feel guilty about the smoking and wonder if it has anything to do with your angina diagnosis. You have found it really difficult to stop.

Concerns: You don't understand what angina is and why you have have it. What is it and what triggered it? Also you are very concerned that your uncle died of a heart attack, surely this couldn't happen to you, could it???
You want to carry on doing all the things you used to do and are worried that this will stop you doing that.

Expectations: You think if someone spent the time explaining things to you, like what happened and why you would feel much better. *You are quite upset about the diagnosis but don't admit to this unless the student asks how you feel and is really supportive*. You expect that the student will be judgemental and tell you that you need to lose weight and to stop smoking, but they wouldn't understand how difficult it is for you.

Feelings: You feel much more upset than you've previously let on to anyone. The pain was terrifying.

When asked, you would like some information about the following:

- What is angina and what causes it?
- Is there anything else I can do to help myself? Maybe give up smoking?
- You are not sure about when to use the spray and what it does.

Information Needs: If asked how much you already know about these – not a lot you don't really trust the information available on the internet and they didn't really have time to explain things when you were in hospital.
You are the type of person who likes to know the main points but you do not like lots of detail.

You are in the GP surgery and have been asked to talk to 63 year old Katherine Simmonds following her recent admission to hospital with chest pain. Miss Simmonds has come for some information and better understanding of her condition.

Information for students

You are in the GP surgery and have been asked to talk to 63 year old Katherine Simmonds following her recent admission to hospital with chest pain. Miss Simmonds has come for some information and better understanding of her condition.

Providing the correct type and amount of information
Asking patients if they have any questions Identifies any underlying reasons for question. Clarifies any concerns What information would be helpful to them?
Assessing patient's starting point What does the patient already know or understand?
Aiding accurate recall and understanding
Using explicit categorisation or signposting e.g. There are 3 main things we need to discuss today
Organising explanations using a logical sequence and relates information to patients own ideas, concerns and expectations **(ICE)**
Chunking and checking Chunks of information are discussed and then patient is invited to ask questions or clarify further before moving onto next section
Using repetition and summarising Key points both at beginning and end of discussion, paraphrasing main information to take away
Using concise, easily understood language Avoiding jargon or medical terminology
Using visual methods of conveying information
Checking patient's understanding e.g. inviting patient to say in their own words what they understand from conversation (consider alternative ways of phrasing)
Inviting further questions Is there something else you would like to ask me about that?

Angina – diagnosed 1 month ago after emergency admission to hospital with chest pain which came on during exercise regime. Had chest tightness on walking for week prior, which resolved on stopping walking. Also felt faint. Exercise makes it worse. Given aspirin and spray under tongue (GTN) in hospital which helped the pain. Discharged with aspirin tablets and spray, whilst awaiting further investigations.	
Ideas – has smoking caused it? Found it difficult to stop smoking.	
Concerns – What is angina and why she has it. What triggered it? Great Uncle died after an angina attack – could this happen to her? Will angina stop her doing things?	
Expectations – wants to be told what angina is, what causes it and what are the triggers? Is there anything she can do to help herself? She doesn't know when she should use the spray. Need to explain that angina is narrowing of arteries supplying blood to heart muscles, resulting in reduced blood flow to heart muscles. Exercise increases blood requirement of heart muscle. It's not usually life threatening, but it's a warning sign that you could be at risk of a heart attack or stroke. Triggers are exercise, stress, cold air. Stopping smoking will help. Help available (NRT and smoking cessation services). Weight loss beneficial.	
PMH – Blood pressure borderline – being monitored.	
DH – GTN spray under tongue – opens up arteries so more blood supplied to heart muscle. Use if experiences pain and can be used prior to exercise. If doesn't relieve pain, take another dose after 5 minutes. If this doesn't work then needs to seek urgent medical advice. (999) Aspirin – thins blood, which helps it to flow better to heart muscle and also helps to prevent blood clots forming, reducing possibility of heart attack in future.	
FH – Great uncle died from angina attack.	
SH – Lives in house with daughter Emma. Smoker – since age 23. Has cut down to 10/day Alcohol – occasionally on night out with friends.	
Systems review – trying to lose weight, short of breath on exercise	

Scenario 3: Shared decision making

Name: Joseph Williams Age: 58

Setting: GP surgery

Occupation: Account manager for Aviva, Norwich.

You have come to the practice for one of your routine diabetic appointments that happen twice/three times each year. The practice nurse asked the doctor to review your management in light of your raised blood glucose levels. He has suggested either adding another tablet or starting on insulin. He has asked the student working in the practice to explain the pros and cons of each of these options and will then see you again.

Clinical details

You were diagnosed with Type II diabetes 8 years ago and for the first few years you were able to keep your blood sugars reasonably stable by losing nearly 2 stone in weight and eating a carefully controlled diet. However, about 4 years after diagnosis a blood test (HbA1c*) revealed that the lifestyle changes you had made were not enough to keep your diabetes in check.

At this time your GP, Dr Smith suggested that you start taking tablets to help reduce your symptoms and avoid future complications. You were prescribed Metformin. You didn't like the idea of taking tablets but were worried about developing complications like your mother, so you agreed.

At the time you remember feeling disappointed that the lifestyle changes you had made were not enough. You had worked really hard to lose all that weight by walking to work every day and had even joined a gym to get fitter.

*The HbA1c test gives your average blood glucose levels over the previous two to three months. The results can indicate whether the measures you're taking to control your diabetes are working.

You have taken the Metformin for the last 4 years, although you feel that it slightly irritates your stomach, you persevere. The doctor also added a new drug, Glicazide, 2 years ago. He explained that this particular medication works in a different way to the Metformin and that you needed to take both in order to manage your diabetes. You prefer the Glicazide as it doesn't give you

indigestion and regularly take this but do not always take the metformin

You do monitor your blood sugars fairly regularly, especially before an appointment, but recognise that you should really do it more often. The trouble is every time you do the finger prick test (and it is raised) it worries you silly.

Patient Perspective:

You are quite an anxious person underneath the confident exterior and you dread

these appointments. You hate the fact that you have diabetes and seem to have no way of controlling it yourself without tablets. You wish you could do more exercise and really give yourself a hard time when you eat or drink too much or don't take the tablets.

Social History: Stopped Smoking 28 years ago.
You did stop drinking when first diagnosed but recognise that you have now slipped back into bad habits and know you have more alcohol more than you should at the weekends.
Nothing excessive, just a glass a two of wine on Friday, Saturday and Sunday evening.

• **Concerns:** You have been feeling very tired and lethargic recently. You are not sure if this is to do with the pressures of work, or getting older or if it has something to do with your diabetes. You feel too tired to go to the gym and as a result have started to put weight on again.

• **Expectations**

You are a bit disappointed that the most recent HbA1c test wasn't as good as you had hoped for but you are not overly surprised by this news as you know you have not been particularly careful with you diet over the last few months and at Christmas and New Year you just ate and drank whatever you fancied. You had hoped that more medication or insulin would not be necessary but would like to know more about what these would involve.

• **Feelings**

You are a bit worried about the results of the tests. You feel low in mood but would not describe yourself as depressed, just stressed. There are a lot of redundancies at work at the moment but at 58 you do not feel ready to retire just yet.
You feel disappointed with yourself each time you do something that may jeopardise your condition.

Medication

Metformin 850mg twice daily (Diabetes)

Glicazide 120mgs daily (Diabetes)

Valsartan 80mg once daily (high blood pressure)

Simvastatin 40mg at night (cholesterol)

Preference

When the student discusses the additional treatments available you are interested in all of the options. Your preference would be to try insulin as lifestyle changes have not worked in the past and your gut feeling is that taking more and more tablets will not do the trick. Your main concern remains how you can best avoid future complications.

Information for students

You are a PA student working in primary care. You have been asked by the doctor to see Mr Joseph Williams (58), who is attending the surgery for a routine diabetic check-up.
His most recent HbA1c level is 10% (86mmol/mol)

Your task is to discuss treatment options with Mr Williams & agree a mutually acceptable plan.

Information for students

You are a PA student working in primary care. You have been asked by the doctor to see Mr Joseph Williams (58), who is attending the surgery for a routine diabetic check-up.
His most recent HbA1c level is 10% (86mmol/mol)

Your task is to discuss treatment options with Mr Williams & agree a mutually acceptable plan.

BUILDING A RELATIONSHIP	• Active listening – appropriate verbal and non-verbal communication • Recognise and acknowledge cues • Develop Rapport – RAV • ICE	
CHOICE TALK	• Assess patient's starting point • Find out how much patient wants to be involved • Make it explicit that you are inviting the patient to be part of the decision making process	
OPTION TALK (Explanation)	• Chunks and checks • Discusses pros and cons • Gives explanation at appropriate times • Signposting • Repetition • Summary • Easily understood language • Visual aids • Check understanding	
DELIBERATION (Planning)	• Finds out what other information would be helpful • Relate options to ICE and patient preferences • Encourage patient contribution • Recognise and respond to cues • Elicit feelings re information given	
DECISION TALK (Planning)	• Negotiates a mutually acceptable plan • Signposts own equipoise or preference regarding available options • Determines patient preferences • Checks with patient • Safety netting	

History –
How long patient has had diabetes
Taking metformin and gliclazide
How diabetes affecting life
Compliance with meds.

Info giving -

Diabetes – what it is and effects –

Diabetes is a lifelong condition that causes a person's blood sugar level to become too high.
There are 2 main types of diabetes:

- type 2 diabetes – where the body does not produce enough insulin, or the body's cells do not react to insulin

Type 2 diabetes is far more common than type 1. In the UK, around 90% of all adults with diabetes have type 2.

Causes of diabetes
The amount of sugar in the blood is controlled by a hormone called insulin, which is produced by the pancreas (a gland behind the stomach).
However, if you have diabetes, your body is unable to break down glucose (from food) into energy. This is because there's either not enough insulin to move the glucose, or the insulin produced does not work properly.

Complications of diabetes – eyes (retinopathy, cataracts), feet (ulcers, neuropathy, amputation), kidneys (nephropathy), CVS (increased risk heart attacks)

Treatment options –
Aiming for HbA1c <6.5% (48mmol)

The main treatments are:

- lifestyle changes - Controlling your blood glucose is just one of several aspects of your care. It is also important to have a healthy diet, keep active, control your weight, blood pressure and cholesterol, and stop smoking if you smoke.
  Pros: These will help to improve your overall health and reduce your chances of heart disease and stroke.
  Cons: Most people need medicine to control their type 2 diabetes.

- Tablets –
  Pros: Easy to take. Helps keep your blood sugar level as normal as possible to prevent future complications.

Cons: Lifelong
Diabetes usually gets worse over time, so your medicine or dose may need to change.
You'll usually be offered metformin first.
If your blood sugar levels are not lower after taking metformin, you may need another 1 or 2 types of tablet. (DPP-4i as already on metformin and SU)
Side effects. (you might be expected to list 2 or 3 of these)
These can include:

- bloating and diarrhoea
- weight loss or weight gain
- feeling sick
- swelling in one or more parts of your body due to a build-up of fluid under your skin
- Hypoglycaemia ('hypos') One possible side effect of taking medicines to control your HbA1c is having low blood glucose (hypoglycaemia) – often called a 'hypo'. Most hypos are mild, but some can be severe, which means that you need help from someone else to treat the hypo.

Not everyone has side effects.

- Insulin - sometimes needed when other medicines no longer work.
  Pros – better glucose control and therefore reduced risk of complications
  Cons – regular injections – greater risk hypos
  Regular monitoring of blood glucose

discuss the pros and cons of each, ***depending on patient preferences.***

Overview | Type 2 diabetes in adults: management | Guidance | NICE

patient-decision-aid-pdf-2187281197 (nice.org.uk)

Scenario 4; Breaking bad news

Name: Colin Greig **Age**: 52

Setting: Respiratory out-patient department at the NNUH

Clinical history: You saw your GP a couple of months ago with a cough. You were given a course of antibiotics which seemed to help a little. A second course of antibiotics was tried, which made you feel a bit better in yourself, but didn't really help the cough. After this, you had an episode where you coughed up a small amount of blood, which really worried you. Your GP sent you up for a CXR and you had a phone call from the hospital asking you to attend for this appointment. If asked, you think you may have lost a little weight and don't have any energy, but are otherwise well.

Past medical history: You are usually well, though you do tend to suffer with constipation and need to take laxatives at times.

Drug history: Fybogel (an orange fibre drink) which you take a couple of times a day when you start to feel that you are getting constipated.

Allergies: None

Social history: You live on your own, since you were divorced from your wife Tina 2 years ago. Your daughter Emily and her family – her husband David, and your two grandchildren – Peter (5) and Lucy (3) live nearby and you visit most weekends.
You work in a telephone call centre.
Non-smoker, you drink around 3-4 glasses of wine per week, usually at the weekends.

Family history: Your father has chronic bronchitis and uses inhalers. He is always coughing up mucky phlegm.

Patient's framework:

Ideas; You know that coughing up blood is worrying, but you have never smoked, so think that this is just a really bad infection that has not responded to the antibiotics given by the GP. It might even be the start of something like your father has.

Concerns: You are worried about having to be off work, but it isn't good being on the telephone and constantly coughing. You really can't afford to be away, especially as you are on a zero hours contract. You just want this cleared up quickly.

Expectations; You are expecting for the PA to tell you that this is a nasty infection or chronic bronchitis, like your father and that you need to have some stronger antibiotics and maybe some inhalers.

You are shocked and upset when the PA tells you that you need to have some investigations. This can't be cancer, because you have never smoked, so it must be some strange infection you have picked up.
After the initial shock, you are relieved to know that there was something wrong and that you weren't just imagining it. You knew you weren't feeling right.

How are you going to tell your daughter?

Does this mean that you will have to have even longer off work?

Instructions:

You are in the respiratory out-patient department.

Colin Greig was sent up for a CXR by his GP.

The CXR shows a large solid mass in the left lung.

Your task is to explain to Mr Greig what the CXR shows and that he needs further investigation with bronchoscopy and CT scan.

Instructions:

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Greets patient and obtains patient's name	
Introduces self, role	
Explains nature of interview (reason for coming to talk to patient)	
Assesses the patient's starting point: what patient knows/understands already/is feeling	
Gives clear signposting that serious important information is to follow (warning shot)	
Chunks and checks, using patient's response to guide next steps	
Discovers what other information would help the patient, attempts to address patient's information needs	
Gives explanation in an organised manner (uses signposting/summarising)	
Uses clear language, avoids jargon and confusing language	
Picks up and responds to patient's non-verbal cues	
Allows patient time to react (use of silence, allows for shut-down)	
Encourages patient to contribute reactions, concerns and feelings	
Recognises, Acknowledges and Validates patient's concerns and feelings	
Uses empathy to communicate appreciation of the patient's feelings or predicament	
Demonstrates appropriate non-verbal behaviour e.g. eye contact, posture and position, movement, facial expression, use of voice (pace, tone)	
Provides support: e.g. expresses concern, understanding, willingness to help (eg telling daughter)	
Avoids platitudes or false re-assurance	

Makes appropriate arrangements for follow-up contact	
Concludes the consultation appropriately	

Content

Presenting symptoms – cough, antibiotics, haemoptysis SH – non smoker. DH – fybogel	
ICE – bad infection, needs more antibiotics, concerned may be chronic bronchitis, like father has. Needs it cleared up quickly – can't afford to be off work (zero hours contract in call centre)	
CXR – mass left lung, could be cancer. Needs further investigation – bronchoscopy and CT.	
Has lost a little weight, lethargy. Doesn't feel right.	

Scenario 5: Angry patient

Name: Mr Anthony Thompson **dob**; 6/6/99 age 23

Scenario:

Three days ago, during a bout of cystitis you began to feel feverish and sweaty and started to vomit. You then developed severe left loin pain, noticed some blood in your urine and felt awful, so your partner brought you to the emergency department. You did not want to go but felt too weak to argue. You feel a little better now although you were hot last night and still cannot face food or drink. You still have some pain although the painkillers help. You feel rather dizzy whenever you stand up. You are receiving antibiotics by injection.

You have never been in hospital before, and you hate it. They put you in a large ward full of noisy, confused patients.

You are also unhappy you couldn't have an ultrasound scan yesterday because you had just passed urine. Nobody told you that you had to have a full bladder and you felt the radiographer was blaming you. You are waiting for the scan today and are desperate to pass urine. Your bladder feels very uncomfortable. You feel tired and angry. You know the nurses are busy, but you can't bear it any longer. You are in no doubt you would be better at home. The scan can wait.

You are prepared to force water down even though you feel sick and think you could take antibiotics and painkillers by mouth.

You are desperate to go home and have called your partner to collect you.

SH: You are a PhD student at university studying epidemiology. You live with your partner, are a non-smoker and do not drink alcohol.

PMH: You have had no other significant health problems and were a healthy child.

Attitude and emotional responses

You are upset by the problems on the ward and still feel unwell. Although angry about the situation, this is not directed at the staff.

You are determined to go home, although you have not considered the implications and are not being rational.

You might be persuaded to stay if the problems can be resolved, and the PA convinces you this would be in your best interests.

Make sure you ask the following question:

-Why can't I go home?

Other questions you might like to ask include:

-Why do I need the ultrasound scan?

-Will the infection be cured by the antibiotic?

-If I go home and get worse can I come back for more treatment?

-If I agree to stay in hospital can I have a single room to be away from the

Instructions

Patient: Anthony Thompson, a 23-year-old male

You are a PA on the medical ward. You are asked to see the patient because he is upset and is insisting on discharging himself from hospital.

He was admitted 2 days ago with severe left loin pain and tenderness, vomiting, fever, haematuria and urinary frequency. A diagnosis of acute pyelonephritis has been made.

MSU shows a significant growth of E.coli sensitive to the intravenous antibiotic already prescribed. He has also been prescribed intravenous fluids and analgesia.

He still has a fever and has not managed to eat or drink anything yet because of persistent nausea.

He is due to have an ultrasound scan of renal tract later today. It was rebooked from yesterday because he did not have a full bladder.

Your task is to respond appropriately to the patient's complaints, ensure he understands the nature of his illness and advise him of the risks of discharging himself.

Instructions

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Feedback

Content

Clarifies the patient's current symptoms and their understanding of the illness	
Allows the patient to describe their complaints fully, empathises with them and discusses how best to resolve the issues	
Explains antibiotics and fluids needed iv as not yet eating and drinking	
Apologises and considers compromises, e.g. asking the ultrasound department to do the scan straight away, and moving the patient to a different ward	
Aware of own limitations and offers to involve to a senior colleague in the discussions if this seems appropriate	
Acknowledges patient autonomy and the fact they may decide to discharge themselves against advice which has been properly considered and given	
Ensures the best possible care for the patient out of hospital should they remain adamant about self-discharge	
Safetynetting - discusses warning signs	
Process	
Introduces self, role and checks pt's name and dob	
Picks up and responds to pt's verbal and non-verbal cues	
Elicits pt's ideas, concerns and expectations	
Recognises, acknowledges and validates pt's concerns and feelings.	
Demonstrates appropriate non-verbal behaviour eg eye contact, posture and position, facial expression, use of voice (pace, tone)	
Screens for any further questions or concerns	
Concludes consultation appropriately	

Scenario 6: Motivational interviewing

Name: Susan/Simon George **Age:** 54

Occupation: Hairdresser (salon owner). You love your job as you are a very sociable person.

Setting: GP Surgery

Clinical Details:

You were admitted to hospital 10 days ago following an episode of abdominal pain. This came on suddenly while you were drinking with friends in a pub after work. You were taken to the Accident and Emergency Department where some blood tests were done and a scan on your tummy like pregnant ladies have. At the time the doctor said there was something wrong with your liver and mentioned alcohol and fat. On discharge you were advised to see your GP for follow up and monitoring.

You have made an appointment to speak to your GP as you are worried about what this liver thing actually is.

Past medical History: You realise now that you might have experienced episodes of tummy pain a couple of times over the last few months but you always just put it down to indigestion. Other than having your appendix removed at the age of 30 you have no significant past medical history.

Medication: No regular medication. No known drug allergies

Family history: Your father died aged 48 in a road accident; your mother is in good health and lives in Essex.

Social History: You have been married three times and divorced for the last time 5 years ago. You have never wanted children.

You have never smoked. You socialise with friends/colleagues at least 3 times and week and drink between 7-10 vodkas and cokes on these occasions (sometimes more).

Lifestyle

Your eating is a little sporadic as you have such a hectic lifestyle but when at home you enjoy cooking and try to make yourself healthy and nutritious meals.

You rarely exercise as you consider that being on your feet all day is enough exercise.

Patient's Framework

Temperament: You have an outgoing personality and like nothing more than being out for the night with a good crowd of people. Much of your socialising is with the team from work who are all much younger than you and full of energy. You like to think that even though you are 'getting on a bit' you can 'keep up with the youngsters' and even show them a thing or two.

Ideas: You think that the GP may be able to help you to understand what causes this liver problem. In the back of your mind you are wondering if your hectic lifestyle is a contributing factor to your recent problem.

Concerns: You feel concerned about having something seriously wrong with your liver. It makes you sound like an alcoholic for one thing. You are really worried about what this means for your future health. Will you get pains again when you are out in the evening? If asked about how ready you are to cut down your drinking, say 6-7 – this admission has really scared you. If asked how confident you are about making changes, you are 4-5 – you know you will find it difficult. Socialising with work colleagues is an important part of your life.

Expectations: You would like to understand more about what exactly liver disease is. You would also like to be reassured that the hospital doctor was right and that this is something that can be reversed.

Instructions:

You are asked by the GP to speak to Susan/Simon George, who visited the surgery this morning to talk to the GP about their recent overnight admission to hospital, after experiencing abdominal pain during a night out with work colleagues.

On admission, blood tests showed deranged liver function. An abdominal ultrasound showed changes consistent with a fatty liver, due to alcohol-related liver disease.

Your task: Take a relevant history

Discuss lifestyle choices and any changes they may want to make.

Instructions:

You are asked by the GP to speak to Susan/Simon George, who visited the surgery this morning to talk to the GP about their recent overnight admission to hospital, after experiencing abdominal pain during a night out with work colleagues.

On admission, blood tests showed deranged liver function. An abdominal ultrasound showed changes consistent with a fatty liver, due to alcohol-related liver disease.

Your task: Take a relevant history

Discuss lifestyle choices and any changes they may want to make.

Introduction Greets patient, introduces self and role, checks patient's name, gains consent to proceed and explains purpose of interview	
Assesses patient's starting point (what the patient already knows) and sets patients agenda for discussion (what the patient wants to know)	
Consultation Skills - Process	
Elicits patients ideas, concerns and expectations and relates explanations to these	
Approaches lifestyle discussion in a patient centred way. Explores with interest and respect the patients' perspective on their current lifestyle behaviours	
Clear organised explanation e.g. small chunks in logical sequence	
Sign-posting e.g. 'there are 3 things I'd like to discuss. first.. then..	
Checks patient's understanding e.g. asks patient to paraphrase information	
Uses easily understood language and avoids or explains jargon	
Assesses patients readiness and/or confidence to change using visual aids such as change behaviour scales	
Closes the session appropriately e.g. thanks the patient and identifies next step	
Consultation Skills - Content	
Fatty liver – Changes that occur in the liver in response to regular high alcohol consumption. Reversible if alcohol consumption reduced/stopped. If no changes made, can result in permanent liver damage - cirrhosis/failure which can ultimately be fatal.	
Alcohol can also cause damage to kidneys and heart, brain, erectile dysfunction (males), problems with mood, sleep. Associated with increased risk of cancers of mouth, throat, breast	
Current recommended weekly intake 14 units. Gives practical advice about substituting/diluting with soft drinks/lower alcohol drinks, being designated driver, reducing number of nights out, alternative venues (pizza/cinema/bowling)	
Support services – AA, NHS (GP)	

Scenario 7: Sexual history

Name: Valerie Smith **DoB:** 9/4/80 **Occupation:** Travel agent

Setting: GP surgery

Clinical details:

You have noticed an increasing amount of vaginal discharge over the last 2 weeks and in the last week it has become smelly and yellow. You have also been quite itchy around the genital area and found that it stings a bit when you wee.

You divorced from your husband 5 years ago and have had a few (2 or 3) brief relationships since. Currently you are not in a relationship and haven't been for about 9 months. The last time you had sex was 2 weeks ago. It was a one-night stand with someone you met at a club. You'd had quite a lot to drink and don't think he used a condom. To be honest, you don't remember a great deal about it and regretted it immediately after.

PMH: IBS which flares up when you are stressed, which you certainly are at the moment.

DH: Mebeverine for IBS when necessary, Progesterone only pill/mini pill (POP) Cerazette – you have to admit you can sometimes be a bit forgetful.

No known allergies

FH: None that you are aware of.

SH: Non smoker. Normally you don't drink a lot, unless you go out with your friends, about every couple of weeks, when you can drink quite heavily – a couple of bottles of wine maybe, though you don't really count.

Relevant info:

LMP – 3 weeks ago. Periods usually light and regular.

You've not had anything like this previously and keep up to date with smears. Your last smear was about 3 years ago.

You don't have any children. You did have a miscarriage when you were married, but split from your husband shortly afterwards, so haven't tried again.

Ideas: You think you might have some sort of STI from the encounter 2 weeks ago.

Concerns: You are deeply ashamed. You're worried about the possibility of pregnancy – this really wouldn't be a good time – you enjoy your work and are in line for a promotion. Deep down, you are concerned that you may have something serious like HIV or herpes.

Expectations: You are hoping that that you won't be judged or reprimanded and that you don't have to contact the partner of 2 weeks ago – that would be hugely embarrassing. You are expecting to have to have some embarrassing tests and are hoping to be given some antibiotics or treatment for the infection and possibly to have a pregnancy test.

Instructions

You are in GP and about to see Valerie Smith, who has a vaginal discharge.

Your task is to take a sexual history and explain what tests will be required.

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You are in GP and about to see Valerie Smith, who has a vaginal discharge.

Your task is to take a sexual history and explain what tests will be required.

Greets patient and obtains patient's name	
Introduces self, role and nature of interview; obtains consent	
Demonstrates interest and **respect**, attends to patient's physical comfort	
Uses appropriate **opening question** (e.g. "What problems brought you to hospital today?")	
Listens attentively, allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing	
Checks and **screens** for further problems	
Encourages patient to **tell the story** of the problem(s) from when first started to the present in own words	
Uses **open and closed questions**, appropriately moving from open to closed	
Reverses the **open to close cone** appropriately	
Facilitates patient's responses verbally and non–verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation	
Picks up verbal and non–verbal **cues**	
Clarifies statements which are vague or need amplification	
Periodically **summarises** to verify own understanding of what the patient has said; invites patient to correct interpretation or provide further information.	
Uses clear, easily understood **language**, avoids jargon	
Actively **determines patient's perspective** (ideas, concerns, expectations, feelings, effects on life)	
Appropriately and sensitively **responds to and further explores patient's perspective**	
Demonstrates appropriate **non–verbal behaviour** e.g. eye contact, posture & position, movement, facial expression, use of voice	
Acknowledges patient's views and feelings; is not judgmental	
Uses **empathy** to communicate appreciation of the patient's feelings or predicament	
Provides **support**: expresses concern, understanding, willingness to help	
Progresses from one section to another using **signposting**; includes rationale for next section and **signposting difficult questions**	
Structures interview in logical **sequence**, attends to **timing**, keeps interview on task	

Content:

Symptoms/reason for attendance	
Date of LSC, partners gender, anatomic sites exposure, condom use, suspected infection, infection risk or symptoms in this partner	
Previous sexual partner details, if in last 3 months & note of total no. partners if>2	
Previous STI's	
LMP, menstrual pattern, contraceptive and cervical cytology history	
Pregnancy and gynaecological history	
Blood-borne virus risk assessment & vaccination history for those at risk	
PMH	
DH, allergies, SH	
Agree method of giving results	
Establish competency, safeguarding children/vulnerable adults	
(alcohol & recreational drug history, recognition of gender-based violence/intimate partner violence)	
Will need vaginal swab, HIV test and PT (give brief details of each)	

Scenario 8: Telephone

Instructions

You are in A&E, and have seen a 37 year old lady Sarah Wickes admitted after collapsing at work with left-sided abdominal pain.

Your task;

- Telephone on call registrar to refer the patient
- Interpret results
- Summarise the case and agree ongoing management

Station

Sarah Wickes 37 year old Female in A&E after collapsing at work with left sided abdominal pain. The patient is semi-conscious, so you are unable to gather much history.

PMH – Under the care of Bourne Hall for infertility treatment (from husband)

Acne – treated with Roaccutane 1 year ago

Migraines

DH – Hormone injections for infertility, sumatriptan, mebeverine

Allergies – none known

O/E T – 37, PR 120 reg, BP 90/50

Chest – trachea central, good expansion, percussion normal, normal breath sounds, apex beat not displaced, HS normal

Abdo soft, no organomegaly, tender LIF with guarding

AXR, urine and blood tests have been done.

You need to take appropriate immediate management and to arrange urgent admission and assessment

Hb	**115**	(130 - 170 g/L)
Hct	0.470	(0.400 - 0.500)
Plat	240	(150 – 410 x 10^9/L)
MCV	93	(83 - 101 fL)
WCC	10	(4.0 - 10.0 x10^9/L)
PT	12.7	(9.8 - 13.1s)
aPTT	26.8	(24.1 - 38.0s)
INR	1.05	

Urinary dipstick – nitrites negative, leucocytes negative, blood +++, pH 6.5
pregnancy test - positive

Your task;

- Telephone on call registrar to refer the patient

- Interpret results
- Summarise the case and agree ongoing management

RP script

You are Dr Roper, the on-call gynaecology registrar. You receive a call from a PA on A&E. If the PA gives a succinct history, has taken appropriate action (administered oxygen, iv fluids and crossmatched blood) and explains their concerns, you will accept the need to review the patient and agree to see her within the next 10 minutes.

Situation – identifies self and site calling from (A&E) Checks identity of person speaking to and that convenient to speak now.	
Identifies patient and reason for calling – because she is collapsed and in hypovolaemic shock. Concerned that patient needs urgent surgery.	
Background – Gives succinct history - admitted with abdominal pain. History of infertility treatment. AXR – good penetration, normal Hb – 115 - patient is likely to be actively bleeding PT positive – likely ectopic pregnancy *No unnecessary information.*	

Assessment – Her current observations are: Pulse: 120, BP: 90/50, Chest –clear Abdo – soft, guarding LIF Has been started on oxygen, iv fluids, crossmatch	
Recommendation – Would really appreciate if Dr Roper could review immediately. Alert On call Anaesthetist for possible urgent surgery. Patient may need blood transfusion. Is there anything else Dr Roper would like you to do in the meantime or anything required as part of their assessment?	
Decision – Checks agreed decision with timescale.	