# Voice: 'VideOing to Improve Communication through Education'

A COMMUNICATION SKILLS TRAINING INTERVENTION USING CONVERSATION ANALYSIS AND SIMULATED INTERACTION

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**Acknowledgments:**

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# SUMMARY

This manual describes the process of developing simulation training to be used in a communication skills training course. The underpinning principle is the use of conversation analysis to enhance simulated interactions. The training uses scenarios based on video data of actual interactions along with transcripts that have been closely examined. The aim is to create authentic experiential learning opportunities for people who want to improve their communication skills.

# BACKGROUND

Experiential learning has been found to be beneficial in communication skills training (CST); particularly interventions that incorporate role play with peers and/or simulated patients. Role play and simulated interaction are widely used in healthcare settings for a variety of purposes including communication training and assessment. Lane and Rollnick (2007) highlight the opportunities role play/simulated interaction gives for practicing newly acquired skills in a supportive environment, with valuable opportunities for observing others and giving and receiving feedback.

Research has shown that role play/simulated interaction is an effective way of improving trainees' confidence in communication, helping healthcare workers to empathise with patients and to be able to practice difficult interactions in a safe and supportive atmosphere.  Some examples are helping medical staff to break bad news (Colletti et al, 2001), delivering genetic counselling (Xu et al, 2016), and discussing care goals with seriously ill patients (Grudzen et al, 2017), as well as everyday interactions aimed at building therapeutic relationships between patients and healthcare staff (e.g. Kruijver et al, 2001). Role play/simulated interaction has also been used in interventions where there are difficulties in communicating with patients, including those affected by stroke (e.g. Zraick et al, 2003), psychiatric disorders (e.g. Doolen et al, 2014) and dementia (e.g. Cockbain et al, 2014).

Despite the benefits, role play and simulated interaction have been criticised, particularly when they are perceived to be inauthentic (e.g. Nestel & Tierney, 2007).  This can lead to trainees feeling embarrassed and/or behaving differently, which can impede the learning process. For example, Stokoe (2013) compared real police interviews with interviews that used role-play for assessment purposes by applying conversation analysis to the transcripts. She found that role players failed to take the interview seriously, used comedy names, and exaggerated aspects which

were part of the assessment criteria. Consequently, Stokoe (2013) expressed concerns that role play and simulated interaction are so prevalent in communication skills training in a range of occupations, including healthcare.

## USING CONVERSATION ANALYSIS IN COMMUNICATION SKILLS TRAINING

Conversation analysis (CA) is a well-established qualitative method for the analysis of social interaction and communication. It has been used in healthcare to develop successful communication skills training interventions in fields such as stroke (Beeke et al, 2007, 2014), psychosis (McCabe et al, 2002, 2008), and primary care (Heritage et al, 2007). For example, Beeke et al (2013) developed the Better Conversations with Aphasia approach to training conversation partners to communicate better with people with aphasia.  It was based on empirical work which used CA to compare the communication of videoed family members before and after training (Beeke et al 2014). From this work, Beeke et al were able to characterise the strategies needed for communicating with people with aphasia, and the training emerging from this has been found to be effective (Best et al, 2016). In another example, McCabe et al (2016) developed a training intervention based on CA analysis of outpatient consultations between psychiatrists and patients who were expressing delusional views. The aim was to improve interactions between psychiatrists and their patients, focusing on agenda setting and decision-making.

CA has also been used to improve communication skills training by using videos and transcripts of real interactions as part of the training sessions. Stokoe (2014) developed the Conversation-Analytic Role-Play Method (CARM) as a response to perceived inauthenticity in role play and simulated interaction. CARM involves trainees watching a video of an encounter but stopping it at certain points to discuss the interaction as it unfolds. Jenkins and Reuber (2014) used the CARM approach to help neurologists to distinguish between epileptic and nonepileptic seizures by identifying linguistic features in the way patients described their symptoms.

Whilst the CARM method is evidently beneficial, it could be argued that it has a degree of inauthenticity because trainees have time to consider and discuss their responses which is not available in real patient encounters. Murtagh (2015) suggests that CA could be used to identify patterns in communication in order to create authentic role play and simulated interaction scenarios. This is the approach taken in the VOICE process outlined here. In developing the intervention for use in dementia care, we have used video recordings and transcripts of actual medical encounters between healthcare professionals and people with dementia to inform

simulated interaction.  The VOICE for dementia intervention aims to improve communication between healthcare professionals and people with dementia by identifying effective practices to facilitate co-operation with everyday tasks, and to close interactions satisfactorily.

## WHAT IS UNIQUE ABOUT THE VOICE INTERVENTION?

The VOICE intervention has parallels with Stokoe's (2014) CARM method, in that trainees are shown videos and CA transcripts of real interactions to help them identify what types of communication work well.

However, what is unique about the VOICE intervention is that trainees are then able to put their learning into practice in simulated interactions which are closely based on data of real interactions. Actors playing simulated patients are trained based on scenarios. These scenarios are based on actual encounters with patients, and actors are trained to use interactional practices which have been found in the video data.

Trainees perform a task (such as transferring the simulator from bed to chair, or doing a swallow assessment) whilst the simulator responds in ways observed in the interaction of real patients, thereby adding authenticity to the encounter. The volunteer reflects on their experience before getting feedback from observers (including other trainees) and the simulator (who comes out of role to give feedback).

An important aspect of the training is to highlight what the volunteer is already doing well, before suggesting what could be done differently. The volunteer then has an opportunity to have another try, followed by further reflection and feedback.

Consequently, the VOICE intervention has the benefits of Stokoe's (2014) CARM method, in terms of using CA to study real interactions. However, it also has the benefit of simulated interaction which enables trainees to practice communication skills in real time, in a safe and supportive environment. Scenarios are based on real interactions, making simulated interaction as authentic as possible.
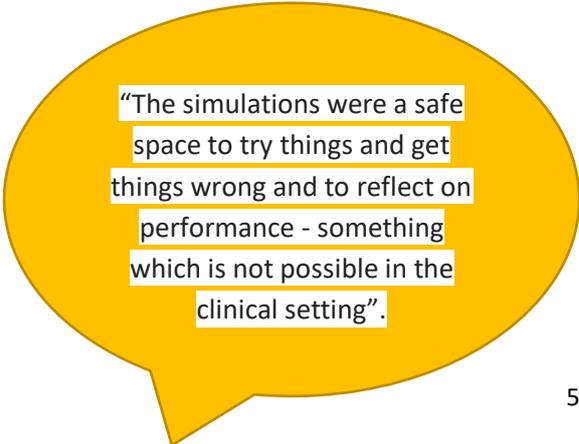
"The simulations were a safe space to try things and get things wrong and to reflect on performance - something which is not possible in the clinical setting".
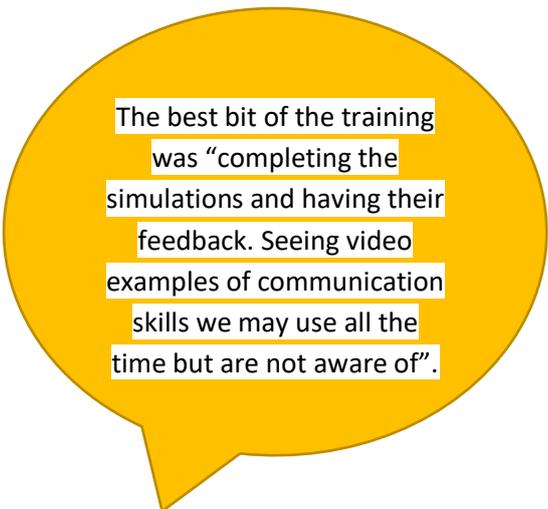
The best bit of the training was "completing the simulations and having their feedback. Seeing video examples of communication skills we may use all the time but are not aware of".

## USING CONVERSATION ANALYSIS TO ENHANCE SIMULATED INTERACTION

CA helps us to understand where healthcare professionals are using existing practices that work well, so that we can identify and disseminate these. It also helps us to be aware of where communication difficulties might happen, and identify ways of changing the way we interact to achieve desired outcomes.

Using simulated interactions gives trainees practical experience of using the successful strategies observed in film footage of actual interactions. Based on Kolb's (1984) learning cycle, it incorporates different ways of learning: 'experience (feeling); reflective observation (watching); abstract conceptualisation (thinking); and active experimentation (doing), in an ongoing process (Cottrell, 2001: 102).
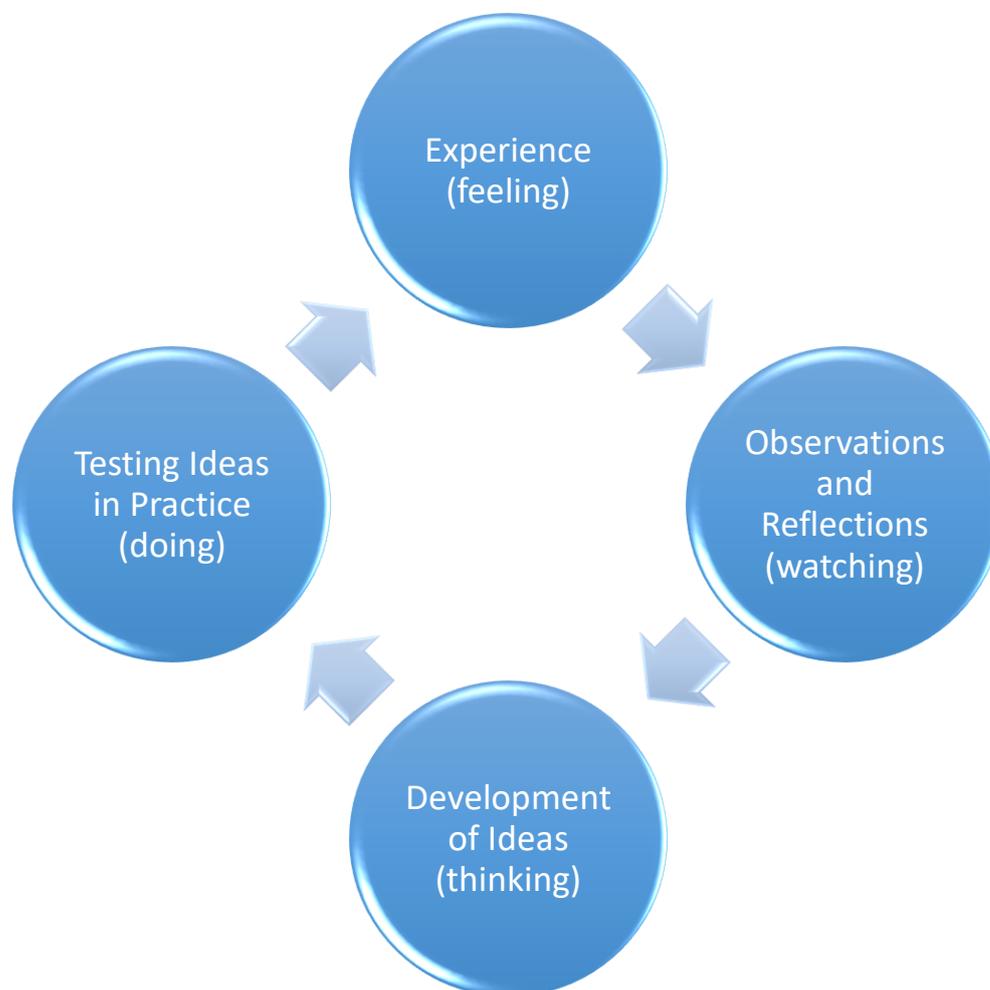
The VOICE intervention process was originally developed to help healthcare professionals (HCPs) learn effective communication strategies when interacting with people with dementia in acute settings. However, the process of developing a CA-based intervention with simulated patients could be used in any area of healthcare where there is a desire to improve communication. This manual outlines the steps in that process:

| Collecting and analysing real interaction data | |
|---|---|
| Video and transcripts | Identify trainable items |

| Developing the training | |
|---|---|
| Prepare scenarios | Train simulators |

| Training including simulated interactions | |
|---|---|
| Preparation | Feedback |
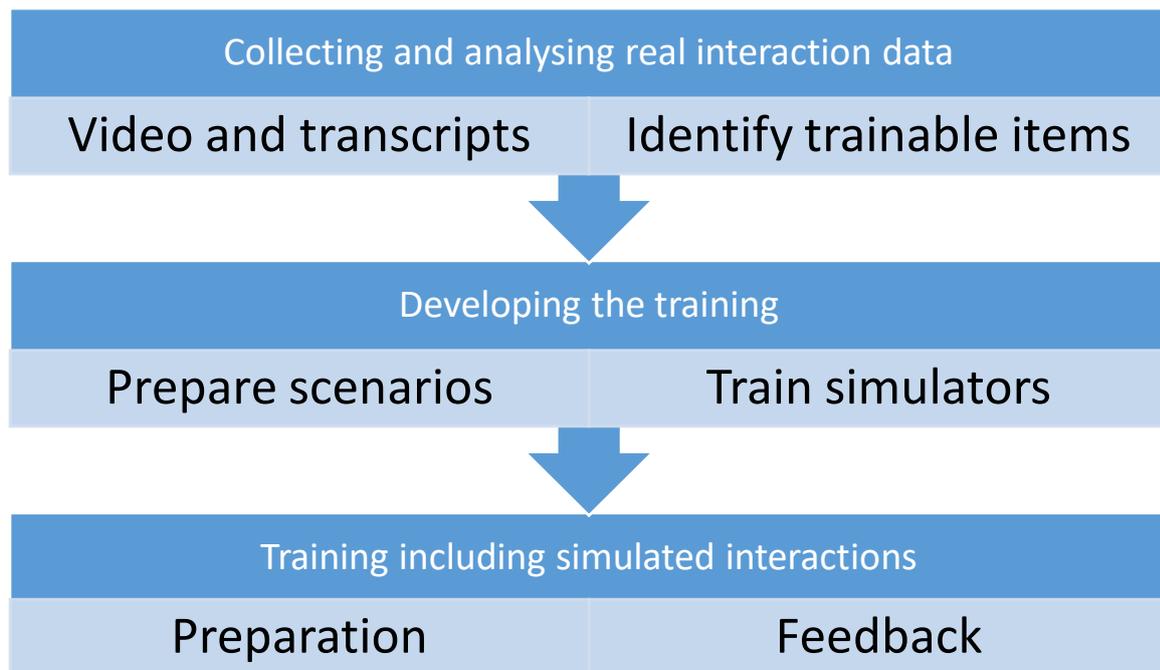
## WHAT YOU WILL NEED TO USE THIS APPROACH

In order to develop a training intervention you will need someone on your team with knowledge of CA and someone with clinical expertise.

To run the training you will need someone to deliver knowledge of CA and someone to deliver knowledge of the clinical area in which the intervention will be used

# STEP 1: COLLECTING RELEVANT DATA

This manual is designed for users who want to target communication challenges in their own services or settings. It will guide users to explore interactions between healthcare providers and patients, and use the findings to develop training to improve communication. Users will need to:

➤ Identify patients for and with whom communication is difficult or could be improved, perhaps because their condition makes it particularly difficult for HCPs, or perhaps because of contextual factors such as the location of the interaction.

This is the approach we took in the VOICE for dementia project because there is no single task that all HCPs routinely carry out. Tasks might include giving medication, taking blood pressure, supporting mealtime, washing etc.

However, this may not be relevant for your intervention

➤ Film this group of people interacting with healthcare providers (recording a range of providers means that any trainables are likely to have wider applicability).

This is the approach we took in the VOICE for dementia project because there is no single task that all HCPs routinely carry out. Tasks might include giving medication, taking blood pressure, supporting mealtime, washing etc.

However, this may not be relevant for your intervention

➢ Length or duration of interaction is less important than having data which will allow comparative analysis, e.g. repeated instances of professionals making requests.

➢ CA is a highly skilled area; in addition appropriate ethical approvals are necessary to do this work, so you may need to identify collaborators with the necessary skills in order to work in this way.

## STEP 2: DATA ANALYSIS

➢ Transcribe the videos, using CA notation to preserve the detail of *how* things were said, as well as what was said.
➢ It may be possible to pay for professional CA transcription services, as long as data confidentiality is maintained

**Example of a CA transcript from the VOICE for dementia study**

**Extract 2: 131_224**

```
158   HCP:  ↑all right then, (0.6) any↑thing
you want to ↑ask me

159        before I go?

160   PAT:  °no° can you su↑ggest anything
(0.4) that I've missed

161        ou::t?

162   HCP:  no: I ↑don't think so, (0.4)
           ↑we're (0.4) we're quite

163        happy with how things are
goi::ng, (0.4) here, (0.4) a:nd

164        (0.4) and everything seems okay
with you for no::w,
```

**(see Allwood R. et al (2017) Should I stay or should I go? How healthcare professionals close encounters with people with dementia in the acute hospital setting,** *Social Science and Medicine* **191: 212-225.***)*

➢ Watch the videos carefully, using the transcripts as an aide. Your team will need to meet regularly to do this and to decide your analytic focus. You may want to
➢
  o Look for interactional behaviours or practices that have been identified in previous literature, or phenomena that are informed by a specific aim of the training intervention
  o Categorise patterns of interaction
  o Group comments about observed behaviours and practices
  o Clarify the issues that are occurring in the interactions that cause problems, and/or the practices that seem to work well in achieving particular goals

- Look for examples of non-verbal communication: does it support the verbal communication? Or are there mixed messages that need to be addressed?

## DECIDE WHAT TO FOCUS ON

Conversation analysis can generate many findings from very small amounts of data. When doing CA to inform training, it is important to concentrate on areas likely to be useful to healthcare professionals (i.e. they address an issue that is problematic in practice) and are also likely to be teachable.

In the VOICE for dementia training our trainees featured a wide range of HCPs (e.g. doctors, nurses, physiotherapists, speech and language therapists) therefore we had to focus on aspects of interaction that were common to them all. We focused on:

**Requests –** many requests from HCPs were refused by people with dementia, **and**

**Closings** – HCPs sometimes had difficulties in leaving the patient after the task was completed.

It is important to identify successful practice. Note which types of communication are most effective in achieving successful outcomes (e.g. improving understanding, gaining co-operation for treatment, easing distress and anxiety). You will then be able to base trainable items on good practice that has been observed in the data. Where difficulties occur,

the good practice you have observed may provide alternative ways of doing things.

In the VOICE for dementia study, we found that being very clear about the task patients were being asked to participate in made co-operation more likely

## IDENTIFY TRAINABLE ITEMS

To identify trainables, you need to establish the specific communicative practices involved. This might include observing how tasks, or decisions, are framed; or how non-verbal communication can support verbal communication. *For example, if you are telling someone you are about to leave, then this could be supported with standing up, offering a handshake, clearing away etc.*

In the VOICE for dementia study our trainable items were:

> ➢ How requests are made
> ➢ How interactions are closed

When you have decided which of these you will focus on, you need to select appropriate extracts from the videos for use in training, for example scenarios where requests are made in different ways.

In the VOICE for dementia study we looked at different kinds of requests and how they were responded to. For example:

> Imperatives e.g. 'I need you to do X'.
> Collaboratively framed requests e.g. 'Shall we do X?'
> Permission seeking requests e.g. 'Can I...?'

> In order to train simulators, and to convince HCPs of the success or otherwise of alternative strategies, you will need several examples of each of these kinds of practice. We suggest a minimum of 3.
> You also need to ensure that you preserve the sequential nature of the areas you identify as trainables, so for example the video clips need to show both a request being made and how it is responded to.
> Clips need to be reasonably short for use in training, so longer sequences may need to be divided up. For example if a request is made 3 times in different ways before it is accepted, then you might choose to show this as 3 shorter clips rather than one long one.

## STEP 3: DEVELOPING THE TRAINING

### BEFORE YOU START:

> It is crucial that you are clear about what you want the learning outcomes to be. What are the issues in communication that you are seeking to address through this course?

> Identify how many simulations you can fit into the training and how many simulators you can train and have available for training sessions. This will be based on the number of days and time available for training, and number of trainees on the course.

> ➢ You will need an experienced simulator to help you train the other simulators, so it may be helpful to work with a local simulation unit or to make sure there is someone with experience of working with simulators on your team.

In the VOICE for dementia intervention we found it extremely beneficial to run the training over 2 days, separated by 1 month. The advantages of this model include the opportunity to increase the difficulty of the simulated scenarios for the second day, as an alternative to teaching a second skill. In our case, we were able to increase the level of communication impairment of the patient in scenarios.

We used 2 simulators for each workshop, as we had 8-10 participants on each course.

## FACILITATORS

There should be (a minimum of) two facilitators to run the training. At least one of them should have knowledge of CA and one should have experience of working with simulators. All facilitators should have experience of healthcare education. It is important to have experienced facilitators to provide a safe learning environment.

The expertise of the facilitator is necessary to be able to manage groups effectively. For instance, if people become upset, or if something goes

wrong, to decide whether to take a time out.



It is good practice to allow trainees or facilitators to ask for a 'time out' at any time in the simulated interaction. The simulation is suspended to allow discussion of what has taken place. For example - the trainee may want suggestions for how to do something differently if things are not going smoothly.

Time out

Facilitators need to be able to deal with elements of feedback from the observers or simulators which might be perceived as negative. Also, they should be able to manage feedback in such a way that it becomes a learning event.

## PREPARING THE SCENARIOS

Scenarios provide full information about the (simulated) patient. Creating them is a lengthy process but it is crucial to pay attention to the details in order for the simulations to be as authentic as possible. The aim of the simulation is for trainees to try out the trainable behaviours, in real time. Therefore, you will need to make sure that the scenarios are going to provide an opportunity for trainees to demonstrate the skills that they have been learning.

➢ Develop each of the scenarios based on a real person from the video data so that the simulator can watch and learn the role.

➢ Although scenarios are closely based on real patients from the data, ensure that details are changed to safeguard anonymity and privacy.

> Scenarios contain clinical information such as the patient's underlying medical conditions and reason for admittance to hospital (if relevant).

Ensure a clinical expert reviews the scenarios for accuracy and plausibility before finalising them.

There are 2 levels of scenarios:

**Level 1. For the trainees.** This will have the details of the patient's background and clinical information.

- o Give the patient a pseudonym and a fabricated social background information for the patient (marital status, previous occupation etc.) to avoid them being identifiable.
- o Clinical information such as the reason for admittance to hospital and any pre-existing health conditions and medications.

**An Example of a level 1 scenario for Trainees is contained in the Appendix.**

**Level 2. For the simulators.** This scenario will contain full details of the patient including the information above. In addition there will be guidelines to help them within the simulated interaction such as:

- o Relevant information about the patient's manner of speaking (for example s/he talks quickly/quietly, smiles a lot, echoes what the HCP says).
- o Suggested responses. For example, possible ways in which the patient has responded to the question 'how are you?'
- o Important information for the simulator about any communicative impairment that exists. *In the case of the dementia study we also included information about the patients' retained abilities.*

It is absolutely core that scenarios are based on the original video data if the aim is for increased authenticity. It is also easier for simulators to base their character on someone they can really watch, than on someone who has been made up. This also means that simulators can be trained to

use actual interactional practices that occurred in real life (e.g. repeated refusal) rather than doing what they think a person with dementia might do.

**An example of a level 2 scenario for simulators is contained in the Appendix.**

Using the video to train the simulators means:

- Simulators can respond in real time in ways that they have observed in the videos.
- They can use key phrases utilised by the real patient.
- They can use specific responses made by patients in the videos to inform their performance of the role.

> 'Most importantly for the purposes of the marriage of conversation analysis and simulation, it is essential to identify the patient's <u>manner</u> of speaking. For example, 'this person is calling out a lot and there's a lot of "hh hh" and a bit of swearing as well' (Megan Murray, simulator coach for the VOICE for dementia study)

Examples of interactional practices can be drawn from more than one video of the same patient.  For example, one video might provide useful interactional detail in relation to requests, while another might provide material for closings. The important thing is that they are all based on interaction that actually occurred in the data.

## TRAINING OF SIMULATED PATIENTS

It will take at least one full day to train the simulated patients.

Simulators are actors who are trained to 'provide realistic presentations of patients with specified conditions to allow students to experience the real sense of treating a patient' (Wong et al, 2008:513)

You will need an experienced simulator or simulator trainer to bridge the gap between simulators and clinicians, who will:

- ➢ Be involved with developing the scenarios with an awareness of what it is possible for simulators to do.
- ➢ Have an awareness of the educational purpose of the scenarios.
- ➢ Observe and feedback on the simulators' performances.
- ➢ Ensure that the simulators do not stray too far away from the character developed in the scenario, offering where necessary to go back to the original film footage as a reminder.

The trainer should identify experienced simulators who fit the profile for the role. *For example, to have a 20 year-old simulator portraying someone who was supposed to be 70 would not have face validity.*

Simulators will need to be experienced in advanced level simulation, and skilful. Not only do they need to stay in character during the simulation, but the role requires them to listen out for trainable items during the simulation, to ensure that the learning takes place.

For example in the VOICE for dementia project we were training HCPs to deal with situations where patients refused to co-operate with a request (e.g taking a sip of water). It was therefore important that the simulator refused initial requests to ensure that volunteer had the chance to try out the learning. For instance the simulator may decide: 'Okay, they are making a request here; I have already refused it twice, I have given them the opportunity to demonstrate the trainables, so at this point I can agree to it.'

Simulators should be experienced in being able to come out of role to give feedback, then return to role for the trainee to have another practice if necessary.

Simulators would generally learn at least two scenarios to ensure HCPs have the chance to practice a range of skills.

## PRIOR TO THE TRAINING DAY FOR SIMULATORS

Send a copy of the full (level 2) scenarios to the simulators so that they can familiarise themselves with the patient(s) they are portraying before they come to the training day.

Also, send information about the health condition that the simulator will be representing. For example, links to charity organisations that provide information and support to patients and their families about a particular condition. The aim is for all simulators to bring a shared understanding of the health condition to the training day.

A relevant HCP should be present to talk about the health condition including how it might manifest itself in terms of patient behaviour.

It is very helpful for simulators to have a Q & A session with the HCP about the condition they are depicting, including symptoms and care.

> In the VOICE for dementia intervention, we wanted to talk about the context in which people find themselves in a hospital setting. We showed the film '*This is Monday*' https://vimeo.com/93365033 made as part of a previous project and depicting a typical day on a ward where dementia patients are treated. We also asked the simulators to complete some reusable learning objects on dementia.
>
> http://sonet.nottingham.ac.uk/rlos/mentalhealth/dementia_hospital/
> http://sonet.nottingham.ac.uk/rlos/mentalhealth/dementia_care/
>
> http://sonet.nottingham.ac.uk/rlos/mentalhealth/communication/

➢ Simulators should watch the video footage of all of the interactions of the individual patients on which the scenarios are broadly based.

This will provide a sense of a patient's demeanour, behaviour, mannerisms, the way they talk (e.g. quietly, hesitantly), the way they dress, etc.

➢ At the same time go through the transcripts of the interactions

Explain to the simulators how the talk has been analysed using CA. This gives the simulators an understanding of where the trainable behaviours have come from and the purpose of the training.

> Most of the day should be dedicated to the familiarisation process:
> - A chance to ask questions about the scenarios
> - Opportunities to have a go (a member of the project team can enable that practice by acting as a trainee)
> - Other simulators can watch and pick up tips from each other

## ALLOW TIME BETWEEN SIMULATOR TRAINING DAY AND THE TRAINING COURSE

Aim to allow about 1 week between the simulator training and the first day of the training course.

It is important for the simulators to have time to process what happened in the training. However, the training should not be too far away from the course start date.

During this time, simulators should have the opportunity to ask any questions that they might have.

Don't forget that simulators are real people as well and it can be difficult and challenging to portray a patient with communication difficulties. Make sure that simulators are fully supported and able to ask questions and give thoughts after reflecting on the simulated interactions.

Make the original video data available to any simulators who want to remind themselves of the characteristics of the patient they are portraying.

# PREPARING THE SIMULATION WORKSHOPS FOR HEALTH CARE PROFESSIONALS

You will need to have sufficient space to do the simulations. Simulations workshops are best in groups of no more than 5 learners, therefore a course for 10 people will require 2 simulators. Separate rooms will be

required for each simulation, plus a room to bring all participants together in for discussion. For HCPs, simulations are best done in clinical training rooms to increase authenticity.

## PREPARING SIMULATION TASKS

In order to support a learner-centred approach, and give the trainee some control over their simulation, the trainee could be given, for example, a choice of task to carry out with the patient. However, this needs to be appropriate within the context of your own training.

You will therefore need to provide a written list of the typical types of tasks which involve interactions between your targeted patients and healthcare providers.

Tasks need to be credible and:

➢ Able to be done with a very limited amount of equipment;

➢ Do-able in a short time frame

➢ The list should reflect the types of interactions within which your trainables will occur, and which would be performed realistically by the type of healthcare providers you are training.

In the VOICE for dementia intervention, examples of possible tasks were:

Transferring a patient from a bed to a chair

Getting a patient to have a drink or something to eat

Listening to a patient's chest

Washing a patient's face (or helping them to wash it)

Asking a patient to carry out an appropriate physical activity (e.g. standing, walking).

Trainees should be allowed to select a task for themselves, choosing one that they would normally perform in their everyday role in that setting.

## PROPS AND EQUIPMENT

You will need to have appropriate equipment for your setting such as beds, patient chairs, tables etc. You will also need a list of the props that will be required for the tasks you chose. These would also include some of the normal objects that HCPs in the specific setting would have access to. *For example, a stethoscope, a glass of water, a blanket.*

If you are asking a trainee to do something that is routine or important in that setting then you have to give them the tools to do it with.

*For example if the task is to help the patient with face washing they need a bowl and a facecloth.*

Trainees need to be advised that if something is not in the room, they should not mime it. *For example, if there are no tea-making facilities, a HCP should not pretend to make a cup of tea.*

These are important points in terms of credibility. The only person in the room who should be 'acting' is the simulator. The trainee should be behaving as they would do normally.

## SIMULATION WORKSHOPS FOR HCPS

### TRAINING DAY 1

Prior to running the simulation sections of the workshops, you need to have taught the trainees the communication skills they will be practicing. This is an experiential learning process, based on Kolb's (1984) learning cycle (see page 6) whereby trainees learn through a process of doing, reflecting, and observing.

In the VOICE for dementia intervention, we began by showing the trainees examples of requests and refusals, using our video data to demonstrate examples of more and less successful ways of making requests, and our CA analysis to explain why some were more or less successful. They then had an opportunity to practice these in the simulation.

## PREPARATION FOR SIMULATION

- ➢ Trainees are divided into small groups of roughly equal size, with one group per simulation/ scenario and one facilitator per group.
- ➢ Small group plus facilitator goes into the room
- ➢ Facilitator introduces the simulation; how the simulation is done. For example: trial and error learning; safe environment; the opportunity to rewind, take time out, or repeat; principles for giving feedback to each other.
- ➢ Groups read scenario on paper – patient's name, reason or being in hospital, background information
- ➢ One volunteer at time picks a task from the task list
- ➢ Feedback sheets are given to the observers

## SIMULATION TASK

- ➢ One volunteer performs the simulated interaction
- ➢ The aim is to incorporate the learned behaviours from the previous teaching.
- ➢ Training simulations need to give the volunteer sufficient opportunity to practice the trainable behaviours, for example refusing a request several times.
- ➢ The other trainees observe the interaction. Being able to observe and identify communication practices in others is an important part of learning, whether seeing it done well or not. This is the 'watching' aspect of Kolb's learning cycle. The observer can then try it for themselves.

'The learner can enhance their own learning of communication skills by critically evaluating the performance of others' (Lane & Rollnick, 2007:14)

➢ You might like to give each observer a specific trainable to look out for and feed back on. This reduces the load for each of them, helping them focus on a specific area each time. Providing feedback sheets can focus the observer on specific areas (see feedback sheets from the VOICE for dementia study in the Appendix)

➢ These roles should be swapped round until everyone has had a turn. The facilitator should be able to give feedback on all relevant areas, so that they can pick up on things that the trainees have missed in their feedback.

➢ The person doing the task can ask for 'time out' at any time, to ask advice from the observers.

> For example, in the VOICE for dementia training, the simulator reacted defensively when a volunteer (who was a speech and language therapist) felt her throat to check her swallowing. The volunteer asked for time out to seek advice from the observers. Following discussion, she had another attempt but this time provided a running commentary. This was much more successful and the volunteer reflected that she would use this approach in future (in her everyday practice).

➢ The simulator suspends interaction whilst the 'time out' discussion takes place.

➢ If there are two simulators, then groups should swap scenarios at a halfway point. This gives the trainees an opportunity to experience/observe a different simulated interaction

## TIMING

Allow about 30 minutes per trainee to:

- Perform the simulation task incorporating the learned behaviours;

- Discuss how it went;
- Allow sufficient time for the feedback discussion
- Ideally, have another try based on the feedback. This might not require the whole task to be repeated, just one specific part.

Sufficient time must be allocated to allow all trainees to carry out at least one simulation

## FEEDBACK

Effective feedback is crucial to the learning process

Pendleton's (1984) model of giving feedback is a useful guide:

Volunteer acknowledges what went well

What went well is reinforced by the facilitator

Succesful use of skills discussed

Volunteer reflects on what could be done better and how

Faciliator and observers suggest how it could be done better

Volunteer has another try, based on the feedback

"The simulation part was really helpful. Being able to stop and replay was particularly good and getting feedback and watching others".

This model identifies feedback on what goes well and what trainees could do better.

Trainees may be unaware of what they are doing which works – having this awareness helps them to bring it into their everyday practice. It also enables them to explain to other people what they are doing that makes a difference.

> ➢ After the task is over, the facilitator asks everyone to silently reflect for a short while on what just happened
> ➢ The facilitator then asks the volunteer how they feel it went, before seeking feedback from the observers and the simulated patient.
> ➢ Observers give feedback on specific points that they have been asked to look for, stating what went well first, then areas that could be improved on.
> ➢ Facilitator summarises the good practice used in the simulation and suggests some ideas for how they might improve.
> ➢ They should pick up on things that happened in the practice ('let's explore what you did there') to demonstrate the learning that has taken place.
> ➢ It is also important to highlight the good practice that the trainee already does well as a matter of course.

If someone is asked to 'do more of something they are already doing well, you are more likely to see behaviour change and success than if you only point out what they are doing poorly' (Grudzen et al, 2016:220).

## FEEDBACK FROM THE SIMULATOR

Feedback has to be:

- Specific (about framing the question in a specific way for the simulator)
- Based on evidence (e.g. 'when you did that it made me feel…').

> The key point is: make sure the simulators are fully conversant with the trainables and that they understand that their feedback should not contradict the training!

The simulator is also in a unique position to feedback on issues such as establishing rapport and empathy. For example, they might say 'the closing felt a bit rushed', or 'when you held my hand it felt very reassuring'.

## AFTER FEEDBACK

Ideally the trainee will have chance to have a practice again in light of the feedback that they have received.

They should then be an opportunity for everyone (particularly the trainee who has tried the simulation) to give feedback on the repeated task.

After this, the process is repeated with another trainee performing a different task

## DEBRIEF AND ACTION PLANNING

Bring the whole group back together in the training room to discuss:

- What went well?
- What would you differently?

Following the course, the facilitators and simulators need to reflect as a group on what went well and what could be improved. These changes can then feed into the next training day.

Training day 2 is run in the same way as Training Day 1, but offers participants the chance to reflect on whether and how they have been able to put the trainables into practice in their roles. They can be asked to keep a reflective diary which can help identify both internal and external barriers and facilitators. Time at the beginning of day 2 should be set aside to discuss these.

The degree of difficulty of the simulation can be increased on day 2, or participants can practice another trainable.

We recommend a 4 week gap between training days 1 and 2.

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# APPENDIX: TRAINING SCENARIOS

Level 1 Scenario for Trainees from VOICE for dementia:

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NAME OF PATIENT:  MAUREEN TOMPKINSON
    AGE: 70
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**Clinical information**

**Reason for hospital admission:**
Maureen slipped on wet floor tiles in her kitchen and fell. She twisted her ankle and badly bruised her left knee, thigh and elbow.  A neighbour found her on the floor and called an ambulance. A chest infection was discovered at the hospital. She is still ill, but is recovering and is able to sit up.

**Previous Medical History:**
Fit and healthy.

**Medication:**
On antibiotics for chest infection.

**Social History:**

Maureen is a widow and was living alone in her own home at the time of admission. She is a retired head teacher. She seems to have quite a few friends who visit, but no family visitors.

**Dementia symptoms:**
Maureen has not been formally diagnosed with dementia, but she has become increasingly forgetful over the past 2 years. Her neighbours have noticed this.

**Communicative ability:**
Maureen's increasing forgetfulness is reflected in her ability to communicate. She struggles to find the right word, doesn't finish sentences and repeats herself, e.g. repeatedly asking for a cup of tea. However, it's possible to hold a conversation with her.

**Retained abilities**
Maureen is able to care for herself with prompting. She can eat and drink independently, but forgets and sometimes chooses not to. (She has been off her food recently.) She can walk, but while she's in hospital she doesn't see the need to get up and move around and so she is becoming more immobile.

Level 2 Scenario for Simulators from Voice for Dementia

**VOICE PROJECT: TRAINING SCENARIO DAY 1**

Name of Patient:     Maureen Tompkinson                              Age:  70

| Patient Information |
| --- |

**Social background 'lifeworld'**
Maureen is a retired head teacher. She lives alone in her own home with her cat. Her husband died 20 years ago, she doesn't have any children and her only relative is a brother who's in a care home. However, she has a good network of neighbours and is supported by people from the church. Up until 2 years ago she was very active. She was a stalwart of the church choir and enjoyed gardening and embroidery.

**Insights into character and behaviour**
Up until 2 years ago, Maureen was resolutely independent - she had managed fine since the death of her husband and considered herself a 'coper'. However, she has become increasingly unable to cope in the past 2 years and this has led to her feeling isolated, anxious and impatient with herself. She is also in denial at what's happening to her as she's always seen herself as being capable and autonomous. This is reflected in her behaviour and she is likely to apologise when she sees herself as being weak and state that she's 'not a moaner'.

**Appearance/demeanour:**
Maureen looks frail. She is wearing a clean nightdress and cardigan. She doesn't smile. She is mostly still and winces at the pain she's experiencing.

| Clinical information |
| --- |

**Reason for hospital admission:**
Maureen slipped on wet floor tiles in her kitchen and fell. She twisted her ankle and badly bruised her left knee, thigh and elbow.  A neighbour found her on the floor and called an ambulance. A chest infection was discovered at the hospital. She is still ill, but is recovering and is able to sit up.

**Dementia symptoms:**
Maureen has not been formally diagnosed with dementia, but she has become increasingly forgetful over the past 2 years. Her neighbours have noticed this.

**Communicative ability:**
Maureen's increasing forgetfulness is reflected in her ability to communicate. She struggles to find the right word, doesn't finish sentences and repeats herself, e.g. repeatedly asking for a cup of tea. However, it's possible to hold a conversation with her.

**Retained abilities**

Maureen is able to care for herself with prompting. She can eat and drink independently, but forgets and sometimes chooses not to. (She has been off her food recently.) She can walk, but while she's in hospital she doesn't see the need to get up and move around and so she is becoming more immobile.

**Previous Medical History:**

Fit and healthy.

**Medication:**

On antibiotics for chest infection.

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**Information for Simulator**

Your name is Maureen. You were born in 1945. You Dad's name was Arthur. You live in your home. It has a garden. You have a cat. You are in hospital. Sometimes you know where you are and sometimes you don't ("I'm not in hospital am I?). You remember you fell at home. Your left side is painful - left ankle, knee, thigh, bottom and elbow. You don't like being in hospital; it's cold. You don't like being ill and being looked after. You are used to looking after yourself. You don't want to get out of bed because it hurts and the hospital is cold. You can't remember what medication you're on. You can't remember what you've had for breakfast. You like tea.

Generally, you can follow what people are saying to you unless the information is long-winded or complex. You struggle to find some words.

**Your manner of speaking**

- **You mostly answer in short sentences due to your pain**
  "yeah", "I know that", "I don't know, leg goes"
- **You sometimes use longer sentences - mostly to show frustration with your situation**
  "I'm cross with me'self, because I don't like not being well."
  "I don't like thinking..., that I'm under the power of a doctor, cos I don't go to the doctors."
  "Don't take any notice of me. No point in moaning is there."
- **Some of your sentences are fragmented/unfinished - these seem to convey conflict**
  "Err...I don't have any problems, but don't talk about them..."
  "It hurts and it's very painful and I don't know sometimes...never been able to..."
- **You mumble about your health situation (externalised, but said quietly)**
  "Not depressed no", "It hurts", "I just hurt"
- **You struggle to find some words, e.g. hospital**
  "We're at umm..it's the... where the doctors are."

**Your responses to Health Care Professionals (HCPs)**

**In response to HCP asking "How are you?"** (depends on rapport from HCP)

(Hello Maureen. How are you?) "All right thank you."

(Morning Maureen. How are you today?) "I don't know."

"Can I have a cup of tea please?"

**In response to HCP informing/talking about your condition**

"I know that.", "I know that, but..."

**In response to HCP requests**

"Yeah", "I'll try."

"No", "I've had enough.", "I don't want to." "I can't" (Response to level of discomfort action entails)

"I haven't got to go outside have I?"

"Can I have a cup of tea please?"

**In response to trying to comply with request**

"I'm ever so sorry."

"Sorry, I'm not any help."

"...but I'm a trier"

"and I'm not a moaner."

**In response to encouragement from HCP**

**"**Oh, I'm not going to pop off the perch then."

"I'm never gonna be right."

"I think I've gone mental in the head."

"I don't know, I can't remember things."

**In response to HCP closing the conversation**

"What can I do now?"

"What happens now?"

**Unconnected utterances - things said with no connection to conversation**

"Maisie's the one you want to try."