Reflection on practice: consultation skills

Lee McLeish and Austyn Snowden

Abstract
The aim of this case study is to illustrate how prescribing decisions can be enhanced through the use of systematic consultation, reflection on practice and relevant information seeking. The enhanced Calgary-Cambridge model was used to structure the consultation. Reflection on practice was achieved using Gibbs’ model. The case study involved a 74-year-old gentleman admitted to a UK-based intensive therapy unit for high flow nasal oxygen, invasive monitoring and further management of an ongoing pneumonia and sepsis that were not improving, despite intravenous antibiotics on the ward. Treatment decisions throughout are backed by guidelines and evidence, and the power of reflection on practice is considered in relation to growing competence as a prescriber.

Key words: Consultation, reflection, guidelines, pain, pain ladder, antibiotics, melatonin

Consultation is a private interaction between health professionals and a patient (Kaufman, 2008). As a non-medical prescriber, it is essential that consultation skills are effective to establish a good relationship with the patient (Hemingsway and Snowden, 2012). Using a model to carry out consultation provides structure and gives direction, without which key information may be overlooked. In this case study, the enhanced Calgary-Cambridge model (Kurtz et al, 2003) was used to structure the consultation (Figure 1). Reflection on practice is also an essential part of practice (Haynes et al, 2008). The best methods of reflection consist of models designed to systematically analyse practice with the aim of improving skills and practice (Phillips et al, 2014). This reflection used Gibbs’ model (Gibbs, 1988) to construct a systemic and detailed examination of the case study: Pseudonyms are used throughout to protect patient confidentiality (Nursing and Midwifery Council (NMC), 2008).

Case study
Patient
Ian Mason, 74

Presenting history
Mr Mason was admitted to hospital with a history of flu-like symptoms—increasing shortness of breath, cough and fever. He was in hospital for 7 days before being admitted to the intensive therapy unit (ITU) for high-flow nasal oxygen (HFNO) for unresolved ongoing pneumonia.

Past medical history
Mr Mason had a 10-day ITU admission abroad 8 months previously with pneumonia. He had a laparotomy and right hemicolectomy in 2014. He was recently diagnosed chronic obstructive pulmonary disease (COPD).

Family history
The patient’s mother died of bowel cancer, and his father died of old age. Mr Mason’s two daughters are alive and well.

Drug/dose/frequency
- Omeprazole 20 mg oral, once daily (OD)
- Tazocin 4.5 g iv, 3 times daily (TID) since admission
- Enoxaparin 40 mg subcutaneous, OD since admission
- Hydrocortisone 100 mg oral, 4 times daily (QID) for 2 days prior to admission
- Osevalamiv 75 mg oral, twice daily (BD) since admission
- Clarithromycin 500 mg oral, BD since admission
- Paracetamol 1 g oral, 4-6 hourly as required (PRN)

Drug history
Allergic to ibuprofen.

Social history
Mr Mason lives with his wife and is normally independent. He is an ex-smoker. He had a good exercise tolerance until 1 year ago when was diagnosed with COPD. He is a retired banker.

On examination/assessment
Mr Mason looks tired, and although short of breath, his breathing is not laboured. He states he has not slept in days.

Heart rate: 110 beats per minute
Blood pressure: 90/40 (normal 130/60)
Temperature: 37.6°C
Respiratory rate: 28–34 breaths per minute
Oxygen saturations: 92–98% on HFNO (100%)
Urine output: 20–30 ml/hour.

Airway
His airway is patent, with no stridor or wheeze.

Breathing
The patient can talk in sentences, but slower than normal and breathless after short periods of time. His breathing feels easier when sitting upright. His respiratory rate is elevated and is coughing, but nil expectorated.

Chest auscultation: decreased air entry to bases and decreased bilateral chest expansion.

Circulation
He is warm and well perfused. Slightly tachycardic at 120 beats per minute. Mr Mason’s blood pressure is low (90/40 mmHg) and urine output borderline. He feels thirsty, tongue dry. He has an arterial line for regular blood sampling and accurate blood pressure monitoring.

Disability
GCS 15 [AQ1: Please write in full]. Mr Mason reports chest pain when coughing. He has generalised aches and pains all over his body with coughing and is unable to get comfortable.

Exposure
Mr Mason had an infection screen and his blood checked prior to admission. The white blood cell count (WCC) was raised at 16 (normal 4–11); C-reactive protein was high: 176 (normal 0–10). Recent CT scan shows extensive bilateral consolidation. CXR [AQ2: Please write in full]—limited improvement from admission. Observation chart reveals very poor sleep pattern since admission. Acute kidney injury resolved and other blood results were improving.

Clinical summary/working diagnosis
Mr Mason is a gentleman with an unresolved pneumonia despite intravenous antibiotics and oxygen therapy in the room.

Figure 1. Refined Calgary-Cambridge model (Kurtz et al, 2003)
ward. No positive bacteriology has been confirmed so far. He is at risk of requiring invasive ventilation if no improvement with HFNO. Mr Mason is clinically dry with low blood pressure and borderline urine output. Pain and lack of sleep is his other main issues.

Treatment management plan
- HFNO 100% flow 35 ppm – reduce as able according to oxygen saturations
- A line (already in situ) close monitoring of arterial blood gases, hourly observations and regular chest physiotherapy
- Analgesia for pain, using the World Health Organization (WHO) analgesic pain ladder (Figure 2) and NHS borders [AQ3: Please provide reference for both] acute pain management guidelines
- Paracetamol 1g changed from PRN to four times a day
- Tazocin were discontinued

The consultation

Description
I was asked to assess Mr Mason, a 74-year-old gentleman who had been admitted to the ITU for HFNO, invasive ventilation, and further management of an ongoing pneumonia and sepsis, which were not improving despite intravenous antibiotics on the ward. I prepared for the consultation by reading his hospital case notes and treatment he had received on the ward. I initiated the session by introducing myself, explained my role and introduced the consultant anaesthetist and my DMP (AQ4: Please write in full) who was present to assess my consultation skills. I gained consent from Mr Mason for the consultation, ensured he was comfortable and asked what he would like me to call him. Mr Mason requested that I called him ‘Ian’ during the consultation. I chose a time for the consultation when the unit was less busy so that there was more privacy and he could hear me clearly without distraction. I also made sure that I was speaking to Ian face-to-face so that he did not feel uncomfortable or intimidated (Baghaian and Smith, 2013).

I began by asking Ian information by asking Ian to clarify the sequence of events and the symptoms that brought him into hospital a few days ago and to ask him to talk at his own pace and in his own words without interruption. Silverston (2013) agrees that this is the most effective way of conducting a patient consultation as people often say everything that is relevant in a short space of time if allowed to speak without becoming distracted. Ian replied in short answers, and appeared tired and anxious and in pain at times.

Ian was able to clarify that the only medication he normally took was omeprazole 10mg daily, for acid reflux, but was under investigation for underlying emphysema because he had been breathless in recent months. He stated that he had an ibuprofen allergy and had a multivitamin tablet once a day. I summarised all the information that Ian gave me and in particular went over his current symptoms of shortness of breath, pain, extreme fatigue and thirst.

I explained to Ian that I would conduct a physical examination. I obtained his consent, spoke to him throughout the examination, explaining what I was doing and sharing my thoughts with him. After considering the history, clinical findings, radiology results and blood results, I explained to Ian that I thought he had an ongoing community-acquired pneumonia—the medical term for a chest infection. He appeared worried about this, but there were no positive blood tests and urine results. I explained that it was important to know what was not working and he was improving despite intravenous antibiotics. Ian was able to give information that I could use to help him sleep as he was exhausted and had not slept in days. I emphasised and told Ian that I would start him on melatonin 2mg, at night. Melatonin is a relatively new drug being prescribed for its effect accordingly. Paracetamol is an analgesic used for the treatment of mild-to-moderate pain and the WHO analgesic pain ladder (WHO, 1986) (Figure 2), I explained that I would commence him on regular paracetamol for pain associated with his breathing and abdominal discomfort which would be reviewed for its effect accordingly. Paracetamol is an analgesic used for the treatment of mild-to-moderate pain and pyrexia (Joint Formulary Committee, 2017 [AQ5: Please supply reference]). It is the first choice of non- opioid analgesic in the local guidelines for acute pain management.

I had also considered prescribing a nonsteroidal anti-inflammatory drug (NSAID), but remembered from my training as a nurse that ibuprofen is a drug that I would have normally prescribed. My DMP and I also discussed the use of melatonin, why it is for specialist use in ITU only to prevent delirium, and how its effects are being monitored.

Conclusion
The enhanced Calgary-Cambridge model was clear, simple and provided direction to the consultation. The consultation experience has highlighted the importance of treating the patient as an individual, and care needed when taking a medical history to aid my prescribing decisions to help reduce medication errors.

Further recommendations
I have accessed and read the 5-minute consultation on melatonin (McAree, 2017) for further information on this drug’s use in ITU and I will apply the Calgary-Cambridge model in future consultations to further enhance my consultation skills.

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