Facilitating Client Centred Learning
Webcast Launch: October 24th, 2012
Questions and Answers

Question:
I tuned in to the webcast and was surprised that very basic communication skills and caring, listening, and patient-focused exchanges had to be so structured. Have we forgotten how to communicate and observe in a patient-centred scenario? Perhaps we should be examining our own motivations in choosing nursing as a profession and looking at how we approach daily interactions with those we have dedicated our time, skills and energies to serve. Is this "new" approach to assessing patient understanding only reframing what used to be a very basic and empathetic response to sharing useful information? (Wondering if I have been in nursing too long?)

Answer:
You bring up several points that were discussed with the panel: 1) putting a structure on basic communication, skills and caring; and 2) motivation regarding choosing nursing. We put a structure around learning so it becomes intentional. Intentional education has associated positive outcomes. The structure of an intentional approach also helps students, novice and experienced nurses to provide facilitation of learning consistently to all clients. Although we as health professionals feel we are good at facilitating client centred learning (FCCL), the literature indicates we are good at providing the information, or demonstrating the skill. We are not as good at checking for understanding and ensuring clients are partners in their care in all instances. Providing a framework reaffirms the actions of health-care professionals, and helps each professional to objectively reflect upon their own facilitation of client centred learning and identify gaps in their practice that they wish to work on or improve. We agree that an empathetic response is crucial, and the model reinforces this essential part of care. This is why reflective practice is so important in our growth as nurses.

Comment:
I have the privilege of being a midwife and having the time to work with and educate my clients, as I am able to visit them in their homes, and schedule my day accordingly. I find that clients discharged from hospital often feel confused about their discharge instructions, and what follow-up is required. The RN in hospital has many clients, and little teaching time, and if these women were not discharged back to midwifery care, they would be left floundering in the community. Our hospital has taken steps to ameliorate this, but the system is not perfect. It behooves RNs, under these guidelines, to prepare patient teaching on their own time in order to be the best teachers they can be. I don't see how hospital RNs can possibly find more time in their lives, and this model does not make it short and sweet for the busy RN.

Response:
In the current health-care climate, where clients are kept in the community or returned sooner and sicker from acute care institutions, consistency and valuable time for teaching can be optimized by creating a learning plan with the client, checking for understanding, and communicating the plan.

Using "checking for understanding" effectively has been shown to improve clients' ability to take their medication appropriately, leading to reduced medication error, related morbidities, and reduced hospital readmissions, among other things. Although the issue of time has not been widely researched to date, one study did examine the effectiveness of "checking for understanding" related to time. This study showed that "checking for understanding" did not take more time than the usual method of client teaching, and improved the clients' ability to recall information or perform a skill.

As a panel, we presented the evidence as concisely as we could. While we acknowledge that time is a crucial issue given the current culture of health-care, we cannot negate the fact that facilitating client centred learning effectively takes time and needs to be intentional if we are to have the associated positive outcomes. Intentional teaching needs to be recognized as an essential part of care. Organizations need to be accountable for ensuring the information needs of their clients are addressed before discharge. You state that clients without a community midwife might flounder. The guidelines support the notion that resources need to be available to reinforce teaching. We agree that nurses are super busy. We need to advocate for more and better use of the nurses' time.

Question:
How would you suggest supporting nursing students and novice nurses in adopting these guidelines?

Answer:
We suggest incorporating the guidelines into nursing curricula and orientation. There needs to be a conscious decision to do this. RNAO provides an implementation toolkit to support this. While FCCL concepts and principles appear simple, they are often hard to perform well. The wording and the actions may feel awkward in the beginning. We would also encourage using case studies and role playing practice to allow the health-care professional to begin to develop his/her own style and to help incorporate the process into their practice. This opens up opportunities for educators to provide constructive feedback and to acknowledge what the learner is able to do well in a supportive and safe environment.

Question:

We are dealing with a new immigrant to Canada. New country. New way of life. New language. New diagnosis. New everything. Do you have any suggestions on how to help them understand they have the right – as well as the responsibility – to be involved in their care, with our help? We want to empower them without overwhelming them.

Answer:
This is a significant cultural shift for many of our new Canadians. You have clearly identified the myriad challenges faced by new immigrants and have provided part of the answer in your question. While we do not specifically look at this literature base, the panel members recognize that not all people are able to participate in their care to the same extent, and some people may actually wish to designate someone else, often a family member, as a proxy. As health-care professionals, part of the planning with clients is to establish the extent to which they are currently able to participate in their own health care, what level they ultimately would like to function at, how to get them to that level, and who could act as proxy for them if they wish to designate someone else. We mention in one appendix within the guideline "Ask me 3", and the universal precautions toolkit, these resources may provide you with more suggestions. There are also fact sheets for clients that may offer clarity as they start to consider their options.

Question:
Have you or anyone else given any thought to how managers might educate nurses on these guidelines. Something more than just giving them the booklet to read.

Answer:
How do you provide your staff with new information on policies, procedures and equipment you are introducing to your facility? As stated in the BPG, this has to be a planned approach. The goal is often to provide staff with the opportunity to learn the information or skill and time to practice it or ask for clarification. Providing opportunity to read and discuss the guideline and how to apply it in your setting may be very useful. Also providing opportunities to practice the skills and/or share personal stories of facilitation sessions that went well and others that may have been more challenging provide opportunities for enhancing capacity in your team. RNAO has an implementation toolkit available that may help with this. You may want to refer to the universal precautions toolkit, which is in the resource section of the BPG.

Question:
It would seem that the guidelines are most effective when used in an environment that supports employees' practice in the same way that we expect the nurse to support the learner. Can you speak to the importance of a work environment that is also safe, shame- and blame-free?

Answer:
You have raised an important point. When health-care professionals feel supported and safe they are able to provide the same type of environment for their clients more easily. Modeling the safe, shame- and blame-free environment for your staff is an excellent way to foster the environment for everyone. If you require other tools to help create a safe, shame- and blame-free environment for your staff and clients, see the resources in the guideline. In particular, you may find the *Universal precautions for health literacy toolkit* useful.

Question:
I think my surgical unit can use this best practice guideline. It's a fast-paced environment where taking time to communicate with/teach clients may mean lost breaks or a longer day in order to finish documentation, etc. How is RNAO going to disseminate this guideline? I think this will support nurses who take time to communicate with and teach their clients. When I say communicate, I mean therapeutic communication.

Answer
This guideline is available for free on the RNAO website. All RNAO members have received email communication about the release and availability of this guideline. This webcast was recorded and archived by OTN. The link to the archived presentation is available at http://rnao.ca/bpg/guidelines/facilitating-client-centred-learning

As well, we are incorporating this guideline into institutes such as the Chronic Disease Management Institutes.

Question:
I must congratulate you and your staff on the webcast, it was really educational and I learned a lot from it. Just to confirm, do we get a certificate after participating in the webcast?

Answer:
Yes, certificates are available. Please email Andrea at astubbs@rnao.ca

Question:
While documenting, is there any criteria for indicating the level of clients' understanding?

Answer:
The panel could not find any criteria for indicating the level of clients' understanding within the literature search. We suggest documenting what the client understood/stated and / or demonstrated; name the new knowledge. In addition, indicate any areas that the client had

difficulty with, and areas that need to be revisted with the client or areas that would benefit from reassessing or reinforcing at another encounter.

Questions:
Can you speak to implementing this guideline when working with clients whose first language is not English, or who are on a closed unit where visitors are not allowed?

Answer:
Addressing the special needs of specific populations was beyond the scope of this guideline. However, nurses working with specialized populations may be able to adapt the recommendations in this BPG to assist them in facilitating learning in these clients. If the client can't speak and understand the language, one would need an interpreter as a part of care.

Question:
How would you apply this guideline when contact with the client is limited? For example, checking the client in for surgery.

Answer:
It is just as important to use the guideline recommendations for short encounters as it is in longer term relationships with clients. Assessing what the person already knows or is capable of doing, determining the client's priorities for learning, and addressing those may be all that you are able to accomplish in a short period of time. For example, what questions do they have? What would lessen their anxiety? What do they expect to happen after surgery?

By addressing the client's needs, you are able to address what you feel are priorities for the client, when the client is ready to learn this information.

Question:
How can I promote these with patients who are non-verbal due to extubation and sedation in an ICU unit?

Answer:
We suggest to communicate with the family or substitute decision maker while still including the client as she/he is able to participate. While intubated clients may not be able to speak, they are often still able to communicate in some manner. As we have indicated in responses above, FCCL principles encourage involving the client in her/his care to the extent that they are able. The ability to participate may be altered by many different factors including sedation, pain, anxiety, fatigue, and distraction, to name a few.

Question:
How can we apply this in a situation where the client's understanding is very poor?

Answer:
Ensuring the client has appropriate support, resources and ongoing follow up are key. Don't forget to utilize family, friends or community support services to assist the client in the ongoing process of learning.

Question:
I wanted to start by saying that I enjoyed your presentation and I thought that everyone provided some fantastic information. I was wondering how this guideline would apply when there is no direct contact with the client. In my current nursing position, I do all of my work by reviewing medical information, then the discussion takes place via the telephone and there is no face-to-face contact between the nurse and the client.

Answer:
Communication skills that promote a partnership relationship should be used. Telephone usage has been shown to be very effective for positive outcomes. Recommendation #7 addresses this.

Question:
I work with clients who struggle with short-term memory loss or other variations of cognitive impairment. The health-care professional's (HCP) express a lot of frustration with the repetition of various teaching topics. Also there is frustration with clients who make choices that contradict our teaching. Are there suggestions on how to support HCP's with frustration and considerations for teaching those with cognitive impairments? Thank you for this presentation and the BPG.

Answer:
Your question shows considerable insight and highlights the importance of practice reflection. We can't be responsible for our client's choices. We need to understand where the client is coming from, or the client's reality, in order to understand the choices they make when they seem to be counter to what we would like them to choose. Often, they have made the choice based on what they know and/or believe at that time. Creating opportunities to work with the client from where they are "at" enables the health-care professional to support the client and to use motivational approaches to possibly change actions/beliefs to a healthier choice.

Reflecting on this partnership model, and recognizing the client drives the learning, is a good way to start.

Question:
I work in an ICU where I often teach family members of the patient more than the patients themselves. Are there any specific recommendations for teaching family members vs. patients? What about tools for learning (i.e. websites, brochures, etc.)? Is there any evidence to suggest that specific tools work better than others?

Answer:
One of the key strategies in health literacy is encouraging clients to bring another person(s) to health-care encounters to help them remember what was covered and to assist them in asking questions if needed. Families are clients too, and creating a safe environment for them to ask questions and express their fears and anxieties is important. Family members should be recruited with the client's permission, or when the client is not aware. Recommendation #7 in the BPG addresses the specific tools; using a variety of tools is the best approach for teaching/learning.

Question:
When we approach group therapy classes, and facilitating our nurses becoming more comfortable to deliver and co-facilitate psycho-education short groups:

1. How creative can we be?
2. Should we have set topics during our weekly practice labs for staff?
3. Should we review what staff needs to learn based on a challenging clinical scenario they encountered in the last few weeks...?
4. Should we have a staff support and education planning meeting? What is this?

Answer:
There is a lot of room for creativity and working with the strengths of each staff member. The facilitator should provide some structure around the learning of the staff/group, but preplanned topics can be helpful. Using situations that staff has encountered can be very empowering, both by encouraging them to reflect on their own practice and in providing opportunity for you to acknowledge what they have done well in the situation. A variety of resources and methods are encouraged.