# Reflection on Communication Skills for Paramedic Practice

## Flawed Communication

I will be using the IFEAR 5 step structure (Gibbs1988) (Incident, Feelings, Evaluate, Analysis and Reaction & Response) developed by Smart (2011) to guide me through this learning process. The model is easy to use and is most commonly used by paramedics in the ambulance service for critical reflections.

As an emergency care assistant (ECA), I was part of a double crewed ambulance (DCA) working with a paramedic, when we were mobilized to a Category 1 call that was 15 minutes away. The information that we received on the Mobile Dispatch Terminal (MDT) was as follows: “82-year-old male, Non-traumatic cardiac arrest”. We were backing up a crew. On arrival, the first crew was performing an Advanced Life Support (ALS) protocols with Cardiopulmonary Resuscitation (CPR) in progress with appropriate airway established, intravenous (IV) access already gained and the first adrenaline administered. The patient by now had been shocked one time and return of spontaneous circulation (ROSC) had been achieved. As per SWAST guidelines, the crew remained on scene for 10 minutes to stabilize the patient, and the post ROSC care bundle delivered. With the patient now stabilized and, having been transferred to the stretcher, he was loaded onto the ambulance. The paramedic and I attended the patient on route to the nearest Emergency Department (ED) which was 25 minutes away on blue lights. On route and within 15 minutes from ED I was asked by the paramedic if I could do a pre-alert to the receiving hospital. I telephoned the red phone and whilst on the telephone, the paramedic handed me an ASHICE mnemonic pre-alert (Age, Sex, History, Injuries/Illness, Condition, Estimate time of Arrival) (NHS Improvements, 2018) with all the relevant information. The nurse in charge on the phone requested I should be doing an ATMIST instead (Age, Time, Mechanism, Injuries, Signs, and Treatment) (Joint Royal Colleges Ambulance Liaison Committee and Association of Ambulance Chief Executives) (JRCALC & AACE, 2019).

I felt immediately frustrated and informed the nurse, I would call her back in a minute with an ATMIST. I am aware the SWAST guideline in Medical Emergencies in Adults via the JRCALC states ATMIST should be used as this is widely used in most hospitals. (JRCALC, 2019) I re-phoned through to the receiving hospital, however, the phone was engaged and this caused a delay in the receiving hospital. When I managed to get through, I read out the ATMIST as requested and 10 minutes later, the patient arrived at the ED and went straight to the resuscitation area (RESUS).

I felt this was poor communication as I was aware that SWAST uses ATMIST as a preferred method pre-alert, not an ASHICE and I felt it was not the appropriate time or place to discuss with the paramedic to explain why they used the ASHICE instead of an ATMIST, as the patient was our primary concern.

After the paramedic handed over in resus, we went outside for a debrief. During the debrief, the pre-alert was raised and the Paramedic explained they have recently transferred from another Ambulance Service and this was their preferred method of pre-alert.

The patient unmet need (PUN) is that it caused a delay in the receiving hospital being given the pre-alert information.

My practitioner educational need (PEN) I should have done the ATMIST instead of the paramedic which would not cause a delay in the pre-alert. Another PEN would be I was not fully aware of the mnemonic ‘ASHICE’ and I was not confident in asking the Paramedic to explain why they used this type of mnemonic.

This has prompted research into what type of pre-alert is used in the pre-hospital and the ambulance services. Handovers are an essential communication in clinical practice when transferring information and it is a professional responsibility among different members of the health care team (Evans et al, 2010).

Several factors need to be considered when choosing the ideal pre-alert mnemonic. This includes the length of the pneumonic. If the mnemonic is too short, important information may be lost and if the pre-alert is too long this may result in unnecessary delay to patient treatment (Sutcliffe et al, 2004).

There are several pre-alert mnemonic communications already existing in the United Kingdom (UK) and they are widely used in the pre-hospital environment and these are used in clinical practice (Loseby, Hudson, and Lyon, 2013). The aim of any pre-alerts is to achieve the efficient communication of high-quality clinical information at any time when the responsibility for patient care is transferred from scene to hospital (Yong et al, 2008). Such difficulties can include a lack of structure, gaining the attention of receiving hospital staff, duration of handover, lack of training, noise and other distractions, and difficulty recalling important multiple facts and complex information (Thakore and Morrison, 2001).

The research showed in the UK we have four commonly used pre-alerts, in pre-hospital.

The AT MIST pre-alert is an effective template, it is both easy to remember and can be easily applied by the clinician. AT MIST has been extensively used by the ambulance service and the military (Berry and Nicholson Roberts, 2012) and is also a pre-hospital key performance indicator for the management of trauma or medical (Stannard et al, 2008). In SWAST guidelines ATMIST is the preferred pre-alert that should be used as this is widely used in most hospitals. (JRCALC, 2019)

However, Budd et al, 2007 states ASHICE has been adopted as the preferred method of translating initial information from the pre-hospital environment to the waiting trauma team. ASHICE is a well-recognized structure by both pre-hospital and hospital clinicians (Budd et al, 2007) The ASHICE structure does include most of the points required in the pre-alert, the main omission being exclusion of a format to allow for the input of any interventions performed by the clinician. ASHICE also does not include incident timings.

But the NHS hospitals, state SBAR (situation, background, assessment, and recommendation) is the simpler and more familiar used template within the hospital setting (NHS Improvements, 2018). However, a potential disadvantage of the SBAR format is for major trauma patient and it doesn’t prompt the clinician to cover key points, such as mechanism of injury, clinical interventions, or suspected injuries.

Compared to the HEMS template (see below), the AT MIST format relies on the clinician to remember to add salient points such as initial GCS. One disadvantage is that it lacks specific details of inclusion of the injured patient, which may be important for those clinicians who are unfamiliar with the major trauma patient. It is believed that the adoption of the AT MIST structure for pre-hospital alerts will increase familiarity with the structure and therefore improve its effectiveness. The Helicopter Emergency Medical Service (HEMS) handover template has eight set headings for the trauma template and six set headings for the medical template. (Loseby, Hudson, and Lyon, 2013)

### The Medical template

- Name/Age/Time
- Mechanisms of injury

### Complaint

- GCS/Limb movement

### Past medical HX

- Injuries top to toe

### Working diagnosis/Clinical findings

- Interventions/Drugs
- Volume issues

### Immediate needs/Other.

- Stable/Unstable in transfer
- Immediate needs.

I have learnt many things by undertaking this research. Firstly, I have widened my knowledge with regards to the different types of mnemonics available in the UK. Pre-alerts are vital in the pre-hospital environment and it is very important for continuity of patient care and can positively influence patient outcome. In my opinion, AT MIST pre-alerts, in SWAST guidelines could be altered to ASHICE because AT Mist is recommended for trauma patients and ASHICE is generally used for both medical and trauma, and other ambulance services in the UK use ASHICE as their preferred pre-alert pneumonic. Finally, I believe a nationalist pre-alert mnemonic should be uniformed out to all ambulance services across England.

## Effective Communication

Effective communication is significant such that the Health and Care Professions Council Standards of Proficiency number eight relates directly to it (HCPC, 2014).

As a Student Paramedic, I was part of a double crewed ambulance (DCA) working with a

paramedic who is my mentor, when we were mobilized to a Category 3 call that was already 25 minutes old and we were 10 minutes away from the scene. The information that we received on the Mobile Dispatch Terminal (MDT) was as follows: “4-year-old male, Fallen of his bike, in a lot of pain in his right leg”. On arrival, the patient was with his mum, sitting on the sofa. Using the Patient Assessment Triangle (PAT), the patient was breathing normally with no signs of shortness of breath, he was fully alert and was of a normal colour for the patient (Halliwell et al., 2011) and it was obvious the child was in a lot of pain as the patient was supporting his right leg. I consciously applied my knowledge of Betaris Box (Willis and Dalrymple, 2015) with keeping the child calm.

On gaining consent from the patient mum, I started the assessment on the child. Using the numerical pain rating score, I asked the child for a pain score, zero no pain, ten being the worst pain (Stinson J, Jibb L, 2014), The child did not understand the pain score rating, and I was advised by my mentor to use an alternative positive way of communicating to the child to gain a more accurate pain rating score.

Using my phone, I logged onto the JRCALC app (JRCALC, 2019) (Joint Royal Colleges Ambulance Liaison Committee and Association of Ambulance Chief Executives) which is provided by South Western Ambulance Service Trust (SWAST) and I found the guideline, ‘Pain Management in Children’. Reading the guideline, Wong-Baker Faces score (Wong & Baker, 1988) and The Face, Legs, Activity, Cry, Consolability scale (FLACC scale) (Merkel SI et al, 1997) is the recommended and a positive way of communicating to the child and gaining a more accurate pain score rate.

Using the Wong-Baker Faces score (Wong & Baker, 1988), I was able to positively communicate with the child and gain an acute pain rating score.

Parkinson (2015) states, each patient has the ethical right to receive prompt analgesia, however, it is necessary to first determine the level of pain to be treated and the mechanism of injury potentially highlighting any contraindications to medication.

The patient unmet need (PUN) is it caused by not using the appropriate pain score rate for the child, which could have caused anxiety and confusing for the patient and a potential delay in administrating the appropriate analgesia to reduce the pain.

My practitioner educational need (PEN) is, I should have been using the guideline, ‘Pain Management in Children’ which is available through the JRCALC (JRCALC, 2019). Another PEN would be myself doing a pain assessment course in paediatrics and what types of pain rating score are used in the pre-hospital environment.

This has prompted a research into why it is important to reduce the pain and what type of pain rate score available for paediatric patients under four years old.

The UK Ambulance Services Clinical Practice Guidelines state that assessment should be undertaken for all children in pain, with regards to the severity, location, duration, and nature (JRCALC, 2013).

The research has identified in the United Kingdom (UK), relief of pain is one of the most important clinical outcomes in paramedic practice (Turner J, Coster J, Wilson R, Phung VH) and

the research has also shown, pain and anxiety in children nervous system is vulnerable to noxious stimuli during development. Not only does the pain has a negative impact on neurological development, but children whose pain has not been adequately treated in children reported lower pain thresholds in adolescents and adults (Ruda, Ling, Hohmann, Peng, & Tachibana, 2000). Pain is also associated with heightened levels of distress and anxiety in trauma, which can result in negative long-term emotional stress for children (Blount, Piira, Cohen, & Cheng, 2006; Brewer, Syblik, Tietjens, & Vacik, 2006; Howard, 2003; Ruda et al., 2000).

In pre-hospital and hospital environment, pain assessment tools are used for ranges from the use of subjective to objective pain-scoring assessment tool. Examples of subjective-pain scoring tools include the visual analogue scale (VAS), numerical rating scale (NRS), and the faces pain scale (FPS). The objective measures include the behavioural pain assessment scale (BPA), functional activity score (FAS), and Abbey Pain Scale (APS) (DHS, 2007).

As stated in the SWAST guideline, ‘Pain Management in Children’ in the JRCALC, 2019 app, the recommend pain score scale system are the FLACC scale (Merkel SI et al, 1997) and the Wong-Baker Faces score (Wong & Baker, 1988)

Researched showed the BPS FLACC tool (see below) (Merkel SI et al, 1997) was found to have high interrater reliability and the preliminary evidence of validity was provided by the significant decrease in FLACC scores related to administration of analgesics. Clinicians must rely on behavioural pain scales such as the FLACC scale and this is used when communication is not an option (e.g. Proverbial, poor cognitive function) (Whitley, 2018).

However, Rebecca Saul, 2016 states the FPS Wong-Baker Faces score (see below) is widely used around the world and is the recommended tool for assessing acute pain in children 3 and older in pre-hospital and hospital environment and the tool was originally created for children to help them communicate about their pain (Wong & Baker, 1988).

Despite pain assessment, measurement, and management being challenged in the pre-hospital environment, there are ways to manage the process effectively. Performing an in-depth assessment of pain can help to identify the correct aetiology; using an age-appropriate pain scale will promote accurate pain-reporting, And managing the pain via a tailored mix of pharmacological and non-pharmacological interventions will help to minimise any distress and anxiety to the child in the pre-hospital and hospital setting, it is usually necessary to have more than one pain assessment tool to cater for children and all patient groups. Ideally, pain assessment tools in a clinical area should all use a common metric – for example, pain rated from 0-10 or 0-5 in all tools (Stinson and Jibb, 2014).

This means that a pain score of 5 will mean the same no matter which tool is used. This will make communication and easier and pain-relieving interventions more effective.

I have learnt many things by undertaking this research. Firstly, it is really important to use the JRCALC app during the assessment of patients. It will provide guidelines and relevant information on assessing patients. Secondly, my knowledge on pain score assessment of children and how it is important to reduce the pain in children in healthcare and emergency settings.

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