Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within 6 weeks of receipt of *Future Healthcare Journal*. Letters should ideally be limited to 350 words, and sent by email to: FHJ@rcplondon.ac.uk

More work is needed on structured admission pro formas

We read the recent article by Smallwood *et al* with interest.[1] We agree that clerking pro formas can increase the completeness of initial information gathering, but we are concerned that they do not always reflect the needs of the elderly population who form the majority of unplanned medical admissions.[2]

We recently contacted all English trusts delivering acute general medicine to survey their clerking documents for features particularly pertinent to older people. We received replies from 53 trusts using a pro forma. Table 1 shows the results.

Encouragingly, most documents included a cognitive assessment, perhaps driven by the recent dementia Commissioning for Quality and Innovation (CQUIN) national goals. However, we found it astonishing that despite its widespread availability, four documents reproduced the 10 question abbreviated mental test (AMT) incorrectly, with one document containing three inaccuracies. Only 38% of documents included a tool for assessing for delirium, despite delirium being present on admission in up to 29% of older patients.[3]

Table 1. Rates of prompts for features particularly pertinent to the care of older people

	Prompt or tool	Number (%) of documents N=53
Social circumstances	Type of accommodation	35 (66.1)
	Cohabitees	29 (54.7)
	Usual mobility	31 (58.5)
	Services received	33 (62.3)
	Usual ADL function	22 (41.5)
Common problems in older people	Falls	14 (26.4)
	Incontinence	19 (35.8)
	Cognitive impairment	14 (26.4)
	Hearing impairment	11 (20.8)
	Visual impairment	13 (24.5)
Ceilings of care	CPR	30 (56.6)
	Other, eg level 2 or 3 care	24 (45.2)
Cognition	Any form of assessment (eg AMT, 6CIT)	51 (96.2)
	Delirium assessment tool	20 (37.7)

ADL = activities of daily living; AMT = abbreviated mental test; CPR = cardiopulmonary resuscitation

No single pro forma can be universally suitable, as they should reflect local service models and availability of facilities. However, there is room for improvement in many of the documents currently in use. ■

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Good Signal? Bad Signal?

With technology developing faster than the health services can keep pace with, outsourcing of digital communications services such as DrDoctor patient appointment system, used in Guy's St Thomas, have already shown a 17.2% improvement in patient appointment attendance, simply by adapting to the way in which people communicate today.[1] Now, a greater number of medical professionals are turning to solutions that can provide them with a greater level of convenience and security, for communication between each other.

Apps such as the Facebook-owned WhatsApp have become ubiquitous to our everyday lives and are already being used on a regular basis in an informal manner by some in clinical practice. However, there are a number of other contenders in the ring determined to take the crown and topple the longstanding king (the dreaded bleep). Now, since the Information Governance Alliance (IGA) has drafted new guidelines on the use of instant messaging,[2] and new rumblings are emerging from top healthcare ministers in the government, we may see a rise in the available options.

A recent article in Digital Health (**www.digitalhealth.net**) stated that 'Jeremy Hunt backs call for Whatsapp-style messaging app for NHS staff', following a recent report by Alan Mak, conservative MP, called *Powerful Patients, Paperless Systems* which seeks

to guide both clinicians and patients in the use of new digital healthcare technologies.

Apps such as MedxNote and Medcrowd seek to integrate fully with existing systems inside trusts; however, since they have to be first adopted by the hospital for the service to then be made available to the staff they are not yet an ideal solution for the vast majority of doctors today.

Another free and already popular service is Signal. Signal is surprisingly similar to Whatsapp with just a few more security features for those determined to meet with IGA recommendations. At first glance, you might be forgiven for mistaking it for iMessage or WhatsApp depending on what type of phone you use, with the real difference coming with the features.

The service is end-to-end encrypted with the Signal Protocol which was developed by the company itself and later adopted by Facebook Messenger, Whatsapp, and Google Allo. You can enable a fingerprint lock for the app, all photos are stored in the app itself rather than being downloaded to your phone's gallery storage, as well as disabling the ability to screen capture any conversations, and hiding the contents of messages from notifications. Another interesting feature which currently seems to be unique to the app is the option to set a time limit (à la Tom Cruise in Mission Impossible) which causes the messages to disappear at a specified time after they have been read by the recipient. Which, if your phone is say used by your children to play games after work, could make all the difference. This may seem at odds with good medical record keeping. However, the IGA states that 'you should not use the instant messaging conversation as the formal medical record. Instead, keeping separate clinical records and ensure original messaging notes are deleted.'

If you're anything like me you may feel that there's a new app coming out every week and that there are more 'solutions' than we ever had problems, but Signal seems like a serious contender for those looking to beef up their compliance, at least until there is one officially endorsed NHS app. Until then…don't forget to change the battery in your pager. ■

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The role of junior doctors in delivering effective clinical teaching

Editor – This is with reference to the interesting article titled 'Participation in teaching opportunities during core medical training: barriers and enablers' by Anyiam *et al*.[1]

The authors discuss an important but rather underutilised resource for clinical teaching. The role of junior doctors as teachers is often underemphasised despite the fact that their great potential in delivering effective near-peer teaching programmes has been established recently.[2]

Following ethical exemption by the University College London Committee, we distributed a similar survey to a small number of core medical trainees (CMTs) in two district hospitals in north east London in 2012, focusing on undergraduate teaching. The survey looked specifically at the barriers to the bedside teaching (BST) of undergraduate students faced by CMTs. Out of the 19 CMTs who responded, the majority (68%) described the frequency of proper BST they delivered to students as rare or occasional.[3] In addition to time constraints, the trainees felt that the general lack of institutional appreciation of teaching and frequent interruptions on the wards were the major obstacles to BST. It also appeared that almost half of the CMTs did not receive any formal training on teaching skills.

Medical students and foundation doctors nowadays tend to be more in touch with core trainees on the wards as senior members of the teams are often expected to cover a wider range of clinical activities. Interestingly, a recent study in Keele Medical School showed that although consultants were perceived to be more knowledgeable, medical students felt more comfortable to have bedside teaching delivered to them by junior doctors.[4] This finding does not undermine the value of clinical teaching delivered by seniors, but in essence, reflects the close relationship forged between medical students and junior doctors in the workplace, thus creating an excellent additional opportunity for clinical teaching.

While Anyiam *et al* highlighted a list of useful suggestion themes in their article, particularly incorporating teaching delivery formally into CMT job plans and training, curricula through regular protected teaching slots can help CMTs deliver high-quality and effective teaching and develop their teaching skills. Nonetheless, it is understandable that this intervention may prove challenging given the ever-rising clinical demands in the NHS and the associated short staffing. Offering formal free in-house training on teaching skills as part of the local CMT teaching programme is another important recommendation which may boost the engagement of CMTs with teaching and education. ■

References

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