Patient education – what is on the agenda?

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Supplement Editor

A wealth of literature supports education as a vital component of diabetes care but little robust evidence exists about what actually works in terms of the process of education. As nurses providing diabetes care, educational consultations are the crux of what we do, yet we have struggled to provide evidence of our effectiveness in this crucial part of diabetes care. The delivery strategy of the diabetes NSF highlights the benefits of 'group structured education programmes' and the National Institute for Clinical Evidence (NICE) will produce an appraisal of structured education in Spring, 2003. Meanwhile, perhaps we should spend some time reflecting on our current practice.

Enabling people to learn

Recently I had the opportunity to speak at the Abracadabra conference on 'The 15 minute education session'. This led me to consider my own practice and how I was prepared for this important aspect of my role. Many of us have teaching qualifications; these are often prerequisites for nurse specialist roles. Personally, I feel that although my teaching qualification taught me how to teach, I am not convinced it taught me how to enable people to learn; a crucial difference. There are lots of theories about how adults learn, but when you take a patient into your consulting room have you ever wondered how they might like to learn... or endeavoured to ask?

In the consulting room, we set out to achieve the following:

- Establish the patient's agenda.
- Content/information exchange.
- Check understanding of the patient.
- Decide what, and how, behaviour change is to be achieved.

A tall order but primarily identifying the patient's agenda is crucial to success of the consultation. I am sure we have all been on the receiving end of a consultation where you felt your needs were not addressed, and agree that this is an incredibly frustrating, time-wasting experience.

Consider your last patient consultation:

- What questions did you ask?
- What was said by the patient that confirmed that you had identified their agenda?

Diabetes is such a familiar concept to us that we may lose sight of that fact that for the healthcare professional the diagnosis is often the solution to the puzzle. While we often make assumptions about what patients want to know, we need to establish how the patient sorts out information. Does he/she do the edges first, or sort out sections? It could be the difference between 'how will diabetes affect me?' (the big picture) and 'what can I eat tonight?' (a small section). The literature informs us there is a discrepancy between what healthcare professionals recall telling patients and what patients recall; patients tend to effectively recall information they perceive to be important. Simply giving information is not enough.

Checking understanding is essential, particularly if we expect behaviour change to occur. In order to change behaviour people need knowledge and skills. Goal-setting should be collaborative. What is often perceived as non-compliance occurs when the healthcare professional's goals differ from those of the patient and the barriers for changing behaviour are not explored. Beware of using closed questions such as 'did that make sense/ did you understand that' as you might just experience social nodding!

We need to reflect on whether we are getting it right. Patients who are referred for education may be able to tell us something about the process. We may be able to learn more from patients who experience problems.

Conclusion

Making a clinical consultation educational is a challenge; if we fail to engage the patient the time will have been wasted. This supplement provides an opportunity to explore and share what has worked well in this crucial part of our role. ■

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