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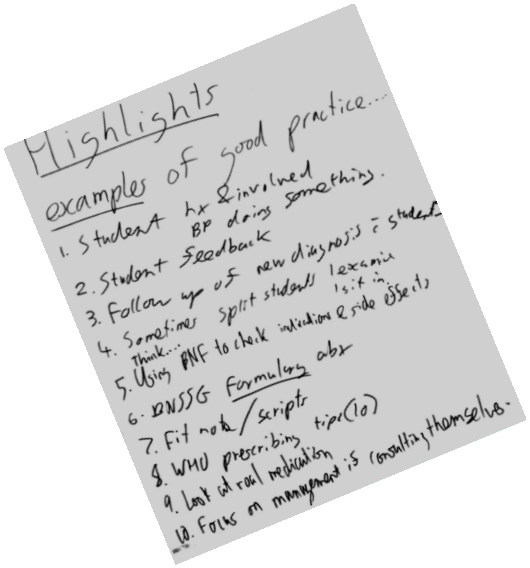
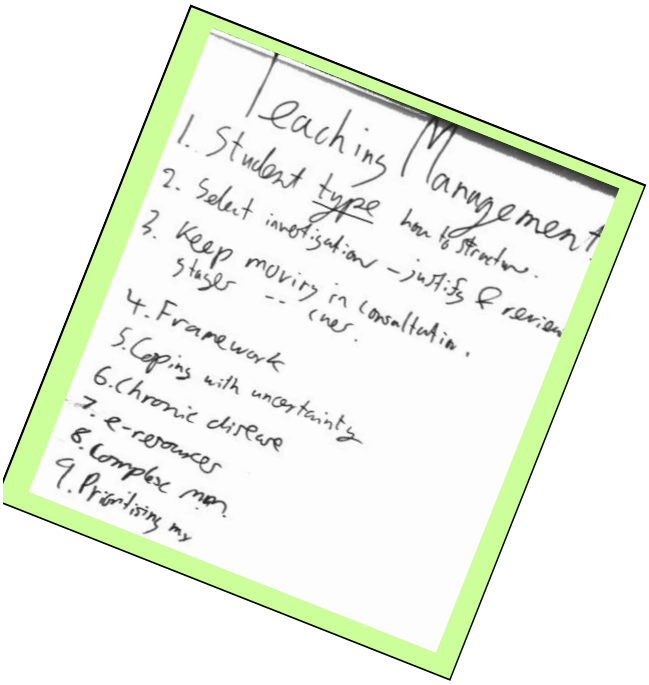


2013 Report

Year 5 GP Teacher Workshop



Organisers	Barbara Laue	David Memel

Welcome

To the

2013 Year 5 GP Teacher workshop report

Content

Talks

Small group reports

Appendix

Introduction and review of PPP course David Memel

The PPP course

- 12 week course based at a single Academy between Jan and April
- Students are post Finals (except long cases)
- Combination of academy, ward based and primary care teaching

The other parts of the PPP course

- Shadowing F1 doctors
- Medicine and Surgery
- Palliative Care and Oncology
- Tutorials at Academies
    - Primary Care responsible for delivering two:
        - 1°/2° Care Interface
        - Advanced Consultation Skills

Brief intro to the organisation and teaching in PPP

- Students post finals, focussed on issues that they will face as real doctors
- Students come in pairs for two weeks
- Themed surgeries
- Students go away and find things out and report back to GP
- Medical Student surgeries

Key learning themes for PPP

- Prescribing
- Consultation skills
- Primary/Secondary care interface
- Complex patients with multi-morbidities
- Exploring Unexplained Symptoms

Feedback for students and GP teachers

Overall learning experience for the students provided by the Year 5 attachment in your General Practice

GP

Poor:	0.8%	1
Satisfactory:	1.6%	2
Good:	22.1%	27
Very good:	54.9%	67
Excellent:	20.5%	25

Student

Poor:	0.6%	1
Satisfactory:	4.8%	8
Good:	15.8%	26
Very good:	33.3%	55
Excellent:	45.5%	75

Highlights of teaching year 5 students

- Everyone likes it – students, doctors and patients
- Students like openness – reviewing their consultations with the patient present
- Students become part of the team
- Year 5 students are more confident and ready to do a surgery
- The students knowledge is good, they can be challenged more
- It stimulates the teacher, they can ask more difficult questions
- Pairs of students are supportive of each other
- Students like peer feedback
- Two way process. We can learn a lot from the students
    - Example: student spent time with pharmacist and came back with new information about what medication can or can't be put in a dosette box

General teaching points

Please note, any patient who has been seen by a 5th year student will need to be checked by a doctor before they go home. In one practice a fifth year student saw a patient and then sent him home. Most students would not have that confidence, but some may.

Please clarify with your students and spell it out to them that patients need to be seen by a doctor after a student consultation before the patients go home

- Learning needs analysis is important, especially at the start, revisit throughout the attachment
- The themes naturally come up
- Keeping student(s) active when they are sitting in with you
    - Student taking history right from start, involving them in examination, taking blood pressure
    - Follow up of new diagnoses with students
    - Splitting students so one examines in separate room, other sitting in
    - Fit notes writing
- Prescribing
    - Using BNF to check interactions & side effects
    - BNSSG antibiotic formulary, printing off and using this to work out management
    - Correct ways of writing a prescription
    - WHO prescribing ten top areas
    - Looking at patients real medication, explaining what is in each packet (dispensing practice) but also used on home visits, nursing home etc
- Practice making management plans
    - If students consulting by themselves it helps to focus on management as they have more time to discuss and by the time GP joins them hopefully will have developed a clear plan
- Peer led student feedback about consultations
- Show how we deal with risk and uncertainty

Challenges	Options and solutions
Room availability	▪ Extend your surgery ▪ Find a 'cupboard' ▪ Use midday slot ▪ Home visits ▪ Visits to homes and sheltered housing
Themes	▪ Can usually be covered opportunistically ▪ Homes ▪ Housebound patients
Get to know your students	▪ Observe them early on to gauge their ability, confidence and attitude
Managing 2 students	▪ Students may have different abilities/knowledge/attitudes etc ▪ Facilitate learning from each other (KSA)
Year 5 students can be a bit arrogant	▪ Raise awareness of attitude problems in a constructive way ▪ Perhaps draw attention and highlight what good/better student is doing ▪ Role modeling by you and/or other student
Time and loss of appointments	▪ Running late ▪ Employ locum ▪ Could students do some genuine tasks, i.e. thorough workup of a complex patient so you don't need to spend so much time on sorting that patient?
So much to talk about	▪ Gaps between patients ▪ Before and after surgery ▪ In the car when doing home visits ▪ Over coffee
Dealing with students who have failed exam	○ In one practice both students had failed the exam and found out whilst on placement - became main focus of week. However was a good situation for getting time for practice and trying to involve students with patients
A surgery full of 'MUPS' could be a nightmare!	Avoid!
Intimate examinations	▪ Easier to ask for consent if the patient has pathology. ▪ Some merit in student observing and talking through the procedure
Telephone consultations	▪ 2 students sitting in ▪ Inform patient, ask for consent patient ▪ Put phone on loudspeaker
Fitting it all in	▪ Need more than one teacher ▪ Advanced planning
Dealing with difficult questions	▪ Be upfront about areas of ignorance ▪ Explore other gaps ▪ Look it up, ask students to look it up
Practical problems	▪ As academy
Electives	▪ Make sure they have made arrangements in advance ▪ Embassy visits for visas may be unavoidable ▪ Shouldn't have time off for vacating Bristol accommodation
Persuading partners	▪ Identify those keen to teach in advance ▪ Again planning, especially time table ▪ Use F2s, GP registrars, nurses for teaching

Teaching patient management

General points

- Mx discussions often come up opportunistically
- Raise awareness that there can be tension between what is possible and what patients want
- Lead a discussion about general mx options from nothing to admission
- Discuss and role model how to cope with uncertainty of diagnosis and unexplained symptoms
- Prioritising mx in a consultation, what needs to be done now, near future and long term
- Difference between mx for acute (i.e. adm.) and chronic problems

Planned mx practice

- Student follow up of new AF, HT, DM etc
- Patients who have a new diagnosis in few weeks prior to students coming of AF, hypertension, diabetes etc are booked into a follow up slot with the medical student.
- The students will have to decide on further investigation and a management plan
- Given 20-30min. slot 20 minutes with student and then 10 minutes when GP joins them to confirm plan and next steps
- Keep list of patients newly diagnosed with a condition
- Encouraging students to decide on investigations for a patient, then justifying them

Encourage them to move on in consultation

- Don't spend all the time to gather further extra history if already have an idea of diagnosis and mx management
- Some GPs using cues to prompt students to move onto next part of consultation

Students typing notes into the computer record

- Initially typing up GP's consultation, then their own
- Do this early on in their attachment
- Encourages them to know how to use the system so when consulting by themselves they can make clear notes and know how to work it
- Students should have a student log on so it can be clearly identified what they have written

Mx tasks and practice

- Look at evidence (NICE, DTB etc)
- Write referral letter (electronic, by hand etc)
- Dictate referral (Students are not used to dictaphones and may struggle with this)
- Using e-resources such as GPnotebook
- Reviewing management of complex multi-morbidity patients e.g. at nursing home, to raise prescribing issues, review care needs
- Use chronic disease nurse reviews and information to help think about ongoing management

Students are generally not very good at structuring. Provide structure, use mx framework

- Investigations
- Treatments (self care, medication incl. OTC etc)
- Referral
- Self care
- Social considerations
- Signposting and safety netting
- Raise awareness of time as a mx tool

Consultation structure

- Differential diagnosis
- Investigations
- Explanations
- Treatments
- Safety net

Observations

- Students struggle when there are many things going on
- May become over focused
    - Remind them to think widely, not to close down the diagnostic process too early
    - To be flexible and able to reconsider diagnoses when the jigsaw pieces don't fit together
    - Keep considering differential diagnose

Records

- Make sure it's all written down
- Itemise necessary referrals

Teaching assessment of patients with complex needs and problems

Kyra Neubauer, a consultant in CoE in North Bristol, highlighted how the role of the CoE physician is changing. In North Bristol she is now seeing all frailer complex patients. That could be a 40 year old with complex MS or a 50 year old patient with complex problems from alcohol dependence. Kyra provided an overview of Year 4 CoE learning objectives to highlight what fifth year students should be bringing to their GP attachments.

Learning objectives

- To understand the definition of frailty
- To understand the multifactorial issues for frail complex patients
- To learn what constitutes a comprehensive geriatric assessment
- To understand how to take a collateral history
- To appreciate the importance of creating and following through a care plan
- To appreciate the importance of timely discharge
- To understand how to identify patients who may be in the last 6-12 months of life and consider end of life planning
- Ethical and legal issues

Definition of frailty students should be familiar with

3 or more of

- Unintentional weight loss, self-reported exhaustion, weakness(reduced grip strength), slow walking speed and low physical activity

  Fried L.P. et al Cardiovasc. Health study Collaborative Research Group J Gerontology A Biol Sci Med Sci 2001

2 or more of

- Inability to perform 1 or more ADL in previous 3 days, stroke in previous 3/12, depression, dementia, history of falls, 1 or more unplanned admissions in previous 3/12, difficulty in walking, malnutrition, prolonged bed rest, incontinence

  From BGS 2010 Best practice guide

Multifactorial nature of issues for the complex frail

- Delirium and dementia
- Falls including fractures/ osteoporosis
- Reduced mobility
- Medication
- Multiple co-morbidities
- Continence issues and constipation
- Sensory impairment
- Requiring formal and informal care

Comprehensive assessment

- Medical assessment
  - Full medical history including severity of co-morbidities, medication review and physical examination
- Assessment of functioning
  - ADLs , activity and exercise status, gait and balance
- Psychological assessment
  - Mental status + cognitive assessment , mood/depression tests
- Social assessment
  - informal and formal support, financial issues
- Environmental assessment

Creating a care plan

- Define a problem list
- Collect collateral information
- Create a list of investigations to reach diagnoses
- Suggest other professionals/agencies who need to be involved (expediting discharge)
- Define patient centred goals and planned outcomes
- Address issues around DNAR and end of life if appropriate
- Outline what issues must be addressed/ goals reached before discharge and what needs to be done after discharge.

Small groups

We reflected on Kyra's talk and a short role-play about teaching consultation skills with complex older people started off our discussion. Many thanks to all the role players for providing some rich material for the discussion.

Complex patient assessment

- Different in GP from hospital
  - no Multidisciplinary Care Team on hand
  - Assessment more piecemeal in several stages
- Being realistic about what it is possible to achieve for some complex elderly patients - not promising solutions to all the problems on the list.
- Teaching students the skills to be able to find the right balance for an individual.
- Nursing homes wonderful resource
  - Medication Reviews - then get student to follow up with pharmacist
  - End of Life Care
- Difficult to do in normal surgeries
- Home visits, involve community matrons or nurses
- Not just elderly – e.g. palliative care patients
- Invite suitable patients in, as in Year 2/3

Differences to CoE

- Home environment
- Family dynamics
- Continuing evolution of the problem

Teaching consultation skills with complex elderly

- Opportunistic
- Clear consent from patient needed
- Pros and cons of the patient and family being present whilst giving the student feedback, and how to involve them in feedback and give feedback in an appropriate way. Generally the feeling was that it was a positive thing
- Benefits of involving the patient, seems more open, depends on the patient

Teaching points

- Give relative chance to offload first
- Bottom line strategy
  - See patient by him/herself
  - Then bring relative in, or see separately
- Collaborative history can be vital. Ok re confidentiality
- May want relative's contact details e.g. if dementia case

Consultation Skills Teaching with Two Students

- Acknowledge the challenge of consulting with two people
- Set the ground rules
  - Think about how to set it up and discuss with the students beforehand
  - Need to discuss and agree when to give feedback
  - When to take over
- Ask student which bit of consultation want to concentrate on
- Give second student task during the consultation e.g. using Calgary-Cambridge list, BNF
- Try to listen to both
- Invite comments from student who was consulting
- Try to involve the second student in the feedback
  - Ask observing student 'What did you see, what would you like to add?'
- Consider asking for feedback from the patient
- Leave teacher feedback till the patient has left
- Teacher to steer the consultation if it goes off track
- Teacher keep quiet

Communication

- The importance of continuity and the use of time in the care of complex elderly patients.
- Communicating with complex elderly
  - Asking the family
- **Beware hearing problems when assessing cognition!**
- Get students involved in communication
  - Phone call – get important relevant information regarding the patient across
  - Referral letter
  - Get students to dictate the letter
  - Teach being succinct, relevant and include important info

Student tasks

- Write current problem list and make a plan
- Asking the students to make a problem list including the impact of the problem, and then asking 'if I could do one thing for you today, what would that be.'
- Get students to do structured presentation (good for long case practice)
- Good to get students involved in formulating/changing care plans
- Medication Reviews - then get student to follow up with pharmacist

Think holistically

In first and second year teaching we really encourage students to take a holistic view and to consider what it is like to be the patient, but in 5th year, the GPs said they don't focus so much on this.
Student tasks to facilitate rapport building and encourage students to consider patient as another person

- Consider what it would be like to be that patient and include this in their presentation
- Find out one interesting non-medical thing about the person

Try different ways for visits or in depth consultations in the surgery and compare

No notes	*With notes*
See patient without looking at notes before ↓ Look at notes ↓ Problem formulation and mx plan ↓ Present to GP	Look at notes before seeing patient ↓ See patient ↓ Problem formulation and mx plan ↓ Present to GP

What to teach about the 1° and 2° Care interface

Brief introduction from Tim Davis, academic GPST4

Key curriculum theme for students to understand the primary and secondary care interface

- Links with prescribing skills
- Half day teaching session in the academy lead by academy GP leads

How can we engage students to prepare them for F1?

- Discharge planning important part hospital jobs
- F1 jobs will be communicating with GPs - admitting/discharging and ongoing care
- F1 will be the main point of contact on ward

All TTA forms written or electronic are prescriptions

- Could link in prescribing practice for your students
- Show the different communications we receive from 2° Care
- Highlight need for legibility
- Highlight to make sure that important information is prominently displayed

Suggestions for getting students engaged

- Listening in to conversations
- Practicing with each other
- Practicing presenting information succinctly
    - e.g. **SBAR** (Situation Background Assessment Response
- Get student to dictate or type referral letter and other forms

Keep a selection of discharge summaries – good and bad

- Do they form a picture?
- What is missing?

Make students aware of

- What GPs can and cannot do?
- Examining patients at home on a sofa
- X ray access

Small groups **Teaching about the 1° and 2° care interface**

- Listen to GP dictate the letter
    - Student to dictate the letter
    - Review and critique discharge letters
    - Collect discharge letter for discussion (anon.) – the good, the bad and the ugly
- Good practice for hospital doctors when they hand patients back to GP
    - Clear information to the patient when they need to see GP, have BT, hosp. FU etc
    - Avoid saying ‘you need to have your blood count checked in a while’ as the patient won’t know what to do and will consult just to find out
    - Simple, non-jargon language
    - Do not raise unrealistic expectations, i.e. you will have an MRI in 2/7
- Chest pain triage - Get student to make 999 call

Teach: Don’t ask the patient to dial 999, do it yourself, patients may collapse before they can do it

- Role model phoning consultant
    - Discuss issues around phoning colleagues or seniors. They will have to do this as F1s
    - In some areas, for example Gloucester, there is a single point of access for medical and surgical admissions. Students could sit in for a couple of hours

Long case examinations – How can we help our students prepare for them?

Small group discussions

No one except Sarah Jahfar had ever examined long cases. Most had had to do long cases as students, but unobserved.

Standardisation

We discussed, very briefly, the concern that there cannot be any standardisation of long case patients, but the general consensus of our group seemed to be that it is fair to expect a finals student to be able to cope with most patients, to a level sufficient to pass the exam (and to be an at least adequate F1). It was felt that it is a fair test of ability, given that they get more than one go.

Marking scheme

Some GPs were concerned about the major and minor fault marking scheme - one GP felt that the various systems should be weighted differently, depending on that patient's problem. For example, why would an abdo examination failure be as crucial as a neuro exam failure in a stroke patient? I explained that it is the global impression that is the deciding factor and that failing one system would not necessarily mean overall failure. I also explained that they get 5 attempts in total, if they fail the first 3 and 4th.

Relative importance of good consultation skills v not missing significant signs on examination

One GP suggested that a student who takes a very good, empathetic and holistic history and exam should perhaps not fail if they miss a major medical sign. This generated a strong reaction from the group and most felt that, whilst manner and empathy are very desirable features, clinical acumen and skill is the most vital thing. (Examples were given of patients who "found the consultant brusque and a bit stroppy, but he certainly cured me!").

The disengaged student

Some GPs mentioned students who were seemingly not that interested in GP and thus a bit disengaged. We discussed how the fear of the long case can be used to hook them into taking GP seriously, as there are so many opportunities to practice.

Question re long case examinations

- What equipment is available for students and what are they expected to bring themselves?
  The Academy give them a bag with it all prepared, so they just have to bring a stethoscope
- Can they use the BNF? Is there one for them to use?
  Yes, although very few do use it
- Should the student be talking through what they are doing or do it silently?
  They should be behaving as if the examiner is not there, building a rapport with the patient, explaining what they are doing to them, but no running commentary for the examiner
- Hand washing - are they expected to demonstrate this or just use alcohol gel?
  Just the gel is fine
- Are they given any proforma for their long case, i.e. history sheet etc
  They have plain paper provided and a clip board, but no proforma

Teaching suggestions for preparing for long case examinations

- Include in first session with student –Learning Needs Analysis
    - Which bits of Long Cases do they want help with?
- We all thought that students would benefit from going through the mark sheet with their GP and with each other when they come in pairs. They could also be asked to assess themselves.
- Send the students off to do a long case (unobserved, as we are unlikely to have time), but that this then forms the basis for a tutorial.
- Get them to present cases including management plan
- Student would then present the case to us, one student the history, the other the exam.
- Be clear whether you want student to present as a) Long Case exam or b) Complex Case or c) focused GP consultation. They are not the same.
- Peer review, get them see/examine long case (without GP) as a pair
- They would critique each other's effort and we would feed back our thoughts
- Use the case as a platform for exploring the five main 5th year themes
- Get them to examine a single body system
- We agreed that GP lends itself very well to asking students to examine one complete system to exam standard, which would be good long case practice
- Address worries re long case early – LNA (learning needs analysis)
    - Discuss what and how much practice they would like
    - Line up some suitable patients for long case examinations – NH or housebound or complex [patient able to come to the surgery
    - Check with colleagues who needs a thorough review and examination
- What equipment needed
- Did the student take in the patient's environment – aids, medications by bedside etc
- Feedback on quality of routine history taking
- Send them to patients where you would like to know more
- Keep a list of patients with good physical signs – as Year 2/3

Long case teaching tips

- **Include in first session with student –Learning Needs Analysis**
    - **Which bits of Long Cases do they want help with?**
- When the brain is seizing up, do review of systems to get things going again and to use time effectively
- Check hearing and vision!
- One GP suggested videoing the long case and using this for feedback

Background to long case examinations

Key observations from examiners

- Observing them fully clerking a patient should allow us to see whether they have the skills to make a diagnosis, formulate a management plan and present it back to us.
- It should also allow us to judge a student's integrity - if they couldn't pin the patient's story down, for example with a poor historian, are they honest and confident enough to say this, thus instilling confidence that they will be good F1s and future doctors?
- Teachers and examiners need to identify when a student is clearly just "going through the motions". For example, are they just looking in the mouth, without actually seeing what is going on there?
- Usually immediately obvious which students have spent hours on the wards talking to patients and which haven't...?

From Sarah Jahfar who attended a long case training session

- The poorly performing students that we saw on video were so obviously not relating in a human way to the person they were talking to, nor to the implications of what was being said.
- They were nervously going through their tick boxes and the history then did not flow, the patient appeared to be a poor historian and it all went wrong.
- Good focused history and establishing rapport with patients is a huge strength in GP and we can make this one of our key messages to students

Possible activities for long case preparation

- Understand that Long Cases are not an exam, they are the bread and butter of their F1 job and this is why they need to be very competent and to be able to do it under time pressure.
- Give them as many history taking opportunities as possible.
- Get them to present back - to each other, to us, to anyone who will listen!
- When examination is needed/possible, try to get them to examine that system to long case standard, giving a running commentary as they go, to show us that they know the implications of what they are looking for and are not just "going through the motions".
- Push them to commit to a diagnosis and a management plan.
- Encourage them to use every spare moment to practice - they could go to local nursing homes, ask GPs or CNOPs about willing housebound patients and do timed 60 min clerking.
- GPs can use every opportunity to emphasise why that question asked/ that sign elicited, etc was key to diagnosis and management.
- Main thing is taking responsibility for talking to patients as much as possible, as this increases confidence, is great practice and allows them to demonstrate their skills as "medical journalists", able to extract a real story in a human way and to apply/synthesise their knowledge as doctors.
- May be near peer learning - give them an examiner sheet and ask them to mark each other during consultations on examination technique? could then discuss the feedback with GP afterwards or even sit in and have two markers?
- Presenting cases concisely with right information - maybe some of the work on presentation formats e.g. sbar (situation, background, assessment, recommendation) lots of different ways but could be something to discuss in group work.

From a fifth year student

- Get us to make management plans
- Observing us presenting cases back and critiquing the presentation
- Suggest patients who would be happy to be practiced on for 60 minutes for a long case.
- In a perfect world students would like to be observed by the GP
- Unlikely that the GP teachers would have the time, but students could do this in pairs and present back to the GP.
- This could be mutually beneficial, as a complex patient would get a complete review and we would undoubtedly learn a lot.

Student Selected Components David Memel

What are SSCs?

- Opportunity for students in Years 2, 3 and 4 to explore an area of particular interest
- Variety of methods
  - Library Projects
  - Audits
  - Research
  - Taught courses
  - Clinical Placements
  - Combination
- Standardised assessment
  - 3-4000 word essay with references and reflections
  - Double marked
  - Counts towards ranking and honours

SSCs in Primary Care http://www.bristol.ac.uk/primaryhealthcare/teachingundergraduate/ssc/

Opportunities for GP teachers

- Practice Audits
- Contributing to Uni taught SSC with Practice Placement e.g. Monitoring Medication
- GPs Personal Interest Project e.g. sports medicine
- Student's personal interest project

Student SSC presentations

We were pleased to welcome **Emily Barton** and **Alex Critchfield** who are now 4th year students. They rounded the day off by presenting their external year 3 SSCs.

They had explored Primary Care in Special settings and had visited prisons and shelters for the homeless. The key message from their talks was how their SSCs had opened their eyes to patients who are living a very different live. They were also impressed with the non-judgmental approach role modeled by a GP caring for the homeless.

Communicating with People who have a Disability

Consulting with people who have a hearing impairment

- Find a suitable place to talk, with good lighting and away from noise and distractions.
- Establish how the patient wishes to communicate (e.g. using hearing aid, lip reading, and interpreter).
- If using a hearing aid, check it is functioning adequately, or whether they would benefit from using an induction loop.
- Even if someone is wearing a hearing aid it doesn't mean they can hear you. Ask if they need to lip-read.
- If you are using communication support, talk directly to the person you are communicating with, not the interpreter.
- Have face-to-face or eye-to-eye contact with the person you are talking to.
- Remember not to turn your face away from a deaf person, particularly when using a computer.
- Speak clearly but not too slowly, and don't exaggerate your lip movements.
- Don't shout. It's uncomfortable for a hearing aid user and it looks aggressive.
- If someone doesn't understand what you've said, try saying it in a different way instead of repetition.
- Keep pen and paper handy in case needed and supplement the consultation with written material/patient information sheets if possible.
- Check that the person you're talking to can follow you. Be patient.
- Use plain language – avoid jargon.

Consulting with people who have a visual impairment

- Introduce yourself.
- Make sure you're talking to the right person.
- Make sure they know you're talking to them.
- Explain in detail what is going to happen next.
- Point out any potential hazards and ask if they would like help "Do you need any help?"

How to guide people with sight problems

- Ask them if they want to hold your arm/shoulder.
- If they have a guide dog approach them from side opposite the dog.
- Doorways: say which way door opens; make sure they are on hinge side and open the door with your guiding arm.
- Seating: never back them into a seat; guide them to a seat, then describe it; ask them to let go of your guiding arm and place their hand on back of the seat.
- Don't leave the room without telling them you are going.

Consulting with people who have speech or language impairments

- Encourage patients to use their own appropriate communication technique in their own time e.g. speech, writing, pointing etc.
- Ask patients to repeat what they have said, if necessary, and never make assumptions from what is unheard.
- Speak naturally and clearly and respect the patient's intelligence.
- Emphasise key words by inflection if the patient has language difficulties.
- Do not complete the words or sentences patients are having difficulty pronouncing.
- Only ask one question at a time – keep these brief and to the point.
- Do not attempt to hurry your patient – the added stress will exacerbate any speech problem. Instead, consider splitting problems over more appointments.
- If necessary, repeat key information as much as possible.

Consulting with people who have learning disabilities

- Focus on abilities, not disabilities, and try to recognise the person's strengths.
- If the person attends with a carer, address the person with learning disabilities first, if you then also need to speak to their carer or relative then ask them about this.
- You may need to allow extra time for the appointment, for example consider allowing a double appointment in general practice.
- Begin with a few simple questions to assess the person's verbal abilities, though bear in mind that some people with mild learning disabilities have good expressive skills but their receptive language skills may not be as good.

History taking

- Patients might have little concept of time and thus be unable to describe the duration of symptoms. Perhaps link symptoms to 'index events', e.g. did you have this problem at Christmas/your birthday?
- Patients with learning disabilities may answer 'yes' to closed questions even if this is not the actual answer, but some may find very open ended questions hard. Try open questions first, and then use closed question with alternatives if they are having trouble with open questions.

Explanation and planning

- When providing an explanation, avoid jargon, and use concrete examples. You might like to use repetition. It can help to use a paper and pen and draw pictures when describing or discussing events e.g. when to take medication, or some of the accessible leaflets and communication aids which are available. It can also be helpful to allow the patient to handle equipment, or to explain by pointing to the relevant body part.
- You may find you need to rephrase things in a different way to make it clearer.
- When asked 'do you understand?' a person with learning difficulties often answers in the affirmative. It is therefore better to ask them to repeat back, in their own words, what has been discussed.
- Involve the person with learning disabilities in the decision making and planning and be aware of the law around capacity and consent.
- Use your local Community Learning Disability Team as a teaching resource.