

Approach to training

approach that attempts to combine both direct and indirect interventions is John Heron's six-category intervention analysis (1990).

It describes six different categories into which all forms of intervention can be reduced. An intervention is defined as 'any identifiable piece of verbal/non-verbal behaviour'. A category is a range of related interventions. Heron suggests that his system identifies intentions and not behaviours. That is, it aims to help practitioners clarify what they intend to do rather than what they actually do.

Heron divides the six categories (see Box 2) into two broad groups: authoritative and facilitative interventions.

The authoritative interventions — prescriptive, directive and confronting — are ones in which the practitioner attempts to direct the behaviour of the client. The facilitative interventions — cathartic, catalytic and supportive — aim to enable the client to take responsibility for their actions.

Education

There is little understanding of what skills nurses use in telephone counselling or what their training needs have been carried out a piece of research to begin to explore these issues.

The initial work has involved practitioners undertaking 10-minute telephone counselling role plays. The person takes on the role of the caller and the counsellor takes the role of the counsellor. The caller is given a patient profile to guide their interactions and the counsellor is asked to respond. The telephone

conversation is audiotaped and then transcribed. The transcripts are then divided into individual verbal interventions and we place each one in one of Heron's six categories. Inter-rater reliability has been established on other transcripts. The findings from four RMNs who agreed to participate in role plays are shown in Table 1.

The analysis of the four role plays produced 211 interventions of which 208 were included in the analysis. The other three were eliminated because no agreement was reached between the raters. The total number of interventions in the authoritative group accounted for 31.73% (n=66), while the facilitative interventions came to 68.27% (n=142). Little variation in the use of the six categories was observed across the four nurses. The rank order of the skills used by the nurses participating were: catalytic, supportive, informative, prescriptive, cathartic and confronting.

The findings are not surprising because it is predictable that practitioners would use catalytic skills to find out about the caller's problem and offer support, information, suggestions and advice as they attempted to work with them to find solutions. More surprising is that only one cathartic intervention was used.

It is possible that no confronting interventions were used because the relationship between counsellor and caller had not developed sufficiently to warrant this type of intervention. However, the underuse of the cathartic and confronting interventions is consistent with nurses' perceptions of these skills reported in previous studies (Burnard and Morrison, 1991; Ashmore and Banks, 1997).

Training courses have been introduced at the University of Sheffield's Department of Mental Health and Learning Disability to address the above needs and issues, both pre- and postregistration.

Conclusion

Telephone service for mental health problems are growing. Addressing the skills to provide a safe, sound and supportive service needs to grow with the new services. Further research is needed to inform practice in this area. **NT**

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• Dean, C., Gadd, M. (1993) *Comparison of community-based service with hospital-based service for people with acute severe psychiatric service*. British Medical Journal; 6902, 473-476.

• Heron, J. (1990) *Helping the Client*. London: Sage Publications.

• Hornblow, A. (1986) *Does telephone counselling have preventive value? Australian and New Zealand Journal of Psychiatry*; 20:1, 23-28.

• Roberts, A.R. (1990) *Crisis Intervention Handbook, Assessment, Treatment and Research*. Belmont Ca: Wadsworth.

• Further research is being conducted jointly with the NHS Direct pilot site, Wakefield. The University of Sheffield also plans to evaluate the effect of an education package on the delivery of intervention by the NHS Direct nurse adviser

BEST PRACTICE IN BARIUM ENEMAS

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Poor communication and inadequate protocols compromise the quality of care given to some patients attending the imaging department for barium enema examinations. Abdul-Karim Conteh, radiographer, at City University, London, and Suzanne Henwood, principal lecturer, offer ideas on how to avoid the mistakes, fear and confusion that often accompany such examinations

The barium enema is an invasive procedure, and in order to ensure an adequate diagnosis, proper patient preparation is essential (Bryan 1987). The literature reports many reasons why patient preparation may be sub-optimal (De Lacey, 1982; Wilson-Barnet, 1978; Schuster, 1982). In one study, 78% of patients did not even know what examination they were attending the imaging department for (MacPherson 1995). Another study identified that 75% of carcinomas of the colon were mistaken for — or missed due to — faecal matter in the bowel resulting from poor patient preparation (Coombs, 1983), showing that there is clearly a need to change current practice in some units.

The key themes arising from the study (full details of the audit to be found at www.nursingtimes.net) were: communication; roles and responsibility; knowledge and training; and resource management. These issues were used to make four major recommendations which could improve the quality of patient preparation and overall care associated with imaging examinations in the future.

Patient Education

The imaging department should provide a patient information leaflet for barium studies in the languages spoken by their local patient groups. The leaflet should outline what is expected of patients, what the procedure entails, how it is undertaken, the time involved, possible complications, drugs used and their possible side-effects and what to expect following the examination. Full dietary requirements should be outlined and should include details for patients with different dietary needs. Patients should be encouraged and empowered to ask questions to clarify any points they feel unsure about.

If no instruction leaflet exists, a ward nurse could work in close liaison with the imaging department to create one. This would meet the requirements of both the imaging department and the ward to ensure optimum patient care.

An example is provided in Box 1, which should be supplemented with more detailed knowledge when required.

Staff education and training

All staff should have clearly defined roles and responsibilities which they understand and accept. The imaging department should collaborate with the

TABLE 1 Interventions used by four RMNs

Intervention	Number
Prescriptive	32
Directive	34
Confronting	0
Catalytic	98
Cathartic	1
Supportive	43

Study Hours: PREP made simple

All articles displaying the clock symbol have been given a Study Hours rating. This is a guide to the time it takes a nurse, midwife or health visitor with no specialist education on the subject to read and reflect on the article and consider the key reading. By doing this you can accrue Study Hours to help towards your PREP study days requirement. Make a note of any related study you undertake and keep a record in your personal professional file. For a free Study Hours pack, call 01483 4171.

Key reading
Important background material for this article:
Heron, J. (1990) *Helping the Client*. London: Sage Publications.
Hemingway, S. (1999) *Growth of telephone counselling highlights training needs*. Nursing Times; 95: 8, 60.

BOX 1: EXPLANATION FOR PATIENTS OF BARIUM ENEMA PROCEDURE

A barium enema examination has been requested by your doctor to investigate a potential problem within your large bowel. X-rays will be used to study your bowel. In order to do this, a combination of barium sulphate suspension fluid and air will be introduced through a tube placed in your back passage.

Prior to the examination, it is essential that the bowel is free of faecal matter which may obscure pathology. As a consequence, you will be put on a 48-hour regime of low fibre food and laxatives.

On the day of the examination, a radiologist or radiographer will undertake the study in the imaging department. There may also be a

nurse present in the room.

You will be asked a series of questions to ensure you are fit to undergo a barium enema. You will be given an injection in your arm to relax your bowel and to reduce movement which would spoil the images. This injection may cause blurred vision for a short while, but this is completely normal and there is nothing to worry about.

You will then be asked to lie on one side while a tube is inserted into your back passage. The barium is then introduced and you will be asked to retain as much of this as possible. Once the barium has reached a designated part of your bowel, air will be introduced to

push the barium along further and to outline the bowel wall.

A series of images will be taken throughout the procedure with a camera that moves above your body.

The radiologist or radiographer also watches the movement of the barium on a television monitor. (Because of this, the room is usually darkened.)

Once sufficient images have been obtained, the majority of the barium is allowed to flow out of the tube into a bag, and you will be given the opportunity to go to the bathroom before returning to the ward.

You are free to ask questions at

any time throughout the procedure and to alert the staff to anything you are unsure about as soon as it arises.

For a couple of days you should expect your stools to be white in appearance, and you should drink lots of fluid and eat fruit to prevent dehydration.

The results of the examination are unlikely to be available on the day, as the images taken with the camera have to be studied in depth under special viewing conditions. The results will normally be available within three days, and the ward should be able to tell you when to expect them and who to contact.

BOX 2: GUIDELINES ON PHYSICAL PATIENT PREPARATION

Laxatives

For example, Picolax. This should be given to the patient at 8am and 6pm on the day before the examination.

● Note: Due to risk of dehydration, patients should be advised to drink plenty of water.

● Note: Some patients should not be given laxatives for preparation, for example, those with Crohns disease.

● Note: Patients should then have easy access to bathroom facilities.

Appointment time

For diabetics, an early morning appointment is preferable as it reduces the disruption to normal meal times. Breakfast should be made available immediately after the examination.

Diet

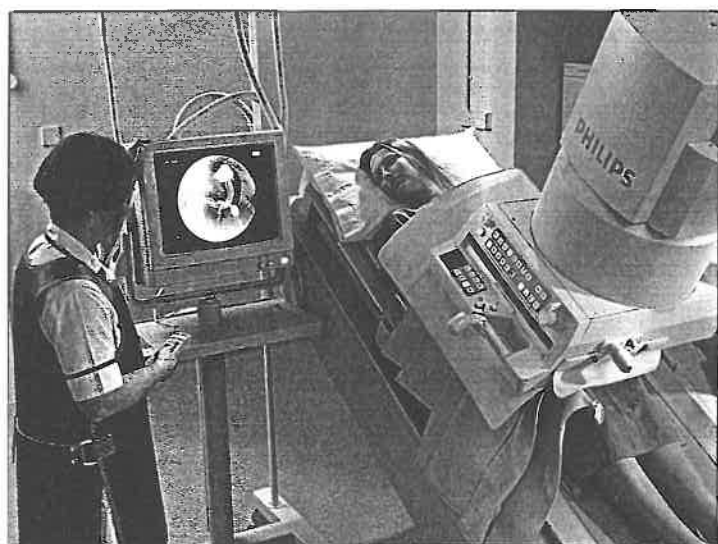
Three days before the appointment, the patient should commence a low residue diet.

On the day of the examination, the patient should have only clear fluids.

● Note: Adequate advice needs to be given to patients who are vegetarian or are from cultural groups who may not be able to follow the 'normal' diet regime.

Dress

The patient should be dressed in a cotton gown with an open back and cotton ties. The patient should also should be given a dressing gown to maintain their dignity during transportation to and from the X-ray department.



Patients need information to prepare them for this procedure

nursing division to design a training course to increase the knowledge and understanding of nurses as regards barium studies. Staff should be aware of the expectations placed upon them.

A booklet outlining the procedure should be made available on the ward for reference purposes and should include details on physical (Box 2) and psychological patient preparation.

Psychological patient preparation

This should include a full explanation of what the examination entails. The patient should be given the opportunity to ask questions about any aspect of the examination from the time they are told they are going to have one. The patient should be informed of the appointment as soon as the ward knows. They should be provided with adequate information on both the bowel preparation and dietary needs to increase understanding and compliance.

Communication

Communication between nurses, doctors and the imaging team should be improved to optimise the standard of patient care. There should be ongoing open communication, but this should be supported by a multidisciplinary team responsible for barium studies, which could monitor problems, audit service

quality, research new techniques or protocols and ensure accountability was being accepted for the procedures.

Preparation checklist

The multidisciplinary team should devise a checklist for preparing patients for barium studies to ensure that nothing is omitted and to enable staff to alert members of the team to potential problems before they arise. This checklist could be included with the patient notes, so that the imaging department always knows exactly what preparation has been given to the patient.

Conclusion

All team members should work together to avoid omissions that would compromise patient care. It is of absolute importance that these recommendations are carefully considered to avoid patient mismanagement due to staff negligence.

While the main focus of this article is on the barium enema, the framework described could be used for any imaging examination, and similar protocols could be written and introduced to ensure that all patients are adequately prepared.

We recommend close liaison with the imaging department in the development of these protocols,

highlighting the need for effective interdisciplin Continuing Professional Development which has an impact on professional practice and quality of patient care. **NT**

● Bryan, G. J. (1987) *Diagnostic Radiography*. London: Churchill Livingstone

● Coombes, B.M. (1983) *Laxatives as colonic preparation for Barium enema: the patient's viewpoint*. *Radiography*; 49: 585; 221-222.

● De Lacey, G. (1982) *Routine colonic lavage is unnecessary for Double Contrast Barium Enema in Out-Patients*. *The British Medical Journal*; 286; 1021-1022.

● MacPherson, B. (1995) *Improving Communication in Imaging Departments*. *Nursing Times*; 91: 8: 49.

● Schuster P. (1982) *Preparing the Patient for a Barium Enema: a comparison of nurse and patient opinions*. *Journal of Advanced Nursing*; 7: 523-5.

● Wilson-Barnett, J. (1978) *Patient's emotional responses to Barium x-rays*. *Journal of Advanced Nursing*; 3: 37-46.

● Details of the audit carried out by the author of this article are available at www.nursingtimes.net