Structured induction course for ENT Junior trainees

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Abstract

The aim of this study is to design a useful departmental induction programme for Foundation and Junior Speciality trainees in Ear Nose Throat Surgery (ENT) and to enable new junior trainees to become safe practitioners with enhanced skills from the beginning of their posts. This proposed course design could be applicable to all hospitals. The main outcome measures would be evaluation sheets completed by the trainees, their colleagues and their trainers. A staged approach to departmental induction is recommended. Such a system including generic as well as specific ENT skills, supported by comprehensive written information, would contribute to meeting the needs of trainees and their trainers in an efficient and effective way. An effective induction programme enables an individual to move quickly and comfortably into making an appropriate contribution to service and to gain more from the training provided.

INTRODUCTION

Radical changes are underway regarding the way in which junior doctors are trained. A reduction in hours of work coupled with an increase in service demands place a significant pressure on a trainee starting a new job [1]. To keep up the junior doctor is expected to deliver from day one. For this to happen effectively there has to be a structured approach to induction.

Induction programmes exist at both hospital and departmental level and both have an important role. Hospital induction programmes aim to integrate doctors into the system as quickly as possible, to allow its continued smooth running [2]. They are recognised to enable new doctors to feel competent and reduce anxiety [3]. Such induction programmes are strongly recommended in a number of reports and by postgraduate deans [2] and are mandatory for all trainees starting a new position.

Though all hospitals have a hospital induction day, there is a wide variation in the topics covered [4]. Interestingly most of the topics/lectures are chosen by senior managers rather than by the trainees [3,5].

Departmental induction allows new doctors to familiarize themselves with the practices and facilities available in their specific area of work. Trainees often have a diverse range of experience, giving rise to different needs and expectations and they may not be readily fulfilled by a generalised hospital induction programme. An effective departmental induction course would allow trainees to attain a satisfactory level of competence in their particular speciality as quickly as possible. Although some effort is required to design and deliver such a programme, the potential returns, in the months following should be significant.

METHODS

The aim of this study was to design a useful departmental induction programme for the Foundation and junior Specialty (ST1 & 2) trainees in Ear Nose Throat Surgery (ENT) to enable them to have the skills necessary for effective practice right from the beginning of their posts.

Concerns have been raised that short didactic lectures may not be the best way to teach adults [2,3]. On reviewing the English language literature, not much has been published regarding specific induction course for ENT trainees. This proposed programme for ENT trainees is based on the pattern of structured programme described by Ward et al for departmental induction.

DESIGN OF THE PROPOSED COURSE

The course is based on the practical needs of the new doctors and it conveys a broad range of information to the new trainees with minimum disruption of service. It places less demand on anxious trainees and gives them time to assimilate the information provided. We suggest this model could be integrated with any existing hospital induction programme [6].

The course should be lead by the consultant responsible for the junior trainees in the department, with contributions from a range of professional colleagues to teach appropriate skills, knowledge and attitudes.

Step one: On the first day in the department (Table 1), basic information would be provided for service commitments to ensure that the new trainees can manage competently during their first emergency on call duty [6]. This first session would also include any practical tips which the previous groups of trainees had acquired over their attachment. Passing on of these tips is usually very helpful [6] and a period of overlap between old and new staff is extremely beneficial.

Step two: Detailed service information would be given once the trainees understood the basic expectations of the job. This session, occurs seven to ten days into the post (Table 2). It would involve more in depth introduction to the service to enable trainees to work more independently [6]. At this stage they would be encouraged to bring up any problems faced in the first week of the job.

Step 3: A session after two to three weeks into the job (Table 3). This would focus on clinical education and training and speciality specific skills and knowledge [6]. The training programme and goals should be given due importance and a fine balance maintained between service provisions and teaching/training. This is an important session from the point of view of the trainees who wish to progress their career in ENT and are looking for appropriate guidance.

The trainees would be given an up to date departmental handbook on day 1, which would contain information relevant to the ENT day-to-day work. It would contain important contact telephone and bleep numbers. It would also mention in brief the common departmental guidelines. Ideally this would be pocket sized.

Feedback is a vital part of any course. Detailed end of day and end of course questionnaires would be completed. The faculty should review the questionnaires on the day of completion to allow any adjustments to be made according to the needs of the trainees. A post course, while in work, evaluation would be sought from the trainees, registrars, educational supervisors, nurses and administrative staff regarding the actual performance of the new trainees. This would help decide about the validity of the course and reflect upon making any changes in future.

DETAILS OF THE COURSE

Topics covered:

- Basic ENT skills
- Advanced ENT skills
- Patient management and diagnosis
- Personnel management
- Social and ethical issues
- Consent taking
- Communication skills

The morning sessions would consist mainly of lectures and seminars while the afternoon would involve clinical skills stations, problem based learning and workshops. The facilitators for practical sessions would provide direct feedback to the trainees.

Course timing:

Step 1: On the first day in the department.

Step 2: 7-10 days after joining.

Step 3: 2-3 weeks after joining.

Figure 1

Table 1: Programme for Step 1 of the induction course

9.00 am-9.30 am: Informal meeting with colleagues.
9.30am-11.00am: Formal introduction to ENT Consultants, Registrars, theatre, ward and outpatients sisters, ward manager, audiologists and speech therapists. Brief introduction from each and feedback from previous trainees.
11.00am-11.30am: Coffee break and informal queries.
11.30am-12.30pm: Departmental policies and guidelines for management and treatment of common ENT conditions. Trainees to be given departmental handbook.
12.30pm-1.30pm: Lunch
1.30pm-2.30pm: Workshop on consent for common ENT operations.
2.30pm-3.30pm: Practical interactive session on answering GP calls and management of common ENT problems.
3.30pm-4.00pm: Coffee
4.00pm-5.00pm: Basic Life Support session.
5.00pm-5.15pm: Evaluation form completion and Close.
5.15pm-5.45pm: Faculty meeting.

Figure 2

Table 2: Programme for Step 2 of the induction course.

9.00am-10.30am: Lecture on other less common ENT conditions and management.
10.30am-11.15am: Personnel management, Roles and responsibilities of SHO's
11.15am-11.30am: Coffee break
11.30am-12.30pm: Breaking bad news & communication skills.
12.30pm-1.30pm: Lunch
1.30pm-2.30pm: Troubleshooting session on problems faced by trainees in the first week of the job.
2.30pm-3.30pm: Practical session on communication skills.
3.30pm-4.00pm: Coffee break
4.00pm-5.00pm: Practical session on common ENT OPD & surgical procedures.
5.00pm-5.15pm: Evaluation form completion and Close.
5.15pm-5.45pm: Faculty meeting and reflect on the day.

Figure 3

Table 3: Programme for Step 3 of induction course

9.00am-10.15am: Information and advice about exams, courses and conferences to attend.
10.15am-11.00am: Research and audits ongoing in the department and opportunities to become involved.
11.00am-11.30am: Coffee break
11.30am-12.30pm: Medicolegal & Ethical issues.
12.30pm-1.30pm: Lunch
1.30pm-2.30pm: Practical session on problem based learning on clinical scenarios.
2.30pm-3.30pm: Practical session on Advanced Life Support including defibrillation.
3.30pm-4.00pm: Coffee break
4.00Ppm-5.00pm: Practical session on other ENT procedures e.g. Flexible Laryngoscopy, Cricothyroidotomy, ligature tying for tonsils.
5.00pm-5.15pm: Evaluation form completion and Close.
5.15pm-5.45pm: Faculty meeting and reflect on the day.

EVALUATION OF THE COURSE

The evaluation of the course would be at three levels, similar to that suggested by Stark et al, 2003 [7] :

Level One: During the course feedback questionnaires would be distributed to assess the usefulness of the individual sessions. A 4 point Likert scale (strongly agree, agree, disagree, strongly disagree) would be used but free comments would be invited. The evaluation sheets would be anonymous.

The end of the course evaluation would be more generalised. The trainees would respond to some key questions:

- I would like more lectures on ---- topics.
- I would like more time to practise my clinical skills in otology/rhinology/laryngology.
- I would like more workshops to be offered.
- I don't think the following topics were useful.
- Comments on the facilities.

The participants would also be asked to rate the course overall on 4 point Likert scale (Excellent, good, satisfactory, not satisfactory). Daily feedback would be analysed by the tutors at the faculty meeting. The data would be recorded for

audit purposes. After step 3 the faculty would meet again to discuss and critically analyse the course.

Level two: Trainees would be sent questionnaires 4-6 weeks into the post. The questionnaire at this stage would seek to discover if the trainees perceived benefit from induction. They would be asked to rate each of the course topics using a 5 point Likert scale (strongly agree to disagree or not relevant) about whether the course had prepared them for those aspects of their current post.

Level three: A further evaluation would be done after the trainees have been in the post for 6-8 weeks. This is to find out what others think about the new trainees. One of the reasons to develop the course was to improve the new trainee's performance right from the beginning of their posts. Thus it is important to discover how others viewed them. Questionnaires would be sent to medical, nursing and administrative colleagues. These questionnaires are to ask rest of the team whether they felt the induction course had prepared the trainees adequately for their work.

DISCUSSION

Currently most doctors will take up a post in ENT after completing their first year as a Foundation trainee (pre registration house officer). During their training at Foundation year 2 or Speciality trainee grade they will undertake increasing responsibility for patient care. At the same time they will develop the general and specific skills needed for their chosen speciality [8].

Though junior doctors training is in the process of change there have been historical problems with the job structure, working conditions and training opportunities provided [8]. Supervision, assessment and appraisal vary from department to department. So starting a new job is full of anxiety for the trainee. During the change over of the trainees, service to the patients does not stop. If there is no overlap, formal handover can be difficult. Lack of preparation for these posts has caused concern for senior medical and nursing staff.

Is induction really required? The cost of running an induction course is manifested in a loss of service cover from the trainees during the course and the work by the tutors. The benefits of induction are rapid integration of the new doctors and reduction in anxiety. An efficient and appropriate induction will reduce pressures on the other team members [3]. Thus induction should be seen as a responsibility rather than a compulsion.

The main principles of induction are [3]:

1. General hospital induction should take place on the first day of the job. It should focus on the needs of the trainees and not the trust (employer).
2. Departmental induction should follow the general induction and can take place over a longer time.
3. Induction must be mandatory to attend.
4. It should be bleep free and in a friendly atmosphere.

It is recognised that formal training must continue into postgraduate life. Short preparatory courses are currently available that teach some of the basic skills required by the junior doctors. ‘Ward Skills Course' in Liverpool [7] is a popular course.

The Standing Committee on Postgraduate Medical and Dental Education (SCOPME) recommended that providing high quality induction programmes based on the principles of adult learning is the responsibility of regional post graduate dean. Thus it could be funded by the local employers in association with the post graduate deanery [7].

The content of induction courses has been under scrutiny. It has been recommended by GMC that these courses should cover the hospital or practice procedures and routines, the accident and emergency services, resuscitation procedures, use of radiology and laboratory services and facilities in the postgraduate centre. Also a postgraduate education report encourages course organizers to apply the principles of adult learning in the designing and implementation of induction courses. Adopting such a learner centred approach focusing on active participation and increased interaction between the tutors and the learners will maximise the benefits of the induction course [9].

Previous research has focused on induction to the whole hospital and failed to separate departmental induction from hospital induction [3]. This lack of differentiation can result in confusion, gaps or overlaps between hospital and departmental programmes. Stark & Mitchell (2003) [7] have designed a course for vocational trainees taking up first dental jobs. A pocket sized junior doctor's handbook is an important part of the induction process. Hospital policies can be distributed separately.

CONCLUSIONS

Induction is an integral part of starting any new job. General hospital induction programmes are important and more so mandatory. We recommend a staged approach to departmental induction, using a relevant, high quality and comprehensive programme supported by written information. We hope this will meet the needs of trainees in an efficient and effective way. The inclusion of practical sessions on consent and communication skills, we feel is of great benefit. It enables a new trainee to move quickly and comfortably into making an effective contribution to service and to profit from the training provided.

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