



THE REPUBLIC OF UGANDA
Ministry of Health

Non Communicable Diseases

TRAINING MODULE AND ROLE PLAYS

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WORLD **DIABETES** FOUNDATION

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Introduction

This module is for training health care workers providing routine care in health facilities' outpatient departments; including health centres, district and regional-level hospitals. It is used hand in hand with the case management and health education desk guide.

The module gives instructions on how to provide essential comprehensive care for patients with major Non Communicable Diseases (NCDs) using the desk guide as a “quick reference” tool. Throughout the training, knowledge, skills and attitudes to appropriately manage and refer patients with NCDs will be developed. Health workers will also learn how to communicate effectively with patients as well as complete chronic care cards, appointment cards and NCD registers.

All health workers undergoing NCD training should complete this module in order to understand the whole patient care pathway.

How to use the training module

The module will refer you to the relevant sections in the desk guide and role plays for practice.

You will have the chance to practice and improve all the skills necessary to do your job by completing the practical exercises, role plays and group discussions. The facilitators will be available to answer your questions and guide discussions.

Instructions for role plays

- Split into groups of 3
- Each group will have practice consultations, lasting about 5-20 minutes each, followed by a few minutes feedback from the group observer
- Each member of the group will have opportunity to play the role of health worker, patient, and observer as guided below;

The patient: Using the case studies, try to play the role of patient. Imagine how this person would think and speak, and try to act as them. Use their way of talking, expressions and concerns. Listen to what the health worker says, but also mention your concerns according to the case study notes provided.

The health worker: When you are the in the health worker role, take a few minutes to recall how to communicate W.E.L.L (Welcome, Encourage, Look and Listen). Remember to practice this during your consultation. Keep open and always refer to the relevant pages of the desk guide during the role play to ensure that you do not forget anything important.

The observer: Refer to the relevant pages of the desk guide. Keep these pages open and look at them during the role play to ensure that the health worker does not forget anything important. Note down some good and “could be better” feedback to mention after the role play. Remember to be specific and constructive. Your feedback could relate to the content of the discussion and how well it was communicated, using W.E.L.L.

Don't interrupt until the role play ends. The observer gives the first feedback to the group.

Proposed House Rules for the training

In order to ensure that the training sessions run smoothly and make the most out of the course, we need to agree on some “rules”.

Discuss and agree on the following:

- Observing time
 - Starting the training day at **8:00am**
 - Ending the training day at **5:00pm**
 - A coffee/tea break of 15 minutes, and 1 hour for lunch
- Switching off cell phones during the training sessions
- Not attending to visitors during training sessions
- Not leaving the room unnecessarily during training sessions

There will be no certification without full participation in each module.

Please suggest, discuss and agree on these and more house rules.

Activities to facilitate learning

During the course the following images may be used:



Role plays



Practical exercises



Group discussions

Role plays

Role plays are particularly useful to improve clinical interviewing and communication skills, which are so important in chronic care. Feedback within these groups should start with the positive points, adding, “what could have been added/said”.

Practical exercises

Practical exercises help to emphasise certain learning points. Once completed, discuss with the other members of your group.

Group discussions

Group discussions allow us to share our experiences and learn from one another. Your own small group may have had a useful learning experience to share with everyone. When contributing to general discussions and giving feedback, there is no need to refer to the individual members of your group by name. It is better to introduce your comment with a statement such as:

“One member of our group had difficulty noticing the nervousness and anxiety of the patient. On discussion we felt that this was partly because....”

If you have any questions, ask the facilitator.

Introductory module: Communication skills

Session objective

To learn how to use effective communication in identifying and caring for people with Non Communicable Diseases

Effective communication

Effective communication is essential to good quality care. Good communication is needed to obtain information about the patient's symptoms and deliver information about the patient's diagnosis and care.

Everyone can improve on their communication skills, even after many years of experience. It is important that we develop our skills so that patients feel comfortable and able to discuss their symptoms freely. This will help to obtain all the information needed to make a diagnosis as well as effectively communicate information which will help patients adhere to treatment and appointments. A patient is more likely to continue with their treatment if they understand their diagnosis, why treatment needs to be life-long, and is fully aware of the risks to their health if they stop treatment. The way these issues are discussed can directly affect how a patient acts.

Interviews conducted with patients require good communication skills because patients are often:

- Worried about the cause of their illness, how long they will have the illness, whether the illness can be cured and how it can be controlled
- Embarrassed by any social stigma of their condition
- Afraid or worried about confidentiality
- Worried about the attitude of the health worker

We will practice these communication skills during the training modules.

There are two stages to effective communication;

1. The health worker must be open and receptive to the feelings and attitudes of the patient.
2. The health worker must be able to respond appropriately.

Communicating “W.E.L.L”

To remember some of these ideas memorize the acronym: **WELL**. Apply this in your daily consultations with patients and throughout the training modules.

W = Welcome your patient

- Ensure privacy and confidentiality
- Greet the patient using their name (for example: “hello Mr/Mrs... please come in”)
- Offer a seat

E = Encourage your patient to talk

- Ask general questions "what is your problem", "tell me your concerns"
- Allow your patient to answer
- Nod, agree or say "tell me more about that" to help your patient explain
- Show empathy (I understand how you feel)

L = Look at your patient

- Make sure that your facial expression is warm and friendly
- Maintain eye contact with your patient as they speak
- Observe their feelings, as well as their general medical condition

L = Listen to your patient

- Listen carefully to what your patient has to say.
- Do not interrupt them.
- Show the patient you are interested in what they are saying.

Open and closed questions

It is important to start taking a history with open questions at least for the first ‘golden’ minute. Open questions have no fixed answers and the patient can express their symptoms and concerns in their own words. Closed questions can be used later in the consultation. Closed questions are phrased very specifically requiring yes and no answers. The problem with closed questions is that some patients may answer closed questions in the way they think you want to hear. Leading questions should be avoided and are often answered inaccurately.

Example: If a patient mentions they have “lost weight”, you may ask an open question such as "tell me more about your weight". If this doesn't give you the information that you need, for example the duration of weight loss, then ask a more specific open question such as "how long have you been losing weight?" If this doesn't get a clear answer you may need to ask a closed question, but with alternatives, such as ".... has this been over weeks, months or longer?", or ask "did your weight loss start before or after?"

Language

Remember to use simple, non – technical language to help your patient understand their illness. For example, saying ‘high blood pressure’ instead of ‘hypertension’ or talking about ‘taking medication’ instead of ‘adhering to treatment’.

Check understanding throughout the consultation.

Practical exercise A

This is a quick exercise to see if we can recognise different types of questions used in consultations and interviews. For each question listed below, decide if it is:

- A. An open question
- B. A closed question
- C. A leading question

Note down your answers.

Questions:

1. Tell me about your problems.
2. You are no longer feeling sick with the tablets now are you?
3. Tell me, how have you been since your last visit?
4. You were feeling ill at the last visit, and I changed the tablet - you're feeling better now, yes?
5. You said you have had urine trouble, tell me more about that?
6. You've had weight loss, is it for a month?

Discuss your answers with your colleagues and the facilitator.

Supportive communication:

Health Educators have a particularly important role in helping patients change unhealthy behaviours. This is discussed in more detail in module 9, however there are some basic communication principles that can support patients and should be used by all health workers. These take practice but can be very effective for helping your patients identify and change behaviours that are causing harm.



Express empathy.

This means showing acceptance of the patient and understanding their feelings. It helps to build self-esteem and a safe place for them to express their fears or concerns. This can be done through listening and questioning as described above and making sure you do not judge the patient.

An important skill is to listen to what the patient is saying and reflect it back to them. This shows you are listening and can help them identify their own feelings and reasons for wanting to change.

Example 1:

Health worker: 'You said you were worried about your heart' (a statement not a question).

Patient: 'I am a little worried, it's all so complicated, I don't know where to begin'

Health worker: 'You're just not sure what to do next'

Patient: 'I think I need some time to get used to what I've been told and what it means for me and my family'

Health worker: 'You need some time to think, which will help you decide the best thing to do next'

Don't worry if you don't summarise correctly, the patient will either respond with a 'yes' or 'no' and you can continue the conversation. The important thing is that this is a powerful tool to show you are listening and will help the patient work out their own feelings

Encourage identification of goals.

The patient should be encouraged to identify their own goals and arguments for changing behaviour. Take time to explore their concerns and reasons why they might want to change using listening and open questions. This can be done by asking them what they might like to change and why, and how they might do it.

Example 2:

Health worker: 'Tell me a little about your drinking'

Patient: 'Well, I drink most days but not that much, really'

Health worker: 'You're quite a light drinker' (reflecting)

Patient: 'Well, I'm not sure; I can hold it quite well, although maybe it is sometimes too much'

Health worker: 'You can drink quite a lot and it doesn't affect you'

Patient: 'I suppose so, although I suppose sometimes it does'

Health worker: 'What have you noticed?' (Open question)

Patient: 'Well I've had these stomach pains and now with this problem with my heart. But until now it hasn't caused any problems.'

Health worker: 'So, until now it hasn't really caused any problems for you'

Patient: 'Well I wouldn't say that, maybe I do need to think about cutting down....'

Avoid resistance

Resistance from a patient is a sign that they view the situation differently from you. Arguing for changes in behaviour with a client is likely to make them voice the opposite argument and give reasons why they should continue doing what they already do.

Use open questions that are non – judgemental and reflect back to the patient, as in the example 2 above.

Support self-efficacy

Self-efficacy means that the patient believes they have the ability to change. Supporting this means supporting this belief and helping the patient identify their strengths. You must also show that you believe in their ability to change.

It helps to be able to identify statements that indicate your patient is ready to change, these include:

- Expressing a desire to change:
'I wish I could', 'I want to', 'I like the idea of'
This could be prompted by asking 'Why do you want to change?'
- Discussing what they think they are able to do:
'I think I can', 'I could', 'I might be able to'
This could be prompted by asking 'How would you do it, if you decided to?'
- Giving reasons for changing their behaviour

Prompted by asking 'What are your three best reasons for change?'

- Speaking of a need to change:
'I must', 'I ought to', 'I need to'
Prompted by asking 'How important is it for you to change?'

The responses to these questions can help you identify and explore your patient's values, which can be powerful motivators for change. If your patient is struggling, you can ask them to remember their reasons for wanting to change in the first place.

Facilitator Role Play: Communication skills

The facilitators will now do a role play. Observe closely and write down 5 possible barriers to communication that occur during the role play. After the role play is finished, you will be asked to share your feedback.

*******Poor communication******



Session 1: Assessment and tests

Introduction

Health workers should think about the diagnosis of cardiovascular disease (CVD), hypertension, Diabetes, Sickle cell disease, Cancer, COPD and Asthma in all patients who attend the health clinic. Assessment should include asking the patients questions, examining them and performing appropriate tests to help to make a diagnosis.

Session objectives

By the end of this session you will be able to:

- Make an assessment of a patient attending a health facility or outpatient department.
- Understand how to diagnose CVD, hypertension and diabetes, Sickle cell disease, COPD and Asthma
- Understand which tests to choose and be able to interpret the results of the tests.
- Identify the critically ill patient needing urgent referral

Assessment of Non Communicable Disease

Take time to read through the 'Assessment of cardiovascular disease (CVD), diabetes hypertension, Sickle cell disease, COPD and Asthma as guided by the facilitator.

Remember to explore each symptom that the patient tells you.

It is important that when a patient mentions a relevant symptom, you ask about related symptoms, previous symptoms and current medication that the patient is taking.

If the patient presents with a symptom that does not fall into the diagnosis of cardiovascular disease (CVD), Diabetes, Sickle cell disease, COPD and Asthma use the Uganda clinical guidelines or the Integrated Management of Adolescent Adult Illness (IMAI) to help make an alternative diagnosis. Do not forget to look for other common important diseases such as HIV and TB.

All patients should be asked questions, examined and managed according to their diagnosis.

<p>Refer to pages 10-15 in the desk guide</p>
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Diagnosis of CVD

If the patient has any of the symptoms of current cardiovascular disease (CVD), you will need to examine for signs of critical illness. This can help you to decide whether the patient needs urgent referral or not.

It is especially important to consider diagnoses of CVD in men and women over 50 years, diabetes patients and DM with poorly controlled BP as their CVD risk is increased by 2-3 times.

If the patient is stable and does not require urgent referral, use the desk guide to manage them appropriately.

Refer to pages 10 and 14 in the desk guide



Role play 1

(Ask the facilitator if you have any questions).

The patient: You are Sam, a 58 year old man who has never been to the clinic before. You have had chest pain for the last week and now have some shortness of breath. Your chest pain comes on during exercise and also when you are sitting at home with your family. You have never had these symptoms before but are worried as your father used to get chest pain. You are not currently taking any tablets or drugs. You smoke about 25 cigarettes a day and have smoked since you were 25.

The health worker: You are seeing Sam in the clinic. This is the first time that you have met him but you have looked after his father before who had angina (chest pain). As he walks into the clinic you notice that he looks flushed and is overweight. Start your consultation using page 10-14 of the desk guide.

The observer: The health worker should ask about Sam about his chest pain and other symptoms, and make an assessment as to whether he needs urgent referral. If the health worker asks to examine the patient tell them the following results: Sam's blood pressure (BP) is 87/50 mmHg and his RR is 28.

Consider the following when observing the role play:

- Did the health worker ask the patient the correct questions?
- Was the patient appropriately referred if they had symptoms or signs of severe illness on examination?
- If the patient was over 50, did the health worker take the blood pressure and measure and calculate his BMI and Waist Hip ratio?

Diagnosis of Hypertension

Many patients with raised blood pressure will not present with symptoms. Raised blood pressure (BP) increases the chance of developing cardiovascular disease and contributes to the complications due to diabetes.

It is important to take a BP reading for all patients presenting to the health facility.

Taking a blood pressure reading

It is important that the blood pressure is taken with the patient after they have been sitting for atleast 5 minutes.

Make sure you have the correct equipment:

- A stethoscope (may not be necessary if using an automated digital machine)
- A sphygmomanometer (blood pressure machine)
- The correct sized blood pressure cuff

Make sure the patient is sitting with their feet flat on the floor and their arm out at heart height, resting on a table.

Make sure the arm cuff is properly deflated before placing it around the patient's upper arm.

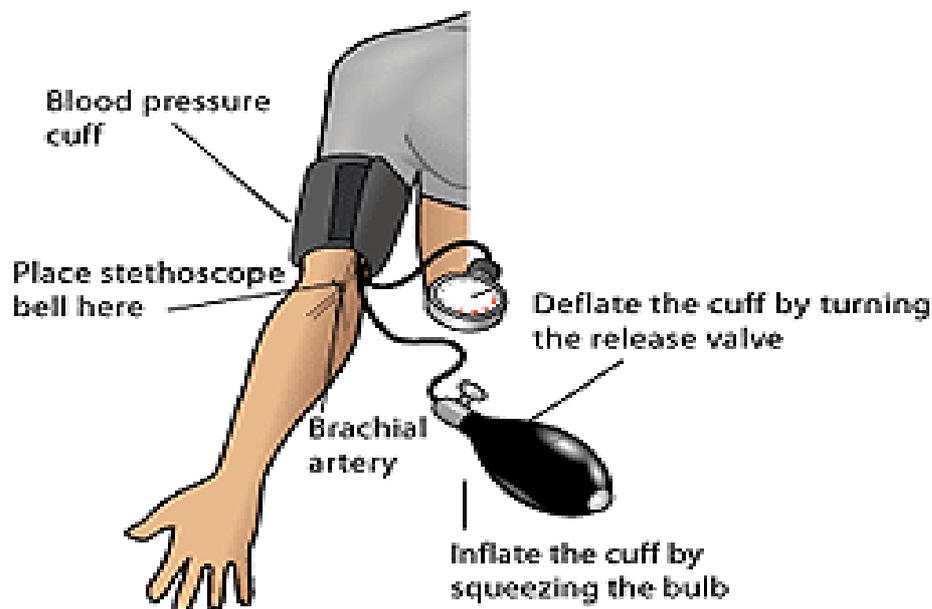
Ensure that the cuff is the correct size for the patient. If required use a smaller or larger cuff.

Wrap the cuff tightly around the upper arm, ensuring the whole cuff is above the elbow, about 2cm (or 2 fingerbreadths) from the cubital fossa.

On the same arm as the cuff, with the palm turned upwards, feel in the inside curve of the elbow on the little finger side of the elbow for the brachial pulse. Place your stethoscope over the pulse (see figure 1)



Figure 1:



Slowly inflate the cuff of the BP machine until you can no longer hear the blood flow through the artery (not necessary in an automated digital machine).

Now slowly deflate the cuff and listen for when the sound of the pulse returns. Note the value of the mmHg on the machine - this is the systolic blood pressure.

Continue deflating the cuff until you can no longer hear the pulse. Note the value of mmHg on the machine – this is the diastolic blood pressure.

If the blood pressure reading is very high (e.g., > 200mmHG systolic, >120mmHG diastolic) or slightly high but with associated symptoms like confusion, then it is important that you send the patient to the hospital/doctor urgently for further assessment and tests.

**Refer to page 16 in the desk guide on diagnosis of hypertension
And page 14 for critically ill patient**

Practical exercise A

Using the desk guide and the information above, take turns to measure blood pressure in your groups of 3

Record your findings and discuss what you would do next.

Refer to page 17-19 in the desk guide on management of hypertension

Practical exercise B

Moses has attended the clinic. You know him well, he often attends as he has a history of anxiety and depression. You notice looking at his records that he has recently turned 50.

Questions:

1. After you have discussed *Moses's* anxiety what else should you consider doing?

You decide to measure his waist circumference and take his blood pressure.

Waist: 104cm

Blood pressure 138/88 mmHg

2. What do you tell *Moses* and what would you do next? Look at pages 46 of desk guide to help you give general lifestyle advice.

Acknowledge that it can be difficult to make many lifestyle changes at one time, but emphasise how important it is for his health. Offer support and referral for health education if appropriate.

Diagnosis of Diabetes

There are a number of blood glucose tests available. When interpreting the results you must know which type was done in order to interpret the result correctly.

Random Blood Glucose (RBG):

This can be taken at any time. It does not take into account what the patient has been eating or drinking. It is therefore less sensitive than the other tests. However, it is the easiest to perform. Diabetes can be diagnosed on the basis of two RBG results if necessary.

Fasting Blood Glucose (FBG):

Before taking the blood test, the patient must have fasted for at least 8 hours. The easiest way to do this is to arrange an appointment for the patient to have the blood test first thing in the morning. They should fast overnight and must not have anything to eat until after the test.

Oral Glucose Tolerance Test (OGTT):

This is the most accurate way of assessing how a patient metabolises glucose although it is rarely performed in most facilities in Uganda.

This test is especially important and recommended in the elderly.

Procedure: Take fasting blood glucose (FBG) in the morning.

Give a glucose drink (75g of glucose or 2 tablespoons of sugar or approximately 400ml of a regular coca cola).

Take blood glucose 2 hours later.

It requires 2 tests on the same day and the patient has to wait at the clinic for a minimum of 2 hours.

You have already learnt how to identify patients for screening. The first stage is to check random blood glucose on all these patients. Depending on the result of this first test you may need to repeat the test or consider another blood glucose test.

Always clearly explain why tests are being done and give appointments for review.

Refer to pages 22-23 (Diagnosing Diabetes) in the desk guide

Complete role play 2

The patient: You are Sarah, a 45 year old woman who has had recurrent vaginal infections. Over the last 3 months you have been feeling thirsty all the time and need to go to the toilet often. You have not been to the clinic since you had your baby and have not had any similar problems before. You bought a cream for your vaginal infection that you have been using for the last week. You are not taking any tablets.

The health worker: Sarah is a 45 year old woman. You have not seen her in the clinic since the birth of her last child a few years ago. She looks tired.
Start your consultation using pages 10-14 of the desk guide

The observer: The health worker should ask about Sarah's symptoms, how long she has had them for, and use the pages in the desk guide to help them decide what tests to do next. If the health worker asks about HIV then you can tell them that she has tested negative. Consider the following when observing the role play:

- Did the health worker ask the patient the correct questions?
- Was the patient asked about HIV?
- Did the health worker take the blood pressure and measure waist circumference/calculate BMI?
- Did the health worker consider testing for diabetes?

Practical exercise C

You are the health worker. Sarah (role play 2, session 1) came to the clinic with recurrent vaginal infections, thirst and urine frequency. You suspected diabetes and sent her for a random blood glucose test immediately after the consultation.

You have now received the following blood result from the laboratory:

Patient ID: Sarah Nassali **DOB:** 12/04/1976 (38yrs)
Random Blood Glucose: 10.4mmol/l (187mg/dl)

Questions:

1. What is the diagnosis?
2. Can the patient be diagnosed with diabetes based on this blood test?
3. What further action is required to make a diagnosis?

You decide to arrange another blood test for Sarah to confirm the diagnosis. She has little money and has to travel a long way to the clinic. She is unable to come first thing in the morning and wait for two hours because she needs to attend to her family.

Questions:

4. Which second blood glucose test would best suit Sarah?

You now have two blood glucose results for Sarah:

05/01/14 RBG: 10.4 mmol/l (187mg/dl)

28/01/14 RBG: 11.8 mmol/l (214mg/dl)

Questions

5. Can you confirm the diagnosis of diabetes in Sarah?
6. Discuss what you will do next?

<p>Refer to page 23-29 (managing diabetes), page 23 (diabetes patient education) in the desk guide</p>

After this section, go to session 2 (page 22 of this module) on complications and referral.

Sickle cell disease, COPD and Asthma will be handled later.

Sickle Cell Disease (SCD)

Sickle cell disease is an inherited disorder characterized by abnormal shapes of the red blood cells. Rather than being round and flexible, red blood cells are sickle shaped, rigid and can block small blood vessels impairing blood flow. This leads to shortened red blood cell survival with subsequent anaemia and other associated complications. The signs, symptoms and complications of sickle cell disease mainly arise from hemolysis and vaso-occlusion.

Early screening, diagnosis and proper management improves the quality of life of sickle cell patients. It is important for health workers to confirm sickle cell diagnosis rather than manage patients clinically. Health workers should also advise couples to go for pre-marital counselling and screening for sickle cells.

Diagnosis of SCD

If patient has any of the signs and symptoms of sickle cell disease, it's important to confirm with Hb electrophoresis. Screening with a sickling test will not differentiate between a sickler and a carrier – which may contribute to delayed decision-making.

You will need to examine the patient for critical illness and decide whether they need urgent referral (see desk guide page 10 and 14).

See desk guide page 42-44 for diagnosis, management and complications of SCD

Complete role play 3

(Ask the facilitator if you have any questions).

The patient: You are a 6 year old boy who has been to the clinic several times. You have been sickly from childhood and now have a fever, with painful bones and joints. Your father is worried because he has lost a child with similar complaints before.

The Health Worker: You are seeing a child in pain, crying inconsolably. You notice that he has yellow eyes and he is small for age. Start your consultation using page 11, 42-44 of the desk guide.

The observer: The health worker should ask about joint and bone pains and other symptoms and make an assessment as to whether he needs urgent referral. If the health worker asks to examine the patient, tell them the following results: Your Hb= 3.2g/dl, T= 39 °C.

Diagnosis of COPD

The purpose of managing COPD is to improve symptoms by providing relief, to improve exercise tolerance and health status. Another purpose is to reduce risk by preventing disease progression, preventing and treating exacerbations and reducing irritability.

If the patient has any of the signs and symptoms of COPD, you will need to decide whether to refer for chest x-ray and/or doctor's opinion.

Examine the patient for signs of critical illness and decide whether they need urgent referral

Refer to page 33-35 of desk guide for signs and symptoms, diagnosis and management of COPD

Complete role play 4

(Ask the facilitator if you have any questions).

The patient: You are a 50 year old man who has never been to the clinic before. You have had chronic productive cough for the past 2 months. You are now worried because you have developed breathlessness, worse on exertion. You have been smoking 20 cigarettes per day for the past 35 years.

The health worker: You are seeing Tom in the clinic for the first time. Start your consultation using pages 10, 11, 33-35 of the desk guide.

The Observer: The health worker should ask Tom about his chronic cough and other symptoms and make an assessment as to whether he needs urgent referral. If the health worker asks to examine the patient, tell him the following results. Chest has bilateral crepitations, RR 32b/m, feet are oedematous.

ASTHMA

Asthma is an inflammatory disorder characterized by hyper responsiveness of the airway to various stimuli, resulting in widespread narrowing of the airway. The changes are reversible, either spontaneously or as a result of therapy. The common triggers are exercise, emotion, infection, drugs and external allergens.

Diagnosis of Asthma

If the patient has any of the signs or symptoms of asthma, you will need to measure PEFr before and 15 minutes after 2 puffs on inhaled salbutamol. If PEFr improves by 20% diagnose asthma, if no or little improvement, diagnose COPD.

If the patient has danger signs, assess for severity and decide whether they need urgent referral.

Refer to page 36-41 of desk guide for signs and symptoms, diagnosis and management of asthma

Complete role play 5.

(Ask the facilitator if you have any questions).

The patient: You are Annette, a 16 year old girl who has never been to the clinic before. You have had recurrent dry cough and chest tightness for a long time. You have now developed difficulty in breathing worse early morning and at night time.

The health worker: You are seeing Annette for the first time in the clinic. As she walks into the clinic you hear her wheezing. As you talk to her, you notice she is unable to complete sentences. Start your consultation using pages 10, 11, 36-41 of the desk guide

The Observer: The health worker should ask Annette about her difficulty in breathing and other symptoms and make an assessment as to whether she needs urgent referral. If the health worker asks to examine the patient tell them the following results. RR= 48, wide spread rhonchi bilaterally.

CANCER

Cancer refers to the uncontrolled proliferation of abnormal cells in any part of the body. The commonest cancers in Uganda are cancer cervix and cancer prostate among women and men respectively. However cases of Kaposi's sarcoma and non-Hodgkin's lymphoma have significantly risen due to the high prevalence of HIV and AIDS. In the initial stages, most cancers may be painless with nonspecific signs and symptoms. These factors contribute to late presentation by patients as well as missed diagnosis by health workers. Therefore, health workers should have a high index of suspicion because early diagnosis greatly improves prognosis.

Diagnosis of Cancer

Consider cancer if signs and symptoms are otherwise unexplained or unintended, e.g., weight loss, fever, ill health. You will need to examine the patient for signs and symptoms of critical illness to help you decide whether the patient needs urgent referral. Remember to rule out HIV and Diabetes.

See desk guide page 10, 11-14

Complete role play 6

The patient: You are a 55 year old post-menopausal woman who has never been to the clinic before. You have had post-coital bleeding for the last 2 months. You are now worried because the vaginal bleeding has persisted and has become foul smelling. You do not have fever and your micturition and bowel habits are normal.

The Health Worker: You are seeing Sarah for the first time in the clinic. As she walks into the clinic, you notice that she is wasted. Start your consultation using pages 10-14 of the desk guide.

The observer: The health worker should ask Sarah about her abnormal vaginal bleeding and other symptoms, and make an assessment as to whether she needs urgent referral. If the health worker asks to examine and investigate the patient, tell them the following results. Sarah's Hb = 6.8 g/dl

Written exercise on Cancer

A 48 year old man who has had cough for 3 months comes to the clinic. He reports that he now has chest pain and the sputum has become blood stained. He also reports smoking for the last 20 years.

1. What other important history would you ask for?
2. List atleast 4 possible diagnoses
3. How would you investigate this patient?

Physical exam findings: digital clubbing, Temp 37.6 C, RR 40bpm, SPO2 = 79%

4. What is the likely diagnosis? How would you confirm the diagnosis?

Complete role play 7

The patient: You are a 28 year old man who has had prolonged fevers. You have been treated for malaria and typhoid several times without improvement. Your clothes do not fit and you sweat so much that your bed sheets get wet at night.

Health Worker: You are seeing John for the first time. You notice that he looks very unwell and wasted.

The Observer: The health worker should explore John's fever and make an assessment as to whether he needs urgent referral. If the health worker asks to examine the patient tell them the following results.

John has severe wasting with weight = 48kg, T= 39 °C, cervical and axillary lymphadenopathy.

Session 2: Complications and referral

Introduction

Patients with uncomplicated diabetes, hypertension and other NCDs can be managed in the health facility by regular clinic appointments with the health worker. If patients have complications from NCDs then you may need to consider referring them to a doctor or hospital for more tests and treatment.

Any patient referred to another hospital should also continue to attend the health facility to make sure that they are not lost from follow up. You will learn more about follow up in Session 8.

Session objectives

By the end of this session, you will know the following:

- Understand the common complications of diabetes, hypertension and other NCDs
- Know when patients may need to be referred for specialist care.
- Know how to record this information and how to make sure that patients are not lost to follow up.

Management and complications

Remember that patients with uncomplicated diabetes and hypertension can be managed in the health facility. Complications can often be prevented by good adherence to medication and lifestyle changes. In the following role plays, use the pages in the desk guide to decide whether you need to refer the patient for specialist care.

Always clearly explain to the patient the reason for referral, where and how best to get there, as well as issues of follow up.

Refer to the following pages:
Management page 17-19 and complications of hypertension page 20-21
Management page 23-29 and complications of diabetes page 30-32

Complete role play 8

The patient: You are Peter, a 37 year old diagnosed with high blood pressure 3 years ago. You have been given some tablets which you take when you remember. On a couple of appointments you have chatted with the health educator and made a plan to stop smoking. You have found this difficult and are still smoking. Over the last month you have started to get pain in your calves when you are working and when you are walking around the village.

The health worker: Peter is a 37 year old man who was diagnosed with hypertension (high blood pressure) 3 years ago. You have been seeing him at the health facility and started him on medication. You know that he is still smoking and doesn't always take his medication. Today is his routine appointment.

Using page 17-21 of the desk guide, start your consultation.

The observer: The health worker should make an assessment of Peter's symptoms and ask about any complications in the list on page 20 of the desk guide. The health worker should then decide whether to refer him for further tests and management at the hospital.

Complete role play 9

The patient: You are Sarah. You have been attending the health facility for the last 6 months since you were diagnosed with diabetes. You have been taking your medication daily and have been trying to do more physical activity. You think you might be pregnant again and are excited about the new addition to the family.

The health worker: You are seeing Sarah for her routine appointment. Since her diagnosis with diabetes you have been seeing her regularly and her blood glucose has been well controlled. Sarah is a pleasant lady and has been very keen to try and improve her health. Her previous appointments have been straightforward and she has had no previous complications. Start your consultations using page 30-32 of the desk guide

The observer: Although Sarah is a patient with no previous complications and her blood glucose is well controlled it is still important that the health worker makes an assessment and looks for signs and symptoms of complications of diabetes. The health worker should find out that Sarah is pregnant. They should suggest that she is referred to the hospital for further care and remember to make another appointment in the health facility.

Practical exercise A

Using the information in your role play with Sarah, update the chronic care card and complete a referral form.

Session 3: NCD recording tools

Introduction

Recording and reporting information on individual patients is a crucial method of monitoring both individual and health facility progress. The tools to be completed in this process are the appointment card, chronic care card and the patient register.

Session objectives

By the end of the session, you will be able to:

- Understand the importance of completing the appointment card, chronic care (follow-up) card and the patient register.
- Be able to complete the relevant sections of the cards.
- Be able to complete the relevant sections of the patient register.
- Understand the importance of annual review and tests in Diabetes and hypertension

Recording information on the appointment and chronic care card

All patients seen at the health clinic who are assessed for NCDs should have an appointment and chronic care card.

It is important that the details about the patient are recorded on the appointment and chronic care cards and register at their first visit. This includes details such as name, address, contact telephone number and date of birth etc. It is also important that the health worker records details of any symptoms, examination results, tests performed and medication started.

These cards should be used at each appointment.

The chronic care card stays in the patient's file/folder at the health facility and the appointment card will be given to the patient to take home.

See chronic care card and appointment card provided

Practical exercise A

You are the health worker. Sarah came to the clinic with recurrent infections, thirst and urine frequency on 5th January 2014. You suspected diabetes and sent her for a random blood glucose test immediately after the consultation.

You have now received the following blood result from the laboratory:

Patient ID: Sarah Nassali. DOB: 12/04/1976
Date of sample: 05/01/2014. Random Blood Glucose: 10.4mmol/l (187 mg/dl)

1. Fill out a chronic care and appointment card for Sarah

Questions:

2. What other information would you need to ask her to complete the chronic care card?



Recording patients with a new diagnosis in the register

When any results of tests are received and a diagnosis made, record these patients in the NCD register.

The date of the patient's next appointment should be added to register. Each time a patient attends the health facility, the date should be entered on the register. This enables patient attendance to be effectively monitored.

If a patient fails to attend an appointment then the reason, if known, should be recorded instead of the date of the missed appointment. An attempt should be made to contact the patient. You will learn more about follow up in Session 8.

There are three possible outcomes;

- Lost to follow up means that any attempt to contact the patient or treatment supporter has failed (3 attempts) and the patient is no longer attending (3-6) appointments).
- If the patient has died then enter this in the corresponding appointment.
- If the patient has been transferred to another health care facility, then indicate as such.

Recording these details on the patient register enables better monitoring and evaluation of NCD services in the health facility. Data from the patient register will be compiled and sent to the district office/Ministry of Health for assessment of patient numbers and diagnoses by the health facility.

See NCD register provided

Practical exercise B

You have arranged a second blood test for *Sarah* and confirmed the diagnosis of diabetes. Sarah attended this most recent appointment two days later than scheduled.

You now have two blood glucose results for *Sarah*:

05/01/14 RBG: 10.4mmol/l (187mg/dl)

28/01/14 RBG: 11.8mmol/l (214mg/dl)

Update the chronic care card from the previous exercise and add Sarah to the NCD register.

Annual review

All patients with a confirmed diagnosis of diabetes and hypertension will need an appointment for an annual review. The annual review is an opportunity for a more detailed assessment of the patient. It should be used to look for any complications of diabetes and hypertension, in particular, in the eyes, heart, kidneys, feet and peripheries.

It is important that the additional tests performed and any results available are recorded in the chronic care card.

NB: The annual review card has been merged into the chronic care card but the annual appointment and tests remain important and should be recorded.

Practical exercise C

Sarah has been attending appointments for 1 year since her first appointment and it is time for her annual review. She is pregnant and you have referred her to the *hospital*. Complete the NCD chronic care card paying particular attention to annual review issues. As part of the exercise, compare the register, the appointment card and the chronic care card to ensure all of *Sarah's* information is the same.

Use the appointment card, chronic care card and NCD register provided



Session 4: Disease specific education

Introduction

Once a patient has been diagnosed with an NCD, it is essential that you take the time to educate the patient on their diagnosis, the importance of adhering to medication, potential complications and ways they can manage their condition. As you may only have a small amount of time, the information included in the desk guide has been limited to the key messages.

Session Objectives

By the end of this session, you will be able to;

- Understand how to communicate effectively with the patient
- Provide key educational messages on major NCDs
- Remind the patient of the importance of adherence to medication.

Disease specific education

<p>Refer to the following pages in the case management desk guide Hypertension patient education – page 17 Diabetes patient education – page 23-24</p>

Take time to read through these pages.

If you have any questions at this stage, please ask the facilitator.

Be aware that the patient has just been told they have an NCD. This is likely to be quite difficult for them. Some patients may prefer to deny reality, and choose not to acknowledge that they have this condition. There may be social stigma, with negative social consequences for patients and their families, especially for women.

It is important to ask the patient about their existing knowledge, and explore any misunderstandings. It is unlikely that the patient will remember all the information you provide at one visit, so refer to these pages during each appointment.

NCDs are long-term illnesses and adherence to medication and appointments is essential for preventing long term complications. At each appointment the key messages on adherence to medication should be reinforced.

It is important to make sure the patient understands the information and checking understanding should be part of the consultations. At each appointment, give the patient an opportunity to share their concerns about their illness and ask any questions.

Complete role play 10



The patient: You are Peter. You are 37 and were diagnosed with high blood pressure 3 years ago. You have been given some tablets which you take when you remember. Although you come to the clinic frequently, you often find it difficult to take in all the information you are given. You still don't really understand why you need to take your medication so frequently and what benefit it will have. Your friends have heard that you have high blood pressure and have now started to avoid you. You are worried that high blood pressure is infectious.

The health worker: You are seeing Peter for a routine consultation. He has previously visited the health educator on a number of occasions, however, is still not adhering to treatment and does not appear to understand his diagnosis of hypertension (high blood pressure). Deliver the important messages given in the desk guide on page 17, but also listen to the patient's concerns. Make sure he understands what it communicated.

The observer: The health worker should have a two-way conversation with Peter and explore his understanding of hypertension.

Here are a few questions to help observe the role play;

- Was the health worker empathetic?
- Did the health worker listen and address the patient's concerns?
- Did they deliver all the important information given in the desk guide?
- Did they communicate W.E.L.L?

Complete role play 11

The patient: You are Moses. Last time you came to the health facility you were told that your waist circumference was high and you had a blood test for diabetes. Your blood test was normal and this reassured you. You were told to improve your diet and do more physical activity but you have found this difficult. You lost your job a month ago. You returned to the health facility last week as you have not been feeling well and had an infection on your foot. The doctor repeated your blood test and you have come today for the result. You are very anxious about the result and what it may mean.

The health worker: You last saw Moses in the clinic last year. At that time his waist circumference was 104cm but he did not test positive for diabetes. Unfortunately, he has recently lost his job and is not settled. His diet remains poor and he has been unable to lose any weight.

Your colleague saw him last week and tested his blood glucose. You have the results of this today and it confirms that Moses has diabetes. You need to tell him about his diagnosis and what it means for him. See page 23 and 24 of the desk guide.

The observer: The health worker should have a two-way conversation with Moses and help him to understand his new diagnosis of diabetes.

Here are a few questions to help observe the role play;

- Was the health worker empathetic?
- Did the health worker listen and address the patient's concerns?
- Did they deliver all the important information given in the desk guide?
- Did they communicate W.E.L.L?

Session 5: Lifestyle advice

Introduction

A healthy lifestyle is important for the prevention NCDs. Addressing key lifestyle risk factors; smoking, alcohol, weight, unhealthy diet, and physical inactivity can greatly reduce the risk of complications and improve quality of life.



If adopted, lifestyle advice can remove the need for a patient to start or increase medication. It is important that advice on lifestyle is given as soon as a risk factor is identified or condition diagnosed.

The chronic care pathway on page 8 of the desk guide emphasises the importance of promoting lifestyle changes to patients. These should be discussed before prescribing medication and the positive impact of such changes should be made clear.

Lifestyle advice should be given to all patients at risk of OR diagnosed with NCDs so that they can begin to make changes that will help to manage or improve their condition.

This advice should also be given to patients who are overweight or who smoke and/or “abuse” alcohol, even if they have not been diagnosed with a specific condition.

Session Objectives

By the end of this session you will be able to;

- Deliver and effectively communicate to patients key lifestyle advice for smoking, alcohol, weight, healthy eating and physical activity and others.
- Understand the importance of the education leaflet if available.
- Understand who to refer for health education for further discussion on these lifestyle risk factors.

Lifestyle advice

Some people may not be aware of the link between their lifestyle and their diagnosis. It is important to explain that behaviours such as smoking, drinking too much alcohol, poor diet, lack of physical activity and weight gain may have contributed to their diagnosis and changing them is an important part of their treatment. Throughout the consultation patients should be encouraged to ask questions

Using the desk guide, you must communicate all the key lifestyle advice, discussing each of them if needed. If the patient is not overweight or does not smoke, you obviously do not need to communicate these specific messages.

These messages should be briefly repeated at each consultation as the patient is unlikely to remember all of them after the first appointment.

After delivering the key messages, it is important that patients with NCDs are sent for health education). At each subsequent visit to see the health worker, the patient should also receive health education to discuss lifestyle changes and adherence strategies in more detail.

Complete role play 12

The patient: You are Salim. Since coming to the health facility, you have been to the hospital and been diagnosed with angina (chest pain) and hypertension (high blood pressure). This is your next visit to the health facility and you are very worried about your condition. You have still been smoking although you have been told by one of your friends that this may be bad for you. Before you had chest pain, you walked to work and around your village regularly, but you are now scared to do this.

The health worker: Salim has previously visited the health facility and was referred for specialist care as he was suffering from a number of severe symptoms. The hospital has diagnosed him with angina (chest pain) and hypertension (high blood pressure) and has started him on aspirin. It is important that he changes his lifestyle to prevent complications. You know that he smokes. Discuss with him the key messages and decide whether he should be referred to the health educator. See page 55 of the desk guide.

The observer: Salim clearly has several areas of his lifestyle that could be improved. The health worker should discuss all relevant aspects of lifestyle advice. See page 50, 51 and 55 of the desk guide.

- Did the health worker listen and address the patient's concerns? (communicating W.E.L.L)
- Did the health worker take into account the individual characteristics of the patient i.e. smokes and is inactive, and deliver the appropriate lifestyle messages?
- Did the health worker consider giving the patient an education leaflet?
- Did the health worker refer to the health educator, if appropriate?

Complete role play 13

The patient: You are Sarah. You have had diabetes for several years and have frequent appointments at the health facility. When you were diagnosed you were told about the importance of lifestyle to improve your health. Since you have had your baby you have struggled to keep active. You had previously made a plan with the health educator to increase your daily activity. You are now very busy at home looking after your family and are worried about how to continue with this plan.

The health worker: You know Sarah well and are looking forward to seeing her today. You know from the nurses that Sarah has had her baby since her last appointment. Her diabetes has been well controlled and she has been under the care of the hospital during her pregnancy. On her chronic care card you see that Sarah was trying to improve the amount of activity she was doing. You should discuss lifestyle with Sarah using page 53-54 of the desk guide.

The observer: Sarah has previously been seen by the health educator and made a plan to increase her physical activity. The health worker should review her progress today

- Did the health worker consider giving the patient an education leaflet (if available)?
- Did the health worker make sure she has a follow up appointment for health education?
- Did the health worker use the key messages in the desk guide?
- Did the health worker listen to her concerns?
- Did they communicate W.E.L.L?

Session 6: Medication and Patient adherence

Introduction

NCDs are chronic conditions that require long term management and medication. It is important to prescribe appropriate drugs for patients and promptly recognise and manage side effects as they occur.

Patient adherence to medication and clinic appointments is essential if their condition is to be managed effectively. It is advised that all patients have a treatment supporter, a friend or family member, who will remind them to take their tablets and who can attend appointments with the health worker and health educator. It is also recommended that each patient diagnosed with a chronic disease understands the importance of treatment commitment. If patients do not attend appointments or do not adhere to treatment, there should be clear procedures outlined to follow-up these individuals.

Session Objectives

By the end of this session, you will be able to;

Part 1: Medication

- Prescribe the correct medication to manage the patient's condition
- Adjust and alter medication and dosage for optimal management
- Monitor potential side effects

Part 2: Patient adherence

- Explain the importance of adherence to both clinic appointments and medication.
- Educate the patient about treatment support
- Explain the role of a treatment supporter
- Help the patient to identify an appropriate treatment supporter
- Manage patients who do not adhere to appointments or medication
- Supervise the treatment supporter
- Remind patients of their appointment through a number of different mechanisms, e.g., a phone call to patient and/or treatment supporter, a visit by health worker or VHT member.

Part 1: Medication

Refer to the desk guide as appropriate;
Management of hypertension and anti-hypertensives - page 17-19
Management of diabetes and oral hypoglycaemics - page 23-26
Contraindications and Side effects – page 57-58

Hypertension

Patients with uncomplicated high BP can initially be managed with lifestyle changes alone. If blood pressure is not controlled or if the patient has complications anti – hypertensives (medication to reduce blood pressure) should be prescribed. Page 17-18 of the desk guide gives you further details on when to start blood pressure medication and how frequently patients should attend the clinic.

The drug of choice for the patient will depend on several factors and you should use the step wise approach on page 17-19 of the desk guide to help you decide what drug to start and what dose. When prescribing new medication it is important to consider any contraindications see *page 57*.

The lowest dose should be started and then increased in a stepwise manner to achieve control of the blood pressure. Medications should be recorded on the patient's appointment and chronic care cards and reviewed at every appointment. It is important to ask about possible side effects of each drug, these can be found on page 58.

Practical exercise A

You have been treating *Peter a 37 year old man*, since his diagnosis. Unfortunately, as he does not always take his treatment, his blood pressure has not been well controlled. Today his blood pressure is 148/95.

Using page 18 of the desk guide, discuss what you would do now if *Peter* had already been started on *enalapril*.

Using the information in the desk guide answer the following.



1. Which drug would you consider adding?
2. What contraindications would you ask Peter about?
3. When would you arrange to see Peter again in the health facility?

At his next appointment Peter mentions that he has been getting some tiredness, nausea and vomiting.

4. Where would you look to see if these are side effects of the medication?
5. What other information would be important to tell Peter about taking his medication?

Diabetes

Blood glucose can be controlled with lifestyle changes and medication, known as hypoglycaemics. Patients with type 2 diabetes usually take oral medication (though may need insulin later). Type 1 diabetes and children are treated with insulin. If the patient does not follow the prescribed course of treatment, blood glucose will remain high and

complications such as blindness or kidney failure may develop. Symptoms should improve when the blood glucose is controlled.

Page 25 and 26 of the desk guide will help you to decide when to start medication and how frequently to monitor blood glucose in the health facility. For the majority of patients the first drug is metformin. If the blood glucose is still not controlled after stepping up metformin to the maximum tolerated dose then a sulphonylurea (2nd step) should be added.

It is important to look at the contraindications on page 57 before starting any of the drugs. If in doubt, refer to the doctor/hospital for advice and management. Patients who are breastfeeding, pregnant or planning pregnancy should be referred to the doctor/hospital, as should patients with:

- Kidney disease or Liver disease,
- HIV on anti-retroviral treatment or
- TB or chemotherapy

The lowest dose of each drug should be started and recorded on the patient's chronic care card. Drugs and possible side effects should be reviewed at each appointment.

The blood glucose of patients should be monitored and it is important to identify a target blood glucose. At each appointment the most recent blood glucose result should be compared to the target. It may be necessary to increase the dose of the medication to reach the target. When choosing a target remember that patients who are elderly or have multiple complications may be slower at reducing blood glucose levels and a less aggressive reduction may need to be chosen.

When prescribing or changing the dose of diabetes drugs, it is important to talk to the patient about the risk of hypoglycaemia (low blood sugar). You should make the patient and treatment supporter aware of the information on page 30-31 of the desk guide.

If the maximum tolerated dose of 2-3 oral agents for 6 months fails to control blood glucose the patient should be referred to the doctor/hospital who will assess whether insulin is required. If a patient has been started on insulin, it is important that both the patient and the treatment supporter know the information on page 26-29 of the desk guide.

Practical exercise B

Moses is a 51 year old man. You have recently diagnosed him with diabetes and are keen to make sure he is given the correct medication. Using the information in the desk guide answer the following questions:

1. What drug and dose would you start *Moses* on?
2. How often would you see *Moses* in the health facility?

After 6 months you have increased the doses of *Moses*'s oral hypoglycaemic drugs but you find that his blood glucose is still not controlled. You are sure that *Moses* has been taking his medication, but you are concerned that he may develop more complications if you do not control his diabetes.

3. What would you do now?

You decide to refer *Moses* to the *hospital to consider starting insulin*.

At his next appointment *Moses* tells you that he has been taking his insulin. He feels well but has had a few episodes when he has been feeling very shaky, dizzy and hungry. He is concerned about these and wants to know what to do.

4. What would you need to tell him?



Part 2: Patient Adherence

**Refer to the case management desk guide as appropriate;
Patient adherence - page 48-49
Chronic care card– availed**

Take time to read through these pages. Review the session objectives outlined at the beginning of the Session.

If you have any questions at this stage, please ask the facilitator.

As well as communicating the importance of adherence and treatment support, you must allow the patient to ask questions and to discuss any concerns they may have relating to attending appointments, adhering to medication or involving another individual as their treatment supporter. The next step is for you to encourage patients to commit to their appointments and medication.

Treatment supporter

It is your job to explain the role of a treatment supporter and help the patient to identify someone appropriate. Once a patient has chosen a treatment supporter, it is expected that they will attend some appointments with the individual. When the treatment supporter first attends, it is important that you discuss with them their role and responsibility, in order that there is a shared understanding by you, the patient and the treatment supporter.

Practice using the information in the case management desk guide to inform the patient and help them to choose a treatment supporter as guided by the role plays below.

Complete role play 14

The patient: You are *Moses* and have diabetes. You have been on tablets for 6 months and have recently started using insulin to control your blood glucose. It is going well, but you are unsure how you are going to remember to take your insulin every day and find that coming to the health facility makes you quite anxious. Your family lives in another town, but you are now staying with a couple of close friends that you know from your previous work.

The health worker: *Moses* has recently begun using insulin. On several occasions you have discussed with him how he could improve his diet and do more physical activity. You are aware that he is an anxious man with depression. You are concerned that he may struggle to adhere to clinic appointments and take his new medication. Discuss with him the importance of treatment support, the role of a treatment supporter and help him to identify someone who may be able to help. See pages 48 and 49 of the desk guide.



The observer: In order for Moses to adhere to treatment and appointments at the health facility it is important that he has a treatment supporter. The health worker should explain the role of a treatment supporter, the importance of adhering to both treatment and appointments and help Moses to identify someone who can help him. The health worker should find out that Moses does not have any family in this town and therefore identify someone else who may be appropriate.

Procedures for non-adherence to clinic appointments or medication

The case management desk guide clearly outlines different procedures for follow-up if a patient does not attend a clinic appointment.

Read through the section on page 49 on appointment reminders.

If an individual is not adhering to treatment or has stopped medication, it is important that you do not criticise. Try to encourage the patient and discuss with them any concerns or difficulties. They may be experiencing side effects, or finding the long term nature of their condition discouraging.

Using the guidelines outlined in the desk guide and the role plays below, practice the procedures for patients who do not attend an appointment or adhere to treatment and how you would communicate with them.

Practical exercise C

Last time you saw Peter, you gave him information about hypertension and discussed the importance of taking medication regularly. However, he has failed to attend his last 2 appointments. You helped him to choose a treatment supporter, who is one of his friends. In your group, use the information on page 48-49 of the desk guide to discuss what you could do next to remind Peter that he needs to return.

Session 7: Concerns and questions

Introduction

It is essential that you communicate effectively with the patient throughout their appointment, using 'W.E.L.L' principles (Welcome, Encourage, Look and Listen) as discussed at the beginning of these training Sessions. However, this Session focuses specifically on the end of the patient's appointment where it is important to use these skills to clarify and discuss any concerns or questions that the patient may have. Refer to page 8 in the case management desk guide to see where this fits within the chronic care pathway.

Session objectives

- Understand the importance of inviting and allowing the patients to ask questions and tell you their concerns.
- Further develop your consultation skills using the W.E.L.L principles so that patients feel comfortable discussing their concerns and questions.

Concerns and questions

In their appointment with you, the patient will have been given a lot of information about their diagnosis, any medication they need to take, possible side effects as well as the importance of lifestyle changes, treatment support and choosing a treatment supporter. It is unlikely they will have remembered all the information you have told them, especially if they have just been diagnosed.

The patient will be able to read the education leaflet (if available/given) once they have left the health facility, however, it is very important that they have the opportunity to ask questions and to discuss their concerns during the appointment.

During repeat appointments, it is also very important to give time for the patient to ask questions. Even though they will have heard the information previously, the patient may have looked at the education leaflet since their last visit or discussed their diagnosis with their family, or realised the long-term implications of their condition and therefore have further questions.

Complete role play 15

The patient: You are Peter. A month ago you received a letter from the health worker reminding you to attend your appointment at the health facility. You have missed two of your appointments recently. Your treatment supporter has also reminded you that you should attend. You decided to attend last week as you have recently been feeling tired all the time and you are often thirsty. The health worker decided to test your blood glucose. When you return to the health facility today, the health worker tells you that you have developed diabetes. You have not heard of diabetes before. The doctor tells you lots of information about diabetes, but you are upset and find it difficult to understand all the information. You are concerned that you may have made your health worse by not taking your tablets for high blood pressure.



The health worker: Peter attended the health facility last week after missing two of his appointments. He has developed additional symptoms, including thirst and often feeling tired. You decided to test his blood glucose. Peter returned today to get his results. You had to inform him that he has diabetes. You have given him all the information about diabetes, his new medication, lifestyle advice, but he is looking quite overwhelmed and upset. Try to apply the W.E.L.L principles and establish if Peter has any concerns or questions.

The observer: Peter has just found out he has diabetes, as well as hypertension (high blood pressure), which he has had for a number of years. He is very shocked, upset and overwhelmed. Make sure the health worker observes the W.E.L.L principles and discusses Peter's concerns and questions. The health worker should;

- Make sure their facial expression is warm and friendly.
- Maintain eye contact with Peter
- Observe his feelings
- Listen carefully and not interrupt

Session 8: Follow-up appointment

Introduction

All patients with NCDs should be given a follow-up appointment at the end of their consultation with you. This is illustrated in the diagram of the chronic care pathway on page 8 of the desk guide.

Session Objectives

- Understand the importance of making a follow-up appointment for all patients.
- Understand the importance of continuing to monitor patients whilst they are under specialist care.
- Learn to set follow-up appointments of the appropriate length depending on the patient's current condition and circumstances.

Making follow-up appointments

It is essential that all patients who have NCDs are given a follow-up appointment at the end of their visit. This should be entered on the appointment card and register as a reminder to both you and the patient when they should next be attending. If a patient has been referred for specialist care, either urgently, or non-urgently, they should still be given a follow-up appointment to provide continuity of care and to prevent patients getting lost in the system during referral.

The length of follow-up is dependent upon the patient's diagnosis, whether their condition is stable, if they have complications or how long they have had the condition. It is essential that where possible, patients are monitored as often as the guidelines recommend.

NB: In cases of referral, always tell the patient to contact you or return to the health facility in case they get any problem, as they look for money/transport to go to the referral facility and after they have returned from the referred centre/specialist.

Complete the following practical exercises;

Practical exercise A

Peter has hypertension and has recently been diagnosed with diabetes. He is currently taking tablets for both conditions. At this appointment, his blood pressure is 145/80 and his most recent blood glucose is FBG 7.5 mmols/l (135 mg/dl). His target level is an FBG of <7 mmols/l (126 mg/dl). He is now more adherent to medication and seems to have accepted his diagnoses. He doesn't have any complications.



1. Discuss when you would next see *Peter* at the health facility.
2. How should you communicate the next appointment to the patient?

Peter has now returned to the health facility for his follow-up appointment. His repeat FBG is 6.9 mmols/l (124 mg/dl).

3. Discuss what other tests are needed.
4. Discuss when you would book his next appointment.

Practical exercise B

Salim has been attending the health facility to see both the health worker and the health educator for the last 6 months. He has managed to reduce the amount he is smoking, but not completely stop. His blood pressure has been well controlled. Today his reading is 135/85. When you talk to him, he tells you that he has started to get more chest pain. You decide to refer him again to see the specialist at the referral hospital.



1. Discuss when you would make a follow-up appointment for *Salim*.
2. How would you document this information and which NCD tools would you fill in?

Session 9: Health education

Introduction

This Session is designed to train all individuals who will fulfil the role of the health educator, as part of the management of NCDs. It is also important that all health workers have an understanding of the role of health education and so should also complete this session.

The health educator will discuss adherence to clinic appointments, medication, treatment support as well as facilitating behaviour change of key lifestyle risk factors; smoking, alcohol, unhealthy diet and physical inactivity. All patients with NCDs will be referred for health education following their appointment with the health worker.

Before starting this session you should look again at the communication section in the introduction.

Session objectives

By the end of this session, you will be able to;

Part 1: Adherence strategies

- Explain the importance of adherence to both clinic appointments and medication.
- Educate the patient about treatment support
- Explain the role of a treatment supporter
- Help the patient to identify an appropriate treatment supporter
- Manage patients who do not adhere to appointments or medication
- Supervise the treatment supporter
- Remind patients of their appointment through a number of different mechanisms

Part 2: Lifestyle assessment:

- Identify and assess lifestyle risk factors with each patient
- Assess motivation for behaviour change in an individual
- Understand how to support and encourage behaviour change, applying appropriate techniques to specific individuals.
- Be able to support the patient to plan specific goals

Part 1: Adherence strategies

Patient adherence to medication and clinic appointments is essential if their condition is to be managed effectively. It is advised that all patients have a **treatment supporter**, who is a family member or friend, who will remind them to take their tablets and who will attend some (or all) appointments with the health worker and health educator. If patients do not attend appointments or do not adhere to treatment, it is important that there are clear procedures outlined to follow-up these individuals.

You need to communicate to each patient the importance of adherence and treatment support, allow the patient to ask questions and to discuss any concerns they may have relating to attending appointments, adhering to medication or involving another individual as their treatment supporter.

The patient may already have a treatment supporter so it is important to check their appointment card to see if the details are noted down. If this has not been completed, you should fill in the contact details of the treatment supporter. Include their mobile phone number, so they can be contacted if the patient misses appointments.

You will need to explain the role of a treatment supporter and help the patient to identify someone appropriate. Once a patient has chosen a treatment supporter, it is expected that they will attend some appointments with the individual, especially the initial ones. When the treatment supporter first attends, it is important that you discuss with them their role and responsibility, in order that there is a shared understanding between you, the patient and treatment supporter.

The desk guide clearly outlines different procedures for follow-up if a patient does not attend a clinic appointment.



Read through the section on *page 49* on appointment reminders.

If an individual is not adhering to treatment or has stopped medication, it is important that you do not criticise. Try to encourage the patient and discuss with them any concerns or difficulties. They may be experiencing side effects, or finding the long term nature of their condition discouraging.

Using the role play and exercise below, practice how to help a patient chose a treatment supporter, how to deal with patients who do not attend an appointment or adhere to treatment and how you would communicate with them.

Complete role play 16

The patient: You are Moses. Since your diagnosis with diabetes you have seen the health worker and they have discussed with you how to eat healthy and the importance of adhering to your medication. On your last appointment you talked to the health worker about asking one of your friends to attend appointments with you. You have come today with Ehime, an old colleague of yours. You feel uncomfortable that he is here and do not completely understand why you have been asked to bring him.

The health educator: Moses has been referred to you after attending an appointment with the health worker. Although he has turned up today with a friend, you are not clear if this is his treatment supporter as there is no information on his card. Chat with Moses and his friend and help them to decide if Ehime should be his treatment supporter and fill in the necessary information. See page 48 and 49 of the desk guide.

The observer: Moses has previously been told the importance of adhering and changing his lifestyle by the health worker. He is attending health education for the first time and does not yet have a treatment supporter. The health educator should establish whether his friend is his treatment supporter, check that both of them understand the role of a treatment supporter and fill in the necessary information on the chronic care and appointment cards.



Practical exercise A

Sarah was due to attend an appointment with the health educator today to discuss her progress with increasing her daily physical activity, but she has not arrived. In the last couple

of times she's attended, she has been difficult to engage in discussions and less interested in changing her lifestyle.

- Discuss how you will contact her and what your next steps would be.

You managed to make contact with *Sarah* and she tells you that she was unable to come because two of her children were unwell. You make a further appointment with her, but she also fails to attend.

- **Discuss what else you could do.**

Part 2: Lifestyle assessment

A healthy lifestyle is very important in the prevention of NCDs as discussed in Session 5. The desk guide focuses on four key lifestyle risk factors; smoking, alcohol, unhealthy diet and physical inactivity. The patient will have heard some of the key messages from the health worker during their routine appointment, however this will not necessarily lead to changes in their lifestyle. It is your responsibility to help the patient to change, but remember, it is not your responsibility to change the patient.

At the start of the appointment, you should check that the patient has a copy of the education leaflet (if available). If they do not have one, give them a copy. You should use the education leaflet throughout the appointment, so that the patient is aware of what is included in the leaflet and can refer to it at home.

It is important to use the W.E.L.L principles for communication and use supportive communication techniques. If you did not read the introduction to the training Sessions, it is important you read this now.



You need to encourage the patient to talk. Make sure you look at them and listen to what they have to say. Use open questions, don't judge and encourage them to set their own goals.

Read through *pages 50-55* on lifestyle assessment, using the notes below to explain the process.

Step 1: Giving information

At the beginning of the lifestyle assessment, you need to establish what the patient already knows about their condition and their lifestyle. For example, the patient may already be aware that increasing their daily activity will help prevent complications of diabetes or hypertension or they may not know that there is any link between the two. At this stage, try not to give any detailed information, but follow the steps on lifestyle change.

It is important to find out what the patient eats on a daily basis, how much alcohol they drink, if they smoke and how much physical activity they do regularly. Some of this information you should know as it may be recorded on their chronic care card. Make sure you check this before asking the patient for this information.

It will be too overwhelming if a patient is asked to address their level of physical activity, what they eat, the amount they drink/smoke all at once, so you should look at one of the behaviours at a time. The patient should choose which behaviour they would like to try and

change. If they choose a behaviour at a time, they are more likely to make the changes necessary.

It may be that the patient does not yet understand the link between their condition and their lifestyle, or simply that they are not willing to change. If this is the case, ask them what would happen if they don't change their behaviour. If they do not know, use the education leaflet to explain some of the risks. If they are still not willing to change, make sure the patient has a leaflet and ask the patient to return on their next appointment at the facility.

Step 2: Supporting motivation to change

Most patients may identify one behaviour.

The next step is to ask some questions to work out if changing their behaviour is important to them.

If it is not important to them, it is important that you repeat the key messages for the behaviour they have mentioned, which are clearly marked at the top of pages 50-55.

If it is important, they are more likely to make the necessary changes.

Some patients may really want to change, but not have the confidence to make the changes that are necessary. It is important to ask whether they feel they are able to change the behaviour they have identified.

Use the 'make a plan' section page 50-51 of the desk guide for the behaviour the patient has identified. Help the patient set some specific goals. Encourage your patient to include their family treatment supporter, (and other family and friends) in the changes they are making; this will make it easier for them

If the patient is not confident in changing their behaviour it is even more important to be encouraging, help them to overcome any barriers they may have to change and ensure the support of their treatment supporter, families and friends. When arranging a follow-up appointment, it may be suitable to see these patients more often.

At all times, encourage the patient to talk, and make sure you look at and listen to the patient. Encourage and reward small steps towards achieving goals, no matter how small they seem, they are probably a big step for your patient. Remember to always use supportive communication as described in the introduction.

Consider setting up a patient support group for patients to meet and share positive stories and discuss barriers to change. It is important that this is facilitated by someone who can provide encouragement and motivation.

Step 3: Maintaining new behaviours

Once a patient has successfully changed behaviour, set a future date for longer term follow up and review of progress. Encourage them to identify risky situations that may cause a relapse and plan for these.

Patients that successfully change behaviours should be invited to become role models or treatment supporters for those at the beginning of the change process.

NB. Successful patients, who are good communicators, can also counsel new patients on their disease, treatment as well as lifestyle change. That is, volunteering to be an "expert

patient” – who may help new patients, facilitate patient support groups, and pass on information to other people they meet in the community settings.

Complete role plays 17-20 for this Session.

Role play 17

The patient: You are Salim and you have angina (chest pain) and high blood pressure. This is your first appointment with the health educator, although the health worker has previously told you that smoking is bad for your health. Your friend has also suggested that it may be bad for your health. However, every evening you spend time with the men from your town and they all smoke. This is a really important part of your life and you are not really willing to give this up.



The health educator: This is the first time you have seen Salim, you are aware from his chronic care card that he has angina (chest pain) and hypertension (high blood pressure). It also informs you that he smokes. Use page 50-51, and 55 in the desk guide to assess Salim’s lifestyle and facilitate behaviour change.

The observer: The health educator should use the steps in the desk guide to assess Salim’s lifestyle. It is important that they follow each step. Salim is unwilling to change any behaviour, therefore the health worker should complete the following;

- Ask Salim what he thinks will happen if he doesn't change his behaviour and respond appropriately.
 - o If Salim is aware of some of the implications, ask him how he feels about this.
 - o If Salim is not aware of any long-term consequences of smoking, use the information on page 55 to inform him.
- If he has an education leaflet, encourage him to read it.
- Ask and encourage Salim to return for a follow-up appointment.

Role play 18

The patient: You are Moses and you have diabetes. This is your first visit to the health educator. Your friend, Ehime is with you at your appointment. So far the health educator has discussed treatment supporters and you and Ehime have decided that he will be your treatment supporter, attend appointments with you and help you take your insulin regularly. You know that there is a link between what you eat and your diabetes as the health worker has told you this a number of times, however now you are being treated for diabetes, you do not think it is important to change your diet.

The health educator: This is your first appointment with Moses. Moses has diabetes and is on insulin. His friend Ehime is with him and you have just educated them about the role and importance of a treatment supporter. Ehime has decided to become Moses’s treatment supporter and you have added his details to Moses’s cards. You now need to assess Moses’s lifestyle, using the different steps outlined on pages 50-51 of the desk guide.

The observer: Moses is attending the health educator for the first time. He is aware that there is a link between what he eats and diabetes. When asked by the health educator, Moses identifies that he could change what he eats, however, it is not a priority for him. The health worker should then follow these steps, as outlined on page 50-53.

- Discuss the key messages for healthy eating.
- Make sure the patient has an education leaflet.
- Ask the patient to return for follow up appointment.

Role play 19

The patient: You are Peter. Since you were first diagnosed with high blood pressure you have seen the health educator a number of times and made a plan to stop smoking. However, you found this difficult and are still smoking. You have recently also been diagnosed with diabetes and this is your first appointment with the health educator since you found out. You were shocked when you found out you also had diabetes and you have realised it is very important that you change your lifestyle. However, you do not feel very confident that you can change as you have tried to stop smoking before.

The health educator: Peter has been to see you many times before. You have made a plan with him to stop smoking previously, but he has been struggling to stop and has found it really difficult. This is his first appointment since he found out he also has diabetes, as well as hypertension (high blood pressure). You should use the lifestyle assessment on pages 50-51 to establish whether changing his lifestyle is important to him and whether he feels he is able to change. His new diagnosis may have changed how he feels.

The observer: Peter has had hypertension (high blood pressure) for a number of years, but has recently been diagnosed with diabetes. This new diagnosis has shocked him and he now thinks it is very important that he changes his behaviour and stops smoking. However, because he has tried before he is not very confident that he'll be able to change. The health worker should complete the following steps;

- Encourage all his previous efforts
- Discuss barriers
- Review the plan made previously.
- Ask the patient to involve their treatment supporter.
- Complete their chronic care card.
- Ask patient to return for follow-up appointment.
- Encourage all efforts and success.

Role play 20

The patient: You are Sarah. You have previously visited the health educator and made a plan to increase your physical activity. However, with the increasing demands of looking after your growing family, the plan you have made seem unrealistic and you are not managing to change your lifestyle. You feel discouraged that you have not made much progress and do not really want to attend your appointment with the health educator today.

The health educator: Sarah has had a number of appointments with you since she was diagnosed with diabetes and you have previously made a plan with her to help her increase her physical activity. You are aware that she has had another baby in the last few months. You are wondering how she is coping with the growing demands of her family. Discuss Sarah's plan and progress with her. See pages 50-51 and 53-54 of the desk guide.

The observer: The health educator should realise that although Sarah has previously made a plan, she is now less confident and less willing to make a change. They should complete the following actions;

- Encourage Sarah.
- Acknowledge any areas of success, even if small.
- Ask Sarah to remind herself of the reasons that she wanted to increase her level of physical activity.
- Discuss the barriers to increasing her level of physical activity
- Plan practical ways to overcome the barriers, given that she now has another child.
- Look at ways that the treatment supporter could help her follow her plan.
- Arrange a follow-up appointment.