

NEW INNOVATIVE TEACHING TOOL TO ASSIST IN THE EDUCATION REQUIREMENTS FOR THE MANAGEMENT OF THE NEUROGENIC BOWEL IN INDIVIDUALS WITH A SPINAL CORD INJURY

Introduction

Bowel care is a complex issue and may often be a difficult and sensitive subject to address in rehabilitation. As individuals we all learn differently by a combination of visual, auditory or kinaesthetic methods. It is difficult to source a dynamic visual explanation tool for the teaching of the practical aspects of bowel evacuation in a condensed and user-friendly manner. Challenges arise when an individual with a spinal cord injury (SCI) requires appropriate bowel care support outside a specialist SCI facility. As bowel care is multifaceted there is often ambiguity about the procedures and training required (1, 2). The acquisition of appropriate theoretical and clinical skills and knowledge is a key element that underpins neurogenic bowel management education. This training should be provided in an appropriate manner in order to foster a culture of learning to support bowel care issues.

Design

Animation is a visual step by step approach, which assists in structuralising the education required for individuals with a neurogenic bowel dysfunction, their family, carers or health care workers (HCW). Animation can offer a standardized way for learning and performing clinical skills. To meet these needs the spinal cord system of care nursing programme designed and developed a short animation training video for the following procedures: insertion of a suppository, digital rectal stimulation (DRS) and digital removal of faeces (DRF)(1,2). The video is produced in a manner that supports the culture and diversity of individuals regardless of age or gender. The animation video is a suitable aid as it is an explicit and nonintrusive method for educating individuals on the practical aspects such as DRE, DRF. By using this video it integrates basic and clinical sciences to give a more enhanced working knowledge on how to perform bowel care safely and effectively. Retention of information is enhanced when it is communicated using both visual and verbal communication. It supports training effectiveness for both skills and knowledge using evidence based practice.

Results

During the animation process regular audit activity helped to create a culture of quality improvement throughout the process and ensured that the video was user friendly. All stakeholders i.e. anyone who attended bowel training during an 8 month period were included in the audit. A questionnaire was distributed using the Likert scale. This reinforced the concept of animation and determined how well the training video was received, and ensured an accepted standard. The audit proved valuable and offered opportunities for improvement throughout the process before completion of the project. An audit was conducted with 103 individuals and 92% stated that it was an excellent tool for HCW, 90% stated that it was excellent tool for patients families or carers and 89% felt it would be a useful tool for training in the practical aspects of bowel care. 'The uses of videos seems to be a promising, relevant, and increasingly used instructional strategy that could enhance the quality of clinical skills education' (3). As an overall recommendation from the audit groups a voice - over for the video phase two is in progress.

Conclusion

Videos are becoming a standard part of clinical teaching resources as they can be beneficial in the explanation of clinical concepts. Overall the animation video has shown to be an excellent quality improvement initiative in teaching such a sensitive clinical procedure. By using this animation DVD to share knowledge it will augment the learning experience by integrating technology and modernising our training for an enriched learning experience. The animation DVD promotes an innovative, comprehensive and flexible educational programme, for all health care workers involved in the management of the neurogenic bowel for the SCI population.

References

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