‘Putting Words into Action’ project: using role play in skills training

Debbie Lewis, Marie O’Boyle-Duggan, Jim Chapman, Philip Dee, Katharina Sellner and Stevie Gorman

Abstract

Research highlights the need to use experienced role-players with skilled facilitation to deliver effective communication skills training (CST) but this is challenging in a large faculty of health. In this pilot project, students from Birmingham City University’s School of Acting and role-players from the Learning Disability nursing programme received role-player training (Phase I) before delivering 26 CST sessions to 520 first year BSc nursing students (Phase II), using role-plays based on clinical scenarios in adult, mental health, learning disability and children’s nursing. A pre- and post-session survey assessed student confidence, with feedback gathered from role-players, and facilitators. Pre-session confidence levels in students who participated and observed the role-play were similar, and using Wilcoxon and Mann Whitney non-parametric tests, a statistically significant increase in post-session confidence levels was demonstrated across all four fields of nursing. This increase in confidence applied to role-play participating students and observers, although role-playing students gained the largest confidence increase. A Higher Education Academy Collaborative Grant extended the project in 2012/13.

Key words: Simulation • Communication • Education • Nursing • Roleplay

The Nursing and Midwifery Council (NMC) educational standards for pre-registration nursing (Box 1) highlight communication and interpersonal skills, across all fields of nursing, as a key feature of effective nursing practice (NMC, 2011). Such standards are timely in a challenging healthcare environment, with shorter hospital stays, more seriously ill patients and dramatic increases in the elderly population leading to a renewed emphasis on patient education and self-care in chronic illness (Department of Health, 2001). Complaints about a lack of care and compassion in dealing with patients’ concerns are common place (Patients Association, 2002) and there are specific concerns regarding clients with developmental disability (MENCAP, 2012), who increasingly receive care in general rather than long-stay facilities (Phillips, 2012).

Box 1: Nursing and Midwifery Council’s (NMC) educational standards for pre-registration nursing (NMC, 2011)

- Communication and interpersonal skills
- Patient education
- Self-care in chronic illness
- Care issues that are common to all patients
- Specific concerns regarding clients with developmental disability
- Care issues that are common to all patients
- Effective communication and interpersonal skills
- Patient education
- Self-care in chronic illness
- Specific concerns regarding clients with developmental disability
- Communication skills that are common to all patients

What do we know about communication skills training?

Early Audit Commission (AC, 1993) reports link communication skills to high patient satisfaction, greater compliance and recovery, although evidence suggests limited success in obtaining this aim within the NHS (Nursing Times, 2012). Acquiring these skills and the confidence to communicate effectively with patients, has been left to practitioners to gain from experience or by luck. Within pre-registration nurse education there is evidence of confusion in deciding what needs to be taught, varying degrees of provision and a lack of field-specific training (Chant et al, 2002). Few nurses receive training on dealing with issues related to end-of-life care, difficult emotional situations such as dealing with distress or anger, or communicating on the telephone, although these are common activities. When training has been provided there is a tendency towards mechanistic skills checklists or using counselling models, which may not be transferable to all practice areas (Boschma et al, 2010) rather than relational communication, which may help nurses deal effectively with issues and demonstrate compassion and empathy. The need to progress from simple to complex skills throughout the undergraduate programme is recognised (Boschma et al, 2010), but rarely achieved, and effective evaluation of CST has also been lacking (Kruijver et al, 2000, Chant et al, 2002).

Accepted for publication: May 2013

Debbie Lewis, Marie O’Boyle-Duggan, Jim Chapman and Philip Dee are Senior Lecturers; Katharina Sellner is Third Year Drama Student and Stevie Gorman is Professional Role-player at Faculty of Health, Birmingham City University.
In the UK and elsewhere, health practitioners' CST education has been informed by research including randomised controlled trials. Maguire et al (1996) demonstrated the value of using simulated patients to promote open questioning to elicit psychological as well as physical concerns, and to reduce giving advice prematurely. Fallowfield et al (2002, 2003) used video-recorded simulations, highlighting the longevity of role-play-based CST. No skills attrition was seen 12–15 months post-training in participants who had previously shown skills improvement. Such experiential learning promotes the personal involvement of students stimulating feelings and the cognitive aspects of communication following the cycle of learning. This was developed by Kolb (1984), whereby simulation of a skill with debriefing is followed by reflection in order to inform practice and aid performance (Aldridge and Wanless, 2012). Although recent national initiatives have focused on oncology and palliative care staff (Connected, 2012) using role-play in CST is becoming more common place for staff working with chronic diseases such as heart failure (Wilkinson et al, 2008) and with learning difficulties (O’Boyle-Duggan et al, 2012). In addition to practicing key skills, such training promotes the value of therapeutic communication moving between the patient’s physical and psychological needs, which may be neglected in practice (Kruijver et al, 2001). It may also raise awareness of blocking behaviours when professionals ignore discussion of emotional or challenging issues despite receiving cues from patients that they would welcome the opportunity to discuss fears. The additional time needed to make reasonable adjustments for clients with complex communication needs, such as those with learning difficulties, is required by the Equality Act (2010), and is an area of deficiency highlighted by MENCAP (2012). Practitioners often cite a lack of time to communicate effectively with such patients (Hensley et al, 2011), though the use of good skills is not necessarily more time consuming (Fallowfield et al, 2003).

**Phase I—Training role-players**

Simulated patients and carers for role-play may be laypersons, staff or other students. Often in CST, such as the nationally accredited Connected (2012) programme, professional actors, specifically trained for working with health practitioners, help teach practitioners how to interact with clients during clinical encounters. This allows a teachable moment to be created, giving students constructive feedback on their performance in a supportive environment. Although used for some time in medical education (Rees et al, 2003), using professional actors is prohibitively expensive for large cohorts of nursing students so in this project alternative options were sought.

Using inhouse pilot funding Phase I increased the pool of role-players within the faculty by training four third year students from Birmingham City University’s School of Acting and three existing role-players from the learning disabilities field of nursing. The group participated in a two-day role-player training programme (Box 3) to standardise practice and provide a common level of training for all role-players. Already well-versed in aspects of communication, such as observing non-verbal behaviours, being attentive, listening and responding to cues, finding a common language with the drama students proved easier than anticipated. The training included identifying key communication skills, practicing role-plays and giving feedback in role including viewing videos of best and worst practice to generate discussion. The role-player training was also useful in developing written scenarios based on commonly occurring issues (Box 4). When written initially these did not include sufficient demographic information for realistic re-enactment by actors—with medical and nursing jargon also a barrier to understanding the scenario. Redesigning them in collaboration with the role-players included discussion of differing playing levels related to difficulty and identifying a degree of challenge suitable for first-year nursing students, although in practice the skill and confidence exhibited between nursing groups varied widely. CST often involves exploration of emotional issues such as serious illness, disabilities and end-of-life care, so role-player training included the value of giving sensitive feedback, adequate debriefing and self-supportive strategies such as withdrawing from topics close to personal difficulties. Feedback after the two days highlighted the benefits of integrating actors and clinicians with existing faculty role-players, valuing the opportunity of seeing drama students’

---

**Box 1. Nursing and Midwifery Council (NMC) Standards for Pre-Registration Nursing (NMC, 2010)**

<table>
<thead>
<tr>
<th>Nurses must be able to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Communicate safely and effectively</td>
</tr>
<tr>
<td>■ Build therapeutic relationships taking into account differences, capabilities and needs</td>
</tr>
<tr>
<td>■ Be able to engage in, maintain, and disengage from therapeutic relationships</td>
</tr>
<tr>
<td>■ Use a range of communication skills and technologies</td>
</tr>
<tr>
<td>■ Use verbal, non-verbal and written communication</td>
</tr>
<tr>
<td>■ Recognise the need for an interpreter</td>
</tr>
<tr>
<td>■ Address communication in diversity</td>
</tr>
<tr>
<td>■ Promote well-being and personal safety</td>
</tr>
<tr>
<td>■ Identify ways to communicate and promote healthy behaviour</td>
</tr>
<tr>
<td>■ Maintain accurate, clear and complete written or electronic records</td>
</tr>
<tr>
<td>■ Respect and protect confidential information</td>
</tr>
</tbody>
</table>

**Box 2. SOLER—A model of non-verbal behaviours conveying attention (Egan, 2010)**

| Square-on position facing towards the patient |
| Open position                                 |
| Leaning towards the interviewee              |
| Eye contact                                   |
| Relaxed position                              |

**Box 3. Role-player training programme**

| What is the job of a professional role-player? How does it differ from stage and screen acting? |
| Naming the skills – What skills do we want to promote?                                       |
| The value of care, compassion and empathy? How can students demonstrate it?                   |
| What do you need to do as a communication skills training (CST) role-player?                 |
| Preparing for role-play                                                                       |
| Using pre-written scenario                                                                   |
| Giving constructive feedback                                                                 |
| The value of a lay person’s perspective                                                       |
| Establishing a suitable playing level                                                         |
| Flexibility and improvisation                                                                |
| Practising role-plays and giving feedback                                                     |
| Role-playing sensitive issues and self-care strategies                                        |

---

© 2013 MA Healthcare Ltd
Box 4. Role-play scenarios

**Adult nursing**
- After a ward round responding to patient’s request “What does palliative mean?”
- Responding to a shocked and distressed patient after a consultation in an outpatient clinic
- Helping an irritable and aggressive older patient who is unlikely to be able to return home
- Approaching a relative of a large extended family who are staying on the ward beyond normal visiting times

**Mental health**
- Approaching a patient having found a half-empty whisky bottle under their bed
- Helping an aggressive, bed-bound patient who has been moved from another ward and is suffering nicotine withdrawal
- Dealing with an approach from a patient to meet up with them for a drink after their discharge from the ward

**Children’s nursing**
- Discussing the care of a baby with a cold with her anxious and socially isolated mother
- Gaining dialogue with a withdrawn adolescent patient with cystic fibrosis after the death of their close friend
- Assessing pain in a patient with moderate learning difficulties and limited speech who wants to return to her home
- Managing a patient in casualty with autism and limited speech who wants to remove a head dressing

Box 5. Pendleton’s Rules for Feedback (Garala et al, 2007)
- The student participating in the role-play has the opportunity to talk first and is encouraged to discuss positive points
- The participating student has the opportunity to suggest alternative strategies to improve their performance
- The observing group are invited to provide feedback but again positive points are required first
- The facilitator and group can provide constructive feedback on the areas identified with care taken to ensure comments are not given in a negative manner

Box 6. Survey items—Pre- and post-assessment of confidence

**Nominal data**
- Branch of nursing
- Participant and/or observer

**Ordinal data—Quantification of confidence in:**
- Approaching patients to explain a nursing procedure
- Ability to use key skills e.g. SOLER, open questioning, eliciting patient concerns
- Exploring patient cues
- Identifying patient and relative concerns
- Explaining professional boundaries to patients and relatives
- Handling strong emotions such as anger or distress
- Communicating with specific patient groups e.g. learning disabilities, children, those with mental health issues or dementia

Skills in action and drama students highlighting the benefits of clinicians’ experience in role-playing clients with mild, moderate and severe learning difficulties.

**Phase II—Implementing the ‘Communication 2 Skills’ sessions**

In Phase II, 26 two-hour sessions were delivered before the first year students’ first clinical placement, with volunteer faculty lecturers as facilitators. A lesson plan and written facilitator guidance was provided before the session, along with session ground rules and feedback strategy. Workshop-style training for facilitators was offered to promote competent facilitation of each session, as recommended by Byland et al (2009). Due to time pressures and the experience of many lecturers, this was not taken up, but a facilitators’ guidance sheet was well received. Informally, facilitators also contacted project team members for advice and tips particularly with regard to obtaining role-play participant volunteers in less confident groups.

Ground rules and the feedback strategy were reinforced at the start of each class with an emphasis on active non-judgmental participation from facilitators, role-players, student volunteers and observers alike. Giving individual feedback during role-plays was based on Pendleton’s Rules (Garala et al, 2007) (Box 5), a strategy widely used in medical education to give constructive feedback on performance. This helped focus on the students’ positive achievements before constructive suggestions for improvement, helping to avoid humiliation, and generating a supportive learning environment to encourage student participation. Each session included two facilitators and one role-player, with field-specific groups of between nine and 20 students. Explicit within the ground rules was a student’s right to withdraw from the class if a role-play topic was too closely related to a personal difficulty, though this happened rarely. An initial ice-breaking exercise, which deliberately incorporated an element of surprise, was popular and useful in gaining active participation in the quieter groups.

**How successful were the sessions? Student evaluations**

Evidence suggests CST is poorly evaluated (Chant et al, 2002), so a systematic approach to session evaluation was taken to assess the effectiveness of this method in teaching students. Students were asked to voluntarily complete an anonymous pre- and post-session survey quantifying their level of confidence in communicating with patients in practical nursing activities and emotional issues. Of approximately 520 first-year students who participated in the CST, a representative sample of 300 completed the evaluation exercise at the start and end of the teaching sessions. In total, 290 surveys were returned at the close of the session with 82 students able to take part in the role-play (identified here as participants) and a further 196 students observing and giving feedback to move the role-play to a satisfactory resolution (observers). Twelve students did not give their identifying group in the questionnaire. Students were asked to add their field of nursing, namely adult, mental health, learning disabilities or children’s nursing. Ignoring ‘missing’ data in the form of incomplete surveys, 271 completed questionnaires were returned.

Survey data focused on the students’ level of confidence before and after the teaching sessions using a Likert scale linked to seven variables such as explaining a nursing task, responding to patients verbal and non-verbal cues, explaining professional boundaries, dealing with strong emotions and communicating with patients with specific issues such as dementia and learning disability (Box 6). On the survey, students were also given
the opportunity to add additional comments which were also collated. Written feedback on the sessions from the role-players and the facilitators was also requested.

Quantitative analysis
Statistics were gathered using a 10-point Likert scale measuring confidences across various themes within the questionnaire, both before and after the CST. Though there are no standardised values of acceptable levels of confidence, such statistical techniques have been used to assess communication competence in delivering clinical skills (Sook Yoo et al, 2010) and it is a technique commonly used by CST specialists (Wilkinson et al 1998, 2008). A useful visualisation of the pre- and post-session confidence scores for the survey as a whole is shown in Figure 1. As the data is at an ordinal level rather than interval or ratio (Polit and Hungler, 1999) the median scores allow a quick comparison of pre- and post-confidence scores to determine if there are any areas of immediate interest. Table 1 illustrates that for the pre-session questions, there was a lower general level of confidence among the students (median=6) compared to the same students post-session (median=8) suggesting both role-play participants and observers benefited from the teaching session.

As the data was ordinal in nature, non-parametric inferential tests were used to demonstrate if these differences were 'real' and unlikely to be due to chance. The Wilcoxon test (see Table 1) revealed a statistically significant increase in confidence following the teaching session with Z=-13.091, p<0.0005, and with a large effect size (r=0.56). The effect sizes have been calculated and interpreted according to Cohen (1988) using the recommended groupings (0.1=small effect; 0.3=medium effect; 0.5=large effect). Table 1 shows the Wilcoxon test results when applied across the fields, illustrating that this global picture is essentially replicated in all fields. All differences have a p-value well below 0.05 (i.e. below 5%) and are therefore statistically significant.

Quantitative analysis was helpful in identifying that both participants and observers benefit from the CST sessions which, building on previous faculty research, added to existing knowledge (O’Boyle-Duggan et al, 2012) (Table 2). All differences seen are statistically significant with the exception of the learning disability participant group, as only four surveys were returned in this group. Applying the Wilcoxon test it can be shown that, variable-by-variable, there is an improvement in confidence comparing pre-session and post-session. Splitting the data into the two groups of participants and observers, Appendix 1 also demonstrates the amount of improvement in confidence (the 'effect size') is generally larger in the participant group compared to the observer group. This may be explained as the act of participation possibly leading to a greater sense of 'ownership' in the topic of communication, whereas observers may feel less engaged in the session. To establish if this difference between participants and observers is 'real' and not due to chance, the Mann Whitney statistical test was used to give a 'between groups' comparison. This illustrated a small positive effect size between observers and participants (ranging from r=0.132 to r=0.219) and as the statistical significance (p) is less than 0.05 in most cases the differences between these two groups is very unlikely to be due to chance.

Qualitative analysis
Qualitative analysis in this project was limited and this has been highlighted as an area for future project development using a Higher Education Academy Collaborative Grant. Students were encouraged to add free text comments to the survey and although the number of free text comments was small they were predominately positive, focusing on the value of this style of learning. As one student notes:

'Talk to them and ask questions—will allow them to open up. This session taught me to concentrate solely on patient (sic.) and relatives and them expressing their concerns'.

Other comments were similarly positive, with only one respondent suggesting the session had not been helpful. Students also highlighted the need for repeated practice, with one student noting:

'Need practice to gain confidence and become more competent'.
Box 7. Facilitator competencies (Byland et al, 2009)

<table>
<thead>
<tr>
<th>Single occurrence items</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Makes introductions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishes roles of role-play</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normalises anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allows time for reading/discussing role-play</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussed the patient’s potential needs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maintaining a learner-centred environment

- Invites learner’s feedback first
- Stays focused on the learner’s need’s and agendas
- Elicits learning goals
- Assesses if learning needs are met

Managing the role-play

- Gives the actor direction
- Ensures the learner understands the starting point

Facilitating feedback

- Facilitates a balance of positive and constructive feedback
- Invites positive feedback first
- Reinforces specific communication skills
- Uses video playback to reinforce learning

Involving the group

- Invites all group members to give feedback
- Involves all group members in addressing challenges or solving problems

Managing time

- Allocates time equally among learners

Using a predominately quantitative survey to collect qualitative data was largely unfruitful and other qualitative research techniques such as in-depth interviewing or focus groups will be used in future to collect a more detailed analysis of the students’ CST experience. Specifically identifying what aspects of the CST were actively used in clinical practice would be helpful along with a greater understanding of the communication issues nursing students encounter both inter-professionally and with patients, clients and carers. More information may also help the development of CST across all three years of the BSc Nursing programme.

Facilitator feedback

Feedback collated from facilitators and role-players suggested the ground rules and feedback strategy was helpful in protecting all participants in the sessions from unnecessary stress and emotional burden. Guidance in the form of a session pack was well received and informal conversations with project team members did take place to clarify teaching issues. Gaining student cooperation was easier when facilitators stressed that students were not being required to act, only to ‘be themselves’, thereby fulfilling their role as a student nurse. Though the art of enlisting volunteers was recognised as a skill that facilitators can develop. Facilitators did suggest the CST may have improved students in their performance in other fields such as in an Objective Structured Clinical Examination (OSCEs) held shortly after the sessions. This is perhaps unsurprising as verbal and non-verbal communications skills are recognised as a critical component of patient consultations (Collins et al, 2011), and in nursing even practical procedures require communication competence (Sook Yoo et al, 2010).

There was no formal assessment of the facilitators’ competence though evidence suggests this can be a key factor in ensuring effective CST (Byland et al, 2009). Facilitation competencies have been designed for CST (Box 7) with standards being taught, reinforced, and reassessment advocated to maintain the quality of training. It is acknowledged that some skills are more easily acquired than others, such as making introductions, giving the actor direction and inviting learner feedback first. More difficult tasks include discussing the patient’s potential needs, summarising learning and involving group members in solving problems. Regular peer review with individual feedback is also recommended (Byland et al, 2009). In the light of this evidence, promoting facilitator competencies and prompting feedback between facilitators may be a useful development in future CST sessions.

Role-player feedback

The role-players’ feedback stressed the satisfaction they felt in using their acting expertise to help health professionals develop key skills for clinical practice. A drama student commented:

‘I guess all of us have been in a situation where we have been misunderstood by a nurse or doctor and it is a great feeling to see all of these talented young people really try to get to the bottom of a problem...’

It was also helpful to their own development with one role-player noting:

‘Personally, I loved working as a role-player. It gave me a chance to work a little more on my improvisation skills and respond immediately to whatever the student nurse came up with in the scenario. They seem to have fully understood in theory how to approach a patient and were very keen to try out everything they had learned’.

Although some role-players already working in learning disabilities nursing had clinical experience, most role-players...
had not and were therefore able to give a lay person's view of the participating student's performance. This can be very useful in highlighting to nursing students unhelpful aspects of communication in clinical practice, such as the use of jargon, as well as promoting discussion on issues such as the use of touch, the individuality of emotional responses and what may be as a compassionate and empathic approach. Negative comments from role-players related to the problems of drama students and clinical staff balancing role-playing sessions with the requirements of academic courses or clinical practice. Although seven role-players were initially trained this proved inadequate to meet the needs of a large faculty of health. Since the initial 26 sessions, the majority of the drama students have undertaken additional CST sessions within the faculty, expanding the repertoire of their work. This may be a useful bridge between university and their employment.

Practical issues and recommendations for the future

In a large faculty of health, adding experiential sessions to the curriculum has the capacity to increase lecturers' workloads, though this did not prove to be a barrier to implementing changes. A coordinator—the role undertaken here by a lecturer—is also needed to contact role-players, organise their attendance and ensure they arrive in the classroom in good time. The long-term benefits of the session to students also need to be assessed. Some debriefing is usually required between facilitator and role-player before and after the session. If, as happened occasionally, an actor was unable to attend at short notice another lecturer or one of the two facilitators undertook the acting role. Although this was appreciated by facilitators, the actors were considered by the facilitators as more effective. There were costs incurred including the role-player training and an hourly rate paid to the role-players. Initially funded as a pilot project, the project has been successful in attracting an HEA Grant Collaborative Grant to develop the initiative. Working in collaboration with a primary care trust and two hospices it is hoped to develop first-year nursing CST sessions and pilot sessions, with increasing complexity in the second and final years—perhaps video-recording role-plays to promote reflection. Such a vision is supported by Waters and Whyte (2012) who suggest, communication skills should be taught with increasing levels of complexity throughout the three years of nurse training.

Conclusion

Using role-players within CST is a productive way of introducing student nurses across all fields to communication skills that may assist them in clinical practice. It appears, in addition, to be a useful way of exposing students to issues more commonly encountered in other fields, enhancing their repertoire of skills. Notably, the scenarios highlighted the commonality of mental health and emotional issues as well as the need to assist patients with learning difficulties, and making reasonable adjustments to ensure care equality. The latter may be particularly pertinent in view of the rising concern of care of people with learning difficulties, particularly at the end of life. Drama students acting as role-players are a cost effective means of providing such teaching and it appears to be a useful addition to their own portfolio. Providing a structure for such sessions is helpful in providing a protective and supportive environment with success perhaps improving performance in OSCE style examinations. Such teaching should be integrated into all three years of a nursing programme, although further research is needed to assess the benefits of such teaching in clinical practice and on patients.

Conflict of interest: none

to Coulthard, Radcliffe Publishing Ltd, Abingdon


Nursing Times (2012) Outpatients say care is dignified but communication can be poor. Nurs Times 26(23): 22-26


Waters A, Whyte A (2012) Nurses have a duty to be kind, friendly and polite'. Nurs Stand 26(23): 17-8


internurse.com

The UK’s largest online nursing archive offering thousands of peer-reviewed articles across all areas of nursing

Exclusive content for all nurses – all specialities