

Talking to the TV! The way of the future or just another fad?"



Comparing the effectiveness of face-to-face with videoconferencing in the NSW BPSD training programme
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Aim of this presentation

- To critically reflect on varying techniques available to teach/ educate/ reflect / learn / create change/ improve clinical skills/ using video conferencing television technologies
- To use the outcomes of the "NSW SMHSOP BPSD Training Project" as an example

Background to this project

- The Specialist Mental Health Services for Older People (SMHSOP) – Behavioural and Psychological Symptoms of Dementia (BPSD) Training Project was funded over 2008-10 by the NSW Health Mental Health and Drug & Alcohol Office and managed by the Dementia Behaviour Management Advisory Services (DBMAS) Central Service in South Eastern Sydney Illawarra Health Service.
- I was engaged to develop and deliver the training
- Developed a one-day workshop entitled "Working with people who have Behavioural and Psychological Symptoms of Dementia (BPSD) – A Person Centred Approach"

Target groups

- Clinicians working in SMHSOP community and inpatient teams in NSW.
- Also available to BASIS teams and T-BASIS units.
- *(One of the more consistent evaluation responses was that the training should be available to a wider range of participants- particularly those working in hospital and residential care)*

Statistics of this project

- Rolled out across **19 sites** in the eight Area Health Services in NSW as Face-to-Face or Videoconference presentation
- The total attendance was **183**. Almost 75% of the clinical staff at the Workshops were nurses and over a third were from rural locations.
- **131** (72%) Face-to-Face
- **52** (28%) Video conference

Why use video conferencing?

- Increase equity to more disadvantaged groups
- Wide coverage of information
- Spreading resources
- When parties of the conversation can't physically come to the same location
- When the expense or time of travel is a consideration
- May be used to:
 - Diagnose
 - Observe or share clinical skills
 - Staff development
 - Special groups - e.g. the deaf



What makes a video conference system?

- Video input :** video camera or webcam
- Video output:** computer monitor, television or projector
- Audio input:** microphones, CD/DVD player, cassette player, or any other source of audio outlet.
- Audio output:** usually loudspeakers associated with the display device or telephone
- Data transfer:** analog or digital telephone network, LAN or Internet

More than watching television!!!

- The television is simply the conduit
- It does provide the potential for :
 - instant communication
 - interaction
 - development of a relationship
 - And all the potentials associated with that

BUT

Murphy's law

It is experience common to all men to find that, on any special occasion, such as the production of a magical effect for the first time in public, everything that can go wrong will go wrong. Whether we must attribute this to the malignity of matter or to the total depravity of inanimate things, whether the exciting cause is hurry, worry, or what not, the fact remains.

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Research indicates that low take up rates are influenced by:

- Eye Contact:** It is known that eye contact plays a large role in one to one and group communication. While traditional telephone conversations give no eye contact cues, videoconferencing systems are seen as worse in that they provide an incorrect impression that the participants are avoiding eye contact.
- Appearance Consciousness:** A second problem with videoconferencing is being on camera, with the video stream possibly even being recorded. The burden of presenting an acceptable on-screen appearance is not present in audio-only communication. *The issue of eye-contact may be solved with advancing technology, and presumably the issue of appearance consciousness will fade as people become accustomed to videoconferencing.*

The BPSD video conferencing experience!!!!

Outline of the BPSD Training Project Workshop

- An introduction to dementia
- What is BPSD?
- Differentiating the three D's (delirium, dementia and depression)
- Holistically assessing people living with BPSD
- Getting to know the person living with BPSD – a Person Centred approach
- Components of caring for people living with BPSD – including psychosocial and pharmacological approaches
- Current research understandings
- Changing practices and influencing others

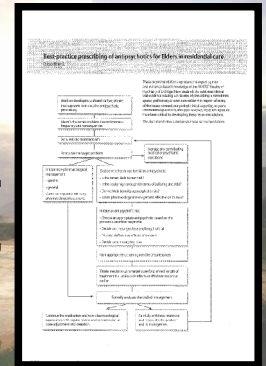
Fundamentals (for me) of this project

- Highly interactive
- Person Centred
- Reflective
- Assist people to "get it"
- Evidence based
- Important to have a supportive workbook containing power point slides, complementary handouts and references and recommended reading



Index

1. Outline of Workshop
2. Copy of the Power Point slides used during the Workshop
3. Summary Table: The Brain and Its Behaviour
4. Psychosocial treatments in dementia: a systematic review of reports meeting quality standards Daniel W. O'Connor,¹ David Ames,² Betina Gardner,¹ Madeleine King³
5. Best Practice Guidelines for People with Dementia from a CALD Background who have challenging Behaviours
6. A copy of Best-Practice Prescribing of Antipsychotics for Elders in Residential Care (Algorithm)
7. A Poem for a Grandfather
8. Additional References – Resources



Combinations of Video link ups

- Bega, Berry, Tweed Heads 12
- Dubbo, Deniliquin, Westmead Hospital 27
(disproportionate number from Westmead)
- Broken Hill, Taree, Tamworth, Lismore 13

It could be this???? But it was



This!!!!!!!



What is happening here?

- I can see them – up to four or five sites
- They can see me
- Each group can see other groups
- They can all hear me
- They can all hear each other
- BUT – I can hear all of them (which can be a lot – given the numbers and people in each group)
- Have to regulate sound – but without sound – I am not receiving affirmation messages...

How could the workshops be improved?

Larger TV screens that enable a more interactive nature to the presentation.

Behaviour of Strong speakers could be minimised allowing rest of group a chance to participate.

All together in one room – interactive sharing -

I would much prefer to do the workshop face to face. Video conferencing loses some of the interpersonal interaction

What did you enjoy most about the workshop

8. What did you enjoy most about the Clinical Workshop?
Interactive discussion

9. What did you enjoy most about the Clinical Workshop?
Presenters skill @ delivering and getting information across to participants, listening to my colleagues reflecting on workshop and all topics after end of day shared they are all inspired & they 'got it'

9. What did you enjoy most about the Clinical Workshop?
Networking connection with other similar teams

Participants' ratings of the BPSD Training Project Workshop %'s

		No response	Strongly Disagree	Disagree	Agree	Strongly Agree
The workshop met expectations	Face-to-Face	2	0	1	31	66
	Videoconference	0	3	5	35	57
The content was relevant to the participants' work	Face-to-Face	0	0	1	38	60
	Videoconference	3	0	2	40	55
The level of content was appropriate for participants' learning	Face-to-Face	2	1	2	35	60
	Videoconference	3	0	10	42	45
The workshop venue was convenient to attend	Face-to-Face	1	0	0	36	55
	Videoconference	5	0	0	52	43
The timing of the workshop was convenient to attend	Face-to-Face	2	0	0	36	62
	Videoconference	5	0	0	52	43
The topics identified with the organisation of the workshop	Face-to-Face	1	0	0	30	68
	Videoconference	5	0	0	45	50

As the workshops progressed I changed the format somewhat

- Involved
 - more visualisation
 - more reflection
 - more interactive discussion between groups particularly around case examples
- This was largely influenced by
 - My increased familiarity with the equipment
 - My confidence in orchestrating via video conferencing
 - An increased understanding of the subtle differences required between face to face content and VC

An application of Murphy's law

- Unable to ring into sites initially
 - Participants at other end not familiar with technology – unable to setup
 - Line goes down(for any number of reasons including work online between you and them)
 - Loss of sound
- All of which = good tap dancing
And a smile 😊
ALL WILL BE WELL!!!!



Important point

Viewing a TV is a "sit-back" experience compared to using a computer, which is a "lean-forward" experience. This has all sorts of implications for type and size of text, graphics and video.

Principles to remember when preparing a power point for a VC are that:

- completed animation (fly ins etc) do not travel well over VC
- more attention needs to be made regarding how much goes onto each slide
- use blank slides to create a pause and opportunity to switch back to the presenter to interact with the participants

Points from experience

- If multiple groups – each group needs to be a similar size
- Pre briefing about video conferencing etiquette required to benefit for all (particularly around microphones etc)
- Cannot show slides and see presenter at the same time (but can switch backwards and forwards)
- Need to also switch between sound on and off
- Interactivity is forfeited somewhat but with good planning can happen

Have a back up plan

and make sure everyone knows the back-up plan

So where to from here?

- Video conference could prove to be an effective method for providing many skills
- Requires planning and thinking
- The important thing is not to see it has a second cousin to face to face interaction but rather be challenged by the potential of creative opportunities for providing true equity

So - how

- Acquaint yourself with the technology
- Within each session
 - Use material which is current and interesting
 - Provide regular periods for reflection and interaction
 - Extend on narrative – story telling
 - Use co facilitators in each setting to pre arrange and manage experiential learning activities
 - Create opportunities to interact between each small group

