CLT Post-Conference Publication

Accessing education: flexibility for the future

24th September 2014

Darren Brand

Accessing education: flexibility for the future

Biography: Darren is a Senior Lecturer in the School of Health Sciences. The research presented at the conference was carried out whilst he was an educator in clinical practice as part of an MSc in Health & Education. A registered nurse by profession, Darren has held roles within the NHS covering Operating Theatre practice, Education and Clinical Governance Manager positions.

Abstract:

Aim – To identify the factors that impact upon attendance at clinical mandatory training sessions.

Method – A quantitative approach was used, utilising a questionnaire sent to 400 randomly selected participants. A total of 122 responses were received, providing a mix of data that was statistically analysed, and open ended responses that were reviewed utilising a mini thematic analysis.

Findings – The study demonstrated that clinical staff hold mandatory training in high regard, and are fully aware of the value and need for such training. However, it was clear that a review of the current delivery format is required.

Conclusion – To ensure that patient safety is a priority, and that staff remain aware of current practice, the delivery of mandatory training needs to move away from classroom based sessions, and into the clinical area. Delivery should be facilitated by local "experts" in order that content can be tailored to the local area, rather than generic delivery. A review of staffing establishments would also facilitate the release of staff to attend educational sessions. From an educational perspective, we need to be aware that healthcare staff cannot easily obtain leave to attend classroom based education, and consideration must be given to alternative attendance methods.

Main Body:

Background: The presentation delivered at the CLT Conference summarised the findings of an MSc dissertation research study into factors that impacted upon attendance at mandatory training sessions within the National Health Service (NHS). The findings of the survey highlighted that although the way in which patient safety training for healthcare staff needs urgent review, there are also implications for staff accessing modules and study within Higher Education (HE) institutions. These will be made clear within the recommendations section of this article.

The author replicated a small scale study undertaken by a medical devices manufacturer after the study author, who was responsible for the delivery of mandatory training noticed that attendance in the classroom was becoming increasingly poor. In many cases, capacity was less than 50%.

The majority of healthcare staff, and this study concentrated on nurses and support workers, are aware of the various mandatory training requirements that are required each year to ensure that consistently safe practice is delivered to patients. This includes infection control, Basic Life Support (BLS) and Manual Handling updates.

Mandatory training in healthcare exists in various forms, with the term “mandatory” defined as being obligatory or compulsory (Collins 2013). This term alone can lead to dissatisfactory perceptions of the training, as staff relate the term to didactic teaching. As a consequence, individual autonomy can diminish, with this view supported by leading educationalists including Dewey (1915), Rogers (1983) and Friere (1972). Strong views and opinions are frequently voiced within the healthcare profession around the volume of mandatory training that has to be covered. Through data collection, this study set out to establish the difficulties experienced in clinical practice that impacted on attendance at such training sessions.

The study intended to gather and review data from staff, in order to make recommendations that would promote and encourage attendance at future training in order to ensure that safe patient care was delivered consistently in all areas of the hospital.

Literature Review: The initial review of the literature demonstrated that education and training are intrinsically linked to a competent workforce, delivering safe patient care. Without suitable investment in education and training, patient safety is potentially placed at risk. That said it was evident that literature specific to mandatory training attendance is limited in quantity. The majority of material sourced is grey literature, made up predominantly of policy documents and Department of Health guidance. As a result, the literature review addressed

the main issues around attendance at mandatory training, such as motivation and patient safety.

Effective education occurs in a social-behaviourist environment in which students are motivated to attend, creates opportunities for learners to achieve through a desire to learn and gain new knowledge (Bandura 1977). However, Mythen & Gidman (2011) argue that measuring the effectiveness of mandatory training in healthcare is difficult.

Maben at al. (2012) researched the relationship between the care delivered by staff (as perceived by staff), and the influence of staff wellbeing, motivation and affect. Their work has suggested that by ensuring the ultimate wellbeing of workers, and in particular having a supportive work environment, the subsequent care delivered will be of a higher quality (Kang et al, 2012). The motivation of staff is clearly key, and this links closely with attendance at mandatory training sessions (Moore, 2002). Published in a peer reviewed journal, although somewhat dated now, Moore (2002) speaks of the importance of empowering staff and the value of lifelong learning. She speaks of support staff in a theatre environment competing for opportunities to attend education and training events.

The inquiry report into the findings of the Mid Staffordshire NHS Foundation Trust had recently been published (Francis, 2013), followed by the resultant response document from the Department of Health (DH, 2013). Unsurprisingly, the recommendations had a heavy focus around the importance of a trained and skilled workforce.

When commencing this piece of work, one of the key concerns that were noted was the number of mandatory training session cancellations directly related to staffing pressures, and the need for staff to remain in wards and clinical areas. This concern is substantiated by Dean (2011), as she has noted that nurses are failing to meet the basic standards required by the NMC to register annually due to poor staffing numbers within their work areas.

The literature explored made it very apparent that the link between education, training and patient safety is clear – the former do not exist without the latter (NMC, 2008a; HCPC, 2012; Pearson, 2013; Timmins & McCabe, 2005; Dean, 2011; Milligan, 2006; McHale, 2012 and Castledine, 2009).

Methods: From the outset of the study, the main aim was to understand the motivational factors of nursing staff to attend mandatory training and to establish if there were any perceived barriers towards non attendance.

A questionnaire, being a form of survey design, was produced to capture a mix of qualitative and quantitative perceptive data from respondents around why they had either attended, or

failed to attend a mandatory training session within the previous six months. Parahoo (2006) defines a questionnaire as *"a method that seeks written or verbal responses from people to a written set of questions or statements" (p.283).* Questionnaires are recognised as being one of the most common forms of research (Dyson & Norrie, 2010) due to the fact that they are flexible and adaptive to the needs of the researcher. A well utilised questionnaire also has potential for influencing clinical practice (Coates, 2004) and assists in eliminating interviewer bias (Davis, Couper and Janz, 2010). This flexibility was of particular importance, as the research question has a strong focus around the perceptions of staff towards mandatory training, and needed to facilitate the authentic expression of views and opinions to be fed back as part of the policy review. Surveys also enable large amounts of data to be collected concurrently, and to effectively compare variables at the analysis stage (Polit & Beck, 2004)

In essence, it was important that the survey tool gained the opinions and views of staff around mandatory training attendance, and their perceptions of what may improve attendance at such sessions. The questions asked in the questionnaire are shown in the table below:

1. Gender Male ☐ Female ☐
2. Age 18-25 ☐ 26-39 ☐ 40-55 ☐ 56-65 ☐ 65+ ☐
3. Professional Role Nurse ☐ Healthcare Assistant ☐ Other ☐
4. Highest Qualification e.g. NVQ, Diploma, First Degree
5. Length of qualification in current role (in years)
6. Area of the trust in which you are employed (Clinical Division)
7. Full Time / Part Time Full Time ☐ Part Time ☐
8. Do you use medical devices in your role?
9. Have you attended mandatory training in the last twelve months?
10. If no, please explain why not
11. What are your feelings around the value of mandatory training?
12. Do you feel that there are any barriers towards attending mandatory training sessions? Please list below.
13. If any, what factors do you feel would lead to increased attendance levels at mandatory training sessions?
14. Do you feel supported by your line manager to attend mandatory training?
15. If no, please comment on this.
16. Does your clinical area prioritise mandatory training events?
17. If yes, how does this prioritisation take place?
18. What factors facilitate attendance at mandatory training events?
19. Please use the space below for any comments relating to factors that would lead to increased attendance at mandatory training.
20. What factors are likely to lead to reduced attendance at mandatory training sessions?
21. Please use the space below to provide any other comment you may have around mandatory training.

The clinical target population totalled 2000 individuals. It was intended to gain a 10% representational view of this section of the workforce, so a total of 200 completed and

returned questionnaires was the aim. Based on an aspirational 50% response rate, 400 initial questionnaires were issued by the Learning & Development administrative team utilising a convenience (opportunity) sample approach.

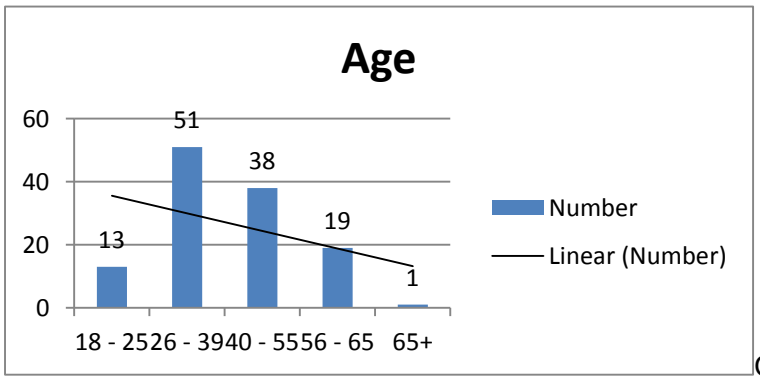
The inclusion criteria for the study was as follows:

i. Respondents must be a nurse, healthcare assistant, midwife, Operating Department Practitioner or allied health professional.
ii. They must have either attended, or failed to turn up at a booked mandatory training session within the previous six months.
iii. Staff must be employed to work within the acute sector of the organisation (as community mandatory training was different).
iv. Packs to be issued to all staff, irrespective of grade or banding.

Follow up packs were re-issued two weeks later to ensure that as many completed responses were received as possible.

Results: Out of a total of 400 questionnaires issued, 122 were returned, equating to a 30.5% response rate. It is noted that this reduces the confidence interval, and will have a negative impact on statistical significance. Of all the respondees, 99 (81%) were female, and 22 (19%) male staff, which is in line with pre-existing knowledge that the nursing workforce is predominantly female. However, the proportion of female to male nurses on the NMC register are not in proportion to this study, as 90% are female and 10% male (NMC, 2008b).

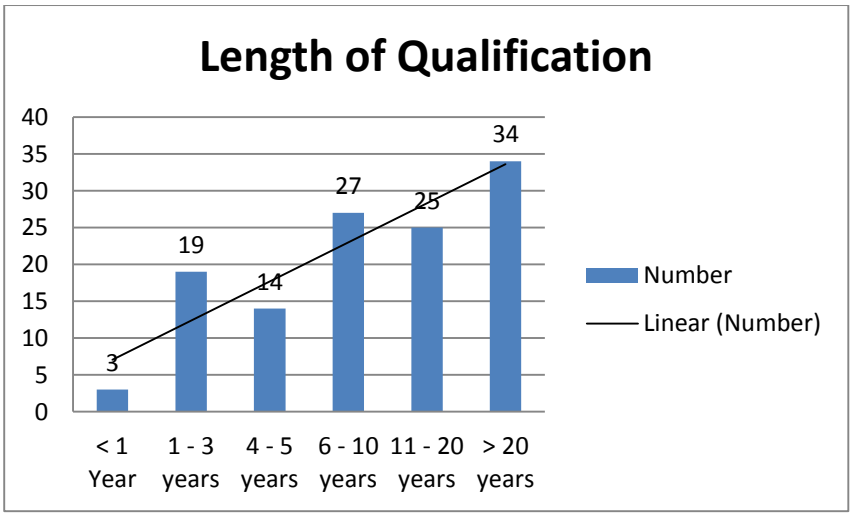
Graph 1 below indicates the spread of ages of respondents, demonstrating that the majority are aged between 26 and 39 years (n=51, 42%), closely followed by those aged between 40 and 55 years (n=38, 31%). These staff are likely to be those that are looking at promotion or career progression, and as a result, will be keen to maintain their level of qualification and competency. For those holding management or supervisory roles, compliance with trust polices is likely to be better, with positive role modelling demonstrated (Curry et al, 2011).



Graph 1

Respondents were asked to indicate their professional role, the term other used to classify all roles outside of that of a registered nurse or healthcare assistant. The majority of respondents (n=72, 59%) were registered nurses, with healthcare assistants (n=28, 23%) and other staff (n=22, 18%). Of the respondents, the majority hold a diploma level qualification (n=50,41%), closely followed by a first degree (n=41, 34%). Only two staff surveyed held a Masters level degree (1.6%), with no respondents qualified to doctoral level.

Although the study saw a relatively equal distribution of respondents in terms of years of experience in role, graph 2 below demonstrates that the largest group is made up of those staff with the most experience – in excess of 20 years (n=34, 28%).



Graph 2

Of the 122 responses received back, 66% (n=81) were full time workers, with 34% (n=41) working on a part time basis.

In order to gain an understanding of the utilisation of medical devices staff, respondents were asked to indicate if they used medical devices, such as infusion pumps, thermometers or vital sign monitors within their role. The majority (n=100, 82%) stated that their role did involve such use, with only n=22 (18%) stating that they did not use such equipment.

When asked if they had attended mandatory training in the last year, the data shows that the majority (n=98, 80%) had attended, whereas only 24 (20%) had failed to do so.

If a negative answer was given, respondents were asked to provide detail around why this was the case. The key themes identified were relating to bookings being cancelled by senior staff due to ward pressures (n=7), and the opinion that medical device training was not relevant to their role (n=7). Sickness on the day of training sessions was also a factor for five

respondents. A number of comments were made relating to the rigidity of the day and timing of the sessions (n=15).

Respondents were then asked to comment around their own feelings towards the value of attending mandatory training. A review of the main themes was undertaken in order to group the responses given. Respondents were not limited to one response, and therefore the percentage given for these questions reflects the response against the overall number of comments provided. The overwhelming response (n=47, 25%) was that such training is essential to remain up to date and hold current knowledge for safe practice. A number of responses relating to improved patient safety were given. The one negative area (n=13, 7%) was that staff felt that the sessions were not updated frequently enough. Twenty-four respondents (13%) gave a matching one word answer – “essential”.

When questioned around any potential barriers affecting attendance, respondents fed back that the greatest issue n=43, 25%) was low staffing levels on the wards. Twenty-two people (13%) felt that there were no barriers with fifteen (12%) giving no comment, which can only be assumed that there are no barriers identified.

When questioned around what factors could improve attendance, no comment was given by the majority (n=40, 33%). There was a relationship with previous questions, in that 21 (14%) respondents commented that increased staffing would improve attendance. Staff also commented on changing the set day of training (n=16, 10%), the option of local delivery, such as in ward meetings (n=14, 9%) and variation in delivery methods, such as e-learning, pod casts and written material (n=17, 11%). It is noted that these statistics are not high, however they were comments made by staff from across the organisation and not specifric to one area. Staff were then asked to state whether they felt supported by line managers to attend mandatory training. The greater majority (n=110) stated that they did feel supported, with only 11 respoding that they felt unsupported. When asked if their areas undertook any form of prioritoisation for mandatory training, 75 stated that there was, and 47 responding that no such focus was given.

It is of worthy note that there is a relationship between the two sets of data discussed above, as the majority of respondents (n=110, 90%) felt supported to attend training by their line manager, and the majority of areas in which respondents are employed indicated that some form of prioritisation took place (n=75, 61%).

In areas where staff did not feel supported, numbers were too small (n=11) to identify specific themes. Comments included a feeling of priority being given to registered nurses

over healthcare assistants (n=2) and a lack of understanding of an indviduals role by a line manager.

Areas in which prioritisation occured tended to be based around a specific indvidual with responsibility for booking and managing all aspects of education and training (n=15, 16%). A system that appears to be effective and common place is referred to as a "traffic light system", whereby RAG (red, amber and green) ratings assist in the prioritisation process (n=10, 10%). Similar comments related to a manual paper based system, and the departmental manager identifying gaps in training.

Table 1 below demonstrates the responses given to a question asking staff to identify factors that facilitate attendance at mandatory training sessions.

Response	**Number of Responses**
Matron Support	91
Time owing in lieu	51
Increasing staffing levels	70
Temporary cover for staff	51
Attend on day off	40

Table 1

Discussion: It was abundantly clear through reading the responses that mandatory training for healthcare staff is held in high regard, with a firm awareness for the sessions in order to maintain patient safety and ensure that all staff demonstrate consistently high skill, competency and knowledge levels. One factor that many areas reported was around the difficulty in releasing staff to attend such sessions, as when patient acuity levels are high, attendance by individuals is often cancelled as a result by managers. The Royal College of Nursing (2010a) report this as an increasing concern, particularly since the funding cutbacks required through the £20 billion of NHS savings required by 2015 (RCN, 2012). Nationally, a third of nurses have been unable to access mandatory training in recent years, as discussed in the RCN report (2010b).

Although not a common theme amongst respondents, a number of inferences were made around new staff to the trust who had recently undertaken mandatory training with their previous NHS employer, and were subsequently asked to re-attend session in order to comply with local policy (Mythen & Gidman, 2011). Holmström (2011) advocates the use of training passports to alleviate this issue, which is currently being explored by the Local Education and Training board.

Recommendations & Conclusion: The intention of this study was to gain an understanding of any perceived barriers or factors that may hinder staff working in an NHS trust from

attending mandatory update training. The data collected demonstrated that as a trust, the staff surveyed are fully conscious of the value and worth of mandatory training, and are fully conversant with the need and principles behind it, but do struggle to attend due to both staffing and clinical pressures facing them on a daily basis. In some areas, a system exists whereby prioritisation for training attendance is given, but this is not common place.

The responses to the questionnaire highlight the place that mandatory training has had, and will require to hold in ensuring that clinical staff are able to access training to ensure that their knowledge and skills remain current, and as such, they consistently deliver safe practice and high standards of care to all patients.

In conclusion, within the rapidly changing face of the NHS, patient safety remains a constant entity and is only delivered through a robust and well trained workforce. The literature and this study overall has demonstrated that the requirement for regular training is not questionable, however the current access format is without doubt problematic.

From this study several recommendations can be made to improve attendance of staff at mandatory training events, which are summarised in table 2 below.

The study also identified the potential for such training to move away from classroom sessions that are booked into a rigid programme, and into the clinical area. This could be achieved through the utilisation of both educators and local “champions” who hold existing link roles in areas such as infection control, falls and moving and handling. These individuals could facilitate local training at times that are convenient to the needs of both the individual and the clinical area.

From a Higher Education perspective, accessing study away from the workplace is more difficult than in previous years. As such, the CLT presentation highlighted the need for us to think about how e-learning and blended learning needs to be considered when developing modules in order to facilitate attendance and participation by such individuals.

Analysis of ward staffing levels, with particular focus around capacity to provide cover for staff to attend mandatory training sessions.
The placing of mandatory training compliance levels on local risk registers, in order to flag the inability of some staff to attend sessions to maintain their knowledge and skills required by professional bodies.
Consideration of the set delivery day on which mandatory training sessions are delivered, thus ensuring that staff who work set days are able to attend and maintain compliance with the trust policy.

To review the mandatory training delivery strategies, with a view to utilising on-line media and summative assessment to confirm learning has occurred.
To further investigate the use of e-learning for the range of mandatory training in order to improve the accessibility for staff in all areas of the trust.
To review the existing mandatory training portfolio, with a view to cutting down the frequency of training and reviewing the classification 'mandatory.
To consider localised training specific to the area in which it is being delivered. By introducing a 'train the trainer' system, role modelling and contextualised training can be delivered at local levels.
To consider the introduction of mandatory training passports, in collaboration with local NHS organisations.
To look at a self-verification of competency scheme for clinical staff who undertake a link facilitator role within their local area, through the development of a training passport system.
A back-fill team facility, employed to cover staff to attend mandatory training, potentially via the Temporary Workforce Service.
A full scale review of the existing mandatory training policy.
Benchmarking against other trust policies to seek best practice solutions to manage mandatory training.

Table 2

Word count - 3322 (excluding abstract & references)

References

Bandura A (1977) *Social Learning Theory.* Prentice Hall, New Jersey

Castledine G, (2009) The Purpose of the NHS. *British Journal of Nursing.* 18 3 211

Coates V (2004) Surveying the scene: using surveys in nursing research. *Journal of Diabetes Nursing.* 8 7 247-252

Collins online Dictionary (2013) *Collins Online Dictionary.* Available at: http://www.collinsdictionary.com

Curry S, Cortland C, Graham M. (2011) Role-modelling in the operating room: medical student observations of exemplary behaviour. *Medical Education.* 45 9 946-958

Davis R, Couper M, Janz N (2010) Interviewer effects in public health surveys. *Health Education Research.* 25 1 14-26

Dean E (2011) Nurses miss out on essential training due to staff shortages. *Nursing Standard* 25 18 8

Department of Health (2013) *Patients First and Foremost – the initial government response to the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* Department of Health: London

Dewey J (1915) *Democracy & Education.* The Free Press: New York

Dyson S, Norrie P. (2010) *Fundamental Aspects of Research for Nurses.* Quay, Huntingdon.

Francis R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* The Stationery Office: London

Friere P. (1972) *Pedagogy of the Oppressed.* Continuum Publishing Group: New York

Health & care Professions Council (2012) *Standards of Performance, Conduct & Ethics.* HCPC, London

Holmström R (2011) *Skills passports show the way ahead.* Available at: http://nursingstandard.rcnpublishing.co.uk/courses-and-careers/career-advice/career-development/education-and-training/skills-passports-show-the-way-ahead

Kang C.M., Chiu H-T et al. (2012) Comparisons of self-ratings on managerial competencies, research capability, time management, executive power, workload and work stress among nurse administrators. *Journal of Nursing Management.* 20 7 938-947

Maben J, Ricardo M, Adams M et al. (2012) *Exploring the relationship between patients' experiences of care and the influence of motivation, affect and wellbeing.* NHS National Institute for Health Research: London

McHale J.V, (2012) Exploring Patients' Rights: what does the NHS Constitution tell us? *British Journal of Nursing* 21 9 552-553

Milligan F.J. (2006) Establishing a culture for patient safety – the role of education. *Nurse Education Today.* 27 2 95-102

Moore S (2002) Changing the workforce. *British Journal of Perioperative Nursing.* 12 6 218-221

Mythen L, Gidman J (2011) Mandatory Training: evaluating its effectiveness. *British Journal of Healthcare Management.* 17 11 522 – 526

Nursing & Midwifery Council (2008a) *The Code: Standards of conduct, performance and ethics for nurses and midwives.* NMC, London

Nursing & Midwifery Council (2008b) *Statistical analysis of the Register 1 April 2007 to 31 March 2008.* Available: http://www.nmc-uk.org/Documents/Statistical%20analysis%20of%20the%20register/NMC-Statistical-analysis-of-the-register-2007-2008.pdf [Last accessed July 2014]

Parahoo K (2006) *Nursing Research. Second edition.* Palgrave Macmillan, Basingstoke

Pearson K. (2013) Training is just the beginning. *Nursing Management.* 20 1 12-13

Polit C, Beck C (2004) *Nursing Research: Principles and Methods. Seventh edition.* J B Lippincott, Philadelphia

Rogers C (1983) *Freedom to learn for the 80's.* Charles E. Merrill Publishing: Columbus

Royal College of Nursing (2012) *Mandatory Nurse Staffing Levels.* Royal College of Nursing: London

Royal College of Nursing (2010a) *Guidance on safe nurse staffing levels in the UK.* Royal College of Nursing: London

Royal College of Nursing (2010b) *Nurses missing out on core safety training as cutbacks start to bite.* Available: http://www.rcn.org.uk/newsevents/press_releases/uk/nurses_missing_out_on_core_safety_training_as_cutbacks_start_to_bite_rcn [Last accessed July 2013]

Timmins F, McCabe C (2005) How assertive are nurses in the workplace? A preliminary pilot study. *Journal of Nursing Management.* 13 1 61-67