Assessing the clinical skills training needs of community healthcare staff

Michelle Chappell, Kay Ford

Due to changes in national healthcare policy community staff, including nurses, are being asked to care for ever-larger and more diverse groups of patients. However, the challenge for staff and service providers is how to deliver higher standards of clinical care while ensuring that patient safety remains a priority. One of the answers is to ensure that staff deliver any clinical skill do so competently, but reports have highlighted technical skills gaps that need to be addressed. No failings should be regarded as acceptable as they can impact on patient safety and there is a responsibility to address any areas for improvement through education and skills training. The study outlined in this article attempted to capture the perceptions and experiences of community staff to gain an insight into the gaps in clinical skills training and make recommendations for improvement.

KEYWORDS: Skills ■ Training ■ Patient safety ■ Evidence-based care

The changes in healthcare policy and provision that have taken place since the 1990s have resulted in fewer UK hospital beds, reduced length of stay and increased reliance on community staff to meet patients’ healthcare needs (Department of Health [DH], 2000). This changing healthcare landscape has also meant that there are less trainers available to examine how clinicians are coping with new technologies, treatments and care packages.

A Strategy for Workforce and Education (Health Education Yorkshire and The Humber, 2009a) states that the challenge for service providers is finding a way to deliver higher standards of clinical care, while ensuring that patient safety is not compromised. One of the challenges is to ensure that staff who deliver any clinical skill do so competently.

The Care Quality Commission (2010) Review of Compliance reported issues relating to technical skills training in a community setting and identified widespread failings and significant training gaps. For example, 54% of staff required training updates and there were ‘serious concerns’ regarding nurses’ lack of training in wound care and infection control.

Of course, no failing in care is acceptable — particularly if it impacts on patient safety — and when clinical skills training gaps have been identified there is a responsibility to rectify them. This can be achieved through the provision of relevant education and skills training, as well making sure that staff have the correct equipment and resources to do the job (DH, 2003).

BACKGROUND

A scoping exercise commissioned by Yorkshire and the Humber Clinical Skills Executive into local clinical skills and simulation training highlighted huge deficits in clinical skills training, resources, equipment and room availability — in particular in community and primary care settings (Health Education Yorkshire and The Humber, 2009b). Management of care varied across localities and even similar areas were managed differently, leading to inequalities in training that subsequently impacted on the quality of care.

In response to the local scoping exercise (Health Education Yorkshire and The Humber, 2009b) and national drivers such as Liberating the NHS: Developing the Healthcare Workforce (DH, 2012), a clinical skills and simulation strategy was developed, which provided a clear programme for education and simulated training, including ‘people’ skills (i.e. communication), and procedural skills (i.e. venepuncture). This strategy was aimed at addressing the inconsistencies and lack of structure identified in the scoping exercise.

The stated aim of the strategy was: ‘To provide direction for the workforce to perform all clinical skills procedures safely through simulated techniques that allow patients to be cared for safely by fully trained and competent professionals.’

CLINICAL SKILLS TRAINING NEEDS ANALYSIS

The overall aim of the training needs analysis (the study featured in this article) was to improve the quality and safety of care by evaluating the existing clinical skills of the community staff (including nurses), as well as identifying any future training requirements. It was hoped that the study would help to improve on the inequities found in the scoping
exercise (Health Education Yorkshire and The Humber, 2009b).

The perceptions and experiences of a variety of clinical skills staff/trainers working in community care across Health Education Yorkshire and the Humber were analysed, with the objective of:

- Defining and reviewing the current provision of clinical skills training in primary care and the community
- Producing information that addressed disparity and inequities in training provision
- Identifying the impact on patients and defining the future training needs of community staff
- Providing recommendations for future training.

**METHODOLOGY**

The training needs analysis adopted a mixed-methods approach combining quantitative and qualitative methods of data collection and analysis, which took place concurrently.

The qualitative element involved running eight focus groups aimed at a representative sample of the staff/trainers involved in the delivery of clinical skills in the community. The focus groups were conducted at eight different sites across the region and were attended by 41 staff in total, with representation from healthcare professions across all grades and all disciplines.

A self-completion questionnaire formulated to identify training needs was targeted at two primary care events in the region and was used to collate the quantitative data. Ninety-six people responded to the questionnaire (out of 200 that were handed out).

**Ethical consideration**

As the study involved analysis of data obtained from healthcare professionals, ethical consideration regarding bias, copyright and anonymity were addressed by following the appropriate guidelines (NRES Ethics Consultation E-Group, 2007). However, as the main focus of the study was service evaluation, ethical review by the research and ethics committee was not required (NRES Ethics Consultation E-Group, 2007). Analysis of findings included transcription of all focus group recordings, which were collated, disseminated and destroyed in accordance with the information on the consent forms.

**FOCUS GROUPS**

A previous interim review of clinical skills in local community mental health services (Ford, 2011) informed the focus group section of this needs analysis. The aim was to include participants who would provide their views on the factors that either facilitated or restricted clinical skills development.

**Recruitment**

Primary and community staff working in various localities across the region were invited to attend the focus groups. The 41 staff that participated were contacted through existing networks that included educational leads and service providers. The participants were identifiable by staff grade and job title (Figure 1).

**Data collection and analysis**

Each focus group comprised a maximum of eight participants and recording took place over approximately one hour. However, as each group did not always have eight attendees, the overall attendance number across the eight groups was 41 staff. The authors acted as facilitator and assistant facilitator for each group and had agreed roles:

- First facilitator: introducing session; format; guidance; asking attendees to respect each other’s contribution; ensuring attendees knew they could withdraw at any time
- Second facilitator: recording the session and identifying any immediate themes during the session and recording these on a flip-chart.

![Figure 1. Focus group participants organised by job title.](image-url)
Participants attended during work hours and no incentives were offered.

Before participants attended the focus groups, an interview information sheet was emailed to them and consent sheets were provided for signing on the day. Participants were given the option to withdraw at any time and were assured of their anonymity — it was a condition that names and organisations would not be used when reporting the findings.

At each focus group the facilitator introduced the study and ground rules were agreed (such as respecting each other’s contribution), then introductions were made (participants cited their initials, grade and profession).

The facilitators then used a set of nine open-ended and predetermined questions to guide discussion and elicit the thoughts and opinions of the participants — these proved successful in stimulating group discussion and interaction (Puchta and Potter, 2004). The questions were:

- What do you think is meant by clinical skills?
- What clinical skills do you need for your current role?
- Do you currently receive any skills training — if yes, how is this delivered?
- If you do not receive clinical skills training, how do you maintain the skills needed for your role?
- Do you think your role may change in the near future? If so, how?
- What clinical skills do you think you may need to prepare for any future changes in service delivery?
- Is there any skills training equipment in your department?
- In conclusion, is there anything else related to clinical skills training that you might like to add?

Table 1: Focus group participants’ understanding of the definition of clinical skills

<table>
<thead>
<tr>
<th>Nursing home staff</th>
<th>Skills needed</th>
<th>Training received/training provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management; tracheotomy care; first aid; catheter care; PEG feeding; syringe driver management</td>
<td>Training provider: private independent trainer; company reps’</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Community staff nurses (including district nurses)</th>
<th>Skills needed</th>
<th>Training received/training provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team management; client assessment; communication skills; risk assessment; wound care; compression bandaging; catheter care; bowel management; palliative care; medicine management; syringe driver management; intramuscular (IM) injection; ring pessary insertion; care of Hickman lines; performing Doppler; intravenous (IV) medication; electrocardiography (ECG) monitoring; peritoneal dialysis; eye-drop insertion; ear syringing; stoma care</td>
<td>Training provider: local NHS trusts; drug companies; hospice</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary care staff (including nurse practitioners, educators, managers)</th>
<th>Skills needed</th>
<th>Training received/training provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication; assessment of competencies; delegation; assessment of client’s health needs; clinical examination; respiratory training; diabetes; phlebotomy; four-layer bandaging; injections; chemotherapy</td>
<td>Training provider: specialist nurses; e-learning; syringe driver training; infection control; diabetes care; chronic obstructive pulmonary disease (COPD) care; vaccination and immunisation</td>
<td></td>
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<table>
<thead>
<tr>
<th>Physiotherapists and occupational therapists</th>
<th>Skills needed</th>
<th>Training received/training provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and treatment skills; therapy skills (manual, neurological, electro-acupuncture, soft tissue massage); full balance management; chronic and long-term management; mental health management; muscular and skeletal management</td>
<td>Training received: management; infection control; mandatory training</td>
<td>Training provider: in-house, university, professional placement educators</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Community healthcare assistants (HCAs)</th>
<th>Skills needed</th>
<th>Training received/training provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bandaging; catheter care; wound care; blood pressure (BP) measurements; observations; team work; communication; record keeping; insulin injections; mandatory training; confidentiality; e-learning</td>
<td>Training received: diabetes; catheter care; e-learning</td>
<td>Training provider: peers; study days at local NHS trust</td>
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</tbody>
</table>
The focus groups were recorded and the results subsequently transcribed. A thematic analysis of the findings was performed on all eight transcriptions using a qualitative data analysis software package (NVivo7©). The analysis involved reading each transcription carefully to filter the data, coding it into specific themes, and organising the findings. The analysis was undertaken by one facilitator, while another crossed-checked the data to enhance the validity of the study.

Focus groups findings
The eight focus groups yielded a large amount of rich data concerning the provision of clinical skills and the training requirements and personal and professional development needs of participants. The major issues arising were similar across the groups and the analysis yielded four major themes.

Clinical skills required and training provided in current role
This section provided an overview of participants’ views about the clinical skills required to undertake their current role as well as their training needs.

Overall, participants had a good understanding of the local definition of clinical skills, which is any action performed by staff involved in direct care of patients that impacts on clinical outcomes in a measurable way and includes:
- Cognitive or ‘thinking’ skills such as clinical reasoning and decision-making
- Non-technical skills such as team working and communication
- Technical skills such as clinical examination and invasive procedures.

Simulation is defined locally as: ‘a person, device or set of conditions that tries to present problems authentically. The student or trainee is required to respond to the problems as he or she would, under natural circumstances’.

After the focus groups, participants were able to identify a range of technical, communication and team-working skills (Table 1).

Access to training
The consensus of participants was that only statutory and mandatory training was available with other training being frozen. Registered staff (particularly nurses) were concerned that they would lose technical clinical skills as healthcare assistants (HCAs) took on their traditional roles, and they saw this impacting on the development and training of others, for example, students and new staff members.

Physiotherapists and occupational therapists felt that there was little training for therapy assistants as training, including national vocational qualifications (NVQs), was particularly nurse-focused. In-house training was delivered by specialist nurses, including training in wound care and bladder and bowel management (including catheterisation).

Specific training required to carry out patient-focused tasks (e.g. ventilation, lifting and handling), was delivered to one or two team members and passed on to others involved in the patient’s care, before being disseminated more widely in an informal manner. Specialist practitioners were found to be generally approachable, however, this was variable and dependent on the specialist staff’s availability.

Training was also largely self-organised, performed in participant’s own time and sometimes at a cost. A range of e-learning was available, but this mostly comprised statutory and mandatory training. Some of these e-learning resources did support clinical skills, but there was limited access to computers and staff cited lack of time to complete this form of learning.

Identified equipment and resources
Participants also identified the clinical skills training equipment they had access to in their area (Table 2).

Future training needs
To prepare for possible changes in service delivery, participants were asked what their future clinical skills training needs were. Analysis of the data identified the following:
- Protected time for learning
- Access to continuing professional development (CPD)
- Regular clinical skills workshops
- Rolling clinical skills programmes
- Allocated funding to attend clinical skills training
- Dedicated clinical skills trainers in community settings
- Dedicated training rooms in community settings

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**Table 2: Training equipment to which participants had access**

<table>
<thead>
<tr>
<th>Community district staff nurses</th>
<th>Community healthcare assistants (HCAs)</th>
<th>Physiotherapists and occupational therapists</th>
<th>Primary care staff (including nurse practitioners, educators and managers)</th>
<th>Nursing home staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tele-health, venepuncture access ‘arms’, practice manikin for catheterisation</td>
<td>Computers, training packs, procedural manuals</td>
<td>Foot manikin</td>
<td>IV access ‘arm’, male catheterisation manikin, glucose metres, stretch bands, resus’ manikin, chest manikin, continence anatomy manikin</td>
<td>Moving and handling DVD</td>
</tr>
</tbody>
</table>

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**Figure 2. Breakdown of participants in the questionnaire — practice nurses (PNs), GPs and healthcare assistants (HCAs).**
Centralised resources in the region
Access to clinical skills training when needed
More funding to purchase equipment
Certificates to recognise completion of skills training
Competency packages
Skills training at no cost
to trainees
Interprofessional learning
Simulation training using community-related scenarios.

SELF-REPORT QUESTIONNAIRE

The self-report questionnaire was developed by the region’s strategic clinical skills advisor team (experts in clinical skills training and resources).

Primary care staff (e.g. GPs and practice nurses, as opposed to the local definition of community staff, which included district nurses, for instance) were selected as the target group, particularly as only one primary care staff member participated in the focus groups. It was anticipated that a wider sample selection would strengthen the findings, i.e. if more participants from primary care participated, this would mean that more professions were represented.

The aim was to determine what primary care staff’s future clinical skills needs might look like. By targeting a large sample group, it was hoped that the study could achieve a greater response rate.

Recruitment

The tool took the form of a questionnaire and included a covering letter with clear instructions. The questionnaire itself included a combination of seven numbered dichotomous questions (fixed-alternative questions that can only be answered in one of the two indicated ways, in this case ‘yes or no’), and multiple choice questions similar to the ones asked at the focus group sessions. The questions were piloted electronically by a small sample of the target population (Kelley et al, 2003).

The purposive selected sample included GPs, practice nurses and HCAs based in the local primary care area (Figure 2). The tool was distributed by hand at two regional events and included information about the review. No incentives were offered. Participants were given the option not to participate, but those that did were assured of their anonymity and advised that names and organisations would not be used when reporting any findings. This resulted in 96 questionnaires being available for data analysis.

Analysis

Following data collection, answers were statistically analysed using a statistics bar chart format. The questionnaire was divided into multiple choice questions (Table 3) and dichotomous questions (Table 4) (Leung, 2001). After each question there was a comment box for further comments. For example, one respondent cited equipment needed as resuscitation aids, manikins, spirometers and double-headed stethoscopes, while emerging themes for training needs included IT skills, communication, implant insertion and travel health training.

Summary of findings

All of the 96 staff surveyed completed every question, meaning that the value of the completed responses was high. Collated findings demonstrated that a high proportion of the respondents had a good knowledge of the definition of clinical skills (n=73), and analysis identified that clinical skills training was delivered on an ongoing basis (n=74). However, 51 respondents indicated that there was a need for more clinical skills training in practice, using a mixture of technical, cognitive and non-technical training.

The analysis found that training was delivered in-house and through study days/courses (n=60) or ‘other’ means (n=9) and staff kept themselves updated through a mixture of journals, the internet and team meetings (n=56), and/or ‘other’ means (n=26). Lack of available equipment to deliver training featured highly, with 72 staff agreeing that this was a problem.

In summary, these findings suggest that a coordinated approach is needed in equipment and access to more clinical skills training in practice settings.

RECOMMENDATIONS

This needs analysis sought to capture the perceptions and experiences of primary care and community staff and offers some insight into the deficiencies in clinical skills training availability and provision.

As recommended in the clinical skills executive summary (Health Education Yorkshire and The Humber,
in multiprofessional teams i.e. communication skills scenarios related to community equipment for staff to ‘practise on plastic’

- Clinical skills training should have direct link to improving patient safety and reducing risks. This can be achieved by regular meetings with risk managers
- Staff should have access to continuing professional development (CPD) courses
- Competency packages should be developed to support the assessment process and achievement should be monitored
- Interprofessional learning should be encouraged
- Simulation training with scenarios related to community settings should be developed, i.e. communication skills in multiprofessional teams comprising GPs and district nurses.

**CONCLUSION**

National and local policies recognise the importance of training and development and their link with patient safety and improved clinical outcomes. The aim of this study was to ascertain the training needs of community staff as well as identifying the training currently in place.

Analysis of the findings shows that the respondents felt strongly about the availability of clinical skills training/resource provision and the need to ensure training is available to all staff. By having a robust clinical skills training strategy in place — in collaboration with partner organisations — clinical staff will be able to address gaps in clinical skills training.

Since completing this work, successful funding has been awarded for a peripatetic clinical skills trainer for nursing homes and community staff in the authors’ locality. This post will remain in place until April 2015 and is currently under evaluation. Findings will be published in September 2014, with supporting evidence showing that the role has reduced patient referral from nursing homes to primary care.

**REFERENCES**

- Ford K (2011) Clinical Skills North Yorkshire and York Community and Mental Health Services. Available from: k.ford@leedsmet.ac.uk

**KEY POINTS**

- Due to changes in national healthcare policy, community staff, including nurses, are being asked to care for ever-larger and more diverse groups of patients.
- The challenge for staff and service providers is how to deliver higher standards of clinical care while ensuring that patient safety remains a priority.
- One of the answers is to ensure that staff who deliver any clinical skill do so competently, but reports have highlighted technical skills gaps that need to be addressed.
- No failings should be regarded as acceptable, as they can impact on patient safety and there is a responsibility to address any areas for improvement through education and skills training.
- The study attempted to capture the experiences of staff to gain an insight into the gaps in clinical skills training.