Introducing a programme for post-registration induction and essential skills development

A review of in service training identified a need for individual skills induction to guide nurses’ knowledge and provide a format for ongoing career enhancement.

INTRODUCTION

Nursing practice involves negotiating an ever evolving and changing set of complex initiatives and objectives. Coordinating workloads with personal career development, adapting to technological and clinical advances, and balancing statutory and mandatory requirements with organisational needs are challenging prospects.

When the Department of Health introduced the Knowledge and Skills Framework (KSF) (2004) it sought to clarify and put into context the processes of developing individual nurses. Despite defining and describing the skills and competencies required, the DH failed to consider how those skills and competencies could be acquired and maintained.

Considering the diversity of nursing practice and specialties, and the distinct capabilities required in different roles, the KSF seems too broad to provide targeted guidance. There is no single standard system that integrates a personal development portfolio (PDP), the KSF and either a skills based or transitional induction within the profession.

This article discusses an initiative in Gwent, South Wales, that has resulted in the development of a comprehensive and flexible means of meeting the needs and expectations of both a wide variety of nursing staff and an organisation.

REVIEW OF IN SERVICE TRAINING

Arthur et al (2003) assessed the effectiveness of training in organisations, and showed that assessing training needs, identifying job requirements, looking at who needed training and what kind should be delivered should result in more effective learning across the board.

In 2008, the training and development department for community, mental health, learning disabilities and therapies in Gwent conducted a systematic review of in service training programmes. This was to establish the extent to which programmes were designed to equip staff with the knowledge and skills they needed.

We also wanted to identify significant omissions in provision and strategic interventions to address these. Gaps were identified by linking courses directly to the KSF and the skill sets required – these were initially in bands 5, 6 and 7.

Mapping continuous professional development activities against the KSF is vital in identifying ways of meeting challenges (Neville, 2006). All training programmes and modules were analysed and mapped against the KSF by content, target audience, specialty and level of educational attainment. We found that in service training was seen to be mainly theoretical and conceptual, rather than clinically practical.

Hicks et al (1996), examining general primary healthcare teams, concluded that the growing demand for professional updating and training had led to a proliferation of post-registration courses, but that many failed to reach the appropriate staff or meet the objectives of participants and their managers. Often this was because courses were designed and delivered in a haphazard way.

In Gwent, there was a need for more clinical and practical skills based courses and initiatives, to include targeted induction and management training. Training and development was viewed as largely ad hoc without a dedicated in service training team or strategy.

Complaints from service users, carers and others – some related to serious incidents with legal ramifications – and the results of inquiries into these almost always resulted in training implications and recommendations. Training and development departments needed to be responsive to these issues.

KNOWLEDGE AND SKILLS FRAMEWORK

The KSF – in tandem with national occupational standards, clinical governance initiatives and individual personal development reviews (PDRs) – is integral to providing guidance for nurses’ training direction and development.

Gournay (2000) discussed the grounds for an increase in “skills based nurse training” throughout the profession. Recommendations included more interdisciplinary courses, more robust training in research methods and closer links between university departments and clinical areas. Neville (2006) felt that educational programme development needed to take account of the KSF at an early stage.

A report by the National Institute of Adult Continuing Education (Bowden et al, 2007) examined the operation of the KSF across six NHS trusts in England and Wales, to understand how it could most effectively support skills development and progression through learning. It concluded that the core dimensions of the KSF required closer scrutiny and that ways of meeting them through creative learning needed to be clarified. It was felt that organisations needed to provide more “responsive” courses and development opportunities.

INDUCTION

Before this initiative, staff induction was more of a broad introduction than a formal
induction; it involved disseminating information on working at the trust. While this was informative, individual skills induction should be distinct from informing staff about mandatory corporate affairs; this should offer guidance on individual skills and personal development.

POST-REGISTRATION FRAMEWORK AND CAREER DEVELOPMENT

Bradshaw (2000) noted that nurse training used to rely on a standardised, explicit syllabus. From the late 1980s onwards, the focus shifted away from clinical settings to the classroom. This resulted in professional boundaries and the competencies needed for new roles becoming far less distinct. Some newly qualified staff can appear ill prepared for basic patient care in their first job, and lack safe clinical and general management skills. Many express concerns about their own knowledge and skills and lack confidence in taking on the role of a qualified practitioner (Last and Fulbrook, 2003).

A comparative study by Gerrish (2001) highlighted the limitations of pre-registration education and its failure to prepare nurses for post-registration roles. Despite education reforms and changes in policy since Gerrish’s study, student nurses still say they are inadequately prepared. Gerrish recommended that pre-registration courses should support the development of students’ clinical, organisational and management skills. The study also suggested there should be “a bridging period between the latter part of the course and the first six months post qualification, to enable nurses to acclimatise gradually to becoming accountable practitioners”.

The Nursing and Midwifery Council (2006) sets out good practice in giving newly qualified nurses a consolidation period. The NMC recommends that new registrants should be given protected learning time in their first year of practice and the support of a preceptor – a qualified, first level nurse with at least 12 months’ experience in the specialty in which the registrant is working. The NMC suggested this consolidation period should be made mandatory in future.

The Welsh Assembly Government, in its Post Registration Career Framework for Nurses in Wales consultation (WAG, 2008), said that induction to an organisation and compliance with mandatory training must be encouraged. It is likely that rotation schemes, where new registrants are being given the opportunity to have “taster” experiences in academic, research, community and inpatient settings, will be expanded in Wales.

BOX 1. FOUR LEVELS OF COMPETENCY

- **Level 1 Observation/demonstration.** The nurse has observed and discussed the key skills for an activity and has demonstrated understanding.
- **Level 2 Active involvement.** The nurse can actively assist in the completion of the key skills.
- **Level 3 Supervised practice.** The nurse has acquired and can demonstrate sufficient knowledge and ability to undertake the activity under guidance or supervision.
- **Level 4 Independent practice.** The nurse can consistently perform key skills and is deemed competent.

The DH (2006) has stated, wherever nurses work, their role has four elements: practice; education, training and development; quality and service development; leadership, management and supervision.

These elements link to the core and specific aspects of the KSF. The proposed career framework is linked to the KSF as defined by WAG (2008): “The KSF is a broad generic framework which covers the functions that need to be carried out by most NHS staff. It links directly to the more detailed national workforce competencies and national occupational standards developed by Skills for Health. Each of the NWc/Nos shows an indicative link to the relevant KSF dimension and these links are established on the basis of the most likely relationship according to the content of the competence.”

Induction and training and development departments need to be connected with individuals’ career progress and the career framework. Career progress and the career framework need to be linked with KSF post outlines and the skills and competencies required, with support from a workplace reviewer or preceptor.

INTEGRATING THE ELEMENTS

To integrate all these elements into a single induction programme, we first looked at standardisation. We needed a model that was flexible enough to incorporate the individual elements of any nursing role in any specialty, which could also be integrated into a single model of knowledge and skills acquisition and development. We wanted to map the pathway to progression in any band for the critical first 12 months and beyond.

We decided an effective way to do this would be through an induction workbook programme, which would incorporate:

- Definitions of responsibility for the team manager, reviewer and reviewer;
- Interview/progress records;
- Personal, local orientation and mandatory and statutory training checklists relevant to the specialty;
- The KSF competency development matrix;
- Practice record comments section;
- Reflective practice framework and record.

The pilot area targeted was community (district nursing) for band 5 nurses.

PROGRAMME AIMS

The main aim of the programme is to guide nurses’ essential knowledge and skills development in the first 12 months of employment after registration, then introduce a secondary workbook to perform the same function for subsequent years. Some aspects of induction are prescribed, including those essential for a role; mandatory organisational requirements are also included.

The system has multiple uses:

- It represents a PDP that ensures regular PDR;
- It forms the foundation of a professional portfolio, identifies learning needs and supports individuals’ CVs;
- It provides hard copy that shows evidence of competency, and tracks how and where that competency was achieved;
- It also complies with the recommendation by Rennie (2009) that such formats should provide an assessment structure that determines safe competent practice, while stimulating continued learning.

KSF COMPETENCY DEVELOPMENT MATRIX

This matrix outlines the core competencies and identified learning needs nurses are expected to achieve in their first year of employment.

There are four designated levels of competency (Box 1), which are assessed through a combination of witnessed practical demonstration and nurses providing valid, reliable, up to date evidence that they have knowledge and skills in identified areas. Workplace reviewers only sign off competencies when level 4 has been achieved.

Each section of the matrix focuses on a core or specific aspect of the KSF post outline. It states the competencies that need to be achieved in those aspects of the KSF to ensure skilled practice. We identified role specific competencies and ways of meeting them by analysing the practice elements required for those roles. Practice records, reviewer and reviewer comments, and reflective practice frameworks are attached.
to each part of the matrix to provide an
continuing narrative of development.

Induction for new starters involves first
attending mandatory corporate induction
sessions, then starting a structured
programme of work based induction that
teaches and develops essential skills over time.

The programme works in much the same
way, whether staff have been promoted or
moving to another specialty. A typical
example is a nurse moving from a band 5
role on an acute medical ward to a band 6
community (district nurse) role. To provide a
guided transition into that new role, the KSF
induction programme workbook for band 6
community nurses would be followed.

IN SERVICE TRAINING AND
DEVELOPMENT
The training and development department is
responsible for coordinating and supporting
the implementation of the new induction
and development programme.

The original, two day induction has been
replaced by a five day mandatory corporate
induction and a half day KSF induction
session, which covers the purpose of the new
workbook and programme. These sessions
are used to advise team leaders, managers and
KSF development reviewers on the system.

Training and development also provides
Open College Network accredited modules.

IMPLICATIONS FOR PRACTICE

The programme has organisational,
individual and wider benefits.

Organisational benefits:

● Mandatory and statutory requirements are
met and monitored;
● The requirements of the KSF are met;
● The PDP and PDR system is automatic
and prescribed, so can be implemented
instantaneously;
● Failures in care relating to human error or
skills gaps could decrease due to a greater
emphasis on skills based development and
competency;
● Staff receive opportunities and guidance
to develop competencies in their roles.

Personal benefits:

● Individual PDP and PDR is linked to
career development and progression;
● The programme offers evidence
supporting the negotiation of KSF pay
gateways;
● It provides a basis for professional
portfolios and CVs;
● Improved skills mean improved
confidence and ability and the capacity to
deliver better care and treatment.

Wider benefits:

● The Programme is intended to be easily
transferable to other trusts or health boards
and organisations;
● It can be adapted to suit the knowledge
and skills needs of other disciplines.

PROJECT BARRIERS

The ongoing development of this project is a
major undertaking and the scope of the
exercise is extensive.

To cover all divisional nurses just in bands
2-7 in the disciplines of community, mental
health and learning disabilities will require a
total of 36 specific workbook programmes.

This pays attention to individual specialties,
such as community psychiatric nursing, and
other areas in mental health alone.

Modules and workshops also require
thoughtful development and delivery.
Meeting these challenges will therefore
require the development of administrative
staff and those in higher management –
delivery with only existing resources would
take considerable time.

Although the multiple uses of this format
are attractive, some might see it as a
requirement for yet more paperwork or
spending time away from delivering care and
services. To avoid staff losing enthusiasm
for the scheme, they need to be aware that their
employer is committed to a KSF review and
PDP. It should also be presented as
something that is positive, meaningful and
of benefit to both staff and patients.

The programme can be launched by
piloting it in a specified clinical area with one
band of qualified nursing staff. This will:

● Identify any difficulties and problems;
● Assess the effectiveness of the process –
do’s it actually do what it is supposed to?
● Provide adequate training and
development support and advice about
the process to managers, team leaders
and reviewers;
● Obtain feedback;
● Monitor progress.

CONCLUSION

Integrating personal development review
and planning, induction and career
development into one comprehensive and
functional package has resulted in a format
that succeeds on a number of levels.

The programme’s flexible design means
that any new skills nurses need to develop in
the future can be added as required; it is
comparatively simple and easy to use and its
multiple uses makes it an efficient means of
inducing nurses.

Practical clinical skills lie at the heart of
nurses’ professional practice (Nicol and
Freeth, 1998). When considering educational
systems in nursing – whether the evidence is
opinion or research based – structured
training and an induction that focuses on
essential skills is the bedrock of providing a
quality nursing service that increases
protection for both staff and patients.

REFERENCES

Arthur W et al (2003) Effectiveness of training in
organizations: a meta-analysis of design and evaluation
features. Journal of Applied Psychology; 88: 2, 303-245.

Bradshaw A (2000) Competence and British nursing:
a view from history. Journal of Clinical Nursing; 9:
321-329.

Bowden E et al (2007) Implementation of the Knowledge
and Skills Framework and Widening Participation in
Learning in the NHS. London: National Institute of Adult
Continuing Education – England and Wales.

Department of Health (2006) From Values to Action: the
Chief Nursing Officer’s Review of Mental Health Nursing.
London: DH. tinyurl.com/values-action

Department of Health (2004) The NHS Knowledge and
Skills Framework (NHS KSF) and the Development

of the newly qualified nurse’s perception of the transition
from student to qualified nurse. Journal of Advanced
Nursing; 32: 2, 473-480.

Gournay K (2008) An international perspective of
psychiatric nursing: the situation in the UK. Journal of
the American Psychiatric Nurses Association; 6: 5:
170-174.

valid training needs analysis instrument for use with
primary health care teams. Health Service Management

Suggestions from a Delphi study. Nurse Education
Today; 23: 449-458.

Neville L (2006) Linking the knowledge and skills
framework to CPD. Nursing Times; 102: 32, 36.

new approach to an old problem. Nurse Education Today;
18: 601-609.

Rennie I (2009) Exploring approaches to clinical skills
development in nursing education. Nursing Times;
105: 3, 22-22.

Nursing and Midwifery Council (2006) Preceptorship
tinyurl.com/NMC-preceptorship

Career Framework for Nurses in Wales. Cardiff: WAG.
tinyurl.com/nurse-career-Wales

Nursing Times 14 December 2010 Vol 106 No 49/50 www.nursingtimes.net