An interactive approach to mandatory training

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Mandatory training provides organisations with a means to update their staff with latest guidance and address any areas of concern, but the two words often fill staff with dread – they illicit images of boredom: “death by PowerPoint”.

Historically, training is delivered in:

- Practical, small-group sessions delivered by a suitably qualified trainer (for skills that need to be practised, such as basic life support);
- A “chalk-and-talk” style.

Recently, there has been a push towards e-learning. This is favoured by many organisations as staff can be tested and it is cheaper than face-to-face teaching. However, the opportunity to ask questions or seek clarification is lost (Dallinger, 2013).

Chalk-and-talk delivery is common. However, we discovered that, although individual speakers were good, over the course of a day, staff accustomed to the bustling of a clinical working environment struggled to engage. By examining the feedback, it was evident that mandatory training was in danger of becoming little more than a tick-box exercise. Little learning was taking place and the desired impact on patient care was lacking – we needed a new training method.

Redesigning mandatory training

We decided to try something different. Much has been written about the need for interprofessional training at pre- and post-registration events (Barwell et al, 2013; Barr and Norrie, 2010) but the concept goes back further to many high-profile cases and the Bristol (Department of Health, 2001) and Laming (DH, 2003) reports.

Much educational literature focuses on the variety of techniques and methods adults utilise to learn, with variability in delivery being key to the retention of the information (Reece and Walker, 2007). As a result, our planning team opted for an interprofessional scenario-based approach, with dynamic content.

McIntyre and Yeoman (2015) found it was difficult to establish a direct correlation between their board-game training methods and improved patient outcomes – however, their staff enjoyed playing games on topics such as pressure ulcers.

Our mandatory training project attempted this on a larger scale, using games and activities over the course of a day.

The training day

Participants

The day is open to all clinical professions, including medical staff. Sixty staff attend the training on any given day. These are then split into two groups, with each group further divided into tables of five or six people.
Activities
The scenarios centre around four fictional patients, with a core theme running through each; subjects such as medicines management and falls are interwoven into those patients’ needs (Box 1). For example, in one scenario, a patient may have a diagnosis of dementia but, rather than dementia being taught as a standalone subject, the patient must be considered holistically. As a result, all topics relevant to their care – such as falls, nutrition and medicines management – will come into play, with an activity or discussion on each. Medicines management will then feature again later in the day when looking at a different patient – this time, one who has a learning disability and requires critical medication.

One of the most popular activities is about consent. The group is given a set of statements that are not as clear cut as they first appear; the group must decide whether they are true or false. Examples include:
- Fathers can only give consent if they are married to the mother of a child;
- Consent for a procedure cannot be withdrawn once it has been given.

Once completed, the facilitator asks each small group what they decided and why; a detailed answer is then provided.

Programme evaluation

Benefits
During the first six months, more than 1,000 staff attended the course; feedback was collected on the day using a Likert scale and free text. Responses have been positive (Fig 1) and attendees particularly value the interaction with others. The benefits of this interactive approach include changes across the trust in a variety of clinical areas:
- Our renal dialysis unit has changed the way it manages deteriorating patients.
- Outreach are called earlier and the sepsis six paperwork was implemented;
- The learning disabilities hospital passport has been extended to, and implemented in, maternity services.

There are also other, less-quantifiable, benefits, including the fact that staff are more aware of how they fit into the hospital and the significant role played by the multidisciplinary team.

An unplanned outcome is that we have also learnt what is not working. Through discussion, staff gain the confidence to say what is actually happening, as opposed to being told what should happen.

As well as reflecting on the events of the day, nurse and midwife attendees are encouraged to think about how what they have learned may change their clinical practice. Nurses can use this to meet some of the requirements for NMC revalidation (Nursing and Midwifery Council, 2015).

Challenges
Facilitators struggled with the change in dynamics from presenting a lecture to facilitating small groups. Activities take longer to complete than a presentation and, consequently, we had to adjust the activities to fit them into the allotted time.

The main challenge, however, has been designing content to suit a variety of professions, abilities and working environments. After feedback, we have become better at signposting the relevance of activities to individual staff groups. Some subjects are not – at least on the surface – applicable to all staff. For example, midwives were initially sceptical about why they had to complete a scenario on a patient who has dementia. But, after completing the scenario, many realised it could help support some women who are caring for, or had contact with, family members with the condition. Some areas, such as outpatients, have requested departmental training. However, with the benefits gained from the interprofessional nature of the training, the planning team has decided to continue with the group scenario approach.

Conclusion
Ideally, all mandatory training would be tailored to each individual’s learning style but the constraints of organisational training mean that is difficult. Through videos, discussion and games, the scenario-based approach has provided a more varied mix of styles and, despite the challenges, the responses are positive. NT

References
McIntyre L, Yeoman A (2015) How board games can be used to improve safety. Nursing Times; 111: 25, 14-17.

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