Training multi-professional staff at pace during a pandemic, to deliver a competent and confident redeployed workforce for our community hospitals

Sandra Speller
Professional Head of Therapies
Sussex Community NHS Foundation Trust

Winner 2020 CHA Innovation and Best Practice Award related to Covid-19

Summary:
At SCFT we developed a speedy process to enable staff that were being redeployed to support patient care needs and therapy programmes on our community wards to develop their knowledge and essential skills in the key areas required. The aim was to ensure they could:

1) Identify the knowledge and skills they needed to learn or review, by completing a self-assessment tool
2) Watch a range of over 20 "bite-size" videos developed by our therapy clinical skills facilitators which covered the basics of a range of tasks, including washing, dressing, toileting as well as respiratory care, transfers, patient handling using a range of equipment and supporting mobility with or without aids.
3) Access 3 weeks of daily virtual sessions so they could ask questions and see further demonstrations on the full range of topics.
4) Access further resources and learning, as well as revisit the videos as and when needed by developing a dedicated area on our Trust intranet.

This approach received excellent staff engagement and feedback, with 94% of those who responded to the survey sent reporting the training increased their level of knowledge and understanding, and 71% felt more confident in their ability to deliver clinical care – all before they were asked to start working in a new environment. Obviously, there was further training and support offered once they were redeployed.

The videos made have continued to be used to support staff and the same approach (video and resources for self-learning, followed by virtual Q&A sessions has since be utilized to deliver our band 4 training programme for our community hospital therapy practitioners.

In addition, staff were able to record their learning with our Training team when completed; this will enable the Trust to easily identify staff with the competencies required should we need to redeploy staff again over the winter period.

Background:
As the Covid-19 pandemic started in March and April this year SCFT, like all other NHS Trusts were asked to prepare for significant patient numbers; at SCFT, as a community Trust we were asked to take large numbers of patients from our acute partners to free space for critically ill patients, and to maintain this rate of patient flow over the coming months.

To enable this, we were required to redeploy a large number of staff into our key services, including our community beds. To do this many of our other services, including children's therapy, podiatry, community neurological care, falls teams and our Healthy Child Programme clinicians were all tasked with preparing for redeployment into clinical areas that for most, they had never worked in – or had not for many years.

For many this was a period of significant anxiety, and it was therefore imperative that we prepared and supported them as quickly as possible. However, we are a very large community Trust, spread over a very

large geographical area with 10 community hospitals, so this presented significant challenges in ensuring that we could deliver at the speed required.

Working with nursing colleagues we were quickly able to identify the key tasks and activities that we would need staff to help with, and also (by considering professional training background) which professions would be best suited to help with which activities. For example, physiotherapists and occupational therapists could support with mobility and dressing practice, whilst speech and language therapists could be taught how to help with basic care on the wards – but also would have skills ideal to help patients communicate with their relatives as visiting was stopped over the pandemic period.

We had developed a new role in therapies last year – our clinical skills facilitators, whose role is to support the training and competency development of unregistered staff in our adult therapy services. Reviewing the knowledge and skills that we had identified as being needed to ensure safe and effective patient care, it was clear they were the team with exactly the skillset to train staff that were being asked to work on our community wards – so we immediately "redeployed" them to work with me, project management support, our Digital Lead and nursing leads to develop the programme.

This summary relates in particular to the work undertaken by the Therapy team to support the learning needs identified, but throughout we worked closely with the nursing leads and practice development team as a cohesive, multidisciplinary education team to ensure all needs were covered by staff with the appropriate level of knowledge and skill.

Description:
Once we had identified the knowledge and skills required, we agreed how we would present this for staff. I was tasked with developing resources to support basic care needs, respiratory care and managing patients who were breathless (we were likely to have patients admitted who were still recovering from Covid-19), patient handling, and therapy tasks such as mobility and activities of daily living – including equipment provision, to enable rapid discharge.

As much of these were very practical in nature, we wanted to provide resources that would demonstrate these tasks, whilst describing the hows and whys (which is very important!). Following discussion with our digital lead we trialed the use of a simple tablet to record videos – and made each of these quite short (a maximum of 15-20 mins). This meant breaking down some topics – for example, respiratory care videos were produced on covid-19, managing breathlessness, airway clearance and inhaler technique and our patient handling videos included topics such as "inserting a slide sheet", "slide board transfer", "hoisting" and "sit to stand with stand aid". This was done for both practical reasons (as the videoing tools we were using were pretty basic, every time a mistake was made the team had to start again, so long videos meant potentially many retakes!) – but it also recognised the needs for staff: giving them short, quick videos, that they could view when they had a quick gap in their day was definitely appreciated, and increased uptake.

Once each video was completed, they were checked by the digital lead to ensure he was happy with the quality and clarity of the resource, and checked by myself and the Chief Nurse for clinical content. Once this had been completed the videos were uploaded onto an internal You Tube channel, and links to the resources added to the dedicated "Covid-19 training resources" intranet page. This also included supporting PowerPoint presentations, and links to other training resources available, aiming to give a variety of learning resources to support individual's learning styles.

Over a period of 6 days the clinical skills facilitators produced 23 videos on a vast range of topics, which was an amazing feat.

Recognising many staff were going to be asked to work in a vastly different clinical environment, and carry out tasks that weren't core skills developed as part of their original professional training, we wanted to make

sure they had the ability to ask questions and seek clarification and further training. Therefore, we set up a 3-week programme of daily Skype sessions, run by the clinical skills facilitators on the following topics – assisting basic care, patient handling, respiratory care and supporting mobility: 3-4 hours of advice and training available each day. They called in additional support from some of our therapy assistants and the patient handling educator – which offered a great opportunity for other clinical staff to be involved in teaching.

At this point staff were ready to be redeployed – with their support and training being continued by the teams on the wards.

Outcome and Impact

Over a period of 4 weeks we developed and ran a multi-professional training programme, utilising the skills of physiotherapy, occupational therapy and nursing staff alongside developing a suite of supportive resources, which enabled 100+ clinicians who had been identified as potentially being available for redeployment to increase their knowledge and skills ready for working on our community wards. In addition, it enabled current ward staff to update in clinical areas such as respiratory care if they wished.

The videos developed by the clinical skills facilitators were watched between 86 and 430 times; that on "the deteriorating patient, sepsis and covid-19" run by one of the practice development nurses was viewed an incredible 710 times.

One member of staff (a health visitor) reported "I am an adult trained nurse but It's been almost 22 years since I last worked in a ward environment so I've found these really helpful…. Now I've watched these videos I am really looking forward to spending some time with patients, chatting & helping them with their activities of living & am no longer panicking about which way elbows bend!"

On completion of training each staff member was sent a survey, so we could evaluate the suitability and effectiveness of this blended method of delivering training.

We received 17 responses from AHP staff; 94% reported they found the training increased their knowledge and understanding and 71% definitely felt more confident in delivering care. 65% felt having different information sources had proved helpful to learning. Indeed, the majority of staff across all professions felt that a combination of video resources and supported Q&A sessions would be a useful approach to learning for other clinical topics.

Therefore, we have utilised this same approach when developing our band 4 training programme for therapy practitioners, which had to be adapted from the usual face to face 3-day programme because of the social distancing restrictions of Covid-19.

Some staff that were redeployed developed such confidence in their new environments that they have taken the opportunity to change career direction and work full time as ward therapists; many have stayed on the bank and have been happy to support where able, and one children's physiotherapist told me that when she retired from her role she intended to take up work in adult services as she enjoyed it so much.

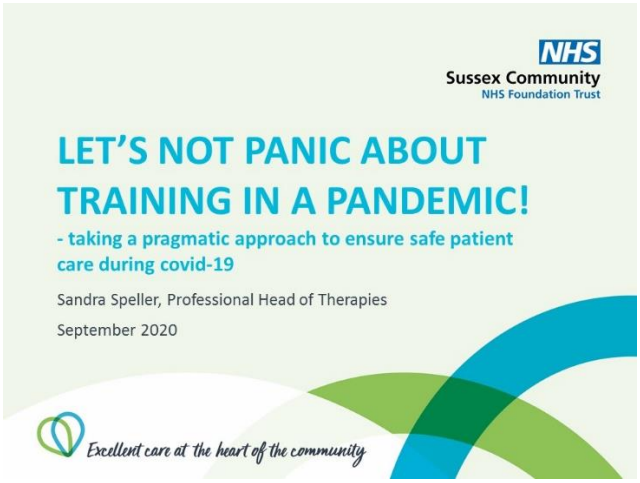
We also have a large number of clinical staff across a range of professions that have been skilled up and could potentially be called upon to support community hospital wards if required in further waves of covid-19 infections, or to support the usual winter pressures.

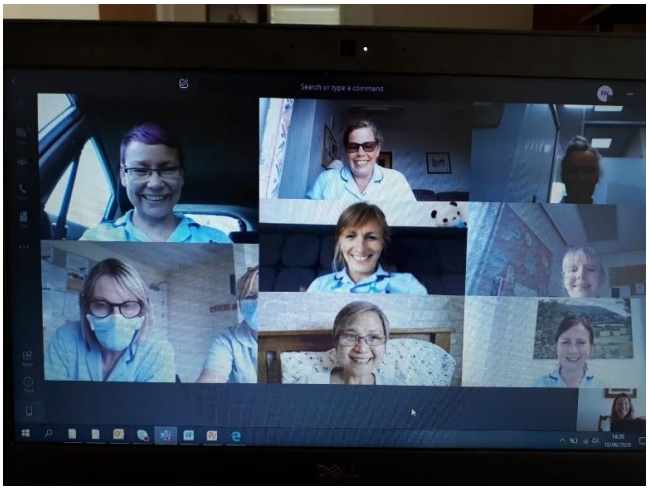
As a multi-professional project, we valued the diversity of skillset available, which enabled us to effectively and efficiently work together to produce resources to a very tight timescale. Throughout the process developed to support staff training and learning during the pandemic we have tried to always consider the individual needs of staff. This meant using a variety of training resources and methods so staff could use

written, pictorial, video and supported virtual sessions. We have several staff who are dyslexic, so ensuring staff with specific learning needs was important.

We also ensured that staff were able to access training sessions at different times; this meant that those who worked part time or had caring commitments were not disadvantaged.
Whilst the resources we developed were at the start of the pandemic before the impact on older patients and those of a BAME background were fully understood and appreciated, these will be reviewed and updated accordingly.

Blog available on the Community Hospital Association website:
http://www.communityhospitals.org.uk/blog.html





For further information contact: sandra.speller@nhs.net

Fifty CHA Years