eWIN Workforce Information Network

NHS Health Education England

Case Study: Community Assessment Training

Previously training available for staff in the community services at Pennine Acute Hospitals NHS Trust has been inappropriate as it focuses on care in a hospital setting. The Simulation and Clinical Skills team wanted to redress this to give community staff the tools to deliver gold standard care to their patients. In April 2015 they approached the community teams at their governance meeting to ask what bespoke training they felt they needed to best serve their patients.

The clinical lead for the Active Case Managers (ACMs) recognised a gap in the skills and knowledge of the team concerning how to earlier anticipate and recognise chronic obstructive pulmonary disease (COPD) patients who had developed chest infections. The clinical lead had been trying to address this as they felt that by developing these skills it would build a standardised and sustainable approach, which would improve the standard and quality of care delivered to all patients. Earlier recognition of deterioration would also reduce crisis intervention leading to improvement in patient outcomes and a reduction in unnecessary hospitalisation.

Therefore the ACM clinical lead asked the Simulation and Clinical Skills team to develop a three day clinical skills and simulation programme on the clinical examination of a patient's chest, including a communication tool.

During May and June of 2015 the pilot session ran successfully and this is now being offered to all ACMs within the Trust. This has resulted in a definitive approach to patient care as now all ACMs perform a clinical examination of a chest on their first visit with every patient as part of the ACM assessment process, following a standardised procedure form and using the 'Situation, Background, Assessment, Recommendation' (SBAR) communication tool.

Key Outcomes

- Introduced the respiratory assessment template which means all new patients referred to the ACM service will have a comprehensive respiratory examination. This standard approach means all patients under the care of the ACMs will experience the same level of high quality care. The ACM team have shared this learning with patients and families who expressed that they feel they have received a much more comprehensive assessment. This shared communication and understanding of why a baseline assessment is done has helped the exploration of a patient's condition and created an environment of shared learning and feedback with the patient.

- Adapted and introduced SBAR communication tool into the ACM service as a structured method for communicating critical information that needs immediate attention and action

- Early data collection is pointing to effective escalation, an increase in patient safety and improved communication between all care providers, both primary and secondary.

- Designed a bespoke training session solely with the ACMs in mind. Training is now much more appropriate for their role meaning staff engagement has increased; this is highlighted by the staff members who took part asking if we can develop more training for them. One ACM said

'It was nice to go to a training session that was designed with my role in mind – it actually reflected what I have to do in practice for patients.'

- Enhanced ACM role leading to an increase in confidence and a sense of empowerment. Staff are engaged with this new standardised approach to visiting patients and actively participated in the creation of the new assessment form. One ACM who took part said

'My confidence in approaching a patient to do a respiratory examination to get a base line has increased meaning my patients are getting a better standard of care. I feel that my role is much more valued as my opinion was asked about how the course should run and what it should include.'

- Supported aim to reduce unnecessary hospitalisation - it is hoped that data collection and key performance indicators (KPI) within the service will highlight this.

- This training will also be used for revalidation purposes for the community nurses and the ACM teams have been discussing how this can be done.

Background

The Pennine Acute Hospitals NHS Trust is one of the largest in the North West of England employing over 9,000 staff and providing high quality care to around 820,000 residents across the North East of Greater Manchester (Bury, Prestwich, North Manchester, Middleton, Heywood, Oldham and Rochdale). The communities the Trust serves are diverse with many areas suffering from high levels of deprivation and are generally less healthy when compared with the rest of England. Where there are high rates of unemployment and deprivation, there tends to be poorer health and a greater demand for health and social care services. In 2014/2015 the Trust saw 688,262 outpatients, 171,656 inpatients and made 152,551 visits to patients in their own home.

The Simulation and Clinical Skills team are responsible for the development and delivery of all simulation and clinical skills training for the entire Pennine Acute Hospitals NHS Trust. This dedicated team deliver a number of high quality courses throughout the Trust to equip staff with the skills to provide quality driven, responsible and compassionate care to every patient both in hospital and out in the community. The team sits within the Learning and Organisational Development Department (run by Head of Learning- Lynda Spaven).

The ACM service was established in January 2005 to support patients with long term conditions (LTC). Since 2014 the ACM service has worked as part of the North Manchester Integrated Neighbourhood Care team (NMINC) to deliver integrated Health and Social care services to North Manchester Registered and Resident patients. The ten ACMs proactively manage patients with complex needs at home by developing care programmes through shared agendas with patients and families to achieve person centred care, which supports and enables self-care and management.

The aim of the service is to reduce crisis intervention and hospital admissions to improve the quality of life for patients with long term conditions, their families and their carers.

This project was set up in an attempt to improve training provided to the community services. The Pennine Acute Hospitals NHS Trust has recently started to raise funds to create a custom made simulation suite for the community services in order to allow community staff to continue their professional development and learn new skills and techniques in a safe learning environment that is realistic by mirroring clinical practice.

Therefore it was decided that the Simulation and Clinical Skills team should approach the community teams to assess staff requirements so they could start creating bespoke simulation programmes for them.

The ACMs recognised that though they are experts in managing patients with long term conditions they felt that they lacked the confidence and the skills to managed acute exacerbations.

In order to do this the ACM clinical lead recognised that the team would need to have training and support to enhance and develop their skills in order to comfortably perform clinical examination of patients.

The ACMs also decided that they wanted to standardise their practice as a team to ensure high quality patient care. They also wanted to empower patients by making them partners in their own care by giving them the skills and knowledge to recognise exacerbations so they can start treatment and inform their key worker earlier with the aim to prevent crisis interventions and reduce hospital admissions.

Evidence base:

Please see Appendix for complete list

Key Aims

- To introduce a standardised approach to the first examination of a patient by a ACM
- To improve communication between all care providers, both primary and secondary, by using a structured SBAR tool to improve clinical assessment communication
- To enhance the role of the ACMs
- To empower patients to enable self-care
- To provide the patients of the ACMs with a gold standard of care
- To reduce unnecessary hospitalisation of patients

Key Stages of Set-up

On the 21st April 2015 the Simulation and Clinical Skills team attended a community governance meeting to introduce themselves to the community teams and ask what bespoke training they felt their staff needed. The ACM clinical lead approached the manager of the clinical skills and simulation team to discuss arranging training about the clinical examination of patient chests.

The two teams met on the 17th February 2015 to discuss the learning objectives and to start designing a course which encompassed these. It was decided that the programme would consist of three, three-hour sessions (if possible to be held over three separate weeks to allow for reflection).
It was decided that the groups would be kept small to allow the learners adequate practice time during the sessions and it would allow the trainer
to observe each learner closely.

Before the pilot the Simulation and Clinical Skill teams designed the action plan paperwork, the sign-off competency paperwork and the respiratory assessment template including the adapted SBAR tool with the ACM clinical lead. This meant that the paperwork could be trialled in the pilot sessions.

It was decided that a pilot programme would run with the clinical leads with reflection at the end of each session for the learners to tell the facilitators what they felt worked and what they felt needed to be altered or added. This gave them ownership over their learning as they could see that this programme was bespoke and were able to shape
it for themselves.

The pilot was held on the 20th May 2015, 1st June 2015 and the 8th June 2015. The team held an evaluation session on the 13th July 2015 where they discussed how the pilot went and when to roll this out to the rest of the ACM team. The respiratory assessment template including the adapted SBAR tool were also edited according to what the ACMs in the pilot felt worked and did not work.

How it Works

The first session took place on the 20th May 2015 from 12.30pm to 3.30pm and was an introduction to clinical examination of a chest including face and hand signs. This was held in a clinical skills laboratory with one clinical skills trainer.

The second session took place on the 1st June 2015 from 9.30am to 12.30pm and was a practical hands on session where the learners went through the process of a clinical examination of the chest. They used each other to practise this process with the trainer observing them and commenting on technique until they felt comfortable. This was held in a clinical skills laboratory with one clinical skills trainer. They then spent time in the simulation suite with the simulation manikin to practise chest auscultation and what different sounds sound like and what that could mean. At the end of the session the trainers took care to impress on the learners that they needed to go out into practice and continue to build on and refine the skills learnt with real patients with real health issues.

The third session took place on the 8th June 2015 from 12.30pm to 3.30pm where the learners had to go through a scenario which was based on their working environment. The simulation suite was converted into a flat environment with a bed bound patient (simulation manikin) and a live actor playing the part of family member. To make the environment as realistic as possible a radio was on, there were trip hazards and the relative would answer the questions meant for the patient or talk over the top of them. The scenario was not only about the actual act of clinical examination but how to communicate to a patient and their relatives and how to have difficult conversations with people.

The learner had a copy of the respiratory assessment template including the adapted SBAR tool and was encouraged to use it during the simulation. The simulation took approximately fifteen minutes per learner with a fifteen minute debrief. Each simulated patient had slightly different conditions with different chest sounds but other than that the scenario did not differ. In the debrief not only were the ACMs practice discussed but also the utility of the respiratory assessment template and the introduction of SBAR.

After the pilot it was decided that the scenario should be more led as the learner spent a lot of time introducing themselves to a patient (as they would do in real clinical practice) but this left little time to go through the skills of a clinical examination. Therefore in the initial brief, it will now be made clear to the learner that introductions have been made and they are there to do a clinical examination of the patient's chest. After the pilot, the ACMs had to complete the action plan paper work with their line manager to identify what further support and practice they felt they needed before feeling comfortable about signing the competency paperwork. The ACMs were then asked to evaluate these documents and again they were edited where appropriate.
The next programme is to be held in January 2016.

Resources

The Pennine Acute Hospitals NHS Trust is lucky to have a fully functioning simulation suite with a simulation team to run it and fully equipped clinical skills labs. The simulation suite had to be converted to resemble a patients home, there were no cost attached to this as facilitators provided them. Recently the team have recently acquired funding to buy some pop up rooms designed to make any space look like a patient's lounge/ bedroom, these cost about £6,000. However these screens are not vital to this course they just increase the fidelity of the session.

This course was free for the ACMs to attend as it is for all Trust staff to attend a simulation course. As with all training there is a cost attached to the learners being released from practice but this cost is small compared to the benefits the learners, and in the long run the patients, receive. This course needed little in the way of consumables.

Key Challenges

- Making the simulation suite look like a community setting - currently the facility is a very acute clinical setting which is just not relevant for the ACMs. This was overcome by the Simulation and Clinical Skills team spending time converting suite into a flat by emptying it of all clinical equipment and introducing a sitting area, a radio and other household objects.

- The Simulation and Clinical skills team needed to develop knowledge of community situations and the home environments the community staff work in, as previously their experience was hospital based. This was overcome by the ACM clinical lead taking time to talk through the ACM role and what that includes. The Simulation and Clinical Skills team also used the expert knowledge of the ACM clinical lead to ensure the course was relevant for the community staff. It was solved by developing a close working relationship between the two teams and supporting each other as much as possible.

- Getting the ACM team to embrace and use the action plan paperwork, the sign off competency paperwork and the respiratory assessment template the Clinical Skills and Simulation team developed. This was overcome by the ACM team being part of developing the paperwork, testing it during the pilot and telling the Simulation and Clinical Skills team what they felt worked and didn't work. The simulation section of the programme also highlighted the benefits of the respiratory assessment template, as it meant that they had a document to ensure they followed a standardised format.

- In order to make this process sustainable and to ensure it is embedded into everyday practice the Simulation and Clinical Skills team have agreed that the ACM team can use the facilities to practice skills after the programme has ended.

Key Learning

- Training provided for community staff needs to be bespoke and created with their service in mind in order for staff to engage with it and for their patients to benefit from it.

Sustainability

All ACMs now have a standardised protocol to follow when they first visit a patient. Every time they go to assess a new patient they will do a clinical examination of their chest to get a baseline for them, they will then do one whenever the patient states they feel a change in their condition to assess whether there has been a change.

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Next Steps

- This session is being rolled out to all ACMs throughout the Trust – the next cohort starts in January 2016.
- To embed the learning in a sustainable way from ongoing development in practice, the clinical skills and simulation team have agreed the ACMs can come on a monthly basis as needed to keep their skills current.
- The ACM service will be conducting a small scale study to measure if the skills, knowledge and experiences that they have learnt are having an impact and benefit to the patients they care for. Mainly focusing on if the patient's knowledge and skills to manage their own conditions have improved and if hospital admissions have reduced.
- A follow up eWIN case study will be written to discuss the outcomes of the small scale study.
- A poster is going to be designed and disseminated to highlight best practice.

Supporting Material

Appendix 1 - North Manchester Neighbourhood Integrated Care Service (NMINC) 2014

Appendix 2 - Active Case Management Service North Manchester (2009)

Appendix 3 - The King's Fund 'Delivering better services for people with long term conditions' Department of Health (2012) http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

Appendix 4 - QIPP LTC Work stream. Commissioning Development Programme. North West Operational Phase Members Guide

Appendix 5 - Lamb. N., (2013) National Health & Social Care, 'Improving Quality of Life for Long Term Conditions', Policy Department of Health