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Development and testing of a tool to support managers' decision-making and evaluation of staff education and training

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Introduction

Managers have a key role in ensuring staff are trained effectively so they can carry out their work to a high standard (Alvarez *et al* 2004, Duffield *et al* 2011). However, within the last five years, a number of high profile reports in England have identified significant failings in healthcare delivery and made recommendations to improve workforce education and training to enhance safety, quality and patient outcomes (Keogh 2013, Francis 2013, Cavendish 2013, Imison et al 2016). Indeed the UK Health Select committee in January 2018 stated that 'Health Education England must reverse cuts to nurses'(House of Commons 2018) continuing professional development budgets. Funding allocated to trusts should be specifically ring-fenced for continuing professional development (CPD) for nurses, and specific funding should be made available to support CPD for nurses working in the community.' They indicated they had heard 'a clear message (…) that access to continuing professional development plays an important role in retention' (House of Commons 2018). Operating in a climate where both time and financial resources are limited, it is important that managers make informed decisions about staff education and training which demonstrate value for money as well as improved service quality. However, factors such as competing organisational priorities and managers' own time constraints may impact on their ability to make such decisions and to evaluate the outcomes of training attended. Decision making takes place in a variety of ways which include, but are not limited to, appraisals. This can result in choices which do not best serve staff, the patient or the organisation. In this context, a tool to aid managers' decision-making regarding staff training may be valuable.

Literature review

Measuring skill acquisition from nurse education and training can be difficult (Gauntlett 2005), and a range of tools have been produced to facilitate this process (Kirkpatrick 1976, 2006, 2016; McConigley *et al* 2011; O'Malley 2013). However, these do not always fully address the complex requirements of the healthcare context (Ellis and Nolan 2005). Additionally, there is little clarity around the strategies adopted by healthcare managers regarding identification of training needs, nor how they evaluate the outcomes of training for staff, the ability of staff to transfer that training to action in the work place or the effect of training on the quality of care delivery (Baldwin and Ford 1998; Awais Bhatti 2013). Whilst mandatory training requires systems to be in place to support its delivery, decisions regarding other staff professional development can be subject to a range of factors, including managers' own experiences and views of training (Hughes 2005; Gould *et al* 2007). Little is known about managers' actual decision-making strategies in relation to staff training, and whether a tool could facilitate this process.

Aims

This two-stage study therefore aimed to:

1. Undertake an in-depth exploration of the strategies and considerations of managers in healthcare settings in relation to their decision-making regarding staff education and training;
2. Develop and test a decision-making tool based on the findings of stage 1.

Stage 1: Methods

Ethical approval for the study was obtained from De Montfort University Ethics Committee.

Data collection

Managers who had experience of making decisions relating to staff training were recruited from a range of healthcare contexts. Participants were identified from managers in Leicestershire and

Lincolnshire using a snowball sampling technique (Atkinson and Flint 2001) in which early participants known to the study team were asked to identify others who met the inclusion criteria. Having obtained participants' consent, semi-structured telephone interviews were conducted by members of the study team. An interview schedule generated from the literature was used to explore a number of key areas: the manager's role in the organisation; reasons for sending staff to attend training or education; views of the nature and type of courses available; factors affecting the selection of staff to attend; and the evaluation of the impact of attendance. Interviews lasted between 20 and 60 minutes, were audio-recorded and transcribed verbatim.

Thematic analysis was used to analyse the data (Braun and Clarke 2006), using an inductive approach to allow key themes to emerge from the data. Each interviewer performed a preliminary analysis of their own transcript, and these were then synthesised into an initial coding framework by the study team to ensure consistency and trustworthiness in the analysis process. A full analysis of all the interview data was then undertaken by two researchers (WP, CG) who refined the coding framework until saturation was reached and no new themes were emerging. The process led to the identification of four key themes which captured the essence of participants' experiences.

Participants

Thirty healthcare managers were recruited. Participants were predominantly female, aged between 45-55, and white British. The majority had an undergraduate degree, with many having a variety of further professional and academic qualifications. Managers were working in a range of healthcare settings including in care homes specialising in the care of older people, people with learning disabilities and mental health problems; in various roles and specialisms within hospitals and hospice; and within the community. A small number had teaching or training roles; sometimes this was in addition to their management responsibilities, whilst others had moved from management into education. Participants had had responsibility for staff development for varied lengths of time ranging from just over a year to more than 20 years; more than half had over 10 years' experience in this area. These managers had responsibility for the development of nurses and care assistants, discussion focused on managers' decision making and as such individual staff were not identified or discussed.

Findings

During the interviews, managers did not differentiate between education and training, and the term "training" is therefore used generically throughout this article, much of what managers said reflected decision making captured during appraisal but did not exclude other scenarios. Four overarching themes were identified in the data: the nature and characteristics of courses relevant to practice; the impact of practice requirements; staff motivation and interest, and the process of staff selection.

1. Nature and characteristics of courses

Managers described their preferences in relation to the format of training, particularly in the light of time and resource pressures within their organisations.

In-house training was identified as reducing the amount of time staff had to be released for training, with some managers able to liaise with training departments to organise tailored training by known providers, particularly for clinical skills training and maintaining staff competency. Other strategies to reduce time 'lost' to staff training included distance or e-learning and other forms of learning in personal time, or organising sessions in lunch breaks. In contrast, external courses which required travel were likely to be more expensive, and could also present challenges for low income staff who lacked transport:

"…if it's a course that's further away we really have to scrutinise what added value that course would give us." (10)

"…a lot of my care staff, don't have cars and therefore find them difficult to access, so that's a massive issue. It rules out a lot of my staff just won't go to courses because they can't get there." (17)

Despite the challenges of covering staff absence, managers frequently expressed a preference for face-to-face training formats. These were considered to be most people's preferred learning method, whilst also allowing for interaction to embed learning and avoiding some of the difficulties of self-directed study:

"...if you're actually attending lectures or have got deadlines that are set by the university you're more likely to complete them." (24).

Cascade training was identified as offering a compromise between releasing staff for external training and providing in-house training:

"we sent two staff members [...] when they came back to run the training trainer bit you could bring it back to base so we weren't having to send staff out to training." (10)

Although this method offered advantages, it relied on excellent recall and communication skills of the 'cascader' and willingness of the 'receiver' in terms of time and commitment, issues which had not always been fully considered.

Some similar issues were identified in relation to mentoring, with managers noting that the lack of staff willing to act in these unpaid capacities, especially GP mentors, limited the number of staff who could be trained in this way. However, this approach did offer advantages, giving 'mentors' an opportunity to pass on their knowledge in practice and enabling 'mentees' to benefit from contact with staff with a higher level of skill, with clear benefits in some cases:

"... you get the whole team growing. And what we're seeing from that particular ward is a level of enthusiasm and confidence." (30)

2. Practice requirements for education and training

The majority of managers noted that service and national requirements to some extent determined what training was undertaken and for which staff in different roles in the organisation. Registered nurses, for example, had professional requirements to maintain their competency levels, and accreditation of training was therefore also a consideration in some instances:

"An awful lot depends what it's about, if it's training to [become a] practitioner it's got to be an accredited course. If it's something like learning to suture then we are not worried about credits for that." (3)

Managers observed how high-profile instances of poor practice had led to a focus on providing

training for improved patient care:

"…really it's to improve knowledge and to improve care is the basis of it [….] So I think it's just crucial from those point[s] of view. I think it leads to better care and a reduction in the risk of abuse." (17)

Blanket directives for training were however seen to sometimes lead to a focus on skills acquisition and measurement with little consideration of the overall educational value to the staff member or whether the training addressed the organisation's need:

"These national programmes that are 'must dos' in terms of implementation but actually no real analysis of whether that will resolve the problem in that particular setting." (30)

For unregistered staff such as healthcare assistants, where requirements were less specified, development of skills and knowledge and an ability to work more proactively with registered staff were highlighted as important. Training was seen as a means of addressing staff's feelings of lack of confidence and value, and changing their relationships with other staff members:

"…it's about their feelings of worth, about being able to challenge registered staff" (25)

3. Staff motivation and interest

Managers recognised that staff often valued training for the sense of recognition and investment in them by the organisation it provided. However, a perceived lack of interest in training was highlighted by some managers, which could have been due to a variety of reasons. A fear of education and of failing was considered to be a factor that held some staff back, particularly unregistered staff and those on lower grades, whilst those close to retirement age were sometimes perceived as sometimes lacking motivation to undertake even mandatory training.

In some instances, lack of motivation appeared to be due to a staff member's lack of clarity about the most appropriate training to attend, which was linked to the absence of clear career progression or monetary reward for skills development:

"…there is not really any career path. So however much you do, and I think this is where the

motivation might lack […] however much motivation they have and however much knowledge they gain the most that would happen is they would go up to senior carer and it's a few pence an hour difference. So our staff are paid the same whether they have got an NVQ or not and that's a big issue." (17)

On a wider level, a lack of career progression was also seen as sometimes being symptomatic of an organisation's own lack of co-ordination or strategy in training development. This could lead to available training not meeting the needs of either staff or the organisation, causing frustration for individuals and an inability to bring about the transformation needed at an institutional level.

4. Staff selection

A range of factors were taken into account by managers in selecting staff to attend training, which related both to the individuals and the wider context of the organisation. In terms of individual staff, whilst appraisals were often a key mechanism by which discussions were begun, many other factors were also considered, particularly in relation to non-mandatory training. With limited budgets, opportunities often had to be 'shared out':

"I try to be fair and equitable and if they went last year then it's somebody else's turn to go this year." (15)

As part of this process, one manager did not consider staff for any additional training until they had been in post for at least a year. This was part of a wider pattern of considering training and development as *"a reward, it's a thank you" (2)* for staff, rather it forming part of a strategic decision-making process.

Managers also made their own informal assessment of staff's suitability for further training. Whilst this was based to some degree on interests indicated by staff, an overriding factor was often the impressions managers had developed of their staff and their capabilities:

"… when you work with them regularly you get a feel for whether they have got anything between their ears or not." (2)

In terms of the wider context, limited resources created a tension between providing opportunities for

further development and meeting mandatory requirements and organisational priorities to maintain service delivery. This created a feeling of pressure to justify the costs and time allocated to training:

"I think any training that is allowed has got to be very specific and you have got to identify what the results of that training will be for the organisation, let alone the individual." (8)

"...my managers, their drive was just to deliver the service more than develop staff. So no they [...] certainly didn't encourage training really because it was taking staff away from the work place." (28).

In this context of limited time and resources, there was a strong belief that a change in behaviour or performance was required to justify attendance:

"...before somebody goes on a course I would always want to know what they anticipate getting out of it which would be in terms of attitude and behaviours and impact on patient care. [...] maybe three months or so after the course has finished I would want to know from that individual what they feel has changed in their practice as a direct consequence of attending that particular course." (8)

However, in spite of the significant resource implications involved, little reference was made to any formal evaluation of the outcomes of this investment. Furthermore, whilst this kind of evaluation might be relatively straightforward in the case of skills-based training, the benefits of longer-term educational development were more difficult to define.

Despite the complexities of the issues involved, or maybe because of them, few managers used any kind of tool to aid their decision-making in relation to staff training. Some considered that they did not need such tools due to their level of experience, whilst suggesting that they could be valuable for newer or more inexperienced managers.

Stage 2: Tool development

Based on the themes identified through the data analysis and informed by the literature, a member of the study team (NW) drafted a decision-making tool which was then reviewed by the team. The tool was intended to create a structure which would enable managers to clearly identify the rationale for

decisions made in relation to training. In addition, as it was clear that there was little consistent evaluation of the outcomes of training, a specific section relating to evaluation drawing on Kirkpatrick's widely-used Four Level Training Evaluation Model (1976, 1998) was included.

The tool was then reviewed using two strategies:

- A small group of nurse managers working in a variety of hospital and community settings with responsibility for staff training were opportunistically sampled whilst attending a course being delivered by one of the study team (KF). The managers were asked to review the tool and give their feedback on the structure and its usefulness in practice.
- The tool was also sent to a senior nurse with responsibility for managing training for a large private care home company with a proactive approach to staff training, to managers of a local hospice and to academic colleagues within the department. Their comments were invited on the usefulness of the tool, and its structure and format.

Feedback was largely positive, with managers considering it appropriate for use in practice:

"I think [this] would be useful in my area and would be a good guidance to ensure staff are sent on courses that will be of benefit to both them and the department" (Manager D)

One manager observed that the tool would be most appropriate for use with staff at more professional levels, and that a simpler version might be needed for work with care staff which could be integrated into appraisal or supervision meetings. They also emphasised that adoption of the tool would depend on managers identifying its usefulness in practice:

"The tool's success (...) will definitely hinge on the buy in from the person using it and if they see that there is a benefit to them and it will add value to what they need to achieve in their own role, they will use it." (Manager E).

Following review, some minor amendments were made to improve the tool's clarity and function, and this version is included as Figure 1.

Discussion

This study examined the influences on healthcare managers' decision-making with regards to staff training. Key themes relating to course delivery methods, practice requirements, staff motivation and the process of selection of staff were identified. In the context of competing resource priorities and a complex range of external and organisational requirements, it was clear that managers made decisions drawing on a range of factors largely based on their own experience and judgements rather than using formal tools or processes. This use of cognitive 'short cuts' confirms Gould *et al*'s (2007) suggestion that managers have a significant personal influence on decisions. Similarly, the findings support Turpin and Marais' observations (2004) that many classic decision-making models unrealistically assume a rational process based on complete information, and that in practice managers also draw on a range of other sources including prior experience, organisational procedure and their own personality and background.

As a result of these findings, the authors developed a tool to facilitate managers' processes of decision-making, evaluation and training transfer in relation to staff training (Baldwin and Ford 1998). Preliminary piloting of the tool suggested this tool may be a valuable aid in some contexts, and there is now a need for further testing.

The study was limited to one geographical region, and the snowball sampling method may mean some groups of healthcare managers were not adequately represented. However, the considerable variation in participants' roles suggests the results may be more widely transferable. As most participants had been in a managerial role for some years, it is possible the findings would differ with less experienced managers, and it would be valuable to undertake further research with this group. Finally, there is a need for wider testing of the tool, and the study team would welcome feedback from healthcare managers who wish to use it in their work.

Conclusions

The study found that healthcare managers' decision-making in relation to planning and evaluation of staff training relied on judgements based on their personal experience and knowledge. Despite the complexity of the decisions, they did not employ tools which could provide a more coherent and informed framework for this process. A tool developed by the study team has the potential to ensure vital resources of time and money are best used, improving outcomes for individual staff, the organisations they work for and the patients they care for.

Implications for practice

- Managers make decisions regarding the planning and evaluation of staff training using informal strategies based on personal knowledge and professional experience, rather than using tools to create a framework for this key area of work.

- An evidence-based tool developed by the study team could improve decision making, ensuring maximum value is gained from staff training for the individuals and the organisation, thus improving patient care.

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