Suppose it’s 2 a.m. on a Saturday, the graveyard shift in a hospital, and a life-critical medical device connected to a patient is not functioning the way it should.

How well prepared are the nurses to deal with that situation? Do they have the technical skills to continue to care for their patients safely and effectively—and keep themselves safe as well? Do they know where to find useful resources quickly to troubleshoot when something goes wrong? Do they know whom to call for just-in-time expertise?

This is the kind of worst-case scenario and questions that Sue Sendelbach, director of nursing research at Abbott Northwestern Hospital in Minneapolis, thinks about when she is making recommendations for training for clinicians, particularly nurses, to use medical technology. “You can have the perfect clinical picture presented in training, but the reality of work and practice isn’t as neat,” says Sendelbach, a clinical nurse specialist. “There are so many aspects to patient care. You can have a patient with 20
devices, which can happen in the critical care area. That's a lot of information you need to keep track of."

Plus, “equipment can change rapidly and all at the same time,” says Tricia Bourney, RN, MS, program director, Nurse Informatics, at Beth Israel Deaconess Medical Center in Boston. That means clinician training is a key component of managing medical devices—and ensuring that they are used optimally for patient care.

Hospitals and healthcare systems are rising to that challenge by blending tried-and-true training methods, such as face-to-face classrooms, hands-on and one-on-one learning experiences, with more innovative methods, such as online modules and participatory, collaborative simulations, to develop and build clinician confidence and skills with medical devices. Rigorous, competency-based training programs emerging now could improve the standard of care as well.

Healthcare technology management (HTM) professionals can contribute to every aspect of medical equipment training. "HTM certainly plays a role in clinical training," says Izabella Gieras, director, clinical technology, at Huntingdon Memorial Hospital in Pasadena, CA. "At our hospital, we do everything from formal to informal training with the clinical staff, depending on the needs and types of equipment. HTM can also be involved in the more formal type of simulation exercises and be part of equipment setup as well as the administration of clinical training."

Starting Points for Training
Nurses and other healthcare professionals typically receive formal training to use medical devices for three purposes:
1. To become acclimated to medical technology in use in a clinical environment during orientation or "on-boarding." The Joint Commission requires hospitals to provide clinicians who are new to a clinical environment with the information and training needed to provide safe patient care, including the use of medical devices pertinent to that environment. This is typically one-on-one training.
2. To learn to use new medical technology. The Joint Commission requires hospitals to train clinicians when new medical devices are introduced into the work environment. This training can involve
The HTM Role in Clinician Training

- Consider the training needs of users with different roles (e.g., pulmonologist vs. respiratory therapist vs. nurse for ventilators) during procurement.
- Review or help develop training plans.
- Set up equipment for training and simulated environments.
- Deliver training.
- Monitor consistency of training by vendors across sessions and by different presenters. Sit in on multiple training sessions to become familiar with the device functions and vocabulary clinicians are being trained to use—and help translate vendor talk into clinician language, if necessary.
- Assist with training and troubleshooting on patient care units when new medical technology goes live.
- Monitor trends in device use and reported issues. For example, HTM professionals can be the first to spot training needs when clinicians in a particular patient care area report similar difficulties, which might be a training or use issue, not a device malfunction.

Hundreds of clinicians in a facility or healthcare system.

3. To refresh or build competencies. The Joint Commission encourages hospitals to improve clinical staff competencies, including the ability to safely use medical technology, through ongoing educational activities.

In addition, hospitals provide periodic re-education or training on some medical devices at the request of clinicians—particularly devices with “high-risk, low-volume” applications, according to Mary Jo Assi, director of nursing practice and work environment at the American Nurses Association (ANA), which represents 3.1 million registered nurses.

For example, mechanical ventilation is a high-risk application, but it’s a low-volume practice for nurses who care for patients on ventilators infrequently. These nurses might ask for periodic refresher training to maintain their knowledge and skills. From her 35 years of experience working in hospitals and other healthcare delivery organizations, Assi says, “chest tubes and ventilators are always at the top of the list of requests for education and re-education.”

“The Joint Commission requirements typically are broad,” Assi adds. “They don’t get into specifics about the types of devices clinicians must be trained to use or how often the training needs to be provided. So organizations find ways to meet these requirements.” In general, she says, a sound framework or strategy for medical device training encompasses:

- Introductory information important to the user, such as the purpose of the device, an overview of how it operates, potential safety issues, and troubleshooting.
- Hands-on skills training in a nonclinical environment that provides time for clinicians to operate the device and run through important components of safe operation and troubleshooting—without risk to patients.
- Demonstrated ability to use the device unassisted, using a standard and competency checklist or assessment provided by the vendor, adapted in-house by clinicians and/or biomedical professionals, or developed in-house.

Trainers and Training Models

Hospitals rely on a variety of in-house, vendor, and, sometimes, third-party specialists to develop and deliver medical device training to clinicians.

Clinical nurse specialists, clinical educators, preceptors, or unit nurse managers typically deliver orientation training for clinicians who are new to a facility or patient care environment, Assi says. These experts are deeply knowledgeable about nursing practice, experienced in the care setting, and skilled users of the medical technology in use there.

Likewise, nurse leadership often takes the lead in planning, coordinating, and delivering training to refresh or build competencies, which could consist of classroom sessions, self-learning kits, or skills labs, Assi says.

For example, Beth Israel Deaconess holds an annual Skills Day for this purpose, a common practice in hospitals. Every year, clinical nurse specialists and unit educators identify a handful of educational topics, considering issues they’ve seen in clinical practice and any events that might have occurred, and targeting high-risk, low-volume practices. They create training content on identified topics. Skills Day is held on a rolling basis for clinicians, who spend half a day or more participating in learning activities. First, they hear a short lecture on a key topic applicable to everyone. Then they rotate through several training stations. They spend 30 minutes or so at each station refreshing skills—such as reviewing the equipment on a code cart, using defibrillators or patient-controlled analgesia (PCA) pumps, and managing peritoneal dialysis—and then demonstrating competency with a hands-on exercise.

At Kaiser Permanente, most hospitals in...
the California region have Environment of Care committees, which meet monthly to discuss patient care issues. These multidisciplinary committees include representatives of patient care units, such as unit nurse managers and staff nurses, as well as healthcare technology managers and other clinical support services. The committees identify training needed to increase or refresh competencies, according to Marlene Davis, senior clinical system engineer at the healthcare system. Any urgent issues would be addressed immediately, not at these monthly meetings.

Some of the most intense and sustained educational efforts go toward training to use a new medical device or system—particularly with complex technology, such as ventilators, electrocardiography machines, and infusion, patient monitoring, telemetry, and imaging systems.

“Any time there is a new device brought in for the nursing staff to use, they are provided formal training,” says Kaiser Permanente’s Douglas Lenaburg, senior director of clinical operations. “The method for the training varies depending upon the complexity of the technology and nurses’ familiarity with similar devices.”

“Sometimes it’s just a quick 15 minutes to show nurses the difference between the old device and the new one,” Davis says. “Sometimes it’s more complex, like with patient monitoring, where everyone needs an hour or two hours or more.”

Like many hospitals and healthcare systems, Kaiser Permanente typically relies on vendors to provide their standard training package for any new device or system, Davis says. Depend-
Cover Story

ing on the vendor and the medical technology, training packages can include:
• Classroom training
• Online learning modules
• Demonstrations
• Hands-on training, including simulation
• “Train-the-trainer” or “super user” models
• On-site, “go-live” support

“Covidien, now part of Medtronic, makes a regular practice of instructing operators on the safe and effective use of our medical devices,” says Cyndy Miller, global clinical marketing manager for Respiratory and Monitoring Solutions at Medtronic. “Product training is generally performed by a special force of trained clinicians. It is augmented by digital assets such as videos and computer-based training that may be used before live training to establish basic knowledge, as a means of advancing the knowledge level obtained during live training, and/or as a refresher course.”

At Kaiser Permanente, training needs are considered and negotiated up front, as part of the cost of the equipment. Training plans and delivery differ from hospital to hospital, depending on clinicians’ needs and schedules. “We’ve got 30-something hospitals across our various regions,” Davis says. “Some places need 24/7 training, because they have people on graveyard shifts that need to be trained. Other places are running 7 a.m. to 6 p.m., so they don’t need night shift training.”

In the past decade or so, train-the-trainer or super user models have become popular. Vendors’ clinical or product educators train hospital or unit educators, or super users—front-line, early adopters on staff—to use new medical technology, who then train other clinicians.

“The super user is really critical in the first several months when you’re adopting a new device, until you come to the point where everyone is proficient,” Assi says. “Not only do you have someone to help with what is often training for hundreds of nurses, but you also then have someone who’s on the unit who becomes a permanent resource, a go-to person, particularly when the device is new in the environment.”

“It is absolutely a good idea to have nurses train other nurses,” Lenaburg says. “Nurses speak ‘nurse.’ By that I am referring to the idea that a nurse can typically teach or talk to another nurse in a way that they can understand. Having an IT [information technology] or other nonclinical person many times is frustrating as they are using acronyms and language that a nurse may not understand.”

To be most effective, super users should be experienced in their hospitals and on their units. “You would probably avoid asking a brand new graduate nurse to be a super user on a new device,” Assi says, “because they are on a very sharp learning curve to develop organizational, technical, and critical think-

LAW SUIT PROVIDES KEY LESSON FOR HOSPITALS

A commentary in the Journal of the American Medical Association warns hospitals that they could face serious legal liabilities if they don’t take steps to ensure clinicians, particularly physicians, are properly trained in the use of new healthcare technologies.

The April 7, 2015, commentary was written by three professionals—two of them medical doctors—with the University of Michigan in Ann Arbor: Jason C. Pradarelli, of the Center for Healthcare Outcomes and Policy; Darrell A. Campbell Jr., MD, with the Michigan Surgical Quality Collaborative; and Justin B. Dimick, MD, of the Center for Healthcare Outcomes and Policy.

The authors wrote about a legal ruling involving robotic surgery, specifically the da Vinci Surgical System from Intuitive Surgical. A patient who underwent robotic-assisted surgery suffered multiple, serious complications and died four years later. While the attending surgeon, his private practice, and the hospital settled individual malpractice lawsuits, the case against Intuitive went to trial in 2013 in Washington state. The jury ruled in favor of the defense. The authors say the implication of that ruling, which is being appealed, is that hospitals—not manufacturers—are ultimately responsible for ensuring clinicians are properly trained in the use of technology.

Not recognizing that fact and rising to the training challenge could cost hospitals if patients are injured or worse during procedures involving new technologies.

“As surgical innovations continue to merge, and as pressures from patients and hospital administrators to be on the cutting edge of technology continue to increase, strengthening hospitals’ credentialing and privileging for new procedures should be a high-yield target for improving patient safety,” the authors conclude.
ing skills during their first year of nursing. You do want to rotate the responsibility of being a superuser among nursing staff so that all staff have the opportunity at some point to be a superuser on a new device. It’s really important to create a pool of super users on a given unit and build that skill set.” Ideally, there should be at least one super user on every unit and every shift when new technology is introduced.

**Becoming Proactive About Training**

As medical technology, clinical practice, and patient care environments become more complex and diverse, healthcare systems and hospitals sometimes want more than stand-
dard, off-the-shelf training packages from vendors. They sometimes also want to provide multiple training options to accommodate different learning styles and preferences, to differentiate training for clinicians with different roles, and to make training more accessible to clinicians. Vendors are responsive to those requests, according to the experts interviewed for this article.

Kaiser Permanente, for example, has pushed some vendors into creating online training to accommodate clinicians’ schedules, especially those who work night, weekend, and per-diem shifts, and those who work in multiple facilities. “It’s hard to get to all these people,” Davis says. “We’ve been somewhat successful there, but obviously not a lot of vendors have online training available just yet.”

When it is available, Kaiser Permanente mandates that clinicians complete the online training before moving on to classroom or hands-on training. “We have a 60- to 90-minute training module for anesthesia machines that we’ve used quite extensively,” Davis says. “Everyone gets familiar with the button-ology, and when they go to the hands-on training, it’s a little more intuitive—they’re not seeing the equipment for the very first time. We’ve also done that for patient monitoring.” Plus, “clinicians are already engaged when they go to the classroom,” she says. “They come with questions.”

Clinical staff can contribute to vendor training to make it better as well. For the online anesthesia module, the vendor

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**Hands Down, Clinicians Find Hands-on Training Most Valuable**

According to the experts interviewed for this article, clinicians most value medical device training that is:

- Hands-on
- Convenient
- Differentiated by role
- Connected to clinical practice, with scenarios or simulations
- Delivered in smaller doses over time
- Focused on the basics first, with more advanced training once the basics are mastered
- Visual

Clinicians also like to have:

- Choices in training methods, such as online training modules and face-to-face instruction
- Dedicated training time, without the distraction of patient care responsibilities, which requires careful planning and scheduling to make sure patient care assignments are covered
- Quick and accessible information and availability of expert support immediately if they need help using equipment or troubleshooting problems

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Healthcare technology management personnel have a crucial role to play in ensuring clinicians are trained effectively in the use of medical devices and equipment.
BETH ISRAEL DEACONESS MEDICAL CENTER

Adjusting the Training Plan To Meet Clinicians’ Needs

A false start with the implementation of a new telemetry system prompted Beth Israel Deaconess Medical Center in Boston to go back to the drawing board to train clinicians to use the medical technology. The new training plan, which focuses on clinician competencies and needs and takes into account the clinical workflow, now serves as a template for other complex technology implementations.

The launch of the telemetry system began with the standard training package from the vendor, with vendor training for super users on staff and then for all staff members on the first patient care unit slated to implement the system. That training consisted of comprehensive online tutorials and face-to-face demonstrations by vendor trainers to groups of clinicians—but no hands-on training.

“There was so much information, but nurses never really got to touch the system,” says Tricia Bourney, program director for nurse informatics. “What we found is that when the system was implemented, the nurses didn’t really have the right information—and they were really lacking the ability to use the new system the way that we wanted.” In addition, the vendor demonstrations were inconsistent; different trainers provided different information to different groups of clinicians, sometimes overwhelming clinicians by highlighting the advanced features of the system.

The revised training for the telemetry system is a three-step process:

1. **Customized online tutorials.** “We went through all of the vendor online tutorials for this equipment,” Bourney says. “We picked out the pieces that we wanted the staff to know about, starting with the basics—just the basics, not all of the bells and whistles and reports and fine tuning.” Those basics include how to get a patient started on telemetry, how to manage the alarm system, and how to troubleshoot.

In addition, Beth Israel Deaconess created some original training content focused on the clinical workflow to supplement the online tutorials. “With the initial implementation, we didn’t appreciate our current workflow and how this technology was going to interact with it,” Bourney says. “It was like we were just substituting one system for another.” And yes, hospitals that are implementing new technology might want to make workflow changes—but those changes should be conscious choices that are made clear to clinicians during training.

The selected pieces of vendor training and in-house content were merged into the
Beth Israel Deaconess learning management system. That makes the content accessible to clinicians anytime, anywhere. Each tutorial includes an online quiz for clinicians to assess their competencies in operating and managing the telemetry system.

1. **Hands-on simulation.** Every staff member who will use the telemetry system goes to a telemetry cart with a telemetry monitor and devices connected to the computer. This simulated environment is configured and functions exactly as it would on the patient care unit. Clinicians spend 20 to 30 minutes working with unit educators and clinical nurse specialists to practice admitting and discharging a “dummy” patient, managing and reviewing alarm signals and conditions, and reviewing patient trends.

Clinicians also can tool around the system in the simulated environment. By attaching a simulator system to the telemetry box, they can simulate sinus rhythm [normal heart rate] and irregular heart rates, such as atrial and ventricular fibrillation and tachycardia, to see how the system displays and records these patient conditions.

2. **Go-live and follow-up vendor support.** Beth Israel Deaconess turned the basic training content created for the online tutorials into a script for vendor trainers to use to coach clinicians during the relaunch of the telemetry system on the same unit. “We wanted everybody to have the same, consistent information, and we wanted the vendor to stick to the script,” Bourney says. “We didn’t want them to go from A to Z. We wanted them to go from A to F, say—just get the basics down first.”

After a month, vendor trainers came back to the unit to confirm basic clinician competencies and answer clinicians’ questions. “Instead of using all of the education time for up-front, pretraining with the vendor, we actually increased the time for on-unit vendor support during the implementation,” Bourney says.

Beth Israel Deaconess now has used this three-step training process, which has been well received by clinicians, for a much smoother, multi-year rollout of the telemetry system to five patient care units. The medical center also is using its “pay it forward” training method, in which nurses who are already trained and using the system support the subsequent implementation on the next unit, and so on. This method, developed for its electronic medical administration record implementation, has proven effective with other technology rollouts as well.

Eventually, Beth Israel Deaconess plans to phase in some of the more advanced features of the telemetry system—with the same collaborative partnership with the vendor for clinician training. Indeed, Bourney says, the vendor has been responsive and willing to work with the medical center at every step of the way.
developed for Kaiser Permanente, “a couple of clinicians on one of our national teams actually went through the online training before it was put out there broadly,” Davis says. “They helped tweak it for the rest of the Kaiser training program.”

Still, online training can be a turn-off. “Most clinicians like to have formal training from an instructor,” Lenaburg says. “It becomes frustrating when they have to complete an online training program without having the device in their hand to follow along with the training.”

Sendelbach of Abbott Northwestern Hospital concurs. “In my experience, nurses find face-to-face training the most effective,” she says. “Face-to-face is optimal, but not always feasible.”

Given these different preferences, “it’s important to have a variety of training methods so that everybody is trained in the way that suits them,” Bourney of Beth Israel Deaconess says. “Everybody learns in different ways.”

To that end, some hospitals and healthcare systems are becoming more proactive and smarter about clinician training to use medical devices. Many bring together multidisciplinary teams for medical technology procurement—and some use the expertise of this team to collaborate with vendors to develop thoughtful, and sometimes customized, approaches to training. Clinicians, HTM professionals, educators, and vendors all offer different and valuable perspectives on training needs and methods.

“When inviting vendors to present on medical devices to clinical staff and leaders, it is very important to include biomedical technicians or their counterparts as participants in the discussion to ensure the best outcomes related to product selection,” Assi of ANA says. “They’re so important to helping us understand the ins and outs of a device in a way that we never would. We know the user end, they know the operations end—and what problems we might have.”

As a director of nursing research, Sendelbach conducts literature reviews for best practices related to the use of medical technology implemented at her hospital. “We look at the best science to guide how we practice with patients,” she says. “When we educate nurses, let’s look at the best science on what needs to be educated and what’s the best way to educate.” While not all hospitals have dedicated researchers, anyone can do a literature search and reach out to peers to learn about best practices in education and training.

**Exciting Possibilities with Simulation**

Simulation is turning heads as a newer method of training to use medical devices for three reasons:

1. It allows clinicians to learn to use medical equipment in an environment that mirrors their actual work environment.
2. It enables clinicians to work their way through routine and rare patient care scenarios without risk to patients.
3. It empowers clinicians to train as teams and strengthens their collaborative competencies with a holistic experience.

“Simulation technology has progressed tremendously in the past 10 years,” Assi of ANA says. “It is held in high regard by many clinicians as a sound method to enhance clinical education and training.”

“Simulation can be very helpful, especially in providing a safe place for things to go wrong,” adds Rick Schrenker, systems engineering manager at Massachusetts General Hospital in Boston.

Early simulation equipment was fairly basic, allowing clinicians to mimic a cardiac rhythm, for example.

“But, organizations have equipment that mimics patient responses to a variety of healthcare conditions and emergencies,” Assi says. “The technology provides opportunities for trainers to observe learners on specific tasks—and also how each person acts and is able to effectively interact with others through an emergency. That’s been of great interest. We now know, as we do more...”
research around this, how important it is to interact well for the safety of patients and for the best outcomes.”

Indeed, a recent study (Hayden et al. 2014) of undergraduate nursing students found that there were no differences in the clinical competencies, nursing knowledge, or pass rates on the registered nurse exam between students who had traditional clinical experiences—taking care of actual patients—and students who had 25% or 50% of their training replaced by simulation. Research is needed to determine if similar outcomes apply to postlicensure nurses, Sendebach says.

Kaiser Permanente uses its Garfield Innovation Center to conduct simulation testing for most large deployments of new technology, as well as for training, Davis says. For example, obstetric and pediatric teams engage in trial runs for transferring newborn babies delivered by Caesarian section to the neonatal intensive care unit—working in an environment with all the equipment found in the real hospital environment. Kaiser also has built simulation centers into its newer hospitals.

Hospitals can set up simulation equipment in a patient room or larger space. Those that might not be able to afford larger, dedicated simulation centers could partner with schools of medicine and nursing, many of which have added them in the past five years. Indeed, Assi says she is seeing some exciting partnerships in this space—and the team aspect of training is “something to pay attention to as best practice.”

Often hospitals can even set up training/simulations in a classroom and do a basic mockup to simulate the clinical environment based on a well-designed training script.

Industry sees interest in simulation rising as well. Pittsburgh, PA–based IngMar Medical, for example, works with researchers, engineers, and clinicians to make its respiratory simulators and test lungs as useful and engaging as possible for hands-on clinician training, according to Brian Linn, marketing manager at the company.

IngMar Medical recently partnered with Eric Kriner, pulmonary critical care clinical specialist at MedStar Washington Hospital Center (DC), to develop three sets of self-paced training modules that prepare

A MANUFACTURER’S PERSPECTIVE

How to Ensure Training Success

Cyndy Miller
Global Clinical Marketing Manager
Respiratory & Monitory Solutions
Medtronic

• Ensure that there is a budget for paying people to attend training so that they are not trying to juggle patient care and training simultaneously and can give full attention and participation in the training.

• Plan for evaluation, installation, and follow-up training sessions that have specific start and end times and a reasonable number of preassigned attendees for each class (avoid drop-in attendees).

• Select super users. Make certain they understand the role and are given additional opportunities for learning and exposure to the product. Also provide them with contact information for reaching the manufacturer’s clinical specialist.

• Meet with the trainer in advance of the training to ensure that the trainer fully understands the role the trainees will play with use of the equipment and how/where the equipment will be employed (e.g., which care unit, what types of patients, which consumables).

• Ensure that the trainer knows how current comparable products are being used and which newly available features will be employed in patient care at the onset of product use. Disclose any foreseeable challenges.

• Meet with employees to explain the goal of the training and the plan for introducing the equipment into the care areas.

• Set clear expectations for attendees by providing pre-reading and training checklists in advance of training.

• Establish a reward system for full attendance at the training ensure there are no work conflicts that prevent full attendance.

• Put up visual notifications well in advance of the training so that all involved have a chance to plan ahead and enter training with a positive attitude.

• Ensure that key cross-functional personnel in all impacted work areas know the schedule for new equipment introduction.

• Arrange for equipment to be available to employees, in advance of and after the training, so that there is plenty of hands-on time prior to introduction in patient care.

• Ensure that the training area is set up so that all attendees are comfortable and can see the equipment and hear the instructor.

• Hold different need-based training sessions for different clinical roles.

• Ensure that all shifts receive training.

• Verify that hands-on, need-based competency is achieved for every attendee.
The FDA’s Role in Clinician Training

Mary Weick-Brady
Senior Policy Advisor
Office of the Center Director
Center for Devices and Radiological Health
U.S. Food and Drug Administration

Q. What is the FDA’s role in encouraging manufacturers to provide adequate training for clinicians who use medical devices?
A. The FDA urges healthcare providers to obtain proper training for a device when training is indicated in the cleared instructions for use, but the FDA does not regulate the practice of medicine and therefore does not supervise or provide accreditation for physician training nor does it oversee training and education related to legally marketed medical devices. Manufacturers, accrediting medical bodies (such as surgical boards), and hospitals/facilities share responsibility for implementing training. Additionally, the FDA will work with professional societies to encourage education and outreach associated with the use of these devices.

Q. Does the FDA consider manufacturers’ provision of clinician training for the safe and appropriate use of medical devices in pre-market approvals, medical device labeling, instructions for use, or post-market surveillance?
A. The FDA reviews submitted relevant clinical training materials, labeling, and other instructional materials as they pertain to the safe and effective use of a medical device. This information may be requested by the FDA for novel devices or when a device is being used for a new type of procedure.

Q. What medical device training-related issues and projects is the FDA working on? Are there particular devices on which the FDA is focusing its clinician training efforts?
A. The FDA provides guidance on device labeling and on human factors to allow for proper instruction on safe and effective medical use in general. We may also work with professional societies and industry to encourage development of appropriate training for medical devices. We may also hold workshops to discuss device development and training needed for devices as they become more complex. One example is a meeting we are having in July to discuss robotically assisted surgical devices. One discussion topic will be the design, administration, and certification of training programs and the FDA’s role in this process. See www.fda.gov/MedicalDevices/NewsEvents/WorkshopsConferences/ucm435255.htm.

Clinicians for hands-on simulation. At MedStar, Kriner wrote and implemented a curriculum for advanced mechanical ventilation that includes over 40 simulations. “We need to ‘flip the classroom’ and move from a lecture-based learning system to a hands-on learning system,” Kriner says. “Learners need hands-on training to enable them to apply their knowledge.”

Validating Clinical Skills Competence in the Clinical Setting
Since 2010, the three major U.S. accreditors of clinician training programs—ANA’s American Nurses Credentialing Center (ANCC), Accreditation Council for Continuing Medical Education (AACME), and Accreditation Council for Pharmacy Education (ACPE)—no longer accredit medical device manufacturers, known as commercial interest organizations, to provide clinician training. Vendors are now discouraged from awarding continuing education (CE) credits for any training they provide, due to the perceived opportunity to influence purchasers.

ANA has developed an alternative that at this point is little used by vendors. “The association’s Nursing Skills Competency Program does permit vendors to apply,” says Kathy Chappell, PhD, RN, vice president, Accreditation Program and Institute for Credentialing Research, and director of the ANCC. “We credential the program, not the organization.”

Vendors need to meet a rigorous standard to have any training program accredited. Training must address nursing skills and abilities—knowledge and practical components—plus any professional behaviors associated with the skill.
nurse finished the course, they were competent to use this piece of equipment,” Chappell says. The certificate goes beyond seat time in training, passing a post-test, going through a demonstration. “This says that you’re competent to use this piece of equipment in the clinical setting.”

As an example, a course by a vendor of a fetal monitor would teach nurses about fetal dysrhythmia and what to do about it—and validate that nurses are competent to use the equipment in a simulated setting and in practice. “When the Joint Commission or state regulators ask, ‘how do you know your nurses are competent?’” Chappell says, “Hospitals can say, ‘because they went through an accredited training program.’”

References

“When the Joint Commission or state regulators ask, ‘How do you know your nurses are competent?’ hospitals can say, ‘because they went through an accredited training program.’”

— Kathy Chappell, vice president, Accreditation Program and Institute for Credentialing Research, and director of the American Nurses Credentialing Center

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