Management Challenges for Point-of-Care Coordinators in Delivering Training and Competency Programs

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The roles and responsibilities of point-of-care (POC) coordinators are numerous and ever-expanding. The ordering and dispatch of reagents and consumables, confirming lot numbers and expiry dates, managing stock wastage, maintenance of quality testing result sheets, management and provision of feedback on quality testing data, verification of patient results, managing device errors, device maintenance and repair, and managing compliance and regulatory issues (to mention just a few tasks) place substantial demands on the POC coordinator’s time. With the support of industry, the ability to automate many of these manually intensive tasks should be a goal to which all managers of POC networks strive.

In practice, the nature and extent of the challenges faced by POC coordinators often depend on the clinical, cultural, and geographic setting in which the POC testing network operates. The 2 largest POC testing models that our unit coordinates are the QAAMS (Quality Assurance for Aboriginal and Torres Strait Islander Medical Services) Program and the Northern Territory POC Testing Program. The QAAMS Program is a national POC testing model for diabetes management operating in more than 160 indigenous medical services across mainly rural and remote Australia.1–3 The Northern Territory Program provides POC testing for acute and chronic diseases in 41 remote indigenous health centers in the territory.4

Because of the extreme geographic isolation of many of these health services and given that the POC device operators who conduct patient testing in these programs may be one of several different health professional groups, the POC coordinators and supporting scientific staff responsible for these programs face unique challenges with the management of operator training and competency assessment in particular. This aspect of delivering these models therefore forms the basis of this editorial.

Organization of POC training sessions for health professional staff from remote communities can be very difficult. Because of the competing time demands on staff in remote health services, not all staff are able to attend on-site training sessions delivered by the POC coordinator; conversely, the cost of flying remote staff to a central location (capital city) for training is prohibitive, and health center managers are reluctant to allow staff the additional time away from the service. Staff turnover rates in remote health centers are also high,5 and it is often difficult to maintain continuity of patient and quality POC testing during periods when services are understaffed or when there are no trained operators available at remote services. Hard copies of manual training resources such as primary training manuals and posters summarizing quick guides on how to perform patient and quality testing are often misplaced when staff turnover, leaving the next POC operator without key reference material. The ability of the POC coordinator to deliver immediate on-site training sessions when new staff replacements arrive is compromised by the demands of distance and time.

For this reason, training for our large networks has evolved in recent years to include a range of flexible automated and electronic options, which aim to simplify the manual workload and the travel and time demands on the POC coordinator and provide a more sustainable means for the delivery of training. In the QAAMS Program, Web-streamed videos of training are now available through a password-protected “Participant Only” section of the Web site. These videos systematically take the participant through the principles and practice of POC testing for this program and can be viewed at any time that is convenient for the trainee device operator. The full training manual, poster sets, training

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Written competency assessment forms can now be downloaded from the Web site. However, in Australia, some remote services experience difficulties with Internet service provision and may be unable to effectively access the Web resources. As a result, all participating services are also provided with a DVD containing a complete electronic copy of all the information that is found on the Web site. As additional options, training is also now available through either videoconference or Skype. This latter low-cost option is now also being used regularly for training with international communities participating in the ACE (Analytical and Clinical Excellence) POCT Program for diabetes management being delivered by our International Centre for Point-of-Care Testing. Opportunities for participants to attend an annual workshop or a regional workshop remain available, and these create an environment where the often isolated POC device operator no longer feels “alone” but rather can experience the cooperative and collaborative nature of the network.

Competency assessment and maintenance of competency registers are an important adjunct to training and another pivotal role of the POC coordinator. For many years, these tasks were performed manually in our 2 remote networks. Our competency assessment processes have traditionally involved the completion of both written and practical components, the written assessment being administered manually by the POC coordinator during on-site visits, and the practical assessment involving the trainee performing testing of both quality control and quality assurance samples (and obtaining analytical sound results for these samples). However, the number of trained operators has now grown to more than a thousand in the QAAMS Program and close to 400 in the Northern Territory POC Testing Program. This has meant that the manual marking of competency forms, checking of quality results, the preparation of competency certificates (including assignment of operator identification numbers), recording of details regarding expiration of competency, and the date for completion of competency renewal has become too time consuming for the POC coordinator. An electronic solution has also been developed to streamline these processes and reduce the manual time and labor burden on the POC coordinator. Written competency assessment forms can now be downloaded directly from the Web site, completed by the candidate after viewing the videos and then e-mailed (or faxed) to the POC coordinator. Alternatively, through a new tailored connectivity package developed for QAAMS, competency forms can be completed and marked electronically, with a competency certificate automatically generated once the practical component has been completed by the candidate. Although many electronically based competency programs now require only a written assessment of competency, our philosophy remains steadfast in the belief that a practical component is essential to the competency process, as it provides evidence to confirm the new operator has the necessary practical skills to conduct the POC test with confidence and assurance. Our new system also alerts the POC coordinator when competency renewal is due for current device operators.

In summary, as POC testing networks grow in size and complexity, there is an increasing need to reduce the time demands that manual processes impose on the POC coordinator. The capacity to automate as many of these processes as possible clears the way for the more efficient and effective delivery of a POC testing service, particularly in geographically isolated regions. This brief editorial illustrates how the automation of tasks relating to just 1 aspect of a POC coordinator’s role—training and competency—can significantly improve the efficiency of such POCT networks.

REFERENCES