The Effectiveness of National Vocational Qualifications in Residential and Nursing Homes
An enquiry into the potential for NVQ to improve the quality of care

BACKGROUND

The impact of the Government’s modernisation agenda on the workforce in residential and nursing homes has particular significance for the training of care staff, directly and indirectly. Major forces for reform were Modernising the Social Care Workforce and the National Minimum Standards for Care Homes for Older People (NMS), which require providers to ensure that 50% of their staff are trained to NVQ level 2.

However, this objective is hampered by the turnover of staff and instability of the workforce. There is competition for a limited pool of people interested in working in care. Some staff leave care work to undertake nursing qualifications and there is potential for career progression. Some homes find that staff gain promotion elsewhere having had the investment of undertaking NVQ.

Dependency levels and needs of residents have risen in the last two decades. Care staff undertaking basic care will need to have a greater knowledge and understanding of all aspects of care and prevention.

RESEARCH AIMS

The overall aim of the research was to investigate whether NVQ has the potential to improve the quality of care and to enhance the quality of life of vulnerable older people. In order to address this, the research investigated:
- the care needs of highly dependent older people;
- the training and competence of care staff to meet residents’ health and personal care needs;
- workforce issues such as recruitment, retention and motivation of staff.

RESEARCH METHODS

A literature review, content analysis of the NVQ in care and a pilot study informed the research design.

Interviews were conducted with representatives of six training providers who were contracted by a county council to provide training and assessment to care staff undertaking NVQ level 2 and 3 in Care. Interviews were carried out with 20 care staff working in residential and nursing homes, who were registered with the training providers. The sample was identified following a postal questionnaire.

RESULTS

Content of NVQs

The analysis of the content of the NVQ found that the units were insufficient in depth or breadth to meet current residents’ health and personal care needs. The emphasis on personal care was of the sort that supported residents who had some independence. Candidates can choose from optional units, and this process, and the content of the units themselves, is unlikely to ensure that achieving an NVQ in Care is sufficient to demonstrate competence in meeting the holistic needs of all residents. In practice, however, training providers / assessors mainly chose or guided the choice of optional units for the candidates.

Eligibility

The requirements for acceptance of candidates to undertake NVQ by each training provider were largely dependent on the funding arrangements. Those candidates who are under 25 have to meet key skills in English and maths, whereas older staff are generally accepted without such requirements. There was a marked difference in approach to the level of acceptable English, in some cases, it was considered not important despite the requirements of staff in homes to be able to read care plans and compile case notes, give correct medication and provide written accident reports. Furthermore, those candidates who are under 18 are not permitted, according to the NMS, to provide personal care to residents, while the NVQ assessment process requires candidates to demonstrate competence on a practical basis. It could be surmised that where candidates are under 18 years of age and employed in care homes that either the homes are disregarding this requirement, or that it is possible to be assessed to achieve an NVQ without providing any personal care.

Training

Not all care staff undertaking NVQ levels 2 and 3 in the sample interviewed received any formal training as part of NVQ, although most had received in-house training from the homes in which they worked. This was partly due to the constraints of the NVQ arrangement of units, but mainly because of the process set out by the training providers. The focus was on completing assignments set by the assessors/trainers and this in itself led to confusion about what was required by the awarding bodies and what was a local arrangement. Most candidates thought that the assignments were set nationally. There was a reliance on experiential knowledge and practice for both the completion of assignments and assessment.

Not one candidate had had a training-needs analysis carried out prior to undertaking NVQ. Training completed by candidates through specific courses arranged by the workplace, such as the mandatory food hygiene certificate, manual handling and first aid, was not necessarily NVQ related, but has been admissible by some training providers as part of the portfolio of evidence. Furthermore, despite the requirement in the NMS for care staff to be given time off during working hours to undertake training, only one of the six training providers made this a requirement of accepting candidates. The other candidates highlighted the difficulties of finding time to complete the NVQ outside working hours.

There appeared to be a failure within the NVQ curriculum to capture any enthusiasm to changing practice from some of the respondents, and that undertaking NVQ is substantially a burden, competing with the demands of work and home commitments, rather than a means of improving themselves. Only one provider built in time for candidates to attend the college, with all other candidates having to complete the NVQ in their own time. However, there was also evidence that some care staff worked hard on their NVQs often...
in the context of poor support. This suggested that there was a desire to improve their own practice and progress, but the system to achieve an NVQ might actually serve to demotivate or frustrate people.

According to nearly half of those interviewed, undertaking NVQ did not make them more competent, as the assessment process was geared to what they already knew. Many were not experienced in learning and there was some resistance to new ideas. Providing written work presented a challenge, particularly to older staff who had to enlist the support of families or colleagues to interpret what was required and produce the written evidence for them. Accessing information was a problem for all except those with one provider with no readily available source of up-to-date literature on current practice. Where handouts were given with answers to the questions contained within the material, there was no incentive to develop thinking.

Care workers’ views of NVQ showed that those with a negative attitude, though having a strong personal commitment to their work, did not possess the same level of commitment to obtaining an NVQ; nor felt in control. There was a lack of drive for continuous improvement in those who did not consider that NVQ had any effect on themselves or the care they provided. Lack of motivation, combined with the challenges and constraints encountered during the process, would result in a poor outcome. Nevertheless, the six candidates who fell into this category still expected to achieve an NVQ.

Some learning took place through candidates’ own research or completion of the assignments supplied by the training provider. Even where interviewees maintained that they had not learned anything, there was some evidence of improved understanding through reflective practice as a consequence of undertaking the NVQ. However it calls into question whether a system which depends on decentralised and uncertain systems of training, on such an ad hoc basis that it relies to a large extent on reflecting on what might not even be acceptable practice, through a highly devolved responsibility for standards and assessment, can be relied upon.

**Assessment**

Competence of care staff is assessed through producing portfolios of evidence against the mandatory and chosen optional units. Some training providers that are contracted to enable care staff to achieve NVQs do not necessarily provide training but are, in fact, assessors. However, some assessors provide training or information for candidates to complete assignments. There is potential for misunderstanding of roles and the possibility of a conflict of interest where the assessor makes judgements of a candidate’s competence based on their own input.

The assessment process is fundamental to assessing the competence of care staff and inconsistencies and lack of safeguards were found to be in evidence. The competence of assessors is critical, as are their judgements and a new assessment process has recently been implemented as a result of concerns. There was no consistency in what was considered to be an acceptable standard from assessor to assessor, or whether it should be an assessment of what is already known and there were differing opinions on what constituted sufficient evidence. There were tensions in the assessor being the line manager or trainer, but the majority of the respondents in the interviews with care staff were satisfied with the support given by assessors, with some reservations made about the quality of training materials and explanations about the process.

**CONCLUSIONS**

There is a widely held perception that NVQ in Care is a training course leading to a qualification. ‘Trained to NVQ level 2’ is a phrase frequently found in the literature, including the National Minimum Standards. This standard an output measure which does not take into account outcomes such as ensuring that staff receive training to provide better care. The inputs (i.e. training) are not mandatory; the output is target driven, and the outcomes not measured.

Furthermore, NVQ is an assessment process of what is already known and not a training course, which suggests that the point of NVQ is solely a means by which people gain a qualification, rather than a means by which there is increased knowledge and understanding that would have a positive effect on improving the quality of care. The implication that a person holding an NVQ in Care had been trained is therefore misleading.

The concept of having a qualified workforce is moving towards professionalising the sector and this may create the effect of offering a more attractive career, which can help with recruitment and retention. There was some evidence to suggest that, if the conditions of learning are met and care staff are motivated, then the qualification will enable staff to provide better care.

In order that there is public confidence that the workforce who provide care to vulnerable older people are competent, shortcomings identified in the study could be addressed by:

- incorporating a flexible but mandatory training programme as part of the process to achieve an NVQ;
- separating the functions of training provider and assessor;
- revising the National Minimum Standards so that all care staff are required to have a training plan, to follow a training programme, starting with induction and leading to a qualification, which includes periodic updating of knowledge subsequent to becoming qualified;
- revising the units of competence so that all aspects of basic care practice to meet the health and social care needs of residents are included in the core (mandatory) units, with specialist knowledge and skills for particular client groups and special needs assigned to the optional units.

This is a summary of PhD research conducted by Marion Witton PhD, MA, RGN, RMN, RHV: The Effectiveness of National Vocational Qualifications in Residential and Nursing Homes: An inquiry into the potential for NVQ to improve the quality of care, doctoral thesis (2004), Personal Social Services Research Unit, University of Kent, Canterbury.