STAFF TRAINING IN HOMES FOR ELDERLY PEOPLE: Who Wants It and What Does It Do?

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ABSTRACT

Training is commonly seen as the most viable way of ensuring good quality care in residential homes for elderly people. Unfortunately, the limited statistical data suggests a serious shortfall in the numbers of trained and qualified staff. Moreover, research has not established what (if any) kind of training is wanted, who wants it and whether it is effective.

The debate on training focuses on two contrasting models - 'professional' social work training and a newer 'entrepreneurial' model, typified by National Vocational Qualifications. The question is whether the 'entrepreneurial' model will appeal to staff and heads of homes and whether it produces 'better' staff. Three surveys were undertaken in order to answer these questions. The first two examined what training heads of homes and staff in the local authority and private sectors said they wanted, why and what background factors influenced their choice. The third survey compared residents perceptions of trained against untrained staff.

Staff and heads of homes were generally keen on training based on the 'entrepreneurial' model which suits those who want specific practical skills, some in-house training and access to nationally recognised qualifications. Staff in the public sector also want training which involves elements of the 'professional' model. Staff want training to combine skill with understanding of residents needs. Residents want

kind, understanding and experienced staff and, when length of time in post was taken into account, did not prefer trained to untrained staff.

The study concludes that homes need to select staff for their good personal qualities and encourage them to stay. Staff need training that integrates skill and understanding and the 'entrepreneurial' model needs to be modified to take this into account. Above all, assessment should reflect this perspective and residents need to be involved in the assessment process.

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INTRODUCTION

In the decade between 1983 and 1993, there was a dramatic increase in the number of residents in homes for elderly people. Nearly all of this increase was accounted for by the private sector - indeed the number of local authority residents declined. (1) The social security bill rose accordingly, from 10 million pounds in 1979 to 1,390 million pounds in 1990, and was expected to rise to 2 billion pounds by 1992. (2) The number of elderly people in these homes and the costs of their care raise vital questions about the efficiency and effectiveness with which their care is delivered.

Official reports contain many references (3) to training as being the means by which good care practice can be maintained and improved. A review of the literature on residential care of the elderly reveals, however, that although the training needs of care staff are thought to be of considerable importance, few studies have provided evidence that training actually meets the needs of staff, their employers, and most importantly, the residents. As the Wagner Report commented,

> "Although something is known about the types of training which staff have, there is almost no evidence on whether trained staff are any 'better' than those who are not." (4)

The issue of training therefore, requires further investigation, since there appears to be a consensus on the value of training, but not on the type of training that is

needed. It is against this background that this present study was undertaken.

This study aims to place training for staff in homes for elderly people in its policy and theoretical context. It then raises three key questions. Who wants training? What kind of training do different 'stakeholders' want and why? What impact does it have on the quality of care as perceived by the residents? These questions are then tackled by three surveys, one involving heads of homes, one care staff and one residents.

Throughout the study, the phrase 'the elderly' has been used but more recently, a preference for the term 'older people' has arisen in the literature. The point of this change is to emphasise the individuality of older people. They have their own personalities, histories and interests and the fact that they are part of the 'elderly' is certainly not the most important thing about them. Nevertheless, the 'elderly' do have needs and disadvantages as a group. For this reason I have maintained the original term as a means of emphasising the particular needs of this client group and the considerations that should be accorded to them.

The study is divided into three sections and eight chapters:

<u>Section One: Overview of Residential Care of the Elderly in the UK.</u> Chapter One is broken down into three sub-chapters. The first charts the growth in demand for residential care, and in particular the rise in numbers of an ageing elderly population. The second looks at the growth of the private

sector and in particular the concerns over standards and quality of care, the lack of choice elderly people have over residential care provision and the issue of effectiveness in home inspections. The continuation of concerns over growth and quality control have led policy makers to look to training. The third section is thus concerned with the belief that training is the most viable means by which to ensure good care.

Section Two: The Theoretical Framework for Training. If training is vital, we need to know what kind of training is needed. Chapter Two looks at the available statistics on training and focuses on two contrasting models of training that are at the centre of a shifting debate on training policy.

The argument distinguishes between those stakeholders who are likely to maintain a 'professional' approach to training and those who are being attracted to a newer 'entrepreneurial' model, that has arisen with the trend towards a reform of vocational qualifications. It suggests that the local authority sector will prefer a social work value-based model of training and the private sector will prefer an efficient and cost-related model that appears to be evident with the implementation of task-oriented National Vocational Qualifications.

The chapter identifies two key problems for training policy. First, the 'professional model' of training appears to have failed residential care. Residential workers have only dubiously been able to claim professional status and the number gaining qualifications have been manifestly insufficient. Second, the

new 'entrepreneurial model' is likely to have attraction for staff and heads of home, particularly in the private sector where the failure of the professional model has been particularly evident. However, this model has been subject to severe criticism and may not be appropriate for residential staff.

For these reasons it is essential to examine what kind of training heads of home and their staff want. For it is only if training is geared to demand from heads of home and staff that it is likely to make a dent in the need for training that is apparent. Second, it is important to see whether the newer forms of training they are likely to want and get in fact improve the quality of care as perceived by the residents.

Section Three: The Research: This section contains five chapters.

Chapter Three is a description of the sample in survey one of local authority officers-in-charge and private home owners, and examines the qualifications and training that they and their staff have gained or undertaken.

Chapter Four is a quantitative analysis of the first survey which sets out to determine how far background training and qualifications and other factors influence local authority officers-in-charge and owners' views on training and whether differences exist between the sectors in terms of preferences for a professional or entrepreneurial model of training.

Chapter Five has similar aims to chapter three and examines a quantitative analysis of a second survey of care staff with regard to the factors which might be expected to influence the keenness of care staff towards training. Chapter Six examines the relationship between these factors and keenness on a professional or entrepreneurial model of training, and in particular the question of whether these attitudes vary by sector.

Chapter Seven is a quantitative and qualitative analysis of a third survey aimed at finding out what impact training has on quality of care as defined by the residents. This chapter is based on interviews with residents who were asked to describe what they wanted from care staff and also to compare two members of staff, one of whom was trained and one of whom was not. The chapter also analyses a survey of the trained and untrained staff whom the residents had been asked discuss.

Each chapter summarises the findings for each survey and provides the setting for the final chapter.

Summary and Conclusions:

This chapter focuses on the key issue of whether training has an impact on the quality of care. It centres on three related issues raised in the study - who wants training?, what kind of training do people want?, and how effective is it?. Emphasis is placed on the findings of the three surveys, and in particular the findings of the residents' survey which highlights the over-riding importance they give to the personal

qualities of a 'good carer', and the fact that if anything they seem to prefer untrained to trained staff. Discussion is then centred on an assessment of the 'entrepreneurial' model and the implications this study raises for the 'new vocationalisation' as embodied in the NVQ model. The chapter concludes with the implications for practice and policy.

SECTION ONE: OVERVIEW OF RESIDENTIAL CARE IN THE U.K.

CHAPTER ONE: RESIDENTIAL CARE OF THE ELDERLY IN THE U.K.

For the foreseeable future, residential care for elderly people is here to stay. The policy of "Community Care" is not backed by adequate funding and it is unclear how far it can deal with the growing numbers of elderly people. Fewer women are able or willing to take on the role of carer and the movement of people around the country has meant that many elderly people have no relatives close by to care for them. These pressures, combined with the availability of funds for residential care from the social security system, have led to a growing demand for residential care.

The resultant growth in the number of residential homes has brought about concerns, particularly with regard to the private sector over standards: the homes are subject to little or no market control, the elderly themselves are often not in a position to choose their accommodation, there is a lack of suitable homes in many areas and elderly people and their families are often limited in their ability to judge what is a 'good' home. Thus residential homes remain an important - and expensive - resource for elderly people and policy makers are concerned that the quality of care they provide is not always high. Of the mechanisms that would lead to improving quality, training is commonly seen as the most viable means by which to ensure a high quality of care.

1. Will the Demand for Residential Care Continue?

The United Kingdom continues to have an ageing population. In 1971, just over 13% of the UK population were 65 years of age or over; this proportion is now projected to rise to around 24% in the year 2051.(1) The rate of increase varies by decade and as Sinclair and Williams point out, the actual increases have been much more rapid between 1971 and 1991 than the projected increases between 1991 and 2001. (2) Indeed, according to Ermisch the major shift toward an elderly population does not begin until the third decade of the next century, reflecting the ageing of the baby boom generation born in the 1960's.(3)

Nevertheless, government projections show that the numbers of persons of pensionable age will remain at about twelve and a half million for the rest of this century, and that an increase will then take place slowly but steadily by about 1% per year until a peak is reached of about seventeen million by the year 2036. More importantly, the projected numbers of people aged 75 or over are estimated to rise between 1991 and 2051, from just under 7% to over 10%.(4)

Increasing numbers of elderly people would be expected to place additional strain on public services. As Phillipson and Walker point out, the welfare state is inadequately prepared to respond to this rise and a crucial factor in this failure,

> "Has been the long-standing shortfall between rising needs and the resources allocated to meet them. Thus increases in a population in need do not necessarily result in increased public resources." (5)

This 'long-standing shortfall' goes back at least 20 years, and reflects in part the difficulties of the British economy.

The mid 1970's saw major cuts in public expenditure, resulting in the view that the statutory sector was failing in its duty to provide for the those elderly needing care and attention. In fact a New Society Survey in 1980 argued that,

> "Our public services are grossly unprepared for the enormous population explosion among the old, and more especially the very old. They will impose a huge strain on local authority social services at a time when the ability of the population at large to provide informal care will be greatly impaired by unemployment and other expenditure cuts." (6)

As Jack points out, approximately half of all expenditure on social security, health and social services is devoted to people over sixty who constitute less than 17% of the population.(7) Any government intent on constraining public expenditure can seek to legitimate this by emphasising the 'disproportionate' demands of older people, particularly in relation to pensions policy. For example, the 1984 Green Paper, "The Next Ten Years" stated,

> "The main factor affecting the social security programme is the provision which has to be made for the elderly....the implications of the present state pension scheme and related issues...remain the major source of future pressures on social security expenditure." (8)

These economic constraints influence but do not determine the priorities of politicians. More could be spent on the welfare of elderly people, and the balance of spending could shift between pensions, and social and medical care. While it is true that mental or physical infirmity increases as ageing progresses, so that the elderly find themselves more than usually dependent on others for help, age in itself does not lead to 'dependency'. In fact Townsend and Walker have suggested that the 'dependency' of elderly people is a consequence of

social attitudes and the state's response, than it is of their age and frailty. (9)

This 'dependency thesis' is a complicated one, but it suggests that certain social and political pressures have combined to create, enhance and maintain a dependent status for elderly people with the result that the demographic projections have been construed as a 'crisis' and elderly people themselves as a 'burden'. In this regard, Townsend has addressed the extent to which long term economic and social policies have presented elderly people as more 'dependent' than they need to be. In his view, enforced retirement from paid work, low levels of 'subsistence pensions', the history of institutional care and the implementation of community care, are vehicles for the artificial creation of forms of social dependency among older people.(10) Further, it has been suggested that a wide and powerful range of groups and interests exist, who have encouraged, unwittingly perhaps, the myth that old age and dependency are synonymous. These groups and interests include doctors, architects, builders, local politicians, administrators and planners, all of whom have tended to favour and work towards the maintenance of institutional care for the elderly. (11)

In keeping with the 'dependency' thesis has been the criticism that the public welfare services can stifle initiative and individual responsibility. This belief has come to occupy a central position in the Conservative Governments' concept of community care which emphasises their aim to "promote choice as much as independence". Integral to this concept has been a shift to policies which advocate domiciliary care as a cost-effective alternative to high cost residential homes. At first sight this

policy seems likely to reduce the demand on need for residential care. In practice, however, parsimony and reluctance to spend money which might encourage dependency have held back expenditure on community services. As Means points out, the reluctance of welfare providers to,

> "Develop domiciliary services that might delay the point at which institutional care is the only feasible option for many elderly people." (12)

has had much to do with fears that 'family' care for elderly relatives is being undermined. As the Audit Commission pointed out,

> "The majority of elderly people fend for themselves or are looked after adequately by relatives, friends and the voluntary sector, without turning to the local authority social services for help." (13)

However, research has shown that domiciliary services correctly allocated, are unlikely to undermine the family because,

> "They tend to reach people who lack a family or whose family resources are slender, or they provide specialised services the family is not equipped or qualified to undertake." (14)

In fact researchers have argued that domiciliary services need to be rapidly expanded to support families and help the isolated. Yet despite these apparently logical arguments, the money spent on caring for a dependent elderly person in the community has been shown to be on average around a seventh of that spent on a similar elderly person in residential care. (15,16) Most of those who are very dependent are, for one reason or another, not going to enter residential care whatever money is spent on them. So the strategy is, implicitly if not

explicitly, to spend very little on any of them and accept the risk that a few will require expensive residential care.

A further factor which limits the viability of care in the community is that it depends to a large extent on the availability of voluntary labour, particularly spouses and daughters or daughters-in-law. As Ermisch has pointed out the relative scarcity of young workers will increase the demand for older female workers.(17) The numbers of elderly people who are living with younger generations are relatively small.(18) Migration of younger people around the country and of the elderly themselves to 'retirement areas' has also contributed to the isolation of elderly people. (19)

Moreover, trends on household composition suggest that future over 80 year olds will have fewer surviving children who will care for them or with whom they will be able to share a home with. (20,21) Elderly people who have not married or had children are also likely to receive limited care from relatives. (22) Even where children exist, many old people are reluctant to ask for help, seeing this as a 'sacrifice' on the part of their families who for their part are often unable to cope with, and face the prospect of, the responsibilities that arise from their relatives' increasing longevity. (23) The 'traditional' picture of the unmarried daughter or daughter-in-law, caring for ageing parents, is also likely to become more complicated, where, for example the consequences of divorce and family reconstruction, together with the increased involvement of women in the labour market, reduces the ability if not the willingness of women to care for an elderly dependent. (24,25)

Where then does the frail elderly person in need of care turn? The number of elderly people is growing fast. Lack of funding, fewer voluntary carers, and the greater isolation of elderly people themselves appears to undermine the success of Community Care policy. On the one hand, to remain in the community on an independent basis implies the support of the domiciliary services and this is often lacking. On the other hand, as Judge and Sinclair show (26), relatives are unable to care for elderly people to the degree required, and they lack the personal and financial resources to acquire an alternative to residential care. In these circumstances, some elderly people have come to want residential care or at least reached the conclusion that there is no other alternative.

Since the mid 1970's both central and local government had been aware of the increased demand for residential care. A DHSS paper in 1976 pointed out,

> "That there will be many old people for whom there is no alternative to residential care." (27)

A Government circular in 1984 stated,

> "Private residential care homes will have a far greater role to play....to complement the provision made by the public services." (28)

This 'complementary' provision was already gaining impetus by way of policies which were encouraging and promoting the growth of the private residential sector, primarily through changes in the system of social security payments. (29)

By 1989, some 2,000 elderly people a month were entering residential or nursing home care on a long-term basis, and yet,

"At least 80 more beds or places a week are needed up to the end of the century to cope with the demographic trend." (30)

And so the door had opened to the private residential sector.

2. What Role will the Private Residential Sector Play in Residential Care?

The 1980's saw a major shift from public to private provision of care places for the elderly. Alongside growing numbers of dependent elderly people, reductions in geriatric and psychogeriatric provision and local authority residential care places, came major reforms in the social security system. This created, as Parker points out,

"A new and buoyant market for private residential care" (31)

More recently, the 1989 White Paper on Community Care to which Langan refers as "The phase of austerity and privatisation inaugurated by the 1988 Griffiths Report" (32), has served to provide further impetus to this shift with the support of a Government approach which appears to advocate an "entrepreneurial revolution in welfare" (33)

A report by Laing and Buisson in 1991 illustrates this trend and shows that the number of residential beds available in the private sector increased from 143,200 in 1989 to 155,600 in 1990 (34) That trend has continued, since by 1993 the proportion of all residents living in private homes was 68% compared to just 32% in the local authority sector. (35)

Tables 1 and 2 give a clearer indication of the massive shift towards the private sector.

Table 1. Local Authority and Private Residential Homes for Elderly and Younger Disabled People in England 1983 - 1993

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
1983	2,670	58	1,940	42	4,610	100
1993	3,370	28	8,650	72	12,020	100

Table 2. All Residents aged 65+ in Local Authority and Private Residential Homes in England, 1983 - 1993

	Local Authority Residents		Private Residents		Total Residents	
	(n)	(%)	(n)	(%)	(n)	(%)
1983	103,598	71	42,14	29	145,208	100
1993	63,520	32	134,510	68	198,030	100

Source:DOH - Residential Accommodation for Elderly and for Younger Physically Disabled People: All Residents in Local Authority, Voluntary and Private Homes, Year Ending 31 March 1993, England.

In Central and North West Humberside alone, where this study took place, the numbers of private and voluntary residential care homes for the elderly rose from 146 in 1986 to 321 in January 1991. This can be compared with an almost static number for the same period, of 58 local authority homes, the numbers of which have gradually declined as homes were sold to an independent consortium since that date. (Source: Humberside Independent Inspection Unit)

This rapid expansion in numbers of people living in private residential homes was accompanied by a dramatic increase in public expenditure on private residential care. As Bradshaw and Gibbs point out, this expansion occurred at the same time as, and perhaps because of, changes in the regulations governing the payments of supplementary benefits to people in residential care homes. (36) Changes in 1980, and further changes in 1983 provided incentives within a climate that was already favourable to private sector expansion. (37) In 1986, the Audit Commission had noted a move by health and local authorities to use supplementary benefit payments for board and lodging to reduce their residential and in-patient care by transferring some of their own homes to private management.(38) The Firth Committee report, published a year later, concluded that financial support for the elderly,

> "Does provide a financial incentive to (private) residential care, and a disincentive to the financing of residential care by local authorities." (39)

In keeping with this lack of "a level playing field", over the past decade the Government has displayed an ideological commitment to private care, arguing that private enterprise can provide a high standard of care for elderly people. As Sinclair et al point out, advocates of the private sector argue that it provides a flexible, competitive and efficient response to consumer demand (40), and that it is acceptable because it is based on payment for services rather than 'professional' assessment for need. However, critics point in particular to the alleged exploitative approach of private home owners, arguing that the ability to pay rather than need is the prime criterion

for admission. As a Centre for Policy on Ageing (CPA) study on the staffing and management in private and voluntary homes points out,

> "A private home represents first and foremost an investment of capital by those who own and (frequently) run it." (41)

As such there may be a conflict between what Walker refers to as the 'cost efficiency' model that the private sector represents, and the 'care effectiveness' model which the local authority sector now seeks to maintain. (42)

3. Perceptions of Residential Homes for Elderly People

Residential homes for the elderly are often viewed as an unfavourable alternative to domiciliary care and some argue that elderly people will 'opt', where possible, for private care as being a more 'homely' and possibly 'superior' option to local authority homes, which retain the historical legacy of the workhouse. The history of public residential care has made many elderly people associate it with the workhouse. In Britain today, residential care is still regarded by many to be the 'last resort', to which the elderly person and/or their families or carers are obliged to accept when all other support systems break down. Elderly people still talk fearfully of being 'put away' into an institution which is seen as little better than the workhouse, and families often assume that placing one's elderly parent or grandparent into care is both cruel and immoral. A paper by Peggy Foster highlights the disadvantages of

such a consensus, which ignores the positive contribution that residential provision can make. As she points out,

> "If we could begin to accept that residential care does not have to be isolating or disabling, but can be a positive choice for frail elderly people and their caring relatives, we might also begin to put some of our energy into improving the overall quality of residential care options. In the long run we might even be able to create innovative forms of residential care of elderly people which would bear no resemblance whatsoever to the institutionalised homes criticised by Townsend in 'The Last Refuge'." (43)

Despite the fact that it is over thirty years since Townsend published his study, the problems associated with residential care have regularly come to the fore. Studies to date have sought to question the function of residential care (44,45,46,47) challenged its historical isolation and separation from the community (48,49,49,50) and provided models by which homes can better provide a service to elderly people in need of care, where care IN the community falls short of the anticipated care BY the community (52,53,54,55,56,57,58,59,60).

These studies and many others, have raised several questions about the quality of care in residential homes. For the elderly person and/or his family contemplating the uncomfortable possibility that greater dependency may require that a person needs to be cared for by others than the immediate family, the dilemma is compounded by the negative and condescending expectations of residential care still prevalent in our society. Misconceptions combined with the fact that local authority homes tend to be large institutions have contributed to a re-evaluation of the role that private residential home have to play.

4. Mechanisms for Ensuring High Quality Care.

These trends in the development of private residential care have led almost inevitably to concerns over the quality of care it provides.

Three mechanisms at least suggest themselves as appropriate for ensuring high quality: inspection to weed out scandalous homes, market forces whereby elderly people choose better homes, and training whereby staff are motivated and enabled to provide better care.

4.1. Inspection. Anyone with the capital and planning permission can open a residential home. The result is that private homes are frequently owned and staffed by people without any qualifications in residential care or nursing care. (61)

Staffing costs are the biggest expense to home owners and inevitably <u>some</u> owners will increase their profits by operating with minimal levels of care staff to the point of causing hardship to their residents. Frail elderly people are extremely vulnerable and open to all kind of abuse, financial as well as otherwise. The need for greater control over home owners is evident where public monies are used to provide considerable potential rewards to those owners who have,

> "A keen eye on rates of return on equity and the minimisation of costs." (62)

These general concerns over the need to 'police' a market in care have been reinforced by scandals. While the small scale' cottage industry' type of establishments are not immune, instances of abuse have occurred and continue to occur, often in

the larger, less 'personalised' homes. Recent examples of abuse have been highlighted though television exposure, a NALGO report 'No Place to Hide", written by a Labour Health Spokesperson, Harriet Harman (July 1991), the publication by Counsel and Care for the Elderly, 'Not Such Private Places' (63) and a Citizens Advice Bureau report, 'Beyond the Limit.' As a New Statesman and Society article warns,

> "Blame rests only in part on the predominance of the business ethic, or on incompetent or unscrupulous proprietors. The rest can be laid at the Government's door." (64)

The Registration of Homes Act, 1984, was implemented to monitor developments in the private sector, introducing measures to ascertain whether home owners are 'fit' persons to run a home and assess the 'quality of care' within it. (65) The wish to control the growth of the private sector arising from financial considerations, there has also stimulated a demand for control through the regulation and monitoring of homes. As Gibbs and Sinclair stress, the inspection of old people's homes is an essential, if complex task, and inspection should ensure,

> "That vulnerable elderly people are protected, that possible sources of scandal are remedied at an early stage, that public funds are available only to respectable private enterprises and that the quality of community care to all is improved." (66)

A further development took place with the NHS and Community Care Act which requires that new 'arms length' Independent Inspection Units are set up by local authorities to monitor standards in all homes in their areas, their own included. These new units follow close scrutiny of the guidelines governing registration and inspection. In 1982, a DHSS consultative

document, 'A Good Home' had underlined an urgent need for legislation aimed at ensuring that 'minimum acceptable standards' of accommodation and care would be provided. (67) The Registered Homes Act which followed, gave little in the way of detailed guidance on standards. A response document published by CCETSW, was concerned over how these 'acceptable standards' and levels of care would in fact be monitored. As the document emphasised,

> "Registration officers hold a key position in current legislation...They have the power to develop operational definitions for an adequate caring environment for the establishments in their patch." (68)

More recently Gibbs and Sinclair question whether inspection is a sufficient tool for ensuring good quality care. In their study inspection judgements proved unreliable in the sense that two inspectors judging the same home independently often came to different conclusions. There are also difficulties in taking action if poor practice comes to light. In particular, deregistration is reluctantly undertaken, since it is often difficult to provide evidence that will stand up at a tribunal and concerns are also raised about what would happen to the residents if a home is closed. (69) In fact the number of deregistrations is probably extremely small. In Humberside for example, only 5 homes closed between 1990 and 1995 as a result of notices being served upon them. The trend may be similar in other parts of the country, although unfortunately, the Department of Health does not keep specific national records on such closures, and refers enquiries to individual Inspection

Units and Social Services Departments. (Source: Department of Health and Humberside Inspection Unit).

A further initial problem highlighted by CCETSW was the need for appropriately trained registration officers. CCETSW laid particular stress on the importance of registration officers assessing training needs in homes. (70) Yet some twelve months later, registration officers were seen to be lacking in even basic training. Indeed, a study of regulation of private nursing homes commented that,

> "The lack of initial training for newly appointed officers surprised the author and confirms her view that an induction course should be available for all new officers asked to undertake the registration and inspection function." (71)

However, if tighter regulations regarding residential and nursing homes are to be applied and monitored adequately, the risk of polarisation may increase if, as Parker suggests,

> "Higher standards are imposed...(therefore) fees will rise and...(will) have the effect of creating a more polarised clientele. Those who are poor enough will continue to have their costs met and those who are well off will be able to pay for improved standards." (72)

The end product therefore may be a two-tier system in which the private and voluntary sectors look after anybody who can raise the required funds 'topped up' in some cases by relatives and leave the local authorities with a residuum of the poorest and most dependent.

It can be argued therefore, that if polarisation is to be avoided, then registration officers should have powers to insist on certain standards in all homes, for example, that,

> "In particular, the person in charge needs to have the skills, knowledge, experience and personal qualities to be able to create the necessary environment both for residents and staff so that the home can achieve its objectives." (73)

and with particular reference to staffing, Griffiths adds, "appropriate staffing (is) at least as important as other aspects of a home." (74) There is however, no indication from Griffiths on how inspection units are expected to monitor this nor how far this recommendation takes particular account of the differences between local authority and private sector establishments. Inspection appears to be a weak link in the maintenance of good quality care.

4.2. Choice. Choice and 'market mechanisms' could be a further means for ensuring high quality care in that it might be expected that elderly people and their relatives would choose the 'better' home. However, research indicates that choice may also be a weak link in ensuring good quality care. The idea of residential care is often not that of the elderly person themselves (75,76,77), applicants are not given enough information about the options open to them in relation to the most appropriate form of care for their needs, very often choice is severely limited because of the lack of places in particular areas, and only a minority make a positive decision (78,79,80).

Biggs questioning the claim that private care has increased quality and choice by arbitration of market forces, argues that,

> "Market forces are too crude a mechanism to enable meaningful participation both within and before entry to a home and in some respects acts against the interests of consumers....Factors such as continuity of care, small scale projects, and client freedom within a home may not be as favourable to old people as the champions of private care would have us believe." (81)

As indicated earlier, costs may also be a factor which affects choice, since poorer applicants for residential care may have limited access to those homes which operate financially outside the social security limits. Financial considerations on the part of the purchaser of care, the local authority Social Services Department, could, in theory, limit further the choice of an elderly person as to whether they need residential care or not, and which homes they will be offered.

For those elderly people for whom cost is not an immediate problem, for example those with capital and/or housing assets, there is still a view that the growth of the private sector gives elderly people *more* choice. This choice should provide a pressure towards higher quality, always provided that it is the elderly person who makes the choice, they are able to assess the quality of what they are choosing, and there is a choice of homes in their area. For those not in this fortunate position, the growth of the private sector provides little reassurance on the quality of residential care.

4.3. Training. So if we cannot rely on inspection and market forces for ensuring a high quality of care in residential homes, we seem to be left with training. One study by Gibbs and Sinclair did indeed find that high quality care as they measured it, was associated with a high proportion of trained staff as

they measured that. This led them to argue that the way to improve the quality of homes would be for inspectors to insist,

> "That a proportion of staff including the head (of home) are trained, and that heads provided evidence that they had successfully completed assessed experience in homes (which) would provide some greater guarantee of good quality." (82)

The authors, however, were cautious, arguing that,

> "It would be useful to show that qualified staff could be observed to behave in a distinctive way, tended to form better relationships with residents than unqualified staff and had distinctive attitudes." (83)

Moreover, to gain qualifications, training must be undertaken, and training comes in many forms and does not always lead to a recognised qualification. Despite its importance, almost nothing is known about who has received training or what training has been undertaken. Staff undertake many different types of training, but we do not know how many have full qualifications or have other specialised or more basic types of qualifications. Within the private sector in particular, there no figures at all relating to how many have received training, how many have undergone training, and what that training involved. Up to date (June 1995) figures supplied by CCETSW, allow for an educated guess, based on the findings of this study, that approximately 15% of local authority staff and 6% of private sector staff have registered for National Vocational Qualifications (NVQ's), but this issue is taken up in more detail in the next chapter.

The key point I would make at this point is that training looks indeed a plausible candidate for improving quality of care. What we need to know is what kind of training is to be

provided, who wants it, and what evidence is there that it will benefit the residents' quality of life?

5. Summary

Residential homes for the elderly are an important resource. They are a response to growing numbers of ageing elderly people with care needs, the limitations of informal care and the limited resources of 'community care'. The massive growth of private sector residential homes, alongside a decline in local authority homes has however, led to concerns over the continued monitoring of standards in a sector that is concerned with profit and cost-efficiency. Research and the recurrence of scandals has suggested that the quality of care in these homes is not always good, and that inspection cannot ensure that it is. The more informal mechanisms that would enable elderly people and their families to make considered choices as to what is a good home are also a weak link in community care provision. Thus the mechanisms of inspection and market control are insufficient to ensure that residential homes can provide good care.

It follows that training appears to be the most viable mechanism that would ensure good care. However, there is very little information on what training has been undertaken and almost no research has been carried out on whether training can, in fact, improve the quality of care in residential homes. It is against this background that the present research was undertaken.

SECTION TWO: THE THEORETICAL FRAMEWORK FOR TRAINING

CHAPTER TWO: THE SHIFTING DEBATE ON TRAINING

From 'Professional' to 'Entrepreneurial' Training Models

Definition of Training: The complete range of provision made to equip staff with the *knowledge and skills for their work within a system of professional values"* (my italics) (1)

Training for residential staff is generally seen as the means by which to ensure good care. There is a debate, however, over the key question of what training should aim to do. This chapter highlights three related issues, whether training should produce 'professional' people with traditional 'professional values' and 'higher order skills' and high status; whether, as a response to the 'new vocationalisation', it should produce 'competent' workers with specific task-related skills; or whether it is a question of producing 'good people', so that training is used to enhance inherent personal qualities.

The chapter examines the rather sparse statistics on what kind and amount of training is actually provided. A discussion of the tension that exists between the different models of training then sets the scene for an analysis of why the different stakeholders in residential care - managers, home owners and staff - are likely to prefer one model of training to another and what impact training may have on the quality of care received by residents. The hypotheses arising from this discussion are then explored in the empirical studies described in later chapters.

1. WHY TRAIN?: Perspectives on What Training Can Do.

Training is a means by which to prepare people for an occupational role and the literature on residential care contains numerous references to its importance. Barr points out that some sixty reports over the past forty years have made recommendations about training for residential work, and that the authors of these reports are generally confident in the capacity of training to improve practice. (2) A key issue, however, is how it is to do this. Should training be a process which involves the whole person in preparation for a 'professional' role or should it be limited to providing a workforce that is skilled and competent in certain tasks? Thus, on the one hand, training may be about knowledge as understanding, the application of that knowledge to a wide variety of techniques and to a variety of situations, and the acquisition of higher level skills. On the other hand training may be perceived as teaching people to do specific things in specific contexts and specific ways. These polarised positions reflect current debates over whether training should be based on a 'professional' model or a newer task-specific 'entrepreneurial' model.

Traditionally, the value of training is seen to lie in some quite general shift in the values and self-perception of the person who is trained which in turn leads to changes in their professional behaviour. Thus Barr maintains, that training is a

form of induction into the culture of an organisation or establishment and that,

> "To press for better training is to press for better practice." (3)

Rather similarly, the Williams committee (1969) while pointing out that training is not by itself a universal cure for the problems that have beset residential homes, nevertheless argued that its essence is to,

> "Inculcate principles, provide a background of knowledge, develop skills and encourage the student to regard learning as a continuous process." (4)

On this view, training is less a matter of learning to do particular things than of acquiring a general disposition which will affect behaviour and attitudes over time. Such changes have consequences for people's perception of themselves as professionals so that staff can be helped to develop a sense of worth in an occupation that has struggled to obtain 'professional' acceptance.

Such training will not, of course, be appropriate for everyone. Williams acknowledged that in residential homes many staff are experienced, older women, who may be unwilling or unable to take advantage of training that often requires full-time attendance. The Committee therefore urged the Government to devise a formula for recognition of work experience. However, while recognising that "experience is essential", it must be reinforced by training which will,

> "Provide knowledge, understanding and skill which are equally vital." (5)

This general assumption that training leads to changes in values and understanding and these in turn lead to changes in practice and hence presumably care is not universally accepted. As Youll points out, it is being increasingly challenged, as users and consumers mount a counter attack, articulating alternative values, standards and requirements. This has led to a general questioning of the nature and purposes of training, (6) and suggests the need for research which will take into account the experience of managers, home owners and staff, as well as the needs and views of residents.

In practice, the relevant research appears to be lacking. A National Institute for Social Work (NISW) Working Party, reporting in 1988, pointed out that while few residential staff had qualifications relevant to working with the elderly, it was also evident that,

"There is little research evidence for or against whether staff training can improve substantially the quality of life of people living in residential homes...the development and training of residential staff at all levels is piecemeal and haphazard. The needs for more research on training effectiveness and processes are indicated by this lack." (7)

As Sinclair states,

"Although something is known about the types of training that staff have, there is almost no evidence on whether trained staff are any 'better' than those who are not." (8)

The point of this study then is to make a start on providing this research, focusing particularly on the newer 'vocational training'. As background to this endeavour we need to examine how far vocational training is in fact replacing the former 'professional training'. We will then need to look at why a

professional approach may have been inappropriate, and why the new approach to training may be more acceptable, but may also bring its own problems.

2. POLICY AND STATISTICS

Following the implementation of the Registered Homes Act, 1984, CCETSW published a paper on Staff Training Issues, which analysed the take-up of the Certificate in Social Service (CSS) and The In-Service Certificate in Social Care (ICSC) courses by local authority, and, in particular, private residential staff.

As CCETSW had already found, DHSS guidelines in the Registered Homes Act, 1984, were not specific on the question of Government responsibility for training. Instead they appeared to regard training of staff more as the responsibility of the Registration Authority. Section 6.6 of the Code of Practice states,

> "Registering Authority may wish to offer Proprietors, Senior Managers and Senior staff...places on courses and training programmes organised for staff employed in Residential Care with the Public Sector....The information about alternative sources of training should also be made available." (9)

This quotation is notable for two things - its permissiveness in relation to the private sector (the registration authority does not *have* to offer places on courses, only provide information on courses it wishes to throw open) - and its lack of any mention of basic care or part-time staff. This attitude reflected and may have helped to perpetuate the

situation which CCETSW uncovered on the ground. According to data supplied by CCETSW, the first posts obtained by CQSW (n=2670) and CSS (n=1450) qualifiers in 1985, were overwhelmingly in the local authority sector, the percentage (n=31) of qualified staff entering the private sector was negligible. (10)

By 1986, as CCETSW pointed out,

> "Existing training courses are currently not being used by the private sector in sufficient numbers to make good the training deficit which is being exacerbated by the rapid increase in private homes. Of the courses used, most are at ICSC level, with minimal use of CSS which is generally accepted to be the most appropriate courses for comparable staff in other sectors." (11)

Further evidence on training initiatives in the private sector were provided in 1986 by a Centre for Policy on Ageing (CPA) study of twenty non-statutory residential homes. This found that 40% of supervisory staff and 87% of care staff were without any qualifications. Of those who were qualified, nearly all had nursing qualifications. (12)

What evidence then is there on how, if at all, the situation has changed since 1986? Unfortunately very little. NISW, in 1988, noted that very little research had taken place into staffing issues and that statistics on staffing were sparse and that there was very little information at all in relation to the private sector. (13) The lack of data from official statistics could in theory be remedied by specific research studies. Unfortunately, however, few research studies have addressed the issue of training directly. As a result, the data on training remains woefully lacking even though the Working Group on Workforce Planning in the Personal Social services had

called on local authorities and non-statutory services to generate meaningful data sets, since, like the Birch Committee in 1976 had found,

> "No information is available on the levels of qualified staff and very little relevant data on the numbers on the numbers of people employed." (14)

Statistics therefore are subject to guesstimates and assumptions, and are bedevilled by the numbers of continuing data sets which do not distinguish homes for elderly people and homes for other client groups. Figures on numbers of care staff in the local authority and private residential sectors are not available for identical years, if at all, and figures on training courses taken up are either out of date or unclear as to status of care staff. Thus any attempt to give a clear overview of the proportion of care staff who at any one time have received training is unsustainable.

That said, we have to do the best we can, and to do so begin with such evidence as there is on the potential need for training. Table 3 gives actual and estimated numbers of residential care staff in homes for elderly people in England in 1986 and 1992.

Table 3. Numbers of Care Staff in Residential Care Homes for the Elderly 1986 - 1992.

	1986	1992
Local Authority	33,952 (i)	31,442 (i)
Private	20,146 (ii)	33,850 (ii)
Total	54,098	65,292

(i) DOH, Health and Personal Social Services Statistics for England, 1993 edition, Table 6.22

(ii) Estimated from figures for total number of residents in Health and Personal Social Services Statistics for England, 1991 and 1993 editions - using as a base figure the ratio of staff to residents (4:1) as calculated in Table 13.

The figures in Table 3 for the private sector are for the full-time equivalents of care assistants and supervisory staff. As discussed later the number of individual staff who may need training is very much larger.

To set against these figures, Table 4 gives a breakdown of numbers of staff who completed CQSW, CSS and ICSC courses in 1986. As CCETSW points out, the CSS introduction coincided with cuts in public expenditure and intakes were far lower than envisaged. (15)

Table 4. Qualifications Gained by Staff in the Personal Social Services, 1986

	All Students (i)		Residential Staff (ii) L.A.		Private		Total Intake	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
CQSW	3040	88	365	10	81	2	3446	100
CSS	1014	93	43	4	28	3	1093	100
ICSC	3796	88	380	9	137	3	4359	100
Total	7850	88	788	9	246	3	8918	100

(i) Working Group on Workforce Planning in the Personal Social Services, 1986, Table 1.1

(ii) Calculated from percentages of local authority and private residential staff in homes for the elderly taking up training in 1984 (source: CCETSW Paper 24, Staff Training Issues) (16)

Whatever the accuracy or inaccuracy of these figures they showed that the number of residential staff in homes for elderly people was minuscule relative to the number of staff employed. This was particularly true of the 'professionally oriented' CQSW and CSS courses, and particularly true of the private sector.

These figures of course only reflect staff who gained qualifications. Their relevance to the proportion of the workforce who were in post and qualified depends on such factors as turnover and the degree to which qualified staff were imported

to or exported from the sector comprising residential homes for elderly people. Unfortunately, the 1986 figure for local authority residential staff in post with social work or other relevant qualifications (650) was only available for care staff in adult homes and centres (Workforce Planning, Table 1.3) or approximately 2% of all local authority staff in residential homes for the elderly. This can be compared with the numbers of care staff with social work or other relevant qualifications in children's homes which was given as 950 (8%). (source: Workforce Planning Table 1.3) No information was available on the levels of similarly qualified staff in the private sector (Workforce Planning, Table 1.6). In terms of social work or social work related qualifications, however, the proportion of qualified staff in the parts of this sector that deal with elderly people must be assumed to have been minimal.

In 1986 therefore, the problem was threefold. The statistics were inadequate; where they could be used as a guideline to numbers of staff with qualifications, they suggested a failure to provide the residential sector with a professionally qualified workforce; and this dismal picture was particularly true of care staff in the private sector.

These problems need to be addressed in the light of development of the system of National Vocational Qualifications (NVQ's) - perhaps the most significant change in training since 1986.

Figures from CCETSW (Appendix I) show that enrolments on to NVQ courses stood at over 15,000 in March 1995 since registering began in 1990. Unfortunately these figures relate to individuals involved in direct care, child care and education as well as criminal justice service, and CCETSW does not distinguish between them when preparing data. However, using figures supplied by the Department of Health on numbers of full time and part time local authority staff in homes for elderly people and elderly people with mental infirmity (17), it is possible to estimate the numbers of full and part time staff in both sectors who have enrolled onto NVQ courses. The figures for the private sector were calculated using the ratio of staff to residents from this research (Table 13). Exact calculations are given in Appendix I.

Table 5. Estimated Numbers of Full and Part-time Residential Staff and numbers enrolled onto NVQ courses in Local Authority and Private Sectors, as at March 1995

	Local Authority			Private Sector		
	F/T	P/T	Total	F/T	P/T	Total
Staff	7330	16452	23782	13451	20176	33627
NVQ Nos.	1306	864	2170	1449	958	2407
Ratio	1:6	1:19	1:11	1:9	1:21	1:14

These figures can be compared with the 1986 figures for CQSW, CSS and ICSC (see Table 4). It must be remembered that the figures in Table 4 relate to those gaining qualifications whereas

those in Table 5 relate to those enrolled who may take a number of years to gain qualifications or never gain them at all. We do not know how many of the 780 who gained qualifications in 1986 were full-time, but it is likely that a high proportion were, and if some of these full-time staff are now taking NVQ's rather than Dip.SW, the proportion of full-time local authority staff taking training now may not be much greater than it was then.

The change in relation to the private sector is, however, dramatic. In relation to NVQ, this sector is now almost as large a consumer of training as the local authority one. Moreover, the lower numbers of staff in the private sector enrolling on NVQ courses is likely to change, as home owners recognise the potential of NVQ's to equip those staff that remain in post with a standard qualification which is acceptable to those registering and inspecting homes.

These changes may in part represent a formal recognition of a previously existing pattern. As early as 1986 CCETSW also pointed out that short courses aimed at specific needs as perceived by private home owners were being provided, but were not accredited by them. Nevertheless, the potential significance of this shift to NVQ is clearly immense. For the first time, it seems, we may have a form of training which appeals to the private sector. It might also in due course make an impact on the intractable problem of providing a sizeable proportion of the workforce with training relevant to residential care.

In order to understand why a shift from 'professional' social work oriented courses to task-based vocational courses may

be occurring in the residential sector, we need to look at the theory and rationale underlying this shift and the arguments for and against a new approach to training.

3. The 'Professional' model of Training: What is a Profession and does social work and, by implication, Residential work, qualify?

Social work is generally assumed to be vocational by nature and 'professional' in approach. The training received by those who care for and help others has maintained roots in certain values. In highlighting the polarised views on training identified earlier, Collins makes values the basis for the distinction between them. He argues that vocational training should emphasise 'personal responsibility' and is thus distinguished from training characterised by 'a cult of efficiency'.

> "Vocation refers to a calling and entails commitment to the performance of worthwhile activities that are not *merely* calculated to advance personal career aspirations or fulfil minimum job expectations...(it) incorporates a strong ethical dimension.....(and) contrasts with the kind of pedagogical orientations and practices that are...steered largely by technical rationality." (18)

As we have seen, social work training has been traditionally linked to a 'professional' model of training in which specialised 'higher level' education allows an individual or group of people to secure practical and theoretical expertise but also to acquire general knowledge and a sense of ethical values. If we are to examine a 'professional' model of training, we need to establish

whether social work qualifies as a 'profession', what 'professional' training entails and whether residential social work, by implication, also qualifies for professional status.

The question of whether social work is or is not a 'profession' involves a discussion of the four related components that are said to make up a profession - autonomy, knowledge, values and status. These components are those identified by the *'trait'* theory of professions, characterised by Greenwood, and based on the idea of Durkheims' service to the community. (19) The question of whether social work is a profession involves the way in which these components are viewed by the practitioners themselves, by potential clients and by other 'professionals'. As Toren points out,

> "Attempting to answer the question of whether social work is a profession, or to determine the extent its professional character, different observers come to different conclusions, depending upon their general viewpoint and on the different degrees of importance they ascribe to various professional traits." (20)

Autonomy:

Wilensky maintains that any occupation wishing to exercise professional autonomy must assert an exclusive jurisdiction, link both skill and jurisdiction to standards of training and convince the public that its services are uniquely trustworthy. The aspiring or developing profession which he sees social work as being, must, in order to achieve traditional professional status, drive out any competition and establish itself as sole suppliers

of a particular service. Training allows a claim to autonomy at work, since,

> "The nature of an occupation's training...can constitute part of an ideology, a deliberate rhetoric in the political process of lobbying, public relations and other forms of persuasion, to attain a desirable end - full control over its work." (21)

This view of a profession was devised in terms of the classical model of professionalism which emphasises autonomous expertise and the service ideal. Bureaucracies, however, require professionals to serve organisations and this curtails, to some degree, the ability of the professional to act in an autonomous way. As Jones et al point out, the Seebohm Report took little account of the fact that the new social services departments would be within the local authority structure and therefore subject to all the regulations, the norms and the devices for public accountability which the wider organisation had already developed. (22)

This potential conflict between professionalism and bureaucracy was highlighted by Carr-Saunders, who differentiated four major types of professions in modern society, emphasising particularly the lack of professional autonomy due to organisational pressures.

> "Social workers...have a dual responsibility to the employer as well as the client. But the employer lays down the limits to the service which can be rendered and to some extent determines its kind and quality. As a result a social worker....is far from free to treat a person committed to his charge in a manner indicated by his professional training and experience." (23)

In this quote Carr-Saunders appears to relate the role of the social worker to that of a Weberian 'expert', who applies his or her expertise at the behest of the organisation. Members of a bureaucracy hold their position because they are placed there and told what to do. A professional,

> "Holds power by social definition, and his expertise is a blend of innate capacity, acquired knowledge and skills, and willingness to use his own personality as a tool." (24)

Thus there may be a potential conflict for the social worker, between what Etzioni calls the 'enforced and sanctioned' values of the bureaucrat and the internalised values of the professional. (25) Etzioni maintains that there are certain occupational groups whose members describe themselves as professionals, which manifest the attributes of a professional in various ways, to varying degrees and which aspire to full professional status, but for socially induced reasons are inherently incapable of achieving a full professional identity and status comparable with fully fledged professional organisations. (26) These occupational groups he refers to as 'semi-professions' and their members are employed to communicate or apply knowledge and are subject to administrative control. Semi-professions are occupations whose members make a claim to comparable status with the traditional professions but they,

> "have less autonomy from supervision or societal control." (27)

and are more accountable for their performance and subject to numerous rules governing work tasks and conduct. Semi-

professionals are usually to be found employed in organisations rather than themselves acting as employers.

Simpson and Simpson (28) suggest that the distinction between professions and semi-professions is gendered. They point out that women predominate in the semi-professions, and argue that women's primary attachment is to the family and that women are therefore less committed to work than men and less likely to maintain a high level of specialised knowledge. The traditional 'profession' is one dominated by *male* power and exclusivity, whereby men are in control, are full-time, have a career structure and are well paid.

These considerations suggest that residential work is at best a semi-profession. Its claim to professional status has been based in part on its description of "residential social work" when social work itself can only lay dubious claim to the autonomy required of a profession. Moreover, women predominate in residential work, and are often employed part-time with few career opportunities as a result. Residential workers thus lack the power base which traditional 'professional' training is said to provide, and may be more likely to accept the bureaucratic controls imposed on them and less likely to seek a genuinely professional status.

Knowledge:

The main, intrinsic appeal of residential work is to the heart, not the mind, attracting individuals who want to work with people and be of service. By contrast, Merton's 'concept of a

profession' depends on a 'Threefold composite of social values' - value placed upon systematic knowledge and the intellect (knowing), value placed upon technical skill and trained capacity (doing) and value placed upon putting this conjoint knowledge and skill to work in the service of others (helping). (29) The question is whether knowing, a central component in what Butrym calls the process of socialisation into professionalism, is as important in social work and social care training as it is in other forms of professional development.

As Timms and Timms point out (30), a knowledge base is important for a profession because it helps to distinguish the layman from the expert and it gives the professional control over the application of certain skills that are informed by this knowledge. However the authors argue that social workers are doubtful and ambivalent about the part knowledge should play, and that there is considerable scepticism concerning the validity of knowledge that does not proceed from direct practical experience. (31) This may be of particular relevance to the residential care workforce where the level of knowledge required has yet to be defined and the lack of attention to this implies that this workforce is not considered worthy of 'professional' status.

Statistics presented earlier suggest that competence based approaches, such as National Vocational Qualifications, are likely to gain popularity at the expense of the type of 'professional' training exemplified by CQSW and CSS which have failed to attract the numbers of staff who were expected to undertake these qualifications. This in turn suggests that a

shift in training for the residential sector is occurring from an emphasis on 'professional' knowledge (knowing) to one on 'technical' knowledge (doing), that is towards training that is task related, at the expense of other areas of knowledge. If residential care staff are not seen as needing the training that leads to the 'professional' status that social workers and the social work 'profession' aspire to, can they then be referred to as *'para-professionals'* who Brawley and Schindler define as,

> "Those persons who are engaged in the provision of social care or social services to individuals, families, groups and communities but who do not have professional training and qualifications." (32)

Para-professionals tend to be the workers who have the most frequent and regular face-to-face contact with clients. This makes it especially important that they be carefully selected for the work that they do, that their tasks and functions be appropriate and clearly defined, and that they receive whatever training is needed to ensure that they can perform their jobs adequately. They are not, however, thought to require professional training.

In line with this analysis CCETSW has maintained that the training of professionals should be placed in perspective whereby it should be accompanied by the training of 'front line' para-professionals who constitute the bulk of the social service work force.(33,34,35) Brawley attributes a similar importance to para-professionals maintaining that there has been a failure to recognise or accept the critical role they play and little effort has been devoted to clarifying their functions, deployment and

training.(36) British para-professionals have been offered training that, while it does not confer professional standing, does signify the holder has undergone a nationally approved training programme. To date, these have included the CSS and ICSC. Brawley maintains that the reform of vocational qualifications, with the introduction of NVQ's,

> "Holds great promise for expanding career advancement opportunities for para-professionals in Britain." (37)

This shift in the kind of training being offered need not conflict with the role of the 'professionally' trained social worker, given the need, as Brawley and Schindler point out, for professional workers to be trained to work alongside the para-professionals and that,

> "Professional social workers and social work educators need to modify their profession-centred view of service provision in order to make the best use of available personnel." (38)

A major advantage of vocational training rather than formal post-secondary or university education is that participants do not have to give up their jobs or move away from their home and families to undertake training. However, if residential staff are viewed as para-professionals, removed from even semi-professional status, will they be offered training that contains a knowledge base thought suitable for the 'profession' of social work? Or will it rather reinforce Butrym's view that there is a difference between social work and social services provision, and that there needs to be,

> "A realistic recognition of the differences of knowledge and skills between professionally trained people and those whose skills are of a more specific or technical nature, thus resulting in an appropriate division of work between them." (39)

The latter group is presumably represented by care workers whose tasks are not seen as requiring the services of a trained social worker.

Values:

If social work is not therefore a profession in the strict classical sense, and is, as suggested by Etzioni and others, a semi-profession, it may nevertheless involve a *process of professionalisation* into professional values, which Heraud (40) considers more important than whether or not social work has achieved full professional status. The value base of social work has, like its aims and functions, developed considerably over several decades. it now encompasses the *traditional* (liberal) professional values which emphasise, for example, respect for clients, acceptance, individualisation, confidentiality, self-determination and choice, and a more recent *radical* (Marxist) agenda in relation to anti-discrimination and anti-oppression. It also encompasses the moral and ethical concerns of ordinary people.

It is in blending these different strands that the problems arise. As Timms points out, the primary concern of social work qua profession is the *development of a distinctive moral character*. For Timms, at least, the fact that social work espouses an ethic similar to that of 'ordinary people' raises

questions about the degree to which its ethics can give it a distinctive professional identity, since,

> "The business of being a good helper is essentially bound up with being a good person." (41)

This could mean either that being a good helper is connected in important ways with being a good person or that to be a good person *is* to be a good helper. This in turn raises the question of whether values are 'professional' in themselves that is, they are *capable of being taught*, or are they 'human', that is, *the property of good people?*. Can such values be formally assessed? What decision making process takes place to determine the set of judgements that define a good person?

All this raises questions of whether social work 'professional ethics' are of a kind which can be taught on professional courses. Becker, for example, maintains that training can affect self-concept and values, that is, encourage the idea of 'self-consciousness', and identity. This is linked to the idea that training can enhance the 'altruistic' qualities of the 'good person'. (42) This entails a 'service orientation' and a primary commitment to meeting the needs of others, or what Flexner calls the 'professional spirit'. (43) This feature of professionalism, however, is not universally seen as characterising social work. As Tolfree points out, discrepancies exist between social values as they have been articulated in the literature and some (then) current practice in social work. (44) Social workers have,

> "Religiously clung to values...(but) have not done these values justice...have not treated them with the seriousness befitting their role as a fulcrum of practice." (45).

If it is doubtful whether social work as a whole has a professional ethical base then even more serious questions must arise in relation to residential work. In part these arise because of the difficulty of applying some of the 'ethical rules' thought suitable for fieldwork practice in a residential setting. While some *traditional* values are apparently straightforward, for example, confidentiality; others such as self-determination and choice can present a problem when transferred from the realm of field social work to that of the residential worker. Thus it is disquieting that social care workers are being offered training that, while recognising occupational 'core skills', does not appear to.

> "Take into account the codification of professional values in social work and their application to residential work." (46)

Status:

Professional status requires public recognition, expressed through accepted training procedures and statutory regulation. It is seen as the main factor in providing that level of commitment to and satisfaction from work which marks off the 'professional', 'committed' orientation to work from the 'instrumental', 'dissociated' attitude believed to characterise non-professional groups.

Status then is a central element in defining a profession, and it requires organisational support. Indeed a profession is,

according to Greenwood, an occupation with 'a professional culture sustained by a formal professional organisation'. (47) The occupational role set by the professional association becomes part of the worker's identity. Aspirations towards such an identity influenced the development in 1970, of the British Association of Social Workers (BASW). This coincided with the launch of the new unified local authority social services departments that were to be the major employers of social workers. But as Henkel states, the association was,

> "Born in climate of emergent hostility to professionalisation. It was set up in the face of fierce internal critique." (48)

Thus whereas the traditional profession maintains a code of ethics which regulate relationships with colleagues and clients, the Association has produced a code of ethics which can only exert an influence on its members, and is not enforceable. Lack of a powerful professional association is one of the factors pinpointed by Toren as part of a more general critique of social worker's status as a profession. She points out that as a semi-profession, social work is likely to,

> "Lack a systematic theoretical knowledge base, and hence entail a shorter period of training for its members; it may not command a monopoly of control over its members, the criteria for their recruitment, training, licensing or performance; its code of ethics may be vague or inconsistent; and the professional association may be divided, inefficient, or powerless." (49)

A further threat to the claim of British social work to professional status came in 1991, when the European Community

general directive (89/48 EEC) outlining a system for Community-wide recognition and mobility of professions came into force. It lays down the level and minimum period of training (three years) and the modes of regulation required for an occupation to be recognised as a regulated profession. It's activities must be, as Barr points out,

> "Subject by law, regulation or administrative provision to the possession of a (higher education) diploma." (50)

As Henkel notes, all member states except the UK met the minimum training period condition, and nine met the regulatory conditions. The UK did not. (51)

If social work is only dubiously accorded professional status the status of residential workers is therefore also questionable. Historically their work has been classed as unskilled or semi-skilled and although residential work was categorised as social work by CCETSW in 1973, this view has never taken root either in reward systems or in social work, or indeed among residential workers themselves, whose professional association firmly grounds itself in social care (Social Care Association) rather than social work.

Thus as social work continues to strive for 'professional' recognition, residential 'social care' work may continue to maintain a low status, and is even less likely to qualify as a 'profession' in its own right. The perceived difference between social work and social care suggests that a 'para-professional' workforce are likely to turn towards newer, task-based

qualifications, as opposed to the traditional 'professional' model of training. The next step is to look at in more detail at why this may occur and at whether the trend towards National Vocational Qualifications can fill this training gap.

4. The 'Entrepreneurial' model of Training: 'New Vocationalisation' and National Vocational Qualifications.

Historically an uneasy relationship has existed between 'professional' social work training, and training for workers in the personal social services who are not engaged in social work, such as residential care workers. The latter group, one could argue, is a prime target for the proposed development of a coherent training policy, based on the reform of vocational education, that the Government is determined upon. This reform has led to the implementation of a new system of task-based qualifications that, it is suggested below, are likely to appeal to the new 'entrepreneurial' home owners in the private sector.

These trends followed earlier attempts by CCETSW to impose a more rational approach to social work and social care training, at arms length from Government intervention. These included the setting up, in 1975, of the Certificate in Social Service (CSS). In an effort to expand the trained residential care workforce, the CSS was established as a 'separate but equal' qualification, which was closely linked to the working environment. The overall responsibility for planning, co-ordinating and monitoring the

training was to be undertaken jointly by colleges and employing agencies. (52) However, as Henkel points out, it incorporated a good deal of knowledge taught on 'professional' CQSW courses which themselves were,

> Vulnerable to criticisms of lack of rigour in student assessment, a disregard for the more technical aspects of social work...and a failure to enable students to combine theoretical understanding with practical competence." (53)

By the end of the 1970's it was clear that many of the problems besetting social work education and its contribution to the personal social services had not been solved, and the 1980's were to see a significant shift in the framing of CCETSW's work. There was also a change in the governance of social work education, following the implementation of annual reports which are structured around agreed strategic objectives with the Department of Health. (54,55)

The Government's rejection of CCETSW's proposals for a new unified three year social work training programme, led to a two-year model, the Diploma in Social Work, being proposed. Crucially this retained the CSS model of employer partnership, and combined a generic first year with a specialist second year. As a result of direct Government intervention, CCETSW had, by the late 1980's effectively ceased to represent the profession's educators. As Cannan points out,

> "'Employers' - in effect a class of managers - had increasingly influenced social work education with the approval of CSS...and by changes in the constitution of CCETSW." (56)

This situation and, as indicated earlier, recognition of the failure of the residential workforce to undertake 'professional' training, came at a time when the new National Vocational Qualifications were being introduced. In order to understand why these new qualifications are likely to gain impetus, we need to know which group of people are likely to be attracted to them, but we also need to understand the underlying ethos of the 'new vocationalism'.

General Background to NVQ

Since the mid - 1970's, the Government, partly in response to increasing competition in Europe and primarily from an industrial viewpoint, has encouraged a redirection of the purposes and practices of education and training. Ainley maintains that the traditional academic bases of training have been replaced by an ideology of enterprise. (57) This major shift has been essentially aimed at vocational training, resulting in what is referred to as a 'New Vocationalisation' which, as one critic argues, replaces one unilinear focus of learning - academic - with another - practical and vocational. (58) This reform has been enthusiastically promoted by Central Government, the Manpower Services Commission, and employers in industry and commerce.

This trend was accelerated, in 1985, by the White Paper, 'Education and Training for Young People', which announced proposals to review vocational qualifications in England and

Wales. (59) The Government followed, that same year, with an invitation to the MSC, in conjunction with the Department of Education, to establish a working group to undertake the review.

The resulting Review of Vocational Qualifications (RVQ) was published in 1986. (60) It proposed the establishment of a broad, centrally controlled framework which would support the interests of employers by promoting an approach to training, earlier encapsulated in the New Training Initiative (NTI) of 1981. This had called for a comprehensive training strategy and educational standards of a new kind, (61) and the RVQ recommendation was that this could be achieved by the setting up of a National Council of Vocational Qualifications (NCVQ). The NCVQ would accredit national educational bodies (such as City and Guilds, BTEC, CCETSW, etc.) whose qualifications met the set criteria, or 'Occupational Standards' which describe what effective performance means as laid down by the Industry Lead Bodies (ILB's), that would lead to the new award of a National Vocational Qualification (NVQ).

Callender outlines the key characteristics of NVQ's thus:

> "NVQ's are qualifications and are a device for assessing performance. They represent the systemisation of the skills and competencies required in a wide variety of occupations and at different levels. Set performance criteria define the standard required and these standards or competencies are the basis for assessment. Individuals must demonstrate competent performance *in what they do rather than in what they know, or understand,* in order to achieve an NVQ." (my italics) (62)

The key words are: <u>qualifications, assessment, performance, skills, competencies, criteria, standards.</u> As

Callender points out, NVQ's are *not* concerned with the training process, how training is delivered or training inputs. They are concerned with outcomes, performances and competence in the workplace and maintaining staff competency profiles or individually focused training programmes.

The central feature of this approach is the emphasis on 'competence', a concept which is, unfortunately, not as clear as it might be. Dictionary definitions of 'competent' include such synonyms as 'sufficient', 'suitable', 'efficient', and 'legitimate', indicating that achieving competence is proof of an ability to satisfy certain basic requirements of a trade or profession. Definitions of *competence* "abound in the literature" (63) and the concept different meanings for different people. To make the point, Hyland presents a representative sample of definitions which,

> "Illustrate not just the differences in interpretation of competence in width and breadth, specificity and the capacity/disposition distinction, but also serves to mark different emphases which characterise the evolution of competence talk from the 1980's to the present." (64)

Despite the profusion of definitions, the term has been taken on board, firstly by educational reformers in several countries, particularly in America and Australia, and most recently by politicians keen to promote competence in the workplace. David Reisman, in a discussion of (American) society's demands for competence, states that in the educational climate of the late 1970's, belief in one's own competence was no longer enough, and that a demand for demonstrated competence motivated

much of education. (65) The demand for competence-based education and training (CBET) which Hyland maintains has its roots in American 'social efficiency' theories of the 1920's, began to have some impact during the 1980's particularly in the UK Further education sector. CBET has also permeated vocational education at secondary level, and is slowly encroaching on the higher education sector.

It is important to note at this point that NVQ's have not been without their critics. Much of this criticism has reflected the diminished emphasis given to knowledge in the new form of training. In defence of the new model, Tuxworth claimed that,

> "CBET does not diminish the importance of knowledge and understanding; it does however change the grounds for its justification." (66)

However, Hyland attacks CBET for being,

> "Conceptually confused, epistemologically ambiguous and based on a largely discredited behavioural learning process." (67)

Despite such attacks, what has now become known as Competency-Based Vocational Education (CBVE) and the conceptual base for NVQ's, has, as Field points out, been,

> "Widely canvassed in Britain and Australia as a secure basis for a system of vocational qualifications that is accurate, efficient and relevant to industry's needs." (68)

Indeed, this strategy has been incorporated into the NVQ model by way of a reduction of occupational work roles to

statements of competence, derived from a functional analysis of work roles as devised by Jessup, Director of Research Development and Information for the NCVQ. Jessup had also been the Head of Quality branch at the MSC during the publication of the New Training Initiative.

A fervent critic of the 'New Vocationalisation', Hyland argues that,

> "The influence of 'new vocationalisation' has been widespread and pervasive, perhaps most noticeably in the post-compulsory sector in which the MSC, at a stroke, took control of 25% of work related non-advanced further education in 1985/86. In subsequent years the Training Agency and later the Training, Enterprise and Education Directorate (TEED), a branch of the Employment Department, and the regional Training and Enterprise Councils (TEC's) have effectively continued the restructuring of (Vocational and Educational Training) policy and practice." (69)

For some, these developments have resulted in a lowered rather than an increased status for training, and in the proliferation of courses designed to prepare individuals to practice in a specific setting rather than in a wide variety of settings. Thus, Ainley maintains that TEC's,

> "Spell the end of the attempt to create a coherent national training system. The TEC's are dominated by the same private sector employers who, as the MSC stated in 1981, 'perceive training as a disposable overhead dropped at the first sight of lowering profit margins.'" (70)

The outcome of this trend towards a managerial dominance of training, in relation to social work education has, according to Cannan,

> "Perfectly complemented the fragmentation, marketisation and residualisation of social services...(and) downplays the helping, supportive and continuing role of social work....This is reinforced by the contemporary weakening and narrowing of the profession's education and research roots, a process reinforced by the *competencies* approach in education and training." (my italics) (71)

Be that as it may, the introduction of NVQ's is a trend with which we have to reckon and which certainly merits serious research attention.

NVQ and the Social Care Sector

The ILB concerned with the delivery of care is the Care Sector Consortium (CSC), set up in 1989. The CSC encompasses five employment areas, the NHS; Local Government, the Private and Voluntary sectors and the Criminal Justice System. In July 1992, the CSC published the National Occupational Standards for Care, derived from two earlier projects, the Residential, Domiciliary and Day Care (RDDC) project and the Health Care Support Worker (HCSW) project. The standards cover those who deliver 'hands on' care in the Health and Social Care field.. These standards form the basis for NVQ's in health and social care.

The trend towards acceptance by staff of new qualifications had already begun when their introduction into the residential sector was given a boost with the publication, in 1992, of the Howe Report (72). This was the result of an inquiry into the pay, conditions of service, training and qualifications of residential staff (excluding the private and voluntary sector). It followed in the wake of the Wagner Report, the NHS and Community Care Act,

Trade Union concerns, and a series of scandals at residential homes in 1991. The Report was enthusiastic about NVQ's, stating,

> "The Inquiry believes that the unprecedented opportunity to assess competence in the workplace by reference to a national standard - providing simultaneously the worker with the basis of a qualification, and manager or supervisor with the chance for detailed specification of quality of service allied to observation of performance - must be grasped." (73)

On similar lines, a report published by the Local Government Management Board (LGMB) in the same year as the Howe report, maintained that those who need to be cared for in residential homes will have higher levels of needs and this will therefore require an increasingly skilled workforce. (74)

Given the lack of formally qualified staff in the residential sector the advantage of an approach which emphasises 'on-the-job' training seems obvious. Indeed, in this new climate of 'enterprise' and 'entrepreneurship', social care staff appear to be natural targets for the task-based, skills oriented NVQ training model. The almost parallel developments of NVQ's and the Community Care programme have led to pressures being placed on Social Services Departments to ensure that residential staff, particularly those without 'professional' qualifications, whether experienced or not, in both the local authority and private sectors undertake NVQ training.

The reform of vocational education that has led to the implementation of National Vocational Qualifications is an innovation in training that is likely to appeal to those stakeholders who take a managerial perspective. This implies a very different approach to training to that required by the traditional 'professional' model. In particular, home owners in the growing private residential sector are likely to be attracted to National Vocational Qualifications as they become more widely accepted in social work and social care training.

The primary function of the private home, according to Phillips and Vincent (75), is to operate as a profit making 'enterprise' run as a family business or by a single owner. As we have seen, however, this 'petit bourgeois' care as they refer to it, has been accused of 'granny farming', that is, looking after the elderly, not for love, but in order to maximise profit from the growth in demand for residential care. Proprietors and owners have sought to apply 'entrepreneurial' skills, often acquired from previous experience of small business or self-employment, to the business of caring for the elderly.(76)

This combination of care and profit in itself encourages a new 'entrepreneurial' approach to the running of a home. While the homes are often small-scale and tightly-knit 'family concerns', the proprietors and owners of these homes are also managers, performing similar kinds of functions as executives in industry. Yet at the same time, private home owners seek

respectability, and 'professional' credibility and authority in the eyes of the public and the social services without whom their businesses would not exist. According to the 'trait' theory of professions, they cannot be seen as 'professionals' in the classical sense, but may retain authority as 'professional experts' with management skills. The staff that they employ may well fit into the 'para-professional' category who require expertise in relation to the needs and routine of individual establishments.

The problems of combining public credibility with a business like approach have led to a need for support. Thus throughout Britain, numerous consortia, often small in number, have grown to offer groups of homes support 'from within'. These consortia emerged, not only to promote business acumen among their members, but also to foster a more acceptable image to external observers, both lay and 'professional'. Three major groups representing the interests of their members, the National Confederation of Registered Homes Association (NCRHA), established in 1981, the National Care Homes Association (NCHA), established in the 1970's, and the British Federation of Care Homes Proprietors (BFCHP), established in 1984, have increased in influence, the largest of the three, the NCHA having approximately 1,800 members "and growing". (Source: NCHA, 1995) These associations have almost inevitably turned their attention to training.

In 1985, a manifesto was published by the NCRHA which stated,

"Training is most important for improving the quality of private care. However, it is not for others to determine the training needs of the private sector. We must ensure that owners have a commitment to training and then set about the task of determining what kind of training is required.....No existing validating body is able to respond to the unique business and care combination adequately." (77)

As can be seen, while outlining the need for the private sector to gain serious recognition of its commitment to training, the manifesto also emphasised that training should be of a type which owners felt to be appropriate, and linked to a national system of accreditation. This implied that the type of training offered and approved by social services, was not altogether appropriate. 'Professional' training is costly and time consuming and this is a very real consideration to the owners of smaller establishments with fewer staff who can be called on to cover colleagues who have been sent on external training courses. It is therefore understandable if owners dispense with what they consider to be non-relevant areas of training, preferring to concentrate on more pragmatic and practical skills.

With regard to training for the home owners themselves, this view appears to be supported by the chairman of the Scottish Association of Care Home Owners (SACHO), which claims that practical experience is more important than formal qualifications.

"Local authorities are being unrealistic in putting so much emphasis on formal qualifications. We need an injection of common sense. There are many people in charge of residential homes who don't have a formal qualification. What they have instead is many years' practical, hands-on experience of running a home and in our view that is satisfactory." (78)

Thus the approach to training within the private sector would appear to be essentially pragmatic, and would be expected to support 'pragmatic values' in that the sector stakes its future on the management skills of owners and practical skills of the care staff rather than on the fostering of 'professional values'. As Etzioni points out, professional and management functions are different, and the possibility of conflict real. In ideal-type terms, professionals make recommendations on the basis of what seems 'right' by professional principles, whereas managers look for solutions that 'work' in terms of the rules and goals of the organisation. (79)

Criticism of the NVQ

If then NVQ based training is set to grow we need to look seriously at the criticisms of it. In this way we may be able to assess whether the criticisms are valid, and, if so, whether they can be overcome. A key issue here is, I believe, the question of what kind of knowledge should people have? We need to focus on whether knowledge should concentrate on the acquisition of higher order skills through knowledge and understanding, or on task-specific skills in the workplace. There is a crucial difference between knowing *that* something is the case and knowing *how* to do it, and it is clear that it is this latter kind of knowledge, based on skills, practice and experience that the 'new vocationalisation' seeks to foster. What then could be wrong with that?

The first criticism is that the distinction between 'doing' and 'knowing' is too crude. Hyland argues, that even practical 'know-how' needs to take account of varying levels of theoretical knowledge. (80) Despite the claim by the Confederation of British Industry to,

> "Accept the broad message that more and better training in vocational education is needed." (81),

many British employers remain narrowly concerned, in contrast to their German and French counterparts, with vocational training that focuses only on a narrow range of job-specific skills, and concentrate on short-term needs, rather than upon generic courses and qualifications that offer a mix of job-specific training and additional general education. (82)

A related issue concerns the 'level' of skill which the new training seeks to promote. Are these skills to be seen as more or less 'routine' performances which can be learned almost by rote? Or do they involve a 'high level' flexible repertoire which can be varied according to the situation and employed in accordance with the issues raised? Argyris defines skills as being,

> "Dimensions of the ability to behave effectively in situations of action," (83)

By using the analogy of learning to ride a bicycle, he points out that an ability to repeat a programme or set of instructions does not necessarily constitute skill learning for three reasons. Firstly, there is an information gap between the programme and concrete performance, filling that gap requires

wider learning in order to solve problems. Secondly, Argyris adds, one cannot replace tacit with explicit knowledge, and thirdly, performance may require change in 'sensory competence'. (84)

What would seem to be required by such skills is therefore both theoretical knowledge so that they can be exercised in a variety of situations, **and** practice so that 'tacit knowledge' and 'sensory competence' may be developed. Following a similar line of thought, Wilensky argues,

> "When we are able to break a skill down to component elements ('competencies'), prescribe sequences of tasks in a performance, leaving little to the judgement and understanding of the worker, we have a job that can be taught to most people, often in a short time....the optimal base of knowledge...is a combination of intellectual and practical knowing, some explicit, some implicit." (85)

A second line of criticism is that NVQ's encourage an acceptance of too low a standard of practice. Being 'competent' does not necessarily imply being 'good' at something - that is, having not only the basic skills, but also being conscientious and capable - only 'not being incompetent'. A competent trades person can demonstrate an ability to turn wood, weld a pipe, mix concrete, but how does a 'professional' demonstrate competence? In professional work value considerations, for example, are inextricably bound up with questions of meaning and application, and suggest a distinction between 'job competence' and 'occupational/professional competence'. The former is, as Jessup explains, "limited to a particular role in a particular company", the latter involves a person acquiring,

> "A repertoire of skills, knowledge and understanding which he or she can apply in a range of context and organisations." (86)

Norris however, is concerned that this concept of competence has become associated with more 'practicality' in education and training, an approach which places a greater emphasis on the assessment of performance rather than of knowledge, and which is viewed as the means by which to achieve greater efficiency and cost-effectiveness in the workplace. (87) Operational definitions of competence are handled in much the same way in that competence is described in terms of action, behaviour or outcome and in such a way that it is capable of demonstration, observation and assessment. This emphasis on behaviour leads, according to Hyland, to a behavioural approach to training which tends to stifle creative and imaginative learning and gloss over individual differences between learners. (88)

A further criticism of NVQ's derives from their reliance on 'functional analysis'. This aims to describe the functions of a skill, then divides these into sub-functions - a procedure similar to Durkheim's approach to investigating the preceding social facts. As Marshall states,

> "The NCVQ clearly consider the overall employment function as a social organism. Within the employment function they seek to isolate the units and elements of competence. These represent the primary functions of skill. Performance criteria are produced by further sub-division of the primary functions into sub-functions. The aim is to state which primary and which sub-functions constitute the overall social organism, the employment function. The function of the primary and sub-functions is then described as the maintenance of the social organism." (89)

The central criticism of dividing employment roles into sub-functions is that it does not allow for people to respond in an unexpected way or to develop individual styles of work that suit them, and that it is self-perpetuating. Because certain functions are seen to be performed it is concluded that there must be a need for these functions. As Marshall maintains,

> "Training is carried out to achieve aims which were constructed by the training agents, that is, the NCVQ. Therefore, the NCVQ construct the purposes of training and define what the outcomes are to be. These are then used as the basis for devising the units and elements of competence. (90)

Thus the argument is that the NCVQ scheme has no place for innovation. By reducing work roles to bits of observable and measurable behaviour, thought by employers to be occupationally relevant, the training undermines individuality of the carer in his/her relationship with the client and their ability to respond flexibly.

These considerations may be particularly relevant to residential care. Roles change in the work situation and particularly so in the residential sector. A care assistant has to develop his/her own understanding of both the situation he/she is dealing with and the role they are trying to perform. Hodkinson argues that this entails the integration of public theory (the accumulated wisdom of the profession from literature or experts) and private theory (one's own personal beliefs and understanding) (91) It may be that many care staff already maintain a level of integration of the two theories in their work with residents, incorporating the cultural induction training

provided by the establishment in which they work, whether that culture is developed within the establishment or from external legislation, and their own personally developed beliefs, values and skills.

The need for this personal development is ongoing and is given fresh impetus each time the situation at work changes. As UDACE, points out, competent performance is context-specific and does not provide a strong indication that a person will continue to be competent or will become more competent.(92) As Argyris notes, definitions of competence change,

> "Whatever competence means today we can be sure its meaning will have changed by tomorrow. The foundation for future professional competence seems to be the capacity to learn how to learn." (93)

We may add that the definition of competence in one home may not be the same as that in another. An example of this comes in an article on the effect on consumer experience, in residential and day care units, of the new 'competency profile' approach to staff training. In an attempt to investigate whether or not individualised training programmes for staff can improve the quality of services experienced by the consumer. Julie Phillips argues that there would not necessarily seem to be a very direct improvement in the quality of services experienced by the consumer and that such individualised training principles as validated by NCVQ, are not designed to develop the functioning of unit staff as a whole. She concludes that,

> "It is essential that attention should continue to focus on: staff attitudes, the value context of the unit's service provision, and the interactive and organisational processes and dimensions which in complex relationships directly effect consumer daily experience." (94)

As Davis (95) and Tizard (96) have shown, differences in consumer experience relate to differences in unit ideology. A criticism of the NVQ approach is then that it is focused on the individual in isolation from the context in which they work. The criticisms of the NVQ model are therefore severe. It has been seen as underplaying the need for theoretical knowledge and higher level skills but by contrast endorsing a level of merely 'competent' performance. Its emphasis an observable routine behaviour has been seen as stifling originality, disabling individuals from developing an individual style, and making them less adaptable to changing demands. Its emphasis on individual performance has been criticised for failure to acknowledge the ethos of the home.

It is doubtful whether these criticisms reflect the inherent defects of NVQ or merely of that version of it which its critics believe to be in place. If, however, NVQ is to meet these attacks, the basis on which competence is assessed may need to be clarified.

A claim to competence cannot be based solely on task-related skills, but must reflect a combination of technical and theoretical expertise which has been the intended outcome of traditional social work training.

The Need for Research

This chapter has centred on two problems. First, traditional 'professional' models of training have failed to attract sufficient trainees to make any substantial impact on the training needs of a substantially untrained workforce. This has been particularly true of the private sector where the bulk of residential care is now concentrated. If this problem is to be overcome, we need to understand what kind of training care staff - and those who have to release them for training - want. Unfortunately it is not clear how heads of homes and staff themselves view training. Research appears not to have taken note of what the stakeholders want and think about training, concentrating instead on the quality of life in residential homes.

The second problem is that the style of training most likely to meet the requirements of staff and heads of homes is NVQ. However, while staff are being encouraged to undertake NVQ training, it is not yet clear how this training may affect the lives of the residents. Documentation on the impact of training and new initiatives in care practice appear to rely on staff and management feedback, and there is almost no feedback from the residents themselves.

Evidence for the importance of involving residents in assessing training comes from the Caring in Homes Initiative (97). This found that the impact of training was greatest where residents were involved in appraisal or commenting after training

took place. Training was only a part of the initiative, but the initiative did underline the importance of making user view central to any evaluation. By contrast, in bulletins and newsletters emanating from NCVQ, CSC and SCA, there is a noticeable lack of evidence from the consumer point of view as to the importance or impact that NVQ training has had to date, and a concentration instead on the contribution that NVQ's can provide towards maintaining a skilled workforce.

The Caring in Homes Initiative found that in several cases manager and their staff do not have a clear or shared understanding of what the establishment is setting out to achieve. Thus, any evaluation of training must take into account the views of Heads of Homes and Staff - for if they are not enthusiastic, training programmes are unlikely to recruit the number they need. It must also involve residents in the evaluation - for they are the ultimate arbiter of quality of care.

5. SUMMARY

The literature on professions and on the trend towards a 'new vocationalisation' in education and training reflects a broad dichotomy between the maintenance of 'professional values' and the emphasis on task-based competencies. The chapter suggests that the 'Professional' model embodied in generic social work training has been overtaken by the 'Entrepreneurial' model which promotes cost-effectiveness, efficiency and reflects a trend

towards a practical/pragmatic approach reflected in competency-based qualifications.

The evidence for this thesis is partly statistical. The figures on training are inadequate and piecemeal but where data is available it is clear that the numbers of qualified residential staff in homes for elderly people are far lower than envisaged by the Williams Report and by other reports that have stressed the need for training. This has been particularly true of the private sector, but figures suggest that NVQ is beginning to make an impact on both sectors.

On this evidence, it appears that the 'professional' model appears to have failed the residential sector in providing a suitably qualified workforce. Social work is perceived as, at best, a semi-profession and the implication for residential work is that, as a social care workforce, it is even less likely to qualify for professional status. As the newer 'entrepreneurial' model gathers momentum it is likely that private home owners in particular will be attracted to this form of training. As a result, it has been argued that residential staff will be trained, rather than educated, for a para-professional role, by way of National Vocational Qualifications.

However, a great deal of criticism surrounds the implementation of NVQ's, and there is some doubt as to whether it is the most appropriate means by which to ensure trained and qualified staff. Therefore, if training is to take place, it is important to determine what effect different forms of training have and who wants them.

The basic issue is should training aim to - produce 'good people'; to produce people with professional values and high level skills; Operatives with a number of specific skills; or an amalgam of these? In addressing these questions we need to consider, firstly, the views of the different stakeholders, that is the officers-in-charge, home owners and care staff, since they have a right to be consulted and will undermine training if not committed. Secondly, we need to consider the views of the residents since they are the ultimate consumers.

The hypothesis is that these different stakeholders will hold different views on what training should aim to do. Their attitudes may also be influenced by other factors, such as the training they have received, the sector in which they work and the type of tasks that are undertaken in the home.

The following empirical chapters will look at who wants training, why they want it, who is getting it, and the effects that training has on residents. This study provides hitherto unavailable data for a defined geographical area. It will give a clearer picture than is available for any other area, of the type of training being undertaken, the preferences that different stakeholders have and the impact on residents. It will then draw out the theoretical, practical and policy implications.

SECTION THREE: THE RESEARCH

CHAPTER THREE: SURVEY ONE – HOME OWNERS AND OFFICERS-IN-CHARGE: A DESCRIPTION OF THE SAMPLE

The debate on training highlights two models that are of relevance to different groups of people involved in the residential care of the elderly. I have argued that owners of private homes may have a particular perspective on training that appears to have been influenced by the shift in attitudes from value-based 'professional' training models to a task-based 'entrepreneurial' training model. By contrast, debates about training in local authority homes have had a longer history and are influenced by earlier aspirations in social services departments towards a more professional style of training. These considerations suggest that local authority managers and private home owners have different views on the training needs of their staff. Chapter four tests this hypothesis while Chapter Three produces findings about part-time staff and other descriptive data, and factors which are likely to affect these preferences.

Introduction

In 1988, I carried out a small survey of private residential homes in East Yorkshire, to establish what home owners wanted with regard to training courses for their staff. The response led me to formulate an initial hypothesis that private home owners hold views and attitudes towards training

that differ from those involved in the training of local authority care staff. This initial hypothesis was re-worked into two hypotheses, which were tested in two surveys of residential homes in Humberside. The general null hypotheses of this part of the study are:

Hypothesis One - Attitudes to training do not differ between the local authority residential sector and the private residential sector.

Hypothesis Two - The local authority sector does not maintain a 'professional' attitude towards training. The private sector does not maintain a more practical, 'entrepreneurial' attitude towards training.

In order to test these hypotheses, we need to see if there is a difference in attitudes to training between the local authority and private sectors. We also need to see whether there are other areas in which the two sectors differ which might explain why these differences in attitudes to training exist, for example, size of establishment, job roles and tasks, resident characteristics, owners and managers' previous experience and qualifications, and staff training and qualifications.

The first step, in this chapter, will be to give a description of the data, which provides information hitherto unknown, on the background, experience and qualifications of

home owners and officers-in-charge, and their staff. In the following chapter we will test the hypotheses to see if there is a difference in attitudes to training and we will test subsidiary hypotheses to explain the differences. The outcome will be to have a clearer understanding of the nature of attitudes towards training in the two sectors.

1. Report on the Data Collection

Between August and October 1991, I conducted the first survey which aimed to find out what training private home owners and local authority officers-in-charge had received, and what their views were on the training needs of their staff. The information broadly covered three areas:

a) *Establishments* - the size and types of homes in the sample; numbers of residents; age composition of the residents; levels of dependency of the residents.

b) *The Care Staff* - the numbers of care staff employed; ratios of residents to care staff; the qualifications held by care staff; the training received by care staff.

c) *The Home Owners and Officers-in-charge* - previous employment and previous employers of home owners and officers-in-charge; the qualifications held and the training received; attitudes of the private and local authority sector towards the training needs of care staff.

The data allowed me to test the hypotheses about differences between sectors, taking into account resident dependency, previous employment, qualifications and attitudes to training of

home owners and officers-in-charge. They also raised some important issues for training, particularly in terms of the numbers of part-time staff.

Method of Research

Addresses of private homes were obtained from the Humberside Independent Inspection Unit with whom I also discussed the purpose of the study. Local authority homes were contacted via the District Managers, following formal endorsement by the Assistant Director (Adults) of Humberside Social Services. A thirteen page questionnaire (Appendix II) with a covering letter requesting participation in the survey, was posted to a total of 173 private residential homes for the elderly in Central (Hull and District) and North West (Bridlington and District) areas of Humberside, during August 1991. Reminder letters were sent out and reminder telephone calls, followed by visits to collect questionnaires where necessary, were made during September and October 1991.

A total of 37 questionnaires were distributed to Officers-in-charge of local authority homes, by the District Managers, in October 1991.

The Response Rate:

Tables 6 and 7 break down the response rates from each sector.

Table 6. Response on Questionnaires sent out to Private Homes asked to take part in the survey

Area	Sent Out	Non Response	Invalid Returns	Returned
Central	83	33	7	40
North West	90	46	7	39
Total	173	79	14	79

Table 7. Response on Questionnaires sent out to Local Authority Homes asked to take part in the survey

Area	Sent Out	Non Response	Invalid Returns	Returned
Central	21	1	0	20
North West	16	3	0	13
Total	37	4	0	33

Overall, 210 homes were approached to take part in the survey. A small number, from the private sector, (n = 14) of the returns were invalid due to Changed status (3), Closure (2), Registered as a Nursing Home (5), or attached to another home in the sample (4). Of the remainder, 79 from the private sector (46%) were valid, and from the local authority, 33 were valid (89%)

Reasons for non-response were the usual - outright refusals, and questionnaires not having been received or, as in the case of the local authority homes, having gone missing in the post on return; and unusual - for example, the discovery that one particular postman would not deliver to homes that had dogs in evidence, and a home owner who was convinced that the survey was being carried out on behalf of the DHSS. Other reasons may be more subtle. For example, business minded home owners may be less favourable towards training and therefore less likely to want to commit their time towards an issue which does not take precedence in the running of a home. If anything, it is likely that this factor would have worked against the central hypothesis with the home owners in the private sector of a more practical disposition being less likely to return their questionnaires.

Overall, if invalid returns are excluded from the survey, the response rate was 57%. Appendix III compares responding and non-responding homes in the private sector, by area and size of establishment. The only apparent bias relates to:

a) Sector - Private homes were less likely to respond than local authority ones,

b) Within the private sector, very large homes (31-50) were less likely to respond, particularly in the Northern area.

For these reasons it is important to present findings by sector, and be alert to any findings within the private sector that may be explained by size of home.

2. Description of Sample

2.a) *Size of Establishments*

Respondents were asked to indicate the maximum number of residents that their homes were registered to accommodate and banded accordingly. The purpose of this data was to highlight any differences between large and small homes, particularly with regard to numbers of trained staff and their qualifications, and numbers of residents suffering from dementia. Larger homes may differ from smaller homes in their approach to training care staff, and their training may also differ in relation to the tasks that are carried out, due to the level of dependency of residents.

Table 8 shows that, in line with national figures, local authority establishments in the sample are larger than those in the private sector. The majority of private homes are small to medium sized, with between 11 to 20 residents. The majority of local authority homes are large, accommodating between 31 and 50 residents. Overall, three-quarters of these are in the local authority, but only ten percent of those in the private sector are in this larger size of home. The average number of local authority residents per home in the sample is 30.8 (Nationally: 35.4) The average number of private residents per home in the sample is 15.0 as it is nationally. (National Statistics: Department of Health: Health and Personal Social Services Statistics for England, 1994 edition, HMSO.)

Table 8. Occupancy levels by Size of Establishments

Maximum no. of residents each home is registered for	Actual No. of Local Authority Residents		Actual No. of Private Sector Residents	
	(n)	(%)	(n)	(%)
Up to 10	-	-	60	5
11 to 20	12	1	660	56
21 to 30	232	23	344	29
31 to 50	775	76	124	10
Total	1019	100	1188	100

The total number of residents recorded in the survey was 2207. Table 9 is a breakdown of the sex and age composition, which shows a markedly high proportion of female residents, accounting for 77% of the sample population.

Respondents were also asked to indicate how many of their residents were aged 75 years or over.

Table 9. Sex and Age Composition of Residents

	L.A. Sample		Private Sample		Total Sample	
	(n)	(%)	(n)	(%)	(n)	(%)
Females	743	73	965	81	1708	77
Males	276	27	223	19	499	23
Total	1019	100	1188	100	2207	100
Aged 75+	839	92	955	81	1794	81

The age composition of residents is in keeping with demographic trends, which have shown an increase in the numbers of ageing elderly people and with the national picture for residential care. The total percentage of residents aged over 75's in the sample is 81%. National figures of residents aged over 75 show a percentage of 86%. (1)

The growth in the number of ageing residents, who are likely to be frail, have special care needs or suffer from dementia, raises an important issue with regard to care staff. They are likely to require substantial knowledge and understanding of disabling conditions, and this has implications for training in both 'professional' and practical terms. In order to establish the dependency levels of residents in the study, respondents were asked to indicate how many required special care.

Table 10 breaks down the numbers of residents suffering from specific disabilities. The percentages are based on the total numbers of residents in each sector.

A number of the differences in Table 10 are very highly significant. Thus local authority residents are significantly more likely to be said to suffer from senile dementia ($x2 = 42.9$, $df = 1$, $p < .001$) and incontinence of urine ($x2 = 84.4$, $df = 1$, $p < .001$). By contrast private sector residents are significantly more likely to require help getting in and out of bed ($x2 = 12.2$, $df = 1$, $p < .001$). It should be emphasised, however, that although these differences are statistically very significant, this occurs because of the size of the sample and the actual difference in percentage points is quite small.

Table 10. Special Care Needs of Residents, by Sector

	L.A		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Senile Dementia/ Alzheimer's	400	39	311	26	711	32
Incontinent of urine	353	35	267	22	626	28
Severe hearing impairment	158	15	164	14	322	15
Severe visual handicap	83	8	96	8	179	8
Require help getting in and out of bed	389	38	541	46	930	42

The high numbers of residents suffering from dementia and incontinence supports the suggestion made earlier (see also Bradshaw and Gibbs 1988; Vincent et al, 1986; and Weaver et al, 1985) that care staff need training which enables them to give appropriate and relevant care to those with these particular disabilities.

2.b. *The Care Staff*

2.b.(i) *Numbers of Staff*

Respondents were asked to indicate how many care staff were employed at their homes, what training they had received and what qualifications they held. Table 11 breaks down the total numbers of care staff employed by sector.

Table 11. Total Number of Care Staff, by Sector

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Care Assistants (i)				
Full Time	144	16	234	19
Part time	396	45	580	47
Domestic Staff (ii)				
Full Time	56	6	53	4
Part time	153	18	188	15
Supervisory Staff (iii)				
Full Time	93	11	128	10
Part time	32	4	62	5
Total	874	100	1245	100

(i) Care Staff who are employed to do routine basic care work

(ii) Cooks/cleaners etc

(iii) Senior Care Assistants, Managers, Deputies, Matrons, excluding the home owner or officer-in-charge.

The main issue raised by Table 11, concerns the large numbers of part-time staff. These comprise about two and a half times the number of full time staff, who average four per home in the local authority and three per home in the private sector. While it may be expected that part time staff would predominate in private homes, the percentage of part time staff as a whole in local authority homes (66%) is perhaps surprising for the statutory sector. The significance of this high proportion of part-time staff for the consideration of training can hardly be exaggerated. The priest, lawyer, doctor who have provided the archetypal roles for a discussion of professions, have traditionally been educated full-time for a subsequent full-time employment. If such training were to be provided for all the staff in old people's homes, it could cover a large group of people who are able to invest less time in work than the full-time professional and to whom employers may be comparatively less committed. In Chapter Four, the difficulties of training as perceived by home owners and officers-in-charge, are discussed. We will see there that there are particular problems associated with the training of part time staff.

Table 12 is concerned with the staffing levels in relation to the numbers of residents, again bearing in mind the numbers of residents with special care needs.

Table 12. Resident/Staff (F/T and P/T) Ratios by Size of Establishment and by Sector

Size of Home (i)	No. of Residents	Local Authority			Private Sector		
		Homes (n)	Staff F/T	Staff P/T	Homes (n)	Staff F/T	Staff P/T
0 – 20	732	1	4.0	1.2	59	5.1	1.8
21 – 30	576	10	7.0	2.7	17	5.6	2.8
31 – 50	899	22	7.1	2.6	3	4.2	2.6

(i) Maximum number of residents each home is registered for.

The respondents were not asked to give details about the number of hours worked by part time staff so it is not possible to make exact comparisons between the staffing levels of the two sectors. The main point again is the relatively high proportion of part-time to full-time staff. If training is to affect the ethos of private homes, it will almost certainly have to incorporate those who work part-time.

2.b.(ii) *Training and Qualifications of Care Staff*

Respondents were asked how many of their care staff had received training in the previous twelve months. The response, with percentages based on total numbers of full and part time

care assistants, and full and part time supervisory staff, is in Table 13.

Table 13. Numbers of Care Staff said to have Received some Training.

	Local Authority		Private	
	(n)	(%)	(n)	(%)
'Some Training'	364	55	607	60
'No Training'	301	45	397	40
Total	665	100	1004	100

These figures can be compared with a recent Scottish survey (2) which asked whether staff had received any form of training. The percentage of care assistants who had was 42% in the local authority sector, and 36% in the private sector. However, the authors point out that the private sector has a higher proportion of qualified senior care assistants who, in the absence of owners and managers, are required to fill these roles. The percentages for senior care assistants in the Scottish study with some form of training are also higher than for care assistants.

Although it appears that the private sector has a higher proportion of 'trained' staff than the local authority sector, the term 'training' needs to be treated with some caution and does not imply an actual qualification. Training may have involved undertaking a recognised course of instruction or it may simply have been some form of basic induction training

covering health and safety skills, for example, basic first aid, lifting and handling awareness, which was considered necessary by the home owner or officer-in-charge.

In the Humberside survey, home owners and officers-in-charge were asked whether their 'trained' staff had received in-house, social services, college based or 'other' training. Where 'other' training was specified responses included the local health authority, district nurses, St John's Ambulance, the local mental health unit and day courses on disability and ageing run by the National Demonstration Centre in Hull.

Table 14 is a breakdown of the number of homes whose staff had received one or more of these types of training.

Table 14. Number of Homes whose Staff received In-house, Social Services, College Training or 'other' training, by Sector

	Local Authority (n = 32)		Private (n = 79)	
	(n)	(%)	(n)	(%)
In-House Training	29	91	63	80
Social Services Training	26	81	9	11
College based Training	26	81	48	61
Other	1	3	12	15

Ignoring for the moment issues of quality and quantity, more or less all homes appear to have been involved with one or more of these types of training. The numbers receiving in-house training in both sectors is high, and may reflect a preference by managers and owners to pitch the level of training to the needs of their particular establishments. The low figures for Social Services training figures in the private sector may be linked to the cost of training. As CCETSW pointed out, in 1986, concern was expressed by private home owners that existing training schemes were too expensive in terms of time and financial cost. (3) The implementation of NVQ, which involves greater emphasis on in-house assessment, would appear to appeal to this sector in particular.

A second difficulty faced by those planning to deliver training to the private sector is that some of the private homes are very small and owners face logistical difficulties in releasing their staff. Employers in both sectors may prefer to employ staff who have already gained a qualification at further education colleges after leaving school, thus keeping the future costs of training down. Following on from Table 14, those homes that said their staff had received in-house training were broken down by size to see if this type of training was likely to occur in certain establishments.

Table 15. Numbers of Homes, by size, where Care Staff received In-house Training

Registered Home Size	L.A. Homes All	(n)	(%)	Private Homes All	(n)	(%)
0-10 residents	-	-	-	13	5	38
11-20 residents	1	1	100	45	37	82
21-30 residents	10	10	100	17	14	82
31-50 residents	22	19	86	4	4	100
All Homes	33	30	91	79	60	76

The numbers and percentages of homes where care staff have received in-house training is high in all sectors although it is relatively low in the small private homes. Written responses at the homes where no in-house training took place, suggested that their staff were already trained before being employed and that any other training was either unnecessary or done on an 'ad hoc' basis, since the numbers of staff are small and these homes are run on a 'family basis'. The larger homes would appear to be able to train groups of staff on a fairly regular basis.

If the numbers of staff who have received some form of training is high, the numbers who have any form of qualification is, by comparison, low. From the total numbers of staff who were said to have received training, respondents were asked to state the number of staff holding specific qualifications.

Qualifications were then banded into social work/social care;

nursing; and 'other'. A list of actual qualifications listed or mentioned as 'other' is in Appendix IV.

Table 16. Qualifications of Care Staff - Survey One (as percentages of trained staff)

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Social Work	76	21	4	-
Nursing	10	3	66	11
Other	38	10	95	16
None	240	66	442	73
Total Trained	364	100	607	100

As can be seen from Table 16, large numbers of care staff seem to have no qualifications at all, particularly in relation to the numbers said to have received training. A comparison with the Donovan and Wynne-Harley study of private and voluntary homes (4), and the Barclay Report (5) on local authority homes, suggests that the numbers of qualified staff have almost doubled in both sectors, from 13% in the private sector and from 20% in the local authority sector. In neither of these previous publications, however, is there a detailed breakdown of 'other' qualifications, except insofar as the Donovan study mentions that supervisory staff, where qualified, held diplomas or degrees in social science, education or hospital administration. Tables 17 and 18 give a breakdown of qualifications held by staff, by the size of homes, in order to examine the differences

between the sectors in relation to the proportion of trained and/or qualified staff.

Table 17. Qualifications of Local Authority Care Staff, by Size of Establishment.

	Maximum No of Residents each home is Registered for							
	11–20		21–30		31–50		Total	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
S/work/care	–	–	25	35	51	18	76	21
Nursing	1	8	2	3	7	3	10	3
Other	–	–	12	17	26	9	38	10
None	11	92	32	45	197	70	240	66
Total	12	100	71	100	281	100	364	100

x2 (Combining Social Work/Social Care and Nursing) = 14.70, df=2, p<.001.

Table 18. Qualifications of Private Care Staff, by Size of Establishment.

	Maximum No.of Residents each home is registered for									
	Up to 10		11–20		21–30		31–50		Total	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
S/W/care	1	2	3	1	–	–	–	–	4	*
Nursing	6	13	34	10	14	9	12	19	66	11
Other	9	19	55	16	25	17	6	9	95	16
None	31	66	252	73	113	74	46	72	442	73
Total	47	100	344	100	152	100	64	100	607	100

A disparity exists between sectors among those staff with social work/social care qualifications and those with nursing qualifications. In the larger local authority homes the focus remains on social work training, in comparison to those with nursing qualifications in the smaller private homes.

The preference for nursing qualifications in the private sector may be linked to the previous experience (Tables 22 and 23) and qualifications of the home owner (Table 25) outlined later in this chapter. Clough has pointed to findings that private owners are more likely to be trained as nurses than social workers. (6) The Donovan Wynne-Harley study also found that in the private sector homes,

> "Of those who were qualified, nearly all had nursing qualifications. Supervisory staff were most commonly SRN's, and care staff SEN's....previous experience in residential care was not common among staff and was largely confined to hospital auxiliary nursing." (7)

Staff with nursing qualifications may also enter private homes as they are less likely to be recruited by Social Services where CQSW and CSS qualifications are regarded as the appropriate qualifications for senior staff by social services departments.

As stated earlier, the low level of staff with any qualification may reflect the large numbers of part-time staff and the fact that care staff are predominantly female. Lack of commitment and of opportunity to develop a career path, may hinder the progression towards a recognised qualification.

Overall, the high proportion of staff who have received some form of training but not a qualification, is likely to increase the pressure, as suggested in Chapter Two, for residential staff, particularly those without 'professional' qualifications, to gain skills oriented, competence based qualifications. As also stated in the previous chapter, NVQ's are being seen by many as the most appropriate means by which to achieve these new qualifications. In this respect it is important that achievement of an NVQ is based on assessment, usually within the establishment, rather than attendance at a recognised educational establishment.

2.c. *The Respondents*

2.c (i) *Employment History*

As already suggested it might be expected that the Officers-in-charge and home owners attitudes to training would be influenced by the training that they themselves had. It could also be influenced by their gender, (since it has been argued that predominantly female workforces are less likely to achieve professional status). For these reasons respondents were asked to give details of their sex, occupational status, their experience in the care sector, previous employment and the training and qualifications they held. It was hoped to establish whether the type of background experience, training and qualifications, could be linked to preferences by home owners

and officers-in-charge for the 'professional' or 'entrepreneurial' models of training.

Table 19. Sex of Respondents by Sector

	Males		Females		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Local Authority	6	18	27	82	33	100
Private Sector	20	25	59	75	79	100

In the local authority sector, 94% of the respondents were Officers-in-charge and predominantly female. The private sector has more male owners, whose history of previous employment included occupations such as hotelier, armed forces etc. (See Appendix V and Table 22)

Tables 20 and 21 are a breakdown of the length of time respondents had been in charge of their establishment, and the length of time that respondents had worked in the caring sector. By caring sector was meant social care as opposed to health care but some respondents from the private sector with nursing experience may have equated nursing with 'caring'.

Table 20. Length of time Respondents have been in charge of their Establishment

Length of time in charge	Local Authority		Private Sector		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Less than one year	8	24	19	24	27	24
1 to 5 years	14	43	40	50	54	48
6 to 10	6	18	20	26	26	23
11 to 19 years	4	12	–	–	4	4
Over 20 years	1	3	–	–	1	1
Total	33	100	79	100	112	100

Table 21. Length of time that Respondents have worked in the care sector.

	Local Authority		Private Sector		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Less than 12 months	–	–	1	1	1	1
1 to 5 years	1	3	9	11	10	9
Over 5 years	32	97	69	88	101	90
Total	33	100	79	100	112	100

$x2 = 18.19$, $df = 1$, $p < .001$ (over 5 years)

Table 20 shows that in both sectors, most respondents said that they had been in charge of their present establishment for

between one and five years, although a third of local authority respondents had worked for more than six years at their establishment.

Table 21 shows that the majority of respondents had worked in the social care sector for more than five years.

Table 22. Previous Occupations of Respondents by Sector

	Local Authority		Private Sector		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Nursing (1)	11	33	40	56	51	46
Social Work/ Social Care (2)	9	28	14	18	23	20
Other (3)	13	38	25	31	38	34
Total	33	100	79	100	112	100

(1.(2).(3). See Appendix V for actual occupations listed and mentioned.

Table 22 demonstrates that respondents' previous occupations. prior to current employment, reflect a nursing bias, from which 50% of staff in the private sector were drawn. At the same time, approximately a third of respondents in both

sectors had no direct previous employment in nursing or social work/social care.

Respondents were also asked to indicate by whom they had previously been employed. Table 23 shows that the health service had been a prominent employer of private sector respondents. Taken together with the information from Table 16, this suggests that respondents from this sector may show a preference for care staff that have a similar occupational background.

Table 23. Previous Employer of Respondents, by Sector.

Sector.	Local Authority		Private Sector		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Local Authority	13	39	17	22	30	27
Private Sector	-	-	16	20	16	14
Health Service	9	27	28	35	37	33
Self-employed	1	3	10	13	11	10
Other (i)	10	31	7	9	17	15
Not employed	-	-	1	1	1	1
Total	33	100	79	100	112	100

(i) Armed Forces/Industry

A key issue here is that in the private sector 20% of owners had come from this sector, 9% from the armed forces and industry and a further 14% from sources other than the NHS or Social Services. Table 23 suggests therefore, that this care sector

cannot rely on the local authority or the health authority to train its owners and managers.

2.c.(ii) *Training and Qualifications of Respondents*

The percentage of respondents who, when asked if they had received any training in social or health care, replied positively, was 100% (n = 33)in the local authority sector and 87% (n = 69) in the private sector. Table 24 breaks down the type of training received.

Table 24. Type of Training received by Respondents, by Sector.

	Local Authority (n = 33)		Private (n = 79)	
	(n)	(%)	(n)	(%)
In-house training	30	91	25	37
Social Services training	30	91	26	38
College-based training	27	82	26	38
Other	11	33	30	43
None	–	–	11	14

Table 24 shows that 91% of local authority respondents had attended courses run by social services, but only a third of private sector respondents had done so. This is perhaps to be

expected in a system in which local authority respondents would probably have received training both before and during their present appointments. Within the private sector, it will be remembered that in only 11% of homes had staff undertaken social services training (Table 14), whereas Table 24 shows 38% of home owners having undertaken this training. A possible explanation comes from CCETSW which points out that owners appear to have taken the opportunity to undertake social services courses in order to comply with the 'fit person' clause of the 1984 Registered Homes Act, by undertaking basic training, "suited to local needs" (8), whereas costs may preclude staff also receiving similar training. The staff figures are far higher for in-house training, often run, as stated earlier, by the owners themselves.

Overall, all forms of training except 'other' were more frequently received by local authority heads of homes than by private owners. Of concern was that in five private homes where owners said they had received 'none' of the training listed, their staff had also received no training.

However, the training experiences are diverse, since 33% of local authority respondents and 43% of private owners said they had received 'other' training, primarily specialised short courses on care of the elderly and management courses, which were not necessarily linked to specific qualifications. In the private sector, in particular, hospital/nursing courses and NVQ assessor courses were mentioned.

Of particular interest are the actual qualifications held by respondents, which appear to reinforce the trend found in Table 16, whereby the private sector attracts those holding nursing qualifications and local authority respondents hold qualifications which relate primarily to the social work/social care field.

Table 25. Qualifications of Respondents, by Sector

	Local Authority		Private	
	(n)	(%)	(n)	(%)
S/work/care	24	73	9	12
Nursing	4	12	33	42
Other	3	9	8	10
None	2	6	28	36
Total	33	100	79	100

$x2$ = (combining other/none) 78.75, df = 2, $p<.001$

NB: See Appendices VI and VII for actual qualifications held.

As can be seen from Table 25, 73% of local authority respondents hold social work/social care qualifications, compared with only 12% in the private sector. The trend is reversed in the private sector where the emphasis is on nursing qualifications. As stated earlier, a comparison can be made with

Table 16, where care staff reflect similar trends. A study by Bartlett and Challis, in 1985, found that in 30% of the cases, the owner was also the person in charge and a qualified nurse, who before starting her present occupation, had left nursing to start a family. However, as the researchers point out,

> "Previous nursing experience was not necessarily related to care of the elderly, and the starting of a business was sometimes the first experience gained outside the NHS." (9)

The number holding no qualifications is much higher in the private sector. However, as Phillips and Vincent point out, small businesses depend to a significant extent upon family labour, usually on the efforts of spouses and children. (10) One member of the family may have a nursing qualification, not necessarily the owner, and this is considered sufficient for registration and training purposes. As one private owner with no training or qualifications commented,

> "We are now on a consortium for the NVQ for the private sector, organised by Hull college. My daughter-in-law who is an SEN, is in charge of our training. Along with my wife and myself, we all three work full-time at the home."

Thus, although the numbers of unqualified home owners is of concern, many employ staff with what are considered to be appropriate qualifications or have a member of the family who is qualified in the home.

Question 16 of the questionnaire asked respondents to specify what further training, if any, they felt would be of benefit to them. The question was open-ended, and the responses were classified into recognised social work/social care courses, nurse training/nursing skills, management courses, and specified

NVQ courses or levels. 'Combination' responses were those that mentioned both social work/care and nursing, social work/care and NVQ, or management and either social work/care or nursing. Other responses were less specific, for example, "any that would help me". Table 26 breaks down these preferences.

Table 26. Preferences for Further Training, by Sector.

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Social Work/care	6	18	6	8
Nursing skills	3	9	4	5
Management skills	8	24	10	13
NVQ	–	–	2	2
Non-specific	5	15	10	13
Combination	2	6	5	6
None	9	27	42	53
Total	33	100	79	100

x2 ('any' vs none) = 6.87, df=1, p<.01.

Of the respondents that said they wanted or needed no further training, two in the local authority sector were retiring. In the private sector there was no association between lack of qualifications and a desire for further training. Indeed, over half of those who had no qualifications wanted no further training either. Fifteen out of the thirty-

three home owners who had nursing training also wanted nothing further. This may imply, as suggested earlier, that, in the private sector, home owners feel they have sufficient staff who hold relevant qualifications, or that their own qualification (in nursing) is sufficient. One respondent however, who held no qualifications and had received no social care training, wanted no further training due to her "20 years experience". The main difference appears to be that private home owners are twice as likely to say that they do not want any more training.

Personal views on further training, and on the importance of training, are covered in the following chapter.

3. SUMMARY

This first survey set out to examine differences between heads of local authority and private homes in both attitudes to training and the factors that might affect this. The response rate was adequate for a postal survey, although private homes were less likely to respond. The only other apparent source of bias arose from the low response rate from large private homes in one area. In general the average size of homes appears comparable to national figures, as did the proportion of residents over 75 years of age.

The survey confirmed the high degree of disabling conditions among residents, with dementia and incontinence more likely to be reported from the local authority sector and physical disability from the private sector. At first sight, such a level

of ill health requires staff who have an awareness of the social and perhaps medical implications.

The survey suggested that this need for training was not yet being met by National Vocational Qualifications. In both sectors part-time care assistants outnumber full-time staff by a ratio of between two and three to one, and few of them were NVQ trained. Most, however had received some training, as had the vast majority of heads of homes, although there was some suggestion that this had been less thorough than in the case of local authority officers-in-charge. Local authority officers-in-charge were also more likely to be qualified than private home owners. There was a stark contrast in the type of qualifications held, with nursing predominately in the private sector and social care predominately in the local authority. A large number of private home owners had no qualifications and taking both sectors together around four in ten came from outside health or social care.

If it is true that residential care for elderly people requires some medical and some 'social' knowledge, and if many of its heads of homes come from outside health or social care, it will require its own training and cannot rely on a major outside supplier of trained staff. Given the number of untrained staff, the predominance of part-time staff and the high proportion who are getting some training, the pressure for some form of 'on-the-job' training with a recognised qualification is clearly going to be strong.

CHAPTER FOUR: WHAT ARE THE VIEWS OF OFFICERS-IN-CHARGE AND HOME OWNERS ON TRAINING FOR CARE STAFF?

The debate in Chapter Two reveals two very different approaches to training. The 'professional' model maintains a 'higher order' skills learning approach, whereas the more recent 'entrepreneurial' model promotes a task-specific skills and competence approach, consistent with the NVQ programme. It was argued that different groups of people - local authority officers-in-charge, private home owners, staff and residents - will, because of underlying interests, incline to one or other side in this debate. The hypothesis that local authority homes maintain a 'professional' approach to training and that private homes maintain a more practical 'entrepreneurial' approach, is tested in this chapter by way of qualitative and quantitative analyses of the personal views of Officers-in-Charge and home owners. The analysis requires measures which reflect attachment to a 'professional' or 'entrepreneurial' approach to training and uses a variety of statistical methods.

Introduction

The descriptive data in the previous chapter revealed important findings about the nature of the residential workforce, and in particular the large numbers of part-time staff. It was suggested in Chapter Two that a predominantly

female, part-time workforce would be offered 'lower order' training that fitted the role of the 'para-professional'. This training is likely to be 'situational' and designed to meet the needs of individual establishments, a result in part of the practical difficulties associated with large numbers of part-time staff and staffing in smaller homes. It was therefore predicted that preference for in-house training, particularly in the private sector, would be evident.

As we have seen, the background qualifications and training of local authority managers and private home owners differ, and it is likely therefore that they will also differ in their views on the type of training needed by staff. It was therefore predicted that differences would exist between the sectors in their preferences for the two models of training highlighted in Chapter Two. The hypotheses was that local authority managers would maintain a preference for a 'professional' model and home owners would maintain a preference for the 'entrepreneurial' model of training.

1. Respondents' personal views on training

Although there appears to be a consensus that training is important, it is still necessary to establish how important training is actually felt to be. Respondents were asked to state whether they felt that training for care staff was Very Important, Important, Not Very Important, or Not Important at all. Only 6% of the sample felt that training was not very

important or not important at all. The responses in Table 27 are therefore condensed into Very Important and Other.

Table 27. How Important is Training?

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Very Important	30	91	56	71	86	77
Other	3	9	23	29	26	23
Total	33	100	79	100	112	100

$x2 = 33.41$, df = 1, $p < .001$

In the private sector, eighteen home owners felt that it was no more than important, four that training was not very important and one that training was not very important at all. Overall, 29% of the respondents from this sector felt that training was less than 'very important' as opposed to only 9% in the local authority sector. The key point to make is the high level of keenness shown for training in both sectors but particularly by the local authority heads of home.

Some respondents amplified their ratings with written responses on the reasons for which training was important. The positive local authority responses laid emphasis on the 'professional' aspects of caring for the elderly, adopting a wider view of the role of training and the 'higher order' skills involved. Training for such respondents may involve the

acquisition of attitudes as well as skills, as pointed out by one local authority manager who states,

> "Training helps to highlight the implications of ageing and ageism; (it) extends the knowledge of various services; helps to update on changes of legislation: to broaden the mind generally as well as question own attitudes/actions; to achieve higher standards of service; confidence building."

Similarly another local authority manager emphasises that the 'professional' approach to the caring role requires a wider view in that.

> "Training highlights the difference between looking after people and caring for them and helps develop healthy attitudes towards care."

Some respondents stressed the importance of integrating this wider range of self-awareness and knowledge with practical skills, since,

> "Looking after elderly people is a skilled job requiring a wide range of knowledge and practical skills. After a good induction training there should be further training for care assistants that helps them think about and develop their own practice. This in turn should benefit residents." (Local Authority manager)

The idea that 'training' and 'education' involve different levels of skill, and that a bridge, at some point, needs to be built between them, was stressed by another local authority manager who wrote,

> "The general term 'training' should be split into two categories...Education...all subject matter that deals with academic subjects..sociology and psychology, as they are applied concepts such as self and the mind, and even more general information, e.g. mental illness (and) Training.. confined to more applied or craft skills...bed making, admission procedure, information on continence. (Education

and Training) should be dealt with separately and later on, a bridging course between the two."

The positive private sector responses covered similar ground, but the language used seemed more 'down to earth' and the responses had a decidedly more pragmatic flavour. A concern with the need to train younger staff was evident by this home owner who stated,

"Residential care changes daily with the elderly. Young and inexperienced care assistants need regular training to give them confidence in themselves, make them aware of the elderly persons' needs: which makes a happy home for both staff and residents alike."

More pragmatic home owners viewed training as important for,

"Job satisfaction. Good for the clients, (and) helps the home to run efficiently."

but that training should be tailored to the needs of the home, whereby training should be,

"Realistic...suited to the situation depending on type of home."

One home owner, who in fact felt that training was not important, qualified this by emphasising the needs of the establishment and expressed a pragmatic view on the importance of looking at individual establishments, in that,

"I have emphasised those comments which reflect three main responses to the importance of training, a) that training should be practical, b) that training is not always relevant and c) that the needs of the establishment take priority."

Safety, improving the public's attitude to the work and increasing competence were also mentioned as being reasons why training is very important. In general however, responses from

the private sector were more 'situational'. Thus care assistants are being helped to improve their performance in relation to a particular job in a particular home, rather than to acquire 'deep' skills relevant to a wide variety of situations.

Those home owners that felt training was not very important or not important at all, tended to emphasise the need for common sense and a natural ability to care. For example, one private home owner wrote that:

> "The most important thing one should have is care and affection for old people. (They) should be keen to help them generally and have a good attitude towards their needs and problems."

and another, that,

> "Patience, common sense and general intelligence are far more important",

Other private home owners felt that training was often not cost-effective, since,

> "Much financial burden is incurred by the proprietor, with little or no improvement to the quality of work."

Home owners were also concerned to motivate staff and it may be that 'situational' training is more acceptable to staff as being less demanding and better suited to the home in which they work. The point made in Chapter Two about gender and the 'para-professional' status of residential staff, and in Chapter Three which shows the high proportion of part-time women, appears to hold up in relation to a view expressed by a home owner who believes that,

"As most of the care assistants are women without academic background, training should be simple, relate to the needs of their client group, and offer a certificate at the end, as a feeling of achievement is of utmost importance."

The contrast between training for a particular situation and training for a profession which might be practised in a wide variety of situations was explored in three further questions asked to establish where training should take place and who should provide it (see Tables 28 to 30).

Overall, respondents appear to prefer a combination of approaches in regard to training their staff. There were, however, clear differences by sector as to who should provide the training and where it should take place, with heads of home from the private sector being three times more likely than their local authority counterparts to want in-house training or none at all.

Table 28. Where should Training Take Place?

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
In-House	2	6	15	19	17	15
At College	-	-	-	-	-	-
A Combination	31	94	62	78	93	83
None of these	-	-	2	3	2	2
Total	33	100	79	100	112	100

No specific question was asked as to how a combination might be achieved. However, one (local authority) respondent suggested that off-the-job training should be linked to in-house induction and supervision, reflecting a view that training based solely in colleges remains remote from the realities of residential care. Certainly, colleges are not seen as a single resource. As can be seen from Table 28, fifteen private home owners clearly feel that in-house training is the most appropriate.

In general, respondents said that they wanted managers and owners to contribute to training, irrespective of the contribution made by the Colleges and Social Services. However, private home owners were more likely to propose that they alone should train than were their local authority counterparts.

Table 29. Who do you feel should provide the training?

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Owners/managers	1	3	11	14	12	11
Social Services	3	9	4	5	7	6
Education Service	1	3	-	-	1	1
A Combination	28	85	63	80	91	81
None of these	-	-	1	1	1	1
Total	33	100	79	100	112	100

Table 29 shows that a combination of all three agencies was the most popular. Interestingly, almost a quarter of local authority respondents favoured a combination of the home and social services, but none favoured home involvement with the education service. In contrast, a quarter of the private sector respondents favoured home involvement with local colleges, but they were far less enthusiastic on home involvement with social services.

Table 30. What combination do you feel is most appropriate?

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Home/social services	8	24	13	16	21	19
Home/education service	–	–	20	25	20	18
Home/social services/education	19	58	32	41	51	45
Social services/ education service	2	6	2	3	4	4
None of these	4	12	12	15	16	14
Total	33	100	79	100	112	100

Where respondents had indicated 'none of these', no comments were forthcoming as to an alternative, except for one private home owner who felt strongly that the Health Service should feature in a combination approach.

The reluctance of some heads of home in the private sector to espouse training in social services departments may both reflect and reinforce an 'entrepreneurial' as against a 'professional' approach to training. The profession of social work has recently been intimately linked with the organisation of social services. The rejection of social services departments, as a sole source of training suggests a rejection of at least some aspects of a social services identity. It may also reflect a preference for 'situational' training for care staff. Thus local authority respondents appear to favour social services input which has maintained 'professional' roots, while home owners may be more likely to favour training that is specifically linked to the individual home. For example one owner who had no social work or social care qualifications felt that training was very important, since it is,

"A greater means to efficiency and good quality care"

but adds.

"It is important that <u>private</u> homes do not become an extension of social services."

and that staff,

"Have a responsibility to their employers and those they care for."

This owner had also had problems with staff leaving and 'moving around in packs' to homes that were paying the best wages at any one time, thus his attitude may be seen as one which sees training as encouraging loyalty from a 'para-professional' group of staff rather than enhancing 'professional' status.

As in the example just given, respondents' views also appeared to be influenced by the practical difficulties that home owners and officers-in-charge associate with getting their staff trained. Table 31 breaks down the responses on what these practical difficulties were and these were coded under six main headings. In several cases, multiple responses were given.

Table 31. Practical Difficulties Associated with Staff Training

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Lack of finance	13	22	16	15
Covering duties	29	50	42	40
Staff motivation	2	3	17	16
Transport/travel	6	10	6	6
Linking theory to practice	-	-	2	2
Places available	3	5	-	-
None	5	9	22	21
All responses	58	100	105	100

The responses given in Table 31 show a clear concern over issues such as staff cover and costs. As argued in Chapter Three, the high numbers of part-time staff is a factor that will affect the costs of training the workforce (for there will be more people to be trained than would be the case with a full-time workforce, and if training is undertaken outside working hours, overtime may need to be paid). One local authority respondent stated,

> "Policy dictates training but funding is not available",

emphasising the problem for managers who feel that training is important but that budgetary concerns often override this. These difficulties were to a large extent common to both sectors. A private sector respondent highlighted another financial concern surrounding the decision to send staff for training whereby,

> "If the employer pays for the training the employee could change employment at the end of the course."

This view once again highlights the preference for 'situational' training that would appear to lessen the risk of staff movement. This problem of trained staff moving on to the statutory sector or to better paid employment was one cited by home owners. Cover for staff was also a major concern, linked in part to financial considerations, but also to the amount of time that a staff member could be spared away from work and the availability of staff that could in fact be released from work. There is also the problem of supervising and supporting staff

who may be undertaking NVQ within the home. The attraction of the NVQ system, however, is that the units can be spread over a relatively long period and undertaken at times which fit in with the routine of the establishment, rather than on an academic year basis.

Motivation, was also quoted as problematic although this seemed to be a problem that was virtually confined to the private sector. As one private sector respondent stated,

> "Previous set ideas, techniques and approach to the elderly are sometimes difficult to change."

similarly, and again in relation to the problems faced by a female workforce, another points out,

> "Most of our staff are part-time working mothers. They have no spare time and do not wish - on the whole - to give up time to train without being well remunerated. Care assisting is not a vocation to some staff, however kind and caring they may be. They take the job because the hours suit. When the families grow up they will go back to being full time secretaries etc."

This comment reflects the findings of Willcocks et al (1), on reasons given by staff in their study, for starting to work with elderly people. They categorised these into three classes - altruism - convenience - experience - and although altruistic explanations dominated, just over a half cited convenience (hours suit, close to home, needing a job) as being influential. The issue of motivation is also linked to the question of 'identity' as looked at in Chapter Two. How far the care assistant can identify with a caring 'profession' is seen as the main factor in levels of commitment and satisfaction with the

job. Thus there may be some resistance by staff to changes in their role through training, suggesting that those staff lacking a 'professional identity' will remain in a 'non-professional' role basing their self-respect on, for example, their experience and common sense rather than professional skills and qualifications.

This question of 'identity' also relates perhaps to possible conflict for the care assistant who is essentially altruistic (a nice and naturally caring person), but is confronted with the dilemma of two different approaches to training, being 'professional' through the acquisition of 'high order' skills (producing care plans etc.) and being practical (developing and improving the task-based skills applicable to needs of the home) A 'non-professional' approach to training could therefore be justified by an appeal to the essentially 'natural' and 'moral' requirements of this job. As a private home owner indicates, learning new skills and/or approaches to care could undermine a natural ability to do the job, since,

> "People are human beings, (they have) difficulty in using and adapting skills learnt on courses to everyday life in a home..Communication...empathy..could be impaired by an overdose of new skills, goals or care plans etc."

The number of respondents however, who stated 'none', is quite high, especially in the private sector, implying that for these home owners, staff training presents no problems. Analysis of the private homes concerned did not clarify specific reasons why this should be so, but it is possible that training was not a high priority in these homes, since all but 2 of the home

owners had said they needed no further training themselves, compared with 45% of the sample as a whole, fifty per cent had no qualifications, compared with 27% of the sample as a whole and a third had trained their staff almost solely on an in-house basis.

2. An Analysis of Respondents Views on the Importance of Specific Training Areas.

Having examined the overall importance heads of homes gave to training, the next step was to test the research hypothesis that attitudes to training differ between the local authority and private sectors and that the local authority sector maintains a preference for the 'professional' model, while the private sector maintains a preference for the 'entrepreneurial' model of training.

The 'professional' model is based on professional social work values and attitudes and emphasises person-based skills such as communication, self-awareness, and assessment. The 'entrepreneurial' model is based on a practical and medical skills approach with lays emphasis on the tasks that are carried out within a home, such as toileting, bathing, lifting and first aid. These two models reflect the training areas, currently included on courses for care staff and listed in Question 27 of the questionnaire.

In order to establish the degree of importance that respondents attached to specific training areas, respondents

were asked to rank them on a scale of 1 (Very Important) to 4 (Not Relevant), in relation to respondents' own homes and the staff employed within them.

The questionnaire lists fifty-three training area variables. Initially, a crude analysis was undertaken by compiling two A Priori lists of forty nine 'Professional' and 'Entrepreneurial' variables (related to the 'professional' and 'entrepreneurial' training models) taken from the original list. The two lists were tested for validity on a panel of 'judges', 22 officers-in-charge and private home owners, not included in the survey, from the Humberside and North Yorkshire areas, who were asked to place these training variables into a 'Professional' column and a 'Pragmatic' ('Entrepreneurial') column. (Appendix VIII gives the Validity Test and outcome. Appendix IX lists the A Priori variables).

Twenty-eight 'professional' variables were selected from the original variable list, which reflect the social work/social care values and attitudes. Twenty-one 'Entrepreneurial' variables were selected which reflected an emphasis on practical, task-based skills.

Two sets of variables were summed to give two scores each for each home. The minimum and maximum range between actual low scores (very important) and high scores (not relevant) was 28 to 112 for 'professional' scores, and 19 to 76 for 'entrepreneurial' scores. Table 32 gives the mean scores for the variables by sector, and it will be noted that low scores imply a keenness in the area concerned.

Table 32. Mean Scores on Professional and Entrepreneurial Variables.

	Local Authority (32 cases)	Private (78 cases)	Total (110 cases)
Professional variables	37.75	44.04	42.41
Entrepreneurial variables	25.97	26.29	26.20

Missing cases 2 or 1.8%

Table 32 shows local authority respondents are on average keener on the 'professional' aspects of training than the private sector respondents. A t-test showed that there is a significant difference in mean professional scores between sectors: t-value = 2.96, df = 108, p <.004.

By contrast respondents from the two sectors do not differ on the 'entrepreneurial' aspects of training and the t-test revealed no significant difference in mean scores between sectors.

It had been expected that the differences between sectors would be reflected in and perhaps even partially explained by differences between those with different qualifications. Tables 33 and 34 show the mean scores by qualifications held. An analysis of variance was carried out to test whether the scores

are related to the qualifications held by respondents. (Appendix X gives the full Analysis of Variance results)

Table 33. Mean 'Professional' Scores by Qualifications held, by Sector.

	Local Authority		Private	
	Mean	Cases	Mean	Cases
Social Work/ Social Care	36.17	23	46.60	10
Nursing	42.75	4	42.53	36
Other/None	41.00	5	44.94	32
Total	37.75	32	44.04	78

Table 34. Mean 'Entrepreneurial' Scores by Qualifications held, by Sector.

	Local Authority		Private	
	Mean	Cases	Mean	Cases
Social Work/ Social Care	25.74	23	27.90	10
Nursing	28.00	4	26.14	36
Other /None	25.40	5	25.97	32
Total	25.97	32	26.29	78

The mean scores in Tables 33 and 34 suggest that respondents with social work/social care qualifications, working in the local authority sector are keener on the 'professional'

variables than their counterparts in the private sector. However, although the effect of sector is significant in the case of 'professional' variables (p=.004), neither the main effects of qualifications ('professional' p=.648, 'entrepreneurial' p=.866) nor their two-way interaction ('professional' p=.242, 'entrepreneurial' p=.599) are significant.

3. SUMMARY

It was argued in Chapter Two that two major approaches to training exist and are likely to appeal to different groups of people who are influenced by underlying interests that affect their views on the nature and purpose of training. The aim of this first survey was to explore the attitudes and personal views of officers-in-charge and home owners, and test the hypothesis that the local authority and private sectors differ in their preferences for a 'professional' and 'entrepreneurial' model of training.

Both qualitative and quantitative data revealed a higher level of keenness by the local authority respondents on the importance of training, than those in the private sector. Written responses suggested that while the local authority retains a preference for social work 'higher order' skills and a wider, integrated approach to training, the private sector was concerned more with practical and pragmatic solutions to staff training. In keeping with these impressions, statistical

analysis showed that the local authority heads of homes were keener on the 'professional' training areas, but that both sectors were equally keen on the 'entrepreneurial' training areas. There was some evidence that local authority respondents holding social work/social care qualifications were more likely to prefer the 'professional' model but in these respects the qualifications of heads of homes seemed less important than the sector in which they worked.

The survey suggested that, in general, private sector heads of homes appeared to favour 'situational' training, aimed at improving performance in a particular job in a particular establishment, supported by the fact that the private sector was three times more likely than local authority heads to want in-house training. A preference for this type of training and a reluctance by some heads of home to embrace social services training reinforces a pragmatic 'entrepreneurial' approach, which is consistent with the NVQ programme. The NVQ programme may also be attractive to heads of homes who have difficulty in releasing staff for training, and who are concerned about the costs of training a predominantly part-time workforce.

CHAPTER FIVE: SURVEY TWO - CARE STAFF: A DESCRIPTION OF THE SAMPLE

The previous two chapters looked at the differences between heads of local authority and private homes in their attitudes to training and the factors that might affect this. This chapter examines the descriptive data from the second survey on care staff in both sectors. The chapter looks at factors which may influence attitudes to training such as whether a member of staff is part-time, age, previous experience, previous employers, the tasks they carry out and the length of time in post. This information will then be used in the following chapter to test the hypothesis that staff in different sectors are inclined towards different models of training, some preferring a 'professional' model and others an industrial, task based 'entrepreneurial' model of training and that this is so even after allowing for these 'influencing factors'.

1. Report on the Data Collection of Survey Two:

Between July and August 1992, 409 questionnaires were delivered to 35 residential homes, selected randomly from the first survey sample. Each fourteen page questionnaire (Appendix XI) was placed in a separate envelope for every member of staff at the homes and given to each officer-in-charge and private home owners to distribute to staff, the numbers of whom had been verified in advance by telephone. Stamped addressed envelopes

were enclosed, but it was also necessary to make arrangements to collect questionnaires personally, following telephone reminders, between September and November 1992.

The Response Rate:

Table 35. Response by Staff, by Sector

Sector	Sent Out (n)	No of Homes (n)	Non-Response (n)	Invalid Returns (n)	Returned (n)
Local Authority	170	10	71	-	58
Private	239	25	110	4	52
Total	409	35	181	4	224
Excluded *	64	3			
Total	345	32	181	4	224

* Three private sector homes were excluded from the sample and from all subsequent analysis due to extremely low response rate (less than 10%).

Four questionnaires were treated as invalid due to being completed by non-care staff. The overall response rate, after excluding those homes which made no returns was 65%.

Reasons for non-response may have been threefold. Firstly, private home owners and local authority managers may not have distributed all the questionnaires. For example, staff who were off sick, had taken holiday leave, or were not on duty at the time of distribution, particularly night staff, may have been left out of the distribution process. Secondly, staff may have received the questionnaires but may then have left, gone on holiday or sick leave and simply not remembered or lost interest in the questionnaire on return. Thirdly, the staff themselves may have lacked the motivation and knowledge of the subject area, as well as the time to fill out the questionnaire. Moser and Kalton (1) point to studies which found that the less educated, those in lower occupational categories and those uninterested in the subject of the survey have higher than average rates of non-response. Staff failing to reply for one of the last two reasons may have been influenced by communication between themselves and the managers and owners, who may, for example, have directly or indirectly implied that completion of the questionnaire was entirely voluntary/non-essential/to be done in own time.

2. Description of the Sample

In order to provide a background to the views of the care staff on training, it was necessary to collect data that would

provide a description of the sample being used. It was argued in Chapter Two, that a predominantly part-time female workforce is subject to poor 'career' progression, whereby they are unlikely to become 'professionalised' but rather progress from a 'proletarian' work role to that of a 'para-professional', which may imply a need for and justification for training of a particular type. In order to appraise this argument, it is necessary to know how many staff are female, part-time and so on, and relate these data to their attitude to training. This information, appears not to be available to those organisations, for example CCETSW, who are concerned with the training and education of social workers and others in the field of care. It is vital if we are to analyse and predict the training needs of staff in both sectors.

No other recent studies have included figures on the length of time that staff have been in post or have worked in the caring sector, or have broken down the previous occupations and employers of staff. The study provides this information and, in particular, otherwise unknown data on the training and qualifications of those staff, their views on the usefulness and relevance of training in general and in relation to specific training areas.

2.a) *Basic characteristics of the Care Staff*

The workforce was, as expected, predominantly female, although seven male care staff were employed in the local authority sector. In order to gain an overall impression of the

staff characteristics. Tables 36 to 42 break down the age, length of time staff have been in post, length of time employed in the caring sector, occupational status, previous occupations and previous employers of those staff, and the tasks undertaken by staff. This information can be used to outline implications for training within each sector and later used in an analysis of preferences for training.

Table 36. Age, Length of Time in Post and Length of Time Staff have Worked in the Care Sector.

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
AGE						
Under 20	5	5	13	10	18	8
20 - 39	28	28	59	47	87	39
40 - 59	65	66	51	41	116	52
60 +	1	1	2	1	3	1
Total	99	100	125	100	224	100
LENGTH OF TIME IN POST						
Under 1 year	9	9	29	23	38	17
1 to 5 years	37	37	72	58	109	49
5 years +	53	54	24	19	77	34
Total	99	100	125	100	224	100

LENGTH OF TIME WORKING IN CARE	Local Authority (n)	(%)	Private (n)	(%)	Total (n)	(%)
Under 1 year	2	2	10	8	12	5
1 to 5 years	22	22	66	53	88	39
5 years +	75	76	49	39	125	56
Total	99	100	125	100	224	100

These three sets of figures highlight some important differences between the two sectors. In the local authority sample, care staff tended to be from the older age group, and also to have worked longer in their present post and in the care sector. Staff in the private sector are younger, and have worked less years at their present job as well as having less experience in caring. This situation probably arises because the private sector is a relatively new employer whose staff are unlikely to have been in the home very long. This, together with the fact that the sector may be particularly concerned to attract less expensive staff, may help to explain the differences in age and length of time in post.

These differences in the sample do not in themselves suggest that staff who differ on these variables have different attitudes to training, but it is expected that later analysis will show whether these factors, or others, are of significance or not. The evidence may well have implications for training. Staff who have been in post a long time and who have no

qualifications, as well as younger staff with little experience, may be attracted to the NVQ model of training which can be utilised on an in-house basis and is aimed at staff who have several years of experience but no formal training or qualifications. Thus later analysis looks at the length of time care staff have been employed at an establishment, since this may influence the type of training that is wanted.

2.b) *Occupational Status of the Care Staff*

Table 37 is a breakdown of full and part-time staff in the sample. The seven male employees in the private sector were all full-time, but the main issue is that, as suggested by the first survey, large numbers of part-time female staff are employed in both sectors, and particularly in the local authority sector.

Table 37. Full and Part-time Care Staff, by Sector

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Full Time	22	22	48	38
Part Time	77	78	77	62
Total	99	100	125	100

The implication of large numbers of part-time care staff is, as argued in Chapter Two, that these staff are likely to receive task-based training befitting their role as 'para-professionals' which may affect career progression. It may be expected that part-time staff also work on a short-term basis, in which case,

length of time in post may also be of importance to the type of training that care staff are likely to want and receive. Initial analysis however, revealed in Table 38 that the percentage of staff who have been in post for five years or more is slightly higher for part-time staff.

Table 38. Length of Time in Post by Full and Part-time Staff

	Full time		Part time	
	(n)	(%)	(n)	(%)
Under 12 months	14	20	24	16
One to Five years	35	50	74	48
Five years +	21	30	56	36
Total	70	100	154	100

The occupational status of care staff also differed between the sectors. In the local authority homes, respondents were predominantly care assistants (97%), but in the private sector, 26% stated that they were senior care assistants. As suggested in the previous chapter, some home owners may employ qualified staff that can run the home in the absence of the owner, even though they may be unable to afford the level of line management found in local authority homes.

Information on previous occupations is a neglected area in training statistics, yet it is relevant to an examination of the skills and attitudes that staff may bring with them. Later analysis seeks to determine whether care staff with a social work or social care background or nursing background are likely

to prefer one model of training to another, and if so whether this explains differences in the preferences of staff in different sectors. Tables 39 and 40 break down previous occupations and previous employers of staff in the sample.

Table 39. Previous Occupation of Care Staff.

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Social work/care	17	17	23	19
Nursing/Health	16	16	19	15
Other *	66	67	80	66
Total	99	100	122	100

* includes other professions (e.g. teacher), housewife, school leaver/student, and other non-profession. (3 cases missing)

Table 40. Previous Employer of Care Staff

	L.A. Staff		Private Staff	
EMPLOYER	(n)	(%)	(n)	(%)
Local Authority	29	30	19	16
Private Sector	8	8	27	22
Health Service	13	13	10	8
Other *	33	33	39	32
Not Employed	16	16	27	22
Total	99	100	122	100

* Includes self-employed, private industry, voluntary sector. (3 cases missing)

$x2 = 29.57$, $df = 5$, $p<.001$

As can be seen from Table 39, previous occupations appear to be split almost equally between the two sectors, with the exception that staff in the private sector were relatively unlikely to have moved from the local authority sector or the health service (only 24% had come from these sectors as against 43% in the local authority sector). As with the data on previous employers of home owners, the implication is that employers cannot rely on the local authority or health service for training staff in the private sector.

Similar conclusions were suggested by an analysis comparing part-time and full-time staff. In the private sector, as many of the part-time staff (15%) had been housewives as had been in health or social services. Some of these may have been taking a career break and having worked previously in health or social services were taking the opportunity to return to work in a similar field but on a part-time basis.

2.c) *Tasks undertaken by Care Staff*

It was expected that the type of tasks carried out by staff would influence the type of training that they wanted. As suggested earlier, basic routine tasks can be carried out by a 'proletarian' workforce, and training may be used to enhance those tasks rather than 'professionalise' the residential worker. For these reasons a checklist similar to that devised by Imber (2) was used to ask staff whether or not certain tasks were carried out as part of their regular duties.

Whilst this list may not be fully comprehensive in terms of staff activity in homes for the elderly, it was important to establish whether certain tasks are carried out frequently and whether an emphasis on certain tasks differs between sectors. It was expected that emphasis on practical tasks would signify a preference for an 'entrepreneurial' model and an emphasis on social tasks would signify a preference for a 'professional' model. Later analysis will look at how these tasks relate to the training models and levels of keenness, indicated by the 'professional' and 'entrepreneurial' scores by staff on training.

Tables 41a to 41c group the tasks together into Practical tasks, Social tasks and Domestic tasks, giving a clearer picture of the regularity of duties done by care staff. Senior care assistants are omitted from the data since their duties may include a larger amount of administration and less practical care work. Percentages are based on the total number of care assistants in each sector.

Table 41a. Practical Tasks Undertaken by Care Staff

	L.A. (n = 97)	Private (n = 77)
PRACTICAL TASKS	(%)	(%)
Wash clothes/bed linen	96	87
Dress residents	97	93
Help with feeding/serve food/make drinks	97	100
Make/change beds	97	86
Toilet residents	98	93
Sluicing	94	66
Washing/bathing/putting residents to bed	96	91
Change dressings	56	54
Administer drugs	30	70
Paperwork	29	22
Average percentage	*79%*	*76%*

Practical tasks appear to have been carried out by the majority of staff in both sectors. Paperwork was a task least likely to be carried out by care assistants. The main difference between the two sectors relates to the administration of drugs where care staff in the private sector were over twice as likely to be involved as they were in the local authority homes.

41b. Social Tasks Undertaken by Care Staff

	L.A.	Private
SOCIAL TASKS	(%)	(%)
Read/write for residents	65	45
Encourage residents to do things for themselves	97	96
Take residents for walks	62	52
Play games with residents e.g. cards/bingo/music	62	47
Shop for residents	72	60
Dealing with visitors	69	78
Organise social events	69	78
Average Percentage	*72%*	*62%*

In relation to social tasks, the average individual percentage is higher in the local authority sector, whose staff appear to be more concerned with the residents' social life within the home. Concern with social life may reflect what Miller and Gwynne describe as a 'horticultural' model whereby residents are allowed to 'grow' rather than remain 'in storage' (3), and is perhaps a central feature of an approach that treats residents on a 'holistic' basis rather than focusing only on physical needs as and when they arise. It may be argued that the social work 'professional' model is more likely to encompass this approach in its training than a task-based competence model.

41c. Domestic Tasks Undertaken by Care Staff

	L.A.	Private
DOMESTIC TASKS	(%)	(%)
Preparing or Cooking Food	45	69
Cleaning/Polishing/ Dusting	63	66
Tidying up	97	92
Mending/Darning/Tagging	87	56
Washing/Drying up	86	92
Laying Tables/Clearing away	97	92
Average Percentage	*79%*	*78%*

Domestic tasks appear to be undertaken by all staff in both sectors, except for cooking which is a specialised job, and mending, a job usually assigned to the night staff. Of these tasks, cooking and preparation of food was significantly more likely to be undertaken by staff in the private sector, ($x^2 = 14.25$, $df=1$, $p>.001$), indicating that private homes are not always able to employ cooks and that staff are expected to help with kitchen tasks, often alongside the owner who would take this role on. As Imber also points out the term is ambiguous - preparing or cooking food covers a wide range of activities and some preparation of food will go on outside the normal hours of domestic staff, particularly in the case of an evening

meal/supper. (4) By contrast, mending was significantly more likely to be undertaken in the local authority sector, x2 = 19.63, df=1, p>.001, indicating that this task is not only assigned to night staff who were excluded from the analyses.

As indicated earlier, a real concern are the large numbers, particularly in the private sector, of staff who say they change dressings and administer drugs, two tasks which require nursing skills. Since, as later data on qualifications shows, the numbers of care staff with actual nursing qualifications is 5 in the local authority, and 11 in the private sector, there remains a considerable number of care staff who undertake these tasks without the appropriate training. Table 42 breaks down the numbers of care staff who say they administer drugs.

Table 43. Number of Staff who say they Administer Drugs

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Care Staff	32	32	54	43
Senior Staff	-	-	33	26
Other *	2	2	12	10
Do not administer drugs	65	66	26	21
Total	99	100	125	100

* Includes deputy matron, deputy officer-in-charge

An overall comparison between the sectors shows that a third of all local authority staff and 79% of all private sector

staff, including senior staff and deputy matrons say they administer drugs.

Staff were also asked to state whether they did any other routine jobs not included in the tasks list. The majority of tasks mentioned were practical rather than social and included such tasks as ironing, banking money and making hospital and GP appointments. Communication skills were also required since many staff mentioned taking messages and using the telephone.

2.d) *Reasons for Taking the Job*

It was expected, for reasons outlined in Chapter Two, that staff attitudes to training would relate to the reasons for which they undertake the job. Respondents were asked to state their reasons for doing the job. The responses were grouped into 'professional' responses that were altruistic in nature, such as a desire to work with the elderly and improving the residents' quality of life, and 'practical' responses which indicated reasons of convenience and practicality such as financial considerations and hours that suited. Table 43 breaks down the responses by sector.

Table 43. Reason for doing the job

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Professional	43	43	52	42	95	42
Practical	3	3	1	–	4	2
Combination	2	2	6	5	8	4
No reason given	51	52	66	53	117	52
Total	99	100	125	100	224	100

As is quite clear, the majority of staff who gave answers stated that their reason for doing the job was altruistic rather than practical, although these figures may be suspect given that staff may have felt that the answers given were the 'correct' ones. Moreover, over half of the staff did not reply, indicating either uncertainty or unwillingness to give a reason.

2.e) *Training and Qualifications of Care Staff*

As indicated in Chapter Two, data on training is sparse and inconsistent and very little is known about the training and qualifications that care staff have, particularly in the private sector. The importance of this information cannot be overestimated if an analysis of training needs is to be undertaken. Care staff were, therefore, asked to state whether or not they had received any health or social care training.

The term 'training' is open to interpretation. In the private sector a number of respondents said 'no', but further

investigation, involving checking each of the questionnaires, showed that several had in fact received in-house or college training in such areas as first aid and basic care. This training was not specified, but was probably practical in nature and varied according to the routine of the home. These responses were therefore placed under 'other training' and excluded from Table 44 which breaks down the numbers of staff who said they received social or health care training by age and sector, as a percentage of all staff in the sample.

Table 44. Care staff who have received Social or Health care 'Training', by Age and Sector

	Local Authority 'Training'				Private 'Training'			
	'some'		'none'		'some'		'none'	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Under 40	26	31	6	43	43	56	27	57
Over 40	59	69	8	57	34	44	20	43
Total	85	100	14	100	77	100	47	100

Overall, 72% (n=162) of staff said that they had received social or health care 'training'. The percentages of staff that have received 'training', are higher than those given by the officers-in-charge and home owners, but this survey was carried out almost a year later and the pressure on homes to get their staff trained appeared to be growing. The main difference between the sectors lies in the high proportion (38%) of private sector staff who have received no social or health care

'training'. The total percentage of staff who said they had received 'no training' in social or health care is much lower in the local authority sector (14%), and lower than was found in the first survey.

A comparison of 'trained' and 'untrained' staff by age revealed that those who had been trained were older on average than those who were not. Later analysis examines whether staff are more likely to receive training the longer they remain in post.

Table 45. Full and Part-time Staff who have received Social or Health Care 'Training', by Sector

	Local Authority				Private			
	f/time		p/time		f/time		p/time	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
'Trained'	64	82	21	100	45	59	32	67
'Untrained'	14	18	-	-	31	41	16	33
Total	78	100	21	100	76	100	48	100

In each sector full time staff were less likely to have received some 'training' than part-time staff. This difference is particularly marked in the local authority. The fact that all local authority part-time staff had received some 'training' may reflect availability of budget to pay them for training out of their usual working hours. The popularity of in-house training appears to be borne out in Table 46, where two-thirds of private sector staff say they have received in-house

training. Care staff were asked whether they had had In-house, social services, college or health service training at any time Table 46 is a breakdown of where staff said they had received 'training', as a percentage of all 'trained' staff. It should be noted that the figures are not exclusive since many staff had undertaken training in more than one place.

Table 46. Where 'Training' Took Place

	Local Authority (n=85)		Private (n=77)	
	(n)	(%)	(n)	(%)
In-House	46	54	52	67
Social Services	68	80	6	8
College	50	59	36	47
Health Service	23	27	20	26

A much higher proportion of local authority staff have undertaken social services training than have staff from the private sector. These figures reinforce the figures supplied by home owners who may find such training too costly and time-consuming, and be more inclined to in-house training which can be constructed to meet the requirements and regime of individual homes.

Closer examination of returns from staff who had attended college shows that 47% of local authority staff, had undertaken a ten-week Social Services approved course, 'Caring for Clients'. This includes ten members of staff who undertook this

training before their present employment. Many of the private sector staff who attended college (18%) had undertaken nurse or hospital based training and may have had their college training while in the health service. Thus the influence from employers appears to remain a factor in where staff undertake their training.

Staff who had received training were asked to state what that training had focused on. It was expected that local authority sector figures would be focus mainly on client needs, and that private sector figures would show an emphasis on practical skills.

Table 47. Focus of 'Training'

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Mainly Practical Skills	2	2	13	10
Mainly Client Needs	20	20	5	4
Mainly your role with other people	-	-	3	2
A Combination	60	61	56	46
Received no training	14	14	47	38
Missing	3	3	1	-
Total	99	100	125	100

As expected, where staff were able to state a clear focus, that focus was client centred for local authority staff, practical skills for staff in the private sector. However, the figures for a combination of types of training are high in both sectors, indicating that elements of both 'professional' and 'entrepreneurial' models of training are considered to be of importance in both sectors.

The problem of financial considerations, stated earlier by the employers, is highlighted in Table 48 where training costs appear to fall primarily to the local authority and the home owners. However, local authorities have, to date, budgeted for training, but individual home owners now have to finance training from their income, following the removal of a short-lived allowance from the Manpower Services Commission for this purpose.

Table 48. Who Paid for Your 'Training'?

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Social Services	71	72	2	2
Home Owner	-	-	47	38
Myself	1	1	3	2
Combination	1	1	9	7
Government (YTS)	1	1	10	8
Education authority	1	1	8	7
Health authority	7	7	8	7
Not applicable	16	16	35	29
Total	99	100	122	100

As would be expected the majority of local authority staff had their training paid for by social services, although some had come to the sector from the health authority. The picture is more diverse in the private sector where 14% had received training by way of a YTS scheme or a local education authority grant. Two senior staff had previously worked for the local authority.

Care staff were then asked to state what qualifications they held as a result of training received, from a given list of recognised courses in health and social care. Table 49 groups the qualifications into Social work (CSS, CQSW), Social Care (City and Guilds 325 series, City and Guilds 356 series, Family and Community Care, BTEC in social care, PCSC, In-Service Certificate in Social Care, and Caring for Clients); Nursing (SRN, SEN, RMN); NVQ levels 2 and 3 in Direct and Social Care and Other (First Aid and Health and Hygiene certificates where these were the only qualifications). The data was intended to be compared with the qualifications held by Officers-in-charge and Home owners. As will be apparent from the earlier discussion of statistics on training in Chapter Two, this set of data on the actual qualifications held by staff in English residential homes is unique and therefore of considerable interest.

Table 49. Qualifications held by All Care Staff by Sector

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Social Work	2	2	2	2
Social Care	55	56	24	19
Nursing	5	5	11	9
NVQ	-	-	7	5
Other	3	3	5	4
No qualification	34	34	76	61
Total	99	100	125	100

Local authority care staff who held a qualification had, in the main, completed a 10 or 13 week 'Caring for Clients' course at a further education college, which is a basic induction course, aimed at care assistants working in all residential areas and home helps. It was used as a basis for the In-Service Certificate in Social Care, which in turn could lead to acceptance on to a CSS or CQSW course. A comparison of the qualifications held by officers-in-charge and home owners (Table 25) and the qualifications of their staff in the first survey (Tables 16 to 18) shows a similar trend in that staff in the local authority were more likely than those in the private sector to have caring qualifications, whereas the reverse was true for nursing ones.

Care staff holding NVQ qualifications appear only in the private sector, and this may have policy implications for future

training whereby pressure is being placed upon home owners by inspection units to provide training for their staff. As I have pointed out in Chapter Two, the new climate of 'enterprise' lends support to the task-based model within the workplace that NVQ represents. This model is also likely to appeal to the more business-minded home owners who, as stated earlier can train their staff on an in-house basis and at a pace more suited to their establishment.

3. SUMMARY

The descriptive data in this chapter set out to examine differences between care staff in local authority and private sector homes in their ages, part and full-time employment, length of time in post, tasks undertaken, previous occupations, previous employers, the nature, location and sender of the training received and qualifications held. The response rate was satisfactory for a postal survey but reasons for non-response may have included staff being unable to complete the questionnaires due to sick leave, holidays and not being given the time at work to do so.

The survey revealed a large part-time workforce in both sectors, but proportionately higher in the local authority homes. Staff in the private sector were, in general, younger, with less work experience than their local authority counterparts. Local authority staff tended to be older with many more years of experience in one establishment. Private staff were less likely to have come from the local authority and this

implies that private homes are not able to rely on the local authority or health sectors for training their staff. A high percentage of training, particularly in the private sector, takes place on an in-house basis.

The numbers of staff who said they had received training was high in both sectors, but the survey revealed that a higher proportion of private than local authority sector staff had no health or social care training. Similarly, whereas all local authority part-time staff had received some training, this was true of only 67% of the private sector part-time staff, a fact which may reflect a difference in budgeting arrangements between the two sectors. Differences between the sectors were reflected in the source of training - a high proportion of local authority staff had received social services training in total contrast to the very few who had from the private sector - and in the means of finance with home owners financing a sizeable proportion of the training in the private sector. There were differences also in qualifications. In the private sector, twice as many as in the local authority had no qualifications. Local authority staff were more likely to hold a caring qualification whereas the private sector staff were more likely to hold nursing ones.

In contrast to these differences in training and qualifications, there were considerable similarities between the sectors in the tasks which care assistants apparently undertook. There was a slight tendency for local authority staff to carry out more 'social' tasks with residents, but practical tasks were carried out by the majority of staff in both sectors. It was of

concern that a large proportion of staff, particularly in the private sector said they administered drugs, and in this respect there was a significant difference between the sectors.

The picture then is one of two staff groups with similar tasks but very different training and qualifications. Some of the tasks they undertake (for example, changing dressings and administering drugs) call for technical expertise, and all of them require understanding for a highly dependent clientele. If the necessary understanding and expertise is to be imparted, this will require training and the training gap is probably particularly large in the private sector. Given the problems of funding care in this sector and the attitudes of home owners, the most plausible candidate for meeting this gap involves NVQ. We need to look next at whether this is the type of training that care staff want.

CHAPTER SIX: WHAT ARE THE VIEWS OF CARE STAFF ON TRAINING?

The previous chapter documented background factors that are likely to influence staff keenness on training. This chapter sets out to examine these factors as they may affect basic attitudes to training and levels of keenness on the 'professional' and 'entrepreneurial' areas in both sectors. As with the heads of homes, we need to know how important care staff feel training to be and why and whether their attitudes are associated with those of their head of home. We need to know in what ways training can help staff as they perceive it and which specific areas of training they considered to be important. The analysis will use a variety of statistical methods and be supported by the qualitative data. This chapter links the first two surveys in determining whether the attitudes of heads of homes influence staff attitudes to training.

1. The Basic Attitudes of Care Staff to Training

Importance of training

The first step in determining the level of keenness by care staff on training was to ask them how important they felt training to be. Questions were asked on the importance of training, where training should take place, and by whom should training be given and were cross tabulated with whether staff were full-time or part-time, previous occupations, age, and

length of time in post. Table 50 is a breakdown by all staff, 'trained' or not, as to whether they felt training to be Very Important, Important, Not Very Important or Not Important at all.

Table 50. How Important is Training?

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Very Important	67	68	92	74
Important	26	26	31	25
Not Very Important	3	3	2	2
Not Important at all	3	3	-	-
Total	99	100	125	100

Analysis of Tables 51 and 52 reveals an interesting relationship between keenness on training and experience of it. In the local authority sector, ten out of the fourteen staff (71%) who had not been trained but less than a quarter of the others, judged that training was less than 'very important'. The same association was apparent in the private sector but was much less apparent, 30 out of the 47 who were not trained in this sector nevertheless judged training to be 'very important'. So those in the private sector have a keenness for training which has not been satisfied.

Table 51. Attitudes to Training by Local Authority Care Staff with 'Some Training' or No Training

	'Some Training'		No Training	
Attitude to Training:	(n)	(%)	(n)	(%)
Very Important	63	75	4	29
Important	18	21	8	57
Not Very Important	2	2	1	7
Not Important At All	2	2	1	7

Table 52. Attitudes to Training by Private Care Staff with 'Some Training' or No Training

	'Some Training'		No Training	
Attitude to Training:	(n)	(%)	(n)	(%)
Very Important	61	79	30	64
Important	15	20	16	34
Not Very Important	1	1	1	2
Not Important At All	-	-	-	-

Since the numbers of part time staff may be of significance, a comparison, shown in Table 53, was made on the importance given to training by full and part-time staff. This showed that part-time staff are marginally less keen on training than full-

time staff but the differences are not significant when tested by chi square.

Table 53. Comparison of Full and Part-time staff on the Importance of Training

	Full Time		Part time	
	(n)	(%)	(n)	(%)
Very Important	54	77	105	68
Other	16	23	49	32
Total	70	100	154	100

Full time staff are keener (just) on training than part-time staff. Thus there is weak support for the hypothesis. A rather more sensitive test which treated 'Importance given to Training' as a variable with four values, did show a significant difference between full and part-time staff in the predicted direction, although the difference was small (see Table 54).

Table 54. One-Way Analysis of Variance on Importance of Training by Full and Part-time Staff

Staff	(n)	Mean
Full time	70	1.23
Part-time	154	1.39
Total	224	1.34

Analysis of Variance F = 3.60, df = 1,222, p<.05 (one-tailed)

Given that full-time staff were only marginally keener than part-time staff on training, it was important to see whether length of time in post, might be a factor in influencing keenness towards training, but initial analysis in Table 55 did not bear this out. Later analysis looks at length of time in post and keenness on specific training areas.

Table 55. Length of time in post by Response on Importance of Training. (all Staff)

	Under 12 months		1 - 5 years		Over 5 years		Total	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Very Important	25	66	84	77	50	65	159	71
Other response	13	34	25	23	27	35	65	29
Total	38	100	109	100	77	100	224	100

Further Training

Care staff were then asked to state what further training, if any, they felt would be of benefit to them. The responses were grouped into three main categories, Social work/social care related training - where staff mentioned ,training that related directly to the care of residents; Practical training - where staff wanted training in areas such as lifting and handling, fire prevention, first aid, food hygiene and management skills, and Nursing and Health related training - where staff mentioned use of drugs and medication, care of the dying and physical and mental disorders. Care of the dying/terminally ill was placed in

this category since skills such as relieving pain and pressure sores may play a considerable part in the work staff do. The 'validity' check by a panel of 'judges', mentioned in Chapter Four appeared to support this view, whereby the outcome was 15:7 in favour of placing this area of training into the 'entrepreneurial' list.

In line with the A Priori lists used in the first survey, these categories were designated as 'professional' (social work/social care and CQSW and CSS courses) and 'entrepreneurial' (practical and health related training and NVQ courses) models of care. The category of Non-specific included staff who said 'any' training.

Table 56. Preferences for Further Training.

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Professional	14	14	7	6
Entrepreneurial	26	26	35	28
Combination	5	5	-	-
Non-specific	9	9	6	5
None/no response	45	46	77	61
Total	99	100	125	100

As can be seen from Table 56, staff in the private sector were significantly less likely to want further training than local authority staff ($x2 = 5.81$, $df = 1$, $p < .01$). Among those who wanted further training, staff in the private sector were

more likely than local authority staff to want 'entrepreneurial' training ($x2 = 6.49$, $df = 1$, $p < .01$).

The large percentage of staff in both sectors who felt that further training was not needed may be due to a belief on the part of some staff that any 'training' they had received was enough. Indeed, there is perhaps an '*anti*-professional' attitude among some staff who feel that 'professional' training is not necessary in relation to the realities of their jobs. These staff may tend to be of the opinion that to be a good carer, innate personal qualities are more important than learnt skills, a view summed up by one respondent who stated,

> "I think the training I've had is quite sufficient for the job that I do, even though I think that a lot of what you do is based on common sense anyway."

It is possible that those staff who said that they had received 'no training', felt that they could not answer the section on further training. Table 57 looks at the relationship between staff who have received 'some training' or not and whether these staff wanted further training or not.

Table 57. Relationship between 'Trained' and 'Untrained' Staff and Further Training (Base percentage - All staff = 222 *)

	Want Further Training		Do not want Further Training/ No response	
	(n)	(%)	(n)	(%)
'Trained'	92	91	71	59
'Untrained'	9	9	50	41
Total	101	100	121	100

* 2 cases missing

The relationship between 'untrained' staff and not wanting further training is highly significant ($x^2 = 29.64$, $df = 2$, $p<.001$). 33% of the staff in the local authority sector, and 28% of those in the private sector who gave no response or said 'none' to further training were night staff, whose roles are limited in comparison to day staff. These staff made up only 25% of the sample as a whole and there appears to be a feeling among some of them that much of the training offered is of little relevance to them or that they would have little opportunity to utilise it. As one night worker commented,

> "I have said that I have done First Aid and Food care. What other things is (sic) there for night staff?"

Similarly, one night worker who wanted no further training commented,

"You train as you go along.....I think if the manager is a trained nurse that is sufficient to train as a care assistant."

Table 58 looks at the relationship between night staff and other staff and whether they want further training or not.

Table 58. Relationship between Night staff and Further Training (Base Percentage - All staff = 223)

	Want Further Training		Other Response	
	(n)	(%)	(n)	(%)
Night Staff	25	25	36	30
Other staff	77	75	85	70
Total	102	100	121	100

* 1 case missing

$x2 = 0.84$, $df = 1$, $p > .50$

The chi square test was not significant on the difference between night staff and other staff in regard to further training.

Despite the differences between sectors, where staff gave a positive response to further training, the responses most frequently given were those relating to dealing with aggressive and violent residents, and health related skills such as First Aid, basic nurse training and use of drugs. Four members of staff from each sector felt that more knowledge of drugs and medication was necessary, but perhaps because they are left to

cope with residents who may refuse medication or ask questions they cannot answer, as suggested by one respondent who states,

> 'To learn more about drugs, side effects etc. As officers give out medication/drugs, (the) care assistant may know some drugs but not all."

Following the question of how important staff felt training to be, an open ended question asked staff to say why they felt training was important or not. Two quotations from the local authority sector exemplify the view that training can enhance 'professional' standards, whereby,

> "The training does not make you a better carer but it can enhance the knowledge that you already have and give you a better understanding."

and,

> "Caring is a profession, we need to be trained to a professional standard to meet our clients' needs."

Other 'professional' responses underpin a view of the importance of training being a combination of knowledge and natural ability, for example,

> "(Training should be) a combination of learning through observation and practice as well as natural aptitude."

The majority of 'professional' responses referred to training as being necessary for the well-being of residents, for example,

> "Training of staff can only be of benefit to the clients they are working with, by giving them a better understanding of their needs."

'Entrepreneurial' responses included those in which staff referred to the nature of the job and the need to be in control and able to do the job 'properly'. Responses included,

"To know what you are doing and doing it properly";

"There are right ways to do everything, lifting, bathing etc, this is beneficial to the residents."

"It shows what you can and can't do."

"Because you need to notice things like bed sores etc."

"Make sure you carry out you job safely and properly."

and, more pragmatically,

"Because we are being paid to look after people."

These responses do not preclude a caring 'professional' attitude but reinforce a view that for some staff training is a means to supplementing their basic caring approach with practical skills. Some respondents gave a combination of the two models, whereby the quality and efficiency were of equal importance, for example,

"To ensure the best care for residents and smooth running of the home."

and,

"To improve standards of care and to ensure all staff do equal work."

indicating a recognition by staff that teamwork is also important in their work with the elderly. More difficult to categorise were the responses which were vague or ambiguous or

apparently not in favour of training. One example of staff viewing training as unnecessary was one local authority care assistant who rated the importance of training as Not Important at all, commenting,

> "I've been doing this job for six years without training. Just common sense."

Overall, the responses generated a paradox for they appeared to demonstrate a higher commitment to a 'professional' model of care among staff in the private sector than is indicated in the responses on further training, which implied a preference for an 'entrepreneurial' approach to training. Responses (Table 59) were classified into 'professional' and 'entrepreneurial' views, that is, an emphasis on knowledge and improving the quality of care, or an emphasis on getting the job done and on health and safety, or a combination of the two. Responses which tended to be negative or could not be categorised as 'professional' or 'entrepreneurial' were given the label of 'neither'.

Table 59 Staff Views on why Training is Important or not.

Response	Local Authority		Private	
	(n)	(%)	(n)	(%)
Professional	41	41	50	40
Entrepreneurial	21	21	25	20
Combination	8	8	18	14
Neither	7	7	1	1
No response	22	22	31	25
Total	99	100	125	100

A clear majority of the respondents were positive in their views on the importance of training and most viewed training as providing a 'professional' or combination approach to care. A higher percentage of combination responses in the private sector may indicate an increased awareness that both approaches to training are of value, whereas local authority staff are perhaps encouraged to concentrate more on social work based values.

This emphasis on the need to integrate practical skills with a professional approach may explain the apparent paradox that although private sector staff were more likely than local authority ones to want training on practical topics, they were equally likely to emphasise 'professional' reasons for being trained. There may in effect be no paradox. Private sector staff want practical training (for example in lifting). However, they want to be able to combine these practical tasks with an understanding of their client's needs, and in a way that enhances their own sense of professional competence.

Location of training

As in the first survey, care staff were also asked to say where training should take place and by whom it should be provided.

Table 60. Where should Training Take Place?

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
In-House	20	20	38	30	58	26
At College	7	7	3	2	10	4
Combination	72	73	84	68	156	70
Total	99	100	125	100	224	100

Table 60 shows a preference for in-house training by the private sector staff over the local authority, similar to that shown by home owners (Table 28). The preference is highly significant ($x2 = 18.77$, $df = 2$, $p<.001$).

In-house training may be given as a preference due to the limited access to external training by the private sector. However, it may also reflect a more situation-specific, less professional approach in the private sector, as suggested in Chapter Two. As shown in Table 61, part-time staff are significantly more likely to prefer in-house training than are full-time staff ($x2 = 15.1$, $df = 2$, $p< .001$).

Table 61. Relationship between Full and Part-time Staff and Where Training should take place

	Full time staff		Part time staff	
	(n)	(%)	(n)	(%)
In-house	13	18	45	29
College	2	3	8	5
Combination	55	79	101	66
Total	70	100	154	100

As with the officers-in-charge and home owners, a combination of on-the-job and off-the-job training is strongly favoured by both sectors, although college training by itself is not. This may indicate that while in-house training is important to staff, a combination approach, possibly with accreditation through NVQ is, in their eyes, the most beneficial.

As with the employers' sample, staff in the private sector were more likely than those in the local authority one to favour in-house training on its own. Table 62 shows the preferences in the different sectors for in-house (establishment) training, social services or education service training, or a combination.

Table 62. Who do you feel should Provide the Training?

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Establishment	7	7	24	19	31	14
Social Services	32	32	6	5	38	17
Education service	1	1	1	1	2	1
Combination	59	60	93	75	152	68
Total	99	100	124	100	223	100 *

* No of missing cases - 1

As can be seen, local authority staff preferred social services over management training and the education service. Only 19% of private sector staff stated a preference for establishment involvement on its own but they were considerable keener on this than on the use of social services and education on their own. As with the location in which training takes place, the preferences as to who should train are very much towards a combination approach. Those staff that indicated a preference for a combination of agencies were then asked to state which combination was the most appropriate.

Table 63 shows a large preference for establishments being involved in the training. From a total sample figure of 224 staff, 62% of staff from both sectors include the establishment in their choice of combination. The percentage is larger in the private sector (69%) than in the local authority sector (54%). The preference for establishments may also reflect a feeling by staff that training should be relevant to the requirements of individual homes and that officers-in-charge and home owners can or should influence such training.

Table 63. What Combination do you feel is the Most Appropriate? (From all staff who preferred a combination (n = 152)

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Establishment/Social services	29	49	34	37
Establishment/ Education service	1	2	17	18
Establishment/Social services/Education	24	41	35	38
Social Services/ Education service	5	8	4	4
None of these	–	–	3	3
Total	59	100	93	100

Practical Difficulties

This preference for establishments may also be linked to practical difficulties that home owners and officers-in-charge in the first survey reported, and care staff were also asked to state what in their view were the main problems associated with day release training. Table 64 is a breakdown of the responses to a given list. Where respondents gave more than one response, 'combination' was used.

Table 64. Practical Difficulties Associated with Day Release Training.

	Local Authority		Private		Total	
	(n)	(%)	(n)	(%)	(n)	(%)
Transport	16	16	8	6	24	10
Family commitments	11	11	18	14	29	13
Cost	4	4	11	9	15	7
Relief cover	22	22	9	7	31	14
Combination	25	26	44	36	69	31
None	21	21	35	28	56	25
Total	99	100	125	100	224	100

The fact that the largest percentages were for a combination indicates that staff were not able to pinpoint one factor but that several factors were problematic, thus reflecting lower figures for specific problems than might otherwise have been the case. Transport is a problem for many staff, especially in rural areas where many of the homes surveyed are in areas not well served by public transport. Care staff also tend to find employment close to home, particularly because of shift work hours, but colleges in Humberside are in towns such as Grimsby, Scunthorpe, Hull, Bridlington, Driffield and Beverley, and the social services training unit was at the time of the surveys, situated in Hessle, a suburb of Hull, thus making travel to colleges and other training establishments time-consuming and

costly. This may also be a reason why the involvement of establishments in training, tends to indicate a preference for in-house training by a number of staff and employers. Relief cover was a particular problem to local authority staff. However, approximately a quarter of staff in both sectors either gave no response or said that the problems listed were not applicable to them. These responses were postcoded as 'none'.

2. How Does Training Help?

Care staff who had received training were asked to say whether they felt that their training had been relevant and/or useful to the job they were doing at their establishment. The data in Table 65 here includes those staff that said 'no' to social care or health care training, but in fact had received in-house or college training which had not been specified. Thus the overall numbers are higher than those in Table 44. Further views were sought in questions 29 and 30, which asked staff to give personal views on any other ways in which training had or had not helped them in their job.

Table 65. Do you feel that your Training, if any, has been Relevant and /or Useful to the job that you do in your Establishment?

	Local Authority		Private	
	(n)	(%)	(n)	(%)
Useful/Relevant	75	75	96	79
Not useful/relevant	4	4	2	2
Not sure	5	5	1	1
Not applicable	14	14	22	18
Total	98	100	121	100

Although the outcome is perhaps to be expected, there is a very small percentage who felt that their training was not useful or relevant or were not sure. The reasons for this are dealt with later in terms of negative responses to question 30 on ways in which training had not helped them. Question 28 of the questionnaire asked staff to say in what ways training had helped them, from a list of statements associated with the benefits of training. Table 66 gives the responses where staff replied that it had. The statements are placed into the categories of 'professional' and 'entrepreneurial' (indicated by P and E in brackets). Average percentages were calculated for the total of the 'professional' and 'entrepreneurial' categories.

Table 66. Positive Responses to ways in which Training has Helped Staff

	L.A. (n=84) (%)	Private (n=77) (%)
See Clients Differently (P)	73	67
Become more self-aware (P)	77	74
Lift and handle clients (E)	79	77
Deal/other professionals (P)	49	60
Understand clients' problems(P)	79	80
Become more assertive (P)	69	67
Help clients with aids/ appliances (E)	79	75
Work in a team (P)	77	78
Understand more about clients' families (P)	59	58
Develop high standards (P)	73	75
Improve record keeping (E)	48	51
Take more responsibility (P)	64	67
Communicate with clients (P)	80	77
Develop confidence (P)	75	77
Work with terminally ill (E)	60	57
Develop good working relationships (P)	75	76

The average percentages for the 'professional' category are identical for both sectors, with both sectors achieving 71% by

staff who felt that training had helped with the 'professional' areas of care, and similar for the 'entrepreneurial' category in that the local authority sector achieved 66%, and the private sector achieved 65%. This suggests that staff found both models of training to be of use within their establishments. It also reinforces the suggestion made earlier that although staff in the private sector may want training that focuses on practical issues, they want it to do this in such a way that they will gain in understanding as well as in practical skills.

The overall written responses to the questions on other ways in which training had helped in the job and whether there were any aspects of training that had not helped in the job, was low, 25% from both sectors. This may be because staff could not think of anything to add, or had too little time to spend on the questionnaire. However the responses to question 29 on what other ways training had helped staff follow a similar pattern to those in Table 66, in that staff gave predominantly 'professional' responses' that related to interaction with the resident, for example,

> "To listen and learn from the resident...all deserve fair and equal choices...it's their home not yours."

> "(Training) made me feel more caring and thoughtful of residents...also made me very interested in their problems."

> "Training has given me more awareness of clients' needs."

Many of the responses from the local authority sector were more in-depth and one member of staff, critical of some established practices, comments,

> "It (training) makes clear that some basic background training should be given to all care staff, not in-house-on-job, as having done (the) Caring for Clients (course), it is obvious that negative attitudes are passed on to new staff by older established members."

A number of respondents, however, may have been critical of courses, not because they had built up practices that certain courses maintain are less than good, but because they did not want what the courses offered. The key points to emerge from these respondents were that many courses were repetitious or were not tailored to the needs of individual homes and that certain parts of the courses were irrelevant. One argued, for example, that,

> "Many courses repetitious. More information could be put at our disposal with more thought for job description, i.e.....more individuality! (sic)"

Others felt that the child care sections in the City and Guilds 325-1 course and on the In-service course in social care, were not of relevance.

Some staff appear to feel that certain courses are a waste of time and that 'common sense' or 'experience' is all that residential staff need. Two respondents, for example, had attended a Caring for Clients course. One commented,

> "Caring for clients all common sense. Things I already know. Nothing really new."

and the other wrote,

> "Caring for clients, I found boring. We could have told them some things."

These reactions may have been as much to do with the quality of teaching as with the content of the course, although the course had been running for some years and was rather 'set' in terms of the nature of the input. However, they highlight a problem that arises when care staff are sent on courses, often unwillingly, which they see as irrelevant and time wasting. A further criticism of established training courses is also tied up with the 'common sense' view, whereby courses are not 'practical' enough, with emphasis being placed on discussion/workshops etc. One respondent made the point that as far as she was concerned,

> "A lot of time is wasted by meetings, i.e. most answers at these meetings are irrelevant and not practical with our residents, thus time and money wasted."

These comments are also related to the basic dilemma of whether a good member of staff is first and foremost a good person, and whether 'professional values' can be 'taught' or are essentially the property of good people. Thus some members of staff may feel that training is irrelevant since they regard 'common sense', 'experience' and an ability to care are of greater importance than the content of standardised courses.

However, the general impression given is encouraging in relation to staff views on training. The next step was to look at staff views on the importance of specific training areas and compare these views with those of the home owners and officers-

in-charge, again with the research hypothesis in mind that differences occur between the local authority and private sector.

3. Which Specific Areas of Training are seen as Important and by Whom?

The personal views of staff suggests that most are keen on training. Which areas, however, do they see as most important and how do their views compare in this respect to those of their employers? The ratings of individual training areas were used to give 'Professional' and 'Entrepreneurial' scores reflecting keenness on different areas of training. The scoring was done on exactly the same basis as had been used in the survey of heads of home. The results from the two surveys could therefore be compared.

The most unpopular training areas (those which scored above 2.00, on average in either sector) in the private sector and apart from human biology, were those areas classified as 'Professional'. AIDS/HIV awareness is not included in the following Tables as it was quite popular with local authority staff and OIC's. However private sector scores were 1.85 for staff and 2.18 for owners (a fact which may reflect the very low prevalence of HIV/AIDS in residents). The scores from employers were very similar to those of the staff, with private owners in particular expressing similar views on areas of training to those of private sector staff. The only apparent difference was

in the local authority sector where heads of homes were noticeably keener on admission procedures and care plans than their staff, the reverse being true for basic sociology and basic psychology. Table 67 gives a breakdown of the least popular scores in both sectors. A full list of the mean scores is in Appendix XII.

Table 67. Least Popular Training Areas, by Sector, by Mean Score

Training Area	Local Authority		Private	
	Staff	OIC's	Staff	Owners
Admission Procedures	1.96	1.40	1.96	1.73
Assertion techniques	1.83	1.89	1.97	2.00
Basic Sociology	1.76	2.33	2.05	2.14
Basic Psychology	1.66	2.00	1.92	1.82
Assessments	1.70	1.67	1.88	1.95
Human Biology	1.88	2.78	2.06	2.45
Care Plans	1.69	1.33	1.83	1.73
Roles/health service	1.84	2.44	2.18	2.68
Legal Aspects of care	1.76	2.11	1.92	2.04
Roles of other professionals	1.79	2.33	2.08	2.73
Reminiscence therapy	1.81	1.78	1.88	2.05
Reality Orientation	1.72	1.56	1.96	2.00
Report writing	1.67	1.90	1.77	1.77
Sexuality and old age	1.73	1.89	1.95	1.86
Study skills	1.97	2.00	2.11	2.23

The most popular training areas, that is, those with the lowest mean scores in both sectors, are in Table 68.

Table 68. Most Popular Training Areas, by Sector, by Mean Scores

	Local Authority		Private	
	Staff	OIC's	Staff	Owners
Dignity/respect	1.08	1.11	1.15	1.09
Fire Prevention	1.09	1.11	1.10	1.00
Communicating/elderly	1.12	1.11	1.12	1.13
Care of the Dying	1.13	1.30	1.14	1.18
Health and Safety	1.15	1.30	1.14	1.18
Falls	1.16	1.56	1.15	1.09
Lifting and Handling	1.19	1.00	1.18	1.23
Dementia	1.21	1.22	1.26	1.27
Attitudes to ageing	1.24	1.11	1.28	1.18
Confidentiality	1.24	1.11	1.25	1.27
Loss and bereavement	1.25	1.60	1.28	1.36
Emergency First Aid	1.25	2.00	1.17	1.22

Training areas which were more popular in the local authority sector than in the private sector included Teamwork, Coping with Aggression, Communication skills, Coping with Stress, Impact of Moving, Self-awareness, Working with the blind and deaf, Toileting and mobility aids. Training areas that were more popular in the private sector than in the local authority area included Emergency First Aid, Hygiene Practice, and Use of Common Drugs.

The remaining training areas scored just above the overall mean for staff, indicating a slightly below average keenness.

These were Nutritional needs, Feeding, Physical handicaps and Basic nursing skills ('Entrepreneurial') and Group living, Dealing with relatives and General Counselling ('Professional').

Staff in both sectors showed a high level, that is scoring below a mean of 1.50, of keenness on a quarter of all the training areas. Comparisons with the mean scores of employers show a general agreement with their staff on the importance of certain training areas, but OIC's were far less enthusiastic than their staff about those areas that require specialist skills such as Use of common drugs and Emergency First Aid, indicating perhaps that these skills are seen as the domain of nursing staff. Teamwork, Attitudes to ageing, Lifting and Handling, Confidentiality and Bathing were given greater preference by employers than their staff, suggesting perhaps that employers see these attributes and skills as being at the 'front line' of care and primary tasks in the care of the elderly.

Preferences by the local authority staff show an almost equal split between 'professional' and 'entrepreneurial' areas, indicating again a need for both types of training, which is summed up by one member of staff who states,

> "Attitudes, understanding, awareness, kindness, lifting and handling, are all necessary for this type of work."

Certain areas were mentioned in writing by care staff on several occasions, in particular dementia, which care staff felt they needed more information on and training in, as well coping with aggression and violence, bereavement and teamwork. Although

Admissions procedure appears to be unpopular as a topic for training, one member of staff felt that knowing more about residents, prior to their move into residential care would help them to

"Understand the trauma clients feel on admission".

Training was seen as a means to improve skills and have more understanding of specific problems, particularly in the use of drugs, as indicated earlier, since,

"Skills are required that are not obtainable through any other means."

and,

"There are right ways to do everything, lifting, bathing etc., this is beneficial to the resident."

Some staff were more concerned with the health needs of residents, and several were concerned about the need to learn basic nursing skills. Specifically, one member of staff pointed out,

"I am assuming that common ailments found in the elderly, e.g. diabetes, bowel management, poor circulation, ulcers, fluid retention, breathlessness due to various causes, are explained and understood under several care of the elderly courses. If not, I think that education in this area is imperative to make accurate continual assessment and gain optimum health for the residents."

Safety was also important in that,

"(It would) minimise the risk of injury to staff or residents."

4. Keenness on 'Professional' and 'Entrepreneurial' Areas of Training: Staff and Heads of Homes

Analysis of the scores for particular areas of training may obscure the key question of whether care staff are more or less keen on training than their heads of home, and whether any differences are more apparent in the 'professional' or 'entrepreneurial' areas of care. As in the first survey, four training areas from the original list in the questionnaire, were omitted from the analysis concerned with this question; mental illness and mental handicap, basic sociology and basic psychology, as these were considered to be too specialist in nature and tended to attract high scores, that is, they were not considered important or relevant, and tended to skew the data. Mean scores were calculated for each of the remaining 49 training areas for both staff and heads of home.

The overall population mean for all training variables by all home owners and OIC's from the first survey was 1.55 with a range of 1.05 to 2.54, indicating a high level of keenness on training, that is just above the half-way point between Very Important and Important. Table 69 gives a breakdown of the mean scores for all home owners and OIC's, the second survey home owners and OIC's and the second survey care staff, on all grouped 'professional' and 'entrepreneurial' training areas. Ten members of staff were treated as 'missing' due to not having completed the list.

Table 69. Mean Scores for All Training Areas

	All OIC's/ Owners	Sample OIC's/ Owners			Care Staff		
	Total	L.A.	P.	Tot.	L.A.	P.	Tot.
All (n=49)	1.55	1.57	1.60	1.59	1.43	1.51	1.47
Professional (n=28)	1.63	1.56	1.73	1.65	1.49	1.68	1.58
Entrepreneurial (n=21)	1.45	1.56	1.44	1.50	1.38	1.41	1.39

Table 69 shows that the mean scores for the sample of OIC's and home owners in the second survey are similar in respect of their scores to those of all employers in the first survey. It also suggests that care staff in both sectors are keener than their heads of home (a difference which is not significant). A one-way analysis of variance (see Table 70), showed local authority care staff to be keener on the 'professional' training areas than private sector care staff but that both sectors have similar preferences for the 'entrepreneurial' training areas.

Table 70. One-way Analysis of Variance on Keenness by Staff on 'Professional' and 'Entrepreneurial' Training areas, by Sector

a) Dependent Variable: Professional score

By level of: Sector

	n	Mean
Local Authority	95	41.78
Private	113	45.83

F = 3.66, df = 1,206, p = .0572

b) Dependent Variable: Entrepreneurial score

By level of Sector

	n	Mean
Local Authority	95	28.18
Private	113	29.02

F = .4904, df = 1,206, p = .4845

5. What Background Factors are Related to Keenness on 'Professional' and 'Entrepreneurial' Areas of Training?

The next step was to look at what factors influence the 'professional' and 'entrepreneurial' scores, in particular whether there is a relationship between sector and these scores and if so whether factors such as the length of time in post, full or part-time status, the tasks carried out by care staff,

previous occupation, previous employment, and age explains this association.

In Chapter Two, it was suggested that a desire for training may be linked to the notion of 'career' and earlier in this chapter, that length of time in post may relate to keenness on training. An analysis of variance, shown in Table 71 a) and b), showed a significant main effect of time in post on 'professional' scores. The relationship between time in post and the 'Entrepreneurial' scores was in the same direction but not significant.

Table 71. One-way Analysis of Variance on Length of Time in Post and Keenness on 'Professional' and 'Entrepreneurial' Training Areas

a) Dependent Variable: Professional score

By levels of: Time in Post

	n	Mean
Under 12 months	33	31.42
1 to 5 years	101	28.44
5 years +	74	27.66

F = 3.77, df = 2, 205, p =.02

b) Dependent Variable: Entrepreneurial Score

By Levels of: Time in Post

	n	Mean
Under 12 months	33	49.82
1 to 5 years	102	44.14
5 years +	73	41.12

F = 2.27, df = 2, 205, p = .1062

It seems likely therefore, that staff who remain longer in post are likely to have a preference for 'professional' training. A two-way analysis of variance was carried out to see if sector explained the effect of length of time in post. The outcome is given in Tables 72 a) and b).

Table 72. Analysis of Variance on Length of Time in Post and Sector, and Keenness on 'Professional' and 'Entrepreneurial' Training Areas.

a) Dependent Variable: Professional Score

	L.A.		Private	
	n	Mean	n	Mean
Under 12 months	8	50.50	25	49.60
1 to 5 years	37	41.70	65	45.52
5 years +	50	40.44	23	42.61

Time in post: F = 3.74, df = 2, p = .025

Sector: F = 1.35, df = 1, p = .246

b) Dependent Variable: Entrepreneurial Score

	L.A.		Private	
	n	Mean	n	Mean
Under 12 months	8	33.13	25	30.88
1 to 5 years	36	27.75	65	28.82
5 years +	51	27.71	23	27.57

Time in post: F = 2.24, df = 2, p = .109

Sector: F = .024, df = 1, p = .878

Earlier (Table 69) it was shown that local authority staff were keener on the 'professional' training areas suggesting that sector have significant input on attitudes to training. However, when length of time in post is taken into account the significance disappears. Table 72 implies that the longer staff remain in post the keener they are on training, particularly 'professional' training. Time in post appears to be more important than sector in its impact on attitudes to training.

Similar analyses were carried out to look for the relationship between previous occupation, previous employment, and age on the one hand and attitudes to training on the other. These analyses produced no significant results.

Analysis, in Table 73 a) and b), of full and part-time staff and keenness on training, by sector, suggests that full-time staff are keener on 'professional' training than part-time staff and that after allowing for this local authority staff are keener than private sector staff.

Table 73. Analysis of Variance on Full and Part-time Staff, and Sector, and Keenness on 'Professional' and 'Entrepreneurial' Training Areas

a) Dependent variable: Professional Score

By levels of: Full and Part time

Sector

	L.A.		Private	
	n	Mean	n	Mean
Full time	22	36.18	42	43.88
Part time	73	43.47	71	46.99

Full/Part-time: F = 3.05, df = 1, p = .082

Sector: F = 4.91, df = 1, p = .028

b) Dependent variable: Entrepreneurial Score

By levels of: Full and Part-time

Sector

	L.A.		Private	
	n	Mean	n	Mean
Full time	22	25.91	42	27.95
Part time	73	28.86	71	29.65

Full and Part-time: F = 2.41, df = 1, p = .122

Sector: F = 0.90, df = 1, p = .345

The fact that sector was significant in allowing for full and part-time staff, but not for time in post suggests that the analysis might be being confused by high numbers of senior care

staff in the private sector. If the analysis is done only on care assistants and senior care staff are omitted, sector is significantly related to 'professional' keenness ($p < .01$) even if time in post and full and part-time staff are both taken into account. On balance therefore it seems that private sector care staff, like private sector heads of home, are less keen on 'professional' training than local authority staff.

These conclusions need to be related to the work that the staff do. In Chapter Two, it was argued that the role of the residential worker fits that of the 'para-professional' whose training can enhance the status of a home without undermining the authority of the employer. Training for the 'para-professional', possibly under the NVQ system, is also relatively cheap to provide. It was therefore argued that, staff, whose 'career' prospects are limited, would seek a para-professional status and be likely to want training that maintains an emphasis on practical skills.

For these reasons, a count was made for the number of times a member of staff carried out a domestic, social and practical task. High task scores, signifying that a member of staff undertook fifty per cent or over of tasks in each grouping were then cross tabulated with attitudes to training. 'High' professional scores were treated as those less than or equal to a professional score of 55, 'low' professional scores as those greater than or equal to a professional score of 56; 'high' entrepreneurial scores as those less than or equal to an entrepreneurial score of 40 and 'low' entrepreneurial scores as

those greater than or equal to 41. As Tables 74 a) and b) show a strong relationship existed between social tasks and 'professional' scores and practical tasks and 'entrepreneurial' scores, indicating that a high number of social tasks are associated with 'professional' training and a high number of practical tasks are associated with 'entrepreneurial' training. There was no relationship between either of the training area scores and domestic tasks.

A weaker relationship existed between practical tasks and 'professional' scores. Thus staff who score highly on practical tasks have similar preferences for both models of training.

Table 74. Comparison between Tasks carried out and Keenness on Training.

a) Social Tasks and Keenness on 'Professional' Training

	'High' Prof. Score		'Low' Prof. Score	
	(n)	(%)	(n)	(%)
High Social Tasks	132	77	17	52
Low Social Tasks	40	23	16	48
Total	172	100	33	100

$x2 = 8.89$, $df = 1$, $p = .003$

b) Practical Tasks and Keenness on 'Entrepreneurial' Training

	'High' Entrep. Score		'Low' Entrep. Score	
	(n)	(%)	(n)	(%)
High Practical Tasks	183	97	16	80
Low Practical Tasks	6	3	4	20
Total	189	100	20	100

$x2 = 11.24$, $df = 1$, $p = .001$

Overall, the implication is that keenness on training rises with the number of tasks staff carry out, and that the more tasks that staff carry out the more training is wanted.

6. Is there a Relationship between the Attitudes of Heads of Homes to Training and the Attitudes of their Staff?

The final step was to examine whether the attitudes of staff to training were related to the attitudes of their employers. Each home in the sample was given a mean score for all staff in the home which was related with the mean score of their employer, taken from the first survey. The mean scores for employers were from their views on training on specific training areas for their staff. "Professional' and 'entrepreneurial' scores were calculated once again from the A Priori lists. A full list of the mean scores for each home is in Appendix XIII.

A correlation analysis (Table 75) of the scores revealed that there is no significant relationship between the mean scores of local authority staff in a home and that of their OIC's (indeed the relationship is, if anything, negative), but that there is some relationship between private sector staff and their home owners.

Table 75. Correlation Analysis of Keenness between Local Authority and Private Sector Staff and Heads of Homes on 'Professional' and 'Entrepreneurial' Training Areas

	'Professional'		'Entrepreneurial'	
	Correlation	Sig.	Correlation	Sig.
Local Authority (n = 9)	-.3226	.397	-.4536	.220 ←
Private Sector (n = 22)	.2747	.216	.5280	.012

With regard to influence by OIC's and home owners, the correlation analysis appears to suggest that private owners are more likely to influence staff views on training, than OIC's.

7. SUMMARY

This chapter set out to examine how important care staff felt training to be and what aspects of 'training' that staff had received had been of help in their job. The chapter also set out to examine the background factors which may affect basic attitudes to training and levels of keenness on the 'professional' and 'entrepreneurial' training areas in both sectors.

As with the heads of home, it was important to establish how important staff felt training to be. A high proportion of staff

in both sectors were keen on training and this applied to a large number of staff who had not themselves been 'trained'. However, the data suggested that staff, both 'trained' and 'untrained' were less keen on further training, and this particularly so among those in the private sector. Where the private sector staff did express a desire for further training it was more likely to be for training in the 'entrepreneurial' areas. The implication is that staff want to be trained but that training for some staff was seen as a means to supplement a basic caring approach with practical skills. Private sector staff in particular wanted practical skill training but combined with 'professional' understanding of residents needs which would enhance their professional competence.

As with the heads of home, the data suggested that care staff, particularly in the private sector, were in favour of in-house training. Part-time staff were significantly keener on on-the-job training than full-time staff. Staff in both sectors were keen on a combination of approaches to training, and private sector staff in particular wanted their individual establishments to be involved in the training process. The implication is that an emphasis on in-house training is linked to the practical problems encountered by staff who are unable to attend external courses due to difficulties in homes providing relief cover, travel arrangements and cost.

Staff who had been 'trained' were, in general, positive about the ways in which training had helped them. For some staff however, courses they had attended were not what they wanted and

it was apparent that some staff were of the opinion that common sense was more important than training.

An analysis of keenness on specific training areas indicated that staff in both sectors wanted both 'professional' and 'entrepreneurial' training areas, reinforcing the need by staff for training that provides practical skills with a wider, professional level of understanding. Overall, local authority staff were keener on 'professional' areas, but both sectors had similar preferences for the 'entrepreneurial' areas.

It was found that certain background factors are likely to affect basic attitudes to training. Staff in the local authority sector, staff who were working full-time, and staff who had been longer in post were all keener than their counterparts on 'professional' training. Overall, the data suggested that keenness on training rises with the number of tasks that staff carry out.

Finally, analysis of the relationship between the attitudes of heads of home and their staff suggested that private home owners are more likely to influence attitudes to staff training than their local authority counterparts.

The overall picture is that staff want training that combines practical skills and an understanding of residents needs but does not ignore the basic, natural skills of a caring person. This then is the staff view. We need to look next at whether training has an impact on the quality of residents lives, and whether residents have a preference for trained or untrained staff.

CHAPTER SEVEN: WHAT IMPACT DOES TRAINING HAVE ON THE QUALITY OF CARE?

THE VIEWS OF STAFF AND RESIDENTS

The previous four chapters explored the attitudes towards training of OIC's, home owners and staff. However, as pointed out in Chapter Two, little is known about the effect that training has on staff, and hence residents, and whether or not it produces 'better' carers. This chapter describes a third survey which aimed to determine what staff felt were the attributes of a good carer and whether they felt training helped to develop these.

A second key aim of the survey was to determine what qualities residents most preferred in staff and whether they prefer trained or untrained staff. Residents were interviewed and asked about their own care needs, to comment on what they liked or disliked about staff at the home, and to say what they felt makes a good care assistant. Residents were also asked to describe two members of staff who had been selected on the basis that one was trained and one untrained.

Early analysis showed that there was general agreement between staff and residents on what makes a good care assistant, but that most staff took the view that while training was useful it did not in itself alter or change attitudes to care of the elderly. Initial analysis suggested that residents preferred trained staff to untrained staff, and that trained staff tended to have been in post longer. Subsequent regression analysis

which took account of both training and length of time in post indicated that the influence of training on preference was negligible – indeed, if anything residents preferred untrained to trained staff. Overall the data suggested that residents are more concerned that staff should be naturally kind, understanding and patient, rather than that they should be skilled, efficient employees.

1. Introduction

In Chapter Two, it was pointed out that little has been done to incorporate consumers views in the evaluation of training and new initiatives. Since the Wagner Report voiced concern over the lack of evidence as to whether training could substantially improve the lives of residents, this omission appears to be serious. The Caring in Homes Initiative did however, highlight the importance of consumer views, and it is with this in mind that the third survey in this study sets out to determine the views of the residents on what makes a good care assistant and whether residents prefer trained or untrained staff.

1.a) Report on Data Collection of Survey Three

Between November 1993 and March 1994, twelve randomly selected private residential homes from the previous survey were visited and a total of 43 residents and 22 staff were interviewed. It was decided to use only private homes in the survey as almost half of the local authority homes in the

original sample were being transferred to independent ownership, and it was felt that the uncertainty felt by heads of homes and their staff in this sector would make access difficult.

Each home was asked to select four non-confused residents and two members of staff who worked regularly with the residents, one who had received training and one who had not. It was felt that by using just two members of staff, it would be easier for residents to answer questions about them. I was given the first names of the two members of staff in order to assist the residents when talking about them.

Two questionnaires were compiled (Appendices XIV and XV), one for staff and one for residents. I interviewed the residents before meeting the staff concerned so that I did not know, unless the resident told me, which occurred in just four cases, which was trained and which was not. Where possible residents were interviewed in their rooms or in a quiet part of the home and in every case, permission was given by the resident to tape the interviews for further analysis of the qualitative responses. Two homes were only able to supply two residents and one home just three. A total of two staff questionnaires (both involving trained staff) were not returned. One of these staff left her establishment shortly after the survey was completed.

1.b) Interviewing elderly people in a residential home.

A useful guide to the issues surrounding interviews with elderly people in residential homes is given in the Appendix to

a Scottish survey on the costs and qualities of residential homes (1). The main obstacles to successful interviewing are summarised and referenced as follows:

i) Levels of frailty (Willcocks et al, 1987; Wilkin and Hughes, 1987): Elderly people may be deaf or visually impaired and they may be unable to hear the interviewer or read any questions presented to them. In one case I needed the assistance of a relative as the resident concerned was profoundly deaf but was able to answer my questions by way of sign language and the use of pre-prepared large print question cards.

ii) Atmosphere and physical location: At one home I was offered the dining room but this was unsuitable, as staff needed to be in and out to prepare for the next meal and there was the occasional interruption by confused residents. I was also aware that some residents who were not being interviewed felt they were missing something, and this was likely to cause problems after I left.

iii) Reasons for residents being in the home: Reasons for admission were often not available. During one interview I found that the resident had been taken for a "short stay" by a relative, only to find that she would never return to her home. Other residents wished to confide that they were resident due to loss of spouse and/or lack of family support. While I do not feel this affected the answers given to me, it can make the interview a distressing one.

iv) Resident's desire to please: While owners and staff appeared to know which residents would be most co-operative, I

felt that some residents were perhaps being co-operative in return, in order to please the staff. However I did feel that most of the residents were quite pleased to have an opportunity to talk to an 'outsider', but the resident does need total reassurance of confidentiality.

v) Reluctance to complain: Perhaps the most common finding by researchers in the field of residential care of the elderly, is the reluctance by residents to complain. To the questions on what residents did not like about staff, very few had anything to say. Several interviews required repeated encouragement on total confidentiality, in order to glean honest opinions from residents. Bland et al, 1992, suggest several reasons for this, from the 'security of tenure' factor, to the 'gratitude' factor, a lessening of anger as the length of time at the home progresses, as well as residents' previous living experience. As Power et al, 1982, have shown, personality, social class and financial considerations can affect elderly people's satisfaction with life in the home. I therefore included a variable which indicated social class on the data base, and in the case of one male resident, it became clear that he was disaffected with staff (and indeed with fellow residents) who did not match his intellectual ability.

2. Description of the Sample

In order to provide evidence of whether training has an impact on residents' lives, the focus needed to be on a direct assessment of residents views of trained and untrained staff

within the home, an area not previously examined. In order to gain an overview of the sample, the characteristics of the residents and staff were established prior to quantifying the information into scores that could be used as a basis for an analysis on the impact of training. The residents were allocated scores based on their characteristics such as length of time in the home, age, class and levels of disability, which, it was expected, would influence their preferences for trained or untrained staff. As described below, these preferences were also quantified.

2.a) The residents and their personal scores

Residents were predominantly female, only three being male from the total of forty-three. The mean age of residents was 84 years, the range being from 64 to 101 years. The most common length of time that residents had lived at their homes was between one to three years (42%), with those resident less than twelve months accounting for 19%, and those being resident over five years 14%.

Female residents were asked to give their spouse's occupation, if married, in order to classify each residents' social class. (Appendix XVI gives a full list of the occupations of residents and their spouses).

Table 76 gives the breakdown of social class of all residents.

Table 76. Social Class of Residents, by sex

	Male	Female	Total	
	(n)	(n)	(n)	(%)
Professional	1	1	2	5
Intermediate	–	6	6	14
Skilled manual	1	15	16	37
Skilled non-manual	–	5	5	12
Partly skilled	1	5	6	14
Unskilled	–	3	3	6
Other	–	5	5	12
Total	3	40	43	100

The high numbers of skilled manual occupations is perhaps not surprising since all the homes involved in the survey, except one, were centred in and around Hull, and those occupations were primarily trades based. All the residents I spoke to came from the area and had selected homes closest to their most recent neighbourhood.

Residents were also given a *sociability score* (high, medium and low) based on how far they preferred to be in the company of other residents, and a *staff attitude score* (positive, medium or negative) taken from questions on whether they liked to be looked after by and to associate with staff. Out of the 70% (n=30) of residents that spent most of their day in the company of other residents, that is, in the lounge or other public areas, just over a quarter (27%, n=8) said that they would like

to spend more time alone. Of these, five respondents were from social classes I and II. Their reasons varied from the intellectual, as one resident stated,

> "Most of the residents are half-wits...some of them are so stupid."

to others who like their own company in their own rooms, or had regular family visits. The majority however, appeared to be content in the company of others, although one resident, who stated that she would like more privacy admitted that,

> "I can't get upstairs. There's nothing much I can do."

A crude *help score* (high, medium and low) was calculated from Question Two which asked residents about the level of difficulty they had with a list of normal activities. However, the responses needed to be treated with some caution since residents are often loathe to admit to inability to function in some areas. It is, as Bland et al (2) point out, important to stress that there are no 'right' answers and that responses remain confidential and will not be disclosed to care staff.

The *independence score* (high, medium and low) was taken from Question Three on what were the main things that staff did for each resident and whether they liked staff to do things for them. These scores were used to check whether resident characteristics could explain preferences for trained and untrained staff. There were no significant differences and the the sociability, help, independence and attitude scores for each

resident (in Appendix XVII) have been used for descriptive purposes only.

2.b) The Staff

All staff in the sample were female. The age range was 17 years to 54 years with a mean age of 35. Average length of time in post was 2 years 5 months. Each of the two members of staff at each home were coded into trained (A) and untrained (B). Those that had received any training were asked what training they had done, whether they were currently undertaking any training and what the training covered in terms of practical and personal skills. Staff were also asked what they personally felt they got from training and whether they felt training had improved their caring skills, or not made any difference, and why. Untrained staff were also asked what training, if any, they wanted and what they expected to gain from it.

Of the ten returned questionnaires from the trained staff, four had a City and Guilds qualification, one had completed a BTEC course, three had undertaken an NVQ Level 2 course and two others had nursing qualifications. Only five were currently doing further training. Out of the twelve untrained staff who returned questionnaires, seven said that they hoped to undertake NVQ training in the future, and one was intending to do a 'basic care course'. The remaining four said that they did not want training.

Question 14 asked the trained staff to consider a list of personal ('professional') and practical ('entrepreneurial')

skills, and rate how far training had helped to develop these skills from 1 (helped a great deal) to 4 (Not applicable/don't know). The same skills were also placed into five groups of six skills and staff were asked to rank each skill in each group, from 1 to 6, in descending order of importance, in relation to their job as a care assistant. The responses are analysed later in the chapter.

In order to compare the views of staff and residents, staff were also asked to say what they felt makes a good care assistant.

3. Analysis of Staff and Resident' Views on the Impact of Training

3.a) What Qualities do Staff and Residents look for in a Good Carer?

The debate on training in Chapter Two lays emphasis on skills as against 'values', but little attention appears to have been given to asking staff and residents what they actually believe to be the qualities, whether task-based or personal, that a good carer should have. The study asked all staff and residents to state, in their own words, "What makes a good care assistant?". The responses gave a strong indication that personal qualities were of greatest importance. Appendices XVIII and XIX give a full list of responses.

(i) Staff

Overall, certain key words featured strongly among the comments: *communication, listening, patience, understanding, caring, humour, kindness and common sense*.

Personal qualities rather than practical skills appear to be given the greatest emphasis by both trained and untrained staff. Several felt that common sense was very important and that this could be applied to most situations, obviating the need for specific skills. Four quotes demonstrate an overall view by staff on the personal qualities needed by a care assistant,

> "Someone who is a good listener, patient, a very naturally caring person. Not someone who is just doing it for a job. Someone who is very interested and enjoys working with the elderly." (21 year old, trained, 4 years in post.)

> "Kindness, giving residents time to talk things over and letting them have their own opinions." (37 year old, trained, in post 4 years)

> "A person who is kind and caring. Able to listen to a resident with any problems they may have. A person who is conscientious. Hard working - able to show initiative." (49 year old, untrained, in post 4 years)

> "Patience when they are not good at walking. Sense of humour. A good stomach and not shy. Kind and gentle, not rough. Common sense." (23 year old, untrained, in post 6 months)

All this suggests a feeling by staff that being a good care assistant involves natural abilities and attitudes to caring for elderly people that are maintained *alongside* the completion of any training.

(ii) Residents

Overall, the residents articulated similar responses to those of the staff, with personal qualities at the fore of quotes, the key words being *patience, kindness, understanding, caring, gentle, friendliness, tolerance, helpful, willing, thoughtful, dedicated,* and *feeling safe.*

Examples of the responses were:

"They need patience, should be kind, understanding."

"To be good and kind...To have someone here, someone with me when I go out."

"To want to look after people. Experience. Interested in the job and people."

"Someone who is dedicated, loves people. Someone who can do things for people. Can see when things need doing."

"Tolerance. Being careful with you....Kindness. Helpfulness."

"Homely, helpful, caring. Consider your needs."

"Mostly kindness. Thoughtful. Good temper. Nice nature."

"Ability to get on with people. Ability to comprehend people's needs."

Two other comments included reference to being good at both practical and personal things. The majority of responses however, centred around personal qualities, some of which could be said to come naturally, while others may require experience and the development of confidence.

3.b) What Qualities do Residents quote as leading them to prefer one member of staff to another?

As pointed out earlier, getting residents to talk freely and critically about staff is difficult. The majority of residents interviewed were full of praise, on the whole, for their carers, and very few gave negative responses. It is to be hoped that this reflects an overall satisfaction with the care received, and in the course of the interviews I had little reason to doubt the sincerity of responses. The following selected responses are matched to the code numbers given to each member of staff (A = trained staff, B = untrained staff).

(i) Positive responses

115A:

"Really cut out for the job. Marvellous. Wonderful friend....without training would be good. My favourite."

"Very nice, bossy, helpful. She would do whatever I wanted. All rounder, kind but firm."

"Good at her job. Always learning things. Could go far. Good at finding out what's what. Naturally good. Wonderful."

018B:

"Seems very nice"

"Happy. Cheerful. Good in general. Older. Got children."

"Wonderful. Useful. kind. Good at everything."

(ii) Negative responses

Negative responses on the above care staff were few, and mostly directed at staff they did not prefer. Staff number 115A drew comments on how busy she always was in that she,

"Ignores you first thing in the morning"

"Is always rushing about"

and a comment on 168A by a male, highly educated resident suggested that she was "lacking in experience and training."

The only negative comment for an untrained member of staff was on 153B of whom a resident commented,

"Trying too hard. Talking to you as if you're a child."

The responses indicated a preference for staff who were kind, dependable, good listeners and 'motherly'. Overall, those members of staff which merited preference, appeared to be the ones who had shown the greatest amount of patience and kindness towards the residents.

3.c) Do Staff think their Qualities are Enhanced by Training?

Given the aims of this thesis it was clearly important to look at whether staff felt that training could enhance these

qualities and in any way change attitudes to the care of the elderly.

In order to establish reasons why staff had undertaken training, Question 10 of the staff questionnaire asked if the home owner had any influence on the training that staff had received. Although most gave no response, those that said yes and then responded to a following open-ended question, indicated that it was to improve their career prospects, for example,

"Being made up to deputy manager"

and at one home the respondent felt that the owner influenced training since staff received,

"In-house training for care assistant level."

In another case the owner organised sessions on practical first aid and fire prevention techniques.

Reasons given for doing a course were not given except in two cases where staff said that it gave them a recognised qualification for the job, one holding an NVQ and another referring to YTS. Another member of staff said that she had undertaken training because, "The manager asked me to". One member of staff had not received her training at the home but held a nursing qualification (ENG), which she felt,

"Is as good a training as the NVQ".

but in fact was about to embark on an NVQ level 3 course.

Question 11 asked staff to say what practical and personal skills their courses had covered. Practical skills included bathing, use of drugs, fire procedures, diets, hygiene, first aid, toileting, washing and dressing. Personal skills revolved mainly around communication skills, confidentiality, dignity and respect for the client, and dealing with relatives.

Question 12 asked for comments on what staff felt they had personally got from their training. Many comments were somewhat vague in that training for example, had "helped me to be better at my job", but clearer comments can be grouped into three categories.

In the first place some staff felt that training gave them greater *confidence,* for example,

> "Confidence to go and do each job in the home with no problems."

Secondly there were those who felt that training had provided more *knowledge,* for example,

> "An understanding of the needs of the elderly"

Thirdly there were those that felt that it had enhanced their *experience,* for example,

> "It made me think more about every aspect of the work that I was doing".

Question 13 on ways in which training improved skills prompted similar responses in terms of knowledge and confidence. Examples include,

"Knowing and understanding things better."

and,

"Gave me more confidence to carry out duties in the home."

There were few responses to Question 15 on other comments about the training they had received, but those that did respond appeared to support the view that training was useful in helping to further understanding and knowledge, for example,

> "It helped me to see the residents point of view more and also to understand the relatives of residents. Plus it has built up my confidence."

(ii) Untrained staff

Comments from untrained staff were sparse, but in response to the question to why, if at all, they wanted training, staff appeared to feel that it would help to understand why things were done in a certain way and, as with trained staff, build confidence. Two negative responses from staff intimated that training was a waste of time, and that experience was more relevant, stating,

"As I have worked at (home) satisfactorily for 10 years I feel that I have gained experience in taking care of the elderly."

and from one who was intending to undertake training,

"I want to do the course for a qualification. I don't expect to get much out of it apart from the qualification."

The remaining seven staff who hoped to undertake NVQ courses were rather more positive about what they thought training would give them, a feeling summed up by those who felt that it would provide,

"Knowledge and experience of caring for the elderly. Also skills that with experience I will be able to transfer to junior members of staff."

and, on a more practical level,

"Practical skills, understanding old people."

and simply,

"A recognised qualification".

The view that training and in particular NVQ's will assist in gaining appropriate qualifications is linked to the argument in Chapter Two. It was suggested there that female residential care staff are unlikely to gain full 'professional' status, but that practical task-based training may focus their career pattern towards that of the 'para-professional' who is able to maintain a slightly higher status than a basic care worker. NVQ's are perhaps seen, by both home owners and staff wishing to undertake training as being the most appropriate means by which to achieve this.

The apparent emphasis, in the written and verbal responses by staff and residents, on personal qualities, required further

statistical analysis. In order to determine which areas of training had most helped them in their work, staff were asked to rank a list of personal ('professional') and practical ('entrepreneurial') areas of work from 1 (Helped a great deal) to 4 (Not applicable/Don't Know). In order to simplify the outcome, each of the areas of work were placed into one of four categories, those that are 'known' already (mending and cleaning); those that are 'difficult' or time-consuming and demanding (nursing); those that are 'teachable' (lifting, first aid, toileting, etc) and those that are 'attitudinal' (building confidence, respect, etc) The closer a score is to 1.00, the more staff felt that this group of training areas had helped with their work. The overall mean score by all trained members of staff on areas that training had helped with is in Table 77.

Table 77. Areas in Which Training has Helped (mean scores)

'Known'	'Difficult'	'Teachable'	'Attitudinal'
2.30	1.80	1.45	1.28

Those areas in which training was seen to have been most helpful, that is, had a mean closest to 1.00, for individual 'attitudinal' areas were *building confidence (1.10), communicating with residents (1.11), being a good listener (1.20) and respecting residents views (1.30).* The lowest mean score for 'teachable' areas was *safe lifting (1.10).*

In order to determine the *preferences* of staff towards the skills and qualities needed by a care assistant, nine trained and nine untrained staff were asked to rank 30 in descending order of importance, grouped into five groups containing six items. Table 78 gives the overall mean for each item, ranked in descending order from very high preference (mean from 1.00 - 2.00) to very low preference (mean of 5.00 - 6.00). Each personal quality is denoted 'P' in brackets. Each practical skill is denoted 'S' in brackets.

(The grouping of personal qualities and practical skills is in Appendix XX. A list of actual mean scores for all staff and trained and untrained staff is in Appendix XXI).

Table 78. Overall Preferences by All Staff, of Qualities and Skills, "Needed by a Care Assistant".

Preference	Item	Mean
Very High:	Privacy (P)	1.94
	Patience (P)	1.94
	Being a Friend (P)	1.94
High:	Respect (P)	2.11
	Getting on with people (P)	2.22
	Letting residents choose (P)	2.22
	Know what residents like (P)	2.28
	Keep residents clean (S)	2.33
	Common Sense (P)	2.44
	Nice Personality (P)	2.44
Medium:	Sense of Humour (P)	3.22
	Bathing (S)	3.50
	Willingness (P)	3.61
	Keeping a secret (P)	3.61
	Good listener (P)	3.61
	Toileting (S)	3.72
	Confidentiality (P)	3.89
	First Aid (S)	3.94
Low:	Dressing (S)	4.11
	Good Talker (P)	4.17
	Safe lifting (S)	4.22
	Giving medication (S)	4.28
	Feeding (S)	4.33
	Maturity (P)	4.33
	Nursing skills (S)	4.67
	Keeping records (S)	4.84
Very Low:	Keeping Rooms clean (S)	5.17
	Not fussing (P)	5.22
	Mending (S)	5.89

The first two preferences, from very high to high preferences, by all staff appear, apart from the practical skill of keeping residents clean to show a preference for basic natural qualities. Medium preferences show a mixed range of personal qualities and skills. The lower scoring preferences, from low to very low preferences are the remainder of the personal qualities and the bulk of the practical skills. Thus the choices of staff as to the qualities and skills considered important to the job of a care assistant, appear to favour personal qualities over practical skills, implying a recognition by staff of the importance of interacting with residents and using the natural qualities present in a carer.

The next step was to look at whether there were differences between trained and untrained staff or whether there were similar preferences. The eighteen personal qualities and twelve practical skills were grouped together, and the overall mean calculated for trained and untrained staff. The outcome is in Table 79. As can be seen, the views of trained and untrained staff are very close.

Table 79. Mean Scores for Personal Qualities and Practical skills, by Trained and Untrained staff.

	All staff	Trained	Untrained
All items			
n = 30	3.49	3.49	3.50
Personal			
n = 18	2.99	3.04	2.95
Practical			
n = 11	4.25	4.18	4.32

Total mean scores show a preference by all staff for the personal qualities.

(iii) Comparison of Staff and Residents

As with the staff, residents were asked to state, from a pre-prepared list, what personal qualities and practical skills were Very Important, Not so Important and Not Important in the people that cared for them. The responses were coded from 1 (very important) to 4 (don't know) to give mean scores, as with the staff. The list of qualities and skills were the same as those the staff had been asked to rank, but two areas were omitted, Building Confidence and Keeping Records. A mean score closest to 1.00 once again indicates greatest preference. The mean scores are in Table 80.(A full list of mean scores for residents is in Appendix XXII).

Table 80. Mean Scores for Personal Qualities and Practical Skills, by Residents

	Residents
	Mean
All Items	
n = 28	1.42
Personal Qualities	
n = 17	1.24
Practical Skills	
n = 11	1.61

A tendency by residents to use the response 'very important' was greater than the staff who had longer to think about their own training and what they wanted from it. The scores do however, show a preference, as indicated from the verbal responses, for personal qualities rather than skills. The most popular personal qualities were Sense of Humour (1.00), Patience (1.02), Respect (1.05), Willingness (1.05) and Tolerance (1.07) The most popular practical skills were First Aid (1.20) and Safe Lifting (1.17). A supplementary question at the end of each interview asked residents to state whether they thought personal qualities or practical skills were more important. Thirty-one residents (72%) said they thought personal qualities were more important, Eight (19%) residents said that both were important, and just four (9%) residents said that being practical was more important. Together with the scores, residents appear to maintain a strong preference for nice, kind, caring people rather than workers with practical skills.

Later analysis looks at resident's preferences for personal qualities and practical skills in relation to their preferences for trained or untrained staff.

There appears to be a general agreement that, as indicated by the written responses of staff, personal qualities are more important that practical ability. As we have seen staff believed that training helped in their attitude to elderly people. The issue is, however, does it, and if so is this something which the residents detect and appreciate? The last question to be raised therefore is what, if any, impact does training have on the quality of care, from the point of view of the residents, and does it lead them to prefer trained to untrained staff.

3.d) Do Residents Prefer Trained or Untrained Staff?

Residents were asked in Question Five about two members of staff, one trained and one untrained, as to whether they preferred one or the other, had no preference, or mentioned another member of staff in the home. These responses were coded into a *preference score* as 0 = not preferred, 1 = no preference, 2 = preferred. They were also encouraged to give qualitative responses on why they had such preferences or not and a *qualitative preference score* was given to each member of staff on a six-point scale (1 = "awful", 2 = "not very nice", 3 = "alright", 4 = "nice/helpful", 5 = "very nice/very helpful", 6 = "wonderful"). Residents were also asked to say which of the

two they felt to be the most *caring* member of staff and which was the most *practical*. These responses were also coded in the same way as the preference score to give a *caring score* and a *practical score*. In some cases, the resident stated that one member of staff was both. Again qualitative responses were encouraged.

The scores were then totalled to give each member of staff an overall *staff score* achieved by adding together *preference score + caring score + practical score + qualitative preference score*. The maximum, most positive, score a member of staff could achieve from sixteen items was 48. A Cronbachs Alpha test was used to test the reliability of the scores. The result was:

Reliability Coefficients 16 items

Alpha = .7889 Standardised item alpha = .7950

The outcome of 0.8 indicated a reliable measure.

The key issue in this chapter is whether residents regarded trained staff more favourably than untrained staff. Initial analysis in Table 81 suggested that they did, since trained staff scored more highly than untrained staff.

Table 81. Mean Trained and Untrained Staff Scores by Mean Age and Length of Time in Post.

	Trained	Untrained
Mean Age	36.50	34.42
Mean Length of Time		
Time in Post (years)	3.56	2.35
Mean Preference Score	30.92	27.25

A t-test was carried out for correlated means between trained and untrained staff. Although the trained staff scores were on average higher than those of untrained staff, the test was not significant. It was therefore suspected that preference was related to another, underlying factor.

It was observed that although residents appeared to prefer trained staff, the preference may in fact relate to length of time that staff had spent in post. Table 82 sets out the relevant data.

Table 82. Mean Trained and Untrained Staff Scores by Length of Time in Post

	Less than 12 months	1-3 years	3+ years
Trained	-	29.75	31.50
Untrained	24.43	28.00	32.00

As can be seen, the mean preference scores rise in relation to the length of time spent in post. In the light of this I

carried out a Regression analysis to explain the preference scores in terms of how long a member of staff had been in post and whether they had been trained or not. This was done in two ways. In one, length of time in post was scored 2 when, compared with their 'partner', the member of staff had been in post longer, 1 when the member of staff had been in post for the same length of time and 0 when they had been in post for a shorter length of time (see Table 83).

Table 83. Analysis of Residents Preferences to Trained and Untrained Staff and Staff Experience

Multiple Regression

Dependent Variable: Staff member score

Variables in the Equation

Variable	B	SE B	Beta	T	Sig T
Trained	-3.2857	2.1799	-.3248	-1.507	.1466
Experience	5.2143	1.1940	.9412	4.367	.0003
(constant)	25.5119	1.1257		22.664	.0000

In the other the actual length of time in post was square rooted. Both regressions showed that length of time in post was a significant predictor of a high preference score, but that being trained was not significantly associated with preference after allowing for time in post.

Importantly the regression coefficient is negative (untrained staff are coded 0 and trained coded 1). Thus if experience is taken into account, staff who are trained are

less popular than those who are not although the association is not significant.

The question of why residents prefer experienced staff, may have one or more answers. Is it a case of staff who stay in post longer in some way become 'better' carers as they develop their 'natural' personal qualities over time?. Were the staff who stay longer keener than others at the start of their 'career' in residential care and thus more inclined to stay longer and to relate better to residents? Or is it perhaps that residents develop a stronger relationship with staff who have been at the home at least as long as they have? All these may be true but are not directly relevant to this study since the main concern is with training.

In Chapter Two it was argued that training can provide either 'higher level' skills such as producing care plans, care packages and assessments, or skills that are tied to relatively limited parts of the job. Residents on the other hand seem to like experienced staff and staff that are good and 'naturally' caring people, rather than skilled workers. Training may need to focus, less on task-based skills, and more on enabling the basic attitudes and natural abilities of the carers to show through in the caring tasks they undertake. If it is unable to do this, the importance of training as a means to producing 'better' carers is in doubt.

4. SUMMARY

The key issue in this chapter has been whether residents prefer trained or untrained staff. This is linked to two further questions, firstly, what qualities do residents and staff look for in a good care assistant? Secondly can training produce these qualities? The outcome is important to the overall question of whether training has an impact on the quality of care received by residents, as perceived by the staff and the residents themselves.

Staff and residents were closely matched in their views on what makes a good care assistant, with personal qualities such as patience, kindness and understanding being of greater importance than carrying out particular tasks.

Staff were positive about the training that they had received, seeing it as increasing confidence, providing knowledge and enhancing experience. Staff answers suggested that the impact was more to do with the enhancement of personal qualities by which to help residents feel 'better cared for', than with achieving safe standards and acquiring skills.

Statistical analysis bore these views out. Initial analysis suggested that residents preferred trained to untrained staff. However, trained staff tended to have been in post longer and when this was taken into account the effect of training was negligible.

CHAPTER EIGHT: SUMMARY AND CONCLUSIONS

SUMMARY AND CONCLUSIONS

This study has focused on the training of staff working in residential homes for elderly people. It has provided new data on the training and qualifications of heads of homes and their staff; on differences that exist between the stakeholders in attitudes to training, and - most importantly - on the impact that staff training may or may not have on residents' lives. Overall it is of relevance to a key issue in the debate on training, that of whether an 'entrepreneurial', skills based model is an appropriate form of training for the residential care sector.

The 'entrepreneurial' model trains people to do specific things, in specific ways and with specific outcomes in mind. The evidence suggests that staff want specific skills such as those related to safe lifting and first aid, located, at least partly, on an in-house basis, and in some cases access to nationally recognised qualifications. These aspirations can, almost certainly, be met by this model. In addition, its modular structure is likely to appeal to part-time staff and its practical focus to the private sector. However, staff want training that combines specific practical skills with professional understanding of residents needs. Residents want kind, understanding and experienced staff. Training may make little difference to these qualities. The major finding in this study is that when length of time in post was taken into

account, the residents did not think trained staff were 'better' carers than untrained ones.

The implications are that staff need to be selected as much for their personal qualities as much as for their ability to carry out practical tasks, and that good staff should be encouraged to stay. While practical skills are important, training should integrate skill and understanding, and assessement should focus on the ability of staff to combine the two. Above all, assessment needs to involve the ultimate arbiters of quality - the residents.

1. The Background to the Research

The growth in numbers of residential homes, particularly in the private sector, has continued despite the implementation of the Community Care Act. As the number of local authority homes has decreased, so the number of residents in private residential homes has increased (by 40% in the decade to 1993).

This clear demand for residential care reflects the limited opportunity for very frail or mentally infirm elderly people to remain in the community. The main explanatory factors are the increasing numbers of very old people, the underfunding of services and a lack of traditional carers. By the middle of the next century, it is expected that 10% of the population will be aged 75 or over. There is a shortage of resources for domiciliary care. Fewer female carers are available as a

consequence of divorce, geographical mobility, family re-organisation and greater numbers of working women.

While demand for residential care continues, so too do the scandals. *Concern has therefore arisen that the quality of care in residential homes frequently falls short of accepted standards*. However, the mechanisms of inspection and market control appear to be unable to ensure good performance. It follows that *training is seen as the most plausible and most viable means by which to promote good quality care*.

2. The Theoretical Framework for Training

Whilst the literature on residential care makes numerous references to the capacity of training to improve practice, there is very little empirical research on the effects of different types of training. Given the lack of evidence, it was necessary to focus first on what kinds of training exist and the ways in which they have been conceptualised.

Traditionally training has been seen to be about the acquisition of knowledge and higher level skills which can be applied to a wide variety of situations. The new debate on training, discussed in Chapter Two, is concerned with the relative advantages of this 'professional' model of training, and of a newer, emergent model of vocational training. This latter 'entrepreneurial' model is typified by National Vocational Qualifications, in which the emphasis is upon assessment of competence in the workplace. It was argued that

this model was likely to appeal, in particular, to the 'entrepreneurial', private sector heads of homes and their staff, and this for two very good reasons.

First, it was argued, that in this context *the 'professional' 'social work' model lacked plausibility.* The background training, if any, of staff in the developing private sector was in nursing and thus grounded in a medical model. Moreover, social care has not been regarded as a profession even when associated with social work, which itself has a dubious claim to full professional status. The statistics appeared to support the idea that the 'professional' model was unsuitable for most of the workforce. Where available, they showed that 'professional' training courses, such as CQSW and CSS, have very rarely been taken up by members of this workforce. *Large numbers of residential staff are under trained and unqualified.*

Second, it was argued, *that NVQ's might be the answer to under-training*. The modular, on-the-job training involved should fit the needs of a part-time, under-trained workforce and a private sector which lacks the funds for traditional forms of training. These underlying factors are likely to result in a greater take-up of NVQ's in the private sector (where the problem of under-training has been particularly severe), and indeed preliminary statistics appear to bear this out.

However, as pointed out in Chapter Two, *NVQ's have been subject to fierce criticism and there are doubts about the relevance of these qualifications to a caring profession.*

More specifically, criticisms of this model focus on its

reductionist approach. It assumes that overall competence follows from the piecemeal acquisition of individual competencies. Typically it is concerned with the skills of an individual in isolation from the context in which they work, and there is a danger that it pays too little attention to 'values', background knowledge and understanding. The *language* of this model is criticised for being esoteric and inappropriate to an occupation concerned with the care of vulnerable elderly people. For these reasons the model is criticised for being *rigid and mechanistic,* for stifling originality and for being better suited to the demands of a 'production line' than of a caring establishment.

If NVQ's are to survive these criticisms, we need to know two things. First is this type of training 'popular' and thus likely, as argued above to reduce the problem of 'under training'? Second, does it, in fact, produce 'better' carers?

Therefore we needed to know whether a skills based 'entrepreneurial' model was in fact wanted, and by whom, and if so, whether it improves care as the residents perceive this. Thus, three key questions about training arose from the discussion in Chapter Two - *i) which model do heads of homes prefer? ii) Which model do their staff prefer? and iii) what effect do these models have on the residents?* The first two questions were the basis for two surveys which tested the hypothesis that different stakeholders would have different views on what training should aim to do. The third question was the basis for the third survey which asked the residents what

qualities they looked for in staff and examined whether they preferred trained or untrained staff.

3. The Findings:

Chapters Three and Four described the characteristics of employers and their staff and looked at the views of the local authority sector managers and private sector home owners.

The survey confirmed the high degree of dementia and incontinence among residents in local authority homes. In contrast, private sector residents were more likely to suffer from physical disabilities. This suggested that these levels of ill health requires staff to have an awareness of both their 'social' and 'medical' implications.

A key finding was that *large numbers of part-time staff were employed*, of which a surprisingly large number were employed in the local authority sector. In both sectors, part-time staff outnumbered full-time staff by a ratio of between two and three to one.

A total of 85% of local authority heads of homes but only 54% of private sector home owners held relevant qualifications. There was a stark contrast in the type of qualifications held, with nursing predominating in the private sector and social care or social work in the local authority. Over 50% of private home owners had no background experience of NHS or Social Services, suggesting that this sector cannot rely on the local authority or health service to train its heads of homes.

Large numbers of staff had no qualifications. By contrast managers and home owners stated that between 55% and 60% of their staff had received at least some training. But this training seems to be unrecognised by qualifications, and may well be specific to an individual establishment and its ethos, and relatively cheap.

Despite the lack of qualifications among their staff, heads of homes in both sectors showed a high level of keenness for training in general. *As predicted, private home owners were less concerned with 'professional' areas of training* although both sectors were equally keen on practical and pragmatic areas. In general, *private heads of homes appeared to favour 'situational' training,* specific to an individual establishment. This was supported by the fact that heads of homes in *this sector were three times more likely to want in-house training,* reinforcing a practical approach, consistent with the NVQ programme.

The next step was to determine whether the care staff (as opposed to heads of homes) in the two sectors held similar or different views on training and what factors were related to the views that were held.

As in the first survey it was found that part-time staff predominated. Staff in the local authority sector were on average older, often with many years of experience. Staff in the private sector were generally younger and more recently recruited. As with the private heads of home, they were less likely to have background experience in the local authority or

health sectors. *Twice as many local authority staff as private staff had qualifications.*

With regard to the location of training, part-time staff were significantly more likely to prefer in-house training than full-time staff. Although in both sectors preference was shown for establishments being involved in the training process, *overall preference for in-house training was stronger in the private sector,* reflecting a situation-specific approach as suggested in Chapter Two. These views may be associated with the practical problems of attending colleges and the cost of training. They may also be associated with the need of employers to ensure that training reflects the requirements of individual homes.

Overall, *staff in the local authority sector, staff who worked full-time and staff who had been longer in post were all keener than their counterparts on 'professional' training.* However, staff in both sectors had similar preferences for 'entrepreneurial' areas of training.

Although private sector staff appeared less keen on 'professional' training, this may reflect a lack of enthusiasm for 'professional' topics, rather than a lack of keenness on a 'professional' approach. *Staff want training that combines practical skills,* such as safe lifting, first aid and fire prevention, *with an understanding of residents needs.* These should encompass such areas as dignity and respect of the client, and of serious disabling conditions such as dementia. Their qualitative responses suggest that they value such

training because, as they believe, it improves their confidence, makes them better at their job, and, in some cases, enhances their chances of better pay.

Thus training is perceived as beneficial in both sectors by mangers, home owners and care staff. Differences however exist between the sectors in relation to the 'professional' and 'entrepreneurial' models of training. However these differences are less important than the recognition that *staff are keen on training that provides them with practical skills with which to carry out their job. Equally, both sectors put a high value on treating people decently* and value training which reflects this perspective.

The final stage in the study looked at an area not previously studied and of particular importance - the question of whether residents preferred trained or untrained staff.

There was general agreement by staff and residents on what makes a good care assistant. From the qualitative responses, personal qualities appear to be of greater importance than practical skills, to both staff and residents. Initial analysis had suggested that residents preferred trained staff. However, staff who had been trained tended to have been in post longer and were thus more experienced. *When length of time in post was taken into account, the impact of training was negligible, indeed, if anything, untrained staff were preferred to trained staff. Residents in fact prefer staff who are naturally caring, kind and understanding. Training appears to make little difference to these qualities.*

4. Assessing the 'Entrepreneurial' Model

This study has focused on the 'entrepreneurial' model, exemplified by NVQ's, in contrast to the 'professional' model, for which the paradigm is traditional social work training. In the light of the findings, a considerable number of questions are raised about the use of this model and its contribution to the debate on training.

The model has seven main characteristics. First it has a *practical* focus. *It trains people to do specific things, in specific ways and with specific outcomes in mind.* Second, it is about specified, and transferable *skills* identified on the basis of job analysis. Third, these skills relate directly to the practical tasks that are carried out in the workplace and are assessed in terms of levels of *'competence'*. Fourth, the training tends to be delivered on a *'situational' or 'in-house' basis,* which should emphasise the benefit to individual establishments. Fifth, the training tends to be *modular* in format thus avoiding the practical problems of full-time training. Sixth, *assessment* takes place in concrete and routine workplace situations and is based on overt behaviour. Seventh, the model forms part of a much wider industrially based movement concerned with training the British workforce for the 21st century. For these reasons it should appeal to the *private sector* 'entrepreneur' with roots in an 'enterprise' culture, to

private sector staff, part-time staff and to current policy makers.

If this is the model on which future training is to be based, what support does it gain from the evidence produced in this study?

On the positive side, this model suits staff who might otherwise not receive training. It emphasises the practical skills that staff say are important, such as safe lifting and first aid. It can provide background knowledge on specific disabilities, such as dementia. It is suited to those staff who need time to undertake training, due to practical difficulties of staff cover and cost. Similarly, this model is suited to in-house training which was particularly popular with private sector staff. Not surprisingly it appeals in particular to those part-time staff and private sector staff who say they want training, and who see it as enhancing self-confidence and self-respect.

The key point to be made is that *focus needs to placed, not on what the model contains, but on what it does not contain*. It emphasises skills which are needed. Neither its assessment nor typically its method of training emphasise the way in which these skills can be informed by the understanding and moral qualities which seem to be required. In these respects, notice needs to be taken of what the staff and residents actually say.

1. Some groups of staff are keener on 'professional' training. This implies that some elements found in this model continue to be valued. This is alongside an equal keenness by staff in both sectors for training in practical skills.

2. In a similar vein, staff said that they want training that combines practical skills with understanding but does not ignore the inherent skills of a 'good person'.

3. In Chapter Seven staff and residents felt that personal qualities of care assistants were of greater importance than ability to carry out practical tasks.

4. Finally, residents did not prefer trained staff. Residents want kind, caring and understanding staff, and are more likely to see these qualities in staff who are there for a long time.

These points raise the key issue of where this leaves us with regard to implementation of an 'entrepreneurial' model? As it stands, *the 'entrepreneurial' model is the model of the future*, with its emphasis on the importance of practical skills which can be taught 'on-the-job'. However, the research reveals its limitations. These are such that the model needs to be looked at in more depth.

The issue is whether training can produce 'good people'. By this is meant the ability of a person to 'see' beyond the task

in hand and to know how, where and when other, covert, needs should be addressed. Professions themselves vary in the priority given to 'skills' and 'values'. An engineer must be precise, objective and skilled. However, people's lives and their quality of life are not at risk if the engineer has an unsociable temperament. A health professional needs expertise but the ethical element rests on the confidential relationship between practitioner and patient. A residential care worker needs to be task-competent but the priority is to be equipped with a 'good' disposition and to be able to understand the needs and feelings of others.

Traditionally 'professional' social work training has aimed to produce people with practical expertise who maintain a set of approved ethical values. The question has been raised, in Chapter Two, as to whether 'ethical values' can be taught or are the property of 'good' people. The problem in the case of 'entrepreneurial' training is even more acute. It is not that this training fails to produce a 'good' person but rather that it does not even try.

A solution to this problem may be to take into account the underlying values that 'good people' bring to the job. Training remains important to staff who need specific skills. If they are to be involved with dressings and medication (as in both sectors but particularly the private sector, they are), they need the skills to ensure that these matters are handled safely. The 'entrepreneurial' model of training can provide this. However it also needs to focus equally on an understanding of the personal

qualities that residents most appreciate and which ensure that the carer does not lose sight of the person when handing out the pill.

An example of the point at which integration of skill and disposition is necessary is the task of bathing residents. Not only do staff need to handle and lift safely and maintain hygiene, but the intimate nature of the task demands understanding, communication and empathy. It is during this seemingly routine task that staff have the opportunity to notice whether a resident has other, less obvious physical or psychological needs. For example a resident may be observed to have bed sores, to be depressed or to be showing signs of confusion. Thus the quality of life may depend on staff who are able to recognise when something is wrong, either by self-evident signs or by the ability to listen to what is being said.

A 'good' carer should be able to have a sense of what action might be appropriate and to communicate this tactfully, at the right moment and at the the right place. Caring requires people who can exercise practical skill with the maintenance of dignity and respect of the resident. This implies that while practical skills are important, staff need knowledge and an ability to utilise their own good personal qualities. It remains to be seen whether assessment can be modified to allow for the necessary integration of skill, understanding and disposition. Training and assessment should therefore focus on this.

In this way training can enhance the quality of care received by residents while ensuring that the safety and security of residents are not at risk.

5. Practical Implications:

The key practical issue is how the 'entrepreneurial' model can be adapted to meet the needs of everyone. As we have seen, personal qualities are of major importance to residents, and so being a good carer is, among other things, about being a good person. This point is linked to the issue of how a job is defined since training is dependent on this. Job descriptions should take account of the need for 'good' people who can listen, are sensitive and able to pick up on the needs of residents.

This suggests that *heads of homes need to select staff carefully, as much for their personality and altruistic qualities as for any other reason*. Having taken on staff, a period of 'probation' may be appropriate. This would allow for personal qualities and practical skills to be assessed at an early stage.

Training needs can then be drawn up. Staff and heads of homes want *access to training and qualifications*, which acknowledges the *importance of practical skills*. They also acknowledge the *importance of naturally caring, understanding and experienced people*. The latter is what the residents want, and the 'entrepreneurial' model needs to take this into account.

Heads of homes and staff also want training that can be undertaken on an *in-house basis*. In this respect NVQ's may be taken up more readily. As Chapter Two has pointed out, NVQ's are modular and thus exclude the need for block release training. They are intended to be assessed in the workplace. They can be completed at the candidates own pace, and assessed when the candidate and assessor feel the time is right.

The practical benefits would be to help staff and their employers overcome the problems of cover and cost. In particular it would enable part-time staff to undertake training on a gradual basis and during working hours.

The NVQ system is intended to be 'employer led' and set within the context of the workplace. As we have seen, heads of homes and staff share a preference for the *involvement of establishments* in training. The current NVQ model suits these requirements and can capitalise on staff experience of the considerable amount of in-house training which is now in place.

Thus certain aspects of the 'entrepreneurial' model can benefit heads of homes and staff. It can be 'sold' to the residential sector on the grounds that it:

* provides access to a nationally recognised system of qualifications.

* it provides training in specific skills needed by staff.

* it can be undertaken on an in-house basis, and linked to the specific needs of individual homes.

* it can build on staff experience and current training.

Given that training can be 'sold', thought needs to be given to how it is to be carried out. Whether the job involves routine domestic tasks or emphasises a caring role, it is likely that personal qualities will surface within its course. However, if training focuses on the tasks alone, the results will be limited. If people are to use their good qualities, these need to brought out in their training. This suggests that they need the opportunity to express these qualities during training, for example in role play or through reflection on their recent work.

Thus, the dispositions of people, as well as their 'competence' in the job, must be assessed. We need to ensure that the *assessment process involves the residents views*. Without them, training remains skills-specific and unsuited to a social care setting.

This raises the question of who will undertake assessments? At present line managers in social services departments are being trained as assessors. It is unlikely that private home owners or their managers will have equal access to this training. Independent Inspection Unit officers may be in a position to take on this role, but resources are extremely limited.

Training for assessment is also time-consuming and costly. Funding may need to be made available to heads of home in the private, as well as the local authority sector, in order that they themselves can become trained assessors. Home owners may need to be trained in staff development and supervision skills if assessment is to be meaningful. Their own development may lead to a better understanding of the training needs of their staff.

Further assessments are needed as a means of providing evidence that staff can maintain quality of care and develop their own personal skills. This is needed to overcome the criticism that assessment of competence occurs in a 'one-off' situation.

Where staff are deemed to have those qualities and skills which match the ethos of the home and the residents, they need to be encouraged to stay. In the study *length of time in post was a significant predictor of preference by residents.* Any steps which enhance the likelihood that 'good' staff will stay is to be welcomed, and eases the task of ensuring that training given to these staff is not 'wasted'. In the light of this, the question of pay and conditions for the residential sector workforce needs to be addressed once more.

Staff may also be motivated to stay if the practical problems of day release training are, to some extent, eliminated. In-house training can overcome the problems of travelling to colleges, cost and relief cover. The implication is that staff will be better motivated towards training that can

be undertaken and assessed during working hours without loss of earnings.

Overall, the evidence in this study *indicates that whatever model of training and method of assessment is decided upon, residents have a vital part to play in the process*. Their views are probably of greatest importance. This implies that a means by which they too can be involved in the training process and called upon to assess staff needs to be devised and tested.

Thus homes need to select staff who possess good personal qualities. The job should be defined with these qualities in mind, staff should be trained accordingly and asessment should take this into account.

6. Conclusions and recommendations

* An 'entrepreneurial' focus on practical skills, in-house training and workplace assessment is likely to appeal to those most in need of training and qualifications - part-time staff and the private sector.
* Focus needs to placed on those elements of the 'professional' model that staff say are important.
* The limitations of the 'entrepreneurial' model need to be reviewed to allow for the incorporation of 'professional' understanding and the disposition of 'good people'.

* Staff in residential homes for elderly people need to be selected for their altruistic qualities as well as their practical abilities.
* Training should acknowledge the importance of specific practical skills.
* Training should, where possible, be undertaken at least partly, on an in-house basis.
* Training should integrate practical skills with professional understanding of residents needs.
* Assessment should take the need for this integrated approach into account.
* Assessment should take into account the views of residents.
* Good staff need to be encouraged to stay.

7. Final Comment

This study has contributed to the debate on training by bringing to light the benefits and limitations of an 'entrepreneurial' model of training. The benefits of the model are that it provides access to training and qualifications which focus on job specific practical skills. It can be 'sold' to the private sector and to a part-time workforce. Its limitations are that it does not take adequate account of the importance of 'good people'. The assumption has been that training makes

people 'better' carers. The study reveals that, from the point of view of the residents, it does not.

APPENDICES

APPENDIX I

NVO CANDIDATES REGISTERED UP TO 31/3/95

(Table 5)

1. Numbers of Full and Part time Staff:

Number of Local Authority full and part-time staff (Source: DOH, Local Authority Social Services Statistics: Staff of Local Authority Social Services Departments at 30/9/94, England, S/F 94/1, Table 7.

Number of Private full and part-time staff - Calculated from Table E, DOH, Residential Accomodation for Elderly and for Younger Physically Disabled People: All Residents in Local Authority, Voluntary and Private Homes, 31/3/93, England, RA/93/2. (Number of Residents = 134,510)
Calculation from Survey One data on Ratio of Residents to private staff (4:1) = 134,510/4 = 33,627. Percentage of Full time staff - 40%, Percentage of Part-time staff - 60%.
Thus Full time staff = 33627 x .40 = 13451, Part time staff = 33627 x .60 = 20176.

2. Estimated numbers of Full and Part time Residential care staff on NVQ Courses: (Source - CCETSW nvqdata2, 24/4/95)

Total Number of Candidates Registered for NVQ up to 31/3/95 15,356.

Employer	SSD	4774 (n1)
	Private	5295 (n2)
	Voluntary	1117 (n3)
	No Information	1720 (n4)
Employer Total =	15356 - 1720 =	13636 (n5)
Employment Basis	Part time	5382 (n6)
	Full time	8133 (n7)
Employment Setting	Residential	10113 (n8)
Client Group	Older People	9404 (n9)
	No Information	119 (n10)
Client Total =	15356 - 119 =	15345 (n11)

A = Estimated no. of local authority residential care staff:

n8 x (n1 / n5) = 3541

B = Estimated no. of local authority residential care staff in homes for the elderly:

A x (n9 / n11) = 2170

C = Estimated no. of full time local authority residential care staff in homes for the elderly:

B x (n7 /(n6 + n7)) = 1306

D = Estimated no. of part time local authority residential care staff in homes for the elderly:

B x (n6 / (n6 + n7)) = 864

E = Estimated no. of private residential care staff:

n8 x (n2 / n5) = 3927

F = Estimated no. of Private residential care staff in homes for the elderly:

E x (n9 / n11) = 2407

G = Estimated no. of Full time private residential staff in care homes for the elderly:

F x (n7 / (n6 + n7)) = 1449

H = Estimated no. of Part time private residential staff in homes for the elderly:

F x (n6 / (n6 + n7)) = 958

APPENDIX II

SURVEY ONE QUESTIONNAIRE

TRAINING NEEDS IN RESIDENTIAL CARE HOMES

Col.

SECTION A

Please give details of your Establishment, your care staff and your clients.

Name of Establishment.....

1-3 | | | |

1. Is this Establishment in the Local Authority Sector or in the Private Sector? (Please circle).

4

Local Authority 1

Private 2

Voluntary 3

2. Please indicate in number how many staff are employed at the home:
(e.g. |0|2|6|)

Care Assistants (Care staff who are employed to do routine basic care staff)		Full Time	5-6
		Part Time	7-8
Domestic Staff (Cooks/Cleaners etc)		Full Time	9-10
		Part Time	11-12
Supervisory Staff (Senior Care Assistants, Managers/Deputies/Matrons, excluding the proprietor/ Officer-in-Charge)		Full Time	13-14
		Part time	15-16

Col.

3.Please indicate how many residents you are able to accommodate:

.....

17-18

4. How many residents are currently being accommodated? (Please indicate number)

Male ☐☐☐

19-20

Female ☐☐☐

21-22

5. Of these residents, how many are aged 75 years and over?

☐☐☐

23-24

6. Are any of the residents in need of special care, that is suffering from any of the following? If so, please indicate how many.

Senile Dementia/Alzheimers Disease (Severe mental infirmity and memory impairment) ☐☐☐

25-26

Incontinent of urine (Require constant toilet attention) ☐☐☐

27-28

Severe hearing impairment ☐☐☐

29-30

Severe visual handicap ☐☐☐

31-32

Require help getting in and out of bed ☐☐☐

33-34

Require help with the stairs ☐☐☐

35-36

Others (please specify).....

.....

37-40

.....

.....

SECTION B

Col.

The following questions ask for details on the training that you have received.

7. Please indicate your occupational status (please circle)

41

Proprietor	1
Officer in Charge	2
Deputy Officer	3
Supervisor/Manager	4
Assistant Officer	5

8. Are you

42

Male	1
Female	2

9. How long have you been in charge of this establishment? ☐☐☐ years

43-44

10. How long have you worked in the Caring sector? (please circle)

45

Less than 12 months	1
One to 5 years	2
5 years or more	3

Col.

11. What if any was your previous occupation? (if housewife please state) 46-47

.....

12. Please state by whom you were employed:(please circle) 48

Self employed	1
Employed by the Local Authority	2
Employed in the Private Sector	3
Employed by the Health Sector	4
Other (e.g. Industry, Forces)	5

13. Have you received any training in social care or health care? (please circle) 49

Yes	1
No	2

14. If yes, please indicate whether you have had;

In-House Training	Yes	1	50
	No	2	
Social Services In-service Training	Yes	1	
	No	2	51
College Training	Yes	1	52
	No	2	

Other (please specify) 53-57

.....

.....

.....

Col.

15. What qualifications did you receive as a result of this training? (please circle) 58-68

CSS		1
CQSW		2
SRN		3
SEN		4
RNMH		5
ICSC		6
City & Guilds	325-1	7
	325-2	8
	325-3	9

Other (please state)

.....

.....

.....

16. What further training, if any, do you feel would be of benefit to you? 69-71

.....

.....

.....

.....

Col.

SECTION C

The following questions ask for details of training your staff have received.

17. How many of your care staff have received training in the past twelve months? ☐☐☐ 72-73

18. How many of these care staff are still employed at your home? ☐☐☐ 74-75

19. If trained, did any receive:

In-house training Yes 1 76
No 2

Social Services in-service training
Yes 1 77
No 2

College based training Yes 1 78
No 2

Other (please specify) 79-80
.....

19. How many have the following qualifications?

CSS	☐☐☐	101-102
CQSW	☐☐☐	103-104
SRN	☐☐☐	105-106
SEN	☐☐☐	107-108
RMNH	☐☐☐	109-110
ICSC	☐☐☐	111-112
City & Guilds 325-1	☐☐☐	113-114
City & Guilds 325-2	☐☐☐	115-116

Col.

City & Guilds 325-3 ☐☐☐ 117-118

City & Guilds 356 1/2 ☐☐☐ 119-120

Other (Please state) 121-124

.....

.....

.....

20. How many had this training paid for :

By your establishment ☐☐☐ 125-126

By the Care Assistant ☐☐☐ 127-128

By a combination of Establishment/Care Assistant ☐☐☐ 129-130

With a Government Training Grant ☐☐☐ 131-132

By the Education Authority ☐☐☐ 133-134

By the Social Services ☐☐☐ 135-136

By Other means (Please state)..... 137-140

.....

.....

SECTION D

This section asks for information as to your views regards the training of care staff.

21. Please indicate whether you feel that training for care assistants is:(Please circle) 141

Very Important 1

Important 2

Not Very Important 3

Not Important at all 4

22. Please state why, 142-146

.....

Col.

.....

23. Where do you feel training should take place? 147

In House 1

At College 2

Combination of both 3

24. Who do you feel should provide the training? (please circle) 148

Establishment proprietors/managers 1

Social Service Personnel 2

Education Service 3

A Combination 4

25. If you have indicated a combination to Q.24, please state which combination you feel is most appropriate: (please circle) 149

Establishment/Social Services 1

Establishment/Education Service 2

Establishment/Social/Education 3

Social Service/Education 4

26. What practical difficulties do you associate with staff training? 150-155

.....

.....

.....

.....

Col.

27. The following is a list of subjects that are currently offered on training courses for care assistants. The list is not exaustive, so please feel free to add your comments at the end of this questionnaire. Please indicate whether the subjects listed are: Very important (VI); Important (I); Not Very Important (NVI); or Not Relevant (NR), in relation to your staff and the job that they actually do.

Please circle one answer only for each subject.

	VI	I	NVI	NR	
Admission Procedures	1	2	3	4	156
AIDS/HIV Awareness	1	2	3	4	157
Anti-Discrimination	1	2	3	4	158
Assertion Techniques	1	2	3	4	159
Attitudes to Ageing	1	2	3	4	160
Basic Nursing Skills	1	2	3	4	161
Basic Psychology	1	2	3	4	162
Basic Sociology	1	2	3	4	163
Bathing	1	2	3	4	164
Care of the Dying	1	2	3	4	165

					Col.
Carrying out Assessments	1	2	3	4	166
Communicating with the elderly	1	2	3	4	167
Communication Skills (Verbal/ Non-verbal)	1	2	3	4	168
Confidentiality & the client	1	2	3	4	169
Continence Aids & Appliances	1	2	3	4	170
Coping with Aggressive clients	1	2	3	4	171
Coping with Stress	1	2	3	4	172
Dealing with Relatives	1	2	3	4	173
Dementia in the elderly	1	2	3	4	174
Dignity & Respect of the client	1	2	3	4	175
Emergency First Aid	1	2	3	4	176
Falls	1	2	3	4	177
Feeding the client	1	2	3	4	178
Fire Prevention	1	2	3	4	179
General Counselling with elderly people	1	2	3	4	180

					Col.
Group Living for elderly People	1	2	3	4	201
Health & Safety at work	1	2	3	4	202
Human Biology	1	2	3	4	203
Hygiene Practice	1	2	3	4	204
Impact of moving on elderly people	1	2	3	4	205
Implementing Care Plans	1	2	3	4	206
Legal Aspects of Care	1	2	3	4	207
Lifting & Handling Awareness	1	2	3	4	208
Loss and Bereavement	1	2	3	4	209
Mental Handicap	1	2	3	4	210
Mental Illnesses in the elderly	1	2	3	4	211
Mobility Aids	1	2	3	4	212
Nutritional Needs of the Elderly	1	2	3	4	213
Physical Handicaps	1	2	3	4	214
Promoting Continence	1	2	3	4	215

					Col.
Group Living for elderly People	1	2	3	4	201
Health & Safety at work	1	2	3	4	202
Human Biology	1	2	3	4	203
Hygiene Practice	1	2	3	4	204
Impact of moving on elderly people	1	2	3	4	205
Implementing Care Plans	1	2	3	4	206
Legal Aspects of Care	1	2	3	4	207
Lifting & Handling Awareness	1	2	3	4	208
Loss and Bereavement	1	2	3	4	209
Mental Handicap	1	2	3	4	210
Mental Illnesses in the elderly	1	2	3	4	211
Mobility Aids	1	2	3	4	212
Nutritional Needs of the Elderly	1	2	3	4	213
Physical Handicaps	1	2	3	4	214
Promoting Continence	1	2	3	4	215

					Col.
Reality Orientation Therapy	1	2	3	4	216
Report Writing	1	2	3	4	217
Reminiscence Therapy	1	2	3	4	218
Roles in the Health Service	1	2	3	4	219
Roles of Other Professionals	1	2	3	4	220
Self-awareness	1	2	3	4	221
Sexuality and old age	1	2	3	4	222
Study Skills	1	2	3	4	223
Teamwork	1	2	3	4	224
Toileting	1	2	3	4	225
Use of Common Drugs	1	2	3	4	226
Working with the blind client	1	2	3	4	227
Working with the deaf client	1	2	3	4	228

Col.

28. As regards domestic staff, do you feel that they should:

a) Receive training similar to that of care assistants? (please circle) 229

Yes 1

No 2

b) Receive training that relates directly to their job?

Yes 3

No 4

29. Finally, are there any other areas which you feel care assistants should receive training in. Please add your comments below or overleaf. 230

1-9

Signed.....

Thank you for your co-operation.

Angela Godfrey.

APPENDIX III

COMPARISON OF RESPONDING AND NON-RESPONDING HOMES IN CENTRAL AND NORTH WEST AREAS, BY NUMBERS OF RESIDENTS EACH HOME IS REGISTERED FOR

APPENDIX III - Responding and Non-responding Homes in Central and North West Areas, by Numbers of Residents each home is registered for.

Area	Homes which Responded		Homes which did not Respond	
	L.A.	Private	L.A.	Private
Central				
Up to 10	-	5	-	9
11 - 20	1	23	-	11
21 - 30	7	9	1	10
31 - 50	12	2	-	3
Total	20	39	1	33
North West				
Up to 10	-	11	-	7
11 - 20	-	20	-	16
21 - 30	3	8	1	14
31 - 50	10	1	2	9
Total	13	40	3	46

APPENDIX IV

QUALIFICATIONS OF CARE STAFF - SURVEY ONE

APPENDIX IV

Qualifications of Care Staff - Survey One:

Local Authority

(1) Includes CSS; CQSW; ICSC.
(2) Includes SRN; SEN; RMN.
(3) Includes City and Guilds 325-1 (n=24); City and Guilds 325-2 (n = 8); City ad Guilds 325-3 (n = 1); Caring for Clients (n = 18); Teacher Training (n = 2); ENB 941(n = 1); First Aid Courses (n = 3).

Private

(1) Includes CSS; CQSW; ICSC.
(2) Includes SRN; SEN; RMN.
(3) Includes Health and Hygiene Certificates; B/TEC 1st Diploma in Social Care; Pre-Nursing Certificate; St. John's Ambulance Basic Caring; City and Guilds Family and Community Care Certificate; City and Guilds Catering (7061/2); "Basic Care of the Elderly"; "Care Course Certificates".

APPENDIX V

PREVIOUS OCCUPATIONS OF OFFICERS-IN-CHARGE AND HOME OWNERS

APPENDIX V

Previous Occupations of Officers-in-Charge and Home Owners

Local Authority Homes:

(1) SRN; SEN; RGN; Ward Orderly; Nurse Auxiliary; Nursery Nurse.

(2) Care Assistant; Social Worker; Deputy Officer-in-Charge.

(3) Teacher; Insurance Clerk; Solicitors Clerk; Comptometer Operator; Secretary; Monk; Shop Assistant.

Private Homes:

(1) RMN; RGN; SRN; SEN; Matron; Senior Nursing Officer; Senior Nurse Tutor; Ward Sister; Doctor; Ambulance Driver; Occupational Therapist

(2) Care Assistant; Senior Care Assistant; Residential Home Manager; Residential Social Worker; Day Centre Social Worker; Social Services Training Officer; Officer-in Charge; Youth Worker; Armed Forces Welfare.

(3) Director (Retailing/Catering); Public Relations Manager; Shop Proprietor; Teacher; Dental Technician; Secretary; Hotelier; Clergyman; Fire Fighter; Armed Forces Personnel.

APPENDIX VI

QUALIFICATIONS OF LOCAL AUTHORITY OFFICERS-IN-CHARGE

APPENDIX VI

Qualifications of Local Authority Officers-in-charge

(1) Includes CSS; CQSW; ICSC

(2) Includes SRN; SEN; RMN.

(3) Includes respondents who listed alternative or extra qualifications:

(a) Management and Staff Development

(b) Other Nurse Training - Midwife; Opthalmics; District Nurse; NNEB; Health Visitor; ENB 941.

NB Dual Qualifications - Thirteen respondents had more than one listed qualification, as follows:

CSS + SEN (n=1)

CSS + SRN (n=1)

CSS + ICSC (n=7)

SEN + ICSC (n=1)

CSS + SRN + ICSC (n=3)

APPENDIX VII

QUALIFICATIONS OF PRIVATE HOME OWNERS

Appendix VII

Qualifications of Private Home Owners:

(1) Includes CSS; CQSW; ICSC

(2) Includes SEN; SRN; RMN

(3) Includes alternative and extra qualifications as follows:

(a) Other Health/Nurse training - ENB; MB/MD; OND Orthopaedic Nursing Certificate; Occupational Therapy.

(b) Degree Courses - includes one respondent who had taken an MSC in Care of the Elderly

(c) Other courses - Management courses; Open University 'Caring for Older People'; Post-Registration Care of the Elderly Certificate; NEBSM; Food Hygiene Certificates; "Various Courses".

NB Six respondents had more than one listed qualification, as follows:

CSS + SEN (n=1)

CSS + SRN + RMN (n=1)

SRN + RMN (n=2)

SEN + RMN (n=1)

SRN + City and Guilds 325-3 (n=1)

APPENDIX VIII

A PRIORI LIST - VALIDITY TEST

(Number of 'judges' who circled the column number in brackets)

The following is a list of areas in which care staff currently receive training. Please indicate whether you consider each area to be "professional" (that is, with the emphasis on social care/social work methods) or "pragmatic" (that is, with the emphasis on practical skills). Please circle one answer only for each area. Thank you.

	Professional		Pragmatic	
Admission procedures	1	(17)	2	(5)
AIDS/HIV Awareness	1	(15)	2	(7)
Anti-Discrimination	1	(19)	2	(3)
Assertion techniques	1	(15)	2	(7)
Attitudes to Ageing	1	(20)	2	(2)
Basic nursing skills	1	(1)	2	(21)
Basic Psychology	1	(11)	2	(11)
Basic sociology	1	(11)	2	(11)
Bathing	1	(-)	2	(22)
Care of the dying	1	(7)	2	(15)
Carrying out assessments	1	(20)	2	(2)
Communicating with the Elderly	1	(16)	2	(6)
Communication Skills (Verbal/non-verbal)	1	(16)	2	(6)
Confidentiality & the Client	1	(19)	2	(3)
Continence aids and appliances	1	(5)	2	(17)
Coping with Aggressive Clients	1	(11)	2	(11)
Coping with Stress	1	(22)	2	(-)
Dealing with relatives	1	(17)	2	(5)
Dementia in the elderly	1	(9)	2	(13)
Dignity and respect for the Client	1	(19)	2	(3)
Emergency First Aid	1	(-)	2	(22)
Falls	1	(1)	2	(21)
Feeding the Client	1	(3)	2	(19)
Fire Prevention	1	(2)	2	(20)
General Counselling with Elderly people	1	(20)	2	(2)
Group Living for Elderly People	1	(13)	2	(9)
Health and Safety at work	1	(4)	2	(18)
Human Biology	1	(9)	2	(13)
Hygiene Practice	1	(2)	2	(20)
Impact of Moving on Elderly People	1	(19)	2	(3)
Implementing care plans	1	(20)	2	(2)
Legal aspects of care	1	(14)	2	(8)
Lifting and Handling Awareness	1	(1)	2	(21)
Loss and Bereavement	1	(18)	2	(4)
Mental Handicap	1	(17)	2	(5)

Mental Illnesses	1	(15)	2	(7)
Mobility Aids	1	(3)	2	(19)
Nutritional needs of the Elderly	1	(8)	2	(14)
Physical Handicaps	1	(10)	2	(12)
Promoting Continence	1	(15)	2	(7)
Reality Orientation Therapy	1	(16)	2	(6)
Report Writing	1	(11)	2	(11)
Roles in the Health Service	1	(14)	2	(13)
Roles of other professionals	1	(15)	2	(12)
Self Awareness	1	(19)	2	(3)
Sexuality and old age	1	(18)	2	(4)
Study Skills	1	(15)	2	(7)
Teamwork	1	(12)	2	(10)
Toileting	1	(2)	2	(20)
Use of Common Drugs	1	(6)	2	(16)
Working with the Blind Client	1	(7)	2	(15)
Working with the Deaf Client	1	(8)	2	(14)

Outcome: From the original list of 53 variables, 27 'professional' variables and 18 'pragmatic' variables were matched by the 'judges'. The criteria for a variable to be placed in one column or another for analysis was a score of 11 or over. Four variables were given equal scores, of which two - Basic Psychology and Basic Sociology - were dropped from the analysis. Of the other two - Coping with Aggressive clients was placed in the 'professional' column as it was intended to reflect an emphasis on understanding rather than physical coping; and Report Writing was placed in the 'pragmatic' column as it is an essentially practical function. Three variables were given scores opposite to the original list. Two (Mental Handicap and Mental Illnesses) were dropped and the remaining variable - Communication Skills remained in the original list as a 'professional' variable, as it involves an understanding of the need to communicate in a professional manner. One variable, Reminiscence Therapy was missed off the list, but remained in the original list.

APPENDIX IX

A PRIORI LIST OF 'PROFESSIONAL' AND 'ENTREPRENEURIAL' TRAINING AREA VARIABLES

APPENDIX IX

A Priori List of 'Professional' and 'Entrepreneurial' Training Area Variables

a) 'Professional'

ADMISSIONS PROCEDURE

AIDS/HIV AWARENESS

ANTI-DISCRIMINATION

ASSERTION TECHNIQUES

ATTITUDES TO AGEING

CARRYING OUT ASSESSMENTS

COMMUNICATING WITH THE ELDERLY

COMMUNICATION SKILLS

CONFIDENTIALITY

COPING WITH AGGRESSIVE CLIENTS

COPING WITH STRESS

DEALING WITH RELATIVES

DIGNITY AND RESPECT OF THE CLIENT

GENERAL COUNSELLING WITH THE ELDERLY

GROUP LIVING FOR ELDERLY PEOPLE

IMPACT OF MOVING ON THE ELDERLY

IMPLEMENTING CARE PLANS

LEGAL ASPECTS OF CARE

LOSS AND BEREAVEMENT

PROMOTING CONTINENCE

REALITY ORIENTATION THERAPY

REMINISCENCE THERAPY

ROLES IN THE HEALTH SERVICE

ROLES OF OTHER PROFESSIONALS

SELF AWARENESS

SEXUALITY AND OLD AGE

STUDY SKILLS

TEAMWORK

b) 'Entrepreneurial'

BASIC NURSING SKILLS

BATHING

CARE OF THE DYING

CONTINENCE AIDS AND APPLIANCE

DEMENTIA IN THE ELDERLY

EMERGENCY FIRST AID

FALLS

FEEDING THE CLIENT

FIRE PREVENTION

HEALTH AND SAFETY AT WORK

HUMAN BIOLOGY

HYGIENE PRACTICE

LIFTING AND HANDLING AWARENESS

MOBILITY AIDS

NUTRITIONAL NEEDS OF THE ELDERLY

PHYSICAL HANDICAPS

REPORT WRITING

TOILETING

USE OF COMMON DRUGS

WORKING WITH THE BLIND CLIENT

WORKING WITH THE DEAF CLIENT

APPENDIX X

ANALYSIS OF VARIANCE FOR MEAN 'PROFESSIONAL' AND 'ENTREPRENEURIAL' SCORES BY QUALIFICATIONS

Appendix X

Analysis of Variance

Table 33

Dependent Variable: Professional score

By Levels of: Sector, Qualifications

	Sum of Squares	DF	Mean Square	F	Sig of F
Main effects	986.593	3	328.864	3.213	.026
SECTOR	897.306	1	897.306	8.766	.004
QUALIFICATIONS	89.207	2	44.643	.436	.648
2-way					
Interactions	294.296	2	147.148	1.438	.242
Explained	1280.889	5	256.178	2.503	.035
Residual	10645.302	104	102.359		
Total	11926.191	109	109.415		

Table 34

Dependent Variable: Entrepreneurial Score

By levels of: Sector. Qualifications

Main effects	13.239	3	4.413	.118	.949
SECTOR	2.413	1	2.413	.064	.800
QUALIFICATIONS	10.826	2	5.413	.145	.866
2-way					
Interactions	38.552	2	19.276	.515	.599
Explained	51.791	5	10.358	.277	.925
Residual	3891.809	104	37.421		
Total	3943.600	109	36.180		

APPENDIX XI

SURVEY TWO QUESTIONNAIRE

TRAINING NEEDS IN RESIDENTIAL CARE HOMES

(Care Staff Questionnaire)

Name of Establishment.....

1. Is this Establishment in the Local Authority Sector or in the Private Sector? (Please circle).

Local Authority 1

Private 2

1 - 4

SECTION A

This section asks for a few personal details. The information you give is for statistical use only.

1. What age are you? (Please circle whichever applies) 5

Under 20 1

20 - 29 2

30 - 39 3

40 - 49 4

50 - 59 5

60 and over 6

2. Are you Male 1 Female 2 (Please circle) 6

3. What is your occupation? (Please circle)

Care Assistant 1 7

Senior Care Assistant 2

Other (Please specify) 3

.....

.....

4. Do you work Full Time 1 Part Time 2 8

5. Are you on duty at night only? (Please circle) 9

Yes 1 No 2

6. Do you supervise other staff? (Please circle) 10

Yes 1 No 2

7. If yes, please give brief details

.....

.....

.....

SECTION B

The following questions ask for details on your work experience and the type of work that you do.

8. How long have you been employed at this establishment? 11 - 12

.....

9. How long have you worked in the Caring Sector? (Please circle) 13

Less than 12 months 1

One to 5 years 2

5 years or more 3

10. What was your previous occupation? 14 - 20

.....

.....

11. Please state by whom you were employed:(please circle) 21

Self employed 1

Employed by the Local Authority 2

Employed in the Private Care Sector 3

Employed by the Health Sector 4

Other (e.g. private business) 5

12. Please read this list carefully and indicate whether or not you do each job <u>as part of your regular duties.</u>
(Please circle)

a)	Washing clothes/bed linen Yes 1 No 2	22
b)	Helping to dress/undress residents Yes 1 No 2	23
c)	Reading/writing letters for residents Yes 1 No 2	24
d)	Encouraging residents to do things for themselves Yes 1 No 2	25
e)	Making drinks/helping with feeding/ serving food Yes 1 No 2	26
f)	Making beds/changing beds Yes 1 No 2	27
g)	Taking residents for walks Yes 1 No 2	28
h)	Paperwork - e.g. rotas Yes 1 No 2	29
i)	Preparing or cooking food Yes 1 No 2	30
j)	Playing games with residents e.g. Cards/Bingo Yes 1 No 2	31
k)	Changing dressings Yes 1 No 2	32
l)	Administering drugs Yes 1 No 2	33
m)	Shopping for the residents Yes 1 No 2	34
n)	Cleaning/polishing/dusting Yes 1 No 2	35
o)	Tidying up Yes 1 No 2	36
p)	Mending/darning/name tagging Yes 1 No 2	37
q)	Washing up/drying up Yes 1 No 2	38
r)	Laying tables/clearing away Yes 1 No 2	39
s)	Dealing with/talking to visitors Yes 1 No 2	40
t)	Taking residents to the toilet Yes 1 No 2	41
u)	Sluicing Yes 1 No 2	42
v)	Organising and/or taking part in social events/outings Yes 1 No 2	43
w)	Washing/bathing/putting residents to bed. Yes 1 No 2	44

13. Are there any other jobs that you do on a regular basis that are not included in Q.12.?(Please specify below)

45 - 50

.....

.....

.....

.....

.....

.....

14. What is your reason for doing this job?

51 - 55

.....

.....

.....

.....

.....

.....

SECTION C

This section asks for details of the training that you have received.

15. Have you received any training in social care or health care? (please circle)

56

Yes 1

No 2

16. Was this training focused on:

57

a) Mainly practical skills 1
b) Mainly client needs and problems 2
c) Mainly your role with other people 3
d) A combination (Please specify) 4

.....

.....

.....

.....

17. Please indicate whether you have had;

In-House Training	Yes 1	No 2	58
Social Services Training	Yes 1	No 2	59
College Training	Yes 1	No 2	60
Health Service Training	Yes 1	No 2	61

Other (please specify) 62

.....

.....

.....

18. What qualifications did you receive as a result of this training? (please circle) 63 - 64

CSS	1
CQSW	2
SRN	3
SEN	4
RMN	5
ICSC	6
Caring for Clients	7
City & Guilds 325-1	8
325-2	9
325-3	10

NVQ Level II 11

NVQ Level III 12

Other (Please specify)

.....

.....

.....

19. Was this training paid for by: (Please circle) 65

Your Employer	1
Yourself	2
A Combination of Employer/Yourself	3
A Government Training Grant	4
The Education Authority	5
The Social Services	6
Other Means (Please specify)	7

.....

.....

20. What further training, if any, do you feel would be of benefit to you? 66 - 70

.....

.....

.....

.....

SECTION C

This section asks for information as to your views regards the training of care staff.

21. Please indicate whether you feel that training for care assistants is: (Please circle) 71

Very Important	1
Important	2
Not Very Important	3
Not Important at all	4

22. Please state why 72 - 75

.....

.....

.....

23. Where do you feel training should take place? 76
(Please circle)

In House	1
At College	2
Combination of both	3

24. Who do you feel should provide the training? (Please circle) 77

Establishment/Managers	1
Social Services	2
Education Service	3
A Combination	4

25. If you have indicated a combination to Q.24, please state which combination you feel is most appropriate: (Please circle) 78

Establishment/Social Services	1
Establishment/Education Service	2
Establishment/Social/Education	3
Social Service/Education	4
Not applicable	5

6. Thinking about day release training, are any of the following likely to be a problem for you? (Please tick appropriate box) 79

a) Transport 1
b) Family Commitments 2
c) Cost 3
d) Difficulty of getting relief cover 4
e) Problems for the home in releasing you 5
f) Other (Please specify) 6

.....

.....

.....

.....

7. Do you feel that your training, if any, has been relevant and/or useful to the job that you do at this establishment? 80

(Please circle)

Yes 1 Not Sure 3
No 2 Not applicable 4

8. Has training helped you to:
(Please answer each statement by circling the appropriate response)(N/A = Not applicable)

a) See clients differently 101

Yes 1 No 2 Not sure 3 N/A 4

b) Become more self aware 102

Yes 1 No 2 Not sure 3 N/A 4

c) Lift and handle clients 103

Yes 1 No 2 Not sure 3 N/A 4

d) Deal with other professionals 104

Yes 1 No 2 Not sure 3 N/A 4

e) Understand more about clients problems 105

Yes 1 No 2 Not sure 3 N/A 4

f) Become more assertive 106

Yes 1 No 2 Not sure 3 N/A 4

TEXT CUT OFF IN ORIGINAL

g) Help clients with aids and appliances

Yes 1 No 2 Not sure 3 N/A 4 107

h) Work in a team

Yes 1 No 2 Not sure 3 N/A 4 108

i) Understand more about clients families

Yes 1 No 2 Not sure 3 N/A 4 109

j) Develop high standards

Yes 1 No 2 Not sure 3 N/A 4 110

k) Improve record keeping

Yes 1 No 2 Not sure 3 N/A 4 111

l) Take on more responsibility

Yes 1 No 2 Not sure 3 N/A 4 112

m) Communicate with clients

Yes 1 No 2 Not sure 3 N/A 4 113

n) Develop confidence

Yes 1 No 2 Not sure 3 N/A 4 114

o) Work with the terminally ill

Yes 1 No 2 Not sure 3 N/A 4 115

p) Develop good working relationships

Yes 1 No 2 Not sure 3 N/A 4 116

9. Are there any other ways in which training has elped you in your job? 117 - 1

.....

.....

.....

.....

.....

0. Are there any aspects of training that you feel have ot helped you in your job? 126 - 1

.....

.....

.....

.....

31. Given the job that you actually do, how important is it that training should be provided for this job in the following areas? The list is not exaustive, so please feel free to add your comments at the end of this questionnaire. Please indicate whether the areas listed are: Very Important (VI); Important (I); Not Very Important (NVI); or Not Relevant (NR).

(Please circle one answer only for each subject).

	VI	I	NVI	NR	
Admission Procedures	1	2	3	4	131
AIDS/HIV Awareness	1	2	3	4	132
Anti-Discrimination	1	2	3	4	133
Assertion Techniques	1	2	3	4	134
Attitudes to Ageing	1	2	3	4	135
Basic Nursing Skills	1	2	3	4	136
Basic Psychology	1	2	3	4	137
Basic Sociology	1	2	3	4	138
Bathing	1	2	3	4	139
Care of the Dying	1	2	3	4	140
Carrying out Assessments	1	2	3	4	141
Communicating with the elderly	1	2	3	4	142
Communication Skills (Verbal/ Non-verbal)	1	2	3	4	143

Confidentiality & the client	1	2	3	4	144
Continence Aids & Appliances	1	2	3	4	145
Coping with Aggressive clients	1	2	3	4	146
Coping with Stress	1	2	3	4	147
Dealing with Relatives	1	2	3	4	148
Dementia in the elderly	1	2	3	4	149
Dignity & Respect of the client	1	2	3	4	150
Emergency First Aid	1	2	3	4	151
Falls	1	2	3	4	152
Feeding the client	1	2.	3	4	153
Fire Prevention	1	2	3	4	154
General Counselling with elderly people	1	2	3	4	155
Group Living for elderly people	1	2	3	4	156
Health & Safety at work	1	2	3	4	157
Human Biology	1	2	3	4	158
Hygiene Practice	1	2	3	4	159

Impact of moving on elderly people	1	2	3	4	160
Implementing Care Plans	1	2	3	4	161
Legal Aspects of Care	1	2	3	4	162
Lifting & Handling Awareness	1	2	3	4	163
Loss and Bereavement	1	2	3	4	164
Mental Handicap	1	2	3	4	165
Mental Illnesses in the elderly	1	2	3	4	166
Mobility Aids	1	2	3	4	167
Nutritional Needs of the Elderly	1	2	3	4	168
Physical Handicaps	1	2	3	4	169
Promoting Continence	1	2	3	4	170
Reality Orientation Therapy	1	2	3	4	171
Report Writing	1	2	3	4	172
Reminiscence Therapy	1	2	3	4	173
Roles in the Health Service	1	2	3	4	174
Roles of Other Professionals	1	2	3	4	175
Self-awareness	1	2	3	4	176
Sexuality and old age	1	2	3	4	177

Study Skills	1	2	3	4	178
Teamwork	1	2	3	4	179
Toileting	1	2	3	4	180
Use of Common Drugs	1	2	3	4	201
Working with the blind client	1	2	3	4	202
Working with the deaf client	1	2	3	4	203

32. As regards domestic staff, do you feel that they should: 204

a) Receive some training similar to that of care assistants? (please circle)

Yes 1

No 2

b) Only receive training that relates directly to their bb? 205

Yes 1

No 2

33. Finally, are there any other areas which you feel care assistants should receive training in. Please add your comments below or overleaf.

206 - 220

Thank you for your co-operation.

Angela Godfrey.

APPENDIX XII

MEAN SCORES FOR ALL TRAINING VARIABLES

Mean scores for all training variables

Training Variable	Local Authority		Private	
	Staff	Managers	Staff	Owners
Admission procedures	1.96	1.40	1.96	1.73
Attitudes to Ageing	1.24	1.11	1.28	1.18
Coping with Aggression	1.19	1.44	1.36	1.45
AIDS/HIV Awareness	1.30	1.20	1.85	2.18
Assertion Techniques	1.83	1.89	1.97	2.00
Carrying out assessments	1.70	1.67	1.88	1.95
Basic Nursing skills	1.57	2.10	1.52	1.68
Bathing	1.35	1.22	1.36	1.27
Human biology	1.88	2.78	2.06	2.45
Implementing care plans	1.69	1.33	1.83	1.73
Care of the dying	1.13	1.30	1.14	1.18
Communicating/elderly	1.12	1.11	1.12	1.13
Communication skills	1.23	1.22	1.38	1.27
Confidentiality	1.24	1.11	1.25	1.27
Continence aids	1.40	1.56	1.40	1.59
General counselling	1.52	1.78	1.53	1.41
Dementia	1.21	1.22	1.26	1.27
Dignity and respect	1.08	1.11	1.15	1.09
Anti-discrimination	1.61	1.44	2.10	2.09
Use of common drugs	1.44	2.11	1.24	1.36
Emergency First Aid	1.25	2.00	1.17	1.22
Falls	1.16	1.56	1.15	1.34
Feeding	1.54	1.67	1.63	1.41
Fire prevention	1.09	1.11	1.10	1.00
Group living	1.66	1.67	1.70	1.45
Roles in health service	1.84	2.44	2.18	2.68
Health and Safety	1.15	1.10	1.17	1.23
Working with the deaf	1.27	1.56	1.55	1.64
Hygiene practice	1.16	1.10	1.21	1.09
Legal aspects of care	1.76	2.11	1.92	2.04
Lifting and handling	1.19	1.00	1.18	1.23
Loss and bereavement	1.25	1.60	1.28	1.36
Mobility aids	1.38	1.33	1.59	1.73
Impact of moving	1.33	1.67	1.57	1.59

Nutritional needs	1.44	1.11	1.45	1.41
Physical handicaps	1.45	1.56	1.59	1.59
Promoting continence	1.41	1.22	1.68	1.41
Roles of other professionals	1.79	2.33	2.08	2.73
Reminiscence therapy	1.81	1.78	1.88	2.05
Dealing with relatives	1.58	1.89	1.67	1.41
Report writing	1.67	1.90	1.77	1.77
Reality orientation therapy	1.72	1.56	1.96	2.00
Self awareness	1.34	1.44	1.63	1.86
Sexuality and old age	1.73	1.89	1.95	1.86
Coping with stress	1.25	1.44	1.40	1.32
Study skills	1.97	2.00	2.11	2.23
Teamwork	1.12	1.00	1.36	1.18
Toileting	1.17	1.44	1.32	1.32
Working with the blind	1.27	1.56	1.63	1.73

APPENDIX XIII

MEAN TRAINING AREA SCORES ('PROFESSIONAL' AND 'ENTREPRENEURIAL') FOR EACH LOCAL AUTHORITY AND PRIVATE HOME BY STAFF, OFFICERS-IN-CHARGE, AND PRIVATE HOME OWNERS

Mean Training Area Scores for each home:

Local Authority Homes:

Home	Staff (P)	OIC (P)	Staff (E)	OIC (E)
LA1	1.45	*	1.36	*
LA2	1.57	1.11	1.40	1.14
LA3	1.56	1.75	1.38	1.89
LA4	1.79	1.50	1.38	1.71
LA5	1.57	1.07	1.44	1.57
LA6	1.45	1.32	1.36	1.24
LA7	1.31	1.50	1.67	1.43
LA8	1.46	1.36	1.31	1.33
LA9	1.33	1.82	1.34	1.52
LA10	1.41	2.64	1.17	2.24
All	1.49	1.56	1.38	1.56

Private Homes:

	Staff (P)	Owner (P)	Staff (E)	Owner (E)
P1	2.18	1.82	1.76	1.71
P2	1.54	2.36	1.32	1.71
P3	1.81	1.43	1.61	1.19
P4	1.57	1.57	1.25	1.19
P5	2.61	2.00	2.19	2.00
P6	1.44	1.71	1.11	1.38
P7	1.66	1.93	1.57	2.00
P8	1.74	2.14	1.34	1.57
P9	1.75	1.36	1.39	1.38
P10	1.29	2.03	1.00	1.00
P11	1.27	1.29	1.16	1.09
P12	1.74	1.29	1.48	1.09

Home	Staff (P)	Owner (P)	Staff (E)	Owner (E)
P13	2.11	1.39	1.92	1.19
P14	1.23	2.04	1.13	1.43
P15	1.25	1.32	1.21	1.09
P16	1.64	2.32	1.40	1.90
P17	1.62	1.75	1.35	1.14
P18	1.36	1.46	1.30	1.33
P19	1.62	1.25	1.31	1.24
P20	2.62	2.29	1.74	2.09
P21	1.36	1.32	1.18	1.09
P22	1.61	1.91	1.38	1.81
All	1.68	1.73	1.41	1.44

APPENDIX XIV

CARE STAFF QUESTIONNAIRE

SURVEY THREE

STAFF QUESTIONS CASE NO

This questionnaire is intended to help me know more about how staff feel about any training they have had or may have, and what staff feel is important regards providing residents with the care they need.
All information will be totally confidential, your name and age being needed only to help me in establishing which members of staff the residents have spoken about. Actual names will not be used at all in the results. Please circle the appropriate number.

Name..... Age.....

Sex: Male 1 Female 2

How long in this job.....

SECTION A

1. Have you had any formal training (that is, leading to a recognised qualification) in relation to your job as a care assistant?

Yes 1 (go to Q.6) No 2 (go to Q.2)

2. If No, are you about to receive any training?

Yes 1 (Go to Q.4) No 2 (go to Q.3)

3. Do you feel you:

a) Want training? Yes 1 No 2

Why is that?.....
.....
.....
.....
.....

b) Need training? Yes 1 No 2

Why is that?.....
.....
.....
.....
.....

4. If you are about to receive training, what is the title of the course. Please give full details if possible.

.....
.....
.....
.....

5. What would you expect training to provide you with?

.....
.....
.....
.....

6. If trained have you done any of the following

a) A City & Guilds course	Yes	1	No	2
b) A B/Tec course	Yes	1	No	2
c) A National Vocational Qualification (NVQ)	Yes	1	No	2

Other (Please State).....

.....
.....
.....

7. If you are currently doing a course, please give details.....

.....
.....
.....

8. If you have done more than one course, please state which course was the most recent. (Please circle only <u>one</u> number)

a) City and Guilds 1

b) B/Tec 2

c) NVQ 3

d) None of these 4

9. Was this training course done during your employment here?

Yes 1 No 2
(go to Q.10)

10. If yes, did the home owner/manager have any influence on the type of training or the course that you did?

Yes 1

In what way.....
.....

No 2

Can you then tell me your reason for doing the course?.....
.....

11. What did the training course cover?

A) Practical Skills (Please give details)

.....
.....
.....
.....

B) Personal skills (Please give details)

.....
.....
.....
.....

12. What, if anything, do you personally feel you got from the course?
.....
.....
.....
.....

13. Do you feel that the training:

(Please circle a) or b)

a) Improved my caring skills 1

In what way?.....
.....
.....

b) Not made any difference 2

Why is that?.....
.....
.....

14. Can you now think about the training you've had. Did it help a great deal (HAGD), help you a litle (HYAL), did not help (DNH) or was not applicable or you don't know (NA/DK) with your job? (Please circle the appropriate number against each statement)

	HAGD	HYAL	DNH	NA/DK
Ensuring the privacy of residents	1	2	3	4
Keeping residents rooms clean	1	2	3	4
Mending residents clothes	1	2	3	4
Being a friend to residents	1	2	3	4
Getting on with people	1	2	3	4
Bathing residents	1	2	3	4
Being patient	1	2	3	4
Knowing what individual residents like	1	2	3	4
Tolerance	1	2	3	4
Toileting residents	1	2	3	4
Confidentiality	1	2	3	4
Letting residents choose for themselves (e.g. clothes)	1	2	3	4
Dressing residents	1	2	3	4
Safe Lifting	1	2	3	4
Communicating with residents	1	2	3	4
Respecting residents views	1	2	3	4
Keeping residents clean	1	2	3	4
Feeding residents	1	2	3	4
Knowing First Aid	1	2	3	4
Being a good listener	1	2	3	4

Giving medication	1	2	3	4
Nursing skills	1	2	3	4
Building confidence	1	2	3	4

15. Do you have any other comments to make about the training you have received.

(Please Turn to Section B)

SECTION B

16. Next, I would like you to tell me what you think makes a good care assistant?

.....
.....
.....
.....
.....

17. I would like you now to rate the following groups of skills and qualities in descending order of importance (1 - 6) to you in your job as a care assistant. Write the corresponding letter (a - f) of each skill or quality in each group next to the number in each box.

GROUP 1. a) PRIVACY, b) BATHING, c) KEEPING A SECRET, d) KEEPING RESIDENTS CLEAN, e) MATURITY, f) NOT 'FUSSING'.

1.

2.

3.

4.

5.

6.

GROUP 2. a) KEEPING ROOMS CLEAN, b) PATIENCE, c) LETTING RESIDENTS CHOOSE FOR THEMSELVES, d) FEEDING, e) WILLINGNESS TO HELP, f) TOILETING.

1.

2.

3.

4.

5.

6.

GROUP 3. a) MENDING CLOTHES, b) KNOWING WHAT RESIDENTS LIKE, c) DRESSING, d) RESPECT, e) COMMON SENSE, f) BEING A GOOD TALKER.

1.

2.

3.

4.

5.

6.

GROUP 4. a) BEING A FRIEND, b) TOLERANCE, c) LIFTING, d) BUILDING CONFIDENCE, e) NURSING SKILLS, f) GOOD LISTENER.

1.

2.

3.

4.

5.

6.

GROUP 5. a) GETTING ON WITH PEOPLE, b) NICE PERSONALITY, c) GIVING MEDICATION, d) SENSE OF HUMOUR, e) KEEPING RECORDS, f) FIRST AID.

1.

2.

3.

4.

5.

6.

18. Do you have any comments to make on any of the above skills and qualities?

.....
.....
.....
.....
.....
.....
.....

Thank you for your help

Angela Godfrey

APPENDIX XV

RESIDENT QUESTIONNAIRE

SURVEY THREE

RESIDENT SURVEY Case No.

I am doing research on what makes a good care assistant and what training care assistants might need. I would like to ask for your help in finding out this information, based on your valuable experience and views. All the information that you are able to give me will be totally confidential.

1. Personal details: These first questions are intended to help me find out a little about you as an individual.

What is your age? .....

Sex Male 1 Female 2

How long have you been living at this home?
.....

(Female respondents) Can I ask if you have been married?

Yes 1 No 2

(If married) What did your husband do?
.....
.....

(All residents) What was your usual job?
.....
.....

Do you have any hobbies or special interests?
.....
.....

How much time do you spend in the company of other residents? (for example, the lounge or any other public area).

Most of the day Part of the day

1 2

Given a choice would you prefer to spend more time on your own?

Yes 1 No 2

Why is that?.....
.....
.....

2. In order to help me to understand how much help, if any, you need from the care staff, I would like to ask you if you have difficulty with any of the following?

(Record further information if resident mentions any specific help that is given)

	A lot	Some	Very Little	None
Mobility (walking, getting around)	1	2	3	4
Climbing Stairs	1	2	3	4
Getting dressed	1	2	3	4
Eating or drinking	1	2	3	4
Having a bath	1	2	3	4
Going to the toilet	1	2	3	4
Getting in and out of bed	1	2	3	4
Sleeping	1	2	3	4
Hearing	1	2	3	4
Reading	1	2	3	4

Is there anything else you need help with?.....

.....

(If applicable) Do you need any help from the staff with your hobby or special interest?

Yes 1 No 2

3. Now I would like to ask you some general questionson how you feel about being looked after by the care staff.
(Record responses)

What are the main/most important things that staff do for you?
.....
.....
.....

How do you like the staff to behave towards you when they are doing things for you?.....
.....
.....
.....

Do you <u>like</u> the staff to do things for you?
.....
.....
.....

Now some more specific questions (Use prompt cards)

	A lot	Sometimes	Not Very Often	Never
Do you mind having to rely on the staff for help?	1	2	3	4
Do you like to talk to staff about things that are worrying you?	1	2	3	4
Do you like the staff to touch you? (e.g. a hug, cuddle)	1	2	3	4
Do you like staff to talk about themselves? (e.g. families, problems)	1	2	3	4

4. Next I would like you to tell me what you think makes a good care assistant. (record)

.....
.....
.....
.....

5. Could I now ask you for your views on two members of staff, x (name) and y (name) who have both given me their permission to talk to residents about them. The reason for selecting x and y is simply that one has been formally trained and one has not, and I am interested in finding out if training makes any difference to the way in which residents are cared for (explain further if necessary).

Care Assistant x) Can you describe to me in your own words the sort of person she is?
(Record responses)
(If resident finds this difficult to do, use questions below).

Do you like her? (If response is negative probe why)

What do you like about her?

Are there any jobs that she is particularly good at?
(Probe practical and personal skills)

Is there anything that you feel she could be better at?
(Probe practical and personal skills)

Do you miss her when she is away (holiday, off sick)

Is there anything else that you would like to tell me about x?

(Ditto with care assistant y overleaf.)

Care assistant y) Can you descibe to me the kind of person she is?

Do you like her?

What do you like about her?

Are there any jobs that she is particularly good at?

Is there anything that you feel she could be better at?

Do you miss her when she is away?

Is there anything else that you would like to tel me about y?

5a. Which of the two care staff would you, given a choice, rather:

	(x)	(y)	NP
Be a friend with?	1	2	3
Bath you?	1	2	3
Toilet you?	1	2	3
Tell a secret to?	1	2	3
Dress you?	1	2	3
Lift you?	1	2	3
Chat with?	1	2	3
Share a joke with?	1	2	3
Tidy your room?	1	2	3
Give you your medication?	1	2	3

5b) Can you tell me, which care assistant, x or y, is:

	x	y
The most caring	1	2
The most practical	1	2

6. Finally, I would like <u>your own</u> <u>personal opinion</u> on what are the most important, next most important and least important practical skills and personal qualities in the people that care for you. To help you with this, I will show you a set of cards that each have a practical skill or personal quality written on them. I would like you to tell me whether you think each practical skill or personal quality is either Very Important, Not So Important or Not Important at all to you. If you're not sure or don't know please say.

(Use cards, explain if necessary and circle the appropriate number)

		VI	NSI	NI	DK
1.	Ensuring privacy when you want it.	1	2	3	4
2.	Keeping your room clean	1	2	3	4
3.	Mending clothes	1	2	3	4
4.	Being a friend	1	2	3	4
5.	Not fussing	1	2	3	4
6.	Getting on with people	1	2	3	4
7.	Good at Bathing	1	2	3	4
8.	Patience	1	2	3	4
9.	Knowing what I like	1	2	3	4
10.	Tolerance	1	2	3	4
11.	Good at Toileting	1	2	3	4
12.	Nice Personality	1	2	3	4
13.	Keeping a secret	1	2	3	4
14.	Letting you choose for yourself (e.g. clothes)	1	2	3	4
15.	Dressing you	1	2	3	4
16.	Safe at Lifting	1	2	3	4
17.	Good Talker	1	2	3	4
18.	Respectful (e.g. of your views)	1	2	3	4
19.	Keeping you clean	1	2	3	4

20. Feeding you	1	2	3	4
21. Common Sense	1	2	3	4
22. Knowing 1st Aid	1	2	3	4
23. Good Listener	1	2	3	4
24. Sense of Humour	1	2	3	4
25. Maturity	1	2	3	4
26. Willingness to help	1	2	3	4
27. Giving Medication	1	2	3	4
28. Nursing Skills	1	2	3	4

APPENDIX XVI

OCCUPATIONS AND SOCIAL CLASS OF RESIDENTS AND SPOUSES

Occupations and social class of residents and their spouses

Social Class I - Professional

Naval Commander

Research Chemist

Social Class II - Intermediate

Garage Owner

Silversmith/musician

Farmer (2)

Charge Nurse

Teacher

Social Class IIIm - Skilled manual

Head Brewer

Train Driver

Fireman

School Caretaker

Electrician

Farm Inspector

Joiner

Beekeeper

Tailor

Tin Refiner

Market Gardener

Maintenance Fitter (2)

Ships Plater

Sheet metal worker

Ships Carpenter

Welder, Steelworks

Social Class IIIn - Skilled non-manual

Transport Clerk

Clerical worker

Cashier

Car Salesman

Policeman

Social Class IV - Partly skilled

Shop worker

Painter and decorator

Dock Worker

Mains Flusher at Water Board

Coal Heaver on Barges

Social Class V - Unskilled

Cleaner, stores

Labourer

Farm Labourer

<u>Social Class VI - Other</u>

Missionary

Unmarried, cared for parents

Soldier

-

APPENDIX XVII

RESIDENTS SOCIABILITY, HELP, INDEPENDENCE AND ATTITUDE SCORES WITH SCORES OF TRAINED AND UNTRAINED STAFF

Residents Personal scores:

Resident No.	Soc.	Help	Ind.	Att.	Trained Score	Untrained Score
115/01	low	low	high	neg	12	3
115/02	low	low	high	pos	7	7
115/03	high	low	low	pos	12	3
115/04	low	low	high	pos	8	6
120/01	high	med	low	pos	6	8
120/02	high	low	low	pos	8	7
120/03	high	high	low	pos	7	8
120/04	med	v.low	high	pos	8	7
153/01	high	low	low	pos	8	8
153/02	high	med	low	pos	10	4
153/03	low	low	low	pos	8	4
153/04	low	low	high	pos	11	3
151/01	med	low	high	pos	7	8
151/02	low	low	low	pos	7	8
151/03	high	med	med	m.pos	8	7
151/04	high	low	high	pos	8	5
105/01	low	low	med	pos	10	6
105/02	high	low	low	pos	11	6
105/03	high	low	high	pos	7	6
105/04	high	low	high	pos	7	8
018/01	high	low	low	pos	7	9
018/02	high	low	high	neg	5	10
018/03	high	low	high	pos	7	8
018/04	low	m.high	low	pos	3	12
053/01	high	med	med	pos	7	7
053/02	high	low	high	pos	9	5
053/03	high	low	med	pos	10	3
053/04	low	low	high	med	6	9
168/01	low	low	high	pos	8	5
168/02	high	low	high	pos	9	5
168/03	high	m.high	low	pos	7	8
168/04	high	med	med	pos	6	9
020/01	high	med	med	pos	9	6
020/02	high	low	med	med	7	6
020/03	high	med	med	pos	8	7
020/04	low	med	med	pos	7	8
163/01	low	low	high	pos	6	6
163/02	high	med	med	pos	7	7
163/03	low	med	low	pos	8	8
096/01	high	low	high	pos	6	9
096/02	high	low	med	pos	9	6
145/01	high	m.high	med	pos	7	7
145/02	low	low	med	med	7	7

APPENDIX XVIII

RESIDENTS VIEWS ON WHAT MAKES A GOOD CARE ASSISTANT

Residents views on What makes a Good Care Assistant

"Need patience, should be kind, understanding."
"Caring, kind, gentle."
"Kindness, sociable, jolly, cheeks you, cleanliness, doing the job as they should."
"Hygiene. Keeping my chair vacant."
"Friendliness, helpful."
"To be good and kind. At hand especially if I'm dizzy. To have someone here, someone with when I go out."
"Good person. Kind. Good natured. Sweet tempered."
"Being able to talk to them. Kind. Normal."
"Look after people without complaint."
"Got to be really good to look after you. Be there all the time. Not to go away and leave you."
"To come when I need them."
"Letting people do as they like. Treat people as though they're at home."
"Friendly, discreet person. Good carer. Sensible. Maturity counts for a lot."
"Tolerance. Being careful with you. Lifting and helping to walk at our speed. Kindness, helpfulness."
"Caring. Kind, not impatient."
"Willingness. Personal things."
"Homely, helpful, caring. Consider your needs. Have vistors at any time, offered a cup of tea."
"Kind, willing to help. Will always help when asked."
"To want to look after people. Experience. Interested in the job, people."
"Listen to what's being said. Let's residents voice their opinion. Training is important."
"Not to be too strict. Make sure they're doing whats good for the residents. Not being bossy. Doing the right things."

"Being cheerful. Willing to help if you need it."
"Helpful. Be around when I need help."
"Someone who is dedicated. Loves people. Someone who can do things for people. Can see when things need doing."
"All the patience in the world. I don't know where they get it from, especially young ones."
"Mostly kindness. Thoughful. Good temper. Nice nature."
"Being patient. They need to be kind."
"Ability to get on with people. Ability to comprehend people's needs."
"To look after people. Be kind. Do what you want."
"Kindness and understanding goes a long way."
"Being able to ask for help and know they don't mind doing it. Some are better than others."
"Kindness."
"Patience. Friendly without being too pushy."
"Patience because everybody is different. Have to be kind to everybody. Not to make anyone jealous, not preferring one resident to another."
"Come when you need them."
"Kindness."
"Kind to people. Should not rush them. Give them time. Helpful. Elderly people have to be helped."
"Being kind, helpful and generous."
"Having practical and personal skills. Able to do everything."
"Friendly but confidential. Genuine."
"Understand the difficulties of the residents. Be sympathetic. Should be good at practical things. Remembering what different people like."

APPENDIX XIX

STAFF VIEWS ON WHAT MAKES A GOOD CARE ASSISTANT

Q.16. What makes a Good Care Assistant?

Trained Staff:

"Getting on with residents and communicating with them with tolerance and confidentiality and a sympathetic attitude makes a good care assistant."

"Being a good listener. Resident should be able to trust you. Understanding and obviously you have to care."

"Understanding, patience, caring, sense of humour."

"Someone who is a good listener, patient, a very naturally caring person. Not someone who is doing it just for a job. Someone who is very interested and enjoys working with the elderly."

"I think you need basic nursing skills, be a good listener and treat the residents how you would treat your own mum."

"A patient caring attitude. Someeone who respects the residents needs and considers how the feel, remembering at all times what their needs are, emotional, physical, and intellectually."

"Kindness. Giving residents time to talk things over and let them have their own opinions."

"A great understanding of the individual resident. What residents needs are, a great deal of patience is needed at all times."

"Patience, understanding, respect of other people and their individual needs and views. Common sense approach and happy environment."

Untrained Staff:

"A person who is kind and caring. Able to listen and help residents with any problems they may have. A person who is conscientious. hard working. Able to work under pressure and show initiative."

"Having lots of patience and being able to chat with the residents."

"Caring personality. Communication. Practical skills, Patience."

"Patience. Undersanding. Caring. Sense of humour."

"Patience and an understanding of old people."

"A pleasant caring nature to all clients. Being able to listen."

"Being caring. patient. understandng."

"Patience and understanding."

"Patience when they are not very good walking. Sense of humour. A good stomach and not to be shy. Kind and gentle. Not to be rough. Common sense."

"Empathy."

APPENDIX XX

PERSONAL QUALITIES AND PRACTICAL SKILLS

Personal Qualities: (18)

Ensuring the privacy of residents
Being a friend to residents
Getting on with people
Being Patient
Knowing what individual residents like
Tolerance
Confidentiality
Building confidence
Letting residents choose for themselves
Being a Good Talker
Respecting residents views
Being a good listener
Maturity
Common sense
Not fussing
Sense of humour
Nice personality
Willingness to help

Practical Skills: (12)

Keeping residents rooms clean
Mending residents clothes
Bathing residents
Toileting residents
Dressing residents
Safe lifting
Keeping residents clean
Feeding residents
Knowing First Aid
Giving medication
Nursing skills
Keeping Records

APPENDIX XX1

MEAN SCORES OF PERSONAL QUALITIES AND PRACTICAL SKILLS BY TRAINED AND UNTRAINED STAFF

Mean Scores for Trained Staff:

Group 1:	Privacy	1.56
	Keep residents clean	2.89
	Bathing	3.11
	Keep a Secret	3.67
	Maturity	4.22
	Not Fussing	5.56
Group 2:	Patience	2.11
	Let residents choose	2.78
	Toileting	3.11
	Willingness to help	3.89
	Feeding	4.11
	Keep rooms clean	5.00
Group 3:	Respect	2.00
	Know what residents like	2.22
	Common sense	2.44
	Dressing	4.11
	Good Talker	4.33
	Mending	5.89
Group 4:	Being a friend	1.89
	Tolerance	2.67
	Good listener	3.00
	Build confidence	3.78
	Lifting	4.78
	Nursing skills	4.67
Group 5:	Getting on	2.44
	Nice personality	2.89
	Sense of humour	3.22
	First Aid	3.67
	Giving medication	3.89
	Keeping records	4.89

Untrained Staff:

Group 1:	Keep residents clean	1.78
	Privacy	2.33
	Keep a secret	3.56
	Bathing	3.89
	Maturity	4.44
	Not fussing	4.89
Group 2:	Let residents choose	1.67
	Patience	1.78
	Willingness to help	3.33
	Toileting	4.33
	Feeding	4.56
	Keep rooms clean	5.33

Group 3:	Respect	2.22
	Know what residents like	2.33
	Common sense	2.44
	Good Talker	4.00
	Dressing	4.11
	Mending	5.89
Group 4:	Being a friend	2.00
	Tolerance	2.67
	Lifting	3.67
	Build confidence	4.00
	Good listener	4.22
	Nursing skills	4.44
Group 5:	Getting on	2.00
	Nice personality	2.00
	Sense of humour	3.22
	First Aid	4.22
	Give medication	4.67
	Keeping records	4.89

APPENDIX XXII
MEAN SCORES OF PERSONAL QUALITIES AND PRACTICAL SKILLS BY RESIDENTS

Personal Qualities:

Letting you choose for yourself	1.33
Common sense	1.14
Being a Friend	1.29
Not Fussing	1.38
Getting on with people	1.10
Sense of humour	1.00
Knowing what I like	1.14
Good listener	1.12
Maturity	2.40
Nice personality	1.07
Patience	1.02
Ensuring privacy when you want it	1.24
Respectful	1.05
Keeping a secret	1.50
Good Talker	1.40
Tolerance	1.07
Willingness to help	1.05

Practical Skills:

Good at bathing	1.33
Keeping you clean	1.31
Dressing you	1.86
Giving medication	1.71
Feeding you	2.31
Knowing First Aid	1.19
Safe at lifting	1.17
Mending clothes	2.23
Nursing skills	1.60
Keeping your room clean	1.45
Good at toileting	1.50

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