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Qualifications of Non-Nursing Residential Care Staff in the Republic of Ireland.

Dr Martin Power and Ms Mary-Joe Lavelle.

Abstract

The ageing of societies is a challenge confronting most developed nations. It is a challenge compounded by diminishing numbers both of informal and formal carers. In response to this challenge and related concerns of recruitment and quality, many nations have introduced new educational and training pathways, qualifications and national standards that require a minimum level of qualification. These trends are reflected in the Republic of Ireland, where, in 2009, the Health Information Quality Authority introduced standards in relation to care of older people in long-stay settings. Against this backdrop, this study explored the level of qualification held or being pursued by non-nursing care staff in long-stay settings. It found that while the Irish care workforce for older people reflects international trends and is likely to experience a period of accelerated qualification, it is at present ill-prepared to comply with national standards. Moreover, given the current economic crisis in Ireland the burden of further training is likely to fall on staff, undermining morale and increasing already tense industrial relations.

Key words – qualifications / standards / professionalisation / Ireland / non-nursing care staff

In recent decades the attention of governments across post-industrial societies has been inexorably drawn to the challenge posed by the ageing of societies. Declining birth rates and greater longevity will mean not only a shift in the old age dependency ratio but also an increase in the proportion of the oldest old (Netten and Darton, 2003; Da Roit *et al*, 2007; European Commission, 2008). For some this could create a 'silver tsunami', as increasing numbers of individuals with ailments or disabilities pressurise care systems (Ikegami and Campbell, 2002). In some EU member states, this situation will be compounded by the ageing of the care workforce, as nearly 50 percent of nurses are over 40 years of age (Tsolova and Mortensen, 2006). However, not all subscribe to such a pessimistic view, as ageing and ill-health are not necessarily synonymous (Caldwell *et al*, 2008). Nonetheless, over a decade ago many nations cited 'ageing of the population as one (if not the major) policy priority...with potential implications for pensions, health care and long-term care' (OECD, 1998, p15).

In Ireland, population ageing has, until recently, been less of a concern. In large part this can be attributed to a slower pace of decline in birth rates, resulting in a near static old age dependency ratio for many decades (Department of Health and Children, 2008). In addition, in marked contrast to the general European trend, in 2008, the birth rate in Ireland was the highest for 110 years (Irish Times, 2009; Health Service Executive, 2010). Nonetheless, projections around population ageing anticipate that by 2041 the percentage of older people in the Irish population will have nearly doubled from 11.4 percent to 22 percent, with the percentage increase in men over 85 likely to exceed 500 percent in the years between 2011 and 2041 (Department of Health and Children, 2008).

If few areas of policy will be immune from the impact of changing population demographics, health and social care systems must contend with the impact of compounding factors that have reduced the supply of both informal and formal carers. While many nations have in the past been keen to rely on 'family', particularly female family members, to provide care for older people, changing family structures shaped by shifting social norms have resulted in an increase in single person households (Pavolini and Ranci, 2008). These trends have also given rise to a weakening of family ties and alterations in what are considered appropriate family roles and responsibilities (Kroger, 2003).

Of more import perhaps, greater female participation rates in education and labour markets have reduced the stock of informal carers in many nations (European Commission, 2008). It is a set of circumstances reflected in Ireland, where female labour force participation has markedly expanded. For example, between 1995 and 2006 there was a '67% increase in the number of women working full time and a trebling of the number of women working part time' (Kavanagh, 2007, p2). As those such as Arksey and Glendinning (2008) point out, policies around labour market participation and care frequently conflict.

The situation in relation to formal carers has also been impacted by such trends, not least because care work is associated with part-time working, unsocial hours, low-wages, job insecurity and limited career prospects (Hussein and Manthrope, 2005; European Commission, 2008). Certainly, these are features of the care landscape that are obvious in Ireland, where almost 40 per cent of care assistants are employed on a part-time basis (Behan *et al*, 2009). With such features characterising the care field, caring as a career is frequently perceived poorly, has few young entrants and high levels of staff turnover, all of which can impact on continuity and quality of care (Escobedo *et al*, 2002; Nemenyi and Herczog, 2006). Given such a backdrop, there can be little surprise that along with 'staff shortages', 'staff qualifications are the number one concern of long-term care policy makers in OECD countries' (OECD, 2005, p13). Policy makers, however, are not alone in expressing concern. As those at the coalface have also acknowledged that the most 'pressing need' is to 'ensure a high quality of basic training for all staff that work with older people, particularly those without formal qualifications' (Drennan *et al*, 2004, p406; Glendinning *et al*, 2008).

In response to these pressures, both short and long-term solutions have emerged. In the short-term, facilitated by EU expansion, many nations have attempted to shore up staff shortages with migrant workers (Simonazzi, 2009; Doyle and Timonen, 2009). However, this is a far from ideal solution, as it depletes the stock of carers in migrants' home countries and is often unsustainable as migrants may not settle, rupturing continuity of care. Moreover, many migrants end up working in 'undeclared' or 'grey markets', with implications for tax-revenues, quality of care and worker exploitation (Hussein and Manthrope, 2005; Nemenyi and Herczog, 2006; Moriarty *et al*, 2008). Again, circumstances in Ireland largely reflect such developments. For example, Walsh and O'Shea (2009) found that almost one

third of those working with individuals over 65 years of age were foreign nationals. While Timonen and Doyle's (2007) research on domiciliary care noted that many interviewees 'hinted at the existence of a large informal grey labour market of care' (Timonen and Doyle, 2007, p258; Doyle and Timonen, 2009). Thus, there can be little surprise that longer-term solutions aimed at combating both recruitment and quality concerns have emerged. In an effort to make caring more attractive as a career, entice new entrants and raise quality, many nations have sought to introduce new educational pathways, training and qualifications, along with accreditation, national standards and registration requirements (Lethbridge, 2007).

In Ireland similar developments have materialised, exemplified by the introduction of legislation governing professionals; Health and Social Care Professionals Act (2005) and, the establishment of the Health Information Quality Authority (HIQA) (2007). The former provides a legislative basis for standards of professional conduct, education, training and competence. It is designed to provide protection both for the public and professionals and is to be enforced through the creation of national registers administered by councils for each of twelve professions detailed in the Act. It has been a critical development, not least because it created for the first time the professional title; social care worker.

The latter, the HIQA, is an equally significant development. An independent body, it is entrusted with ensuring quality through the development, inspection and enforcement of standards within the health and social care sector. Of particular importance here were the National Quality Standards for Residential Care Settings for Older People, launched on July 1st, 2009. Hailed by the CEO of the HIQA, Dr Tracey Cooper, as an 'important and significant milestone' the standards detail provider obligations, including requirements in relation to staff training and qualifications, with section 24.2 requiring that 'all newly recruited care staff and those in post less than one year commence training to FETAC (Further Education and Training Awards Council) Level 5 or equivalent within two years', and that 'long standing staff have their competency and skills assessed to determine their need for further training (National Quality Standards for Residential Care Settings for Older People in Ireland, 2009, 24.2).

It is against this backdrop that this study is located. Conducted just prior to the introduction of the national standards it examines qualifications held or being pursued by non-nursing care staff in long-stay settings for older people in the

Republic of Ireland. As such, it presents a timely snap-shot of levels of qualifications among staff in this sector, provides a basis for comparison with care workforces in other nations and suggests that the older care workforce in Ireland is largely ill-prepared to meet the challenges of professionalisation; a situation aggravated by the current economic crisis confronting Ireland.

Sample and Methods.

The population group for this study were non-nursing frontline care staff employed in long-stay residential settings for older people in the Republic of Ireland. These residential settings included private nursing homes, public nursing homes, centres or hospitals, as well as voluntary sector homes that catered for older people or individuals with mild intellectual disabilities on a 5/7 day per week, 48-52 week per year basis. In total 280 service providers throughout the Republic of Ireland were contacted (100 private/100 public/80 voluntary). Residential centres for individuals with mild intellectual disabilities, largely voluntary sector providers, were included to create a basis for intra-national comparison. However, the low response rate from these stakeholders provided little data and, no comparisons have been made here.

The 100 private nursing homes were selected from a possible 418 homes contained in the Annual Private Nursing Homes Survey Report (2007), supplied by Nursing Homes Ireland, an umbrella organisation for private and voluntary nursing homes. State-run institutions were selected from a directory of 140 centres provided by the Health Service Executive (HSE). A stratified sampling approach was employed, with the aim of gathering country wide data. The HSE directory listed 10 geographical subdivisions and 10 private and, 10 public centres were randomly selected from each area.ⁱ

Initial contact with service providers was by phone and where a provider agreed to participation, a short-survey was dispatched, either by email or post. A reminder call or email was sent no later than 3 weeks after initial contact. The survey was comprised of 6 questions, the first 3 dealt largely with contact details. Question 4, examined the capacity of the service provider, as measured by the number of residents the provider was registered to cater for. Question 5, explored the number of 'non-nursing care staff'. Question 6, a multipart question, sought data on current and future levels of staff qualifications, as per the National Framework of Qualifications (NFQ), as set out by the National Qualifications Authority of Ireland (NQAI). The

Irish NFQ has 10 divisions, the upper 6 of which can be loosely grouped; level 5 vocational, levels 6, 7 and 8 under-graduate (Higher or Advance certificate, Ordinary and Honours Bachelor Degree), levels 9 and 10 post-graduate (Masters/PhD). The document '*Qualifications can cross boundaries – a rough guide to comparing qualifications in the UK and Ireland*' (2009) – suggests that level 5 of the Irish NFQ is roughly equivalent to level 6 (SVQ level 3) on the Scottish Credit and Qualifications Framework and level 3 (NVQ level 3) on the National Qualifications Framework for England, Wales and Northern Ireland.

Results.

The response rate to the survey was 52 percent (51 of 100 private providers and 53 of 100 public providers responded). The total capacity of service providers surveyed was 7,149 residents (n=104). There were 2,480 (35%) places in the private sector and 4,669 (65%) in the public sector.ⁱⁱ The total number of 'non-nursing care staff' (n=105) was 3,878. Of these staff 1,499 (39%) worked in the private sector and 2,379 (61%) in the public sector. From the total number of staff surveyed, 1,438 (38%) held a qualification at level 5 or above and 308 (8%) were pursuing a qualification at this level or above. This meant that 2,132 (55%) non-nursing care staff neither held nor were pursuing a qualification within the NFQ. Of the staff that did hold a qualification, the vast majority were at level 5 (90%) and a similar trend was apparent for staff engaged in training/education, with 291 (91%) pursuing a qualification at level 5. Tables 2 and 3 detail the qualifications attained or being pursued.

Table 2: Level of qualification held by non-nursing care staff.

Sector	Private	Public	Percentage of Total Staff Surveyed (3,878).
Level 5	415	883	33.5%
Level 6	10	20	0.8%
Level 7	21	6	0.7%
Level 8	55	21	2.0%
Level 9/10	4	3	0.8%
Total	505	933	37.8%

Table 3: Level of qualification being pursued by non-nursing care staff.

Sector	Private	Public	Percentage of Total Staff Surveyed (3,878).
Level 5	127	152	7.2%
Level 6	6	2	0.2%
Level 7	14	1	0.4%
Level 8	3	2	0.1%
Level 9/10	1	0	0.03%
Total	151	157	8.0%

Discussion.

Though the response rate both from private and public providers was relatively high, given the large number of private providers and the self-selecting nature of participation, some caution is necessary in extrapolating beyond the organisations that contributed to this study. Generalisation from the public sector findings, in spite of the larger numbers, is however, no less formidable a task. Within the public sector non-nursing care staff perform a variety of functions from personal care to housekeeping duties and are frequently classified as 'multi-task' staff. In spite of these complications the large number of non-nursing care staff included in the survey does provide grounds for confidence in the findings, which suggest that: the majority of staff do not hold a qualification within the NFQ; among staff that do

possess a qualification, most hold minimal vocational qualifications; a limited number of staff are pursuing either minimal or further qualifications; and, of these staff a considerable majority are pursuing only the baseline qualification.

The finding that qualifications among non-nursing residential care staff in Ireland tend to be vocational in nature and/or that the majority of staff do not hold a qualification, mirrors the situation internationally. In New Zealand, for example, Smith *et al* (2005) reported that fewer than 25 percent of residential carers held vocational qualifications (Smith *et al*, 2005). While in Australia, though the no qualification/'base qualification' percentages were almost the reverse of New Zealand, with 23.7 percent of residential carers having no post-school qualification and 65 percent a 'base qualification' (Certificate III in aged care), few carers held qualifications above the baseline level (Martin and King, 2008). Similarly, in the U.K., a National Survey of Care Workers (Hall and Wreford, 2007) observed that 38 percent of care workers held vocational qualifications (National Vocational Qualifications levels (NVQ) 2 & 3; BTEC National; and, Higher National Diploma), while 6 percent held a degree and 2 percent a higher degree (Hall and Wreford, 2007).

If such comparisons highlight a significant skew in favour of vocational qualifications, they also suggest that care labour forces are becoming increasingly qualified. Certainly, in the U.K. a marked shift has emerged over the last decade. In 1998, for instance, the U.K.'s Department of Health noted that nearly 80 percent of residential and home care workers held no qualifications (in MacFarlane and McLean, 2003). A situation that those such as Davies *et al*, (1999) observed was compounded by training opportunities for carers in nursing homes arising infrequently. In large part, changes in the U.K. can be attributed to movement toward professionalising the care workforce and the introduction of provider standards. For example, the Care Standards Act was introduced in 2000 and, in turn, the General Social Care Council and Care Homes for Older People: National Minimum Standards (2001).

In Ireland, developments along similar lines, such as the Health and Social Care Professionals Act (2005) and the National Quality Standards for Residential Care Settings for Older People (2009) have emerged more recently. Thus, it seems reasonable to suggest that an increasingly qualified workforce will also emerge in Ireland. Certainly, given the later introduction of these measures, the finding that 8 percent of staff are currently pursuing qualifications does not compare unfavourably

with the situation in the U.K. Where the National Survey of Care Workers (Hall and Wreford, 2007) recorded that one in ten carers had begun studying for a care related NVQ at level 2, a further 12 percent had started pursuing an NVQ level 3 qualification and, 2 percent were enrolled on more advanced programmes (Social Work Degree or Diploma, 1%; Health and Social Care NVQ level 4, 1%). Indeed, while in the U.K. the care home standards required that 50 percent of care staff be trained to NVQ level 2 (Care Homes for Older People: National Minimum Standards (2002) 28.1), in Ireland 'all newly recruited' staff must achieve the minimum qualification within 2 years and long standing staff must have their training needs assessed and met (emphasis added, National Quality Standards for Residential Care Settings for Older People in Ireland, 2009, 24.2). Given such requirements it seems reasonable to suggest that the pace of change may be more rapid in Ireland than it has been in the U.K.

However, while such comparisons may provide grounds for optimism that the care workforce in Ireland will become increasingly qualified in the not too distant future; such optimism can only be tempered by Ireland's current economic situation. Hailed previously by the OECD for its 'peerless performance' (OECD, 1999), Ireland now faces a period of 'prolonged' adjustment that 'will require both further increases in revenue and cuts in public expenditure' (OECD, 2009). As the HSE is the largest employer in the state, directly or indirectly employing nearly 140,000 staff and managing a budget of over 15 billion euro, it is likely to feel the brunt of adjustments (<http://www.hse.ie/eng/about/>). Indeed, some estimates suggest that the health sector is likely to see a reduction of 3,700 staff by the close of 2010 (O'Donnellan, 2009).

In light of such circumstances, emigration may again become a significant feature of Irish life, reversing the impact of any baby boom on the old age dependency ratio. Certainly, the Irish Nurses Organisation (INO) has warned that the majority of those who graduated in 2009 are likely to emigrate, while a Royal College of Surgeons in Ireland (RCSI) survey observed that one in five migrant nurses have requested verification of their data, a process described as 'signifying serious intent to migrate' (McGreevey, 2009; Houston, 2009, p3). While in the broader social care sector such issues may have less of an impact, as some contend that Ireland is overproducing qualified social care workers (Lalor, 2008). In the area of care for older people, Walsh and O'Shea's (2009) finding that over 30 percent of

workers were foreign nationals would appear to suggest that Irish workers are not keen to seek employment in this area. As such, even if Ireland is overproducing qualified social care workers, the older care sector is unlikely to benefit from any oversupply. Indeed, if anything undersupply is likely to be a concern, as a greater share of the older adult care workforce is nearing retirement (Walsh & O'Shea, 2009). Moreover, social care workers, particularly those with higher level qualifications, may come to view emigration as a tantalising prospect, as professionalisation in other nations improves pay and conditions.

Of more importance perhaps, against a bleak economic backdrop, recruitment embargos, pay cuts and industrial unrest have become common. In such circumstances it seems plausible to suggest that training and education programmes are unlikely to be prioritised, that time off for such efforts will be restricted and, that the workload on staff will increase. Certainly, minutes of HSE Board meetings conducted during 2010 'confirm that significant reductions in employee numbers and cost reductions in travel and subsistence, recruitment, and formal academic training have been achieved' (HSE, 2010, p5).

In such circumstances, the onus for pursuing training is liable to fall on staff rather than employers, whether in the public or private section. This will further increase pressure on staff as the cost of qualification can be 'considerable, both financially and in time' (Wanless *et al*, 2006, p126). Indeed, who pays for training and education may become a bone of contention, exacerbating industrial tensions and lowering morale. It is a situation that may be compounded by the pursuit of only minimum levels of qualification, since in austere economic conditions, increased qualifications may not lead to matching increases in pay. Such considerations have consequences for quality of care. While training and education have been associated with improved outcomes around diabetes, dementia, mental health and end of life care, to name but a few (Davies *et al*, 1999; Deakin and Littley, 2001; Eisses *et al*, 2005; Smith *et al*, 2005; Chrzescijanski *et al*, 2007; Hirakawa *et al*, 2009; Mcphail *et al*, 2009), training and education are far from 'silver bullets' (Campbell 2007; McCabe *et al*, 2007; Oorsouw *et al*, 2009). As they are only one element of the complex interaction between personal qualities, experience, skills, motivation, inter-professional relationships, working conditions, organisational cultures and structures (Warr 2002; Perry *et al*, 2003; Kane, 2004; Zimmerman *et al*, 2005; Thornley, 2007; Oorsouw *et al*, 2009). Indeed, for those such as Campbell (2007) a problematic area of training

programmes, in particular, is that they frequently concentrate on short-term criteria 'that will keep the staff, the service users and the services safe: safe from injury, harm, abuse and legal action' (Campbell, 2007, p145).

In spite of these challenges, the findings of this study suggest that there is a significant need to invest in basic education and training and, for supports to be put in place to assist care staff in the pursuit of qualifications. Certainly, the finding that over half of non-nursing care staff did not hold nor were pursuing the basic qualification, suggests strongly that basic training needs to be prioritised. More importantly perhaps, given that increasing longevity will increase the proportion of residents with 'complex comorbidities and multiple treatment regimes' the need for basic training as a minimum simply cannot be ignored (O'Connor, 2009, p35). Indeed, in the private sector this need may be more acute, since it has been noted previously that there is a higher ratio of non-nursing/nursing staff, which can often result in 'little capacity for supervision of care assistants' work' (Murphy *et al*, 2007 p143). Moreover, lower staff to resident ratios are also apparent in this study, with the private sector averaging 1.65 non-nursing care staff per resident, while in the public sector it is 1.96.

If these findings make a strong argument for direct investment by both the state and employers in basic education and training for non-nursing care staff, increasingly complex comorbidities will also require an increasingly sophisticated workforce. Here again, direct investment in education and training would appear the most straightforward mechanism. Nonetheless, given that work-based learners are likely to make up a large proportion of those engaging in further study, there are also opportunities to encourage qualification progression and continued professional development (CPD) through less direct means. For example, the capacity to offset a portion of course fees through the tax system, which currently applies to many under-graduate and post-graduate courses in Ireland, could be increased and/or expanded to include shorter courses. In a similar fashion, employers could be encouraged to fully or partly fund staff education and training programmes through a comparable tax offset mechanism. As with funding for basic training, strong economic arguments can be made for the introduction of such measures, since any revenue forgone by the exchequer is likely to be recouped in savings from the prevention or limiting of costly hospital admissions.

Incentives of a non-monetary nature could also be employed to encourage an ethos of continued professional development, counteracting the mere compliance approach that those such as Campbell (2007) have warned against. Certainly, non-monetary factors have been cited by carers as primary drivers of job satisfaction and employers could acknowledge staff commitment to CPD by altering the ratio of care/domestic tasks of more qualified non-nursing staff (TNS, 2007). Indeed, those such as Schmidt and Diestel (2010) have noted that among elderly care nursing staff a more individualised and anticipatory approach to care emerges from a virtuous circle of control over care work and knowledge of service user preferences (Schmidt and Diestel, 2010). While those such as Brown Wilson, Davies and Nolan (2009) have observed that it is through direct care that interpersonal relationships, which contribute significantly to residents' views of care quality, flourish (Brown Wilson, Davies and Nolan, 2009).

In spite of such benefits there can be little doubt that Ireland's current economic woes will act as a brake on the professionalisation project, potentially foisting responsibly for education and training largely on the shoulders of care staff. However, the benefits of education and training are simply too many to be ignored and, not to invest in supporting staff to pursue qualifications or to rely solely on regulatory standards to drive professionalisation, would be an abdication of the state's responsibility to its older citizens. Moreover, given demographic trends, it would be simply postponing crisis. It is a situation that would appear cautioned against by the old axiom of penny wise and pound foolish.

Conclusion

The ageing of societies presents challenges to all stakeholders from policy-makers to providers. As the number of older people increases health and social care systems, in particular, are likely to be placed under increasing pressure. Such pressures will call for increasingly sophisticated working environments that will demand a ratcheting upward of staff qualifications to ensure quality of care. In Ireland, as in many other nations, steps toward meeting these challenges have revolved around raising qualifications and introducing national standards. Against this backdrop the results of this study suggest that the Irish older care workforce is at present largely ill-prepared to meet these expectations and that Ireland's current economic woes will only exacerbate the challenges faced. Nonetheless, improvements in outcomes

associated with education and training require that challenging circumstances do not result in stagnation of the professionalisation project and that the non-nursing care workforce is supported and encouraged to pursue both basic and more advanced qualifications.

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ⁱ Health Service Executive geographical subdivisions.

The 10 HSE areas were: East Coast Area (Dublin Mid-Leinster); South West Area (Dublin Mid-Leinster); North Area (Dublin North East); North East Area; Midlands Area (Dublin Mid-Leinster); North West Area; Western Area; Mid-West Area; Southern Area; and South East Area