Training Carers of Older People: An Advisory Report
NATIONAL COUNCIL FOR THE ELDERLY

The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June 1981. The terms of reference of the Council are:

To advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister, and in particular on:

- measures to promote the health of the elderly;
- the implementation of the recommendations of the Report, The Years Ahead - A Policy for the Elderly;
- methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly;
- ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly;
- meeting the needs of the most vulnerable elderly;
- ways of encouraging positive attitudes to life after 65 years and the process of ageing;
- ways of encouraging greater participation by elderly people in the life of the community;
- models of good practice in the care of the elderly, and
- action, based on research, required to plan and develop services for the elderly.

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TRAINING CARERS OF OLDER PEOPLE:
AN ADVISORY REPORT
TRAINING CARERS OF OLDER PEOPLE: AN ADVISORY REPORT

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NATIONAL COUNCIL FOR THE ELDERLY
REPORT NO. 47
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Foreword

In publishing this advisory report, prepared for it by the Department of Health Promotion, University College Galway, the National Council for the Elderly wishes to contribute further to the task of promoting the health and well-being of older people.

In this instance, the Council is concerned to focus particularly on social care of the frail and dependent elderly and to highlight the importance of appropriate training to good practice in providing this care.

The advisory report demonstrates that more widespread availability of training would have a positive impact on the lives of older people in receipt of social care and on those who provide such care, many of whom are older people themselves.

The report raises important issues in relation to social care of older people and in relation to the education and training of those who provide that care. The findings of the research conducted for the study contribute considerably to the debate on education and training for social care. And the overview of existing education and training provides a useful picture of how training in social care is developing in Ireland.

For this most valuable work we are indebted to Professor Cecily Kelleher, and to Ms. Orla O’Donovan, Ms. Margaret Hodgins and Ms. Verna McKenna who prepared the advisory report under her direction.

I would like to thank all the members of the Council’s Consultative Committee on the Training of Care Workers so ably chaired by Ms. Una Doherty. These were: Mr. Edward Collins-Hughes, Mr. Len
Commins, Mr. Damien Courtney, Mrs. Ann Harris, Ms. Martina Healy, Mrs. Anna Hennigan, Mrs. Maino McDonald, Ms. Madeleine Mulrennan, Ms. Céline Phelan, Ms. Aideen Stanley, Mrs. Lillian Sullivan and Ms. Pam Towers.

I would also like to thank our Secretariat for their support of the project. Particularly I thank Mr. Bob Carroll, Secretary, Ms. Trish Whelan, Projects Officer and Mr. John Browne, Research Officer for their role in setting the project in motion and their input throughout. Also I thank Ms. Trish Whelan and Ms. Catherine Mulvenna for supervising the publication of the report and Ms. Carol Waters and Ms. Fionnghuala Ní Néill for their secretarial assistance at all stages of the work.

Michael White
Chairman
December 1996
Introduction
1. This advisory report is a most valuable contribution to the literature on social care. The National Council for the Elderly is conscious, however, that the report and its recommendations have been prepared primarily from an educational perspective, rather than from a health service perspective. As social care is generally provided under the auspices of the health services, training in this area is both a health and an education issue. In preparing its own comments and recommendations, based on the report, the Council has sought to address both the health and the education aspects of training in social care.

Social care
2. Care of dependent older people, whether in community or residential settings, involves both health and social care. It can range from social care provided by a family member in the home to specialised health care provided by a geriatrician in a hospital environment. The distinction between health and social care is not easy to define as the two overlap and both can be seen to contribute to health and social gain. However, for the purpose of this study the Council is concerned with 'social care' which is generally provided by non-medical personnel in community and residential settings. In a recent Council study of the implications of population ageing in Ireland for health and social care services, Fahey provided the following useful description of social care, "most social care takes place in the cared-for person's home, or failing that, in an institutional setting which is a substitute for home for those who have become too dependent to live in the community" (Fahey 1995, p. 63).
3. The tasks involved in social care are therefore seen as an extension of the functions of the home and include personal care (e.g., lifting, dressing, feeding, bathing, toileting, taking medication), home care (e.g., cooking, cleaning, washing, shopping), social support and monitoring. Providers may or may not receive payment for their work. This distinction based on payment status gives rise to the terms ‘formal social care worker’ and ‘informal carer’ which are generally used in the literature in this area. Formal social care workers include Home Helps and Home Care Attendants working in the community, and Nursing Aides and Care Attendants working in residential or hospital settings. Informal carers are generally family carers or volunteers working in the home and the community. In making the distinction between health and social care, Fahey went on to say that, “social care has been the Cinderella service of the health system, and generally is overshadowed in expenditure, scale and status by the more medical side of the health services” (p. 63).

4. Training is one area in which social care is overshadowed by health care. Training in social care falls outside the more conventional system of training for health professionals and as a result the training opportunities available vary considerably between and within health board areas and categories of carers. The Council is concerned that in many instances, older people are being cared for by people who have little or no training in the tasks that they perform.

Implications of demographic and policy developments
5. According to population projections generated for the Council, the older population is expected to grow from 11.4 per cent of the total population in 1991 to 14.1 per cent in 2011, that is, an increase of 119,000 persons in the over 65 age group. While all older age groups are expected to increase, the largest increase will
be in sections of the population who have traditionally consumed the largest share of health and social services. For example, the over 80 age group is expected to increase by two thirds, that is, an increase of 51,000 persons and the number of older people living alone is expected to increase by more than 41,000 persons. Demographic developments will also have an adverse effect on the numbers of people available to provide social care to older people given that family sizes will decline and the numbers of women participating in the labour force are set to increase (Fahey 1995).

6. The emphasis on community care among policy makers also has important implications for the current and future provision of social care services for older people. If the Department of Health’s (1994a) target of at least 90 per cent of people aged 75 years or more living in their own home is to be realised, social care services in the community will need to be developed considerably. According to the Council’s population projections there will be an extra 60,000 people over 75 years living in the community if this target is to be reached, that is, an increase of over 40 per cent on current levels (Fahey 1995). Previous research has shown that despite improvements in social care services, there is still a substantial amount of unmet need among older Irish people. For example, the Council’s study of the home help service found that the proportion of older people receiving a home help service in Ireland (3.5 per cent) was lower than in many other countries (Lundström and McKeown 1994).

7. In the past, social care services have been overshadowed by other health services. However, the current emphasis on health and social gain provides an opportunity for the benefits of social care services, in terms of improving the quality of life of older people, to be given proper recognition. The Council wishes to emphasise that given the demographic developments outlined above, a
significant growth in the area of social care will be required if policy objectives regarding older people are to be met. Training in social care will be an essential part of this growth to ensure that social care services are provided by people with relevant skills in the care of older people.

**Employment opportunities in social care**

8. The demographic and policy developments outlined above, together with high unemployment levels in Ireland, provide an opportunity for the expansion of social care occupations. A Council submission to the National Economic and Social Forum highlighted the need for the development of community support services for older people and identified a range of employment opportunities for social care of frail older people at home and in local communities. It also suggested that an expansion of this nature would require a substantial input into training and education for social care workers - family, voluntary and formal (National Council for the Elderly 1994, p. 38). Developments in training for carers of older people will help promote employment opportunities and improve the status of social care of older people as an occupation. It will also enable carers to work in different settings and help to remove the demarcation that exists at present between different categories of carers.

9. The Council suggests that every effort should be made to develop national policy in regard to employment creation in social care of older dependent people in suitable fora such as the National Economic and Social Forum and national agreements between the social partners.

**Social care training**

10. In publishing this report, the Council wishes to highlight the importance of training in assisting and supporting both formal
social care workers and informal carers who care for older people. The range of courses outlined in the study is evidence of the widespread development in social care education and training in recent years. While these developments are encouraging and reflect the increasing demand for training in social care, the Council is concerned that, in the absence of national policy on training in the care of older people, the needs of those who care for older people may be overshadowed by the needs of those who care for other groups, such as children, adolescents, people with learning disabilities and people with physical disabilities.

II. The Council wishes to encourage further co-ordination between the agencies responsible for the delivery of social care to older people and the agencies responsible for the provision of training in social care, to ensure that the training needs of those who care for older people are addressed. In the present study, the health boards were identified as the agencies which should take responsibility for the provision of training for both formal social care workers and informal carers, although other employers and educational institutions were also identified as having a role in this regard.

The need for training

12. The need for training for formal social care workers who work with older people has been acknowledged by policy makers for some time now. For example, when a policy for the home help service was first defined in a Department of Health Circular in 1972, the need for training was recognised as follows, “training would provide guidance regarding their approach to the people being served, the broad range of home help duties, the work undertaken by medical, nursing, and social workers and some practical instruction on the best manner of carrying out the services they are to provide” (Department of Health 1972).
13. The need for training for nursing home personnel such as Nursing Aides and Care Assistants was recognised in the Nursing Home Regulations 1993 which state that, "a health board may provide training facilities for staff of nursing homes by agreement with the registered proprietor or person in charge upon such terms, charges and conditions and to such an extent as the health board may determine following discussion with the registered proprietor of the home (Department of Health 1994b, Paragraph 32).

14. The Safety, Health and Welfare at Work Act 1989 requires employers to ensure safe working practices for all their employees. This applies to all employees and may be of particular importance to formal social care workers employed to care for older people to prevent accidents and injury to clients. Nurses working in the community and in institutions are becoming increasingly involved in administrative and supervisory work and have less time for providing social care to older dependent people. As a result, the responsibilities of formal social care workers are broadening, although they receive very little training in the tasks they are expected to perform.

15. The Council's study of carers in 1988 also highlighted the need for training for people who provide care on an informal basis. The study found that informal carers would welcome practical training and advice on lifting, bathing, changing beds and clothes as one of the requirements for people embarking on a caring role (O'Connor et al. 1988). The Carers Charter, which was compiled in 1991, recognises and acknowledges the role of carers and identifies the supports which carers require to enable them to continue to care in a way that ensures a high quality of life for the carer and the person being cared for. Amongst the rights identified are, "the right to easy access to information and advice and the right to skills’ training and development of their potential" (Ruddle 1994).
The benefits of training

16. The benefits of training for formal social care workers and informal carers have been documented in a number of studies including the present study, which found that training would help to:

- improve the quality of care provided to older people
- improve the quality of life of older people
- increase carers' knowledge and understanding of older people's needs and of the ageing process
- increase carers' skills, such as lifting
- improve carers' and older people's awareness of safety issues and reduce accidents
- increase both older people's and carers' confidence in the care being provided
- assist carers in coping with the stress of caring
- improve carers' personal skills

Current training programmes

17. The Council is concerned that although the need for and benefits of training have been clearly identified, the training opportunities available in the care of older people are not meeting the demand. Issues in relation to suitability, availability, accessibility, equity and comprehensibility must be addressed if the potential benefits of training are to be fully realised. The majority of people who care for older people are women who are middle aged or older themselves and who are likely to be out of mainstream education for some time. Yet most of the courses identified in the study are aimed at school leavers rather than this group of carers. The venues for courses and the learning methods used are more suitable and accessible to young people who are familiar with the education system. The time commitment required also serves to make training less accessible to people who are already involved in a caring role.
18. The majority of courses identified in the study are generic in that they aim to prepare participants to work with a variety of groups including children, adolescents, people with learning disabilities, people with physical disabilities and older people. While the Council welcomes the recent shift from child care centred social care training to generic training, which includes care of older people, it is concerned that participants do not tend to see care of older people as a career choice. For example, the study findings indicated that there was a low level of interest in working with older people among young people already undertaking generic courses in social care in Regional Technical Colleges and Vocational Education Colleges because of perceived poor career opportunities in this area of work.

19. The relationship between the training that carers of older people receive and the courses available in educational institutions is minimal. The training which most formal social care workers receive is in the form of short induction courses which vary within and between health board areas and which have little or no relationship with courses in educational institutions. The Council’s 1993 study on the home help service found that the training offered to Home Helps varies within and between health board regions. It mainly involves in-service instruction by the Public Health Nurse or Home Help Organiser in the tasks to be undertaken and some day-long seminars covering areas such as personal care, lifting, first aid, AIDS and mental handicap (Lundström and McKeown 1994, p. 157). However, the work undertaken by Home Helps has changed since the establishment of the service in 1971 and Home Helps are increasingly becoming involved in a wider range of tasks including personal care. Both the Home Help Council and the National Association of Home Care Organisers have expressed an interest in drawing up standards for training so that best practice can be assured (personal communications 1996).
20. The present study does not present information on in-service training available to Nursing Aides or Care Attendants working in nursing homes and other institutional settings, or on the number of participants in social care courses who go on to work in these settings. However, the study findings indicate that the majority of younger participants do not go on to work with older people. The Irish Registered Nursing Homes Association has expressed a keen interest in training and has called for accredited training with registration for care workers (personal communication 1996). This will be particularly important given the increasing role of the private sector in the provision of nursing home care.

21. Training offered to informal carers is very limited and, if available at all, is usually provided during Public Health Nurse visits or through carer support groups.

**Positive developments in training**

22. The Council welcomes the fact that educational institutions are increasingly reserving places for mature students and that in some instances learning methods, duration of courses and accreditation policies are being adapted to facilitate the more mature student. In addition, a number of courses have been introduced which are specifically aimed at experienced formal and informal carers. These courses are generally organised to suit the needs of carers who are likely to have been out of mainstream education for some time and who have limited time available to spend on training due to their caring commitments.

23. The *Continuing Education Certificate in Caring* provided by the City of Dublin VEC and the National Association of Home Care Organisers is one example of a course which is designed to meet the specific needs of existing formal carers. This is an example of an in-service, formally accredited course which is
provided by an agency with responsibility for the delivery of social care to older people, in association with educational institutions. The Certificate and Diploma Courses in Social Care, provided by University College Galway, are examples of courses which are provided by an educational institution and are designed to meet the needs of both formal and informal carers. They are not in-service courses but they employ flexible learning methods which are accessible to people currently involved in a caring role.

24. The introduction of modular courses in social care at various centres, which are accredited by the National Council for Vocational Awards, may also have an important role to play in co-ordinating in-service training and training provided by educational institutions and in making accredited training accessible to existing formal social care workers and informal carers.

Main recommendations on training for carers

25. The Council acknowledges and appreciates the wide range of training programmes which are currently available in both the health and education sectors. However it is concerned that, in the interest of older dependent people and their carers, the current ad hoc position in relation to the organisation, provision and accreditation of training in the care of older people needs to be addressed. Further co-ordination between and within the statutory and voluntary agencies responsible for the delivery of social care to older people and the agencies responsible for providing training in social care is necessary, so that closer links between in-service training and training provided by educational institutions can be forged.

26. The Council recommends that the Department of Health should take responsibility for formulating a national policy on training for formal social care workers and informal carers who
care for older people, and for introducing a standardised system of training. The Council has already made recommendations in relation to the home help service on a number of issues including training, to the Department of Health (Lundström and McKeown 1994) and understands that a fundamental review of the home help service will be undertaken shortly on behalf of the Minister for Health.

27. The Council suggests that the Department of Health should review the broad range of current training programmes, both inservice and those provided by educational institutions. The aim of the review should be to determine the effectiveness of existing programmes in meeting the training needs of carers and how they might be co-ordinated on a national basis. The review might also have a role to play in determining how a balance can be achieved between care of older people and care of other groups in existing courses and when new courses are being developed. In this regard it will be important that courses in social care, particularly those aimed at young people, seek to promote positive attitudes to ageing and to ensure that participants have a clear understanding of the ageing process.

28. In recognition of the invaluable contributions of formal social care workers and informal carers to the care of older people, the Council wishes to emphasise the importance of providing training to ensure that older people receive a high standard of care and as a means of supporting carers in their work. It believes that training contributes significantly not only to quality of care provided but also to the quality of life of older people in receipt of social care. The Council recommends that all formal social care workers should receive a minimum standard of training related to the level of service being provided and to the client's needs and their own needs. The Council also recommends that training should be made
available to informal carers who want it. It will be important however to ensure that informal carers do not feel obliged to undertake training.

29. Different levels of training should be provided so that participants can progress from one level to the next as the need arises. This would allow care workers to adapt their skills to the dependency level of the person receiving care, for example. It would also allow care workers to improve their employment prospects and to move from one sector of social care to another if they should so desire. While the work undertaken by formal social care workers and informal carers is similar, the training needs of both categories of carer may differ. Training for informal carers should be more flexible and tailored to meet the individual needs of the carer and the person being cared for.

30. Fears have been expressed in the present study, and in others, in relation to the possibility that training will result in the over-professionalisation of social care and will undermine the voluntary ethos often associated with social care in Ireland. While the voluntary ethos in social care is desirable, it requires statutory supports such as training, if it is to be fully successful and if a genuine spirit of partnership between the voluntary and statutory sectors is to be achieved. It will be important therefore to ensure that the primary aim of training is to enhance the overall quality of care provided rather than to over-professionalise social care services.

31. Topics which should be covered in training for formal social care workers and informal carers include: personal care skills; interpersonal skills such as listening and communication skills; personal development; knowledge of ageing and the needs of older people and their families; and nutrition. In accordance with the
Safety, Health and Welfare at Work Act (1989), instruction in safe working practices should also be an important element of training to prevent causes of injury to clients or workers and to prevent accidents. Training for informal carers should also cover stress management to assist them in coping with the stress of caring.

32. Particular emphasis should be placed on providing training for people who provide personal care services and should cover basic personal care skills including: lifting; help with feeding, dressing, bathing, toileting and physical exercise; and giving prescribed medicines.

33. Training for formal social care workers and informal carers should be flexible and accessible in terms of geographical location and the duration of courses. The learning methods employed should take account of the needs of participants, the majority of whom are likely to be mature women. Training methods employed for informal carers may need to be different than for formal social care workers, for example, training may need to be provided in the home.

34. Carers who wish to advance to further education should be encouraged and facilitated to do so. In this regard, further research should be carried out to look at the possibility of introducing a system of Accreditation for Prior Learning (APL) whereby carers may receive accreditation for their experience in caring.

35. The Council suggests that adequate provision should be made by health boards, in association with educational institutions, to train the relevant personnel to provide training to carers. At present Home Help Organisers and Public Health Nurses are the main people involved in providing training to carers at health board level. Other health board personnel, such as GPs, geriatricians,
physiotherapists, occupational therapists and social workers may also have a role to play in training for carers so that a more holistic approach can be adopted. This is one area where further co-ordination between health boards and educational institutions would be particularly beneficial so that existing resources may be more fully utilised.

36. The Council suggests that adequate funding for developments in the area of training should be made available by health boards. An appropriate guideline in this regard may be the recommendation in the Strategic Management Initiative's document, Delivering Better Government, that each Civil Service Department should allocate additional resources to staff training and development until it reaches at least three per cent of payroll (Strategic Management Initiative 1996, p. 42).

37. European Union channels for funding should also be investigated for developments in the area of training in Ireland. The study findings indicate that there is a lack of co-ordination in social care provision and training not only in Ireland but across Europe and that the issues which need to be addressed in Ireland are similar to those which need to be addressed at a European level. The Force Eurocare Project is an example of a transnational project on training which was developed with support from the EU.

The way forward
38. The findings of this study on training in social care of older people clearly indicate that national policy and practice in relation to training for both formal social care workers and informal carers needs to be co-ordinated if the needs of older people in receipt of social care services and of carers, many of whom are older people themselves, are to be addressed. This is particularly important given the projected increase in the number of older people who will
need social care and the decrease in the number of people available to provide such care.

39. Training in social care of older people is both a health and an education issue. However, as social care is generally provided under the auspices of the health services, the Council recommends that a cross sectoral committee be established under the Department of Health to provide guidelines on the content and operation of a training system for formal social care workers and informal carers and to consider the Council’s recommendations in this regard. The Council suggests that the following sectors should be represented on this committee: the health boards; education authorities with responsibility for the accreditation of courses; educational institutions providing courses; voluntary organisations providing social care to older people; representatives of informal carers; and representatives of the older population.

References


Authors’ Acknowledgements

The authors would like to thank the many people who contributed to this project and without whom the undertaking would have been impossible.

They would like to thank Trish Whelan, Projects Officer, and Bob Carroll, Secretary of the National Council for the Elderly, for their guidance and support at all stages of the research project.

For their invaluable time and expertise, we extend our gratitude to our Consultative Committee: John Browne, Edward Collins-Hughes, Len Commins, Damien Courtney, Una Doherty, Ann Harris, Martina Healy, Anna Hennigan, Mamo McDonald, Madeleine Mulrennan, Celine Phelan, Susan Reilly, Aideen Stanley, Lillian Sullivan and Pam Towers.

We also extend our thanks to Claire Mitchell and Anna Marie Leonard, Secretaries in the Department of Health Promotion, University College Galway, for their assistance in the typing of this report.

Verna McKenna wishes to thank in particular Susan Reilly for her assistance in setting up interviews with health board personnel, Madeleine Mulrennan for her assistance in the identification of post-Leaving Certificate and pre-nursing courses, Damien Courtney for his important contribution and insight on education and training issues, Pam Towers for her help in the identification of voluntary organisations and Pat Haverty for her help in setting up interviews with the Home Helps. Finally, she wishes to thank the following persons for their participation in this project: the health board personnel, directors of private nursing homes and voluntary home help organisations, the Home Helps and Nursing Aides.
representatives of the education and training institutions, and all of
the young people who gave so generously of their time for the
purpose of this study.

Orla O'Donovan would like to acknowledge Helen Duggan, who
conducted all of the interviews with the older people and informal
carers with tremendous sensitivity, skill and efficiency. She would
also like to express her gratitude to the public health nursing
service staff in the Southern Health Board who assisted in setting
up the interviews with the older people and informal carers.

In particular, she wishes to thank the Superintendent Public Health
Nurse, Margaret Daly, and Public Health Nurses, Mary Ryan, Sr.
Martha Leamy, Sheila Drew and Vera O'Donovan. Furthermore,
she would like to thank Noel Byrne and the members of the
Ballincollig Senior Citizens' Club and Claire O'Callaghan and
Eleanor Looney in the Deerpark Day Centre. Finally, and of
course most importantly, she wishes to thank all of the older people
and informal carers who agreed to be interviewed, and the
representatives of the national organisations of older people and
carers who made submissions.
CHAPTER ONE

Introduction

1.1 Introduction

The overall objective of this report is to assist the National Council for the Elderly in determining if it should recommend to the Minister for Health a national training initiative, which might benefit older people in receipt of social care services, formal and informal carers and young people with limited employment opportunities who may wish to work in the social care field.

In relation to what might be meant by a national training initiative, several elements need to be examined. Fundamentally, it was agreed that a needs assessment had to be undertaken to establish whether a systematic training programme is required for carers. The arguments for this start with the needs of older people themselves. In developed Western societies like ours there are now many more older people than previously and a questioning of the assumptions underlying ‘community care’ has necessitated a reappraisal of care services. The shift in public health policy, as exemplified by the Government’s strategy document *Shaping a Healthier Future - A Strategy for Effective Healthcare in the 1990s* (1994), stresses health and social gain as outcome objectives and a more proactive approach to health maintenance, disease prevention and primary care. It is not possible to offer services in primary care without some consistency in standards by those involved in service provision. This has been accepted for over a century for the established professionals involved in services and is now increasingly seen to be true for all those involved in health care. This by no means has to imply that everyone has to have the same degree of training or that a form of professional drift has to occur, but some conception of standards is required once an explicit
relationship between a client and a service provider evolves, whether it is paid or unpaid, formal or informal. A national training initiative therefore needs to define the content of training, to identify who requires such training and establish how it might be resourced. A cost/benefit analysis, taking into account the expected health and social gains and the opportunity costs of a training initiative, should also be carried out. It can be seen that this goes beyond a simple review of curriculum and necessitates a review of practices at service level. The partners in such an initiative are those statutory agents charged with the provision of care, the recipients of such care and those who represent them, the carers themselves and those with a role in their training and education.

1.2 Objectives of Advisory Report
Within the wider context of exploring the case for a national training initiative, the National Council for the Elderly and the authors agreed that the study would address the following broad questions:

- What would be the benefits and general implications of such a national training initiative for older people in receipt of social care services and their informal carers?

- What would be the benefits and general implications of such a national training initiative for paid formal social care workers who work with older people?

- What would be the benefits and general implications of such a national training initiative for statutory, private and voluntary organisations that employ social care?

- What form (in terms of curriculum, accreditation, relationship with existing courses, funding, etc.) might such a national training initiative take?
• What benefits might such a national training initiative have for young people who may wish to work in the field of social care provision for older people?

• What might be the likely uptake of such an initiative?

In order to address these broad questions it was agreed that work would be undertaken under three headings. Firstly, it was agreed that a review of the Irish and European literature on the training of social care workers would be conducted, in order to examine assessments of the need for and impact of training. Secondly, it was agreed that an overview of the existing provision of training courses in social care in Ireland would be drawn up, including courses accredited by Irish awarding bodies, those accredited by British awarding bodies and those that have no accreditation. It was agreed that a description of each of these courses would be provided, including details of the curriculum, accreditation and target student group. In the context of examining the possible development of a national qualification in care of older people, it was agreed that the issues of cohesion, relative standards and mutual recognition of existing courses would be examined. Furthermore, it was agreed that the feasibility of introducing a system of accreditation of prior learning for people who have extensive experience of caring for older people would be examined. The third heading under which it was agreed work would be undertaken concerns consultations with relevant parties about the proposed national training initiative. The discussion in Chapter Two of this report on the findings of the National Council for the Elderly's study of the home help service (Lundström and McKeown 1994) highlights that opinions are divided on the merits of national qualification for social care workers who work with older people. In order to get the views of a full range of interested parties on the merits, demerits and general implications of a
national training initiative, it was agreed that consultations would take place with the following:

- older people, including those who are currently in receipt of social care services in both institutional and community settings,
- informal family carers,
- formal carers, including those working in both institutional and community settings,
- statutory, voluntary and private organisations that employ social care workers who work with older people,
- national organisations of older people,
- education and training institutions that are currently involved in the provision of social care education and training,
- young people who may be interested in working in the social care field.

1.3 Structure of Advisory Report
This report contains five chapters. Chapter One provides an introduction to the report and outlines its objectives and structure. Chapter Two provides a literature review which examines Irish research on the extent and nature of formal and informal care of older people and reviews debates about social care in general, and in particular: the debate concerning the education and training of carers of older people. This chapter then briefly examines the situation in a number of European countries in relation to the training of carers of older people. Chapter Three briefly describes the research methods used in the consultations that were conducted as part of this study and presents the findings from these consultations. Issues around which there were high levels of agreement and disagreement are identified. Chapter Four
describes the existing provision of social care education and training in Ireland. The final chapter, Chapter Five, offers conclusions based on the findings of consultations in relation to a national training initiative for formal social care workers and informal carers of older people. Appendix One provides details on the curricula of existing social care courses in Ireland. Appendix Two provides a comprehensive account of the research methods employed in the consultations. Details of agencies that supplied information on social care training in EU member states are contained in Appendix Three.

1.4 Note on Terminology
It should be noted that the terms 'informal carer' and 'formal social care worker' are used in this report to distinguish between unpaid carers, who are usually female relatives, and paid carers such as Home Helps and Nursing Aides. This distinction between informal and formal care is used extensively in the social care literature. Abrams (1978) is credited with having introduced this terminology, where informal care relates to unpaid care based on personal relationships and formal care relates to care "delivered through a bureaucratic structure by specified individuals working within a framework of bureaucratic rules and professional accountability" (Robenson Elliot 1996, p. 126). The authors acknowledge that this dichotomy between informal and formal care has been the source of much debate, where it has been argued that it is not precise and that it serves to mask assumptions made about work performed in different contexts. Feminist writers, such as Ungerson (1995) and Graham (1991), have been to the fore in developing a critique of this dichotomy and have argued that conceptually it is better to dissolve the boundaries between informal and formal care. These issues receive further attention in the literature review in Chapter Two.
CHAPTER TWO

Education and Training for Carers of Older People
A Review of the Literature

2.1 Introduction
This chapter starts by reviewing the literature on the nature and extent of formal and informal social care for older people in Ireland. It then examines a number of debates concerning social care for older people and in particular the debate concerning the education and training of social care workers. Much of the literature on the training debate is focused on a particular type of formal social care worker, namely the Home Help. The final section of the chapter reviews the situation in a number of European countries in relation to the training of carers of older people.

2.2 The Extent and Nature of Formal and Informal Social Care of Older People in Ireland
In 1991, there were 402,900 people over 65 years living in Ireland, which represents 11.4 per cent of the population (Central Statistics Office 1994). Of these, 24 per cent (96,492) were living alone in private households, 67 per cent (272,056) were living with others in private households and nine per cent (34,352) were living in non-private households, including long-stay geriatric institutions.

**Formal social care**
O'Shea et al. (1991) estimate that in 1988 there were approximately 19,120 beds for older people in formal long-stay care, and provide the following information on the distribution of these beds in the different types of institutions:

- Health Board Geriatric Hospitals provide care mainly for highly dependent and frail older people. These institutions have places for 7,005 older people.
• Health Board Welfare Homes provide care mainly for older people who do not need extensive nursing care. These institutions have places for 1,589 older people.

• Health Board District Hospitals provide a mixture of long-stay, acute, and maternity care and therefore are not exclusively involved in the provision of care for older people. These institutions have 1,465 places for older people.

• Private Nursing Homes provide for-profit care for older people. These institutions have 5,552 places for older people.

• Voluntary Nursing Homes, which are run mainly by Religious Orders, provide not-for-profit care for older people. These institutions have 3,509 places for older people.

For the purposes of this study, the Department of Health was requested to provide information on the numbers of formal social care workers, such as Nursing Aides, who are employed in public institutions that provide long-stay care for older people. Unfortunately, this information was not available. However, O’Shea et al. (1991) report that there are 321 nursing home facilities and, in O’Connor and Thompstone’s (1986) study of private and voluntary nursing homes in Ireland, they found that on average, there were 3.2 Nursing Aides employed per nursing home. This indicates that there are over 1,000 Nursing Aides in the nursing home sector alone. Given the numbers of older people who receive care in geriatric hospitals, welfare homes and district hospitals, it can be estimated that at least the same number of Nursing Aides are employed in those settings.

It is in the community setting, however, that the largest group of formal social care workers who work with older people are employed. Under the Health Act 1970, health boards were empowered to provide a home help service to people who could
not be supported by their family or neighbours. The role of the Home Help was envisaged as follows:

A Home Help is a person who undertakes in a companionable and caring way, normal household duties (for example laying fires, making a light meal, cleaning the house, making beds, getting messages) for a sick or infirm person living at home who cannot do some or all of these things (Department of Health 1972).

The National Council for the Elderly's recent study of the home help service highlighted that the service has expanded considerably since its establishment (the number of Home Helps rose from 5,206 to 10,599 between 1978 and 1993) and that the range of tasks performed by many Home Helps is much broader than was originally envisaged (Lundström and McKeown 1994). In four health board regions, it was found that Home Helps are involved in the provision of personal care, including assisting in the management of incontinence, feeding, giving prescribed medicine and lifting. In the study's comparison of the home help service in Ireland with similar services in Northern Ireland, Britain and Sweden, it found that the Irish service is considerably more cost-effective, but that this "is achieved by less expenditure on staff salaries, inferior conditions of employment and a lack of investment in training" (Lundström and McKeown 1994, p. 297).

In 1993, 99 per cent of Home Helps employed by health boards were women and only 1.4 per cent were employed on a full-time basis.

Lundström and McKeown (1994) report that since 1990 four health boards have introduced the new position of Home Care Attendant/Assistant, to provide personal care to older people in the community (one of these health boards discontinued this practice after a pilot phase because the service was found to be too
expensive). This has resulted in the division of formal social care into personal care and home care, where in some instances Home Care Attendants/Assistants are exclusively involved in personal care and Home Helps are exclusively involved in domestic tasks. Home Care Attendants/Assistants are generally paid at a higher rate than Home Helps and receive more training - four weeks full-time training in the case of one health board.

**Informal social care**

In the absence of comprehensive statistical information on informal social care of older people, various estimates of its extent have been made. Ruddle (1994) estimates that there are in the region of 100,000 informal carers who provide care to dependent relatives, including older people. O’Connor et al. (1988) estimate that there are approximately 66,300 older people who live at home and who require some degree of social care. Of these, it is estimated that approximately 77 per cent (50,800) are cared for by family members and 23 per cent are cared for by people from outside their family. Larragy (1993) estimates that 17 per cent of older people in Ireland are dependent on informal care.

Taking estimates of the extent of informal care with the estimates of the extent of formal care, this represents a ratio of 10:1 in favour of informal care. By contrast, Richardson et al. (1989) estimate that there are approximately six million carers in Britain, 1.7 million of whom are informal carers. While direct comparisons cannot be inferred, these are startlingly contrasting ratios.

There is extensive literature on the nature of informal care. In the British context, for example, Baldwin and Twigg’s (1991, p. 124) review of research on informal care points to the following general findings:
• the care of non-spousal dependent people falls primarily to women;
• it is unshared to a significant extent by relatives, statutory or voluntary agencies;
• it creates burdens and material costs which are a source of significant inequalities between men and women;
• many women nevertheless accept the role of informal carer and, indeed, derive satisfaction from doing so;
• the reasons for this state of affairs are deeply bound up with the construction of female and male identity, and possibly also with culturally defined rules about gender-appropriate behaviours.

Two Irish studies that have explored the nature of informal care for older people have been conducted by O'Connor and Ruddle (1988) and Blackwell et al. (1992). Fifty three per cent of the 200 carers in O'Connor and Ruddle’s study reported that they were confined to the house for between five and 10 hours every day and 24 per cent reported that they were confined for periods longer than this. The study identifies a number of ‘costs’ of caring that fall into the following categories: (a) financial costs, including restrictions on opportunities for labour market participation and expenses incurred in caring; (b) social costs, mainly associated with being confined to home for long periods of time; (c) costs to personal relationships; and (d) costs in terms of physical and emotional health and well-being.

Blackwell et al.’s (1992) study of 207 carers found that 73 per cent were women and 27 per cent were men. Forty-seven per cent were aged between 40 and 60 years and 37 per cent were over 60 years. On average, the carers spent 47 hours per week engaged in caring
activities and those caring for older people in the highest dependency category spent on average 86 hours per week. The implications of caring for the female labour market participation, is highlighted by the finding that only 11 per cent of the women carers were in paid employment, compared to 27 per cent of the national population of women in 1988. Furthermore, Blackwell et al. note that, “when carers do work, a relatively high proportion, almost a third, work part-time” (p. 156). They add that the poor occupational status of informal carers “reflected the educational background of the carers, with almost 60 per cent having an educational level of primary level or less” (p. 156). In this regard, the study of formal and informal carers conducted by O’Donovan et al. (1993) found that 45 per cent of their sample had completed their formal education at Intermediate Certificate level or lower. Blackwell et al. also examined the health costs of caring and by using the General Health Questionnaire they concluded that 29.5 per cent of the carers in their sample were at risk of psychiatric illness due to stress. Using the same instrument Whelan et al. (1991) found that 16.2 per cent of a national representative sample of people were at risk of psychiatric illness due to stress. It is worth noting in this context, that in her review of the literature on elder abuse, O’Donovan (1996) found that the approach to understanding the causes of elder abuse that formed the basis of most research in this field emphasised carer stress.

The above discussion of the extent of formal and informal care indicates that there is a considerable reliance on social care services for older people in Ireland. When this is considered in the context of demographic trends which predict an increase in the proportion of older people, it is highly likely that the need for formal and informal carers will increase. Fahey (1995), for example, predicts that over the period 1991 to 2011 the “most dramatic change . . . is the increase of two-thirds in the numbers
aged 80 and over” (p. 43). Additionally, in Ireland there are important demographic variations, such as high rates of unmarried older people, particularly men in rural areas, which have implications for demands on formal social care services (Kelleher 1993). Such predictions highlight the importance of reviewing the training needs of formal and informal carers. The research findings on the nature of formal and informal social care, particularly in relation to the tasks performed, changes in the nature of formal care services, the occupational and educational backgrounds of informal carers, the amount of time they spend caring and the ‘costs’ of caring, have clear implications for the provision of education and training of carers.

2.3 Debates Concerning the Need to Expand Social Care Services and Concerning the Relative Values of Formal and Informal Care

The debate concerning the need to expand social care services

In his review of the health and social care implications of population ageing in Ireland, Fahey (1995) points out that social care is very much the Cinderella of health care in terms of expenditure and status. He acknowledges that the two fields of medical care and social care frequently overlap but argues that they are distinguishable. He suggests that there are two main distinctive features of social care. Firstly, since social care usually takes place in the home, or in institutional settings that are a substitute for the home, it is regarded as an extension of the functions of the home and the family. Secondly, it is dominated by personal and social services that are generally provided by non-medical personnel, including family. As discussed above, in relation to demographic developments, Fahey (1995, p. 64) concludes that by the year 2011 not only will there be a substantial increase in the number of older
people in Ireland but that there will also be a significant increase in the number of very elderly people, thereby increasing the population pool which is at high risk of being in need of social care.

The poor status of social care services in Ireland occurs in a policy context in which the upgrading and expansion of social care services for older people has been advocated for at least the past decade. Policy documents, such as *The Years Ahead - A Policy for the Elderly* (1988) and more recently, *Shaping a Healthier Future - A Strategy for Effective Healthcare in the 1990s* (1994), made specific recommendations regarding the expansion of social care services and viewed such expansion as crucial to the development of community-based services for older people. The health strategy, in particular, contained a target that social care services should be strengthened to ensure that by 1997, not less than 90 per cent of people over the age of 75 years continue to live at home. The National Council for the Elderly (1994, 1995) has repeatedly called for the establishment of social care services, such as the home help service, as core services, arguing that this is a “vital and key service in supporting frail and dependent older people in the community” (National Council for the Elderly 1994, p. 35).

**The debate concerning the superiority of informal care**

Much of the research literature on the social care needs of older people assumes that these needs involve two discrete elements, namely, needs in relation to emotional or psychological support and needs in relation to a range of practical services, such as housekeeping, preparing meals and personal care (Robertson Elliot 1996). These two types of care have been characterised by Ungerson (1983) as ‘caring about’ and ‘caring for’, where the former involves the provision of affective or emotional care and the latter involves the provision of practical assistance. A key
debate concerning care of older people is whether or not these types of care can be separated and delivered by different kinds of people.

On one side of the debate it is argued that the two types of care are necessarily intertwined, that ‘caring about’ involves ‘caring for’ whereas simply ‘caring for’ without an affective dimension cannot be considered as ‘real care’. Abrams (1978), who made the distinction between formal and informal care in his study of neighbourhood care networks, argued that informal care, which is provided on a voluntary basis, has an affective or ‘caring about’ quality that is absent from formal care provided by paid care staff. However, Graham (1983) and a number of other writers have pointed out that the view of informal care as the superior type of care which encapsulates both ‘labour’ and ‘love’, is based on a number of questionable assumptions. Firstly, informal care is largely assumed to be a feminine activity, performed on an unwaged basis by family members who are women. Secondly, it assumes that familial care is always loving. Thirdly, it assumes that there cannot be an affective dimension to formal care. Those opposed to the claim that informal care is the superior type of care argue that ‘caring about’ or the affective type of care can be provided on both a waged and unwaged basis and by both family members and paid health service staff (Parker 1981, Ungerson 1990, Graham 1991). It is argued that ‘caring about’ is not the exclusive preserve of the private domain of the family.

2.4 Debates Concerning the Education and Training of Carers of Older People

The debate concerning the ‘caring about’ and ‘caring for’ dimensions of care provision for older people is of significant relevance to the current debate in Ireland concerning the training of social care workers. It has been suggested by some that the
training of care workers will result in professionalisation which in turn will undermine the voluntary ‘caring about’ quality of their work. Conversely, others have argued that training will enhance the overall quality of care. Before discussing the specific debate regarding the training of Home Helps that was prompted by the National Council for the Elderly’s study of the Home Help Service (Lundström and McKeown 1994), general arguments that have been made in relation to the education and training of carers are examined.

Research indicates a substantial demand for education and training amongst formal and informal social care workers. The support most frequently sought by informal carers in Ireland is direct payment for services (Blackwell et al. 1992), but the second most frequently sought support, as identified by O’Shea and Hughes (1994), is access to training. In the British context, Challis and Davis (1980) and Graham (1983) report that informal carers have expressed the desire to know more about the medical conditions of older people for whom they are providing care and to have access to training in different aspects of caring. The need for training has also been identified by Ruddle (1994) and Finucane et al. (1994). The Charter of Rights for Carers was compiled in 1991 in association with Soroptimist International Republic of Ireland (Ruddle 1994). One of the rights included in this charter is the right to skills training and development of potential. Arising from the Charter, Soroptimist International supported the Carers’ Charter in Action Project which aimed to address needs identified by carers. Education and training emerged as key needs identified by carers in this project (Ruddle 1994). A study conducted by University College Galway (O’Donovan et al. 1993) found considerable demand for training amongst both formal and informal social care workers. Ninety per cent of the formal social care workers and 72 per cent of informal
carers surveyed reported that they would be interested in doing an accredited course in social care.

A range of benefits of training social care workers have been identified. The European Foundation for the Improvement of Living and Working Conditions (1993) has emphasised the potential contribution of training to improving the quality of care provided to older people. It also identifies the additional benefits of combating the isolation of informal carers, providing peer support, increasing the confidence of informal carers and giving recognition to social care work. Advantages of training identified by carers themselves in the O'Donovan et al. (1993) study mentioned above, highlighted the perceived benefits of training in relation to improved employment prospects. In relation to the benefits of training Home Helps in Britain, Hedley and Norman (1982), stress the role of training in improving the quality and stability of services to older people. They discuss the role of the British Institute of Home Help Organisers and endorse its view that "the aim of training is to encourage Home Helps to do a better job by improving their skills and using their initiative in a constructive manner" and furthermore, that "a sound training programme will reduce the labour turnover, increase stability, reduce the sickness and accident rate, improve efficiency and performance of duties" (p. 33). They also argue that social care work is too complex and too important to be treated as a matter of 'common sense' (p. 33). They note, however, that it is not sufficient to train formal social care workers but that they should also be paid accordingly.

Concerns about the training of social care workers have included that it may result in the over-professionalisation of social care services, and thus in the altering of the ethos of those services, and that it may facilitate the further exploitation of carers by the State. The concern in relation to professionalisation is central to the
debate in Ireland regarding the training of Home Helps, and is discussed in detail below. Ungerson (1995) is concerned about the exploitation of informal carers. She is circumspect about the introduction of supports to informal carers and argues that these may constitute attempts on the part of the State to “reinforce and ensure an adequate supply of informal caring labour” and to provide “lubricant that will ease the transfer of caring responsibilities to the ‘community’ and hence to a cheaper form of care” (p. 44).

The debate about the training of Home Helps
The National Council for the Elderly’s study of the Home Help Service in Ireland brought to the fore a long-standing debate concerning the training of Home Helps (Lundström and McKeown 1994). Arising from the finding that there is minimal provision of training for Home Helps, the views of health board representatives on a nationally recognised qualification were elicited. Three of the health boards indicated that they would be in favour of such an initiative on the basis that it would improve the quality of the service provided by Home Helps. Five of the health boards indicated that they would not support such an initiative on the basis that Home Helps are already competent, that training would over-professionalise the service and would thus undermine its ‘good neighbour’ dimension and that training would result in pressure for increased wages.

Despite the reservations of some health board representatives who were interviewed, training for Home Helps emerged as one of the National Council for the Elderly’s central recommendations from the study of the home help service. The Council argued that in order “to address the emerging needs of dependent older people at home we need to provide Home Helps with practical caring skills, relevant listening and communications skills, and basic knowledge
about ageing and the needs of clients and their families” (Lundström and McKeown 1994, p. 26). The National Council for the Elderly did, however, suggest that perhaps not all Home Helps need to be trained. It also suggested that training courses for Home Helps may be relevant to other groups of people who are working with older people, such as family carers and staff in nursing homes.

A recommendation for the provision of education and training for social care workers in general who work with older people, subsequently formed an element of the National Council for the Elderly’s submission to the National Economic and Social Forum (National Council for the Elderly 1994). Here it was argued that a substantial input into education and training for social care workers, including both paid and unpaid carers, is a requirement for the expansion and development of community support services for older people.

The debate about the training of Home Helps emerged as one of the key themes at the conference at which the findings of the study on the home help service were presented (National Council for the Elderly 1995). In his review of the issues which arose from the study, Kieran McKeown (one of the authors of the report on the study) argued that the debate about training raises the broader issue of the model or ethos of the service, namely, is it a service that is informed by voluntarism or professionalism? This harks back to the debate discussed above regarding ‘caring about’ and ‘caring for’ older people.

At the conference a health board executive advocated the voluntarist model for the home help service. He outlined the special voluntary ethos of the service and suggested that Home Helps have charitable motives for their involvement in the service, as they “see their role as providing a personal service by helping
people less fortunate than themselves” and that they benefit personally “from providing the service, from being needed, and by sharing with others in the community” (National Council for the Elderly 1995, p. 20). There were mixed feelings on the voluntarism/professionalism debate on the part of a Home Help who addressed the conference. She stated that she was in favour of a nationally recognised qualification for Home Helps but added, “I would not favour too much training which might lead to over-professionalisation . . . I value the fact that the people I care for see me as one of them, as an extended family member” (National Council for the Elderly 1995, p. 37). Another speaker at the conference, from the National Association of Home Care Organisers, challenged the arguments against training Home Helps, claiming that it would not undermine good neighbourliness and would not result in a demand for higher wages. She argued that training would be beneficial on a number of fronts, including improving Home Helps’ commitment to their work, improving the quality of care and reducing the high turnover of staff in the service. A review of the reports from the workshops at the conference reveals a high level of support for the call for training for Home Helps. The summing up at the conference echoed this support for training, with, however, some reservation. It was stated that training for Home Helps is essential but that “care must be taken to avoid over-institutionalising the home help service” (National Council for the Elderly 1995, p. 73).

From this review of the debates concerning the education and training of carers of older people, a number of key questions can be identified. These are as follows:

- Do services for older people that are based on a model of voluntarism necessarily have a good neighbourliness or affective quality?
• Do services for older people that are based on a model of professionalism necessarily have to be devoid of the good neighbourliness or ‘caring about’ quality?

• Do different social care workers have different training needs?

• Does training alter the ethos of a service?

• As will be seen in Chapter Three, many of these issues arose in the course of the consultations that were conducted as part of the present study.

2.5 Education and Training of Carers of Older People in Europe

As part of this study, the Departments of Health in 13 of the member states of the EU were contacted and asked to supply information on education and training provision for social care workers involved in the provision of services to older people. A summary of agencies contacted can be found in Appendix Three. The requested information was not, however, forthcoming. This reflects, perhaps, the lack of a comprehensive system in place, that the health sector was not always responsible for social care and that definitions of social care can vary. Clearly, standardisation and harmonisation are required. Information on training provision for social care workers, was, however, gleaned primarily from two reviews of social care services, compiled by Jamieson (1991) and Hutten and Kerkstra (1996).

In her review of home care services for older people in Europe, Jamieson (1991) notes that in most countries there is a tradition of a division between qualified Nurses and Nursing Aides, with Nursing Aides doing the non-technical tasks related to personal care. Similar to the Irish experience described above, she notes that throughout Europe the home help service originally developed
as a non-technical, non-professional occupation concerned with providing assistance with domestic work. Also similar to the Irish experience, Jamieson notes that home help services in Europe have tended to take on a wider range of tasks, particularly in relation to personal care, and that the "proportion of time devoted to personal care, although still relatively small, has actually increased as a consequence of the needs of the 'new' clientele" (p. 260).

This, she argues, is related to the growing ambiguity in the division of labour between nurses and social care workers that is found in a number of countries.

In relation to education and training of social care workers throughout Europe, Jamieson reports that formal social care services are predominantly provided by untrained people, mainly women, and that there are very few national standards or requirements for qualifications and training. She notes, however, that the lack of provision of training "is increasingly seen as inadequate for people who are not only carrying out a clearly defined set of tasks, like cleaning, making beds, or washing older people, but also have to be skilled in social relationships, and in assessing and dealing with a range of social, psychological, and emotional problems" (p. 253). She argues that there are competing pressures in this regard, where on the one hand there is pressure to upgrade social care services for older people, including the drive to professionalise workers like Home Helps, but on the other hand there is the pressure to economise in health expenditure and to be cost-effective. The separation of personal care from home care in social care services is interpreted by Jamieson as a compromise between these competing pressures. In the case of the Netherlands, she argues that financial considerations have been the main impetus for the introduction of this distinction in social care services. 'Alpha Helpers', who have minimal training and who are
exclusively employed as cleaners, have been introduced in the Netherlands as a way of providing help as cheaply as possible. Zeyl (1995), in his account of training provision for employees in the home help services in the Netherlands, notes that there are four grades of Home Help, with the Alpha Helpers at the lowest grade. As one moves up to the higher grades, increased training is required and there is increased responsibility in respect of personal care. It is significant that in his account of the Amsterdam Home Help Service, he notes that Alpha Helpers are required to complete a twelve week foundation course.

Jamieson (1991) provides the following information on the varying situations regarding the education and training of Home Helps in Belgium, England and Wales, Germany and Italy.

**Belgium**

In Belgium, in order to work in recognised social care services, all Home Helps are required by decree to have a recognised qualification such as a certificate as a family and home help worker from an acknowledged training centre. This training must include moral, psychological, hygienic, social and domestic skills and knowledge. It must include 500 hours of theoretical training and 150 of practice learning. Furthermore, Home Helps are required to participate in in-service training every two years.

**England and Wales**

In contrast to the situation in Belgium, there are no legislative requirements for qualifications or for the provision of training for Home Helps in England and Wales. In general they receive minimal training, which may consist of a short induction course, accompanying an existing Home Help or the provision of in-service courses on particular aspects of caring and safety. There are, however, considerable variations between different local
authorities in this respect and there is a growing emphasis on training due to the shift towards a personal care service.

**Germany**
There are no legislative requirements in relation to the qualifications of Home Helps in Germany. In general, Home Helps or Home Care Assistants have very little training, if any, and while they are involved in a range of care tasks, they are generally perceived as domestics.

**Italy**
There are no regulations or legislative requirements in relation to the training of Home Helps in Italy. In some regions, however, such as in Genoa, there has been extensive provision of training for Home Helps. In this instance, a course, consisting of 700 hours, has been provided in conjunction with the local authority in home care centres.

**Overview**
More recently, Hutten and Kerkstra (1996) have compiled an overview of the organisation and financing of home care services in fifteen EU states. They report that there are large differences between the member states in the degree of development of home care services. Some countries have a long-standing tradition of home care and have well developed services, whereas for others, home care services are still in their infancy. All fifteen member states have organisations for both home nursing and home care, although in Italy and Greece these are still in early stages of development. In some parts of Italy and Greece no home help services are available. In all countries home nursing is part of the health system, while in most countries home help services are provided by social services. Ireland (along with Germany and the Netherlands) is atypical in that both home nursing and home help
services are the responsibility of the health sector. In almost all countries (with the exception of Greece) home help services are funded or subsidised by central government, local authorities or both. In most countries co-payment for home help services is required, generally related to the financial circumstances of the family. In all countries Home Helps provide direct help to clients, and in most countries there is only one home help organisation in a region.

Hutten and Kerkstra (1996) identify key problems that are common to the home care services in many countries. These problems include waiting lists, co-ordination of care with other professionals, budgetary limitation and, notably, shortages of home care workers due to the fact that the 'profession' is low status, poorly paid and training is inadequate. In their discussion of the home help service in Ireland, they identify two key problematic aspects, namely, the reimbursing of home help organisations and remuneration for workers.

Similar to Jamieson (1991), Hutten and Kerkstra (1996) report that in most countries Home Helps do not have formal training but undertake on-the-job training or short, informal training courses. However, they report that in Belgium, Germany, Italy, Sweden and Finland, either all or the majority of Home Helps are formally trained. In Denmark, a one year educational programme has recently been introduced. The EU has, however, funded a number of projects to address training issues. One such project is the EU Force Eurocare Project, which involves the preparation of a basic training pack for first line carers of older people working in both domestic and residential settings. The training manual has been completed but, at the time of writing, is not yet available to the public. University College Galway has also been in receipt of EU funding to develop training courses and materials for social care
workers. Such projects offer potential for harmonising training in this area throughout Europe.

Throughout Europe, there appear to be very few training initiatives for informal carers. Where training is provided, it is usually provided by voluntary organisations and again there appears to be no formalised or uniform training.

A report of the Commission of the European Communities (Nijkamp et al. 1991) argues that the question of the qualifications of care workers, though complex, requires attention. It also points to the low remuneration for social care employment in all countries as a hindering factor in the provision of high quality care to older people. In a brief discussion of her review of home help services for older people in the EU. Kerkstra (1995), concludes that, while the problems encountered in home help services ignore the borders of member states, “the unification of Europe with regard to the organisation and financing of home help services is still far away” (p. 50).

2.6 Conclusion
There is evidence that the extent of social care in Ireland, both formal service provision and informal, is substantial and when viewed in the light of predicted demographic trends, it is likely that the need for such services will greatly increase. Research findings on the nature of social care, particularly in relation to the profile of formal and informal carers, the broadening scope of formal care services, the amount of time informal carers spend caring and the low rates of pay for formal care, have implications for social care training curricula and provision. With regard to the debate concerning the training of social care workers, benefits of training that have been identified include improvements in the quality and stability of care provided to older people, improved support for
informal care, giving recognition to social care work and improving the confidence of social care workers. Concerns about training have focused on the threat posed by professionalisation to the ethos of social care services, cost implications and the risk of training being used as justification for the withdrawal of other primary health care services. The review of education and training provision for social care workers in Europe points to the absence of any harmonisation in this regard, but also to the fact that social care is predominantly provided by untrained women. Some countries are exceptional in this respect, such as Belgium where it is mandatory that Home Helps have a recognised qualification.

Many of the debates regarding social care training that were addressed in the literature review arose in the consultations that were conducted as part of this study. The research methods and findings of these consultations are discussed in the next chapter.
CHAPTER THREE

Consultations Regarding Training Carers of Older People

3.1 Introduction
The previous chapter highlighted that the implications of training formal and informal social care workers have been a source of considerable debate in Ireland. A key part of the research brief for the present study was to contribute to this debate by consulting with a range of interested parties involved in the provision of social care services to older people regarding the proposed national training initiative for people. The nine groups that were consulted were (1) older people; (2) informal carers; (3) formal social care workers: representatives of (4) statutory, (5) private, and (6) voluntary organisations that employ social care workers; (7) national organisations of older people; (8) representatives of education and training institutions; and (9) young people who may be interested in working in the social care field. This chapter describes the results of the consultations. A detailed description of the research methods that were employed in each of the consultations and a profile of the sample in each group is provided in Appendix Two. Table 3.1 provides a list of the various groups consulted, the size of the samples and the research methods that were employed. A range of research methods were used, including semi-structured interviews, written submissions, telephone interviews and a self-completed questionnaire survey. The time scale for the entire study was seven months, from September 1995 to March 1996.

3.2 Focus of Consultations
From the review of literature on training of social care workers, a number of key questions were identified. While a range of
research methods were employed in the study, it was decided that
the consultations with the various groups should broadly explore
these key issues. These issues are listed below. Summary charts
detailing the questions that each group was asked can be found in
Appendix Two, Tables A13 and A14. In each of the tables below,
the number of respondents who were asked questions relevant to
the issue is reported at the top of the table.

**Table 3.1: Groups that were consulted, sample sizes and
research methods employed**

<table>
<thead>
<tr>
<th>Groups consulted</th>
<th>Abbreviation in tables of results</th>
<th>No. consulted</th>
<th>Research methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people in a selected health board</td>
<td>P</td>
<td>50</td>
<td>semi-structured interviews</td>
</tr>
<tr>
<td>Informal carers in a selected health board</td>
<td>IC</td>
<td>50</td>
<td>semi-structured interviews</td>
</tr>
<tr>
<td>Formal social care workers in a selected health board</td>
<td>FSCW</td>
<td>19</td>
<td>semi-structured interviews</td>
</tr>
<tr>
<td>Employers of social care workers (a) Representatives of each health board</td>
<td>HB</td>
<td>10</td>
<td>semi-structured interviews, telephone interviews and written submissions</td>
</tr>
<tr>
<td>(b) Proprietors of private nursing homes in each health board</td>
<td>PNH</td>
<td>32</td>
<td>telephone interviews and semi-structured interviews</td>
</tr>
<tr>
<td>(c) Representatives of voluntary organisations in a selected health board</td>
<td>VOL ORGS</td>
<td>14</td>
<td>telephone interviews</td>
</tr>
<tr>
<td>All national organisations of older people and informal carers</td>
<td>ORGS/OP</td>
<td>8</td>
<td>written submissions and telephone interviews</td>
</tr>
<tr>
<td>Education and training institutions</td>
<td>ED/TRG</td>
<td>12</td>
<td>semi-structured interviews, telephone interviews and written submissions</td>
</tr>
<tr>
<td>Young people</td>
<td>YP</td>
<td>224</td>
<td>self-completed questionnaire survey</td>
</tr>
</tbody>
</table>
Key issues/questions addressed in relation to formal social care workers:

1. Should they have some kind of training? What are the potential positive or negative effects of training formal social care workers?

2. Should this training be mandatory?

3. Who should take responsibility for the provision of this training?

4. Should it be specialised training in care of older people or generic social care training?

5. What should be the priority subjects on the curriculum?

6. Accreditation:
   a. Should there be national recognition for such a training programme?
   b. Should training be accredited to allow educational advancement?
   c. Should an accreditation of prior learning (APL) system be developed for formal social workers?
   d. Should there be a system of mutual recognition across EU member states?

7. Would employers of formal social care workers facilitate training?

8. Should a distinction be made between personal care and home care in the provision of social care services to older people, with a resultant distinction in personnel and training?

Key issues/questions addressed in relation to informal carers:

9. Should they have some kind of training? What are the potential positive or negative effects of training informal carers?
(10) Should the content of a training course for informal carers be similar to or different from one for formal social care workers?

(11) Accreditation:
Should training of informal carers be nationally recognised?

Key issues/questions addressed in relation to young people's perceptions:

(12) Do you think there are employment opportunities in the field of care of older people?

(13) Would a recognised qualification in care of older people increase job prospects?

(14) Is there a preference for generic social care courses or specialised training courses in care of older people.

3.3 Summary of Findings
All respondents were asked a number of core questions and then a number of related questions, as relevant. We asked whether respondents felt that formal social care workers should have some form of training. There was almost unanimous support for this on the part of service providers of all types, educational institutions and national organisations. Six of the nine groups consulted were unanimously in favour of training for formal social care workers, ninety seven per cent of young people were in favour, and older people themselves and informal carers were also highly supportive at 88 per cent and 86 per cent respectively. All groups identified the potential positive impact of training on the quality of care provided to older people as a reason for training formal social care workers. Although there were very few reasons given as to why formal social care workers should not be trained, there were some reservations, mainly based on concerns about 'over-training' and 'over-professionalisation' of social care services. Some
respondents identified the possibility that training might lead to an over-supply of workers, presumably also in likely competition with existing providers on the ground, not so well trained.

There was more mixed support for mandatory training for formal social care workers. Only the educational institutions were unanimous, although young people (88 per cent) and the proprietors of nursing homes (75 per cent) were also highly in favour. The majority of organisations of older people (62 per cent), and older people (60 per cent) were in favour, as were the formal social care workers (58 per cent) and informal carers (52 per cent). Forty three per cent of the representatives of voluntary employers and two (20 per cent) of the representatives of health boards were in favour of mandatory training. The arguments in favour of training for formal social care workers as a requirement centred around setting and maintaining standards of care and giving recognition and status to care work. Doubt centred on the problems of pay and conditions and over-professionalisation, and concern regarding the exclusion of existing workers. On the part of some respondents, there was a worry about a loss of flexibility that exists in the current system.

Five groups were also asked to suggest who should be responsible for the provision of training. The health boards were clearly the organisations most frequently mentioned, followed by national educational bodies. This would indicate that training is seen as a statutory responsibility and one in which the health sector should be involved.

If training programmes were to evolve, respondents were asked whether these should be generic or specialised. This was somewhat equivocally answered, perhaps reflecting the range of needs seen to be met by training ventures. The young people were
evenly divided on this point, as were the private nursing homes representatives. Almost all the representatives of voluntary organisations were in favour of generic programmes (93 per cent) as were a majority of the educational institutions (75 per cent), formal social care workers (74 per cent), older people (72 per cent), seven of the eight health boards, 66 per cent of informal carers and 50 per cent of national organisations of older people.

There was very strong support for a national qualification: all educational institutions were in favour, as were 97 per cent of private nursing home respondents, 92 per cent of informal carers, 90 per cent of older people, 90 per cent of formal social care workers, 88 per cent of young people, 88 per cent of organisations of older people and 71 per cent of voluntary organisations. Only half of the health board respondents, however, were in favour of a national qualification. The educational institutions were also asked to address a number of further issues. All were in favour of accreditation to allow further advancement. The majority were in favour of some form of accreditation of prior learning (75 per cent), though with reservations about the difficulties in standardising such a system, given the range of possible applicants and the fact that many carers might indeed have quite low levels of formal education. There was unanimous support for a system of mutual recognition across EU member states. Such a system was felt to operate best by agreement of common criteria in the first instance.

The majority of representatives of voluntary organisations (78 per cent) and private nursing home operators (70 per cent) agreed that social care employees should be facilitated to attend training. Fifty per cent of health board respondents reported that it would be possible to facilitate social care employees regarding training. The costs involved for the provision of training, and/or the loss of time
for staff in training, was a concern expressed by employers of formal social care workers.

Whether or not a distinction should be made between home care and personal care in terms of service provision and training was another issue addressed in the study. The majority of groups who were asked this question were not in favour of a distinction in service provision. The majority of representatives of health boards, national organisations of older people, private nursing homes and formal social care workers themselves were against the distinction. Older people, informal carers and representatives of voluntary organisations were more evenly divided on this issue. Among those who favoured the distinction, most respondents felt that both types of workers should be trained, with less agreement on whether such training should be different or similar.

The young people on training courses were, perhaps understandably, quite optimistic about job prospects. Sixty six per cent reported that they felt there were jobs in the field of care of older people and a similar percentage thought that nationally recognised training would increase job prospects.

Respondents were also highly supportive of training for those informally involved in care. Support was virtually unanimous across interview groups, with only one health board respondent and one older person dissenting. As with training of formal social care workers, an increase in the quality of care was seen as a likely and positive outcome of training informal carers, as were skills development and greater understanding of the needs of older people. A reservation expressed about training in this context was that informal carers should not be pressurised into undertaking training:
Respondents were also asked to identify priority areas for training in the case of formal social care workers. In terms of the curriculum, personal care skills and interpersonal skills training were unanimously identified as priorities by respondents, followed by education on the nature of ageing and its particular needs. Home care skills were identified as a priority subject area only by the representatives of the health boards. A majority of respondents felt that the content of courses aimed at formal and informal carers should be similar, although the representatives of educational and training institutions were more equivocal on this point. Possible differences in content usually reflected the perception that more attention to stress management was required in the circumstance of informal carers.

Providers were asked whether training for informal carers should be nationally recognised. There was more equivocation on this point from respondents compared to the situation for formal social care workers. This mainly arose from the difficulty of obtaining comprehensive coverage for such training and the reality that many informal carers are not recognised in that role at present. Some concern was expressed that a nationally recognised training course might seem daunting to informal carers, especially those who have been out of formal education for some time. Apart from this, respondents could not identify any significant reasons for not supporting training and again, educational institutions were in favour in principle of credit for prior learning.

3.4 Key Issues Regarding the Training of Formal Social Care Workers

**Issue No. 1: Should formal social care workers have some kind of training?**

The responses to this question were almost unanimously positive. A large proportion of the total sample felt that formal social care
workers should receive training, as can be seen in Table 3.2. Only older people, informal carers and young people had some slight reservations about training. All employers of formal social care workers, all representatives of educational and training institutions, all organisations for older people and all formal social care workers were in favour of training, thus providing very strong support for facilitating the uptake of training by formal social care workers.

Table 3.2: Should formal social care workers have some form of training?

<table>
<thead>
<tr>
<th></th>
<th>OP  n=50</th>
<th>IC  n=50</th>
<th>FSCW n=19</th>
<th>HB  n=10</th>
<th>PNH n=32</th>
<th>VOL ORGS n=14</th>
<th>ORGS /OP n=8</th>
<th>ED/ TRG n=12</th>
<th>YP  n=224</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>44 (88)</td>
<td>43 (86)</td>
<td>19 (100)</td>
<td>10 (100)</td>
<td>32 (100)</td>
<td>14 (100)</td>
<td>8 (100)</td>
<td>12 (100)</td>
<td>218 (97)</td>
</tr>
<tr>
<td>no</td>
<td>4 (8)</td>
<td>3 (6)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4 (2)</td>
</tr>
<tr>
<td>don't know</td>
<td>2 (4)</td>
<td>4 (8)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2 (1)</td>
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</tbody>
</table>

Numbers in parentheses indicate percentages.

All groups were asked to give reasons for their response and to identify possible positive and negative effects of training formal social care workers. In many cases, the positive effects identified were similar to the reasons given in support of the provision of training. A summary of the reasons given and the possible positive effects can be found in Table 3.3.

There was some similarity across all groups consulted regarding reasons for training formal social care workers. All groups were aware of and emphasised the impact that training formal social care workers would have on older people. The potential increase in the quality of care older people receive was identified by all groups, and was frequently mentioned by respondents, as was the potential
increase in understanding the needs of older people that training would create. The development of specific skills such as lifting procedures and knowledge of entitlements was also mentioned by most groups.

Positive effects of training formal social care workers
The reasons cited by older people for being in favour of training for formal social care workers include that:

- it would contribute to improving the quality of care provided,
- it would instil more confidence on the part of older people in formal social care workers,
- it would instil more confidence among formal social care workers in themselves,
- the work involves high levels of responsibility and therefore requires training,
- that older people are entitled to receive care from qualified personnel.

An example of this last point is Mr. O’Rourke (fictional names are used throughout) (interview no. 2), who is a resident in a nursing home. He explained why he was in favour of training as follows:

Older people are entitled to get care. They are entitled to get good care and I think some of the Nursing Aides aren’t capable of giving proper care.

In relation to improving older people’s confidence in formal social care workers, Mrs. Halpin, an older person (interview no. 9), stated:

Although they’re pretty good, I think they should have training. Old people would be happier to know that they know something about caring.
Table 3.3: Potential positive effects of training formal social care workers identified in the consultations

<table>
<thead>
<tr>
<th>Effect</th>
<th>OP</th>
<th>IC</th>
<th>FSCW</th>
<th>HB</th>
<th>PNH</th>
<th>VOL ORGS</th>
<th>ORGS /OP</th>
<th>ED/ TRG</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the quality of care given to older people</td>
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<tr>
<td>Facilitate the broadening of responsibilities to include personal care</td>
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<tr>
<td>Increase the confidence of the formal social care worker</td>
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<tr>
<td>Increase the confidence of older people in carers</td>
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<tr>
<td>Increase carers' knowledge of the needs of older people</td>
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<td>Develop the practical skills of carers</td>
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<tr>
<td>Facilitate more care at community level</td>
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<tr>
<td>Improve the motivation and morale of carers</td>
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<tr>
<td>Fulfil legal obligations to provide staff with training in safe working practices</td>
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<tr>
<td>Facilitate equity of standards</td>
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<tr>
<td>Facilitate an holistic approach to service delivery</td>
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<tr>
<td>Improve recognition of social care work</td>
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<tr>
<td>Enhance the image of social care work</td>
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<tr>
<td>Improve awareness of safety issues/reduction in accidents</td>
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<tr>
<td>Improve capacity to support informal carers</td>
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</tbody>
</table>
The ways in which the quality of care could be improved by training formal social care workers, as mentioned by the informal carers, include the belief that they would be more understanding of older people and that they could be involved in a wider range of tasks. Mrs. Joyce (interview no. 20), for example, said:

Our Home Help helps with making the tea and lights the fire. If she had proper training she could do more . . . but she'd have to be paid a proper wage and have to answer for what she was doing.

The informal carers who were in favour of some kind of training for formal social care workers tended to emphasise the skills required to care adequately for older people and to understand the needs of older people. Mr. Sullivan, an informal carer (interview no. 11), stated:

Older people have special needs that are not familiar to most people . . . workers should be trained in these needs.

Similarly, Mrs. Looney, also an informal carer (interview no. 7), said:

Without training people don't know how to handle old people properly. They hurt them if they're moving them up and down the bed . . . Some people are very rough . . . training would stop this . . . By right, you need training for that sort of thing.

The benefits to informal carers of training formal social care workers were generally regarded as being in the two areas of improving the capacity of formal social care workers to advise informal carers, and their ability to act as respite workers. Mrs. Kelly (interview no. 10), for example, said:
If these people were properly trained, families would feel all right about leaving them with the elderly person and taking a break.

Other benefits identified were that formal social care workers could advise and instruct informal carers about practical procedures such as lifting, and that they could be more involved in personal care. Mrs. Looney (interview no. 7), explained this latter benefit as follows:

My mother is embarrassed when I do her personal care . . . it would be much better if there was someone from outside who could do it. It would be better for her and for me.

The reasons given by formal social care workers for the provision of training chiefly related to benefits to older people, in that, training would give formal social care workers a greater understanding of the needs of older people and would improve the status of care work. Training was seen as essential “to do the job properly”.

Representatives of the health boards gave several reasons for training formal social care workers. In addition to reasons mentioned above, representatives from the health boards drew attention to the obligation on the part of a health board to provide training. One interviewee stated, for example, that:

They are working in the public arena as a representative of the health board.

Accountability, standardisation of care and of training, fostering community care and promoting safe practices were also frequently mentioned by the health board respondents. The importance of increasing the understanding of the nature of problems formal social care workers may have to deal with, the complexity of the
role. the importance of older people having confidence in their workers, and the issue of 'getting the best' from employees were all given as reasons for training formal social care workers.

Proprietors of private nursing homes frequently mentioned the specialised nature of working with older people, and that older people deserve quality care. One respondent said, for example, that:

"Care for the elderly and sick is a specialised job and requires great care and attention to their needs. The elderly deserve a quality of care that can only be provided by trained personnel."

Also of particular importance to this group was skills training in health and safety issues. It was considered that older people would feel more secure with trained staff. One interviewee stated that:

"It is irresponsible to send untrained workers into a situation where they are providing care to a client who may be infirm, incapacitated or where the carer faces a situation of complex and difficult needs."

Representatives of voluntary organisations, as with other groups, focused on the importance of an understanding of the needs of older people and recognition of the importance of the work of the carer.

The representatives of the national organisations of older people and the educational and training institutions were unanimously in favour of the provision of training for formal social care workers. One organisation of older people suggested that training is essential to:

"Reinforce the importance of their (social care workers) role, not least among other health care workers."
Overall then, support for training for formal social care workers was very strong and seen as essential for various reasons. Of these, increasing the quality of care of older people, the importance and skilled nature of the work, and the need to recognise and accord status to the work were recurrent themes.

**Negative effects of training formal social care workers**

The possible negative effects of training identified in consultations are summarised in Table 3.4. These were fewer in number than positive effects.

Older people’s concerns about the negative effects of training were chiefly in relation to current formal social care workers. Specifically, concerns were expressed regarding the exclusion of good carers from care work, in that they may be unable to access training, and that it may be unreasonable to expect formal social care workers to obtain training given the current low rates of pay. One of the older people who did not think that formal social care workers needed training thought it unnecessary. Mrs. O’Dowd (interview no. 17), stated:

> So long as they come and see the patient and make a cup of tea... they don’t need training because they’re used to doing the sort of things they do for the patient for themselves.

No negative effects of training formal social care workers were identified by the informal carers, or formal social care workers.

The health boards identified more possible negative effects of training than other groups consulted, expressing concerns about costs, loss of flexibility in the service and possible difficulties regarding access to training in rural areas. They were particularly concerned about how training formal social care workers could lead to over-professionalising the service, over-training personnel, and undermining the ‘good neighbourly’ ethos of the service.
Proprietors of private nursing homes were concerned that training formal social care workers might result in the domestic aspect of care work being ignored. They also had some concerns about people unsuited to care work securing places on training courses and stressed the importance of rigorous recruitment procedures for training.

Representatives of voluntary organisations were concerned that training might professionalise formal social care workers, and also that those who are competent carers might be excluded from care work, if unable to access training.

Organisations of older people, representatives of educational and training institutions and the young people consulted did not identify any possible negative outcomes of training formal social care workers. This is exemplified in the following response from one organisation of older people:

We cannot think of any plausible reason why formal social care workers should not be trained. Our experience is that formal social care workers want training and get too few opportunities for training.

**Issue No. 2: Should training of formal social care workers be mandatory?**

The idea that training for formal social care workers be mandatory received considerable but not unanimous support across all groups (see Table 3.5). The majority of the groups consulted were largely in favour of training being mandatory, the strongest support coming, not surprisingly, from the representatives of education and training institutions. However, considerable support was also given by young people, proprietors of private nursing homes, the organisations for older people and older people themselves. The
Table 3.4: Potential negative effects of training formal social care workers identified in the consultations

<table>
<thead>
<tr>
<th>Potential negative effects</th>
<th>OP</th>
<th>IC</th>
<th>FSCW</th>
<th>HB</th>
<th>PNH</th>
<th>VOL ORGS</th>
<th>ORGS/OP</th>
<th>ED/TRG</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase cost of social care services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training might lead to a loss of flexibility in the service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training may lead to over-professionalisation/reduce neighbourly ethos of social care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who are competent carers might not be able to take up training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Might be difficult to recruit trained personnel in rural areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic side of work might get ignored</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training not necessary for work involved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic rewards not enough for trained personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People unsuited to care might do the course</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
groups least in favour of mandatory training were informal carers, formal social care workers and representatives from voluntary organisations and the health boards.

Reasons given in support of mandatory training
Older people and informal carers reported that mandatory training was required particularly in instances where formal social care workers are providing personal care and are caring for highly dependent older people. Mr. Conway, an older person (interview no. 13), for example, stated:

Training would help Home Helps to understand the patient. They need training to help them understand old people, especially if the old people are very sick or very old.

Table 3.5: Should training of formal social care workers be mandatory?

<table>
<thead>
<tr>
<th></th>
<th>OP n=50</th>
<th>IC n=50</th>
<th>FSCW n=19</th>
<th>HB n=10</th>
<th>PNH n=32</th>
<th>VOL ORGS n=14</th>
<th>ORGS /OP n=8</th>
<th>ED/TRG n=12</th>
<th>YP n=224</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>30 (60)</td>
<td>26 (52)</td>
<td>11 (58)</td>
<td>2 (20)</td>
<td>24 (75)</td>
<td>6 (43)</td>
<td>5 (62)</td>
<td>12 (100)</td>
<td>197 (88)</td>
</tr>
<tr>
<td>no</td>
<td>17 (34)</td>
<td>17 (43)</td>
<td>6 (32)</td>
<td>4 (40)</td>
<td>6 (19)</td>
<td>8 (57)</td>
<td>2 (25)</td>
<td></td>
<td>11 (5)</td>
</tr>
<tr>
<td>don't know</td>
<td>3 (6)</td>
<td>7 (14)</td>
<td>2 (10)</td>
<td>4 (40)</td>
<td>2 (6)</td>
<td></td>
<td></td>
<td></td>
<td>11 (5)</td>
</tr>
<tr>
<td>other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (13)</td>
<td>5 (2)</td>
</tr>
</tbody>
</table>

Numbers in parentheses indicate percentages

Similarly, another older person, Mrs. Wilson (interview no. 11), stated:

I think training should be a requirement when people are caring for an elderly person who needs nursing care like
bathing and changing. I don’t think it’s needed for people who are looking after elderly people who are up and about.

Mrs. Looney, an informal carer (interview no. 7), explained why she thought training should be mandatory, as follows:

Some of them definitely need training. A lot of people do not know how to handle an old person who is confined to the bed.

Similarly, Mr. O’Brien, an informal carer (interview no. 13), stated:

Training should be essential for people who are looking after a disabled patient. Otherwise, how do you control or oversee what is actually going on?

The reason most frequently given by formal social care workers in favour of mandatory training was that it would increase the status of and give recognition to the work undertaken by formal social care workers. Setting standards for care work was also mentioned in a number of cases. Benefits identified by one formal social care worker were as follows:

... to ensure a standard of care... also national recognition would give better status to the job.

Representatives from the health boards who were in favour of mandatory training felt that it would professionalise the job and give formal social care workers the necessary skills and information to do their job well. One representative commented that:

The key to achieving high standards is to provide training.

Giving recognition to care work and setting standards for care work were mentioned frequently by the proprietors of private nursing homes. Within this group, mandatory training was also
seen as a way of ensuring quality care. Additionally, they felt that caring for older people is a speciality and that mandatory training would provide recognition of this. It was also highlighted that from the point of view of the employer, it would be helpful to know that formal social care workers have reached a certain level of skill and knowledge which has been validated by an independent body. For those already working in nursing homes, it was felt that mandatory training would help facilitate promotion.

Representatives from voluntary organisations who favoured mandatory training emphasised that basic training should be a requirement for all workers, and was necessary, as formal social care workers are expected to be responsible for the care they give.

Five of the organisations for older people reported in their submission that they thought that it should be a requirement that all social care workers have some kind of formal training, and one other organisation recommended that the introduction of mandatory training should be accompanied by the establishment of a national register of home care workers.

There was unanimous agreement among the representatives of education and training institutions that training should be mandatory. The main reasons given in support of mandatory training was that such a venture would set standards and give status to care of older people. It was also pointed out that mandatory training would help to establish progression links such as EU recognition, career opportunities and study opportunities.

Reasons given for opposition to mandatory training
Forty per cent of the older people interviewed were either uncertain or were opposed to the introduction of mandatory training for formal social care workers. The main reason given in these
instances was that mandatory training could restrict involvement in social care or exclude some people who are very good carers. Mrs. O'Brien, an older person (interview no. 15), reported:

My Home Help mightn't qualify. But I wouldn't change her.

Similarly, Mrs. O'Callaghan (interview no. 50) said:

I think training is a good idea but some people are good anyway. Some people just understand older people. How good they are depends a lot on the individual.

Mr. Murphy (interview no. 3) was similarly opposed to mandatory training because he felt it would restrict the involvement of neighbours in the home help service. He stated:

It's very handy if the neighbour can help . . . if there was a law that they have to have training, although she's very good, she couldn't do it.

Another reason for opposing mandatory training that was mentioned by a number of older people was that owing to the poor pay levels of formal social care workers, it would be unreasonable to expect them to invest in training.

The arguments against mandatory training for formal social care workers made by the informal carers also tended to focus on its implications for untrained people currently working in the field. Mrs. Fitzpatrick, an informal carer (interview no. 14), for example, noted:

I don't think it should be a requirement because it would push out people who don't have training and who are very good. I think it would be good to have training, but it should not be compulsory.
Among formal social care workers, only 32 per cent were opposed to mandatory training. In a similar vein to the informal carers, it was felt that mandatory training might deter capable people from working in the area. For example, one formal social care worker commented that:

Fewer people might do the work if you had to have a qualification.

Concern was also expressed by informal carers and formal social care workers about a reduction in the supply of carers.

Eight of the 10 representatives of the health boards were unsupportive of, or uncertain about, mandatory training of formal social care workers. Reasons given included possible problems regarding salary entitlements, feelings that locally tailored initiatives or in-service training might suffice, and that mandatory training was not needed. One health board representative stated that:

Training is unnecessary for the actual skills needed.

One health board representative who was opposed to the idea of mandatory training pointed out that there were problems inherent in bringing in mandatory training. Specifically, it was pointed out that the idea of developing another grade of worker within the community care sector would lead to difficulties in relation to salary entitlements. It was also pointed out that, from a service delivery perspective, nationally accredited mandatory training is not necessary as long as training skills are provided to the worker. The representative from another health board pointed out that there is no need to create a new discipline of worker and that the most important aspect of training is that it is client focused. Concerns were also expressed that mandatory training might adversely affect
the supply of carers, particularly in rural areas where access to training courses might be restricted. The point was raised that the existing skills base of personnel would have to be recognised. As a result, some workers would not be in need of national level training. In short, representatives of the health boards opposed to mandatory training felt that in practical terms it would cause problems and impose restrictions.

Furthermore, it was pointed out by the health board representatives that mandatory training raised the issue of the differential between a needs-based and an entitlement-based service and that training may put more of an emphasis on being entitled to a service as opposed to actually needing it. It was also felt that training of formal social care workers and informal carers might take the responsibility away from the family to some degree as there would be a named service with specially trained people to care for the older person.

Eighteen per cent of the proprietors of private nursing homes were opposed to mandatory training of formal social care workers. These representatives from private nursing homes felt that mandatory training might be difficult to implement and that in-house training might suffice.

Fifty seven per cent of the representatives from voluntary organisations were also opposed to mandatory training for formal social care workers. Reasons given particularly concerned the possibility that mandatory training would place unnecessary restrictions on who could become involved in care work. For example, ‘neighbours’ who may perhaps have a lot of practical experience and/or be well known to the older person. One interviewee stated that:

The good neighbour ethos would break down.
Respondents within the group of young people who were opposed to mandatory training (five per cent) felt that, while training is very important, work experience may often be sufficient. It was also pointed out that there is the danger that training might impose a routine system of standards leading to a pre-determined ‘package’ approach to the care of the older person and that such a development might deter people from taking up training.

In summary, mandatory training of formal social care workers was seen as desirable in that it would foster the setting and maintaining of standards of care, which is seen as essential for the care of older people, and would also increase knowledge of ageing and personal care. Arguments against such training being mandatory tended to focus on how restrictive this practice might be, especially having negative implications for those untrained at present. Deterring ‘naturally’ good care workers was also a frequently expressed concern, as were costs and difficulties with access.

**Issue No. 3: Who should be responsible for the provision of training for formal social care workers?**

Five groups, namely, representatives of statutory, voluntary and private employers of formal social care workers, representatives of educational and training organisations and national organisations of older people were asked this question. Results can be seen in Table 3.6. Overall, the health boards were clearly the most frequently mentioned organisations who should take on this responsibility. Slightly less than half (43 per cent) of the suggestions referred to the health board/Department of Health as being the body that should be responsible, and when suggestions for health boards in conjunction with agencies other than the Department of Health were added to this figure, 59 per cent of suggestions included the health boards.
The remaining organisations suggested were fairly evenly spread across educational institutions, nursing organisations or a combination of two such organisations. Vocational Educational Committees and FÁS were the next most frequently mentioned, although by much smaller proportions of the sample.

Between the five groups some interesting differences emerged. The national organisations of older people, proprietors of private nursing homes and representatives of voluntary organisations were much more likely to suggest the health boards than the health boards were themselves, as can be seen in Table 3.6. Only the proprietors of the private nursing homes suggested that nursing personnel or a nursing organisation should be responsible for training formal social care workers. Similarly, the most favoured candidates for taking responsibility for training formal social care workers among the representatives of the educational and training institutions were national educational bodies.

**Issue No. 4: Should training of formal social care workers be specialised training in the care of older people or generic social care training?**

In general, generic training of formal social care workers was favoured over specialised training. Results can be seen in Table 3.7.

**Reasons given in support of generic training of formal social care workers**

Older people (72 per cent) and informal carers (66 per cent) were largely in favour of generic training, as were formal social care workers (74 per cent). Factors cited in favour of generic training include that it would improve employment prospects in a number of social care settings and that many people who work with older people are also involved in providing social care services to other
Table 3.6: Who should be responsible for the provision of training to formal social care workers?

<table>
<thead>
<tr>
<th>Suggested organisations to provide training to Formal Social Care Workers</th>
<th>HB n=8*</th>
<th>PNH n=26*</th>
<th>VOL ORGS n=8*</th>
<th>ORGS /OP n=6*</th>
<th>ED/ TRG n=12*</th>
<th>TOTAL n=60*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employers</td>
<td>2 (25)</td>
<td>15 (57.7)</td>
<td>5 (62.5)</td>
<td>3 (50)</td>
<td>1 (8.3)</td>
<td>26 (43)</td>
</tr>
<tr>
<td>Health Boards/Dept. of Health</td>
<td>2 (25)</td>
<td>1 (12.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Boards with Supt. Public Health Nurse</td>
<td>1 (12.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Health Boards with Educational Authority</td>
<td>1 (12.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Health Boards with Nursing Homes</td>
<td>1 (3.8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Health Boards with FÁS</td>
<td>1 (3.8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Health Boards with National Council for the Elderly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (8.3)</td>
</tr>
<tr>
<td>Voluntary Agency with Supt. Public Health Nurse</td>
<td>1 (12.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>National Educational Body</td>
<td>1 (12.5)</td>
<td>1 (16)</td>
<td>9 (75)</td>
<td>11 (18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational Education Committee</td>
<td>2 (7.7)</td>
<td>1 (12.5)</td>
<td></td>
<td></td>
<td></td>
<td>3 (5)</td>
</tr>
<tr>
<td>FÁS</td>
<td>3 (11.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 (5)</td>
</tr>
<tr>
<td>Voluntary Agency with Educational Body</td>
<td></td>
<td>2 (34)</td>
<td></td>
<td></td>
<td></td>
<td>2 (3.2)</td>
</tr>
<tr>
<td>Registered Nursing Homes Association</td>
<td>1 (3.8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Experienced Nursing Home Personnel</td>
<td>2 (7.7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 (3.3)</td>
</tr>
<tr>
<td>Nursing Body</td>
<td>1 (3.8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Community Care Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Supt. Public Health Nurse and Home Help Organiser</td>
<td>1 (12.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1.7)</td>
</tr>
</tbody>
</table>

Numbers in parentheses indicate percentages

* n here refers to number who responded to the question
groups of people. The majority of the health board representatives (70 per cent) were also in favour of generic training, pointing out that it is more cost-effective to have one individual trained who can deal with a wide range of situations.

Table 3.7: Should training of formal social care workers be specialised or generic?

<table>
<thead>
<tr>
<th></th>
<th>OP n=50</th>
<th>IC n=50</th>
<th>FSCW n=19</th>
<th>HB n=10</th>
<th>PNH n=32</th>
<th>VOL ORGS n=14</th>
<th>ORGS /OP n=8</th>
<th>ED/ TRG n=12</th>
<th>YP n=224</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>36 (72)</td>
<td>33 (66)</td>
<td>14 (74)</td>
<td>7 (70)</td>
<td>16 (50)</td>
<td>13 (93)</td>
<td>4 (50)</td>
<td>9 (75)</td>
<td>108 (48)</td>
</tr>
<tr>
<td>Specialised</td>
<td>9 (18)</td>
<td>17 (34)</td>
<td>5 (26)</td>
<td>3 (30)</td>
<td>16 (50)</td>
<td>1 (7)</td>
<td>2 (25)</td>
<td>3 (25)</td>
<td>99 (44)</td>
</tr>
<tr>
<td>Don't know</td>
<td>5 (10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17 (8%)</td>
</tr>
</tbody>
</table>

Numbers in parentheses indicate percentages

The proprietors of private nursing homes were evenly divided on this issue. Those in favour of generic training felt that, once the person had a general knowledge of the caring principles, specialist knowledge might be gained through work experience.

The majority of voluntary organisations (90 per cent) were in favour of generic training of formal social care workers. Here, it was felt that there was a need for general training for Home Helps, as they deal with a wide range of clients, and formal social care workers should have a general awareness and understanding of the needs of different client groups. It was also pointed out that generic training would be more useful and local organisations could then add their own specialisation to the content as the need arose.

Representatives of educational and training institutions were largely in favour of generic training (75 per cent): reasons given
included that it was felt to be more practical in relation to community care, in that the care worker should be able to apply skills learnt to various settings. It was also pointed out that generic training would allow greater flexibility regarding client care which may mitigate against possible 'burn-out'. Finally, as mentioned by other groups, it was suggested that students would be adaptable to a variety of work situations and therefore would be more employable.

Among the young people surveyed there was almost an equal amount in support for specialised training and generic training. Those in support of generic training felt that such a programme would be necessary to help people to decide which area of care work they would like to specialise in.

*Reasons given in support of specialised training of formal social care workers*

Arguments in support of specialised training all emphasised the specific physical, psychological and social needs in a care context, and that these could be best met through specialised training. Among the representatives of educational and training institutions, those in favour of specialised training pointed out that, while there are core skills that can be seen as generic to all social care settings, some aspects of training should be specialised and specialised care is required to meet the specific needs of older people.

Proprietors of private nursing homes in favour of specialist training (50 per cent) pointed out that such knowledge would lead to a more professional approach and would help to avoid high rates of turnover of staff. In particular it was pointed out that specialisation might encourage more long-term prospects in employment in nursing homes.
**Issue No. 5: What should be the priority subjects on the curriculum for formal social care workers?**

Eight of the nine groups consulted were asked to identify three subject areas that they felt should be prioritised on a training course for formal social care workers. The results for all eight groups are reported in Table 3.8.

The two most frequently identified priority subject areas were interpersonal skills and personal care skills: these were identified by seven of the eight groups consulted on this matter. Inclusion of a supervised placement element was mentioned by three groups, and other topics were not prioritised by more than two groups. In the consultations with the national organisations and formal social care workers, knowledge of the ageing process was identified as a priority area. A number of the national organisations of older people also addressed the importance of ageism and discrimination.

**Table 3.8: What should be the priority subject areas in the training curriculum for formal social care workers who work with older people?**

<table>
<thead>
<tr>
<th></th>
<th>OP</th>
<th>IC</th>
<th>FSCW</th>
<th>HB</th>
<th>PNH</th>
<th>VOL ORGS</th>
<th>ORGS /OP</th>
<th>ED/ TRG</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal skills</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td>•</td>
<td>-</td>
</tr>
<tr>
<td>Personal care skills</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td>•</td>
<td>-</td>
</tr>
<tr>
<td>Welfare entitlements</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding old age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Knowledge about ageing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Supervised placement</td>
<td></td>
<td></td>
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</tbody>
</table>
One representative from an educational organisation pointed to the importance of establishing core skills and elective units. It was suggested that core skills could include communications, interpersonal skills, coping skills, personal care and lifting skills. Elective units could include understanding ageing, human development, an understanding of dependency, social policy, health promotion, leisure and recreation, first-aid and nutrition. A dual approach to delivery and learning was recommended, that is, learning about personal needs of the carer and learning about the delivery of quality care services.

**Issue No. 6: Accreditation**

(a) *Should there be national recognition of training of formal social care workers?*

(b) *Should training be accredited to allow advancement?*

(c) *Should an accreditation of prior learning (APL) system be developed?*

(d) *Should there be a system of mutual recognition across EU member states?*

The vast majority of respondents were in favour of national recognition of training of formal social care workers. Very high proportions of all the groups consulted were positive about such a development, with the exception of the representatives of health boards, of whom only half felt that national recognition would be desirable. Results can be seen in Table 3.9.

**Arguments for national recognition of training of formal social care workers**

Almost all of the older people (90 per cent) and the informal carers (92 per cent) reported that training of formal social care workers should have some kind of nationally recognised qualification.
Within each group there were varying levels of importance attached to national recognition, from those who felt ‘it would be no harm’, to others who felt that accreditation could be accompanied by the establishment of a register of qualified social care workers. The majority (90 per cent) of formal social care workers felt that there should be nationally recognised training programmes, as this would accord recognition and status to the work.

The five health board representatives (50 per cent) who were in favour of national accreditation of training of formal social care workers, stated that formal training would give recognition to the work of formal carers and assist in the setting of standards and goals in the service.

The majority of the proprietors of private nursing homes (97 per cent) and of voluntary organisations (71 cent) felt that there should be national recognition of training of formal social care workers, and reported that it would give status and recognition to the work, set standards and increase the supply of Nursing Aides who could be employed in nursing homes.
Seven of the eight national organisations of older people recommended that training for formal social care workers should have some kind of nationally recognised qualification. One stated that in its experience:

Those who argue against nationally recognised qualifications do so on the grounds of cost in terms of raised expectations of salaries and conditions of service, or of undervaluing the role of formal social care workers.

A second organisation recommended modular training with accreditation based on a system of credit accumulation, while a third recommended that a register of those with the national qualification should be established.

All the representatives of education and training institutions and the majority of young people (88 per cent) reported that there should be national recognition for training of formal carers.

Arguments against national recognition of training of formal social care workers
The representatives of the health boards constituted the group that was the least likely to be in favour of nationally recognised training of formal social care workers who work with older people. Four representatives were unsure and one was opposed to this idea. The representative who was opposed to the idea of national accreditation, argued that it is not necessary. Those who were unsure about national accreditation of training reported that, while some form of accreditation would be desirable, national accreditation was unnecessary as such a qualification would require increases in payment which would not be possible, and at present there is no structure for this in place. It was stressed that the suitability of the worker was more important than their
qualification. Two representatives felt that local training to meet local needs would be more suitable.

Only one of the proprietors of private nursing homes was opposed to national accreditation, saying that this would be an overly formal approach. Those opposed to national accreditation of training among the representatives of voluntary organisations pointed out that it might discourage the involvement of neighbours in caring for older people and might also deter capable people from engaging in care work.

Representatives of educational and training institutions were specifically asked further questions about accreditation for formal social care workers. In relation to support for advancement opportunities it was reported that people should be given the opportunity to advance if required, as it would provide a better career structure for formal social care workers and informal carers. It was pointed out that, in order to avoid a 'cul-de-sac' training situation, a very flexible system needs to be in place. Such an accredited system would allow students to build on their previous work and not duplicate it.

When asked for their views on a system of accreditation of prior experience, the majority (75 per cent) reported that they were in favour of such a system. Those in support of the system pointed out that the paucity of formal training in an area where there is simultaneously a large number of experienced practitioners, would allow many such practitioners to reap the benefits of their years of experience. The difficulties involved in setting up such a system were also highlighted. For example, it was pointed out that accreditation of prior experience is a complex issue that needs to be looked at in detail and carefully regulated, with agreement between different organisations on levels of mobility across
training programmes. Those who were unsure about the development of such a system pointed out that, while the individual should certainly be credited for having experience to qualify for the course, it would be more difficult to devise an accreditation system with regard to specific academic subject requirements.

All of the representatives of education and training institutions were in favour of a system of mutual recognition among EU member states which would be based on agreement on common criteria including modules and qualifications. One of the representatives reported that their organisation is at present involved in a number of mutual recognition projects which are attempting to investigate how to operate such a system. It was pointed out that mutual recognition of content, learning and standards is important. Recognition of standard levels may be a practical model, as it reflects the fact that care work and needs may differ from country to country. The identification of core skills was emphasised as being crucial.

**Issue No. 7: Would employers of formal social care workers facilitate training?**

The employers of formal social care workers, namely, representatives of the health boards, private nursing homes and voluntary organisations were asked if it would be possible to facilitate staff to undertake training. Of the three groups, the representatives of the health boards were least likely to indicate that staff would be facilitated to participate in training.

Five of the ten health board representatives reported that facilitating staff to undertake training would be possible. However it was pointed out that extra funding from the Department of Health would be required and facilitation would only be possible for full-time permanent staff and semi-permanent 'key-workers'.

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Two of the health board representatives did not think that facilitation would be possible as it would be too expensive to provide time off or to replace all staff. It was pointed out that in-service training, provided by the health board, would be a better model. The remaining three representatives who were unsure pointed out that facilitation is limited due to budget constraints and lack of flexibility within the health board to provide training.

The majority of the proprietors of private nursing homes (70 per cent) reported that facilitation in the form of time off without pay for formal social care workers would be possible. Twenty per cent felt that facilitation in the form of paid leave would not be possible, as this would not be cost-effective due to the very high turnover of staff in nursing homes. The remaining 10 per cent were unsure about facilitation and pointed out that external funding would be necessary.

Of the representatives of voluntary organisations, 78 per cent reported that facilitation would be possible. 14 per cent were unsure and seven per cent (one representative) reported that it would not be possible. Those who said that facilitation would be possible reported that they would need extra funding from the health board to put facilitation into practice but that time off without pay would be possible. The organisation that felt facilitation would not be possible pointed out that extra funding would be required to facilitate staff. Those who were unsure felt that such facilitation would have to be paid for and organised through the health board and that, because it was so difficult to replace staff, it would be necessary to have training in the evenings. Thus it would seem that, while all employers were favourably disposed to facilitating the participation of formal social care staff in training, the costs involved were the key concern.
Issue No. 8:
(a) The distinction between home care and personal care
(b) Training in home care and personal care

Seven of the nine groups were asked if a distinction should be made between personal care and home care in the provision of social care services to older people, with a resultant distinction in personnel and training. The responses to the first part of this question are summarised in Table 3.10.

Table 3.10: Should a distinction be made between personal care and home care?

<table>
<thead>
<tr>
<th></th>
<th>OP n=50</th>
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<th>FSCW n=19</th>
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<th>ORGS /OP n=8</th>
<th>ED/ TRG</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>24 (48)</td>
<td>18 (36)</td>
<td>6 (31)</td>
<td>2 (20)</td>
<td>13 (41)</td>
<td>7 (50)</td>
<td>2 (25)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>No</td>
<td>19 (38)</td>
<td>25 (50)</td>
<td>11 (58)</td>
<td>8 (80)</td>
<td>15 (47)</td>
<td>6 (43)</td>
<td>5 (63)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7 (14)</td>
<td>7 (14)</td>
<td>2 (10)</td>
<td>4 (12)</td>
<td>1 (7)</td>
<td>1 (12)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*Numbers in parentheses indicate percentages*

Arguments in favour of the distinction between home care and personal care

Forty eight per cent of the older people were in favour of the distinction between home care and personal care. Reasons given for favouring the distinction included that they are two entirely different types of jobs, that the older person gets more time and attention and that it facilitates more social contact by ensuring that there are two, rather than one, regular visitors. Mrs. Morgan (interview no 1), an older person, explained why she felt that having carers exclusively involved in personal care would be beneficial, as follows:
There should be one person who just looks after the patient. If that is all she has to do, she can give more time and attention to the personal care of the older person.

The informal carers were less likely than the older people to favour the distinction (36 per cent). Formal social care workers who were in favour of the distinction (31 per cent) pointed out that at present, Home Helps are largely viewed as cleaners and that the distinction provides a means of getting recognition for the personal care work done by some. It was also pointed out that the distinction takes some of the pressure off Home Helps who are often expected to perform a wide range of tasks.

Two health board representatives were in favour of the distinction. They pointed out that many individuals are happy to carry out housework duties but do not want to get involved in personal care and that there is a considerable difference in the level and type of skills involved.

Forty one per cent of the representatives of private nursing homes were in favour of a distinction between home care and personal care, suggesting that such a distinction would attract different staff to different areas: It was felt that personal care is more of a specialised 'one-to-one' skill in an area to which not all persons might be suited. Furthermore, it was felt that some workers might not be able to cope with both sets of tasks.

Among the representatives of voluntary organisations, half were in favour of the distinction, reporting that personal care is a specific role and requires different skills. However it was also pointed out that there is scope for both services and with good communication skills carers could work together quite well.
Arguments against the distinction between home care and personal care

Thirty-eight per cent of the older people who were interviewed reported that they were opposed to the distinction between home care and personal care. Reasons given for opposition to the distinction tended to emphasise that it made practical sense for the care work to be conducted by one person and also that there was a better chance of the older person developing a good relationship with a person who performed both types of tasks. Mr. McKeown (interview no. 3), explained his opposition to the distinction as follows:

Some old people might not like too many people around them, they could get used to one person. If there were two people involved there could be a lack of co-operation.

Fifty per cent of the informal carers reported that they were opposed to the distinction between personal care and home care, while over half of the group of formal social care workers (58 per cent), were opposed to the distinction. As many of those surveyed are presently involved in the provision of both home care and personal care, it was not, perhaps, surprising to find such a low level of support for a distinction being made. Formal social care workers opposed to the distinction argued that it is in the interest of older people in receipt of care that social care services are integrated.

Eight of the ten health board representatives were opposed to the distinction between home care and personal care. It was argued that the distinction results in inefficiencies and the fact that Home Helps have covered both areas of work for years emphasises that it is possible to combine the two skills in one person. It was felt that
this is more practical, particularly in rural settings. In the community care sector, multiskilled personnel represent greater cost-effectiveness, which in turn emphasises the importance of appropriate recruitment practices. The importance of examining the issue from the perspective of the client was also raised. For example, older persons might not be happy with having more than one person coming into their homes. It was also reported that the needs of the client might change over time from predominantly home care needs to personal care needs. In such a situation it would be beneficial for the older person to have the same trusted person to carry out the work.

Forty seven per cent of representatives of the private nursing homes were opposed to the distinction, reporting that one person should be able to integrate all tasks and that lines of demarcation are unnecessary. It was also pointed out that the caring process requires a 'whole person' approach and that dividing the work reflects an 'institutional philosophy' rather than a 'holistic philosophy'. Having this distinction might not be the most efficient use of resources. The importance of examining the issue from the point of view of the client was also raised, again drawing attention to the possibility that having two different workers coming in would be stressful and unfair to older people.

Forty three per cent of representatives of voluntary organisations were opposed to the distinction, feeling that it was not unusual for Home Helps to provide personal care to clients and that it was a denial of the experience and skills of Home Helps to bring in other grades of care staff. In this regard a holistic approach to care was emphasised.

Five of the eight national organisations of older people felt that the distinction should not be made. Submissions from these
organisations included the following statements:

Any such distinctions have led to conflict and to the downgrading of those social care workers such as Home Helps, whom others regard as having a primarily personal care function.

It is important that the present artificial division of home-based services between Home Helps and Home Care Attendants be abolished as it serves no purpose for carers and is a major cause of confusion and grievance.

In summary, the groups consulted tended to be divided on the issue of the distinction between home care and personal care. The arguments against a distinction included the cost-effectiveness of multiskilled workers, issues of trust, continuity of care, and that a distinction mitigates against the development of a holistic model of care. In the National Council for the Elderly's report on Home Help Services for the Elderly, (Lundström and McKeown 1994) unease with this distinction was reported, specifically, that Home Help and Home Help Organisers have not welcomed the introduction of Home Care Attendants, seeing it as involving "unnecessary partitioning of clients' needs into personal care and other types of care" (p. 144). The equivocation in groups may well reflect this unease. It is interesting to note that the group least in favour of a distinction between two types of worker was the health board representatives, suggesting that they have revised their ideas about this since 1994, when four health boards had introduced Home Care Attendants and a fifth had expressed an intention to do so (Lundström and McKeown 1994).

The formal social care workers and representatives of statutory, private and voluntary employers who favoured the distinction between home care and personal care, were then asked whether
both types of worker would require training. These respondents constituted 31 per cent, 20 per cent, 41 per cent, and 50 per cent of each group respectively. Additionally, it was explained to representatives of education and training institutions and young people that some health boards had introduced two types of worker, Home Helps for domestic tasks and Home Care Attendants for personal care. These two groups were then asked whether both types of worker would require training. Results can be seen in Table 3.11.

<table>
<thead>
<tr>
<th></th>
<th>FSCW n=6*</th>
<th>HB n=2*</th>
<th>PNH n=13*</th>
<th>VOL ORGS n=7*</th>
<th>ED/ TRG n=12</th>
<th>YP n=224</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, both require training</td>
<td>2 (33)</td>
<td>2 (100)</td>
<td>9 (64)</td>
<td>7 (100)</td>
<td>10 (83)</td>
<td>153 (68)</td>
</tr>
<tr>
<td>No, both do not require training</td>
<td>2 (33)</td>
<td>4 (36)</td>
<td>2 (17)</td>
<td></td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td>2 (33)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9 (4)</td>
</tr>
</tbody>
</table>

* Numbers in parentheses indicate percentages  
* Represents number of respondents who favoured a distinction between personal care and home care

The majority of respondents were in favour of training for those who undertake personal care and home care. Within each group consulted, with the exception of the formal social care workers, there was a clear majority in favour of training, and unanimously so for the representatives of the health boards and the voluntary organisations. This indicates that, in employment situations where there are two types of worker, there is strong support for both receiving training. It also suggests that, where one formal social care worker undertakes both domestic work and personal care, training could cover both aspects of their work.
The formal social care workers who were asked this question (31 per cent) felt that both types of work would require training in, for example, interpersonal skills and an understanding of the ageing process, and that training both types of worker would give status and recognition to each, accordingly.

Health board representatives pointed out that today, employers are obliged to train all employees and, as Home Helps may be the first contact between the health services and a person in need of care, they should be appropriately trained. It was also felt that, although those who undertake home care may require less training than those who undertake personal care, both types of worker would require training in such matters as confidentiality and knowledge of the community care team.

Respondents who reported that they felt that both types of worker require training were then asked whether such training should be similar or different. Results are presented in Table 3.12.

<table>
<thead>
<tr>
<th></th>
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<th>PNH n=9*</th>
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<th>ED/ TRG n=10*</th>
<th>YP n=153*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Different</td>
<td>2 (100)</td>
<td>7 (78)</td>
<td>3 (43)</td>
<td>4 (40)</td>
<td>65 (42)</td>
<td></td>
</tr>
<tr>
<td>Similar</td>
<td>1 (50)</td>
<td>2 (22)</td>
<td>4 (57)</td>
<td>5 (50)</td>
<td>77 (51)</td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (50)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td></td>
<td></td>
<td></td>
<td>1 (10)</td>
<td>11 (8)</td>
<td></td>
</tr>
</tbody>
</table>

* Numbers in parentheses indicate percentages
* Represents number of respondents who felt both types of worker require training
One formal social care worker felt that training for each type of worker could be different but that an overlap would be possible, for example, regarding communication and interpersonal skills.

Both of the health board representatives who felt that training was required in home care and in personal care felt that training should be different in each case. Those who conduct personal care were seen to require more in-depth training, although both types of worker should receive a basic induction course.

The majority of proprietors of nursing homes felt that training should be different, in that it should be more intense for those who provide personal care. It was felt that those providing home care should receive training in basic care practice, but that those providing personal care would require additional training in personal care skills. Those in favour of similar training felt that an awareness of the needs of older people would be necessary for both types of worker.

Both the representatives of voluntary organisations and representatives of educational and training institutions were evenly divided on this question. In support of different training for each type of worker, voluntary organisations pointed out that personal care is specialised work. In support of similar training for both types of worker, representatives of voluntary organisations felt that there is an overlap between each set of tasks, and both types of worker need basic skills in, for example, observation, alertness and interpersonal skills.

In summary, it would seem that the majority of respondents are of the opinion that there should not be two distinct categories of worker, and that in practice, Home Helps undertake both personal care duties and home care duties. Where those consulted felt that
there is a need for both types of worker, the vast majority agree that both require basic training in interpersonal skills and 'care practice', with supplementary training in personal care skills for those who perform personal care.

3.5 **Key Issues Regarding the Training of Informal Carers**

Eight of the nine groups were consulted regarding the training of informal carers. The sample of young people were not asked questions on these issues.

**Issue No. 9: Should informal carers have some kind of training?**

Support for training of informal carers was almost unanimous, as can be seen in Table 3.13. Interestingly, there was greater support for training informal carers than there was for formal social care workers.

**Table 3.13: Should informal carers have some kind of training?**

<table>
<thead>
<tr>
<th></th>
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<th>ORGS /OP n=8</th>
<th>ED/ TRG n=12</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>47 (94)</td>
<td>50 (100)</td>
<td>19 (100)</td>
<td>9 (90)</td>
<td>32 (100)</td>
<td>14 (100)</td>
<td>8 (100)</td>
<td>12 (100)</td>
<td>-</td>
</tr>
<tr>
<td>No</td>
<td>1 (2)</td>
<td></td>
<td>1 (10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Don't know</td>
<td>2 (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Numbers in parentheses indicate percentages*

Respondents were asked to identify possible positive and negative effects of training informal carers. The positive effects that were identified are summarised in Table 3.14. As with the positive effects identified in relation to training of formal social care workers, increasing the quality of care for older people was identified by almost all groups as a possible benefit of training, as
Table 3.14: Potential positive effects of training informal carers identified in the consultations

<table>
<thead>
<tr>
<th>Effect</th>
<th>OP</th>
<th>IC</th>
<th>FSCW</th>
<th>HB</th>
<th>PNH</th>
<th>VOL ORGS</th>
<th>ORGS/OP</th>
<th>ED/ TRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the quality of care given to older people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the confidence of the informal carer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve relationship between carers and older people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase confidence of older person in carer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older person will feel more secure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase informal carers' knowledge of the needs of older people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop the skills of informal carers, for example, use of appliances, lifting, coping with emergencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal carers would be more willing to take older people from hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older person could remain in the community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve recognition of informal carers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced stress for informal carers and in household</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase safety, reduce accidents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
was increasing carers’ understanding of the needs of older people, the development of relevant skills and training as a means of reducing stress in informal carers.

Potential positive effects of training informal carers
The vast majority (94 per cent) of the older people interviewed reported that training in social care should be made available to informal carers. Informal carers who were interviewed were unanimously in favour of the provision of training for informal carers. The kinds of reasons given by older people for supporting the provision of training for informal carers included that training could assist informal carers in coping with the stress of caring, that it could provide assistance with practical tasks and that it could help in giving older people more confidence in the informal carer’s ability to care. Mr. Barry (interview no. 19), who had been an informal carer himself, stated:

I was a tradesman and I had to look after my wife. I knew nothing about it... if I could have got even a handbook or a pamphlet at the beginning it would have been of great use.

All of the formal social care workers who were interviewed stated that they felt that social care training should be made available to informal carers. They stated that it was desirable because it would improve their caring skills, possibly reduce the number of accidents and play a role in reducing the stress associated with informal care.

All but one of the representatives of the health boards, all of the proprietors of the private nursing homes and all representatives of voluntary organisations were in favour of the training of informal carers. It was felt that training would increase the confidence of informal carers, reduce levels of stress and isolation, and provide informal skills that can improve the quality of the care delivered.
All of the organisations of older people reported that they thought that social care training should be made available to informal carers. Three organisations emphasised that informal carers should be encouraged to avail of this training only if they feel they need it themselves. Another organisation recommended that informal carers, in receipt of the Carers’ Allowance, should, be encouraged to participate in social care training, stating that:

This is particularly the case if they are in receipt of public money. This could be supplemented on foot of a certificate.

The point was also made that it is important for the persons requiring care to know that the person looking after them has the skill and knowledge to perform their duties satisfactorily.

All representatives of education and training institutions felt that informal carers should have access to training and the opportunity to develop their care skills, as this would reduce the stress levels of the informal carer and improve the quality of care.

**Potential negative effects of training informal carers**

Despite the high level of support for making training available to informal carers, some possible negative effects of training were identified. These are summarised in Table 3.15 and refer to concerns about costs, increased stress experienced by informal carers left with increased responsibility and the lessening of support from others.

The older people’s reservations about providing training for informal carers centred around the fear that informal carers would feel pressurised into going for training and that it would become another source of stress to them. Furthermore, it was suggested that it might result in restricting informal care. In discussing this
Table 3.15: Potential negative effects of training informal carers identified in the consultations

<table>
<thead>
<tr>
<th>Effect</th>
<th>OP</th>
<th>IC</th>
<th>FSCW</th>
<th>HB</th>
<th>PNH</th>
<th>VOL</th>
<th>ORGS</th>
<th>ORGS/OP</th>
<th>ED/TRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too costly to the state</td>
<td></td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training may lead to over-professionalisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Trained person in family might be left with all responsibility</td>
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<td>*</td>
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<tr>
<td>People might feel that caring could not be undertaken without a qualification</td>
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</tr>
<tr>
<td>Informal carers should not be obliged to take up training</td>
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<td></td>
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</tr>
<tr>
<td>Training may add to the stress of caring</td>
<td></td>
<td></td>
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<td></td>
<td>*</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Training would not have any impact on a poor relationship between older person and carer</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>If informal carers were trained it may reduce resources from health board</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Informal carers may not want to take up training</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>*</td>
</tr>
</tbody>
</table>
point, Ms. Buckley (interview no. 14) stated:

If your neighbour was kind enough to come in, shouldn’t you take her the way she is?

Informal carers could also think of reasons why informal carers should not be trained. A number said that they thought that training should be targeted especially at people who have recently become involved in caring, and regretted that such training had not been made available in their own situations. In relation to this, Mrs. O’Brien (interview no. 2) said:

I learnt the hard way. Everybody has it built into them to care... all it needs is to be brought out. Training at the start would have been useful.

For a variety of reasons, a number of the informal carers stressed that such training should not involve high costs or time commitments. Examples given were that informal carers may not be able to avail of it, it might be too costly to the State, it may not always be necessary, or it may increase the tendency of other family members to leave the informal carer with sole responsibility for caring.

The representative of the health board who was opposed to the idea of training informal carers pointed out that, while there is a need to support informal carers in their caring role, training is unnecessary. In the case of another representative who reported support for training of informal carers, it was also pointed out that, while training is an ideal, in reality informal carers are given ‘support’ as opposed to training in practical skills. Concern was also expressed about potential costs of training and the possible ‘over-professionalisation’ of care.
Issue No. 10: Should the content of a training course for informal carers be similar or different from one for formal social care workers?

The majority of respondents felt that training programmes for formal social care workers and informal carers should be similar. Results can be seen in Table 3.16 below.

Table 3.16: Should the content of a training course for informal carers be similar or different from one for formal social care workers?

<table>
<thead>
<tr>
<th></th>
<th>OP n=50</th>
<th>IC n=50</th>
<th>FCSW n=19</th>
<th>HB n=10</th>
<th>PNH n=32</th>
<th>VOL ORGS n=14</th>
<th>ORGS /OP n=8</th>
<th>ED/TRG n=12</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Similar</td>
<td>28 (56)</td>
<td>32 (64)</td>
<td>16 (85)</td>
<td>5 (50)</td>
<td>22 (69)</td>
<td>8 (57)</td>
<td>3 (38)</td>
<td>6 (50)</td>
<td>-</td>
</tr>
<tr>
<td>Different</td>
<td>22 (44)</td>
<td>18 (36)</td>
<td>3 (15)</td>
<td>4 (40)</td>
<td>9 (28)</td>
<td>5 (36)</td>
<td>1 (13)</td>
<td>6 (50)</td>
<td>-</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (10)</td>
<td></td>
<td></td>
<td></td>
<td>1 (7)</td>
<td></td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>No response</td>
<td></td>
<td></td>
<td></td>
<td>1 (3)</td>
<td>4 (50)</td>
<td></td>
<td></td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

Numbers in parentheses indicate percentages

Forty four per cent of older people and 36 per cent of informal carers felt that the training should be different. It was emphasised that training for informal carers should be less intensive. The subject areas that were identified by those who thought the curriculum should be different included assisting families in making both the transition into and out of informal care, training in managing the finances of elderly relatives and caring for the carer.

Four of the health board representatives reported that training for informal carers should be different to that given to formal social care workers, in that it should be tailored to the needs of particular client groups. It was also suggested that training could be less
formal for informal carers and could prioritise coping with stress, knowledge about entitlements and personal care skills.

Fifty per cent of the representatives of education and training institutions felt that there should be differences in the types of training offered to the formal and the informal carer. For example it was suggested that the duration of the course could be shorter for informal carers and the course could be offered on a part-time basis with less stringent examination requirements to those expected of formal social care workers. The other 50% suggested that the content of training courses for informal carers could be similar to that for formal social care workers, although there could be differences in intensity and the level of technical knowledge provided.

Three of the organisations of older people recommended that the content of the training for informal carers should be the same as that for formal social care workers, with one suggesting an overlap in the two types of training and the forging of progression routes between training for informal care and training for formal care.

**Issue No. 11: Accreditation**

*Should there be national recognition of training for informal carers?*

The majority of older people, informal carers, formal social care workers and organisations of older people were in favour of national recognition of training for informal carers. Representatives of the health boards, voluntary organisations and educational and training institutions were chiefly opposed to this development or unsure whether it would be favourable. Proprietors of private nursing homes were evenly split on the issue. Results can be viewed in Table 3.17.
### Table 3.17: Should there be national recognition of training for informal carers?

<table>
<thead>
<tr>
<th></th>
<th>OP n=50</th>
<th>IC n=50</th>
<th>FCSW n=19</th>
<th>HB n=10</th>
<th>PNH n=32</th>
<th>VOL ORGS n=32</th>
<th>ORGS /OP TRG n=8</th>
<th>ED/ TRG n=12</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32 (64)</td>
<td>36 (72)</td>
<td>14 (73)</td>
<td>1 (10)</td>
<td>13 (41)</td>
<td>4 (29)</td>
<td>5 (63)</td>
<td>4 (33)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>17 (34)</td>
<td>14 (28)</td>
<td>5 (27)</td>
<td>4 (40)</td>
<td>14 (44)</td>
<td>8 (57)</td>
<td>1 (13)</td>
<td>8 (67)</td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td>↑ (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (13)</td>
</tr>
</tbody>
</table>

Numbers in parentheses indicate percentages

Formal social care workers who thought that training courses for informal carers should be nationally accredited, commented that this would allow the informal carers to develop their skills. It was pointed out that informal carers should be “as entitled to a diploma or certificate as formal social care workers are.” Representatives of private nursing homes reported that national recognition of training of informal carers may assist in raising their self esteem, and contribute to the recognition of informal care.

Of the 36 per cent of older people who did not think training for informal carers should be accredited or who were undecided, the kinds of reasons given included that they thought it would not be a priority for informal carers and that many informal carers who are elderly would not be interested in participating in the paid labour force.

Informal carers who felt that training should not be accredited said that a diploma or certificate would not be a priority if they were to do such a course, but rather that they would be more concerned with getting practical assistance from a course.
There was much less support (33 per cent) among representatives of educational and training institutions for the national recognition of training of informal carers. Specifically, it was felt that since many informal carers may have been out of formal education for some time, a nationally accredited training course might seem very daunting. As training for informal carers is seen to primarily address their personal development needs, national accreditation was therefore seen by this group as being unnecessary.

3.6 Key Issues Regarding Young People’s Perceptions of Social Care Training

(12) Do you think there are employment opportunities in the field of care of older people?
(13) Would a recognised qualification in care of older people increase job prospects?

Issue Nos. 12, 13 and 14

(a) Young people’s perceptions of employment opportunities in the field of social care of older people
(b) Whether a recognised qualification in care of older people would increase job prospects
(c) Preference for generic or specialised training courses

The young people consulted in the study were asked about their perceptions of employment opportunities in the area of care of older people. Sixty six per cent of the group reported that they thought there were jobs available in this area.

The group was also asked if a nationally recognised qualification in the care of older people would increase the prospects of employment. Sixty seven per cent of the group reported that they felt it would. Those who felt that there would be no increase in prospects reported that policy changes would be required (e.g., in
areas such as pay levels) before any improvements in job prospects would come about.

Finally, the young people were asked whether they would like to obtain specialised training in care of older people or if they would prefer to focus on a more general social care course. Just over half (54 per cent) reported that they would prefer generic social care training (see Table 3.18).

**Table 3.18: Young people's interest in generic or specialised training**

<table>
<thead>
<tr>
<th>Wish to obtain specialised training in care of older people</th>
<th>69 (31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wish to undertake generic training courses</td>
<td>121 (54)</td>
</tr>
<tr>
<td>Don't know</td>
<td>18 (8)</td>
</tr>
<tr>
<td>No answer</td>
<td>16 (7)</td>
</tr>
<tr>
<td>Total</td>
<td>224 (100)</td>
</tr>
</tbody>
</table>

*Numbers in parentheses indicate percentages*

The reasons young people gave for generic training included, that it would offer a wider variety of employment possibilities and that the status and pay in the area of working with older people is not very good. Within the 31 per cent who were in favour of specialised training in the care of older people, respondents felt that older people have very special needs and that work in this area would be very rewarding.

### 3.7 Conclusion

Almost unanimous support for the provision of training for both formal and informal social care workers was reported in the consultations with the nine different groups. There was less
agreement, however, on the issue of whether or not this training should be mandatory for formal social care workers. The majority of those consulted reported that they felt that training of social care workers could play a significant role in improving the quality of care provided to older people. Several other benefits of training were also identified, including improving the support provided to informal carers, improving the availability of social care staff and improving the morale and motivation of formal social care workers. The possible negative implications of training social care workers identified included restricting the involvement of skilled carers who are currently working in the field, and fears about over-professionalising care work. Concerns about the costs of training formal social care workers were also expressed. With regard to the curriculum of social care training, the two priority areas that were identified were interpersonal skills and personal care skills.
Overview of the Existing Provision of Education and Training in Social Care in Ireland

4.1 Introduction
In this chapter, the existing provision of education and training courses in social care in Ireland is reviewed. Educational and training institutions and voluntary organisations who provide short training courses were consulted to obtain this information. As details regarding in-service training of Home Helps was reviewed in the Report *Home Help Services for Elderly People in Ireland* (Lundström and McKeown 1994), detailed information on in-service training of Home Helps was not sought in the course of this study.

From a listing of social care courses in Ireland (Nolan 1993), courses that were specifically aimed at working with older people were highlighted for the purpose of the present study and the relevant institutions and organisations were contacted. Between October and December 1995, all providers identified in Nolan’s study were contacted and requested to supply information on their current course(s). In addition, a further number of relevant courses were identified through the research process. Organisations known to represent the interests of carers were also contacted. Information received is summarised below. For each course, information is provided on the course provider, the accreditation body (where relevant), whether the course is generic or specific, the target group and duration of the course. A short description of the course content is included where available. Further details of the curricula of courses can be found in Appendix Three. The information on education and training courses, training programmes and projects listed is not meant to be exhaustive, but
instead offers a picture of current activity in the area.

In Ireland there are a large number of institutions and organisations that are involved in the provision and accreditation of education and training for formal social care workers and informal carers. A summary of providers and existing courses is shown in Table 4.1.

These organisations and institutions can be categorised as follows:

1. Courses accredited by Irish awarding bodies (e.g., courses run by the various third level institutions that are accredited by the National Council for Educational Awards (NCEA), the National Council for Vocational Awards (NCVA) or the National University of Ireland (NUI)).

2. Courses accredited by both Irish and British awarding bodies (e.g., courses accredited by City and Guilds and FÁS).

3. Courses that have no formal accreditation (e.g., courses run by voluntary organisations).

4.2 Courses Accredited by Irish Awarding Bodies

Within this category are courses provided by Athlone, Cork, Sligo and Waterford Regional Technical Colleges (RTCs), by the Dublin Institute of Technology (DIT), by University College Galway (UCG), by the National Council for Vocational Awards (NCVA) and the Irish Red Cross Society. The courses provided within the RTCs and the DIT represent three types of courses, (Certificate, Diploma and Degree) provided across five separate colleges.

A report by the National Council for Educational Awards (NCEA), Working Party on Social and Caring Studies (1992), highlights that changing social circumstances, and particularly changes in public policy in the areas of health and social care in recent years, have created a need for a review of educational provision in this area.
Table 4.1: Providers, accrediting bodies and titles of social care courses in Ireland

<table>
<thead>
<tr>
<th>Accrediting body</th>
<th>Educational/training body</th>
<th>Course title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accredited by Irish accrediting bodies</td>
<td>NCEA Athlone, Cork, and Sligo RTCs and DIT</td>
<td>National Certificate in Applied Social Studies in Social Care</td>
</tr>
<tr>
<td></td>
<td>NCEA Athlone, Cork, Sligo, Waterford RTCs, and DIT</td>
<td>National Diploma in Applied Social Studies in Social Care</td>
</tr>
<tr>
<td></td>
<td>NCEA Cork RTC</td>
<td>BA in Applied Social Studies in Social Care</td>
</tr>
<tr>
<td></td>
<td>UCG UCG</td>
<td>Certificate in Social Care</td>
</tr>
<tr>
<td></td>
<td>NUI UCG</td>
<td>Diploma in Social Care</td>
</tr>
<tr>
<td></td>
<td>NCVA Any NCVA approved centre</td>
<td>Community and Health Services</td>
</tr>
<tr>
<td></td>
<td>NCVA Any NCVA approved centre</td>
<td>Community and Health Services, Community Care (Award Level 2)</td>
</tr>
<tr>
<td></td>
<td>The Irish Red Cross Society and Institute of Community Health Nursing</td>
<td>The Irish Red Cross Society</td>
</tr>
<tr>
<td></td>
<td>The Irish Red Cross Society and Institute of Community Health Nursing</td>
<td>Certificate in Caring for the Sick</td>
</tr>
<tr>
<td></td>
<td>City &amp; Guilds and FÁS</td>
<td>Community Care Practice</td>
</tr>
<tr>
<td></td>
<td>Business and Technology (BTEC) and CDVEC</td>
<td>City of Dublin VEC</td>
</tr>
<tr>
<td></td>
<td>BTEC, CDVEC</td>
<td>City of Dublin VEC</td>
</tr>
<tr>
<td>Unaccredited courses</td>
<td>Trinity College Dublin</td>
<td>The Challenge of Ageing Course</td>
</tr>
<tr>
<td></td>
<td>Cork Social and Health Education Project (CSHEP)</td>
<td>Working with Older People</td>
</tr>
<tr>
<td></td>
<td>Baggot Street Community Hospital</td>
<td>Carers' Programme</td>
</tr>
</tbody>
</table>


Another factor contributing to the growing need for the provision of the training and qualification of social care workers is the demographic trend in recent years which points to a huge increase in the number of older people requiring help and support. Therefore it is only in recent years that there has been a shift from courses that were largely child care centred to generic social care courses. Such generic courses include issues pertaining to the care of older people, as evidenced by those offered by the RTCs. In Ireland, the main training provision for formal social care workers has traditionally been within the RTCs. The NCEA report notes that child care workers to date have been the only group of carers singled out for formal training. In the absence of formal training for other categories of social care work, like for example, the care of older people or of adults with learning disabilities, many students have taken the (then titled) National Certificate or National Diploma in Child Care, (NC/DCC) in order to receive a qualification to work in other care situations.

The report recommended that a broader approach to training care workers be taken. As a result of this the former NC/DCC courses, available in five RTCs, are now entitled National Certificate/National Diploma in Applied Social Studies in Social Care and have altered their training materials to reflect this broader thrust.

1. **National Certificate in Applied Social Studies in Social Care**

<table>
<thead>
<tr>
<th>Providers:</th>
<th>Athlone, Cork, Sligo RTCs and DIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation Body:</td>
<td>NCEA</td>
</tr>
<tr>
<td>Target group:</td>
<td>School leavers and mature students</td>
</tr>
<tr>
<td>Duration:</td>
<td>2 years, full-time</td>
</tr>
<tr>
<td></td>
<td>(part-time option available in Cork RTC)</td>
</tr>
<tr>
<td>Type:</td>
<td>Generic</td>
</tr>
</tbody>
</table>
The National Certificate in Applied Social Studies in Social Care is available in Cork, Athlone and Sligo RTCs and the DIT. The details regarding course content, duration, and placement component are summarised in Appendix Three. The primary target group in each case is school leavers who wish to work in personal social services. This includes working with persons with disabilities, working with children, adolescents and older people, in either residential care, day care or community settings. Minimum entry requirements are a Leaving Certificate D3 in five subjects. In each college a proportion of places is usually reserved for mature applicants. In order to facilitate mature applicants, Cork RTC offers the National Certificate through an accumulated courses and credits system (ACCS), in addition to the regular full-time programme.

2. **National Diploma in Applied Social Studies in Social Care**

**Provider:** Athlone, Cork, Sligo and Waterford RTCs and DIT

**Accreditation Body:** NCEA

**Target group:** School leavers and mature students

**Duration:** 1 year, full-time (part-time option available in Cork RTC)

**Type:** Generic

The Diploma in Applied Social Studies in Social Care is seen as a continuation of the National Certificate in Applied Social Studies in Social Care and is open to those students who have completed the Certificate in Cork, Athlone and Sligo RTCs or the DIT. It aims to develop knowledge and skills acquired on the Certificate course and to promote a more extensive and deeper knowledge of at least one client group (e.g., older people). Entry requirement for the
course is by way of:

- a merit or distinction in the National Certificate in Applied Social Studies in Social Care or equivalent, including a minimum of 90 days appropriately supervised placements, undertaken prior to acceptance. (‘Equivalent’ is the usual term used by educational institutions to allow ad hominem assessment of applicants).

- a pass in the National Certificate combined with a minimum of one year’s subsequent relevant work experience.

The Diploma in Applied Social Studies in Social Care in Waterford Regional College, and one course in the DIT is an ab initio programme (i.e., students enter to a full-time three year cycle, and do not have to pass from a Certificate to a Diploma).

3. **BA in Applied Social Studies in Social Care**

Provider: Cork RTC  
Accreditation Body: NCEA  
Target group: Those working in a Care environment  
Duration: 2 years, part-time  
Type: Generic

At both Cork RTC and Waterford RTC the Diploma in Applied Social Studies in Social Care has been granted degree status. Both courses are designed for holders of the National Diploma in Applied Social Studies in Social Care and the National Diploma in Child Care. At Waterford the course “aims to further advance the students’ understanding of therapeutic care for children and adolescents and to acquire further skills in this area to enhance their practice” (NCEA 1996, p. 72). Thus the Waterford course cannot be described as either generic or specialised in the care of
older people. At Cork the course is two years, part-time with students spending two days per week in college. The objective of the course is to develop therapeutic skills and managerial understanding for those who work in a caring service for children, young people, older people or persons with a learning disability (NCEA 1996, p. 73). This course is therefore a generic care course. The main subjects studied include Care Management, Applied Social Studies, Social Care Context and an applied research project.

4. **Certificate in Social Care**

<table>
<thead>
<tr>
<th>Provider:</th>
<th>UCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation body:</td>
<td>UCG</td>
</tr>
<tr>
<td>Target Group:</td>
<td>Informal Carers and Formal Social Care Workers</td>
</tr>
<tr>
<td>Duration:</td>
<td>1 year, part-time, distance education</td>
</tr>
<tr>
<td>Type:</td>
<td>Generic</td>
</tr>
</tbody>
</table>

The Certificate in Social Care was developed in UCG in 1993 with the aid of a grant from the New Opportunities for Women (NOW) EU fund. It is targeted specifically at carers, both informal and formal, who have not previously had the opportunity to train in the field. In response to the needs of carers, as identified by research (O’Donovan et al. 1993), UCG developed the Certificate in a flexible distance education format. In 1995-1996 the course was offered in eleven locations throughout the country. The Certificate in Social Care is a one year part-time course, it has three components:

1. course modules - some modules place an emphasis on the development of practical caring skills and some are knowledge-based and address broad issues relating to social care.
(2) seminars on different care settings.

(3) work placements.

5. Diploma in Social Care

Provider: UCG
Accreditation body: NUI
Target Group: Informal Carers and Formal Social Care Workers
Duration: 1 year, part-time
Type: Generic

The Diploma in Social Care was developed in UCG for students who have successfully completed the Certificate in Social Care. In order to progress through to the Diploma in Social Care, students must pass all assignments in the Certificate in Social Care. The Diploma is a one year part-time course, undertaken at UCG. The course has three components:

(1) six course modules - some placing emphasis on the development of practical caring skills while others are theoretical and address relevant issues relating to social care,

(2) seminars on different care settings,

(3) work placements.

6. Community and Health Services (Award Level 2)

Provider: NCVA approved centres
Accreditation body: NCVA
Target Group: Any person interested in a career in care
Duration: 1-2 years, part-time
Type: Generic
The NCVA was established to develop a comprehensive system of certification for a wide range of vocational education and training programmes. Awards are made at four levels - Foundation followed by Levels 1, 2 and 3. NCVA awards are designed to provide access to employment and progression to further education and training. National standards for awards are set by the NCVA in consultation with employers and course providers. As with any NCVA award at Level 2, a minimum of eight modules must be completed. A module is a self-contained unit of study within a vocational programme which is delivered and assessed independently and which may be combined flexibly with other modules. For the Community and Health Services award the student must select five vocational modules and also undertake a mandatory Communication module, a General Studies module and a Preparation for Work/Work Experience module, thus completing the requirement of eight modules. For the five vocational modules, at least two must be taken from a specified list (see Appendix Three) along with the elective modules Sociology and Psychology or an appropriate module developed or approved by the NCVA.

7. Community and Health Services - Community Care (Award Level 2)

Provider: NCVA approved centres
Accreditation body: NCVA
Target Group: Any person interested in a career in care
Duration: 1-2, years, part-time
Type: Generic

As with the previous course, students undertaking the Community and Health Services Community Care award are required to complete a minimum of eight modules. They must also undertake the mandatory Communication module, General Studies module
and Work Experience module. For the five remaining vocational modules, students must undertake the modules Care Provision and Practice; Hygiene, Health and Safety; Human Growth and Development; and two modules from a specified list (see Appendix Three).

8. **Certificate in Caring for the Sick**

Provider: The Irish Red Cross Society  
Accreditation body: Certificate from the Irish Red Cross Society and the Institute of Community Health Nursing  
Target Group: Informal Carers  
Duration: 12 weeks, 2 hours per week  
Type: Generic

This course is designed to provide the informal carer in the home with the skills necessary to meet the physical, psychological, social and spiritual needs of all age groups. The objective of the course is to introduce the student to the basic concepts of home nursing with a view to enabling them to care for the short-term minor illness and the long-term chronic illness of a patient of any age.

9. **Certificate in Voluntary Care**

Provider: The Irish Red Cross Society  
Accreditation body: Certificate from the Irish Red Cross Society and the Institute of Community Health Nursing  
Target Group: Voluntary workers providing social care to people in their own homes  
Duration: 1 evening per week throughout the academic year, and 20 hours practical experience  
Type: Generic
On completion of this course, it is expected that volunteers will be eligible to assist with the care of older persons and those in need in the community and will do so within the structure of the Irish Red Cross Society.

4.3 Courses Accredited by Irish and British Accrediting Bodies

10. Community Care Practice

Provider: FÁS
Accreditation bodies: FÁS and City and Guilds
(City and Guilds 325-1 Community Care Practice)
Target Group: Those interested in a career in community care
Duration: 32-36 weeks, full-time
(regional variations in exact duration)
Type: Generic

The purpose of this programme is to train interested persons in the area of community care. Participants must be over 18 years of age, have a Leaving Certificate or equivalent, have an interest in care work and comply with FÁS eligibility criteria (i.e., on live register).

11. Caring for the Elderly

Provider: CDVEC
Accreditation body: CDVEC and BTEC
Target Group: School leavers
Duration: 1 year, full-time
Type: Specialised
The course is aimed at developing the skills necessary for a profession in caring. Students are required to have a Leaving Certificate with five passes. Each applicant is interviewed and must demonstrate a genuine interest in caring.

12. *Diploma in Social Care*

Provider: CDVEC  
Accreditation body: CDVEC, NCVA and BTEC  
Target Group: School leavers  
Duration: 2 years, full-time  
Type: Generic

Those wishing to pursue career opportunities in the following areas apply for this course: care of people with disabilities, care of older people in the community or institutional situations, support networks for youth and other groups, provision of care for preschool children and administration in either voluntary or statutory organisations. The entry requirement for the course is a Leaving Certificate with five passes. Applicants are interviewed and should have experience of voluntary work.

4.4 *Unaccredited Courses*

13. *The Challenge of Ageing Course*

Provider: Faculty of Health Sciences, TCD  
Target Group: Formal Social Care Workers and Informal Carers  
Duration: 10 weeks, 2 hours per week  
Type: Specialised

This course is aimed specifically at those involved in caring for older people. It is open to private individuals as well as to groups
<table>
<thead>
<tr>
<th>Provider</th>
<th>Title</th>
<th>Duration</th>
<th>Target group</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Athlone, Cork, and Sligo RTCs and DIT</td>
<td>National Certificate in Applied Social Studies in Social Care</td>
<td>2 years, full-time</td>
<td>School leavers, ACCS* course available at Cork RTC</td>
<td>Generic</td>
</tr>
<tr>
<td>Athlone, Cork, Waterford and Sligo RTCs and DIT</td>
<td>National Diploma in Applied Social Studies in Social Care</td>
<td>1 year, full-time</td>
<td>Those who have completed Nat. Cert. in Applied Social Studies in Social Care (with pass or merit)</td>
<td>Generic</td>
</tr>
<tr>
<td>Cork RTC</td>
<td>BA in Applied Social Studies in Social Care</td>
<td>2 years, part-time</td>
<td>Those working in a care environment and who have completed Nat. Dip. in Applied Social Studies in Social Care</td>
<td>Generic</td>
</tr>
<tr>
<td>UCG</td>
<td>Certificate in Social Care</td>
<td>1 year, part-time, distance learning</td>
<td>Mature students</td>
<td>Generic</td>
</tr>
<tr>
<td>UCG</td>
<td>Diploma in Social Care</td>
<td>1 year, part-time</td>
<td>Mature students</td>
<td>Generic</td>
</tr>
<tr>
<td>NCVA approved centres</td>
<td>Community and Health Services (Award Level 2)</td>
<td>1-2 years, part-time</td>
<td>Any interested persons</td>
<td>Generic</td>
</tr>
<tr>
<td>NCVA approved centres</td>
<td>Community and Health Services Community Care (Award Level 2)</td>
<td>1-2 years, part-time</td>
<td>Any interested persons</td>
<td>Generic</td>
</tr>
<tr>
<td>The Irish Red Cross Society</td>
<td>Certificate in Caring for Sick</td>
<td>12 weeks, 2 hours per week</td>
<td>Informal carers</td>
<td>Generic</td>
</tr>
<tr>
<td>The Irish Red Cross Society</td>
<td>Certificate in Voluntary Care</td>
<td>1 evening per week, throughout academic year</td>
<td>Voluntary carers</td>
<td>Generic</td>
</tr>
<tr>
<td>FÁS</td>
<td>Community Care Practice</td>
<td>32 - 36 weeks, full-time</td>
<td>Any interested persons</td>
<td>Generic</td>
</tr>
<tr>
<td>CDVEC</td>
<td>Caring for the Elderly</td>
<td>1 year, full-time</td>
<td>School leavers</td>
<td>Specialised</td>
</tr>
<tr>
<td>CDVEC</td>
<td>Diploma in Social Care</td>
<td>2 years, full-time</td>
<td>School leavers</td>
<td>Generic</td>
</tr>
</tbody>
</table>

*Accumulated courses and credits system
from private organisations (e.g., nursing homes). The aim of the course is to offer a wide range of practical advice, combining relevant theory with current practice and a knowledge of resources. The course does not contain a placement element.

14. **Working with Older People**

Provider: Cork Social and Health Education Project (CSHEP)

Target Group: Formal Social Care Workers and Informal Carers

Duration: 10 weeks, 2 hours per week

Type: Specialised

The course is open to any person interested in working with older people, either on a voluntary or formally paid basis. It is based loosely on Open University study materials, and there is no placement element.

15. **Carers’ Programme**

Provider: Baggot Street Community Hospital

Target Group: Informal carers

Duration: 26 weeks, 2 hours per week

Type: Generic

This programme aims to provide the informal carer with practical help on how to enhance the caring role and to provide guidance and support to carers in looking after themselves. Each evening involves two sessions, (1) education and information sessions for carers in the home, and (2) support and self-help. Following completion of this course participants can continue with a further follow-up programme in the form of a support group.
### Table 4.3: Main characteristics of unaccredited courses

<table>
<thead>
<tr>
<th>Provider</th>
<th>Title</th>
<th>Duration</th>
<th>Target group</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trinity College Dublin</td>
<td>The Challenge of Ageing Course</td>
<td>10 weeks, 2 hours per week</td>
<td>Informal carers and formal social care workers</td>
<td>Specialised</td>
</tr>
<tr>
<td>Cork Social and Health Education Project</td>
<td>Working with Older People</td>
<td>10 weeks, 2 hours per week</td>
<td>Informal carers and formal social care workers</td>
<td>Specialised</td>
</tr>
<tr>
<td>Baggot St. Hospital</td>
<td>Carers Programme</td>
<td>26 weeks, 2 hours per week</td>
<td>Informal carers</td>
<td>Generic</td>
</tr>
</tbody>
</table>

### 4.5 In-Service Training

As outlined in the National Council for the Elderly report *Home Help Services for Elderly People in Ireland* (Lundström and McKeown 1994), Public Health Nurses or Home Help Organisers are usually involved in the training of Home Helps. This typically takes the form of one-day seminars, covering personal care, first aid, lifting, AIDS and issues relevant to working with a client with a disability. In addition to such seminars, which take place in “almost every health board region” (Lundström and McKeown 1994, p. 156), a number of innovatory or pilot training projects for formal social care workers have also taken place. Projects within the Coolock Home Help Service, the Galway Carers Association, the National Association of Home Help Organisers, the Carers Association and the Alzheimer Society of Ireland, serve as examples of such developments.

A pilot project of one year’s duration is currently taking place within the Coolock Home Help Service. This project commenced in response to a situation in which a Superintendent Public Health Nurse was not able to request Home Helps to work with clients who had personal care needs since Home Helps have not received recognised training in this area. As a result, the Coolock Home Help Service has, in conjunction with the Eastern Health Board, devised a programme which involves training ten Home Helps in...
personal care skills. The project is being evaluated on an on-going basis.

The Galway Carers Association, working with the Western Health Board, offered a pilot course for Home Helps and informal carers. The course took place over a ten-week period, with classes for two-and-a-half hours per week. Course topics included financial entitlements, nutritional matters, basic physiotherapy, skin care, incontinence management, management of a patient with impaired communication skills and coping with bereavement. Feedback from course participants is currently being sought.

An ongoing in-service training project takes place within the Eastern Health Board region. The National Association of Home Help Organisers, working with the City of Dublin VEC, offers an accredited course for Home Helps. This course takes place one day per week for the duration of an academic year. There is a strong emphasis on personal development. Students undertake five modules and three written assignments (details of the curriculum can be found in Appendix Three). Appropriate seminars and field trips are also arranged. Participants receive a BTEC First Award in Caring.

The Carers Association also organise an ongoing in-service training programme. The Association employs people as carers, with funding from FÁS. These workers receive a training programme covering topics such as human physiology and development, personal care, first aid, lifting procedures, administrative skills and holistic approaches to care.

An interesting project has been developed by the Alzheimer Society of Ireland with funding from FÁS. The Alzheimer Society is training workers in domiciliary care, who are then assigned to
client families. The objectives of the programme are to provide respite to client families, to help participants source likely employment prospects and to consider care work enterprises. The training consists of a five-week induction period followed by ongoing in-service training, including first aid certification and education regarding dementia care. Participants work towards NCVA Level 2 Care Awards, for example, the Community and Health Services Community Care Award discussed above. (Neville 1996, Personal Communication). Participants are employed under a FÁS Community Enterprise Scheme, which generally only operates for a one year period, and therefore has limitations in relation to continued work in the project, which in turn has implications for the carer/care recipient relationship.

4.6 Discussion of Existing Course Provision
The above details on the existing provision of courses for formal and informal carers is not exhaustive. In particular, the unaccredited courses listed serve as examples of such courses.

Courses in social care vary according to whether they are accredited or not, whether they are targeted at school leavers or adults with social care experience, whether they are full or part-time, whether they have a placement requirement or not and whether they focus particularly on the care of older people or offer a more general training in social care studies and skills. Available details of the curricula of these courses, if not specified above, are summarised in Appendix Three.

Accreditation of an educational or training programme is linked to the duration of the course. A course normally requires a minimum of 100 hours for certificate accreditation. All accredited courses provided by educational institutions run for at least the duration of one academic year. Shorter courses of 10-12 weeks are generally
not formally accredited by educational organisations though they may include certificates of participation or certificates awarded by other bodies.

Any training initiative for those who provide care to older people must be seen in the context of the life situation of carers. Those in employment as formal social care workers may not be able to undertake full-time training and those in an informal caring situation are also highly unlikely to be free to undertake full-time courses.

For carers to gain access to training, it must be either part-time or available in flexible learning format. Of the part-time courses identified in this report, only those offered by UCG, Cork RTC, the Irish Red Cross Society, the NCVA and the CDVEC/Home Help Organisers are accredited. The only example of a course offered in distance education format is the Certificate in Social Care offered by UCG. The majority of courses that are formally accredited are full-time and many of these are aimed primarily at school leavers. Students enter via the Central Admissions Office (CAO) system and a minimum points level is set (i.e., points for grades attained in the Leaving Certificate examinations). Although mature students do not have to qualify via the CAO system, this, combined with the full-time requirement for the course, may act as a substantial barrier to many carers. Thus the accredited courses may well attract predominately school leaving students resulting in a situation where those with the most recognised qualifications are young persons, with (compared to informal carers for example) relatively little care experience.

All of the unaccredited courses identified in this report are part-time, and therefore more likely to be accessible to carers. However, while such courses may provide valuable information
and the opportunity for practical skill development, they do not include a practice placement, and do not have formal recognition. If carers, both formal and informal, are not able to access accredited courses they are unlikely to receive training that will enhance the status of their work.

In relation to generic versus specialised training, very few of the courses identified in this report specialise in the care of older people. Only one accredited course and two unaccredited courses could be so described.

Very little information seems to be available regarding trainers on courses that are devised for formal social care workers and/or informal carers. It is highly likely that those involved represent several disciplines (e.g., nursing, psychology, sociology, education, nutrition, physiotherapy) as social care is only emerging as a discipline in its own right. While this may lend richness and diversity to training in a general sense, it is also a matter for concern. Personnel from various disciplines may have their own respective biases and cannot, at an individual level, be guaranteed to offer an integrated approach to training. Similarly what is seen as acceptable in terms of standards may vary from course to course, in the absence of a co-ordinating body.

Standardisation of training in social care could usefully include setting acceptable standards for trainers, and could perhaps consider the development of an induction training programme which would focus trainers on key issues in social care. The training of distance education tutors for the Certificate in Social Care at UCG is one model for such an initiative. The development of a registration system for trainers might also be a worthy development, as would greater emphasis on evaluation of training initiatives in the area.
4.7 Progression Routes

Mutual recognition of existing training courses and progression routes between courses are relevant to a national training initiative for formal social care workers and informal carers. At present progression routes exist within the NUI, NCVA and NCEA systems and progression routes are being developed between the NCEA and NCVA systems.

In the NUI, students who complete the Certificate in Social Care at UCG can progress through to the Diploma in Social Care. Those who secure a distinction in the Diploma in Social Care can apply for the evening BA in Health Studies (available at UCG) and are exempt from one element of the BA programme.

For the courses accredited by the NCEA, students can progress from the Certificate in Applied Social Studies in Social Care to the Diploma in Applied Social Studies in Social Care, and then on to the BA in Applied Social Studies in Social Care at Cork RTC.

Within the NCVA system, students can progress from Foundation Level, for which awards are currently being developed and for which no formal qualification is required, through Levels 1 and 2 to Level 3. Some RTCs have now established links with the NCVA and students can progress into the NCEA Certificate in Applied Social Studies in Social Care with NCVA Care (Level 2) awards. The facility to progress from Level 2 through to degree level is an important development in the field. There is, however, potential for further development in this area, for example the forging of further links between each of the systems. The introduction of TEASTAS, the Irish National Certification Authority, could contribute to this process. The terms of reference of TEASTAS include the establishment of progression routes from NCVA Foundation Level to degree level.
4.8 Accreditation of Prior Experience, Achievement and Learning

In recent years increasing attention has been given to accreditation systems, both the accreditation of community-based education and training by existing formal educational structures, and the development of models of accreditation of prior learning, experience, experiential learning and achievement (APEAL). Such systems have also been discussed as accreditation of prior learning (APL), accreditation of prior achievement, (APA) and accreditation of prior experiential learning (APEL) (Halpin 1996; Kelly 1994). The term APEAL will be used throughout this discussion and also in Chapter Five. Kelly defines accreditation as the process of ascribing credit, and "giving official recognition to work skills or abilities" (p. 2). She goes on to say that this "ascribes value to the work, confers status, reflects that certain standards of attainment in skill or learning have been reached, verified and appropriately awarded" (p. 2).

The burgeoning interest in accreditation for prior experiential learning and achievement can be seen in the context of the proliferation of training and education in the community sector, much of which is unaccredited, combined with the interest taken in community-based education and training on the part of women, for whom acknowledgement of prior achievement and experience is a salient issue.

Developments in accreditation systems are of particular importance in the context of training formal social care workers and informal carers. Given the demands of care work, especially for informal carers, only 15 per cent of whom spend less than four hours each day in caring (O'Connor and Ruddle 1988) the traditional route to training, that is, full-time education, is often not accessible. APEAL models are very relevant for carers given the
depth and breadth of their practical experience in the delivery of care. The issue of access has been identified as one of the central issues facing social care training (O’Donovan 1994). As such, any expansion of options for training, education and accreditation, such as the development of an APEAL model, is a positive development for carers.

Accreditation in the context of current learning refers to the process of ascribing credit or official recognition by an educational or training authority to the competencies developed by learners. For formal social care workers and informal carers this is relevant for those who have undertaken unaccredited courses, as described above. Kelly (1994), in her study of accreditation in community learning, found a large demand for such accreditation. Seventy nine per cent of adult learners felt that options should be available to all participants engaging in community-based learning and training activities, and recommended that currently available options for accreditation should be expanded.

APEAL is of particular relevance to carers who have accumulated experience but who may not have had the opportunity to attend any training courses. APEAL is not context locked, that is, the context in which skills are acquired is not necessarily relevant and therefore the potential exists for these approaches to be applied to situations in which carers have developed skills in their care environment (Kelly 1994). What is generally required is the provision of evidence “that verifies the level of skill or learning outcomes attained previously” (Kelly 1994, p. 3).

In Ireland, APEAL systems are in their infancy, although developments in the area are encouraging. The NCEA has published an official policy document on such systems operating in RTCs. According to this document, “Credit for prior experiential
learning is intended for mature students who may or may not have had structured formal education but who have learned from their involvement in employment, community activities, home duties, sport, etc. This learning, when evaluated both qualitatively and quantitatively might entitle them to credits or exemptions from a course of study” (NCEA 1993, p. 1).

Such a system, applied within social care education, will hopefully increase access to the NCEA Certificate/Diploma/BA courses in Applied Social Studies in Social Care. It is the intention of the NCVA to put in place a system of APEAL for its awards, and FÁS is also currently developing such a system. The fact that there are no educational requirements for entry to the UCG Certificate/Diploma in Social Care is evidence of an acceptance, within this institution also, that learning in a practical caring context is adequate to embark on an accredited educational course.

The DIT is at present developing a system of APEAL in the area of Early Childhood Learning and Development, funded by the EU NOW programme. This system involves the drawing up of a ladder of progression within the existing educational system which will be matched by an APEAL ladder, along which verification will be considered, according to set criteria, on the basis of a submitted portfolio. The development of a similar system, including NUI, NCEA, NCVA and VEC courses could usefully be explored in the context of social care.

Typically, the development of APEAL systems is seen as being complex or intricate. However, this may be more a ‘knee jerk’ response to an idea that is new and radical, as opposed to an objective assessment of what is involved. Kelly wryly points out that “What gains official recognition in the education and training culture reflects what and who society regards as valuable” (Kelly
1994, p. xxviii), and in this light it is easy to see that work undertaken in the home and often within the family is likely to suffer in this regard.

4.9 Conclusion
It is encouraging to see that there is a lot of activity regarding training in social care. Existing courses, summarised here, include accredited and unaccredited, part and full-time, long and short courses and those with generic and specific care emphases. It can be argued that some of the most 'highly prized' (i.e., accredited) courses are those least accessible to formal and informal carers. Further development in accrediting current learning systems, both those provided by educational organisations and in-service training programmes, together with the development of APEAL systems should help bridge the gap between the extensive experience many carers of older people have and the formal educational environment. Such endeavours are however still in their infancy in Ireland.
CHAPTER FIVE

Conclusions

5.1 Introduction
The objective of this chapter is to discuss the findings of our consultative process in the context of the terms of reference for the study given to us by the National Council for the Elderly. The first part of this final chapter provides an overview of the previous chapters. This includes a summary of the findings detailed in Chapter Three on the consultations with various relevant parties concerning training of formal and informal social care workers who work with older people. Also included is a summary of information secured on existing training courses for formal social care workers and informal carers. The second part of this chapter presents a series of our conclusions in relation to the proposed training initiative.

We have considered that a national training initiative might contain the following elements:

(1) A rolling curriculum of education and training appropriate to the needs of all categories of carers. This would include a review of existing courses and their potential for contributing to an initiative, and consideration of the needs for different types of courses or different levels of training by those involved in social care tasks, whether as formal social care workers in different situations or settings or informal carers.

(2) Identification at both individual and task level of the needs for such training and the benefits thereof, for both those receiving and providing care, whether through the statutory or voluntary sector.
(3) Review of the costs and benefits and opportunity costs of such provision by service providers, to include the recruitment and training of staff, the financial and pay implications of such an initiative, the provision of actual courses of training or the payment to educational providers for such training and the cost of staff replacement during such training. All these need to be balanced against outcome measures such as improved quality of life for those receiving care, improved health status or reduced need to avail of more costly services, particularly in a hospital setting.

(4) Collaboration across sectors to identify the process of implementing the steps above. This means identifying the service providers, the educators, those likely to need or want training and those clients likely to want or need care.

This report was primarily an assessment of need and a review of the available educational routes and options that involve some kind of credit. The latter two elements described above would need to follow from the review undertaken in this report. It is clear that further steps need to be taken to instigate an initiative in any formal sense and that such a process must necessarily be inclusive if it is to be effective. Our final conclusions make some suggestions to the National Council for the Elderly in this regard.

The following points are justified, we believe, from our findings. Firstly, the fundamental motive for undertaking the training and further education of those involved in the care of older people is that, on balance, it is likely to be beneficial to older people themselves. Secondly, with due consideration to the degree of training required, it is likely to benefit all categories of carers in the way they go about their tasks. Thirdly, training should contribute to improved standards of care and hence to the health
and social gain of those being cared for, an objective of all service providers.

However, we wish to acknowledge a variety of important qualifications to those general statements of principle above which arose from this review and which impinge on the process and content of caring. Firstly, it is clear that different degrees of need exist in care delivery, varying from simple domestic support to explicit personal care. While the tasks could, with systematic audit, be successfully discriminated, it is the case that the same carer might engage in a range of such activities, either at different times, with different clients, or even with the same client over a period of time. The distinction therefore must be at the level of the task and not at the level of the carer. Secondly, there is much semantic and practical distinction drawn between formal, paid care work in an employed context and informal provision of care. While the motivation and obligations might be somewhat different, the fundamental tasks do not necessarily differ and this has practical significance for the content, at least, of training programmes. Furthermore, many individuals engaged in care have at different times been involved in both formal and informal care and so the distinction is not just fine, but invisible.

We have considered all of these issues in reaching the conclusions we now present.

5.2 Background to Consultation
The introductory chapter, Chapter One, detailed the objectives of the report. The overall objective of the report is to assist the National Council for the Elderly in determining if it should recommend to the Minister for Health a national training initiative for those involved in the provision of social care services which might benefit older people, formal and informal social care workers and young people with limited employment opportunities
who may wish to work in the social care field. More specifically, the report aimed to examine the benefits and general implications of the proposed training initiative for (1) older people in receipt of social care services; (2) informal carers; (3) formal social care workers, such as Nursing Aides and Home Helps, and employers of social care workers in the (4) statutory, (5) private and (6) voluntary sectors; (7) educational and training institutions involved in the provision of social care education; and training, and (8) young people who are interested in working in the social care field. Furthermore, the report aimed to explore the most appropriate form that a national training initiative should take, in terms of its curriculum, accreditation, and mode of delivery. Finally, the report aimed to assess the likely uptake of a national training initiative and in particular to examine the likely uptake amongst young people with limited employment opportunities.

The literature review, provided in Chapter Two, began by reviewing research on the extent and nature of informal and formal social care of older people in Ireland. The literature reveals that informal social care is extensive, with estimates that up to 17 per cent of older people are dependent on informal care (Larragy 1993). While the proportion of older people who receive formal social care is lower than those in receipt of informal care, there is evidence that the number of formal social care workers has increased considerably in recent years and that the future potential for formal social care is vast, given that, for example, only 3.5 per cent of the older population are in receipt of the home help service at present (Lundström and McKeown 1994). The literature also reveals that the majority of both informal and formal social care workers are women, many of whom are in the older age groups. Research conducted by Blackwell et al. (1992) also revealed that the majority of informal carers have had very limited formal education opportunities in the past and that their labour force
participation rates are very low. The review highlighted the growing body of research on the "costs" of caring, which examines the financial, social, personal and health costs of informal care.

Chapter Two also examined the debates about the provision of social care services to older people in Ireland which prompted the National Council for the Elderly to consider the idea of a national training initiative for people involved in the provision of social care to older people and to commission this study. The background can be characterised by a policy context in which endorsement has repeatedly been given to the expansion of social care services for older people, where such an expansion is viewed as crucial to supporting frail and dependent older people to remain in the community. The National Council for the Elderly has advocated that home help, and other services which enable frail older people to continue to live in the community, should be designated as core services rather than as discretionary ones. This has also been advocated in the light of population predictions up to the year 2011 (Fahey 1995) which highlight the substantial projected increase in frail older people with high dependency levels. In Ireland, where there is a two tier health service with variable entitlement structures, the role of informal care is, if anything, more crucial. However, despite repeated calls for the expansion of social care services, they remain severely under resourced and at a low status.

Research into informal and formal social care has prompted debates about the potential contribution of training. Benefits of training which have been identified include improvements in the quality of care provided to older people, stability in social care services due to reductions in staff turnover and accidents, improved supports for informal carers, increasing the confidence and motivation of carers and giving recognition to social care work. Concerns about training include that it may result in over-
professionalisation and that it may facilitate the withdrawal of external support services and an over-reliance on informal care. The National Council for the Elderly study on the home help service in Ireland (Lundström and McKeown 1994) prompted a debate on a national training initiative for Home Helps. On one side of the debate it has been argued that training Home Helps would be beneficial to older people as it would improve the quality of service provision and broaden the scope of the service. Those opposed to training have suggested that training would result in an over-professionalisation of social care, thus reducing its 'good neighbourliness' and its affective or 'caring about' dimensions. Opposition to training has also been based on the fear that it would result in claims for higher wages. Clearly, therefore, this study aimed to ascertain the views of specific interest groups in relation to the implications of training social care workers and to contribute to this debate.

The brief review of education and training provision for social care workers throughout Europe which drew primarily on the work of Jamieson (1991) and Hutten and Kerkstra (1996) concluded that there is no harmonisation in the organisation and financing of social care services for older people in Europe. However, throughout Europe, social care services are predominantly provided by untrained women. This lack of training is increasingly being viewed as unsatisfactory, particularly in the light of the trend across Europe for social care workers to be involved in personal care. Jamieson (1991) has highlighted the competing pressures in Europe between upgrading the skills of formal social care workers to facilitate their greater involvement in personal care work and economising on health expenditure. She has suggested that the separation of personal care from home care is a compromise between these competing pressures. Some countries, such as Belgium, have introduced mandatory training for some formal
social care workers. However, the situation in most European countries is similar to that in Ireland, namely, there are neither national standards nor national requirements for formal social care workers to be trained. Responses to direct requests from the Departments of Health in each EU member state, undertaken in the course of this research, were very limited. From this it would seem that the health sector is not always responsible for social care and that definitions of social care and caring tasks vary. Clearly, standardisation and harmonisation is required at this level.

From the review of the literature, the following key questions concerning the education and training of social care workers were identified:

• What are the benefits to older people and informal carers of social care training?

• Do formal and informal social care workers have similar or different training needs?

• Is it preferable to provide social care workers, who work with older people, generic social care education and training or specialised training in care of older people?

• Should training for formal social care workers be a requirement?

• Should social care workers, either formal or informal carers, receive education and training in relation to both home care and personal care?

• Should social care training, for formal social care workers or informal carers, be formalised in the sense of being accredited and offering progression routes to further education and training opportunities?
In order to ascertain the views of a wide range of interested parties on the above questions, consultations were held with nine groups of people, selected as far as possible to be representative. The research methods employed in each of these consultations, together with the details of the sample sizes, are described in Appendix Two. The groups with which consultations took place are as follows:

- older people, including those who are currently in receipt of social care services in both institutional and community settings,
- informal family carers,
- formal social care workers, including those working in both institutional and community settings,
- statutory, voluntary and private organisations that employ social care workers who work with older people,
- national organisations for older people and informal carers,
- education and training institutions that are currently involved in the provision of social care education and training,
- young people who may be interested in working in the social care field.

The findings from the consultations with these groups are presented in Chapter Three.

Chapter Four provided an overview of the existing provision of education and training for social care workers in Ireland. There are currently three broad categories of courses available in Ireland, namely, those accredited by Irish awarding bodies, those accredited
by British awarding bodies and a range of short unaccredited courses. The largest providers of social care education and training are the RTCs. Their National Council for Educational Awards accredited courses have evolved from being primarily concerned with child care training to courses which prepare people for working in a range of social care contexts, including working with older people. These courses offer the advantage of graduated access to higher qualifications where, for instance in Cork RTC, it is now possible to reach degree level in this field. In recent years the National Council for Vocational Awards has been developing a comprehensive system for the certification of a wide range of courses including those in social care. The shorter term courses are heterogeneous in both content and objectives. They have evolved largely to meet a specific need or client group. Chapter Four includes a discussion on the topic of accreditation of prior learning, achievement and experience (APEAL). The role of TEASTAS, the Irish National Certification Authority, is briefly discussed in relation to the development of progression routes and accumulation of credit through prior experiential learning.

Returning to the six broad questions which the study aimed to address (see above), a summary of the findings from the consultations in relation to each of these questions is now discussed.

5.3 Benefits and General Implications of a National Training Initiative for Older People in Receipt of Social Care Services and their Informal Carers

The need for training
The findings indicate that there was overwhelming support for the provision of some kind of training for both formal and informal social care workers. There was considerable support also from
most of the consultative groups for the view that training for some formal social care workers, particularly those involved in the provision of personal care services, should be a requirement. It is significant that the statutory service providers, that is, the health boards, were least supportive and we will return to the likely reasons for this later.

In relation to the training of formal social care workers, 88 per cent of the older people and 86 per cent of the informal carers reported that they considered that formal social care workers should have some form of training. There was, in fact, unanimous support for training for formal social care workers on the part of employers of all types, educational institutions, national organisations for older people and formal social care workers. The young people who were surveyed were almost unanimous. There was also a very high level of support expressed in relation to the provision of training for informal carers. Support was virtually unanimous across the consultative groups, with only one health board respondent dissenting. Ninety-four per cent of the older people and all of the informal carers reported that training in social care should be made available to informal carers.

There was more mixed support for the introduction of mandatory training for formal social care workers. The educational and training institutions, who clearly have a vested interest, were the only group unanimously in favour of mandatory training for formal social care workers. However, the majority of older people (60 per cent) and informal carers (52 per cent) were in favour of training being a requirement, as were the majority of formal social care workers (58 per cent), nursing home proprietors (75 per cent), national organisations of older people (63 per cent) and young people (87 per cent). Two (20 per cent) of the health board representatives and 43 per cent of the voluntary organisation
representatives were in favour of mandatory training. A number of the older people who were in favour of training being a requirement argued that it is particularly required in instances where formal social care workers are involved in the provision of personal care services and are caring for highly dependent older people.

**Perceived advantages**

The research findings show that the vast majority of respondents in each consultative group perceived that training would benefit older people in receipt of social care services by improving the quality of care. For example, 94 per cent of the older people said they thought that the training of formal social care workers would result in improvements in the quality of care, as did 90 per cent of the informal carers. Examples of the ways in which the training of formal social care workers could improve the quality of care, as identified by the older people, included that it would improve the motivation or morale of formal social care workers, that it would improve their sensitivity to older people and that it would increase their practical skills. Additional ways, identified by employers of formal social care workers, in which training of formal social care workers could improve the quality of care, were that it would enhance the general competence of formal social care workers in terms of skills development, that older people would feel more secure, the possibility of accidents would be reduced, and that it could contribute to greater consistency in standards. The potential for training playing a role in the setting of standards of care was also highlighted by the nursing home proprietors. Some of the older people, formal social care workers and employer representatives also suggested that older people would have more confidence in formal social care workers if they knew they had training.
The perception that the training of formal social care workers would benefit informal carers was also widely held. Eighty-eight per cent of the older people and 84 per cent of the informal carers reported that they felt that training of formal social care workers could benefit informal carers. The benefits to informal carers, as identified by the older people, were generally regarded as being in the two areas of improving the ability of formal social care workers to support and advise informal carers and their ability to act as respite workers. One of the key ways in which the training of formal social care workers could improve their ability to support informal carers, identified by the informal carers themselves, was that it could facilitate the extension of their responsibilities to the area of personal care.

The perception that the training of informal carers could improve the quality of care they provide to older people was also widely held. Ninety-four per cent of the older people reported that they thought that training informal carers would improve the quality of care that they provide, as did 80 per cent of the informal carers, whereas it was unanimously reported by the national organisations of older people, formal social care workers, health board representatives, nursing home proprietors, voluntary organisation representatives and the educational and training institutions. Examples of the ways in which the training of informal carers could improve the quality of care, that were identified by the older people, included that it may result in greater understanding of the needs of older people, skill development, improved coping skills and stress management and thus an improvement in the relationship between the informal carer and the older person. Training could reduce the number of accidents in the home and improve practical skills, particularly in relation to coping with emergency situations. The training of informal carers was widely viewed as being not just beneficial in terms of improvements in the
quality of care provided to older people but also in terms of having benefits for informal carers themselves, particularly in relation to stress management and in relation to obtaining support from other informal carers.

The above findings highlight that there was overwhelming support for the view that a training initiative would be beneficial to both older people in receipt of formal and informal social care services, and to informal carers.

**Negative implications**

However, a number of possible costs or negative implications of a national training initiative were also identified in the consultations. These costs were identified particularly by respondents when they were discussing their reasons for opposing the introduction of mandatory training. Possible negative implications of a national training initiative for older people and informal carers, particularly if training was a requirement for formal social care workers, included that it could adversely affect the supply of social care workers. This could happen by, perhaps, restricting the involvement of people in caring who have not been trained or who cannot gain access to training (especially if from rural areas), and could thereby reduce the support available to older people and informal carers. This was raised by some of the older people and informal carers, who expressed concern about the possible threat that a national training initiative may pose to the formal social care workers who are currently providing services to them and with whom they are highly satisfied. Clearly, the introduction of any kind of training initiative would need to take particular care to avoid alienating existing social care workers from the care services. If training for formal social care workers was offered through flexible learning formats, such as distance education, and if a training initiative included development of models of
accreditation of prior experience, achievement and learning (APEAL), the likelihood of these eventualities would be greatly reduced. In this way many formal social care workers already active in care work could, if they wished, gain access to training, and could gain credit for the skills developed in their work.

Another argument made by some of the voluntary organisations and health boards was that a national training initiative would have negative implications for the supply of social care by undermining the voluntary or ‘good neighbour’ dimension of much social care. In this regard, it is notable from our sample of informal carers that they were mainly involved in the provision of informal care to close kin, and that only four per cent were caring for non-family members, or were ‘good neighbours’. Similarly, only 4.5 per cent of a nationally representative sample of older people receiving care from an informal carer were receiving care from a non-household member (O’Connor et al. 1988). The ‘good neighbour’ ethos has also been noted as a characteristic of the home help service, and thus it may be a motivation for formal social care workers since the remuneration is currently relatively low. However, this aspect of the home help service is seen to be relevant to the earlier evolution of the service, and is “certainly not a guarantee that the service will be provided to the required standard” (Lundström and McKeown 1994, p. 316). In addition, it has, according to Lundström and McKeown (1994) conflicted with the development of the service as a core service. They conclude their report with a call for “consistent terms, conditions of employment and training as a pre-condition to the achievement of delivery of a consistent and professional service” (Lundström and McKeown 1994, p. 316).

It was also felt that training could over-professionalise social care and thereby reduce the ‘caring about’ element of the caring process and perhaps lead to a loss of flexibility in the provision of care.
Some of the health board representatives were concerned that training might have a negative impact on the caring process by altering the relationship between the social care worker and the older person. Here it was suggested that training would result in professionalisation and would consequently make the relationship 'cold' and 'clinical'. However, when asked to identify what the priority areas in the content of a training programme for formal social care workers should be, almost all groups consulted elected interpersonal skills. The inclusion of tuition and skill development in this area is a practical way to counter this possibility.

Another possible negative implication of a national training initiative, identified by the older people and some of the national organisations, was that it might result in informal carers feeling under pressure to obtain training. This presumably would be the case where an existing or potential carer would be discouraged from the role because of the training requirement. It was stressed that training should be made available to those informal carers who feel in need of it but that under no circumstances should they feel obliged to participate in training. A final negative implication that was identified in the consultations with informal carers and health boards was that training may exacerbate the tendency for informal carers to be the sole providers of care and to receive minimal external support.

5.4 Benefits and General Implications of a National Training Initiative for Formal Social Care Workers who Work with Older People

As outlined above, there was a very high level of support from all of the consultative groups for the provision of some form of training for formal social care workers, such as Nursing Aides and Home Helps. Furthermore, the majority of older people, informal
carers, formal social care workers, nursing home proprietors and young people were in favour of the introduction of mandatory training for some formal social care workers, though the health board representatives and voluntary organisations were chiefly opposed to this. The broad support for training was based, not just on the view that it would have positive implications for older people and informal carers, but a number of positive implications for formal social care workers themselves were also identified.

**Perceived advantages**

All of the consultative groups reported that training would improve the general competence of formal social care workers, in that it would equip workers with a greater knowledge of the needs of older people, and facilitate skill development. Amongst the benefits identified by both the older people and the informal carers was that training could be instrumental in improving the confidence and motivation of formal social care workers and in encouraging them to be more interested in their work. Both the older people and informal carers suggested that training could also result in the broadening of the scope of the work of formal social care workers, particularly in the areas of personal care and respite care.

Four of the consultative groups, namely, the national organisations of older people, formal social care workers, nursing home proprietors and education and training institutions, identified the benefit that training would have in relation to improving the status and recognition of formal social care work. In relation to Lundström and McKeown's finding (1994) that the home help service is under-valued, any increase in status and recognition in this area would clearly be welcomed. The nursing home proprietors and educational and training institution representatives also identified the benefits of training in relation to improving the
career opportunities of formal social care workers. This issue was raised in particular regard to training being a requirement. The educational and training institution representatives also highlighted the benefit of further educational and training opportunities, and of facilitating mutual recognition across EU member states.

**Negative implications**
The primary possible negative implication for formal social care workers of a national training initiative, identified in the consultations, was that it might pose a threat to existing social care personnel by not recognising or valuing their social care work experience. This issue reinforces the importance of incorporating a system of accreditation of prior experience, achievement and learning into the national training initiative.

A further negative implication that was identified in the consultations with the older people related to the financing of training, where it was argued that, given the poor pay rates in social care employment, it would be unreasonable to expect formal social care workers to bear the full cost of training, as it might be beyond their personal means. Additionally, the majority of employers of formal social care workers felt that facilitation of staff to undertake training would involve time off without pay, a negative implication for many workers.

Five of the ten health board respondents, 78 per cent of the voluntary organisations and 70 per cent of the nursing home proprietors agreed that employees should be facilitated to attend such courses. The feedback from the health boards suggests, however, that support for training may only be provided to full-time and/or permanent staff. It was also suggested that training might result in further distinctions being made between different types of social care workers, where some may benefit more than
others. Such an eventuality might be further exacerbated by the fact that those who would benefit represent a very small proportion of workers, given that, in their study of home help services, Lundström and McKeown (1994) found that 99 per cent of home helps were employed on a part-time basis.

5.5 Benefits and General Implications of a National Training Initiative for Statutory, Private and Voluntary Organisations that Employ Formal Social Care Workers

Perceived advantages
Some of the positive implications of a national training initiative for formal social care workers that were discussed above could also be regarded as having positive implications for agencies that employ formal social care workers. The improvement in the general competence of social care workers, promoting of safe practice and the broadening of their range of skills is highly likely to lead to an improvement in the quality and scope of service provision, a development which should clearly be viewed positively by all employers of formal social care workers. With specific regard to the home help service, training could address the problems of the lack of status and recognition, and the lack of national standards of service provision, identified by Lundström and McKeown (1994).

In addition to this, a number of direct implications for organisations that employ social care workers were identified. Firstly, representatives of health boards pointed out that training could allow recognised targets for service delivery to be set, and might facilitate the evaluation of the services. Secondly, in the consultations with the national organisations of older people, health boards, voluntary organisations and educational and training institutions it was suggested that the employer organisations, the
health boards in particular, should be involved in the provision of training. Almost half of the suggestions as to who should take responsibility for the provision of training of formal social care workers referred to the health boards. The health boards identified a role for themselves in training provision, particularly for informal carers. The voluntary organisations also reported that they felt that the health boards should have a role in the provision of training but also that voluntary organisations should have some involvement. Suggestions were also made regarding health boards working with educational authorities, private nursing homes, the National Council for the Elderly and FÁS. To take such responsibility would clearly have implications for health boards, both in terms of costs and organisational demands. However, a national training initiative of a co-operative kind might not leave the health boards as the sole providers.

In the consultations with the proprietors of nursing homes, benefits to employers in relation to the recruitment of staff were identified. It was suggested that a national training initiative would mean that there would be a pool of trained social care workers who could be targeted in recruitment. Also, it was suggested that a national training initiative could be instrumental in improving the image of social care work in nursing homes, thereby easing recruitment and reducing the current rapid staff turnover. It is worth noting again at this stage that there was particularly strong support from the nursing home sector for mandatory training of formal social care workers. Twenty-four out of the 32 nursing home proprietors (75 per cent) were in favour of mandatory training. Additionally, a large proportion of the proprietors of private nursing homes (70 per cent) reported that facilitation in the form of time off without pay would be possible, but the remainder felt that external funding would be necessary to replace staff being trained.
Negative implications
The health boards, (amongst whom there was the lowest level of support for training as a requirement), identified a number of costs or negative implications for employers of a national training initiative. Firstly, it was suggested that it could result in an escalation of costs, in terms of its implications for wages, and in terms of the costs of training. These concerns were expressed in regard to the costs of facilitating staff who would have to be replaced while in training. However it was also pointed out, by the representatives of the health boards, that training formal social care workers could permit more care to be provided within the community, and this could offset costs incurred in a training initiative in other sectors. Secondly, it was suggested that it would restrict the supply of social care personnel, particularly in rural areas. As mentioned above, the provision of training in flexible learning formats (e.g., distance education) could facilitate the uptake of training by those with access difficulties. Such options could also reduce the likelihood of staff having to be replaced while in training. Thirdly, it was suggested that training may alter the nature of services by undermining the voluntary dimension. This latter cost was also identified in the consultations with the voluntary organisations.

The relationship between training and service provision
It is therefore quite clear that if a training initiative is to be established, the implications identified in this section have to be addressed. Since the health boards already provide their own in-service training and were the key group targeted by everyone to bear responsibility for training, then they have the most concern to justify a training initiative. As things currently stand they do not have all the information they need for such an initiative and a more detailed cost/benefit analysis is necessary. There are also cost implications which are beyond the remit of the report but which
should be identified here. As a long-term career for younger people the remuneration is certainly a relative disincentive, and the extent to which informal carers would require remuneration is yet to be established. Given the low levels of pay for many social care workers, including Nursing Aides and Home Helps, and the fact that informal and formal care is inordinately associated with those in the lower socio-economic groups, at the very least statutory funding for tuition fees and time in lieu needs to be made available.

Also of relevance here is the question of how training might influence standards of care. Firstly, a national initiative would mean that within each health board region and across the various settings in which such care is delivered standards would have to be set in order to identify who should be trained. The heterogeneity currently in existence is certainly contributed to by the lack of a training policy. Secondly, if the benefits identified by all concerned were realised through training then standards of care would be more easily achieved. If it were necessary to distinguish those staff with a personal care function then the job descriptions of all formal social care workers would need to be itemised according to agreed standards across sectors and institutions. The introduction of mandatory training for those social care workers exclusively involved in home care services may be neither appropriate nor necessary. In all cases where the health boards are involved in assessing the health needs of older people who are resident in the community (e.g., in discharge situations and in the compilation of the public health nursing service’s ‘at risk’ registers) the informal social care input could be assessed and quantified in order to identify those for whom training might be an option.

Given the shared need due to our socio-demographic profile across Europe and the lack of harmonisation in social care services and
training across EU member states. This is clearly an area of potential priority funding in some of the EU training programmes. UCG has benefited from the EU NOW (New Opportunities for Women) programme to develop a social care course and the Dublin Institute of Technology is at present developing an APEAL model for early childhood learning and development, with the help of EU NOW funding. There is also potential through the ADAPT initiative. Most EU funding programmes require matching funding, therefore statutory funding (possibly from the Departments of Health, Education and Enterprise and Employment) should also be sought.

5.6 Possible Form of a National Training Initiative

In order to ascertain views about the characteristics of a possible training course for either formal social care workers, informal carers or both, the various groups were asked questions in relation to a proposed curriculum: whether it should involve generic social care training or specialised training in working with older people; if training should be similar or different for informal carers and formal social care workers; the process of accreditation; and whether or not a distinction should be made between personal care and home care, with a resultant distinction in the training of personnel.

From the findings of the consultations with the nine groups presented in Chapter Three, and the collation of information on the existing provision of educational and training courses for formal social care workers and informal carers in Chapter Four, the following suggestions are made in relation to the form a national training initiative should take. In the long-term, this initiative would aim to establish a co-ordinated national policy and practice in social care education and training.
Curriculum content

A training initiative should be structured around the training needs, as identified by the research process, of formal social care workers and informal carers. The findings from this study suggest that all groups consulted feel that there is a need to provide training for these two types of carers. This process of needs assessment, which is the primary contribution of this report, accordingly provides direction for any co-ordinated national initiative, and should be useful for existing providers of courses as well.

The content of educational and training programmes that would form part of the training initiative should therefore include the priority subject areas most frequently identified by almost all of the consultative groups, that is, interpersonal skills and personal care skills. Other elements which should also be included are knowledge of the ageing process, combating ageism and discrimination, safe working practices and supervised placements. It is important that older people are actively involved in the refinement of these curriculum requirements.

A preference for generic as opposed to specialised training was generally expressed in the consultations. This implies support for core skills common to any caring situation but with specific focus on the particular needs of older people. This makes good sense in educational terms and in our view also broadens the potential employment possibilities for holders of such qualifications, an advantage for them and their employers. It also reflects the finding that the vast majority of courses already existing for carers are generic courses.

There was a strong tendency for the respondents in each group to suggest that the content of training for formal and informal social care workers should be similar. It was noted, however, that the
courses for these two types of carers may need to differ in terms of their duration and mode of delivery. While it is acknowledged that formal social care workers and informal carers may have different priorities and aspirations in relation to training, there is no evidence from our research for this report or from previous teaching experience that the actual curriculum content should differ just for this reason alone but rather that the intensity and content should be dictated by the requirements of the task.

**Distinction between personal care and home care**

As the findings from the consultations tended to show a low level of support for the distinction between personal care and home care, with a resultant distinction in personnel and training, a national training initiative could further explore this issue. For example, only 36 per cent of the informal carers and 37 per cent of the formal social care workers were in favour of the distinction. Eight of the ten health board interviewees reported that they were opposed to the distinction. The arguments against a distinction included the cost-effectiveness of multiskilled workers, issues concerning the continuity of care, and that such a distinction mitigates against the development of a holistic model of care. It is notable, however, that a high level of support for the distinction was found amongst the older people (48 per cent). The lack of such a distinction in training, however, does not mean that trained individuals might not engage in exclusive tasks as necessary.

**Mode of delivery**

Considerable concern was expressed regarding the possible exclusion of formal social care workers and informal carers from a training initiative, on the basis of costs, physical access (i.e., access from rural areas) or entry requirements. Additionally, since many of the accredited courses that are presently available in social care are full-time, it is clear that a national training initiative would have
to include flexible learning options, such as distance education and models of accreditation of prior experience, achievement and learning.

**Context of an initiative**

It is clear that graduated degrees of training are required and that there needs to be a coherent policy in respect of this agreed by the partners in such an initiative. Our findings demonstrate a range of existing courses which could well meet the needs of the client groups with some modification. There also needs to be close liaison between service providers, many of whom sponsor, support and run short-term and in-service courses, and existing educational providers. It is important, given the range of courses currently available to formal social care workers and informal carers, that providers of these courses would form a central part of the framework of a national training initiative. A training initiative could usefully explore the setting up of progression routes between existing courses, and the establishment of a ladder of progression in social care education and training. Additionally, an accompanying structure for accreditation of prior experience, achievement and learning could be constructed which would give formal social care workers and informal carers, who have accumulated experience in their work and who have perhaps undertaken short unaccredited courses, access to qualifications. This is seen to be essential as there was strong support for the accreditation of social care education and training from all of the consultative groups, as it would facilitate both career and educational and training advancement. There was also unanimous support for a system of mutual recognition of qualifications across EU member states, which would be facilitated by the further development of mutual recognition of existing courses within Ireland.
Partners in a proposed initiative
A national training initiative would include enlisting the support of bodies primarily responsible for formal social care service delivery, whose support is critical. Given the concerns expressed by the employers of formal social care workers regarding the costs of training, it would be essential that a cost/benefit analysis be conducted as part of the initiative. A key element of cost/benefit analysis must be to place a value on both the health gain and the social gain inherent in training formal social care workers and informal carers, in relation to the improvement in quality of care for older people. Additionally, such an analysis would require more detail regarding the resources involved in the provision of training, the identification of appropriate training models, and would need to explore the impact of training on social care services within service providing organisations (O'Shea 1996, Personal Communication).

Evaluation
Establishing a structure for the evaluation of educational and training courses would be a critical component of a national training initiative. Increasingly, principles of quality assurance inform educational initiatives. This could include evaluation for both ‘product’ oriented measures, such as outcomes and ‘process’ oriented measures such as the perceptions of older people in receipt of social care services, formal social care workers and informal carers. Evaluation could also contribute to monitoring developments in the area, in particular to ensure that fears expressed by some groups consulted in this study do not materialise, that is, that informal carers could be subjected to pressure to engage in training, and that training could be exploited or used to reduce levels of support provided to informal carers.
5.7 Benefits of a National Training Initiative for Young People who may wish to Work in the Field of Social Care Provision for Older People

The findings from our survey of young people who are currently participating in social care education and training indicate that there was not as high level of interest amongst this group in working specifically with older people. We were not asked to explore the economic issues related to this but the low levels of pay and poor career opportunities in this area of work may play a significant role in this regard, and this warrants further investigation. It is unlikely that it will be an attractive career option for young people as currently funded and structured. The national training initiative, however, could usefully address how the option of working with older people is considered in existing social care education and training, and how positive attitudes towards working with older people could be fostered in the secondary school curriculum.

5.8 The Likely Uptake of a National Training Initiative

The findings from the consultations indicate that it is likely that there would be a high level of uptake of a national training initiative by formal and informal social care workers, where both groups reported a high level of support for the provision of such training. The findings also highlight, however, that the participation of these two groups may be dependent on the training being accessible both in financial terms and in terms of its duration and local provision. The fact that the majority of respondents in the three groups of employers, namely, health boards, voluntary organisations and nursing homes, agreed that staff should be facilitated to participate in a national training initiative is also a positive indication in relation to uptake.

Currently, there appears to be a mismatch between the supply and demand for social care education and training for people who work
with older people. The bulk of social care education and training consists of full-time courses that are targeted at young people, whereas there is evidence of considerable demand for part-time courses for mature students.

As discussed above, the findings from the survey of young people indicate that there may not be a very high uptake of the initiative by young people, as only approximately one third of the sample expressed a preference for working specifically with older people. It would appear, therefore, that initially, the key target student population for the national training initiative will be mature people, mainly women, who are already involved in the provision of social care to older people either in a formal or informal capacity. In the longer term, however, the national training initiative should also give priority to targeting young people.

5.9 Recommendations

No. 1

We recommend to the National Council for the Elderly the establishment of a national training initiative for formal and informal social care workers who work with older people following a framework suggested in this report. We believe that, on balance, such an initiative would have positive implications for all groups concerned, not the least of which is older people.

No. 2

Every effort should be made to ensure that formal social care workers who are exclusively involved in the provision of home care services but not personal care receive an agreed minimum of in-service training, as part of the national training initiative. The content of this should be focused on interpersonal skills, knowledge of ageing, and safe working practices.
No. 3
All formal social care workers who are involved in the provision of personal care (see Chapter 2) to older people should be facilitated in undertaking additional training. The curriculum here should include personal care skills, and nutritional matters.

No. 4
Health boards should ensure that training in social care is offered to informal carers of older people. The curriculum should include stress management, knowledge of ageing and personal care skills. This training may, in part, be achieved in the home setting.

No. 5
Given the concerns expressed by some respondents regarding access to training, and the fact that the majority of formal social care workers and informal carers are mature women, the national training initiative should be largely informed by the principles of adult education and should place considerable emphasis on maximising access. This could involve training provision at regional or local centres, the development of flexible learning options such as distance education and the opportunity to accumulate credits over a period of time.

No. 6
In the light of concerns regarding the situation for existing carers with whom older people were highly satisfied, it is recommended that the national training initiative should include examination of existing models of accreditation of prior experience, learning and achievement, (APEAL) with a view to developing an appropriate model for social care. This would allow progression into training courses and in so doing would recognise and validate the experience of formal and informal social care workers.
No. 7
The national training initiative should ultimately ensure that qualifications for social care workers, both formal and informal, have national recognition. Qualifications should be available at a number of appropriate levels and should offer routes to further education and training opportunities and enhance the employment opportunities of learners. This would clarify the relationships between and the relative standards of existing courses. National qualifications, involving different levels of certification and progression routes, should be established with mutual recognition between existing providers of training courses in all sectors, including in-service training modules.

No. 8
It is clear from the research that young people do not see care of older people as a career priority. However, since most of the accredited courses were not designed with the care of older people in mind, the specialism may not seem appealing and there may be a misunderstanding by students of the process of ageing. These issues should be reviewed in a process of curriculum assessment. It is also appropriate to consider the introduction of courses in the secondary school curriculum, such as in transition year, that would foster the positive aspects of ageing and social support for older people.

No. 9
The existing curricula of educational and training courses in social care should be evaluated from the particular perspective of appropriate care for older people. This evaluation should be conducted with a view to ensuring that the care of older people is given the same importance as the care of other client groups and to increasing the interest of young people in working with older people. There should also be consultation with relevant bodies
when new courses are being planned or existing courses are being revised.

No. 10
Statutory funding needs to be earmarked and made available to facilitate social care workers' participation in any national training initiative, both to support fees and course costs, to provide leave and substitution arrangements and to take account of the costs involved for providers. A cost/benefit analysis of these issues is warranted.

No. 11
A lead agency needs to be identified to undertake the national training initiative, using fixed terms of reference. It is clear that the Department of Health and the health boards have a major role in this issue because of their clients' needs. A cross sectoral committee involving the various interests surveyed for this report could effectively take the process forward.

No. 12
Training provision under the national training initiative for people involved in providing social care to older people should commence within two years. A time-flow sheet for the implementation of the above recommendations is provided in Table 5.1.
<table>
<thead>
<tr>
<th>Implement immediately</th>
<th>6 months</th>
<th>12 months</th>
<th>18 months</th>
<th>24 months</th>
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<tbody>
<tr>
<td>Recommend to the Minister for Health that a national training initiative for formal social care workers and informal carers who work with older people be established</td>
<td>Appoint lead agency</td>
<td>Secure EU and national statutory funding</td>
<td>Establish system of accreditation of prior learning</td>
<td>Commence training provision under national training initiative</td>
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<td>Establish cross sectoral committee</td>
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<td>Complete evaluation of existing social care curricula</td>
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<td>Identify appropriate training programmes either within existing framework or additional courses for both home care tasks and personal care skills that could be accessible to both formal social care workers and informal carers</td>
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<td>Establish national qualifications</td>
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</table>
## APPENDIX ONE

### Agencies that Supplied Information on Social Care Training in EU Member States

<table>
<thead>
<tr>
<th>Country</th>
<th>Agency contacted</th>
<th>Reply received from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Dept. of Health</td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Dept. of Health</td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>Dept. of Health</td>
<td>Director of Education</td>
</tr>
<tr>
<td>France</td>
<td>Dept. of Health</td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>Dept. of Health</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>Dept. of Health</td>
<td>Ministry for Families</td>
</tr>
<tr>
<td>Greece</td>
<td>Dept. of Health</td>
<td></td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Dept. of Health</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>Dept. of Health</td>
<td>1. Ageing Well Europe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 'Driekant'</td>
</tr>
<tr>
<td>Norway</td>
<td>Dept. of Health</td>
<td>1. Norwegian Embassy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Dept. of Social Affairs</td>
</tr>
<tr>
<td>Portugal</td>
<td>Dept. of Health</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>Dept. of Health</td>
<td>Plan Gerontologic Nacional</td>
</tr>
<tr>
<td>Sweden</td>
<td>Dept. of Health</td>
<td>Gerontology Research Centre</td>
</tr>
</tbody>
</table>
APPENDIX TWO

Research Methods Employed In Consultations

A.1 Introduction
A key part of the research brief was to consult with a range of interested parties regarding training for people involved in the provision of social care services to older people. The nine groups that were consulted were (1) older people, (2) informal carers, (3) formal social care workers, representatives of (4) statutory, (5) private and (6) voluntary organisations that employ social care workers, (7) national organisations of older people, (8) representatives of education and training institutions, and (9) young people who may be interested in working in the social care field.

A.2 Research Method Employed in Consultations with Older People
Semi-structured interviews were conducted with 50 older people who reside in the Cork area (i.e., the County or County Borough). The sample was selected using stratified random sampling to ensure that the type of residence, age and gender composition of the sample reflected that of the national population of older people. The discussion below shows that our sample closely resembles the national population of older people with respect to these variables.

Profile of sample
Table A1 shows that, of the national population of older people in 1991, 24 per cent were living alone in private households, 67 per cent were living with others in private households and nine per cent were living in non-private households. This latter category includes people who were in long-stay and short-stay institutions, such as geriatric hospitals, welfare homes and nursing homes.
Twenty-eight per cent of our sample of older people were living alone in private households, 62 per cent were living with others, mainly family members, in private households, and 10 per cent were resident in nursing homes.

**Table A1: Type of residence of people aged 65 years and over in Ireland in 1991 and in the sample**

<table>
<thead>
<tr>
<th>Type of residence</th>
<th>No. nationally</th>
<th>% nationally</th>
<th>No. in sample</th>
<th>% in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private households - living alone</td>
<td>96,492</td>
<td>24</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Private households - living with others</td>
<td>272,056</td>
<td>67</td>
<td>31</td>
<td>62</td>
</tr>
<tr>
<td>Non-private households</td>
<td>34,352</td>
<td>9</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>402,900</td>
<td>100</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Census of Population 1991

Table A2 shows that of the national population of older people in 1991, 60 per cent were in the 65 to 74 age group, 33 per cent were aged between 75 and 84 and seven per cent were aged 85 years or over. In our sample, 64 per cent were aged between 65 and 74 years, 28 per cent were between 75 and 84 years and eight per cent were 85 years or more.

**Table A2: People aged 65 years and over in Ireland in 1991 and in the sample classified by age group**

<table>
<thead>
<tr>
<th>Age group</th>
<th>No. nationally</th>
<th>% nationally</th>
<th>No. in sample</th>
<th>% in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 - 74</td>
<td>240,077</td>
<td>60</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>75 - 84</td>
<td>133,383</td>
<td>33</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>85 and over</td>
<td>29,440</td>
<td>7</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>402,900</td>
<td>100</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Census of Population 1991

Table A3 shows that 57 per cent of the national population of older people in 1991 were women and 43 per cent were men. In our sample, 56 per cent were women and 44 per cent were men.
Table A3: People aged 65 years and over in Ireland in 1991 and in the sample by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>No. nationally</th>
<th>% nationally</th>
<th>No. in sample</th>
<th>% in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>229,175</td>
<td>57</td>
<td>28</td>
<td>56</td>
</tr>
<tr>
<td>Men</td>
<td>173,725</td>
<td>43</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>Total</td>
<td>402,900</td>
<td>100</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Census of Population 1991

Thirty-eight per cent of the sample of older people were in receipt of some kind of formal social care service. Twenty-six per cent received care from a Home Help and 10 per cent (i.e., all of those resident in a nursing home), received care from Nursing Aides. The proportion of people in the sample in receipt of formal care is significantly higher than in the national population; this reflects the method that was used to identify the study participants, which is discussed below. Lundström and McKeown (1994) found that in 1993, only 3.5 per cent of the elderly population were in receipt of the home help service. Fifty-two per cent of the sample of older people received care from an informal carer and 70 per cent were medical card holders.

Selection of sample
In order to randomly select older people who were resident in nursing homes, the Southern Health Board was requested to supply a list of all of the registered private and voluntary nursing homes in its region. One nursing home was randomly selected from this list and the owner asked to facilitate the research process by explaining the purpose of the study and seeking the consent of a number of older people to be interviewed. The proprietor of the nursing home agreed and supplied a list of people who had agreed to be interviewed and whom he deemed to be capable of being interviewed. Five people were randomly selected from this list and a date and time for the interviews were arranged with the assistance
of the owner of the nursing home. When it came to the interviews actually taking place, two of the older people reported that they had changed their minds, so two other people from the original list were selected and were interviewed. A total of five interviews were conducted with older people in the nursing home.

The remainder (45) of the sample of older people was selected primarily with the assistance of the public health nursing service but also with the assistance of a health board day care centre and a senior citizens' club. Initially, it had been intended to select all of the remainder of the sample from older people who were in receipt of the public health nursing service, but due to the age profile of people in contact with this service it proved necessary to use other avenues to select 'younger' older people, namely, those in the 65 to 74 age group.

With the assistance of the Superintendent Public Health Nurse, four Public Health Nurses were randomly selected from the list of all Public Health Nurses in the Southern Health Board region, two based in the city and two based in predominantly rural areas. These Public Health Nurses were then approached to assist the researchers in randomly selecting and contacting older people. One of the four selected was on leave and due to time considerations it was agreed not to select a replacement, but just to work with the other three who had agreed to assist. Two of these Public Health Nurses were based in Cork City and the third was based in County Cork.

One of the researchers met with each of the Public Health Nurses and randomly selected, within the strata identified, older people who were in contact with the service. The names of the older people were not revealed to the researcher at this stage. The Public Health Nurses subsequently informed the selected older people
about the study and asked them if they would agree to be interviewed. They then supplied the researcher with a list of the names, addresses and telephone numbers (where available) of the older people who had agreed to be interviewed. The researcher then contacted the older people and arranged a time to call to conduct the interview in their homes. Two older people refused to be interviewed at this stage and they were replaced by two others who were randomly selected in the same way. A total of 33 older people who were selected via the public health nursing service were interviewed.

With regard to the day care centre and the senior citizens' club, a staff member was approached and asked to assist in the selection of older people. In each case, the staff member informed the older people about the study and sought their consent. Eight and four older people were interviewed in the day care centre and senior citizens’ club respectively.

**Semi-structured interviews**

The research method used in the consultations with the sample of older people was a semi-structured interview. Cognisance was taken of the finding from other research with older people that highly structured interviews, particularly those involving direct questions about client satisfaction, tend to elicit positive responses that are framed in terms of politeness or gratitude (Wilson 1993). Prior to the actual interviews taking place, the researcher explained in detail the purpose of the study and discussed some of the issues to be addressed with the older person. The 21-item interview schedule was used very loosely and served mainly as a guide to the interviews. All of the 50 interviews were conducted by the same researcher and all of the interviews were tape recorded. The interviews generally lasted in the region of half an hour.
A.3. Research Methods Employed in Consultations with Informal Carers

Semi-structured interviews were conducted with a sample of 50 informal carers who reside in the Cork area (i.e., the County or County Borough). As with the sample of older people, stratified random sampling was used to ensure that the age and gender profile of the sample of informal carers was similar to that of informal carers nationally. In the absence of national census statistics on informal carers, it was decided to use the profile that was found in the national sample of 206 informal carers in a recent Economic and Social Research Institute (ESRI) study as a framework (Blackwell et al. 1992).

Profile of sample

Table A4 details the gender breakdown of the informal carers in the ESRI study and the gender breakdown in our sample. Seventy-eight per cent of the informal carers in the ESRI sample were women and 22 per cent were men. The gender breakdown of our sample was very similar, with 72 per cent women and 28 per cent men.

Table A5 shows the age profile of the informal carers in the ESRI and in our sample. In the ESRI study, 14 per cent of informal carers were under 40 years of age, 47 per cent were between 40 and 60 years and 39 per cent were over 60 years. The age profile of the

<table>
<thead>
<tr>
<th>Gender</th>
<th>No. in ESRI study</th>
<th>% in ESRI study</th>
<th>No. in sample</th>
<th>% in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>152</td>
<td>78</td>
<td>36</td>
<td>72</td>
</tr>
<tr>
<td>Men</td>
<td>55</td>
<td>22</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Blackwell et al. 1992
informal carers in our sample closely resembles that of the ESRI sample, as 16 per cent were under 40 years, 44 per cent were between 40 and 60 years and 40 per cent were over 60 years.

It is clear from this age profile of the sample of informal carers, that a sizeable proportion of them are actually older people themselves and could have been included in the sample of older people. Indeed, in many cases where older people were living together, the distinction between who was the carer and who was the older person in receipt of care was far from clear.

Table A5: Informal carers in the 1992 ESRI study and in the sample by age group

<table>
<thead>
<tr>
<th>Age group</th>
<th>No. in ESRI study</th>
<th>% in ESRI study</th>
<th>No. in sample</th>
<th>% in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 40 years</td>
<td>30</td>
<td>14</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>40 - 60 years</td>
<td>97</td>
<td>47</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>Over 60 years</td>
<td>80</td>
<td>39</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>100</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source: Blackwell et al. 1992*

In addition to age and gender, information was also gathered from the sample of informal carers in relation to their health services eligibility status, their relationship with the older person in receipt of care and whether or not they were in receipt of the Carer’s Allowance and support from a formal carer. Seventy-eight per cent of the sample of informal carers were medical card holders, reflecting the low socio-economic status of informal carers that has been reported in other studies (O'Connor and Ruddle 1988; Blackwell et al. 1992). The data on the relationship between the informal carer and the older person in receipt of care, as detailed in Table A6, highlights the close kin nature of informal care. Seventy-eight per cent of the informal carers in the sample were either caring for their spouse or parent/parent-in-law.
Table A6: Relationship between informal carer and older person in receipt of care in the sample

<table>
<thead>
<tr>
<th>Relationship</th>
<th>No. in sample</th>
<th>% in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>Parent/parent-in-law</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>Sister/brother</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other relation</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Non-relative</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The low level of state support for informal care was highlighted, where only three (six per cent) of the informal carers in the sample were in receipt of the Carer’s Allowance. Furthermore, only four (eight per cent) of the informal carers received support from a publicly funded formal social care worker.

Selection of sample
The sample of informal carers was selected with the assistance of the public health nursing service in the Southern Health Board in a similar way to that described above in relation to the sample of older people. Indeed, to some extent the stratified random selection of informal carers ‘piggybacked’ on the selection of older people; in instances where an older person who was in receipt of care from an informal carer was selected and interviewed, where possible the informal carer was also selected and interviewed. In these cases, the interviews were conducted separately.

Semi-structured interviews
Semi-structured interviewing was the research method used in the consultations with the sample of informal carers. Similar to the interviews with the older people, all of the interviews took place in the homes of the informal carers and prior to the actual interviews, the researcher spent some time explaining the purpose of the study.
and-discussing some of the issues to be addressed. A 22-item interview schedule was used to guide the interviews. The 50 interviews were conducted by the same researcher and all of the interviews were tape recorded. Similar to the interviews with the older people, the duration of the interviews was generally in the region of half an hour.

A.4 Research Methods Employed in Consultations with National Organisations of Older People

A total of nine national organisations representing older people or informal carers were identified with the assistance of the National Council for the Elderly. The researchers wrote to each of these organisations explaining the purpose of the study and requesting a written submission in relation to the proposed national training initiative. Guidelines for submissions, consisting of a list of 15 questions, were sent to all of the organisations. After a number of follow-up telephone calls, seven of the organisations made written submissions. The representative of one organisation said that he was not in a position to make a written submission and agreed to make an oral submission over the telephone. The eight organisations that made submissions are listed in Table A7 below.

<table>
<thead>
<tr>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Action Ireland</td>
</tr>
<tr>
<td>Age Alliance Ireland</td>
</tr>
<tr>
<td>Age and Opportunity</td>
</tr>
<tr>
<td>Alone</td>
</tr>
<tr>
<td>The Irish Association of Older People</td>
</tr>
<tr>
<td>The Alzheimer Society of Ireland</td>
</tr>
<tr>
<td>The National Federation of Pensioners' Associations</td>
</tr>
<tr>
<td>The Carers Association</td>
</tr>
</tbody>
</table>

Table A7: National organisations representing older people or informal carers that made submissions
A.5 Research Methods Employed in Consultations with Formal Social Care Workers

Home Helps and Nursing Aides were identified as the two main categories of formal social care workers who provide care to older people. The National Council for the Elderly’s study of the home help service (Lundström and McKeown 1994) found that there was a total of 10,559 Home Helps employed by health boards and voluntary organisations in 1993. The vast majority of these Home Helps were employed on a part-time basis. Less than one per cent of this figure were full-time employees. National figures on the numbers of Nursing Aides who work with older people are not available as they fall into the Department of Health’s category of an ‘unrecognised grade’.

As detailed in Table A8, a total of 19 formal social care workers were interviewed, including six full-time Home Helps, five part-time Home Helps and eight full-time Nursing Aides. It had been intended to include Home Care Assistants/Attendants in these consultations, but efforts to set up interviews with these social care workers proved unsuccessful.

Table A8: Profile of sample of formal social care workers

<table>
<thead>
<tr>
<th>Type of social care worker</th>
<th>No. in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Help (part-time)</td>
<td>5</td>
</tr>
<tr>
<td>Home Help (full-time)</td>
<td>6</td>
</tr>
<tr>
<td>Nursing Aide (full-time)</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
</tr>
</tbody>
</table>

All of the formal social care workers who were interviewed were women. They were aged between 20 and 55, with the largest number (7) falling between the ages of 40 and 49 years.
Selection of sample
The sample of Home Helps was selected with the assistance of the Home Help Organiser in the Western Health Board. These were primarily Home Helps who were able to attend a weekly meeting, thus explaining why full-time Home Helps were over-represented in the sample. The Nursing Aides were selected with the assistance of the proprietors of three nursing homes.

Semi-structured interviews
Semi-structured interviewing was the research method used in the consultations with the sample of formal social care workers. Ten of the interviews with Home Helps took place in the Community Care Headquarters of the Western Health Board and one interview took place in a health centre in a rural area. The interviews with the eight Nursing Aides took place in three nursing homes. Prior to the interviews the researcher spent some time explaining the purpose of the study and discussing some of the issues to be addressed in the interview. A 23-item interview schedule was used to guide the interviews. All of the interviews were conducted by the same researcher and detailed notes were taken during the course of the interview. The duration of the interviews was generally in the region of 20 minutes to half an hour.

A.6 Research Methods Employed in Consultations with Employers of Social Care Workers
The consultations with the employers of social care workers were divided into three groups, as follows:

(a) statutory bodies, namely, health boards
(b) private organisations, namely, private nursing homes
(c) voluntary organisations, namely home help organisations

The research methods employed in the consultations with each of these three groups is described below.
Consultations with health boards
A staff member in the Department of Health who was on the National Council for the Elderly’s Consultative Committee for this study wrote to the Chief Executive Officer in each health board requesting that they nominate a representative to be interviewed in relation to the proposed national training initiative. All of the health boards nominated at least one representative. As detailed in Table A9, in the case of five health boards, semi-structured interviews were conducted, in the case of one health board, a written submission was made and in the case of another two health boards, telephone interviews were conducted.

Semi-structured interviews
Semi-structured interviews were used in the with consultations with seven of the health boards. This was not possible for the remaining health board as the response of nominees was made at a late stage in the research process. All nominees were sent a copy of the interview schedule at least one week in advance of meeting the researcher so that they had time to prepare for the interview. Detailed notes were taken during the course of the interviews which lasted from half an hour to one hour in duration. A 23-item interview schedule was used to guide the interviews. Four of the interviews took place in the offices of the nominees and the fifth interview took place in the National Council for the Elderly buildings at the request of the nominees.

In the case of the telephone interviews, the nominee was again sent the interview schedule in advance and the researcher telephoned the nominee at a pre-arranged time and the interview was conducted. The interview lasted for approximately half an hour. The written submission that was received from the remaining health board was based on the interview schedule which had been provided by the researcher.
<table>
<thead>
<tr>
<th>Health Board</th>
<th>Title of nominee(s)</th>
<th>Method of consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastern</td>
<td>Superintendent Public Health Nurse Development Officer, Services for the Elderly</td>
<td>one face-to-face semi-structured interview was conducted</td>
</tr>
<tr>
<td>North Western</td>
<td>Superintendent Public Health Nurse Training Officer</td>
<td>one face-to-face semi-structured interview was conducted</td>
</tr>
<tr>
<td>Eastern</td>
<td>Director of Community Care Co-ordinator of Services for the Elderly</td>
<td>two separate face-to-face semi-structured interviews were conducted</td>
</tr>
<tr>
<td>Western</td>
<td>Superintendent Public Health Nurse Home Help Organiser</td>
<td>two separate face-to-face semi-structured interviews were conducted</td>
</tr>
<tr>
<td>Southern</td>
<td>Superintendent Public Health Nurse</td>
<td>one telephone interview using the semi-structured interview format</td>
</tr>
<tr>
<td>South Eastern</td>
<td>Superintendent Public Health Nurse</td>
<td>one written submission based on the interview schedule</td>
</tr>
<tr>
<td>Mid-Western</td>
<td>Superintendent Public Health Nurse</td>
<td>one telephone interview using the semi-structured interview format</td>
</tr>
<tr>
<td>Midland</td>
<td>Home Help Organiser</td>
<td>one face-to-face semi-structured interview</td>
</tr>
</tbody>
</table>

**Consultations with private nursing homes**

Each of the health boards was contacted and asked to supply a list of the registered nursing homes in its region. Having obtained these lists it was found that there are a total of 336 registered nursing homes in the country and it was decided to randomly select a 10 per cent sample of these. Having selected the sample, the director/proprietor of the relevant nursing homes was contacted by letter, the background to the study was explained and a copy of the interview schedule was sent. The proprietor was then contacted by
telephone and the researcher requested a suitable time to conduct the interview.

As detailed in Table A10, the total number of interviews conducted with private nursing home proprietors was 32. The 10 per cent target was not met in some regions but was extended in others. Four of the interviews were conducted as face-to-face semi-structured interviews and the remaining were telephone interviews. All interviewees had the opportunity to study the questionnaire prior to the interview.

**Table A10: Number of proprietors of private nursing homes who were interviewed by health board region**

<table>
<thead>
<tr>
<th>Health board region</th>
<th>No. of private nursing homes in region</th>
<th>No. in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastern</td>
<td>25</td>
<td>2</td>
</tr>
<tr>
<td>North Western</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Eastern</td>
<td>117</td>
<td>8</td>
</tr>
<tr>
<td>Western</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>Southern</td>
<td>56</td>
<td>6</td>
</tr>
<tr>
<td>South Eastern</td>
<td>45</td>
<td>4</td>
</tr>
<tr>
<td>Mid-Western</td>
<td>42</td>
<td>2</td>
</tr>
<tr>
<td>Midland</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>336</td>
<td>32</td>
</tr>
</tbody>
</table>

**Consultations with voluntary organisations**

It was decided to confine the consultations with voluntary home help organisations that employ formal social care workers who work with the elderly to organisations in the Eastern Health Board region, as this is the region with the largest number of such organisations. The directors of 18 organisations were contacted by post, explaining the purpose of the study and requesting a telephone interview, following receipt of a detailed questionnaire. A total of 14 interviews were conducted.
A.7 Research Methods Employed in Consultations with Education and Training Institutions

Table A11 outlines the education and training institutions with which consultations took place. All of the institutions were contacted and asked to nominate a representative to be interviewed. A total of twelve interviews were completed. Five of these involved semi-structured interviews and five involved telephone interviews. The remaining two consultations involved written submissions.

Table A11: Education and training institutions with which consultations took place

<table>
<thead>
<tr>
<th>Types of institutions</th>
<th>Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irish accreditation bodies</td>
<td>National Council for Educational Awards, National Council for Vocational Awards, National University of Ireland</td>
</tr>
<tr>
<td>Education and Training institutions offering social care courses</td>
<td>Cork Regional Technical College, Sligo Regional Technical College, Athlone Regional Technical College, Dublin Institute of Technology, Waterford Regional Technical College, University College Galway, FÁS</td>
</tr>
<tr>
<td>Voluntary organisations that provide unaccredited social care courses</td>
<td>Irish Red Cross, Carers Association</td>
</tr>
</tbody>
</table>

A.8 Research Methods Employed in Consultations with Young People

The aim of the consultations with young people was to examine their likely uptake of a national training initiative. It was decided to survey the students on the National Certificate and National Diploma in Applied Social Studies (Social Care) in each of the RTCs. Students taking an NCVA recognised Post-Leaving Certificate course in social care and a pre-nursing course in two VEC colleges in Galway were also included in this sample. A total of 222 students participated in the survey.
Each RTC was sent 100 questionnaires. Due to the fact that some classes were on placements at the time of the study, the numbers of returned completed questionnaires varied for different groups. The co-ordinators of the courses took responsibility for distributing and collecting questionnaires. In the case of the post-leaving and pre-nursing courses, the researcher distributed and collected the questionnaires. Table A12 details the distribution of the survey respondents by the courses they were taking.

**Table A12: Sample of young people by social care course**

<table>
<thead>
<tr>
<th>Course in social care</th>
<th>Nos.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterford Regional Technical College</td>
<td>31</td>
</tr>
<tr>
<td>Cork Regional Technical College</td>
<td>30</td>
</tr>
<tr>
<td>Sligo Regional Technical College</td>
<td>72</td>
</tr>
<tr>
<td>Athlone Regional Technical College</td>
<td>59</td>
</tr>
<tr>
<td>Galway VEC (NCVA certified course)</td>
<td>16</td>
</tr>
<tr>
<td>Galway VEC (NCVA certified pre-nursing course)</td>
<td>14</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>222</strong></td>
</tr>
</tbody>
</table>

A large volume of both qualitative and quantitative data was gathered in the consultative process. Summary tables of questions follow in Tables A13 and A14.

**Table A13: Summary of key questions regarding the training of formal social care workers**

<table>
<thead>
<tr>
<th></th>
<th>OP</th>
<th>IC</th>
<th>FSCW</th>
<th>HB</th>
<th>PNH</th>
<th>VOL ORGS</th>
<th>ORGS /OP</th>
<th>ED/ TRG</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should FSCW have training</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Positive/negative effects of training</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Should training be mandatory</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Who should be responsible for provision of training</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>
## Table A13: Continued

<table>
<thead>
<tr>
<th></th>
<th>OP</th>
<th>IC</th>
<th>FSCW</th>
<th>HB</th>
<th>PNH</th>
<th>VOL ORGS</th>
<th>ORGS /OP</th>
<th>ED/ TRG</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should training be generic or specialised</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Suggested content</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>National recognition</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>APL systems and EU recognition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Facilitation of training by employers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care/personal care distinction</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Training for home care and personal care staff</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Different training for home care and personal care staff</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Availability of and prospects of employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*</td>
</tr>
</tbody>
</table>

## Table A14: Summary of key questions regarding the training of informal carers

<table>
<thead>
<tr>
<th></th>
<th>OP</th>
<th>IC</th>
<th>FSCW</th>
<th>HB</th>
<th>PNH</th>
<th>VOL ORGS</th>
<th>ORGS /OP</th>
<th>ED/ TRG</th>
<th>YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should informal carers be trained</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Positive/negative effects of training</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Different/similar content to training formal social care workers</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Should training be nationally recognised</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>
APPENDIX THREE

Details of the Curricula of Existing Training Courses for Formal Social Care Workers and Informal Carers in Ireland
### Courses Accredited by Irish Awarding Bodies

#### National Certificate in Applied Social Studies in Social Care

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>CORK RTC</th>
<th>ATHLONE RTC</th>
<th>SLIGO RTC</th>
<th>D.I.T.</th>
<th>WATERFORD RTC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CURRICULUM</strong></td>
<td><strong>YEAR 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demography &amp; Economics Psychology Sociology Communications Leisure &amp; Health Education Home Management Art in Social Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>YEAR 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PLACEMENT DURATION</strong></td>
<td>A 6 week observation placement in year 1 and a 12 week placement in year 2 e.g., residential centres, family case work and centres for the elderly</td>
<td>18 weeks duration</td>
<td>14 weeks</td>
<td>6 weeks placement</td>
<td>3 terms</td>
</tr>
</tbody>
</table>

*At Waterford RTC Year 1 and Year 2 represent the first two years of the *ab initio* National Diploma in Social Care.*
**National Diploma in Applied Social Studies in Social Care**

Providers: Athlone, Cork, and Sligo RTC, DIT

(1 year, full-time course, intended to develop the knowledge and skills acquired by students who have secured the National Certificate in Applied Social Studies)

*Curriculum includes:*
Applied Social Studies
Psychology
Sociology and Social Policy
Counselling and Group Dynamics
Creative and Recreational Studies
Care of older people, persons with disability, young persons and delinquency
Practice project evaluation

*Placement Element:*
60 days

DIT and Waterford RTC also provide an *ab initio* National Diploma in Applied Social Studies in Social Care

(3 year, full-time courses)

*Curriculum includes:*
Principles and Practices of Child Care
Counselling
Behavioural Sciences
Child Psychiatry
Drama
Crafts
Legal Aspects of Child Care
Economics and Social Policy
Project Work

*Placement Element:*
3 days per week
Certificate in Social Care
Provider: UCG

Curriculum includes:
Redefining Health and Well-being
Basic Nursing
Caring for the Carer
Accessing Services and Support
Knowledge and Uses of Drugs and Medicines
Social Policy and Social Care

Placement Element:
80 hours

Diploma in Social Care
Provider: UCG

Curriculum includes:
Sociology for Social Care Workers
Psychology for Social Care Workers
Basic Physiotherapy
Nutrition
Counselling and Referral
Management and Administration Skills

Placement Element:
80 hours

Community and Health Services (Award Level 2)
Provider: NCVA approved centres

Curriculum includes:
Mandatory Modules:
  Communication
  General Studies
  Work Experience
Vocational Modules
  Sociology
  Psychology

and three modules selected from following list
  Care Provision and Practice
  Anatomy and Physiology
  Health, Hygiene and Safety
  Human Growth and Development
  Child Development
  Introduction to Nursing

*Placement Element:*
A minimum of 4 weeks’ duration is required

*Community and Health Services - Community Care (Award Level 2)*
Provider: NCVA approved centres

*Curriculum includes:*
Mandatory Modules:
  Communication
  General Studies
  Work Experience

Vocational Modules
  Care Provision and Practice
  Health, Hygiene and Safety
  Human Growth and Development

and two modules selected from following list
  Child Development
  Early Childhood Education
  Exercise and Fitness - Introduction
  Sport and Recreation Studies
  Caring for Children with Special Needs
Nutrition and Dietetics
Planning the Care Environment
Sociology
An appropriate module developed or approved by NCVA

Placement Element:
A minimum 4 weeks’ duration is required

Certificate in Caring for the Sick
Provider: The Irish Red Cross Society

Curriculum includes:
Needs of a patient
Communication
Patients’ surroundings
Comfort and mobility
Rest and sleep
Washing and bathing
Clothing/dressing
Diet
Aids to eating/drinking
Communicable diseases
Learning and relearning
Recreational activities
Recovery and rehabilitation
Giving medication
Breathing difficulties
Controlling temperature
Care of the terminally ill
Caring for wounds
Cardio-Pulmonary Resuscitation (CPR)

No placement element
Certificate in Voluntary Care
Provider: The Irish Red Cross Society

Curriculum includes:
Older population - trends
Process of ageing and understanding older people
Confidentiality
Hospital experience
The role of the carer
The role of the Public Health Nurse
Community experience
Use and care of appliances
Lifting, dressing and undressing
Communication skills
Management of incontinence
Art of home visiting
Problems of the chronic sick
Care of the dying
The grieving process
Senile dementia
Nutrition
Needs of carers
Crime and the older person
HIV, AIDS and Hepatitis B
Observation and record keeping
Mental health of the chronic sick

Placement Element:
One evening per week throughout the academic year, and in addition to this students must undertake eight hours’ practice in a hospital/day care centre. and 16 hours in a relevant community setting.
Courses Accredited by Irish and British Awarding Bodies

**Community Care Practice**
Provider: FÁS

*Curriculum includes:*
Communication and personal effectiveness
Principles and practices of social care
Care practice of
  - the older person
  - the person with a learning disability
  - the socially disadvantaged
Nutrition and diet
First aid
Welfare entitlements
Enterprise skills
Job seeking skills
Practical work training/integrated assignments

*Placement Element:*
4 weeks

**Caring for the Elderly**
Provider: CDVEC (City of Dublin VEC)

*Curriculum:*
Human development
Behavioural and community studies
Caring skills
Data collection and interpretation
Biology
First aid
Communication skills
Design and creativity
Numerical skills
Placement Element:
6 weeks

Diploma in Social Care
Provider: CDVEC

Curriculum includes:
The modules give a foundation in the physiological, psychological and sociological aspects of life-span development. Government policy, social administration and information technology are fully integrated into the course.

Year 1
Focuses on child care and development; gerontology/ageing and the provision for special needs' groups in the community.

Year 2
Further development of research and caring skills.

Placement Element:
Students undertake six work placements in a wide range of organisations - private and voluntary.

Unaccredited Courses

The Challenge of Ageing Course
Provider: Faculty of Health Sciences, Trinity College Dublin

Curriculum includes:
The social aspects of ageing and the experience of retirement
The psychology and the physiology of ageing
The experience of loss and bereavement
Promotion of continence and management of incontinence
Common illnesses of old age
Statutory and voluntary resources for the care of older people in Ireland in 1995 and beyond
Crime, elder abuse and family stress
Mobility problems (including advice on footcare and footwear)
Communication with sensory impaired and/or confused older people
Nutrition

No placement element

**Working with the Elderly**
Provider: Cork Social and Health Education Project (CSHEP)

*Curriculum includes:*
Ageing today
Retirement
Getting help
Care by the community
Home care and home nursing
Crisis care and rehabilitation
Dying and bereavement

No placement element

**Carers' Programme (Programme 1)**
Provider: Baggot Street Community Hospital

*Curriculum:*
Month 1: Occupational therapy
Month 2: Physiotherapy
Month 3: Nursing
Month 4: Entitlements
Month 5: Stress management
Month 6: Stress management

No placement element
In-Service Training

Continuing Education Certificate in Caring
Provider: CDVEC and the National Association of Home Help Organisers

Curriculum includes:
Organisation and administration of health and community services
Organisation and administration of home help services
Ethics of care and responsibilities of Home Helps
Attitudes to caring for different client groups
Importance of client confidentiality
Home management: general hygiene, budgeting, food, nutrition, and safety in the home
First aid course (certified by Irish Red Cross or Order of Malta)
Health, hygiene and safety at work
Stress management
Back care/lifting
Awareness of occupational/technological aids
Dressing/undressing/washing and bathing of clients
Feeding of infirm or handicapped person
Observation of medication
Prevention of hypothermia
Interpersonal/communication skills
Addictions awareness
HIV/AIDS and Hepatitis B
The physical, psychological and social aspects of ageing
Awareness of violence and elder abuse
Coping with loss, grief and bereavement
Social welfare entitlements for persons with disabilities and older people
Social and recreational skills, for example, relaxation, aromatherapy, massage
References


Wilson, G., 1993. ‘Users and Providers: Different Perspectives on

RECENT NATIONAL COUNCIL FOR THE ELDERLY PUBLICATIONS
(Report Numbers 23a to 47)

23(a) Co-ordinating Services for the Elderly at Local Level: Swimming Against the Tide. A Report on Two Pilot Projects. September 1992

23(b) Co-ordinating Services for the Elderly at Local Level: Swimming Against the Tide. Summary of an Evaluation Report on Two Pilot Projects. September 1992

24. The Impact of Social and Economic Policies on Older People in Ireland, January 1993


27. Co-ordination of Services for the Elderly at the Local Level. (Seminar Proceedings) September 1993


29. Dementia Services Information and Development. (Seminar Proceedings) September 1993


32. Measures to Promote the Health and Autonomy of Older People in Ireland. (Conference Proceedings) February 1994

33. Theories of Ageing and Attitudes to Ageing in Ireland. (Round Table Proceedings) May 1994


35. The Economics and Financing of Long-Term Care of the Elderly in Ireland. August 1994


38. The Economics and Financing of Long-Term Care of the Elderly in Ireland. (Seminar Proceedings) November 1994


40. Support Services for Carers of Elderly People Living at Home. December 1994


44. Elderly Return Migration from Britain to Ireland: A Preliminary Study. May 1996

45. Mental Disorders in Older Irish People: Incidence, Prevalence and Treatment. September 1996
