

N/SVQ Care (3152/3155)

Quality Guidance - Frequently Asked Questions

3152/3155 N/SVQs

N/SVQ Care (3152/3155 – 21, 31, 41)

N/SVQ Children and Young People (3152/3155 – 32)

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N/SVQ Blood Donor Support (3152/3155 – 22)

Q1. Has any additional guidance or clarification been provided for individual N/SVQ Units?

Any additional guidance and clarification agreed is provided below and is listed in alphabetical unit order. The list is comprehensive, relating to several N/SVQs in the Community & Society portfolio. Careful matching to the unit identification code (letters and numbers) and titles is required when searching for additional guidance/clarification.

“Unit B3 Obtain venous blood samples using invasive techniques

Element B3.2 Collect venous blood samples

Range 1b Non evacuated sampling systems”

Skills for Health have advised that where this method is not used by an organisation, performance evidence may be gained from alternative evidence gathering methods eg simulation perhaps using a ‘practice arm’

“Unit B4 Obtain and test capillary blood samples”

This is a generic unit with application to a wide spectrum of settings. Therefore the equipment used to obtain the blood sample will vary as to what is appropriate within the particular setting and the amount and purpose of the sample collected.

If there are any particularly unusual situations, centres should refer to their external verifier for advice and guidance.

“Element B4.1 Prepare individuals and equipment for the collection and testing of capillary blood samples

Range 1 environments in which collection and testing takes place:
a) permanent clinical environment e.g. wards and clinics
b) non-clinical environments (eg individual’s home, blood collection venues)”

Therefore, appropriate help is sought as soon as is practicable, immediate safeguarding actions are undertaken to ensure the situation does not deteriorate further and reassurance is given to the individual.

Possible examples could include:

- A foster carer coping with a suddenly choking child
- A domiciliary worker entering a house to find a client collapsed
- A health support worker escorting a patient who falls and is in a precarious situation

N.B. If a candidate has a physical limitation or disability which means they cannot carry out the task themselves, they may **instruct** others on the appropriate action to be taken.

“Element CU1.3 Minimise the risks arising from health emergencies”

Performance criteria/range requirements

There is recognition, clearly identified in the Evidence Requirements that all the performance criteria and all aspects of range for this element might not be observed by the assessor in naturally occurring, real work activities and therefore some simulation is allowed (see Special Considerations).

Section 2 Other types of evidence of your performance and knowledge confirms this point and states that:

‘Your assessor will want to see other evidence to feel confident that you can consistently repeat this standard of work... They will also want to see evidence that you know, understand and can apply in practice the knowledge which is listed in the specification....’

Also in the ‘Summary’ section there is detailed guidance of the extent of the appropriate level of involvement in the minimising of health emergency risks as follows:

‘... The third element relates to minimising risks from health emergencies. To achieve this element, the worker must be able to undertake the appropriate initial action for the full range of health emergencies listed up to that point in time when they are able to hand over the care of the person involved to someone more competent in that area of practice. First aid training and certification may be a useful route of development to consider for this element.’

The content of this guidance does therefore not allow for this element to be evidenced solely by questioning.

It is likely there will be some ‘performance’ component on which an assessor can make a reliable judgement regarding consistent, competent practice.

Most candidates will have had involvement in an emergency situation, albeit perhaps a minor one, eg an individual feeling faint or someone choking on a piece of food.

The assessor might not have observed the situation. A witness or records might be available, or the candidate can describe and be questioned in detail about their intervention.

All of these sources can be reviewed by the assessor who will then make their judgement as to sufficiency of evidence.

At the very least an assessor should be able to observe simulated activities on appropriate dummies etc. in order to be satisfied that the candidate can actually carry out the techniques, the knowledge of which might well have been demonstrated by questioning.

This does not mean that all candidates must undertake a full first aid training programme, although many employers/assessment centres permit access to basic first aid training as a development opportunity and evidence of good practice.

A recent first aid training programme and certificate is **one** way that candidates can gain evidence of the knowledge requirements and of simulated performance. It is not sufficient on its own to cover the complete performance component.

Assessors are making the judgement that the candidate can respond appropriately in an **actual emergency situation**, not a simulated, pre-planned episode. A candidate who could competently demonstrate first aid techniques, or answer questions effectively, might panic in a real event.

Summary

CU1 is an essential component of the qualification it constitutes. Individuals involved with candidates are all to some extent vulnerable. Their health and safety is a vital consideration. They should be able to rely on the competence of workers (within the limitations of their job role) with whom they come into contact, often in isolated situations.

Candidates are therefore required to provide evidence that they:

- know what to do (First aid training is one way to demonstrate this)
- can demonstrate this knowledge (Again first aid training that involves simulated activities can be useful in this respect)
- provide some evidence from real work activities that their practice is competent (while recognising that assessor observation of these interventions might not have been possible).

NB This guidance has been accepted and endorsed by TOPSS (UK).

First Aid Certificates

First Aid certificates from both known and unknown sources may provide potential evidence towards CU1.3. In both cases assessors will need to check the training/assessment content of the programme leading to certification, ensuring that it matches the N/SVQ unit requirements. This will be particularly important where performance evidence has been presented from training exercises and simulations. The currency of certificates should be established, as some do have 'expiry' dates attached to them. Where the certificate is from an unknown source, the assessor should also check the credibility of the organisation issuing the certificate.

“Unit CU5 Receive, transmit and retrieve information”

The range requirements in this unit seek to ensure that candidates can use some of the newer technologies used for the receiving and transmitting information. If candidates do not have access to these and it is not part of their job role another more suitable optional unit should be chosen. As technology advances some new 'electronic' means will become part of usual practice and can therefore be used to cover the range so long as the evidence remains auditable eg text messaging.

“Unit CU7 Develop one’s own knowledge and practice

Element CU7.1 Reflect on and evaluate one’s own values, priorities, interest and effectiveness

Performance criteria

- (1) one's own values, interests and priorities in relation to health and social well-being are identified
- (3) the factors which have influenced one's own health and social well-being are acknowledged together with how these have affected one's own values
- Range 2 Factors
- a) life experiences
 - b) socio-economic background and status
 - c) cultural background"

The underlying principles of the unit are very much encapsulated in the **Summary** notes on the initial page.

This unit describes the development of one's own **knowledge and practice** – a key part of a worker's role. Therefore in-depth reflection on candidates' own very personal life experience is **not** a requirement of this unit

The first element is about reflecting on and evaluating one's own values, interests, priorities and effectiveness in practice as it is only through knowing oneself that one can reflect on the effectiveness of one's interaction with others. This is particularly the case in the health and social care sectors when so many areas of practice are inter-mixed with potentially conflicting values and priorities. This element is based upon the belief that to be effective in practice a candidate needs to know not only the starting point of the people with whom (s)he works but also be aware of the factors which affect his/her own beliefs and actions.

Individuals working in the health and social care sectors therefore have to frequently engage with service users and others whose belief, patterns of behaviour etc differ markedly from the candidate's own.

Examples could include:

- a passionately non-smoking worker involved in the care of someone who continues to smoke despite the fact that they are dying from a smoking-related illness.
- a foster carer/ residential childcare worker interacting with those who may have abused the children of young people now in their care.

The candidate must retain genuine ongoing concern and non-judgemental acceptance of the individual without imposing their own beliefs etc.

One of the responsibilities required of the assessor when approaching this unit is to forewarn the candidate (before engaging in detailed assessment planning) that CU7 requires the candidate to review their approaches and belief systems in so far as they affect their work role.

The candidate is NOT required to enter into in-depth counselling sessions, which might reveal painful episodes in their own personal lives.

The candidate should be given the time and opportunity on her/his own consider which areas (s)he wished to discuss before beginning to plan the assessment of this unit.

“Element CU7.2 Synthesise new knowledge into the development of one's own practice”

This element allows the candidate and the assessor to review developments in the candidate's practice and knowledge over a period of time.

It is particularly useful for those candidates who have previously achieved a Level 2 qualification to reflect on further experiences and/or knowledge gained in those areas already covered by the units achieved at Level 2.

It does NOT mean the reassessment of any/all of the Level 2 units but should be an individualised appraisal of the particular candidate's development since the achievement of their previous award.

This reappraisal may involve a candidate undertaking further observed practice or training in certain agreed areas which will in turn contribute evidence toward CU7.

“Unit F3 Manage Continuous Quality Improvement

Unit F6 Monitor compliance with quality system”

In deciding which of the above two units is most appropriate for candidates to do assessors will need to establish with managers the exact nature of their management responsibilities for quality systems within their organisations. The summary overviews which precede the unit standards in the Registered Managers (Adults) Award Guidance & Record of Assessment provide guidance on the sort of activities and responsibilities that candidates will need to have in order to evidence the unit. Very broadly, individuals with responsibility for developing, implementing, maintaining and identifying necessary improvements to quality system should consider F3 Manage Continuous Quality Improvement.

Individuals with responsibilities for monitoring and reporting the organisations compliance with **existing** quality systems should consider **F6 Monitor compliance with quality systems**.

Once the area and breadth of the manager's responsibility is established, the centre should support the candidate to carry out a detailed matching of evidence generating opportunities arising from their work role to the standards (p.c, range & knowledge). This should ensure that there is a sufficient fit, for the candidate, to progress through the unit.

“Unit NC12 Enable clients to eat and drink”

The unit summary for NC12 states that:

‘To comply with accepted good practice, it is expected that they (the candidate) will hold an appropriate level of food hygiene qualification, such as those approved by the Institute of Environmental Health officers and in – house certificated courses’

The critical word is ‘expected’ rather than ‘required’ or ‘demanded’. This indicates that as many care candidates will be/have been expected to gain a Certificate of Hygiene to meet the requirements of their workplace they are likely to have this certificate available to present as evidence. It is not however an S/NVQ requirement and where candidates do not hold this qualification their assessor may identify alternative ways to evidence this unit.

“Units 01, 02, 03 and CL1”

It is possible for assessment of the above units to be undertaken as discrete separate entities.

It is likely, and probably preferable, that many assessors and candidates will continue to evidence the above units by a process of cross-referencing; as evidence for these units should naturally occur during everyday practice.

However, some candidates may elect to have them assessed separately, or even to achieve them as their first units, as assessors might, for example, wish to reassure themselves by this practice that candidates are sufficiently aware of the underlying care values.

If candidates have met all the requirements of the above units early in the assessment process (i.e. after only achieving 2 or 3 other units) then accreditation is appropriate.

Nonetheless assessors will still need to be reassured of a candidate's consistent competent practice throughout the course of the award. This competent practice will include application by the candidate of appropriate Care values. Assessors should therefore not make positive judgements regarding competence for ANY unit where a candidate has not applied these values.

“Unit OD1 Contribute to the control of infection in clinical work areas

Element ODI.4 Decontaminate & sterilize clinical instruments”

The evidence requirements state that observation is required for all p.c's in this element with the exception of p.c 8 and 10. Some centres are reporting that because of changes in working practice ODS staff are not likely to undertake this activity within a theatre environment. Instrument sets are frequently removed by either sub – contracted firms or to depots off site for decontamination and sterilization.

Therefore where there are no work practice opportunities available to evidence the p.c and range requirements, assessors may use candidate explanation of process or responses to assessor devised questions as an alternative assessment method.

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“Unit RM1 Manage a service which achieves the best possible outcomes for the individual

Element RM1.4 Manage and monitor systems for the administration of medication”

This unit is mandatory and simulation is not allowed.

Prior to registration for this qualification centres need to complete a skills audit with candidates to ensure their job role will allow them to present sufficient evidence to complete the unit. Every workplace should have a medication policy and even if it is not part of the managers' responsibility to dispense medication, they will be responsible for devising, implementing and monitoring the policy. Records of this activity would count as product evidence gained from real work activity. Where this is not possible, candidates should be advised that they can opt to undertake the unit route or to undertake a qualification that more appropriately reflects their job role.

“Unit SC14 Establish, sustain and disengage from relationships with clients

Element SC14.3 Disengage from relationships with clients”

Many foster carers with long-term placements have experienced difficulty in providing performance evidence during the period of their assessment for this element.

Where performance evidence is not available the assessor can identify alternative evidence collection methods, including 'what if' situations, short case studies, APEL etc.

“Unit TC1 Record and evaluate an ECG at rest”

Concern has been expressed about the use of the word ‘evaluate’ in

“Element TC1.1 Prepare the patient and equipment for an ECG at rest

Element TC1.2 Monitor and evaluate the patient’s condition and performance of equipment during and after an ECG at rest

Element TC1.3 Produce, evaluate and despatch an ECG at rest”

This concern stems from worries that the candidate might be required to evaluate the recordings which is an activity they are not qualified to undertake.

The requirements of this unit are clear and it is the responsibility of the candidate to ensure that:

- the equipment is actually working correctly and is making an appropriate recording;
- (s)he is able to recognise where the equipment is indicating **serious or life threatening conditions** so that **advice is sought without delay**.

It is therefore not a requirement that the candidate would actually evaluate either the patient or the recording in any further depth or detail.

“Range
Types of Patient
Adult
Child”

Evidence from candidate work practice should be used to cover one aspect of the above range unless they are working with both adults and children when they should evidence both. Assessors should then question candidates to ensure they understand the difference in procedure when working with the group they have not evidenced from work practice.

“Range
Single channel”

In contexts where this equipment is not used assessors may question candidates to cover this aspect of the range.

“Unit X9 Support others in the implementation of physiotherapy programmes and treatments.

Element X9.2 Implement physiotherapy treatments

Range
1e Intermittent compression”

Where intermittent compression is no longer practiced in the candidate’s work environment, assessors may use alternative methods for gathering performance evidence. Assessors must be aware that candidates may move to different contexts where this technique is still used and therefore must be confident that the candidate could completely transfer their skills and knowledge to another setting.

“Unit X12 Support clients during clinical activities”

Element X12.3 Assist clients to recover from treatments, investigations and procedures”

Performance criteria (2) following the activity, the client is correctly informed of any clinical need for refreshment

A ‘clinical need for refreshment’ could be:

- the administration of a litre of fluid given to a patient after a Barium enema.
- the provision of food to a diabetic patient who had ‘nil by mouth’ because of tests etc.

“Unit X19 Prepare and Undertake agreed clinical activities with clients in Acute Care settings

Element X19.3 Obtain and test specimens from clients”

Notes on this element Blood (Range 1e) would be obtained by a thumbprick or by venepuncture

Thumb pricking is no longer acceptable practice as it can cause damage to nerve endings. This issue will be referred to the NTOs.

The agreed interim guidance is that pricking should take place on the outer aspects of the forefingers.

“Range 1b) blood sugar analysis”

There is concern that the candidates are being asked to provide evidence of competence for blood sugar analysis when health care assistants are not allowed to carry out the procedure or make a judgement of the analysis (this procedure is only done by medically qualified staff). However this policy is not consistent throughout NHS Trusts.

Although performance evidence by observation is not required for all parts of the range of the element, some centres are not too keen to use other methods such as questioning/simulation as this would imply that the candidate is competent to carry out blood sugar analysis when in fact it is not good practice to do so.

This issue will be referred to the NTOs.

The agreed interim guidance is that where this practice is not acceptable, the candidate can be questioned as to knowledge of the process, with a clear indication this is not an expectation of their role.

Taking capillary blood from babies in a maternity unit is reported by some NHS Trusts to be appropriate to the midwife’s role and not the HCA (Candidate). X19 is an optional unit and does not include babies in its range requirements. It is therefore necessary for the centre/assessor to check their own NHS Trust policy to identify whether this activity is part of a care worker’s normal role on a maternity unit. These checks should be made prior to embarking on the assessment of this unit and, where the activity is in conflict with Trust policy, alternative units should be identified.

“PC6 Client behaviour and condition is observed and monitored throughout contact and any unexpected change or aspect which gives cause for

concern is reported to an appropriate member of the care team without delay.”

Some NHS Trusts have expressed concern that this element implies candidate responsibility for monitoring patients without supervision. This is not the case. Candidates must demonstrate that they know what needs to be observed and monitored in order that they can contribute to the total team process and in particular, that they can observe and report unexpected or abnormal developments to appropriately qualified personnel.

“Unit X22 Process, reproduce and assure the quality of permanent images

Element X22.2 Prepare and reproduce permanent images

Range Types of permanent image.”

Centres may interpret the range requirement ‘permanent image’ more broadly to include digital imaging where this has replaced other methods used in the candidates’ workplace.

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