

Oral Health Care N/SVQ (3231)

Quality Guidance - Frequently Asked Questions

Q1. What are the direct observation requirements?

Where direct observation is a unit assessment requirement, it must be carried out by an occupationally competent assessor who is registered for A1/A2 or has already achieved D32/D33.

Witness testimony does not demand observation against the performance criteria and therefore those providing witness testimony do not need to possess the assessment skills acknowledged by units D32/D33/A1/A2. It follows that anyone who is occupationally competent but is neither registered for nor possesses D32/D33/A1/A2 can only provide witness testimony.

Q2. Have any of the direct observation requirements been varied from those recorded in the Award Guidance & Record of Assessment?

In an effort not to compromise the observation requirements but at the same time allow more flexibility in the assessment methods available for the collection of performance evidence, Skills for Health, NEBDN and City & Guilds Care Health & Community have agreed the following statement to replace the existing ones for:

Units DN01, 2, 12, 13, 14, 15, 19, 20, 21, 22, 23, 24, 25, 26, 27, 27, 30, 39 and 40.

‘The candidate must be observed for at least one aspect of the range in each element. The assessor observing the candidate must be occupationally competent and have achieved or be registered and working towards achieving Units D32 and 33 or their replacements A1 or A2. Other performance evidence to cover the outstanding performance criteria, evidence and range requirements may be gathered from an appropriate mix of

- 1) additional observation
- 2) expert witness testimony
- 3) products of the candidate’s work
- 4) candidate explanation

The existing guidance on the use of simulation remains unchanged in all the above units with the exception of Unit DN12 where simulation may be used as one form of alternative evidence gathering.’

Endorsed by Skills for Health

Q3. Can Dental Hygienists be used as assessors and /or internal verifiers

Dental Hygienists may assess and internally verify those units in which they are competent only. Dental Hygienists who trained as Dental Nurses will be able to assess a wider range of units.

Q4. 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 CU1 Promote, monitor and maintain health, safety and security in the workplace”

There is recognition in the unit summary guidance that this unit has very wide contextual applications, covering at one end of the spectrum those working in their own and others homes (foster carers and domiciliary carers) to those working in acute settings at the other (various hospital settings including operating theatre departments).

As a result, the performance criteria, range and knowledge requirements have been written in sufficiently generalised terms to enable their application to the immense variety of situations in which workers function.

The fact that many workers act alone, in isolated and unsupported situations, is also acknowledged by the requirement that the candidate must be able to demonstrate that (s) he can competently and without panic, cope with an emergency situation which (s)he is the first person to encounter, while at the same time **demonstrating awareness of their own limitations**, up to and including the point where, if appropriate, more qualified support is summoned and is available to take over responsibility for the situation. Examination of the PCs indicates the level of action and intervention required eg 'Action appropriate to the condition is begun'.

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 DN12 (Mandatory Unit) Offer information to individuals on the protection of their oral health and support them in doing so.”

Some centres have reported that it is unlikely that a trainee would be entrusted with the provision of such in depth knowledge to patients. The evidence requirements are for observation of real work activity and do not allow for simulation.

This activity has been identified as central to a Dental Nurses role. It is vital that centres discuss, at the outset, any barriers to candidates’ progress which may exist and develop a strategy to overcome these.

It is recognised that a ‘trainee’ N/SVQ candidate requires supervision when carrying out this activity and that until competence is confirmed, the need for supervision will continue. This is one reason why there is a strong emphasis on the ‘observation’ of performance in a real work environment, in that an occupationally competent person is present at information giving sessions.

It is further recognised that when peripatetic assessment is being used, the present observation requirements may prove to be overly demanding on assessors’ time. The observation requirements have been modified, as recorded below, to overcome this problem.

‘The candidate must be observed on at least one occasion. The assessor observing the candidate must be occupationally competent and have achieved, or be registered and working towards, D32/33/A1 or A2 All other occasions where the candidate provides performance evidence to cover the performance criteria and range requirements must be either observed by their assessor or witnessed by a person who is occupationally competent in the area of work concerned and who is familiar with the standards’

“Unit DN14 Process dental radiographs or support their production

Range Intra oral films

Range Extra oral films”

Some candidates, working in dental surgeries may have difficulty evidencing both aspects of the range requirements when the equipment for processing extra oral films is rarely on site.

In such cases the range requirements, as related to the above elements, may be varied so that candidates can demonstrate competence against the type/s of film used in their assessment location eg intra oral film and/or extra oral film. Where the candidate is only able to present performance evidence for one type of film they must present knowledge evidence for the outstanding film type. This may be via candidate explanation of process records and/or responses to assessor devised questions.

Endorsed by Skills for Health.

“Range Instant Processing”

Instant processing means self-processing dental radiographs which are neither polaroids nor lasers. They are a self-contained pack with their own developer and fixer and are often used in mobile clinics where there are not the necessary facilities for processing.

The guidance given above for DN14 applies equally to this range item.

“Range Processing Methods
1a) manual
1b) automatic
1c) instant processing”

The range requirement to cover at least one out of the three processing methods from real work activity is problematic for dental practices that only use digital imaging.

Therefore, where digital imaging is the only method used in the candidate’s worksite, the currently recorded range can be interpreted more widely to include digital imaging. Candidate explanation of process, responses to assessor devised questions or simulation may be used to cover all the outstanding p.c’s/range where there are no other work based opportunities for evidence generation.

Endorsed by Skills for Health

“Unit DN15 (Mandatory Unit) Provide chairside support during the prevention and control of periodontal diseases, oral care and the restoration of cavities.

Element DN15.3 Support the oral health care team in the preparation and restoration of cavities.

Range 2 Patients
2a Adults
2b Children”

Candidates must demonstrate that they can work competently with children and adults equally. Candidate must demonstrate their competence for each of the four restorative treatments. However, they do not have to provide evidence from both children and adult for each restorative

treatment. Therefore the candidate might cover **provisional restorations** and **amalgam restorations** with children and **composite restorations** and **glass ionomer** restorations with adults.

Endorsed by Skills for Health

“Unit DN20 Provide chairside support during prosthetic dental treatment.

Element DN20.3 Support the oral health care team in the design construction and fitting of removable prostheses.

Range 2a Children”

This range requirement may be varied to allow the candidate to demonstrate their competence with either children or adults or both as appropriate to cover the removable prostheses range requirement. Where a candidate can only provide performance evidence for either children or adults the assessor should question the candidate to ensure they can differentiate between the process used for children and adults.

Endorsed by Skills for Health

“Unit DN21 Provide chairside support during endodontic treatment

Element 21.1 Prepare equipment, instruments, materials and medications for endodontic treatment.

Range 1 Endodontic Surgery
a) Root Canal treatment
b) Pulp capping
c) Apicectomy
d) Pulpotomy
e) Pulpectomy”

The above range requirements have been varied to assist those candidates experiencing barriers to the completion of this unit because the events occur rarely.

Candidate performance evidence must now cover Range 1a and 1b and **at least** one further aspect of root canal treatment (1c Apicectomy, 1d Pulpotomy, 1e Pulpectomy). Any outstanding range requirements may be evidenced by candidate explanation of process reports and/or responses to assessor devised questions where the opportunity to provide naturally occurring evidence from the workplace is unlikely to occur during the candidates period of assessment.

“Element DN21.3 Provide close assistance to the team and support patients during surgical endodontic treatment.

Range 1 Endodontic Surgery
a) Apicectomy
b) Pulpotomy
c) Pulpectomy”

The above range requirements have been varied to assist those candidates experiencing barriers to the completion of this unit because the events occur rarely.

Performance evidence gathered from observation is required for a minimum of one of the three activities identified in Range 1. The outstanding two range activities may be evidenced by candidate explanation of process reports and/or responses to assessor devised questions where the opportunity to provide naturally occurring evidence from the workplace is unlikely to occur during the candidate's period of assessment.

Endorsed by Skills for Health

“Unit DN22 Provide chairside support during the extraction of teeth and minor oral surgery

Element DN22.1 Prepare patients, environments, equipment and materials for the extraction of teeth and minor oral surgery

- Range 1 Extraction of teeth and minor oral surgery
- a) extraction of erupted teeth
 - b) extraction of buried and unerupted teeth
 - c) removal of roots
 - d) investigation of soft tissues lesions

Element DN22.3 Provide close assistance to the team and support patients during oral surgery to remove roots, buried and unerupted teeth.

- Range 1 Oral surgery relating to
- a) the removal of roots
 - b) the removal of buried teeth (permanent, third molar or deciduous)
 - c) the removal of unerupted teeth (permanent, third molar or deciduous)”

Some centres have difficulty in meeting the revised evidence requirements for at least one of the activities identified in Range 1 of both DN22.1 and 3 to be observed by the assessor.

As this is a competency based qualification there can be no relaxation of the requirement for candidates to provide performance evidence. However, in an effort to assist candidates who work in settings where these activities are non – routine and therefore difficult to plan in for observation, it has been agreed that assessors may use either observation **or** expert witness testimony. Assessors should also identify other supporting performance evidence to establish consistency in candidate practice, eg candidate reflective accounts.

Endorsed by Skills for Health.

“Unit DN23 Prepare for and provide chairside support during surgical periodontal therapy.

Element 1 Prepare equipment, instruments, materials and medicaments for surgical periodontal therapy.

Element 2 Provide chairside support during and after periodontal therapy

Range 1	Surgical Periodontal therapy (both elements)
	a) flap surgery
	b) pocket eradication
	c) sulcus deepening
	d) gingivectomy and gingivoplasty
	e) free gingival grafting “

Some of the range requirements include some very specialist and uncommon procedures. Therefore observation is required for a **minimum** of one of the activities identified in both elements DN23.1 Range 1 and DN23.2 Range 1. The remaining range requirements in both elements may be covered by evidence gathered from expert witness testimony, work products and candidate explanation of process reports. Where candidates experience difficulty in providing performance evidence in all five range requirements **one** only may be evidenced by the presentation of knowledge evidence derived from responses to assessor or devised questions.

Endorsed by Skills for Health

“Unit DN39 Provide chairside support before, during and after the use of conscious sedation in oral health care treatment. (Option B)

Unit DN40 Support patients and anaesthetists before, during and after the use of general anaesthetics in oral health care treatments. (Option B)

Unit DN41 Determine the need for and perform verepuncture, intra-venous cannulation and intravenous infusion. (Option B)”

Centres should not embark on the planning or assessment of these units. Discussion has taken place between Skills for Health, NEBDN and City & Guilds CHC and in consequence further guidance is being sought from the General Dental Council as to whether they are appropriate for continued inclusion in this qualification.

“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.