**Promoting person-centred care in the home support of older people through Situational Judgement Tests: a feasibility study**

**Background**

An ageing population across the developed world is bringing forecasts of substantial new demand for long-term care, and a commensurate need for a workforce to meet these needs. In the USA, the workforce for personal aides at home is predicted to grow by nearly 90% over two decades (Spetz et al, 2015), whilst in England the number of adult social care jobs is predicted to rise by a third in the next 15 years (Skills for Care, 2021). Even retaining the existing workforce is challenging, with difficulties reported across Western nations (Schneider et al, 2019). It is clear that meeting future demand will require a structural change in the care workforce, with new staff being drawn from outside traditional sources. This poses new challenges for recruitment, and begs the question as to the necessary attributes new workers must bring.

The homecare sector makes a virtue of relationship-centred approaches to support, demanding that its staff draw on a host of personal qualities and interpersonal skills beyond those taught in formal education and training (Pollock et al, 2021). Technical care skills can be acquired through training provision, on-the-job mentoring and reflective practices; by contrast, so called ‘soft’ skills, including those relating to social and emotional competencies, may be more challenging to teach. Moreover, care work is founded on essential values befitting a role supporting vulnerable adults with little supervision (Schneider et al, 2019). ‘Values’, in this context, can be defined as enduring beliefs or guiding principles that transcend specific situations, which steer individuals and institutions towards particular goals, via behaviours and choices (Patterson et al, 2016). They are normative: they help to shape the appropriate response to any problem and establish what good outcomes may be. Values can be learned and thus to some degree can be adopted by people moving across occupations (Cable and Parsons, 2001), although more generally, values tend to be relatively stable across adulthood (Patterson et al, 2016). Values are often linked to underlying personality traits, such as ‘agreeableness’ or ‘conscientiousness’ (Motowidlo et al, 2006). These may represent fairly stable behavioural dispositions, not readily amenable to change.

These attributes are crucial. Recipients and families of social care often describe preferences for support in terms of values and character traits, emphasising kindness, empathy and respect for independence as consistently desired features of care (Moriarty et al, 2019; Manthorpe et al, 2017; Pollack et al, 2020; Schneider et al, 2019). When care is values-led, service users appear to have better outcomes (Malley et al, 2019). ‘Socioemotional skills’ appear to be key. Such abilities, relating to empathy, emotional self-regulation and interpersonal effectiveness are sometimes referred to collectively as ‘emotional intelligence’ (EI). Indeed, there is evidence that key components of EI predict work performance in ‘high emotional labour’ jobs, above and beyond measures of traditional intellectual ability (Joseph and Newman, 2010). Data from a large US survey found that the (self-reported) key skills and abilities most needed in care work were communication and reasoning, problem sensitivity (the ability to tell when something is wrong), social perceptiveness and active listening (OECD, 2020). At a qualitative level, research has recognised the vital position of ‘situational awareness’ in care, and the ability to read emotional expression (Pienimaa et al, 2021). Moreover, a number of countries are shining a growing policy spotlight on social care as a ‘values-based’ occupation (OECD, 2020).

In England, the experience is that values do not easily spread amongst the 1.54 million workers within the sector. Unlike some other countries, there are no formal qualifications required on entry, and no overseeing professional bodies, such as those which regulate social workers and occupational therapists. Although there are some expectations that employers adopt a national ‘Care Certificate’ as part of introductory training, research has found it is not universally completed, since it is not an externally accredited qualification (Leverton et al, 2021). This limits opportunities to establish and shape values, and for establishing and sharing occupational standards. (Manthorpe et al, 2017). Consequently, relevant values are largely sought through values-targeted recruitment and retention policies. Values based recruitment (VBR) has become standard practice in the UK health and social care sector, with its use being accelerated in the aftermath of the ‘Francis Report’ review of a care scandal in which older people were mistreated (Francis, 2013). The Report recommended a culture of shared values to be encouraged and introduced at the recruitment stage. This has been reinforced by English regulatory system led by the Care Quality Commission, which has values embedded throughout the inspection process.

As a result of these trends, the social care sector has espoused a commitment to VBR. However, there is little clarity about the degree to which this is underpinned by a sector-wide shared understanding. Furthermore, there is no evidence as to whether VBR leads to improvements in the values embodied by care staff, and consequent improvements to the experience of service users (Manthorpe et al, 2017). Most organisations recruit care staff using traditional interviews as the principal source of evaluating a candidate’s suitability. However, used alone, they are known to suffer from a range of biases and errors likely to distort appraisal of values, including stereotyping, ‘halo and horn’ effects (being unduly influenced by single positive/negative characteristics), and using easily-observed characteristics as (error-strewn) proxies for less-observable value traits (Patterson et al, 2016). Traditional interviews also suffer from poor validity and reliability.

*Situational Judgement Tests*

Situational judgement tests (SJTs) are widely used to support recruitment to many occupations in which values play an important role. SJTs are commonplace in the medical profession, policing and customer-facing service roles, and are particularly useful when there is limited information about relevant behavioural performance because the candidate is new to the sector. A typical SJT (see Tiffin et al (2020) for an exemplification) will present candidates with a range of scenarios (or ‘critical incidents’) which depict a challenging work-based situation requiring an appropriate behavioural or attitudinal response. The test-takers will then be invited to consider the suitability of possible responses to the scenario, typically using Likert-type scales or a ranking format. These answers will be compared against a scoring rubric, often developed from responses from ‘subject matter experts’ (SMEs), such as senior professionals in the field. This enables a judgement to be made as to the likely level of candidate performance, compared to such experts. Whilst SJT content varies, most of these assessments include items evaluating test-takers’ understanding of professional, ethical or moral practice. As such, SJTs are often assumed to be measuring procedural knowledge of appropriate or effective workplace behaviours (Webster et al, 2020). There exists a limited range of SJTs in social care and no research findings in relation to their development and properties have been published to date.

An optimal SJT in social care should examine procedural knowledge that could be assumed to be a *necessary* (though not presumed to be *sufficient*) condition of exhibiting behaviours congruent with desirable values. Of the many values relevant to social care, high priority has been given to those that give rise to behaviours enshrined within person-centred care (Kitwood, 1997). In the UK, person-centred practices are seen as essential to social care values, forming part of the national Care Certificate and associated architectures (Skills for Care, 2015). Being person-centred has three core behavioural dimensions for care workers: (i) valuing the person and their capabilities, (ii) promoting service user voices in decision making, and (iii) reciprocal relationship with service users and carers (Wilberforce et al, 2018; Wilberforce et al, 2017). If a carer behaves in a person-centred way the care is more likely to be perceived by service users as being kind and respectful to the individual, and hence of high quality (Moriarity et al, 2019; Manthorpe et al, 2017; Pollock et al, 2021). Person-centred care is a values-rich approach to care, and is therefore a promising option to focus new SJTs upon.

This paper aims to describe the development and refinement of a suite of SJTs to assess knowledge relevant to person-centred behaviours and values in home care; and to assess the likely acceptability and feasibility to employers. A secondary aim is to provide a methodological exemplar of how SJTs can be constructed within social care.

**Method**

The core methodological features of this study followed those described within the medical education literature (Tiffin et al, 2020), but with important differences linked to social care’s distinct ethos. A flowchart summarising the four stages is shown in Figure 1.

[Figure 1 about here]

1. Critical incident interviews

In-depth interviews were conducted with homecare workers to elicit detailed narratives of real-life incidents where their values had been tested or stretched. The style of interviews used the critical incident technique (Flanagan, 1954), which is used to gain a thorough understanding of a key events and processes. In this approach, practitioners working in the field of interest are asked to recall a specific incident that went well or went badly, with probes used to examine antecedents, behaviours and consequences of actions. Interviews continue to elicit further examples, prompting for a variety of incidents.

Eligible participants were people working in homecare in England who provided care directly to service users over the age of 65. Homecare workers were purposively recruited via existing networks with employers, advertisements in local newsletters aimed at care providers and via twitter adverts. Specific efforts ensured the sample included male carers and those from Black, Asian or Minority Ethnic groups. As interviews took place during a Covid-19 lockdown all interviews took place either over the phone or using Zoom video conferencing software.

Eleven interviews took place. Interviews began with a narrative introduction to person-centred values, and participants encouraged to discuss examples in practice. All interviews were audio recorded and transcribed for analysis. The transcripts were organised into distinct examples of challenging care, and used to construct draft SJTs. The scenarios were anonymised and were presented in an abstracted form to ensure it contained only relevant information and could be completed by any individual regardless of prior experience of social care. Scenarios were sense-checked through informal and broad-ranging consultations with seven sector stakeholders.

1. Scoring rubric: An expert (by experience) panel

Scoring a situational judgement test is more complicated than scoring a test of ability, or even of a psychological trait, since the appropriateness of answers is subjective and contextually determined (Weekly, Ployhart and Holtz, 2006). Most SJTs use subject-matter experts to reach consensus on optimal responses, using a Delphi procedure (Tiffin et al, 2020). In most instances, experts are adjudged to be experienced clinicians or professionals in the specific discipline under examination. However, in the realm of person-centred care, it is the *service user and family* who are adjudged to be expert, and in keeping with this philosophy, this study drew on people with lived experience. Thus, a modified Delphi process was created (Moreby et al, 2019; Hasson et al, 2000).

A national user-led organisation, with a remit to empower people with lived experiences, was commissioned to lead a two-stage process. In the first, people with lived experiences (together with a family carer if desired) were invited to complete the SJTs together with a researcher, and to voice their opinion on the appropriate response. This was repeated across a number of consultees. On completion, where 70% (an a priori-established threshold, common to ‘Delphi’ consensus approaches, noted in seminal guidance (Hasson et al, 2000)) of subject matter experts agreed on the optimal response to the SJT, this was taken as having reached consensus. Fifteen interviews were undertaken with older people (again representing a mix of gender and ethnicity), and in three instances the primary participant was supported by their spouse.

A second round of the Delphi was held as a collective online discussion, in which participants were presented with the results from the first round. Discussions then focused on those items falling below the 70% threshold, signalling disagreement. SMEs discussed interpretations and together either reached a narrative consensus, or else, determined that no consensus could be reached.

1. Preliminary Pilot

The final stage in the development was a small, pragmatic pilot the tool with a small group of participants. The purpose of this step was a simple ‘sense check’ of the wording and format of the SJTs, and the ability to complete on different devices (including mobile phones with differing operating systems). This sense check was to be conducted from the perspective of a group outside of the research team, and outside of the work environment in which the research team is based. There was no requirement for this group to have specific characteristics, nor was the sample seeking to meet some theoretical range of experiences. Therefore, a convenience sample of 10 people was justified, and recruited via personal networks of the research team. Nevertheless, a degree of purposiveness ensured variation in ages (from early 20s to late 60s), gender (male, female and non-cisgender) and educational attainment (highest qualification ranging from GCSEs to higher degree). Participants in the pilot were asked to complete the initial version of the SJT in Qualtrics and then took part in a debrief with a member of the research team to assess comprehension, time taken to complete and highlight any technical issues with completion.

1. Consultation with home care providers

Alongside the pilot of the finalised tool we wanted to understand how this tool would fit into the recruitment processes already used by home care providers. For the tool to be useful it had to meet the needs of home care providers, in terms of practicality and adding value to existing recruitment processes.

We recruited home-care providers who had expressed an interest when the project was publicised in networks and forums the research team was part of. Initially focus groups were planned, however as research was taking place over zoom against a backdrop of Covid-19 we found it was not possible to convene focus groups, so instead moved to paired interviews. A group interview approach was chosen to allow participants to interact and challenge each other, adding value to the data, balanced out against the availability of participants. Interviews took place over zoom, and were audio recorded and transcribed. Participants spanned managers and HR functions in home care organisations, and social care recruitment specialists employed by local authorities. Interviews could be done with a participant dyad (e.g. agency manager and HR lead together). Interviews took approximately one hour. The data was analysed using thematic analysis to understand how we could facilitate the use of a validated tool for recruitment of home carers. This data was supplemented with fieldnotes from informal discussions with providers and stakeholders held throughout the project life.

Ethics

Ethics permissions were granted by the Department of Social Policy and Social Work Research Ethics Committee (ref: SPSW/S/20/6) at the University of York. All data collection reported on in this paper took place between November 2020 and November 2021.

**Results**

***Constructing SJTs***

The ‘critical incident’ interviews yielded 59 passages providing distinct examples of person-centred principles either being illuminated or challenged. These were organised into one (or more) of the three broad themes of person-centredness noted above. Those viewed as most proximate to a theme were considered for drafting into a refined critical incident. The process continued, with new passages chosen to represent some diversity in terms of the type of social care being portrayed (e.g. different forms of personal care, household support, help with leisure and community participation); different context and setting (e.g. involving other family members); and different service user characteristics (e.g. those living with different causes of impairment such as dementia or frailty; people with different cultural heritage). Efforts were taken to ensure there was no repetition, with passages offering distinct and contrasting examples to earlier passages being preferred when drafting new scenarios.

From these, 19 critical incidents were drafted. The drafting process involved abstraction to ensure that the critical incident was highly attuned to the person-centred value being examined, and would be relevant and comprehensible to all test-takers (e.g. those with no experience as a care worker could engage equally well). In Table 1, this is illustrated in reference to a family member who did not recognise how sitting and conversing with service users can be an important aspect of care work. The original passage was modified to stress the wishes of the service user, and to remove the question as to whether other care tasks were being neglected.

**[Table 1 about here]**

Feasible response options (behaviours or actions to take in response to the critical incident) were created for each critical incident. Test-takers would be asked to evaluate the appropriateness of each response option on a 4-point Likert scale. Candidate response options were also sourced from the transcripts. By way of illustration, one critical incident related to a service user with early stages of dementia who had mislaid an item, but had complained to her employer saying her care worker had stolen it. The care worker initially decided not to say anything, even though her feelings were hurt. Yet in further discussion, the carer said that she later raise the matter since she felt the accusation could impair the care relationship by embedding an anxiety between them. She decided to gently address this with her client, saying she was hurt, and saying that they could have looked together to find the missing item. This appeared to work, with them reaching a shared understanding:

*She took it on board; she wasn’t offended and … she said ‘oh yes, I realise that, I realise that, it’s just that when things go missing and I can’t find them it worries me that things have been stolen’.”*

The 19 critical incidents were then the subject of consultation with a mix of homecare provider managers as sense-checks. Although most appeared successful, several proved problematic. For example, one scenario required background cultural understanding around Islam (and the importance of cleanliness before prayer) which would stray beyond testing values-based care, and would require specific knowledge. A related scenario, requiring test-takers to appreciate the importance of cultural identity, but without needing specific knowledge of any faith, was used instead. In another example, a family dynamic being portrayed appeared too complex for what should be a concise and simple representation of a person-centred value. Wherever possible, problematic scenarios were simplified and clarified in the light of the feedback of our expert panel, but otherwise would be dropped.

In a final review, we considered the balance of gender and ethnicity of the scenarios, and assigned images to support people taking the SJT to visualise the service user. These pictures were obtained from Centre for Aging Better’s free library of positive and realistic images of older people. At the end of the consultation process we had a core of 11 scenarios, with 63 potential response behaviours for test-takers to evaluate. These are summarised in Table 2, with the critical incident for one scenario presented as Figure 2.

**[Table 2 about here]**

**[Figure 2 about here]**

**Development of the scoring rubric**

In total, 15 subject matter experts were consulted to consider appropriate scoring rubric. We asked SMEs whether each response item was a ‘good’ or ‘bad’ action in the situation described by the SJT. Consensus was defined at 70% agreement amongst subject matter experts, and was reached for 38 of the 63 response items (60%) in the first round of individual interviews. For the remaining 25 response items we held a Delphi consultation with 6 of the original 15 contributors to reach a group agreement. During this process agreement was reached for how to score 23 of the remaining items. There were two items where agreement about how to score these items could not be reached and these were therefore left out of the final scored version of the SJT.

**Piloting**

Nine participants took part in the pilot. Participants found the scenarios to be engaging and felt that they were interesting. Those participants with experience of care work felt that the scenarios were realistic in their portrayal of care work. Of those participants who did not have experience of care work, the majority felt that the scenarios increased their interest in care work as a career. Participants generally found the SJT straightforward to complete. Participants used a variety of phones, tablets and laptops encompassing all major operating systems to complete the SJT and no accessibility issues were reported. The test took approximately 15 minutes to complete.

**Usability in existing recruitment process**

Discussions with homecare managers and sector specialists identified several important themes relevant to implementation. First, all participants agreed that values were essential to recruitment, and were already seen as being a central component of their current practices. In emphasising the emotional congruence with care work being sought, one went so far as to say that:

*“[We have] recruited people that cried at interview, because they knew what we were doing, they understood what we were trying to do, by changing lives. And that laid the blueprints of the type of person that we recruit; … we’re here to bring joy to clients and to help them live life to the full”*

However, recruitment processes varied between providers, which reflects the nature of the sector as dominated by small businesses, often with a registered manager and office administrator, but without a specialist HR function *per se*. All providers reported using a combination of phone discussion, application form and face to face interviews to elicit values. However, the interviews highlighted the significant challenges faced in trying to identify whether candidates held the desired values. Several referred to “gut feel” or equivalent instincts, rather than necessarily relying on how they express themselves:

*“I don’t look for certain words really, because if they’re not from the care sector they wouldn’t really know the buzzwords to say. But you get a feeling for the things they’re telling you about who they’ve cared for and, and how they are…So I think you get a good feel for, you know, how caring they are then”.*

However, another stakeholder with experience in HR functions outside social care had reservations about whether recruiting providers had the skills to make such judgements.

*“[There’s a need for help] around the non-verbal communication and also using people’s body language to understand whether people have naturally got these values, or there’s a fabrication identified, or things like that. … but for SME organisations where you’ve got registered managers taking lead on recruitment, I don’t feel that they’ve been given the correct training to be able to identify the non-verbal communication as well as really comprehensively understanding the technique”.*

Interviewees had mixed experiences of using objective toolkits and testing to support values-based recruitment. Reference was made to resources made available by Skills for Care (an English strategic body to support workforce development), which include personality profiling. These were found to be helpful as supplementary information that would be used “*not* *necessarily to decide whether somebody joins or not join but to highlight to them whether care comes natural to them”*. However, after a pilot phase, the resources became proprietary and subject to a fee, and the organisation suspended their use because of high cost.

The interviews highlighted some disagreement over the scope of situational judgement tests and other values-based recruitment tools. Some felt that these should be extended to encompass a wide-range of different values and behaviours – a suite of resources that could be used in a way that would be tailored to the individual role being recruited to. Others had some concerns about the length of testing, and concern it may be off-putting for candidates.

In respect to the specific SJTs developed in the present study, reports were universally positive, with each saying they could be incorporated alongside existing methods for recruitment. One explicitly stated that it would be used to triangulate their evaluation, alongside other evidence of suitability and ‘instinct’. A particular strength of the SJTs was perceived to be in promoting a realistic vision of what care work would be like, and in promoting care careers, especially to people who may not be aware of the different aspects of social care, in a fun and friendly way: “*a little bit of a quiz as a potential advert that might actually generate a different group of people”*. Several providers highlighted the potential for SJTs to be used as induction tools, rather than for recruitment, since they highlighted common dilemmas that care workers may encounter during their work.

One contentious issue identified in some discussions was the apparent discretion and autonomy that the SJTs were implying care workers may have. The notion of ‘judgement’ appeared uncomfortable for some, in a sector dominated by regulatory requirements and organisational policy. Several felt that the most appropriate response to some scenarios would be to seek guidance from the manager or supervisor, rather than *“take matters into their own hands”*. For example, complex care tasks involving more pronounced dementia would require input from senior practitioners who were appropriately trained. Further, several voiced a view that the scenarios may be too simplistic and that care workers should seek further information that would be relevant before responding to the situation – particularly that documented in care plans.

**Discussion**

Care work with older people has a poor public image, dampening recruitment efforts worldwide. Despite international attempts to reverse this, evidence suggest that few inroads have been made. A recent review (Manchha et al, 2021) found that care work with aged populations faces deep stigma, grounded in ageist societal attitudes, and particularly that support of older people is menial and unskilled. One reason proffered is that aged care work is commonly viewed in terms of the ‘dirty work’ and physical tasks involved: washing, dressing, cleaning, moving, feeding etc. Dirty work brings a ‘taint’ (Clarke and Ravenswood, 2018) and feeds a perception that care of older people is socially or morally less attractive than other occupations. These attitudes are reinforced by intensely negative media perceptions of care work that discredits its staff (Manchha et al, 2012; Walker et al, 2019). Attempts to push against this stereotype, presenting care workers as ‘heroic’ or ‘saintly’ seem to bring its own problems, implying that “only a hero or a saint would take this type of job as the working conditions are do bad” (Timonen and Lolich, 2019: p739).

There is scant recognition of the diversity of care work beyond physical activity, including the emotional and social support that intertwine with physical tasks. In truth, care work with older people is complex and highly context-based, requiring its staff to use emotional intelligence and attuned judgements. Interviews with care workers identified many potential scenarios in which values were tested, and demanded real-time judgement calls. The 11 scenarios (Table 1) present care workers facing accusations of theft; helping to find an acceptable way to bathe a person with dementia; balancing issues of risk whilst supporting someone wishing to bake; amongst other challenging scenarios. All would require problem-solving skills and delicate handling, incongruous with the societal image of later life social care.

Interestingly, interviews with employers also indicated that managers were not always comfortable that such judgements were taken in the field. Yet homecare unequivocally involves such dilemmas, and tensions between organisational oversight and workers at the frontline. Other studies have highlighted the routine balancing of tensions and pressures that are inevitable in complex interpersonal work such as care (Leverton et al, 2021). For example, homecare workers in Norway are found to deploy decisions based on ‘situated ethics’, making judgements informed by the specific context in which the decision is taken, more than by governing regulations (Lundberg, 2018). Potentially, these SJTs have an added benefit of making explicit the judgement calls involved in care work.

These SJTs explicitly adopt ‘person-centred care’ as the framework for social care values, mirroring their place in England’s regulatory and training infrastructure. Whilst person-centred care is not a panacea, and cannot be considered a comprehensive values structure, it nevertheless has the benefit of being an internationally-recognised and long-standing concept. The SJTs are oriented to three specific facets of person-centred care, derived from previous conceptual reviews of community care (Wilberforce et al 2017, 2018). As a set of principles, person-centred care has gained global traction as the hallmark of service quality (WHO, 2015), although as a framework for practice, it proves nebulous and lacking clarity (Nolan et al, 2004). The vast majority of research attention has been devoted to residential care, with sparse successful efforts to implement a framework in the community (Ruggiano and Edvardsson, 2013). Specifically, measuring progress towards person-centred care is challenging, with few attempts meeting the standards of modern psychometrics (Wilberforce et al, 2018). An interesting feature of SJTs is that they enable a specific measurement of the workforce trait of interest, since test-takers receive a score based on their answers. Subject to satisfactory psychometric assessment, the SJTs presented here could be used evaluatively, to assess the extent to which person-centred values are held across the workforce in any particular service. Further research could examine the suitability of using SJTs in this way.

How employers might adopt the SJTs must be set in context of chronic worker shortages, as highlighted in the opening to this paper. Such is the scale of this challenge, arguably employers are not seeking a means for ‘screening out’ potential candidates. There may be some truth to this position: certainly, SJTs in the context of applications to medical school (wherein the number of applicants greatly exceeds the supply of places) are influential because of the need to be highly selective. Nevertheless, two counterarguments can be considered. First, regardless of the low supply of care workers, there is nevertheless the need for high standards in care, both to satisfy inspection by regulators, and also to successfully attract clients and local government contracts. Most employers recognise that the calibre of the care worker is pivotal to delivering successful outcomes, and there is a high reputational risk to employing sub-standard staff. Analysis of SJT scores in medical school selection finds a negative relationship between scores on admission and later disciplinary action for misconduct as qualified doctors (Tiffin et al, 2022). Given that domiciliary care workers in England operate without professional oversight or registration, without close supervision, in the homes of often vulnerable older populations, the case for caution and additional scrutiny in recruitment is perhaps warranted.

Second, even where SJTs are not used to ‘screen out’ candidates, it is perhaps better to recruit staff in full awareness of where an individual’s values may be mis-aligned to care work. This would enable closer attention to training, induction and onward supervision, and potentially further appraisal of suitability of care work after a probationary period. Some providers we interviewed noted that the SJTs could be used in induction or training. Indeed, the authors later learned that the SJTs used in the research had been taken by one interviewee and used at a subsequent training event with success. The literature is only recently turning its attention to SJTs as a tool for formative assessment: identifying needs for further learning and understanding (Sahota et al, 2023). A study of training for disaster relief workers found that incorporating SJTs into formal taught sessions led to greater mastery of the content (Cox et al, 2017), but the true range and potential of SJTs for training remains largely untested. Further research may be warranted.

Some limitations need to be considered. First, all SJTs face a degree of uncertainty over what they actually evaluate (Tiffin et al, 2020). Our implicit assumption within this paper is that our SJTs assessed procedural knowledge of behaviours relevant to person-centred values. However, further validity evidence would be required to test this assumption. More broadly, the data presented here do not supply evidence on the overall psychometric properties of the SJT. Since SJTs are a form of measurement, it is natural to expect any appraisal of their worth to include inspection of both validity and reliability. That work is underway at the time of writing, and assessment of test-retest reliability and convergent validity with personality-measure derived scores will follow. Also, the use of service users in creating the scoring key for SJTs is a methodological advance, but introduces some complexity. There are fewer guarantees that providers using these SJTs would agree with the scoring system had a panel of professionals been used. However, person-centred care demands that users lead decisions relating to their care, and to use any other panel of experts would have been contrary to the very values the SJTs sought to appraise. Thus, it seemed most appropriate to put the user and carer perspective at the heart of development. Indeed, the user and carer voice has previously been noted to be often absent from debates about professionalism in healthcare (Aylott et al, 2019).

In conclusion, this study presents the feasibility of the design and usability of Situational Judgement Tests in social care. In keeping with the ethos of social care, methodological changes could provide a more inclusive role for people with lived experience, acting as the ‘subject matter experts’ when devising a scoring rubric. The SJTs are now being quantitatively evaluated to examine their psychometric properties. If promising results are achieved, further examination of SJT implementation in social care practice would be warranted.

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