IO 1 HCEU Competence Matrix ‘Elderly Care’ (Draft) – Readers Manual

Authors: Tanja Bacher & Sabine Schwenk (3s research laboratory)

With contributions from: DEKRA Adademie Gmbh (DE), TEI-A (HE), DEKRA Akademie Kft. (HU), Jagiellonian University (PL), Polish Nurses Association (PL)

Date of finalization 01/2016
Version 1
www.project-hceu.eu

Co-funded by the
Erasmus+ Programme
of the European Union

The HCEU project

More than any other sector the healthcare sector is already today dependent on the mobility of workers from across Europe and even on an international scale in order to overcome skill shortages that are strongly influencing this sector in EU Member States. So far the mobility of skilled workers is strongly hindered by highly complex and time consuming validation and recognition processes and by missing transparency among healthcare qualifications in the European Member States. HCEU makes a major contribution towards transparency of healthcare qualifications across borders and facilitates processes to formally recognise and validate healthcare qualifications acquired abroad as well as through in- and non-formal learning within different healthcare recognition and validation systems in the European Union.

For this purpose the HCEU consortium makes use of the highly awarded and already in many cases practically applied VQTS model. The VQTS model does not focus on the specificities of national VET systems but uses learning outcomes and work processes to enhance transparency. It provides a 'common language' to describe competences and their acquisition and a way to relate these competence descriptions to concrete qualifications/ certificates and competence profiles of individuals. The VQTS model relates on the one hand to the work process and follows on the other hand a 'development logical' differentiation of a competence profile. This makes it an ideal and comprehensive tool to appreciate the lifelong learning of healthcare professionals in the context of formal recognition processes.

Based on this approach HCEU develops VQTS matrices, profiles, tools and instruments for the healthcare profiles 'nurse' and 'carer for the elderly' for the national contexts of the project partners and in order to facilitate recognition praxis in between those European Member States. In addition HCEU develops transfer kits in order to facilitate the transfer of those tools also to other national (within and beyond Europe) contexts and to other fields within healthcare. Those tools are expected to make a major contribution to the work of VET providers and recognition bodies/authorities involved in transnational mobility of healthcare professionals. In this way HCEU facilitates the establishment of a European labour market that helps to overcome skill shortages and high unemployment rates through fostering mobility of healthcare professionals across the European Member States.

Project coordinator:

DEKRA

DEKRA Akademie GmbH
B2 Business Development International
Handwerkstrasse 15, 70565 Stuttgart (DE)

Project contact:
Claudia Ball (claudia.ball@dekra.com)

Project website:
www.project-hceu.eu

Co-funded by:

Co-funded by the Erasmus+ Programme of the European Union

ERASMUS+/ KA 2/ Strategic partnerships
Project duration: Sep 2015 – Aug 2018
ERASMUS+ grant agreement no:
2015-1-DE02-KA202-002316

Contents

Introduction

This report summarises the approach applied for developing the HCEU competence matrix in elderly care and should provide the reader with information on how to read and use the HCEU “Elderly Care” Competence Matrix.

One objective of Intellectual Output 1 (IO 1) of the HCEU project is to develop a Competence Matrix for the occupational field of elderly care that displays work-related competences and competence development steps of elderly care givers in the project countries Austria, Greece, Hungary, and Poland. The usage of work-related competences enhances the transparency of competence profiles of a training programme, a qualification as well as of a person in training and therefore supports the understanding between the world of education and the world of work as well as between countries.

The HCEU Competence Matrix “Elderly Care” is based on two sources: First, on the NoBoMa Competence Matrix “Elderly Care” which was developed in a European Leonardo da Vinci project (2011 – 2013). Second, a validation process on the NoBoMa Competence Matrix conducted within the HCEU project. On the basis of the results of this validation process the NoBoMa Competence Matrix was revised and condensed, so that it fits the purpose of the HCEU project and the job realities of elderly care givers in the HCEU project countries.

In the first chapter of this report the VQTS model – on which the competence matrix is based – is presented. Chapter 2 provides an overview on the methodology applied for developing the competence matrix, the scope and introductions for interpreting and reading the HCEU Competence Matrix “Elderly Care”. Chapter 3 comprises the HCEU Competence Matrix “Elderly Care”.

1 The VQTS model

Comparing training programmes and understanding qualifications from the VET systems of other countries is one of the primary education and training challenges in Europe, as there are various established national approaches, concepts, and traditions for designing and describing qualifications. The VQTS model is one approach to tackle this incomparability by focussing on work processes (Luomi-Messerer 2009, p. 10-11)[1].

The VQTS model assumes that although there are differences between national approaches in how training is offered and organised, it is possible to identify many similarities in the tasks of modern work processes. For example, different professions in different countries tend to apply similar material, technologies, and processes. Thus, occupational requirements, the core work tasks including the required vocational or professional competences in a respective occupational field, are often easier to compare than different national training programmes in terms of achieving the required competences. Therefore, "the VQTS model provides a 'common language' to describe competences and their acquisition and also offers a way to relate these competence descriptions to the competences acquired in training programmes" (ibid., p. 10-11). The VQTS model uses a 'development logical' differentiation of competence profiles and can be used for describing the acquisition of competences. The core elements of the VQTS model are the 'Competence Matrix' and 'Competence Profiles'. In the following, these two elements are described in more detail.

1.1 Competence Matrix

The main aim of a Competence Matrix is to enhance transparency of competences and qualifications and to foster mutual understanding between different countries and different contexts in the comparison of qualifications. In a Competence Matrix, learning outcomes related to an occupational field are presented in a table. The vertical axis of the Competence Matrix contains the 'competence areas', based on the various core work tasks of the respective professional field. The horizontal axis shows the 'steps of competence development' described in the form of learning outcomes, which indicate the progress of competence development from beginner to expert. The learning outcomes are described as professional competences which provide information about which core work tasks a person is able to carry out in a specific work context (Luomi-Messerer 2009, p. 10f).

When developing a Competence Matrix, several aspects have to be taken into consideration. First, the occupational field in which the Competence Matrix is to be developed must be selected and the professional and educational profiles that will be included in the matrix should be determined. Second, experts should be involved in the development process.

Experts that should be consulted are experts who are able to provide support in applying the VQTS methodology, as well as practitioners from the occupational field (from both the world of work and the world of education) from different countries, to ensure that transnational

[1] The VQTS model was initially developed in the Lifelong Learning project 'VQTS' (Vocational Qualification Transfer System) and was further refined in the follow-up project 'VQTS II'. Cf. http://www.vocationalqualification.net/ (08.01.2016).

competence areas (core work processes) and steps of competence development are identified effectively. Third, the competence areas of the respective occupational field should be defined. As mentioned above, the foundations of these competence areas are core work tasks which are comprehensive tasks undertaken by an individual within the work context of the respective occupational field. Rather than drawing on subjects from traditional subject-based curricula, the core work tasks should be derived empirically from the working world (work practice/work place). A varying number of competence areas are to be defined on the basis of the work tasks, depending on the complexity and range of activities or job opportunities within the respective occupational field. Fourth, the competence development steps for each competence area are to be described. Competence development steps illustrate the process of progression from the lowest to the highest step of competence development. Between two and six successive competence development steps should be defined, depending on the complexity of the respective competence area. Therefore, no concrete number of steps can be pre-determined. This means that the steps only make sense within one single competence area (horizontally), and the numbers of steps of competence development for one competence area do not necessarily correspond with the steps of another (ibid., p. 15).

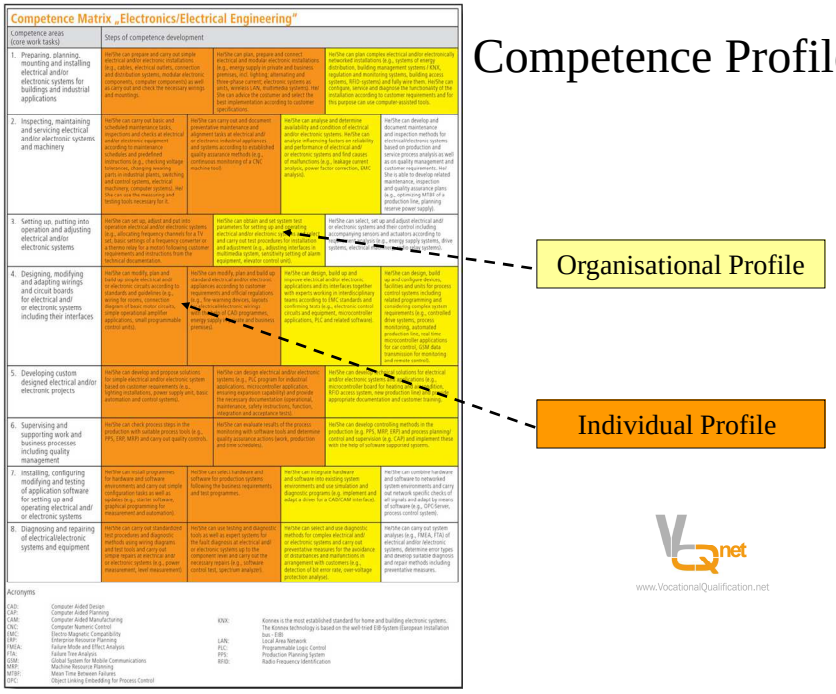
A Competence Matrix is a flexible instrument as major changes in the respective occupational field can be accommodated and acknowledged by adding or removing elements, or undertaking a restructuring process. The titles of the competence areas should be chosen in such a way that they promote mutual understanding and are comprehensible to experts working in the occupational field (ibid.).

1.2 Competence Profiles

Through the use of a Competence Matrix, competence profiles can depict the stages of competence development to be achieved throughout a training programme, or the stages already achieved by a learner or a graduate of a training programme. These profiles are formed from particular parts of the matrix and generally cover a limited range of the total competences described in the matrix. The competence profiles are developed by identifying the competences that are part of a specific training programme or qualification (Organisational Profile), or by reflecting the competences already acquired by a person currently in training or having completed a programme or qualification (Individual Profile). The competence profiles refer only to the competences described in the Competence Matrix (ibid., p. 44).

The development of competence profiles requires an interpretation against the background of the specific training and work context. The crucial issue is how well a curriculum or training plan can be mapped in the Competence Matrix. Since the competences described in the Competence Matrix are derived from work processes and are not explicitly related to specific subjects of a curriculum or a training plan, the mapping process is easier in cases in which a training programme or qualification is developed and described in a competence-based or learning-outcomes-based manner.

Table 1: Competence Profiles



Source: 3s research laboratory.

1.2.1 Organisational Profile

The Organisational Profile represents the breadth and scope of competence development that can be achieved within a specific VET programme. Organisational Profiles indicate the 'relevant' competences of the specific training programme in the Competence Matrix. In this context, 'relevant' means that learners (participants of the particular training programme) will acquire the competences indicated in the Organisational Profile.

Typically, Organisational Profiles are developed by the authorities responsible for a training programme. Those involved in the development process, should have in-depth knowledge on the curriculum or training plan as well as a strong understanding of the core work tasks expected of a graduate of the respective training programme. Therefore, the development of Organisational Profiles should include the participation and input of individuals involved in the training process (for example, teaching and training personnel or people with similar functions), representatives from the working world, and graduates or persons in training).

1.2.2 Individual Profile

An Organisational Profile helps to identify the competences that will be/have been acquired by a learner or graduate of a particular training programme. An Individual Profile however, allows for the identification of competences already acquired by an individual at their current

stage of learning. Teaching and training personnel familiar with the competence development process during the training programme should be involved in terms of indicating the Individual Profile in the Competence Matrix. The Individual Profile can be developed at any time during training, and could perhaps be undertaken at the end of semesters when examinations are conducted, as this could prove a useful indicator in evaluating the competences already acquired by a learner.

2 Methodology and scope of the HCEU Competence Matrix "Elderly Care"

In the following sub-chapters the methodology for developing the HCEU Competence Matrix "Elderly Care" and the scope of the competence matrix are specified.

2.1 Methodology

The HCEU Competence Matrix "Elderly Care" (see chapter 3) displays competence areas (vertical axis) and competence development steps (horizontal axis) in the occupational field of elderly care. The development of the HCEU Competence Matrix "Elderly Care" was based on two main sources: First, on a Competence Matrix for "Elderly care" already developed in the European Leonardo da Vinci project "NoBoMa"[2] and second on a validation process of the NoBoMa Competence Matrix "Elderly Care" organised by the HCEU project consortium.

The NoBoMa Competence Matrix "Elderly Care" was developed by the NoBoMa project partnership between 2011 and 2013[3]. The Competence Matrix is based on intensive desk research and literature review in Elderly Care and project results of similar European projects as well as on analyses of national curricula of elderly care training programmes and job profiles in the respective project partner countries. The following resources have been analysed for developing the competence matrix:

- American Association of Colleges of Nursing (2010). *Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults. A Supplement to 'The Essentials of Baccalaureate Education for Professional Nursing Practice'*.
- Benner, P. (1994): Stufen zur Pflegekompetenz. From novice to expert. Bern: Hans Huber-Verlag.
- Klein, B.; Gaugisch, P.; Stopper, K. (2008). „Pflege 2015": Neue Arbeitsanforderungen und zukünftige Qualifizierungsbedarfe. Hans-Böckler Stiftung und ver.di.

[2] 'No Borders Manual in elderly care to promote mobility , international lifelong learning and the transfer of competences in Eastern, Central and South-Eastern Euope'. Cf. http://3s.co.at/en/node/1035 (08.01.2016).
[3] Participating countries were Austria, Bulgaria, Romania, Slovenia and Hungary. 3s research laboratory was one of the Austrian project partners.

- Luomi-Messerer, K. (eds.) (2009): Using the VQTS model for mobility and permeability. Results of the Lifelong learning project VQTS II. Vienna: 3s Unternehmensberatung.
- Luomi-Messerer, K.; Markowitsch, J. (eds.) (2006): VQTS model. A proposal for a structured description of work-related competences and their acquisition. Vienna: 3s research laboratory.
- Petek, Cäcilia (2011). Projektbericht Kompetenzmodell NEU für Pflegeberufe in Österreich, erarbeitet vom ÖGKV Landesverband Steiermark. In: Österreichische Pflegezeitschrift, 11/2011.
- Sahamel, K-H. (2011). Wandel der Pflege – Neue Kompetenzen für Pflegekräfte. Vortrag auf der Tagung der Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege am 16.2.2011 in Berlin.
- National curricula and job profiles in the NoBoMa project countries (Austria, Bulgaria, Romania, Slovenia and Hungary).
- Pro Care Career Project (2011). Individuelle Durchlässigkeitskarrieren im Sektor der Altenpflege und Medizinpflege. Leonardo da Vinci, Transfer of Innovation, 2011. Online: http://www.pro-care-career.de/en/wunschland-en.html (11.01.2016).
- Proper Chance (2011). Die Implementierung von ECVET im Bereich der Gesundheits- und Sozialpflege mit dem Ziel der Förderung beruflicher Durchlässigkeit und Mobilität. Leonardo da Vinci, Transfer of Innovation, 2011. Online: http://www.proper-chance.eu/website_english.html (11.01.2016).

In a further step, a draft of the NoBoMa Comptence Matrix “Elderly Care” was developed and validated by undertaking interviews and expert workshops with elderly care experts in the NoBoMa project countries (Austria, Bulgaria, Romania, Slovenia and Hungary). These sources lead to the final version of the NoBoMa Competence Matrix “Elderly Care”.

Within the HCEU project the NoBoMa competence matrix was used as a basis that should be validated and further developed to serve the purposes of the HCEU project. For the purpose of validating the NoBoMa competence matrix within the HCEU project countries, 3s research laboratory developed a validation interview questionnaire along with interview instructions and recommendations for carrying out the interviews which were sent to the HCEU project consortium[4].

The target group for the validation interviews were defined to be professionals and experts active in the field of elderly care (e.g. elderly care givers, employers in the elderly care sector, vocational education and training providers in the field of elderly care, social partners, national authorities and competent bodies, etc.). The validation process started in October 2015 and lasted until November 2015 and was conducted in four of the HCEU project countries (Germany, Greece, Hungary and Poland). For each country five validation interviews were required. At the end of the validation phase, 3s research laboratory (3s)

[4] The questionnaire for the validation of the NoBoMa Competence Matrix “Elderly Care‘‘ asked for basic information on the interviewees (contact data, professional background, professional function) and for general feedback on the eight competence areas of the NoBoMa Competence Matrix “Elderly Care”. Furthermore, the eight NoBoMa competence areas were presented in detail with all competence development steps and the interviewees were asked whether they agreed with the description of the working tasks or if they wanted to change or add anything.

received a total of 20 interviews.

As a next step, the interview results were analysed by 3s research laboratory. Most of the proposals for the modification of the NoBoMa Competence Matrix “Elderly Care” were accepted, though some proposals could not be implemented for different reasons (e.g. they represented singular opinions, they represented a point of view from a pure medical/nurse perspective, some modifications or proposals for working tasks of elderly care givers were too detailed or unclear). The results of the validation process of the NoBoMa Comptence Matrix “Elderly Care” resulted in the first version of the HCEU Competence Matrix “Elderly Care” which was then subject to a final review concerning wording and inner logic of the Competence Matrix (see chapter 3).

2.2 Scope of the HCEU Competence Matrix “Elderly Care”

The HCEU Competence Matrix displays work-related competences of elderly care givers who are described as people who care for the elderly. These can be individuals in training who have already gained some practical experience of caring for elderly people (e.g. who have cared for relatives or have already worked as health care assistants or have done an internship) or experts in the field of “Elderly Care”, notwithstanding whether they have gained this expertise through the completion of an advanced training programme (e.g. Master Studies in “Nursing Science” in Austria), or through several years of work experience in the field of elderly care.

In order to make the competence matrix readable, easy to understand and useful for training providers and employers, it is important to note that only a limited amount of information can be provided. The HCEU Competence Matrix “Elderly Care” should allow to grasp the scope of the occupational field “Elderly care” at one glance and to get a quite swift overview over the important competence areas and steps of competence development. More detailed information on the occupational field will be provided once the HCEU “Elderly Care” Competence Matrix is expressed in learning outcomes which is foreseen in Intellectual Output 3 of the HCEU project.

The HCEU Competence Matrix “Elderly Care” comprises eight competence areas with work-related competence descriptions (vertical axis of the Competence Matrix) and between three and six steps of competence development (horizontal axis) for the occupational field of an “Elderly Care Giver” in Austria, Germany, Greece, Hungary, and Poland (see chapter 3).

2.2.1 Competence areas of the HCEU Competence Matrix “Elderly Care”

1. Planning and conducting daily care

This competence area refers to direct care activities which include, for example, ensuring the personal hygiene of elderly clients, providing support in daily living activities (dressing and

undressing, combing hair, assistance in using the toilet, etc.), mobilisation of the client or guidance for self-care and a number of psycho-social activities (e.g. reading, playing music, singing etc.).

2. Planning and carrying out nursing activities

This competence area refers to nursing activities. These include, for example, the ability to perform simple medical procedures (e.g. measuring blood pressure, wound management, taking blood samples, etc.), the ability to identify the most common disease patterns of elderly people, and the ability to read and understand medical documents (e.g. care instructions from medical professionals etc.).

3. Creating and maintaining a health promoting and safe environment

Several different elements are included in this competence area. Material aspects such as the ability of an elderly care giver to recognise and avoid possible dangers for elderly people (e.g. preventing them from falls), or the ability to decorate or clean the room of an elderly client so it has an inviting and health promoting atmosphere fall under the working tasks relevant in this competence area.

4. Communicating with different stakeholders involved in the care process

This competence area comprises several communication and cooperation/interaction flows. These include, for example, the ability of the care giver to interact and communicate with elderly people in general, the ability to mediate between doctors and clients (e.g. explaining a care plan to an elderly person and relatives), and the ability to consult family and relatives with regard to future actions, etc.

5. Recording, evaluating and assuring the quality of the care process

Administrative and organisational tasks are incorporated in this competence area, particularly activities such as creating care plans, recording the care process or review care plans.

7. Managing the process of care

The ability to instruct colleagues or apprentices, the mobilisation and coordination of resources, and taking a lead in managing care processes are subsumed within this competence area.

8. Expanding and regularly updating skills and knowledge

This competence area includes further and continuous training measures for care givers: that the care giver has the ability to identify and communicate his/her own training needs or that

he/she takes part in theoretical as well as practical training measures in order to keep his/her knowledge up-to-date.

9. Reflecting and handling the impact of the job (job-related self-understanding)

This competence area deals with the health of the care giver (their physical as well as mental health). It includes competences that address issues such as how to handle closeness and distance, stress- and burn-out-prevention, the development of coping strategies, participation in supervision activities, and knowing and acknowledging one's own limits.

A challenge in the process of defining the competence areas was the positioning of crossover competence areas such as personal, social, and intercultural competences as well as empathy. Although social, personal, and intercultural skills and empathy seem to be very important for the "Elderly Care Giver" profession, they are not described as distinct competence areas, because these skills are inherent in the respective descriptions and should be integrated in the general care process. Therefore, social and personal skills (like stress resistance, empathy, active listening, patience, psycho-social skills etc.) are integrated in the context-related descriptions but do not form competence areas of their own. Furthermore, the acceptance of responsibility and quality awareness are integrated in the occupational competences (competence development steps), as without these competences work tasks could not be executed in a manner that indicate professional ability (cf. Luomi-Messerer, 2009, p. 24).

2.2.2 Competence development steps of the HCEU Competence Matrix "Elderly Care"

For each competence area competence development steps have been defined which comprise the horizontal axis of the HCEU Competence Matrix "Elderly Care". In total, between three and six successive competence development steps have been identified for each competence area, illustrating progression from the lowest to the highest step of competence development. The first competence development step of the HCEU Competence Matrix "Elderly Care" refers to individuals in training who have already gained some practical experience of caring for elderly people (e.g. who have cared for relatives or have already worked as health care assistants or have done an internship). The final competence development step refers to experts in the field of elderly care who gained their expertise either through the completion of an advanced training programme (e.g. Master programme in 'Nursing Science' in Austria) or through several years of work experience in the field of elderly care.

2.3 Information on interpreting the HCEU Competence Matrix "Elderly Care"

Although the descriptions included in the competence matrix reflect higher autonomy and responsibility on the higher steps of competence development, they do not include aspects of legal regulatory legitimacy. Especially for workers in the health care sector this depends

greatly on national regulations which are not displayed in the competence matrix, but are of course important for working as an elderly care giver in a respective national context. In the HCEU competence matrix we therefore refer to be able to apply legal requirements, but do not specify them as these vary from country to country (Luomi-Messerer 2009:50).

Please note that not all competence areas, respectively competence development steps have to be part of the national profile of an elderly care giver. For example competence area 2 “Planning and carrying out nursing activities” is not relevant in all countries of the HCEU project. For example in Poland elderly care givers are not allowed to undertake any medical treatment not even simple ones on the patient, this is done by nurses, doctors or social workers. Furthermore, not all steps of competence development must form part of the national profile. For example it might be that the higher steps of competence development are not part or that some of the working tasks described in a respective competence area do not form part of the job and qualification profile of a country.

Therefore, countries and education providers can use the competence matrix to indicate their organisation (national) profile by indicating which parts of the matrix are part of the national job and qualification profile and which are not. This also helps to compare one’s own situation with the situation in the same occupation in another country. This step will be undertaken in the Intellectual Output 4 of the HCEU project.

2.4 Reading the HCEU Competence Matrix “Elderly Care”

A Competence Matrix should always be read comprehensively. This means that the title of a competence area should not be seen on its own nor should one only make conclusions based on single key words, but rather the description related to the entire core work tasks should be read.

When reading the HCEU Competence Matrix “Elderly Care”, the description of higher steps of competence development must always be viewed along with the previous steps of competence development. Thus, higher competence development steps should be understood as including the competences described in lower steps. Only in cases where a specific work task described in a lower competence level has a different characterisation in a higher competence development step, this task is repeated in the higher step.

Whereas the steps of competence development are presenting an order of their necessary development, the sequence of competence areas does not indicate the competence acquisition process (Luomi-Messerer 2009:48f).

3 HCEU Competence Matrix "Elderly Care"

Competence Area	Steps of Competence Development Basic level → Expert level				
Professional skills and task related competences (Steps of competence development)					
1 **Planning and conducting daily care**	1.1.a To support the client in daily duties and hygiene (e.g. cleaning bed, toilet duties, nutrition).	1.2.a To carry out basic body care procedures, personal hygiene and daily activities with guidance.	1.3.a To carry out body care procedures, personal hygiene and daily activities.	1.4.a To supervise body care procedures.	
	1.1.b To apply care plans on the basis of the identified care needs/ diagnosis and by considering the needs of clients with guidance.	1.2.b To apply care plans on the basis of the identified care needs/ diagnosis and by considering the needs of clients.	1.3.b To develop care plans according to the identified care needs and diagnosis (e.g. select methods, techniques, tools and forms of implementation of the care plan).	1.4.b To select and implement therapeutic interventions by reflecting theories and practical observations.	1.5.a To conduct special intervention based on evidence in the caring process (e.g. being aware of professional and legal guidelines and protocols, counselling in special situations).
	1.1.c To be informed on legal requirements (e.g. patients' rights, ethical standards, health law, and moral rules of etiquette).	1.2.c To apply legal requirements (e.g. patients' rights, ethical standards, health law, and moral rules of etiquette).	1.3.c To take responsibility for the implementation of care based on professional and legal requirements.		
	1.1.d To know about psychological impacts on health and to be able to provide, motivate and support creative elements (e.g. singing, reading, cognitive exercises) in the care process.	1.2.d To plan and carry out multiple social activities with the client at home and outside (e.g. diabetes club, non smokers club etc.).	1.3.d To implement care processes facilitating the health promotion (prevention) and the independency of the client (e.g. motivating clients for independency or providing guidance for the personal well-being of clients).	1.4.c To apply adequate care utilities (e.g. applying incontinence equipment, hearing and visual aids, mobility aids).	1.5.b To decide when a sub-division of tasks is necessary considering parameters such as relevance of needs, clinical situation and qualification.
	1.1.e To identify critical situations for the client and ask for help (e.g. change in health status, accidents, conflicts).	1.2.e To report unforeseeable and modified situations to superiors knowing how and to whom to report to (e.g. basic symptoms, accident hazards, family conflicts, crises, deterioration of nutritional status, pain).	1.3.e To react adequately to unforeseeable situations (e.g. by giving instructions how to react).	1.4.d To plan, evaluate and, when necessary, to change resources which maintain quality of life, well-being, health and social integration situations (e.g. financial resources, physical assets and family/household resources, risk management, care in case of apoplectic stroke, fall injury).	
2 **Planning and carrying out nursing activities**	2.1.a To apply nursing instructions from superiors (e.g. to measure blood pressure, etc.).	2.2.a To make simple diagnoses (e.g. change of skin; identify health status that is out of the norm).	2.3.a To recognise common disease patterns of the client (e.g. cardiac, infective diseases).	2.4.a To create structural changes to prevent diseases from spreading (e.g. coordinating and organizing the dissemination of infection control masks, to manage health promotion programs and health care programs, developing a hygiene guideline and emergency actions).	
	2.1.b To support superiors to carry out monitoring, provision of medication and wound nursing with regard to basic hygiene rules.	2.2.b To provide medication and wound nursing with regard to basic hygiene rules.	2.3.b To perform monitoring of provision of medication and wound nursing with regard to basic hygiene rules.		

	2.1.c To consider current legislation and local rules regarding the workplace, medical instruments and contaminated waste, health and safety measures and to inform superiors in case of discrepancies.	2.2.c To care, clean and disinfect medical equipment.	2.3.c To ensure adequate storage, handling and recording of therapeutic substances.	2.4.b To maintain current regulations and local rules regarding the disposal of sharp medical instruments, contaminated waste in the work area, and personal protective equipment and to be actively involved in the regular re-evaluation of the process.
	2.1.d To start first aid.	2.2.d To apply first aid.	2.3.d To respond immediately and appropriately to emergencies and disasters, and to begin, if necessary, with basic life support and other emergency measures.	2.4.c To develop emergency plans and overtake coordination in case of emergency (e.g. coordinating and organising the dissemination of infection control masks, to manage health promotion programs and health care programs, developing a hygiene guideline and emergency actions).
3 **Creating and maintaining a health promoting and safe environment**	3.1.a To create and maintain a health promoting and safe environment (e.g. arrangement of the room, basic cleaning, prevention of falls and accidents).	3.2.a To judge the safety conditions of the living environment by following the relevant criteria and to be able to report possible dangers to colleagues or superiors.	3.3.a To avoid situations that might have a negative impact on the security of clients and colleagues.	3.4.a To choose instruments for the assessment of existing and potential security risks, to apply them and to inform the relevant authorities.
	3.1.b To be informed on applicable laws and local rules regarding the safety of the workplace.	3.2.b To proceed according to applicable laws and local rules regarding the safety of the workplace.	3.3.b To advise team members in creating and maintaining a health promoting and safe environment (e.g. promoting health promotion programmes, applying risk management and safety procedures in case of fall, infection).	3.4.b To be actively involved in the development of regulations in the work place (e.g. safety measures, health promotion programmes, etc.).
	3.1.c To identify the needs of clients with respect to the arrangement of their rooms.	3.3.c To participate in arranging and furnishing residential areas which satisfy the demands of clients, including provision of care utilities.	3.4.c To arrange the environment of clients to facilitate autonomy in the activities of daily living.	
4 Communicating with different stakeholders involved in the care process	4.1.a To communicate with clients and relatives and to be able to give them information in an appropriate way (e.g. about care products, care services, homes for elderly people, etc).	4.2.a To provide information about the care process to clients and families and to inform the client on aspects of the care plan.	4.3.a To inform and educate clients and verify that the information has been understood.	4.4.a To lead and accompany consulting and empowerment processes for the client and his/her social environment (e.g. relatives, municipalities, governments, NGOs).
	4.1.b To build, maintain and finish verbal and nonverbal (e.g. touching) interpersonal communication through empathy and appreciation .	4.2.b To explain basic health diagnoses to the client and his/her family (e.g. high or low blood sugar, skin problems, etc.).	4.3.b To initiate and terminate stakeholder-oriented relationships by using professional communication methods.	4.4.b To professionally intervene in crises.
	4.1.c To choose and apply the right methods of communication according to the institutional environment (e.g. home-care or nursing home).	4.2.c To recognize crises (e.g. psychological or physical) and to inform superiors and seek support from methodically competent persons.	4.3.c To identify communication barriers and conflicts, to apply solutions and to perform mediation.	4.4.c To advocate for clients, families or carers requesting support or having language barriers or limited abilities in decision-making.
	4.1.d To collaboratively work in inter-professional teams (e.g. elderly care givers, nurses, doctors, etc.).	4.2.d To network with professionals and ordinary persons (e.g. relatives of the client, colleagues who support the care process).	4.3.d To lead and guide inter-professional teams.	4.4.d To communicate effectively within the team and to develop, implement, and evaluate mechanisms for optimising the processes of professional cross-group collaboration.
5 **Recording, evaluating and assuring**	5.1.a To assist superiors in creating care plans.	5.2.a To gather health data (e.g. weight, temperature, blood pressure, blood sugar) and to transmit data for	5.3.a To determine a care plan on the basis of a diagnosis by using data from different	5.4.a To regularly review, revise and adapt the care plan.	5.5.a To control care plans, evaluate them and supervise other staff members in the	

quality of the care process		the assessment by generalists and specialists for developing the care plan.	sources.		care planning process.	
	5.1.b To conduct basic administrative work by using common paper or computer-based documentation systems.	5.2.b To record the care process and report changes.	5.3.b To evaluate progress towards planned outcomes in consultation with clients, families and/or professionals and to use evaluation data to modify the care plans.	5.4.b To order diagnostic tests and procedures permitted in the scope of specialist practice and legislation		
	5.1.c To have a basic understanding of quality standards and quality criteria in care.	5.2.c To apply quality standards and criteria in care work.	5.3.c To document findings, interventions and patient responses accurately complying with professional standards and organisational policies (e.g. using the nursing documentation in effect).	5.4.c To be specialised in systematic health and nursing assessments (e.g. professional guidelines, care protocols).	5.5.b To develop and maintain quality management systems within the care process or in institutions .	5.6.a To introduce assessment tools into praxis by considering the context of nursing sciences methods and to delegate the change of care interventions if necessary.
6 **Managing the processes of care**	6.1.a To instruct colleagues and apprentices and to work and coordinate inter-professional teams (e.g. setting priorities).		6.2.a To mobilize and coordinate human resources and to take the lead role in managing the care process.		6.3.a To manage a care division and to make staff decisions.	
	6.1.b To be informed on the "case management" approach in the care process.		6.2.b To apply the "case management" approach in the care process.		6.3.b To continuously estimate the needs of clients and client groups as well as available financial, material and staff resources, and the organisational development.	
Personal attitudes of an elderly care giver (competence areas 7 – 8)						
7 **Expanding and updating skills and knowledge**	7.1.a To recognize one's own training needs and to motivate oneself for trainings.	7.2.a To adapt existing skills to new technological developments.		7.3.a To communicate new empirical knowledge to colleagues and be able to implement it.		
	7.1.b To be willing to frequently choose and attend formal education measures.	7.2.b To communicate one's training needs to a supervisor.				
	7.1.c To support superiors in research projects.	7.2.c To interpret and evaluate research findings critically.		7.3.b To acquire and manage research projects.	7.4.a To create new empirical knowledge in the field of nursing sciences.	
8 **Reflecting and handling the impact of the job (job-related self-understanding)**	8.1.a To recognize one's own limits and to abide them.		8.2.a To communicate one's own health needs to carry out the job as a care giver.			
	8.1.b To recognize psychological impacts on one's own health.		8.2.b To pay attention to one's own limits and maintain professional distance and to look for professional help (e.g. methods of supervision).			
	8.1.c To be aware of symptoms of burn-out.		8.3.c To apply methods of burnout prevention an use available tools for assessing burnout.		8.3.a To produce new knowledge about prevention and management of burnout.	

For further information on this publication please get in touch with:

Sabine Schwenk
3s research laboratory

Wiedner Hauptstraße 18, 1040 Wien
E-mail: schwenk@3s.co.at
Telephone: +43 1 5850915-54
URL: www.3s.co.at