FINAL VERSION

Competence Matrix "Elderly Care"
&
International Future Competence Matrix of Success "Elderly Care"

NOBOMA - *No Borders Manual* in elderly care to promote mobility, international lifelong learning and the transfer of competences in Eastern, Central and South-eastern Europe

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Introduction

For some years now the European Commission has sought to strengthen transparency and comparability of VET (Vocational Educational and Training) within the European Union. With the Lisbon Strategy (2000)[1], vocational education and training became a crucial and integral part of the overall European strategy to become the 'most competitive and dynamic knowledge-based economy in the world'. In the following decade, the European Commission issued several policy documents that focused on creating more transparency and greater recognition of skills and competences and thus enhancing transnational mobility in VET. The Copenhagen Process (2002)[2] played a crucial role in raising awareness of the importance of VET at both national and European levels. In 2010, the Bruges Communiqué[3] called for the establishment of communication strategies for different stakeholder groups, and focused on the implementation and added value of transparency tools (for example, EQF, ECVET). Finally, one of the long-term strategic objectives of the Europe 2020 strategy (2010)[4] is 'making lifelong learning and mobility a reality' (Bacher, Lengauer 2012). The diversity of VET systems in Europe, derived from differences in the culture and traditions of individual countries, makes the comparability of education programmes difficult. Comparability, however, is needed in order to enhance worker mobility within the European Union. Consequently, the European Commission has for some years encouraged the development of transparency instruments to help improve understanding of VET systems between countries and boost transnational mobility.

The VQTS model is one approach to enhancing the transparency and comparability of different training programmes that identifies similarities/differences through an analysis of core work tasks in a specific occupational field. The NoBoMa project is applying the VQTS methodology as developed in the VQTS I and VQTS II projects[5]. It follows the procedure for developing a competence matrix which displays work related competences and the progress of competence development in a specific occupational field (cf. Luomi-Messerer 2009, p.12-32). In this context, the occupational field "Elderly Care" refers to a profession that deals with the fulfilment of the special needs and requirements of older people. Due to the wide variety of elderly care provision found around the world, as well as differing cultural perspectives on elderly citizens, the subject cannot be limited to any one practice. Therefore, the NoBoMa project develops a Competence Matrix for "Elderly Care" (see Chapter 2 of this report) which displays work related competences and competence development steps for elderly care givers in Romania, Bulgaria, Slovenia, Hungary, and Austria. Furthermore, Competence Profiles (ibid., p. 43-53) that depict the stage of competence development to be achieved in a training programme (Organisational Profile) or the stages already achieved by a person at a particular time (Individual Profile) are indicated in the NoBoMa Competence Matrix (ibid., p. 44). Two NoBoMa project partners have specific "Elderly Care" training programmes: Austria and Hungary. Therefore the Organisational Profiles for the Hungarian *Caritas Pécs* (4.1) and the Austrian *Vinzentinum* (4.2) are indicated in the NoBoMa

[1] http://www.bka.gv.at/site/4913/default.aspx (accessed 10.11.2012); European Trade Union Confederation (ETUC).
[2] http://ec.europa.eu/education/lifelong-learning-policy/doc/vocational/bruges_en.pdf, p.4 (accessed 10.07.2012).
[3] http://ec.europa.eu/education/lifelong-learning-policy/doc/vocational/bruges_en.pdf (accessed 10.07.2012).
[4] http://ec.europa.eu/education/lifelong-learning-policy/framework_en.htm (accessed 10.07.2012).
[5] See http://www.vocationalqualification.net/vqts/.

Competence Matrix by colour coding the parts of the matrix which are part of the respective training programme. Furthermore, an International Future Competence Matrix of Success (IFCMS), which displays future competence requirements in "Elderly Care", has been developed within the NoBoMa project.

The NoBoMa Competence Matrix and the International Future Competence Matrix of Success have been built on a number of different sources: firstly, on a review of relevant literature as well as the findings of other European projects in the field of "Elderly Care", particularly those relating to health and social care (e.g. 'Pro Care Career', 'Proper Chance' etc.); secondly, Synthesis Report I developed in WP1 that displayed the existing occupational and educational profiles in "Elderly Care" in Austria, Bulgaria, Romania, Slovenia, and Hungary; thirdly Synthesis Report II including the results of interviews conducted with learners, professionals, and experts/employers in "Elderly Care" in the investigated countries (WP2); fourthly, on input from practitioners in the field of "Elderly Care", namely Pál Csonka from *Caritas Pécs* (Hungary), and Markus Greger from *Vinzentinum* (Austria); and finally, on the input received from Austrian, Bulgarian, Hungarian, and Slovenian practitioners at an expert workshop. The International Future Competence Matrix of Success additionally builds on relevant literature and skills forecasts.

The following report provides a general description of the VQTS model in Chapter 1, including an explanation of how to develop a Competence Matrix, how to indicate Organisational Profiles, and how to issue competence profile certificates. Chapter 2 explains the methodology and scope of the NoBoMa Competence Matrix "Elderly Care", its competence areas and competence development steps, and presents the final version of the NoBoMa Competence Matrix. Chapter 3 describes the methodology and scope of the International Future Competence Matrix of Success, its competence areas and competence development steps and presents the final version of the International Future Competence Matrix of Success. Finally, in Chapter 4 the development of the Organisational Profiles for the training programmes offered at *Caritas Pécs*, Hungary and *Vinzentinum*, Austria are described and displayed in the matrix.

1 The VQTS model[6]

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). The 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'.

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, Competence Profiles, and Competence Profile Certificates. These three elements are described in more detail below.

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 the 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 tasks a person is able to carry out in a specific work context (Luomi-Messerer 2009:10f).

When developing a Competence Matrix several aspects have to be taken onto consideration. Firstly, 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. Secondly, experts should be involved in the development process. Experts able to provide support in applying the VQTS methodology should be consulted, as well as practitioners

[6] For further information visit: http://www.vocationalqualification.net/vqts/.

in the occupational field (from both the world of work and the world of education) from different countries, to ensure that transnational competence areas (core work processes) and steps of competence development are identified effectively (ibid., p. 16). Thirdly, 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 defined on the basis of the work tasks, depending on the complexity and range of activities or job opportunities within the respective occupational field (ibid., p. 17). Fourthly, the competence development steps for each competence area are 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 (ibid., 19ff).

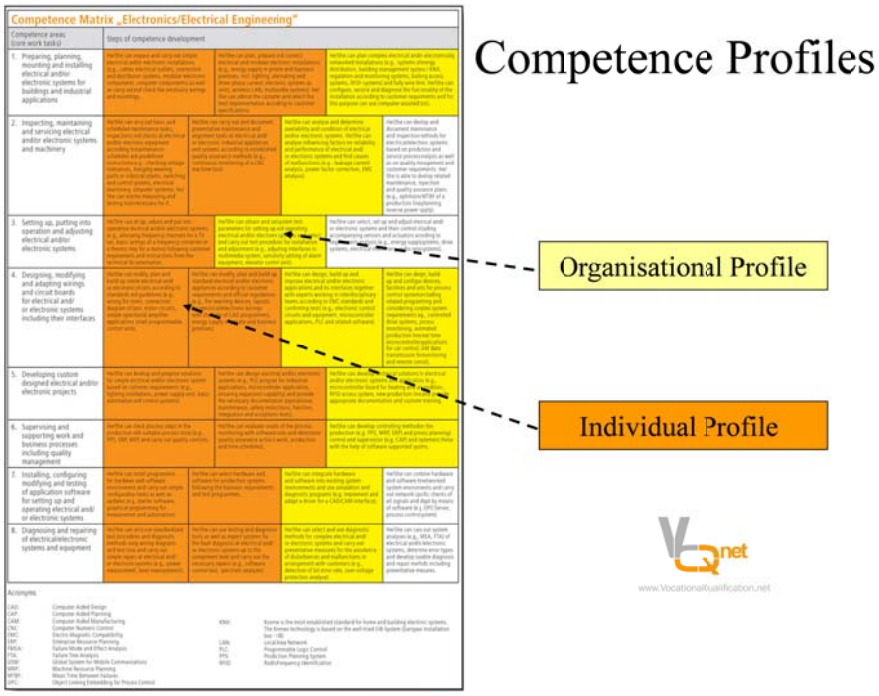
The Competence Matrix is a flexible instrument as major changes in the respective occupational field can be accommodated and acknowledged by adding or removing elements, or undertaking a restructuring process. The titles of the competence areas should be chosen in such a way that they promote mutual 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 who has 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 (ibid., p. 44-45).

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 the 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

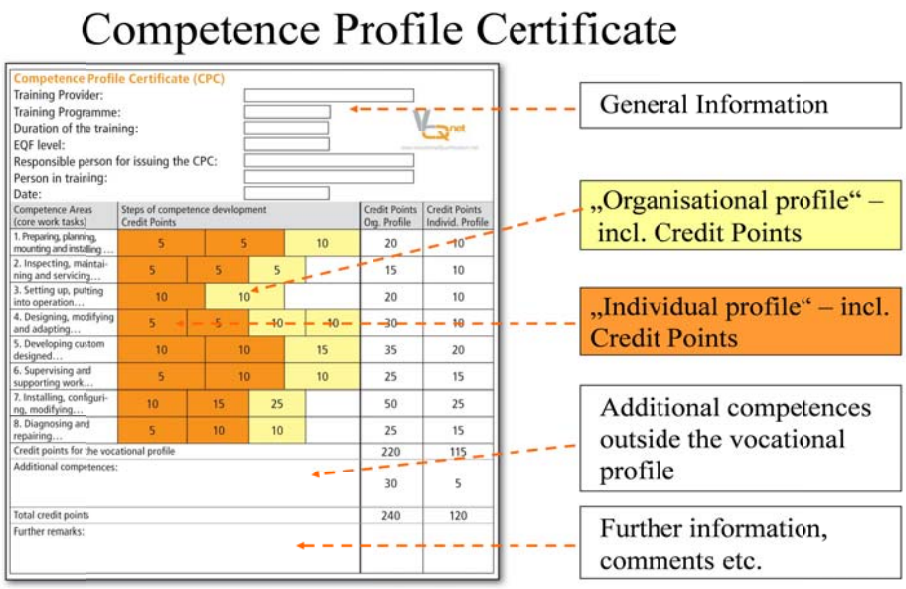
could perhaps be undertaken at the end of semesters when examinations are conducted, as this could prove a useful indicator in evaluating the competences already acquired by a learner.

1.3 Competence Profile Certificate (CPC)

The creation of a Competence Profile Certificate for a training programme requires the development of an Organisational or Individual Profile and the allocation of credit points (cf. Luomi-Messerer 2009, p. 53f). VQTS credit points are quantitative measurements of specific parts of a training programme or qualification. In the VQTS model the credit points reflect the duration of competence development based on the 'learner workload' required to achieve the objectives of the programme (specified in competences acquired). The total amount of credit points for a training programme is determined according to the average time an individual in training requires to obtain competences or to reach a step of competence development. A maximum of 60 credit points can be achieved within one year of a formal full-time VET programme (ibid: p. 88).

Certain information must be included in the Competence Profile Certificate: the title of the training provider/programme; the duration of the programme; the EQF or NQF level if applicable; the name of the person responsible for issuing the CPC; the date of issue; and in the case of an Individual Profile the name and personal information of the person in training. Furthermore, the Organisational Profile of the training programme and/or the Individual Profile should be indicated including the relevant competence areas, steps of competence development, and the corresponding credit points if applicable. Additional information can also be included, for example, supplementary competences that can be acquired in the training programme, but which are not part of the vocational profile (ibid.).

Table 2: Competence Profile Certificate



Source: 3s research laboratory.

2 Methodology and scope of the NoBoMa competence matrix "Elderly Care"

The draft Competence Matrix "Elderly Care" is embedded in the Social and Health Care sector and displays competence areas and competence development steps in the occupational field of an "Elderly Care Giver". The draft version of the matrix is based on a number of different sources. Firstly, the project team undertook a review of relevant literature (for example Particia Benner (1994): Stufen zur Pflegekompetenz: From Novice to Expert) and results of pertinent projects (for example 'Pro Care Career'[7] or 'Proper Chance'[8]). Secondly, the results of the Synthesis Report developed in WP1, which included an analysis of national curricula of training programmes and job profiles in "Elderly Care" in Austria, Bulgaria, Romania, Slovenia and Hungary, were examined. Thirdly, Synthesis Report II (produced in the context of WP2) was evaluated, including the results of interviews conducted with learners, professionals, and experts/employers in "Elderly Care" in Austria, Bulgaria, Romania, Slovenia, and Hungary.

The process of developing the draft Competence Matrix "Elderly Care" consisted of several levels. In the initial stage 3s research laboratory – an organisation experienced in the development of Competence Matrices for different professional fields[9] – began by screening various sources via desk research. These sources included: publications[10] which contained attempts to frame the competence areas of "Elderly Care Givers"; project reports dealing with competence requirements in "Elderly Care" in particular, as well as in the health and social care sector in general[11]; general job descriptions found, for example, in the national legal frameworks of Austria, Bulgaria, Romania, Slovenia, and Hungary and presented in Synthesis Report I (WP1); and interviews conducted in the frame of WP2 in the same countries and summarised in Synthesis Report II. After reviewing these sources in an internal workshop at 3s research laboratory, initial suggestions for possible competence areas were developed. In the next step the identified competence areas were supplemented by initial examples of possible competence development steps indicating the lowest and the highest step of competence development. Thirdly, the NoBoMa project partners with subject-specific professional background, namely Pál Csonka (*Caritas Pécs*, Hungary) and Markus Greger (*Vinzentinum*, Austria) were asked to refine the structure of the matrix, and to define multiple steps of competence development covering all imaginable work processes of an "Elderly Care Giver" within each competence area. After receiving input and feedback from *Caritas Pécs* and *Vinzentinum*, 3s research laboratory incorporated the suggestions and developed an initial draft version of the Competence Matrix "Elderly Care". Following further discussion between the project partners, the draft Competence Matrix "Elderly Care" was further revised and condensed in January 2013. In the concluding stage the matrix was finalised on the basis of the results of an expert workshop held in March

7 http://www.pro-care-career.de/ [07.12.2012].
8 http://www.proper-chance.eu/ [07.12.2012].
9 For example in tourism, mechatronics, in the area of foreign trade etc. See also http://www.vocationalqualification.net/vqts/.
10 See i.e. Benner, P. (1994). Stufen zur Pflegekompetenz. From novice to expert. Bern: Hans Huber-Verlag.
11 See i.e. Pro Care Career Project (2011). Individuelle Durchlässigkeitskarrieren im Sektor der Altenpflege und Medizinpflege. Leonardo da Vinci, Transfer of Innovation, 2011. Online: www.pro-care-career.de [accessed 09.12.2012]. 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: www.proper-chance.eu/ [accessed 09.12.2012].

2013 with participation of representatives from Austria, Bulgaria, Hungary, and Slovenia.

In the final Competence Matrix "Elderly Care" the project partners agreed on eight competence areas for "Elderly Care Givers" that are described more in detail in the following sub-chapter.

2.1 Competence areas of the NoBoMa Competence Matrix "Elderly Care"

The competence areas are based on the various core work tasks of "Elderly Care Givers" (vertical axis of the competence matrix) and have been derived on the basis of secondary sources (literature, project results, existing educational profiles etc.) and empirical investigation (interview results of the Synthesis Report II). A total of eight competence areas have been identified for the NoBoMa Competence Matrix:

1. *Planning and conducting daily care*

This competence area refers to direct care activities. These 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.

2. *Planning and carrying out nursing activities*

This competence area refers to the nursing activities of "Elderly Care Givers". These include, for example, the ability to perform simple medical procedures (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 a 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 this category. A number of psycho-social activities (e.g. reading, playing music, singing etc.) are also subsumed 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 diagnosis to an elderly person), and the ability to consult family and relatives with regard to future action 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, and the organisation of ward rounds in nursing homes.

6. *Managing the processes of Elderly 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.

7. *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.

8. *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 and cope with and death and grief, stress- and burn-out-prevention, the development of coping strategies, participation in supervision activities, and knowing and acknowledging one's own limits.

One of the main challenges in the process of defining the competence areas was the positioning of crossover competence areas such as personal, social, and intercultural competences, and empathy. Although social, personal, and intercultural skills seem to be very important for the "Elderly Care Giver" profession, the project team took the decision not to describe them 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 by the demonstration of professional ability (cf. Luomi-Messerer, 2009, p. 24).

2.2 Competence development steps of the NoBoMa Competence Matrix "Elderly Care"

Competence development steps have been defined for each competence area, and comprise the horizontal axis of the Competence Matrix (ibid, p. 19-20). In total between three and five 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 NoBoMa Competence Matrix 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), but who have received no formal education in "Elderly Care". The final competence development step refers to experts in the field of "Elderly Care", 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".

When interpreting the Competence Matrix the description of higher step of competence development must always be viewed alongside previous step(s) of competence development or alongside competence development in other competence areas. Thus, higher competence development steps should be understood as including the competences described in lower step(s) (ibid., p. 49). Only in cases where a specific work task detailed in a lower competence level has a different characterisation in the higher competence development step this task is repeated in the higher step.

2.3 Final NoBoMa Competence Matrix "Elderly Care"

After submission of the Interim Report the first draft version of the NoBoMa Competence Matrix was further developed and condensed by the project partners in January 2013. This resulted in a second draft version. The final version of the NoBoMa Competence Matrix is based on the draft versions of the NoBoMa Competence Matrix which was developed by Viktor Fleischer and Tanja Bacher (3s research laboratory), Pál Csonka (*Caritas Pécs*, Hungary) and Markus Greger (*Vinzentinum*, Austria) with support from the remaining project partners. The core work tasks of "Elderly Care Givers" in Slovenia, Romania, and Bulgaria have also been integrated into the matrix via an analysis of the results of the expert interviews conducted in WP2, as well as through integration of the results of the expert workshop that included participation of Bulgarian and Slovenian practitioners.

Following the expert workshop held in March 2013 some amendments were made to the matrix. For example, the wording of the competence areas was improved, and the complexity of the steps of competence steps was reduced. Furthermore, some competences described in certain competence development steps were shifted to other competence areas or other competence development steps. Finally, an additional competence area, *Managing the processes of Elderly Care,* was introduced and the overall layout of the Competence Matrix was aligned to the VQTS layout.

The following table displays the final version of the NoBoMa Competence Matrix "Elderly Care" as developed in March 2013.

Table 3: Final version Competence Matrix "Elderly Care"

Competence area	Steps of competence development Basic level					Expert level
Professional skills and task related competences (competence areas 1 – 6)						
1 Planning and conducting daily care	S/he is able to support the client in domestic tasks (e.g. cooking, washing, etc.). S/he is able to maintain rituals and habits of clients. S/he is able to follow, adhere to, and apply legal requirements (e.g. client rights, ethical and moral standards, health law, knowing that s/he is only allowed to assist with basic care).	S/he is able to assist superiors in identifying the care needs of the client. S/he is, with guidance, able to develop care plans on the basis of identified care needs. S/he is able to consider the needs of clients by asking about individual sensitivities and assistance needs in an empathetic manner. S/he is able to report unforeseeable and modified situations to superiors and knows how and to whom to report (e.g. symptoms, accident hazards, family conflicts, crises, deterioration of nutritional status, pain). S/he is, with guidance, able to carry out basic body care procedures, personal hygiene, and daily activities. S/he is able to perform basic mobility actions with the clients (e.g. instruction how to use walking and standing aids, wheelchairs, etc.). S/he is able to deliver health care independently and regardless of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.	S/he is able to identify the care needs of the client and to conduct professional care interventions on the basis of identified care needs. S/he is able to develop care plans according to identified care needs. S/he is able to independently carry out body care procedures, personal hygiene, and daily activities. S/he is able to implement care processes that facilitate and promote the health and independence of the client (e.g. encouraging client independence or providing guidance for the personal well-being of clients). S/he is able to react adequately to unforeseeable and modified situations (e.g. by giving instruction on how to proceed). S/he is able to coordinate and plan with the client in an aim-oriented manner in order to provide appropriate care measures.	S/he is able to link theoretical concepts (according to the latest evidence-based guidelines) with practical observations. S/he is able to select and implement therapeutic interventions by reflecting theories and practical observations.	S/he is able to decide when a sub-division of tasks is necessary considering parameters such as relevance of needs, clinical situation, and qualification. S/he is able to plan, evaluate and, when necessary, to change resources which maintain quality of life, well-being, health and social integration (e.g. financial resources, physical assets and family/household resources, risk management, care in case of apoplectic stroke, injuries caused by falling). S/he is able to conduct special interventions based on evidence in the nursing process (e.g. being aware of professional guidelines and protocols, nursing scientific research, counselling in special situations). S/he is able to apply adequate care equipment (e.g. applying incontinence equipment, hearing and visual aids, mobility aids). S/he is able to supervise body care procedures. S/he is able to take responsibility for the implementation of care based on professional and legal requirements.	S/he is able to conduct research about care and nursing concepts, care utilities, nursing interventions. S/he is able to estimate the quality of the outcome (effectiveness of the research) and to ensure that the research results are applied in practice.
2 Planning and carrying out nursing activities	S/he is able to apply nursing instructions from superiors (e.g. measuring blood pressure, taking blood samples, etc.). S/he is able to support superiors in carrying out monitoring, provision of medication, and nursing of wounds with regard to basic hygiene rules. S/he is able to take care of, clean, and disinfect medical equipment. S/he is able to look for help in case of emergency and is able to call the ambulance, fire brigade, or police as necessary. S/he is able to consider current legislation and local standards regarding the workplace, medical instruments and contaminated waste, and health and safety measures, and is able to inform superiors in case of discrepancies.		S/he is able to make simple nursing diagnoses (e.g. change of skin colour or condition; identify an irregular health status). S/he is able to perform monitoring, provision of medication, and nursing of wounds with regard to basic hygiene rules. S/he is able to perform first aid.		S/he is able to recognise common disease patterns of elderly people (e.g. Cardiac problems, infectious diseases). S/he is able to respond immediately and appropriately to emergencies and to begin, if necessary, basic life support and other emergency measures. S/he is able to adhere to current regulations and local standards regarding the disposal of sharp medical instruments, contaminated waste in the workplace, and personal protective equipment, and is actively involved in the regular re-evaluation of the process. S/he is able to ensure adequate storage, handling, and recording of therapeutic substances.	S/he is able to create structural changes to prevent the spread of disease (e.g. coordinating and organising the distribution of infection control masks, manage health promotion and health care programmes, develop a hygiene guideline, and emergency actions). S/he is able to develop and implement emergency plans and to oversee coordination in case of emergencies.
3 Creating and	S/he is able to perform basic cleaning and environmental care procedures.		S/he is able to evaluate the safety conditions of the living environment by		S/he is able to avoid situations that might have a negative	S/he is able to arrange the environment of clients to

maintaining a health promoting and safe environment	S/he knows about psychological aspects of health and their impact, and is able to provide and support creative elements (e.g. singing, reading) in the care process. S/he is able to create and maintain a health promoting and safe environment.		following relevant criteria and is able to report potential dangers to colleagues or superiors. S/he adheres to applicable laws and local rules regarding the safety of the workplace. S/he is able to plan and carry out multiple social activities with the client at home and outside.	impact on the security of clients and colleagues. S/he is able to participate in arranging and furnishing residential areas which meet the requirements of clients, including provision of care utilities.		facilitate autonomy in the activities of daily living. S/he is able 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 a fall, taking measures to prevent infection). S/he is actively involved in the development of regulations in the work place (e.g. safety measures). S/he is able to choose instruments for the assessment of existing and potential security risks, to apply them, and to inform the relevant authorities.
4 Communicating with different stakeholders involved in the care process	S/he is able to build, maintain, and conclude verbal and nonverbal (e.g. through touch) interactions with empathy through interpersonal communication S/he is able to choose and apply appropriate methods of communication according to his/her institutional environment (e.g. home-care or nursing home). S/he is able to communicate with clients and relatives and provide information in an appropriate way.		S/he is able to explain simple medical diagnoses to the client and his/her family. S/he is able to provide information about the care process to clients and families and to inform the client about aspects of the care plan. S/he is able to recognise crises and inform superiors, and seek support from competent persons. S/he is able to network with professionals and ordinary persons (e.g. relatives of the client who support the care process).	S/he is able to identify communication barriers and conflicts, apply solutions, and perform mediation. S/he is able to professionally intervene in crises. S/he is able to initiate and terminate stakeholder-oriented relationships by using professional communication methods. S/he is able to plan and conduct counselling sessions. S/he is able to inform clients and verify that the information has been understood. S/he is able to lead and participate in consulting processes for the client and his/her social environment.		S/he is able to communicate effectively within the team and to develop, implement, and evaluate mechanisms for optimising the processes of professional cross-group collaboration. S/he is able to advocate for clients, families, or carers that request support, or have language barriers, or limited decision-making abilities. S/he is able to present and support positions of clients and colleagues in inter-professional teams and can manage negotiations.
5 Recording, evaluating and assuring the quality of the care process	S/he is able to assist superiors in creating care plans. S/he has a basic understanding of quality standards and quality criteria in care. S/he is able to conduct basic administrative work by using common computer-based documentation systems. S/he is, with guidance, able to plan and attend ward rounds (in nursing homes).	S/he is able to record the care process and report changes to her/his superior. S/he is able to gather health data and to transmit data for assessment by general care practitioners and specialists. S/he is able to conduct medical educational programmes for clients and relatives with an approved syllabus (e.g. hair care, oral care, bathing, use of medical aids, wound care, changing of incontinence pads , skin protection, stoma and PEG tube care, nutrition, hydration, mobilisation and positioning). S/he is able to evaluate and adapt care plans under supervision. S/he is able to apply quality standards and criteria in care during his/her work. S/he is able to report the outcomes of an intervention in a structured manner.	S/he is able to determine a care plan on the basis of a nursing diagnosis by using data from different sources. S/he is able to evaluate progress towards planned outcomes in consultation with clients, families, and/or professionals and to use evaluation data to modify the care plans. S/he is able to gather accurate and relevant objective and subjective data about the client through systematic health and nursing assessments (e.g. objective and subjective symptoms, physical, social, environmental, psychological factors, Norton Scale, Frohwein scale, MNA, descriptive personal profiles). S/he is able to document findings, interventions, and patient responses accurately, complying with professional standards and organisational policies (e.g. using the nursing documentation in effect).	S/he is able to apply critical thinking and clinical reasoning skills when developing a care plan. S/he is able to regularly review, revise, and adapt the care plan. S/he has specialised knowledge of systematic health and nursing assessments (e.g. professional guidelines, care protocols, application such as Braden Scale, Norton Scale, Frohwein Scale, MNA, Barthel-Index, and Mini mental state examination) and is able to apply it. S/he is able to order diagnostic tests and procedures permitted in the scope of specialist practice and legislation. S/he is able to involve clients in care planning, ensuring that they receive accurate, understandable information.	S/he is able to control care plans, evaluate them, and supervise other staff members in the care planning process. S/he is able to develop and maintain quality management systems in institutions or within the care process.	S/he is able to examine assessment instruments and to participate in the development and application of assessment instruments. S/he is able to introduce assessment tools into practice by considering the context of nursing sciences methods and to delegate the change of care interventions, if necessary.
6	S/he is able to instruct colleagues and		S/he is able to regulate processes and to collect individual		S/he is able to manage a care	

Managing the processes of elderly care	apprentices and to coordinate interprofessional teamwork e.g. by setting priorities.	resources and needs (e.g. assessing the physiological, safety, social, self-actualisation, self-esteem or mobility of clients). S/he is able to mobilise and coordinate resources and to take the lead role in managing the care process. S/he is able to apply the "case management" approach in the care process.		division and to make staff decisions. S/he is able to exchange information with other health occupations and to plan a common approach if necessary. S/he is able to continuously estimate the needs of clients and client groups as well as the available financial, material, and staff resources, and the requirements for organisational development. S/he is able to establish and manage research projects.
Personal attitudes of an elderly care giver (competence areas 7 – 8)				
7 Expanding and updating skills and knowledge	S/he is able to recognise his/her own training needs. S/he is able to motivate him-/herself for training. S/he is able to communicate his/her training needs to his/her supervisor. S/he is willing to frequently choose and attend formal education measures. S/he is able to apply up-to-date knowledge of legal regulations (e.g. familiarity with client rights, ethical standards, health law moral and ethical standards, first aid rules and their context). S/he is able to learn from her colleagues in practice (on-the job).	S/he is able to adapt existing skills to new technological developments. S/he is willing to specialise in a specific field of care (e.g. caring people with dementia or pain, etc.) S/he is able to support superiors in research projects.	S/he is able to communicate new empirical knowledge to colleagues. S/he is able to implement new empirical findings into daily practice. S/he is able to interpret and evaluate research findings critically. S/he is able to investigate new empirical knowledge and information in nursing science databases and peer reviewed journals.	S/he is able to create new empirical knowledge in the field of nursing sciences.
8 Reflecting and handling the impact of the job (job-related self-understanding)	S/he is able to take care of her/his own health to perform the job of a care giver. S/he can recognise her/his own limits and is able to acknowledge them. S/he is able to access methods of supervision and apply its results. S/he is able to recognise psychological impacts on her/his own health. S/he is able to carry out prevention and health promotion activities for care givers. S/he is able to maintain a healthy work-life-balance.	S/he is able to develop and apply individual coping strategies for clients. S/he is able to apply methods of burn-out prevention. S/he is able to pay attention to his/her own limits and maintain a professional distance from the clients. S/he can assist the elderly to address topics such as loneliness and death.	S/he is able to provide the elderly with tools to help them face chronic and terminal illness, loneliness, and death (e.g. establishing contacts, involvement in activities and events). S/he is able to apply special concepts and models in elderly care (e.g. chronic care model, patient-centred care).	

Authors: Tanja Bacher & Viktor Fleischer (3s); Pál Csonka (Caritas Pécs, HU) and Markus Greger (Vinzentinum, AT) with support from Gregor Herzog (AT), Miklós Lukács (HU), Sabine Pleschberger (AT), Andreas Salmhofer (AT), Andrea Smioski (AT), Georgi Shopov (BU), Spela Zajsek (SI).

Sources: Synthesis Report I (WP1); Synthesis Report (WP2); Benner, 1994; Pro Care Career and Proper Chance Project.

3 Methodology and scope of the International Future Competence Matrix of Success (IFCMS)

The final version of the International Future Competence Matrix of Success in "Elderly Care" is also embedded in the Social and Health Care sector. It displays the competences required in the occupational field of an "Elderly Care Giver" in the future. The compilation process for the draft International Future Competence Matrix of Success followed a similar procedure as that for the NoBoMa Competence Matrix, although some different sources were consulted. Firstly, the results of the interviews conducted with learners, professionals, and experts/employers working in "Elderly Care" in Austria, Bulgaria, Romania, Slovenia, and Hungary (part of WP2) were examined, as in this process interviewees were also asked to estimate future trends and competences in the field of "Elderly Care". Secondly, a review of relevant literature was undertaken, including for example:

- Klein, B.; Gaugisch, P.; Stopper, K. (2008). *„Pflege 2015": Neue Arbeitsanforderungen und zukünftige Qualifizierungsbedarfe*;
- Davis, A.; Fidler, D.; Gorbis, M. (2011). *Future Work Skills 2020*;
- Sahamel, K-H. (2011). *Wandel der Pflege – Neue Kompetenzen für Pflegekräfte.*

These sources were assessed via content analysis by 3s research laboratory with assistance from *Vinzentinum* (Austria) and *Caritas Pécs* (Hungary). Input was also obtained from Bulgaria, Romania, and Slovenia through interviews with practitioners. Initially, more general trends in "Elderly Care" (e.g. demographic changes, new supply concepts such as development of new living facilities for elderly people, or new technologies in elderly care) had to be differentiated from the skills and competence requirements that will accompany these future trends. Differences in the structure of the sources (some provided precise information on future competence requirements, while others made more general conclusions about future trends in elderly care) necessitated a reformulation of the information derived from the sources into learning outcomes that elderly care givers will require in the future. For example, demographic changes are likely to have a significant impact on the overall care sector in general, but less of an impact on the specific competence requirements of "Elderly Care Givers" (although an implicit trend towards a more efficient work process can be assumed in order to deal with the anticipated increase in the number of care receivers). These learning outcomes were then placed within the relevant competence areas and allocated to the appropriate steps of competence development by 3s research laboratory, *Caritas Pécs*, and *Vinzentinum*. The IFCMS was presented to practitioners/experts from the project countries and discussed at the expert workshop in March 2013. The matrix was finalised on the basis of the discourse and feedback from the workshop.

3.1 Competence areas of the International Future Competence Matrix of Success

Practitioners assume that in the future "Elderly Care Givers" will perform the same work tasks and processes as displayed in the NoBoMa Competence Matrix "Elderly Care", alongside new

tasks and duties. Therefore, the competences described in the IFCMS must be understood as additional competences that will become important in the future. Consequently, the NoBoMa competence areas are also displayed in the International Future Competence Matrix of Success, and one additional competence area is added that addresses those work tasks that will become more relevant in coming years.

1. *Planning and conducting daily care*

This competence area refers to direct care activities. These include, for example, ensuring the personal hygiene of the elderly clients, providing support in daily living activities (dressing and undressing, combing hair, assistance in using the toilet, etc.), mobilisation of the patient or guidance for self-care. In the IFCMS the delivery of care in a manner that maximises resources, and the ability to apply specialised care procedures (e.g. palliative care or kinaesthetics) are also included in this competence area.

2. *Planning and carrying out nursing activities*

This competence area refers to the nursing activities of "Elderly Care Givers". These include, for example, the ability to apply simple medical procedures (measuring blood pressure, wound management, taking blood samples, etc.), the ability to identify most common disease patterns of elderly people, and the ability to read and understand medical documents (e.g. care instructions from medical professionals etc.). In the IFCMS, the ability to undertake nursing activities for clients suffering from diverse illnesses (e.g. gerontological or psychiatric disorders, etc.), and the ability to develop and implement nursing measures with regard to the needs of the client in collaboration with other health professions, virtual teams, etc. are included in this competence area.

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 a 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 this category. A number of psycho-social activities (e.g. reading, playing music, singing etc.) are also subsumed in this competence area. Here the additional IFCMS competences are primarily related to the home care environment which will become far more significant in future.

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. in explaining a diagnosis to an elderly person), and the ability to consult family and relatives with regard to future action etc. The use of new forms of technology in the provision of care (e.g. e-nursing, webcams, "emergency bracelets", etc.) is the central element of the additional competences in the IFCMS.

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, and the organisation of ward rounds in nursing homes. The additional IFCMS competences for this competence area reflect the importance of the development and use of new state-of-the-art tools for recording care processes that will become increasingly significant in the future.

6. *Managing the processes of Elderly 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. Future developments will increase the need for managers in the care sector to be proficient in assigning nursing interventions/diagnostic procedures in advanced nursing practice, and in the management of hygienic conditions.

7. *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 her/his knowledge up-to-date. In the future, Elderly Care Givers will require even further expansion of skills and knowledge, and the ability to speak more than one language to have better access to the European labour market, and work with clients with different cultural backgrounds will become more relevant for this competence area.

8. *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 and cope with death and grief, stress- and burn-out-prevention, the development of coping strategies, participation in supervision activities, and knowing and acknowledging one's own limits. This aspect of competence development does currently not comprise a standardised element of competence development in all project countries, although it is highly appreciated and in general will become more important in future.

9. *Dealing with different organisational contexts*

This competence area does not yet form part of the general work processes of Elderly Care Givers, but will be a crucial issue in future, and consequently comprises part of the International Future Competence Matrix of Success. This competence area refers to the ability to develop and apply organisational skills according to specific institutional environments (e.g. entrepreneurial skills for self-employed care givers).

3.2 Competence development steps of the International Future Competence Matrix of Success

As with the NoBoMa Competence Matrix "Elderly Care", between three and five successive competence development steps were identified for the IFCMS, illustrating the progression from the lowest to the highest steps. Once again the first competence development step of the

NoBoMa Competence Matrix refers to persons in training who have 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), but who have received no formal education in "Elderly Care". When interpreting the Competence Matrix the description of higher steps of competence development must always be viewed alongside previous step(s), or alongside competence development in other competence areas. Thus, higher steps should be understood as including the competences described in lower step(s) (ibid., p. 49). Only in cases where a specific work task detailed in a lower competence step has a different characterisation in the higher competence development step this task is repeated in the higher step.

3.3 Final International Future Competence Matrix of Success

The first draft version of the International Future Competence Matrix of Success was developed by Viktor Fleischer and Tanja Bacher (3s research laboratory), Pál Csonka (*Caritas Pécs*, Hungary), and Markus Greger (*Vinzentinum*, Austria) and with support coming from the remaining project partners. The results of the expert interviews conducted in WP2 were considered and provided insight on future trends and work tasks of "Elderly Care Givers" in Austria, Hungary, Slovenia, Romania, and Bulgaria.

Following the submission of the Interim Report the first draft version of the IFCMS was further developed in January 2013 by the project partners. In comparison to the initial draft, the second draft was far more extensive and included more insight on future competence requirements drawn from the literature. The extended International Future Competence Matrix of Success was discussed at the WP4 expert workshop which took place in March 2013 in Vienna. Future competence requirements not yet incorporated into the matrix, and the placement of future competences at different levels of competence development, were the prevailing issues of discussion.

Generally speaking the experts also experienced difficulties in anticipating which competences will become more relevant for "Elderly Care Givers" in future. There was consensus that technological innovations, the sub-division of tasks between different kinds of health professionals (e.g. care givers, nurses, medical professionals, physiotherapists, etc.), and caring for more clients due to demographic shifts will become more relevant in the professional field of "Elderly Care". The point was also made that future developments depend very much on the position adopted in a respective country and the respective education and training system, and that there may be considerable differences therefore on the future developments / trends within the investigated countries.

As outlined above, the IFCMS displays the same competence areas as the NoBoMa Competence Matrix "Elderly Care", but adds one additional competence area to accommodate a number of future competence trends identified in this field (which are not yet a part of the professional profile of "Elderly Care Givers"). In the following table the International Future Competence Matrix of Success is displayed.

Table 4: Final International Future Competence Matrix of Success

Competence area	Steps of competence development Basic level					Expert level
Professional skills and task related competences (competence areas 1 – 6)						
1 Planning and conducting daily care	S/he is able to support the client in domestic tasks (e.g. cooking, washing, etc.). S/he is able to maintain rituals and habits of clients. S/he is able to follow, adhere to, and apply legal requirements (e.g. clients' rights, ethical and moral standards, health law, and moral, knowing that s/he is only allowed to assist with basic care).	S/he is able to assist superiors in identifying the care needs of the client and is able to operate within a multiprofessional team (e.g. with other health professionals, psychotherapists, etc.). S/he is, with guidance, able to develop care plans on the basis of identified care needs. S/he is able to consider the needs of clients (including those with differing religions or cultural backgrounds) by asking about individual sensitivities and assistance needs in an empathetic manner. S/he is able to report unforeseeable and modified situations to superiors and knows how and to whom to report (e.g. symptoms, accident hazards, family conflicts, crises, deterioration of nutritional status, pain). S/he is with guidance, able to carry out basic body care procedures, personal hygiene, and daily activities. S/he is able to perform basic mobility actions with the clients (e.g. instruction how to use walking and standing aids, wheelchairs, etc.). S/he is able to deliver health care independently and regardless of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status. S/he is able to deliver health care in the most efficient way possible with available resources and avoids waste; (e.g. timely and geographically reasonable health care provided in a setting where skills and resources are appropriate to medical needs). S/he is able to apply methods of palliative care.	S/he is able to identify the care needs of the client and to conduct professional care interventions on the basis of identified care needs (considering the physical, emotional, social, economic, and spiritual needs of the client). S/he is able to develop care plans according to identified care needs. S/he is able to independently carry out body care procedures, personal hygiene and daily activities. S/he is able to implement care processes that facilitate and promote the health and the independence of the client (e.g.. encouraging client independence or providing guidance for the personal well-being of clients). S/he is able to react adequately to unforeseeable and modified situations (e.g. by giving instructions on how to proceed). S/he is able to coordinate and plan with the client in an aim-oriented manner in order to provide appropriate care measures.	S/he is able to link theoretical concepts across multiple disciplines (e.g. ethics, medicine, psychology) according to the latest evidence-based guidelines) with practical observations. S/he is able to select and implement therapeutic interventions by reflecting theories and practical observations. S/he is able to apply health-promoting work methods (e.g. kinaesthetics).	S/he is able to decide when a sub-division of tasks is necessary considering parameters such as relevance of needs, clinical situation and qualification. S/he is able to plan, evaluate and, when necessary, to change resources which maintain quality of life, well-being, health and social integration (e.g. financial resources, physical assets and family/household resources, risk management, care in case of apoplectic stroke, injuries caused by falling). S/he is able to conduct special interventions based on evidence which is gathered and processed electronically in the nursing process (e.g. being aware of professional guidelines and protocols, nursing scientific research, counselling in special situations). S/he is able to apply adequate care equipment (e.g. applying incontinence equipment, hearing and visual aids, mobility aids). S/he is able to supervise body care procedures. S/he is able to take responsibility for the implementation of care based on professional and legal requirements.	S/he is able to conduct research about care and nursing concepts, care utilities, nursing interventions. S/he is able to estimate the quality of the outcome (effectiveness of the research) and to ensure that the research results are applied in practice.
2 Planning and carrying out nursing activities	S/he is able to apply nursing instructions from superiors (e.g. measuring blood pressure, taking blood samples, etc.). S/he is able to support superiors in carrying out monitoring, provision of medication nursing of wounds with regard to basic hygiene rules. S/he is able to take care of, clean, and disinfect medical equipment. S/he is able to look for help in case of emergency and is able to call the ambulance, fire brigade, or police as necessary. S/he is able to consider current legislation and local standards regarding the workplace, medical instruments and contaminated waste, and health and safety measures and is able to inform superiors in case of discrepancies.	S/he is able to make simple nursing diagnoses (e.g. change in skin colour or condition, identify an irregular health status) and recognise disease patterns and conditions that will become more prevalent in the future, particularly gerontological and psychiatric disorders, elderly people severely in need of care (multimorbid clients; those with dementia and depression, chronically ill clients). S/he is able to perform monitoring, provision of medication, and nursing of wounds with regard to basic hygiene rules. S/he is able to perform first aid. S/he is, with guidance, able to apply nursing interventions for elderly clients who suffer specific conditions (e.g. gerontological and psychiatric disorders; dementia and depression, chronic illnesses, or multimorbid clients). S/he is able to utilise new medical appliances and diagnostic techniques and possesses the necessary technical and clinical knowledge.	S/he is able to recognise common disease patterns of elderly people (e.g. Cardiac problems, infectious diseases) and apply appropriate, state-of-the-art nursing measures. S/he is able to respond immediately and appropriately to emergencies, and begin, if necessary, basic life support and other emergency measures. S/he is able to adhere to current regulations and local standards regarding the disposal of sharp medical instruments, contaminated waste in the workplace, and personal protective equipment, and is actively involved in the regular re-evaluation of the process. S/he is able to ensure adequate storage, handling and recording of therapeutic substances. S/he is able to work with e-health initiatives, which enables diagnostic services at great geographical distances, and is able to adapt her/his working methods to these techniques.	S/he is able to create structural changes to prevent the spread of disease (e.g. coordinating and organising the distribution of infection control masks, manage health promotion and health care programmes, develop hygiene guidelines and emergency actions). S/he is able to develop and implement emergency plans and to oversee coordination in case of emergencies. S/he is able to develop and implement the most appropriate nursing measures with regard to the needs of the client in collaboration with other health professions, in virtual and multiprofessional teams.	

			S/he is able to recommend alternatives to medication, such as natural remedies.	
3 Creating and maintaining a health promoting and safe environment	S/he is able to perform basic cleaning and environmental care procedures. S/he knows about psychological aspects of health and their impact, and is able to provide and support creative elements (e.g. singing, reading) in the care process. S/he is able to create and maintain a health promoting and safe environment. S/he possesses a driving licence and is able to visit clients at their homes and in their social environment (e.g. providing services in the context of home care).	S/he is able to evaluate the safety conditions of the living environment by following relevant criteria and is able to report potential dangers to colleagues or superiors. S/he is adheres to applicable laws and local rules regarding the safety of the workplace. S/he is able to plan and carry out multiple social activities with the client at home and outside.	S/he is able to avoid situations that might have a negative impact on the security of clients and colleagues. S/he is able to participate in arranging and furnishing residential areas which meet the requirements of clients, including provision of care utilities. S/he is able to consult relatives / relevant persons in establishing a health promoting environment for the client.	S/he is able to arrange the environment of clients to facilitate autonomy in the activities of daily living. S/he is able 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 a fall, taking measures to prevent infection). S/he is actively involved in the development of regulations in the work place (e.g. safety measures). S/he is able to choose instruments for the assessment of existing and potential security risks, to apply them, and to inform the relevant authorities.
4 Communicating with different stakeholders involved in the care process	S/he is able to build, maintain, and conclude verbal and nonverbal (e.g. through touch) interactions with empathy through interpersonal communication S/he is able to choose and apply appropriate methods of communication according to his/her institutional environment (e.g. home-care or nursing home). S/he is able to communicate with clients and relatives and provide information in an appropriate way.	S/he is able to explain simple medical diagnoses to the client and his/her family. S/he is able to provide information about the care process to clients and families and to inform the client about aspects of the care plan. S/he is able to recognise crises and inform superiors, and seek support from competent persons. S/he is able to network with professionals and ordinary persons (e.g. relatives of the client who support the care process). S/he is able to use new forms of communication (e.g. e-nursing, consulting on the internet/Skype/E-Mail, webcams for initial diagnosis, “emergency bracelets”, reminder systems, tablets etc.). S/he is able to communicate within a virtual team.	S/he is able to identify communication barriers and conflicts, apply solutions, and perform mediation. S/he is able to professionally intervene in crises. S/he is able to initiate and terminate stakeholder-oriented relationships by using professional communication methods. S/he is able to plan and conduct counselling sessions. S/he is able to inform clients and verify that the information has been understood. S/he is able to lead and participate in consulting processes for the client and his/her social environment.	S/he is able to communicate effectively within the team and to develop, implement, and evaluate mechanisms for optimising the processes of professional cross-group collaboration. S/he is able to advocate for clients, families or carers that request support, have language barriers, or limited decision-making abilities. S/he is able to present and support positions of clients and colleagues in inter-professional teams and can manage negotiations. S/he is able to lead virtual teams and/or other information platforms to exchange experience and information on nursing and care procedures.

5 Recording, evaluating and assuring the quality of the care process	S/he is able to assist superiors in creating care plans. S/he has a basic understanding of quality standards and quality criteria in care. S/he is able to conduct basic administrative work by using the latest computer-based documentation systems. S/he is, with guidance, able to plan and attend ward rounds (in nursing homes).	S/he is able to record the care process (and adapt to the use of institution-specific instruments and the latest electronic recording tools) and report changes to her/his superior. S/he is able to gather health data and to transmit data for assessment by general care practitioners and specialists (via using tablets, voice-recording equipment). S/he is able to conduct medical educational programmes for clients and relatives with an approved syllabus (e.g. hair care, oral care, bathing, use of medical aids, wound care, changing of incontinence pads, skin protection, stoma and PEG tube care, nutrition, hydration, mobilisation and positioning). S/he is able to evaluate and adapt care plans under supervision. S/he is able to apply quality standards and criteria in care during his/her work. S/he is able to report the outcomes of an intervention in a structured manner.	S/he is able to determine a care plan on the basis of a nursing diagnosis by using data from different sources. S/he is able to evaluate progress towards planned outcomes in consultation with clients, families, and/or professionals and to use evaluation data to modify the care plans. S/he is able to gather accurate and relevant objective and subjective data about the client through systematic health and nursing assessments (e.g. objective and subjective symptoms, physical, social, environmental, psychological factors, Norton Scale, Frohwein scale, MNA, descriptive personal profiles). S/he is able to document findings, interventions, and patient responses accurately, complying with professional standards and organisational policies (e.g. using the nursing documentation in effect).	S/he is able to apply critical thinking and clinical reasoning skills when developing a care plan. S/he is able to regularly review, revise and adapt the care plan. S/he has specialised knowledge of systematic health and nursing assessments (e.g. professional guidelines, care protocols, application such as Braden Scale, Norton Scale, Frohwein Scale, MNA, Barthel-Index, and Mini mental state examination) and is able to apply it. S/he is able to order diagnostic tests and procedures permitted in the scope of specialist practice and legislation. S/he is able to involve clients in care planning, ensuring that they receive accurate, understandable information.	S/he is able to control care plans, evaluate them, and supervise other staff members in the care planning process. S/he is able to develop and maintain quality management systems in institutions or within the care process.	S/he is able to examine assessment instruments and to participate in the development and application of assessment instruments. S/he is able to introduce assessment tools into practice by considering the context of nursing sciences methods and to delegate the change of care interventions, if necessary.
6 Managing the processes of elderly care	S/he is able to instruct colleagues and apprentices and to coordinate interprofessional teamwork e.g. by setting priorities.		S/he is able to regulate processes and to collect individual resources and needs (e.g. assessing the physiological, safety, social, self-actualisation, self-esteem, or mobility of clients). S/he is able to mobilise and coordinate resources and to take the lead role in managing the care process. S/he is able to apply the "case management" approach in the care process.		S/he is able to manage and coordinate (intercultural) teams. S/he is able to manage a care division and to make staff decisions. S/he is able to exchange information with other health occupations and to plan a common approach if necessary. S/he is able to continuously estimate the needs of clients and client groups as well as the available financial, material, and staff resources, and the requirements for organisational development. S/he is able to establish and manage research projects. S/he is able to assign defined medical interventions / diagnostic procedures in advanced nursing practice and to manage the overall hygienic conditions of the institution/home.	
Personal attitudes of an elderly care giver (competence areas 7 – 9)						
7 Expanding and updating skills and knowledge	S/he is able to recognise his/her own training needs. S/he is able to motivate him-/herself for training. S/he is able to communicate his/her training needs to his/her supervisor. S/he is willing to frequently choose and attend formal education measures. S/he is able to apply up-to-date knowledge of legal regulations (e.g. familiarity with client rights, ethical standards, health law, and moral and ethical standards, first aid rules and their context). S/he is able to learn from her colleagues in practice (on-the job). S/he is able to keep her/his ICT skills up-to-date in order to meet growing work demands.	S/he is able to adapt existing skills to new technological developments. S/he is willing to specialise in a specific field of care (e.g. caring people with dementia or pain, etc.) S/he is able to support superiors in research projects. S/he is able to filter and prioritise information, and understands how to maximise cognitive function using a variety of tools and techniques. S/he is able to communicate in more than one language to have better access to work opportunities on the European labour market, and is able to deal with a growing number of clients with differing cultural backgrounds ('aging migrants').	S/he is able to communicate new empirical knowledge to colleagues. S/he is able to implement new empirical findings into daily practice. S/he is able to interpret and evaluate research findings critically. S/he is able to investigate new empirical knowledge and information in nursing science databases and peer reviewed journals. S/he is able to apply concepts of "managed care" (new forms of cooperation with cost bearers and care providers) to reduce unnecessary health costs.	S/he is able to create new empirical knowledge in the field of nursing sciences.	

8 Reflecting and handling the impact of the job (job-related self-understanding)	S/he is able to take care of her/his own health to perform the job of a care giver. S/he can recognise her/his own limits and is able to acknowledge them. S/he is able to access methods of supervision and apply its results. S/he is able to recognise psychological impacts on her/his own health. S/he is able to carry out prevention and health promotion activities for care givers. S/he is able to maintain a healthy work-life-balance.	S/he is able to develop and apply individual coping strategies for clients. S/he is able to apply methods of burn-out prevention. S/he is able to pay attention to his/her own limits and maintain a professional distance from the clients. S/he can assist the elderly to address topics such as loneliness and death. S/he has the capacity to adapt to flexible forms of employment (e.g. self-employment).	S/he is able to provide the elderly with tools to help them face chronic and terminal illness, loneliness, and death (e.g. establishing contacts, involvement in activities and events). S/he is able to apply special concepts and models in elderly care (e.g. chronic care model, patient-centred care).
9 Dealing with different organisational contexts	S/he is able to develop and apply organisational skills according to the specific institutional environment (e.g. entrepreneurial skills for self-employed care givers; adapting to specific institutional standards and norms etc.). S/he is able to work in newly created elderly care environments (e.g. new forms of joint household). S/he is able to work in an intercultural team setting.	S/he is able to apply her/his care knowledge in different organisational and institutional settings (e.g. home care, home communities, new forms of living etc.).	

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Sources: Synthesis Report (WP2); Klein, B.; Gaugisch, P.; Stopper, K. (2008). „Pflege 2015“: Neue Arbeitsanforderungen und zukünftige Qualifizierungsbedarfe. Hans-Böckler Stiftung und ver.di. Sahamel, K-H. (2011). Wandel der Pflege – Neue Kompetenzen für Pflegekräfte. Vortrag auf der Tagung der Bundesarbeits-gemeinschaft der Freien Wohlfahrtspflege am 16.2.2011 in Berlin. Davis, A.; Fidler, D.; Gorbis, M. (2011). Future Work Skills 2020. Institute for the Future for the University of Phoenix Research Institute; http://ec.europa.eu/health/workforce/policy/skills/index_en.htm [13.02.2013].

4 NoBoMa Organisational Profiles

As mentioned in Chapter 2, an Organisational Profile reflects the range and extent of competence development offered by a specific training programme in a Competence Matrix occupational field. Programmes offered by the Hungarian *Caritas Pécs* and the Austrian *Vinzentinum* were used in the NoBoMa project as examples of "Elderly Care" training provision from which Organisational Profiles could be developed. The Organisational Profile for *Caritas Pécs* was developed by Pál Csonka, and the Organisational Profile for *Vinzentinum* was developed by Markus Greger. Both Pál and Markus possess extensive knowledge on the curricula and training plans of these programmes, as well as a thorough understanding of the core work tasks expected from graduates of the programmes (cf. Luomi-Messerer, 2009, p. 44). 3s research laboratory suggested the use of the following procedure for the creation of Organisational Profiles, a process which was followed Pál Csonka and Markus Greger throughout development of the profiles.

Firstly, all of the descriptions contained within the entire Competence Matrix were read. The Competence Matrix descriptions were then compared with the competences and curriculum or training plan/programme of *Caritas Pécs* and *Vinzentinum*. The relevant competence areas and competence development steps that formed part of the curricula or training plan of the Hungarian and Austrian programmes were then identified. After ensuring that all relevant elements of the training programme/curricula were identified in the competence areas and competence development steps, additional competences developed through the training programme but not covered by the Competence Matrix were determined. Furthermore, additional information regarding differences between the descriptions in the Competence Matrix and descriptions in the curriculum / training plan (for example, in some cases only parts of the description of a competence development step might be relevant for the training programme) were noted. These results were reviewed in collaboration with individuals involved in the training process. This included teaching and training personnel or individuals who perform similar functions, representatives of enterprises in which graduates of the training programme are employed, individuals in training, and graduates. A revision of the Organisational Profiles was undertaken on the basis of the feedback provided. Finally, the Organisational Profile was completed by indicating the parts of the Competence Matrix covered by the training programme through the use of colour coding.

4.1 *Caritas Pécs* Hungary

The elderly care training programme provided by *Caritas Pécs* (Hungary) is the outcome of two Leonardo da Vinci-projects. The first is the ECVLeonardo project in which an e-learning curriculum[12] was developed and supplemented by practical, work-based learning at elderly care provision centres. The second is the follow-up ECVC[13] "Elderly Care Vocational Certificate" project in which a certification procedure was developed that was designed to implement a

[12] See www.ecvleonardo.com.
[13] See http://www.ecvc.eu/.

vocational training system that empowered the local communities with vocational skills in "Elderly Care". The "Elderly Care Vocational Certificate" is a post-secondary, pre-tertiary education qualification at ISCED level 4. It provides: 1) E-learning on elderly care ergonomics through the use of the ECV software; 2) practical experience of elderly care acquired by working in the real environment of an elderly home under supervision by experienced care professionals; 3) verification of theoretical knowledge via the ECV software and skill validation through observation of workplace practice; 4) Competence certification by the ECVC Certification Committee on the basis of the learner's training dossier. The E-learning programme provides learners with theoretical knowledge enriched with practical experience in the following subjects:

Module 1 – Vocational awareness: The purpose of this module is to inform and raise awareness regarding the status, rights, and needs of older people in society. This is achieved through the development of an understanding and recognition that the work of the "Elderly Care Givers" is a significant factor in the advancement and promotion of necessary social structures.

Module 2 – Assessment and basic ageing pathology: The caregiver must be aware of the basic pathological states of health which arise frequently in the third and fourth age. The caregiver should have the ability to: recognise danger signs in the health status of the elderly, convey accurate information, understand instructions given by doctors, and provide compassionate assistance where needed. While ECV caregiver training is not comparable to training received by medical or nursing students, the caregiver should know some basics.

Module 3 – Environmental care: Maintaining a clean and safe environment is inextricably linked to the provision of effective professional care to the elderly. Keeping the environment in good order is essential for ensuring the physical and psychological health of the elderly given their limited ability to change their living conditions and to organise and shape their surroundings. Maintaining a clean and tidy environment is a crucial element of the everyday role of the "Elderly Care Giver".

Module 4 – Basic body care: Basic body care can be vital aspect of caring for the elderly. The elderly client may depend entirely on the caregiver in ensuring basic body care, although the caregiver should encourage older people to undertake their own body care tasks as much as possible.

Module 5 – Hygiene: Activities related to maintaining personal hygiene are a significant element of caring for the elderly. The caregiver should be able to apply relevant skills to ensure that older people receive necessary care to maintain a good standard of hygiene and quality of life.

Module 6 – Nursing: The caregiver can provide the elderly with basic medical care. Only those nursing procedures that can be provided safely in an elderly care environment by non-medically qualified staff are taught to students. The caregiver must possess knowledge to a level that ensures that the elderly people receive safe and professional nursing services (e.g. measuring temperature, measuring pulse frequency, measuring blood pressure, etc.).

Module 7 – Handling incontinence: Incontinence is an embarrassing problem for both elderly people and caregivers. Prolonged exposure to the effects of incontinence can cause significant health problems for older people. Therefore, this topic must be viewed as a vital matter of urgent care.

Module 8 – First aid: Elderly people are more susceptible to health problems. The caregiver must be able to respond immediately to health problems through the provision of first aid. The caregiver cannot make conclusive decisions on tackling complex health problems, but acts as a

health care intermediary before an elderly person is able to see an appropriate specialist.
Module 9 – Physiotherapy: Physiotherapy is practiced as a non-invasive, soothing recovery tool. Implementation of physiotherapy procedures requires a high degree of competence and should be considered an equally important cognitive element in professional care context.
Module 10 – Mobility and entertainment: Physical and mental mobilisation is key to maintaining the physical and mental functions of the bodies and minds of elderly people. Active and passive motion should be part of care of the elderly. The elderly should be strongly encouraged to maintain an active lifestyle and, crucially, undertake mental and physical activities.
Module 11 – Tools and materials: Knowledge of some specialist medical tools, ergonomic equipment, and materials used to perform specific ergonomic processes in the professional care of the elderly. This module contains descriptions relating to the utility, handling, and maintenance of specialised tools and materials, and the caregiver should understand their importance and how to use them appropriately in caring for the elderly.

Following completion of the modules participants undertake a standardised electronic test designed to assess their knowledge. The examination is comprised of a randomly selected assortment of true or false questions related to different elements of care knowledge. When completion of the examination leads to the issue of a certificate in elderly care, the exam must be taken under supervision.

The Organisational Profile for the ECVC training programme offered by *Caritas Pécs* in Hungary has been indicated in the Competence Matrix on the basis of a comparison between the matrix and the training programme. The competences that form part of the Organisational Profile of *Caritas Pécs* "Elderly Care" training programme are indicated through colour coding of the relevant competence areas and steps of competence development. However, some parts of the coloured competence development steps do not form a part of the *Caritas Pécs* training programme, but have been coloured because most competences in the respective competence development step do form part of the ECVC training programme. This applies to the following competence areas and competence development steps:

"S/he is able to adhere to current regulations and local standards regarding the disposal of sharp medical instruments, contaminated waste in the workplace, and personal protective equipment, and is actively involved in the regular re-evaluation of the process.", found on competence development step 3 in competence area 2, does not form part of the Organisational Profile of *Caritas Pécs* but the competence development step is coloured because the vast majority of competences described within this level do form part of the training programme. The same applies to parts of competence development step 2 in competence area 3, *"S/he is adheres to applicable laws and local rules regarding the safety of the workplace"*; parts of competence development step 2 in competence area 4, *"S/he is able to explain medical diagnoses to the client and his/her family"*; and parts of competence development step 3 in competence area 4, *"S/he is able to plan and conduct counselling sessions"*. Aspects of competence development step 1 in competence area 5, *"S/he is able to conduct basic administrative work by using common computer-based documentation systems"* and *"S/he is, with guidance, able to plan and attend ward rounds (in nursing homes)",* are not taught in the *Caritas Pécs* training programme, but are coloured in the matrix because the majority of competence development step 1 is relevant to the training

course.
Furthermore, some competence development steps are included in the ECVC training programme, but have not been coloured as Organisational Profile as the majority of competences described in the respective competence development steps are not covered by the ECVC training programme. This applies to the following competence areas and competence development steps:

Elements of competence development step 5 in competence area 2, *"S/he is able to plan, evaluate and, when necessary, to change resources which maintain quality of life, well-being, health and social integration (e.g. financial resources, physical assets and family/household resources, risk management, care in case of Apoplectic stroke, injuries caused by falling)* and *"S/he is able to apply adequate care utilities (e.g. applying incontinence equipment, hearing and visual aid, mobility aids",* forms part of the Organisational Profile of *Caritas Pécs*. However, this competence development step is not coloured as part the Organisational Profile as only these competences are relevant to the training programme and the remaining competences in competence development step 5 are not. Elements of competence development step 2 in competence area 6 are included within the ECVC training programme, specifically *"S/he is able to collect individual needs (e.g. assessing physiological, safety, social needs of clients)"*. However, since the majority of competences contained within this competence development step do not form part of the training programme it is not coloured and thus, does not comprise a part of the Organisational Profile. The same applies to elements of competence development level 1 in competence area 7, *"S/he is able to recognise his/her own training needs"*, *"S/he is able to communicate his/her training needs to his/her supervisor"* and *"S/he is willing to frequently choose and attend formal education measures"*, as well as aspects of competence area 8 *"S/he is able to develop and apply individual coping strategies for clients"* and *"S/he is able to apply methods of burn-out prevention"*.

A number of additional competences are taught in the *Caritas Pécs* ECVC training programme that are currently not included in the NoBoMa Competence Matrix. These are: *"S/he is able to stimulate the clients for activation (breathing and physical exercises)"*; *"S/he is able to organise and steer social gatherings and activities for the clients"*; *"S/he is able to assist the clients in keeping pets and indoor plants, and in outdoor gardening"*. If these skills were integrated in the NoBoMa Competence Matrix, they would comprise a part of competence development step 2 in competence area 1. Another element taught in ECVC training but which does not yet form part of the NoBoMa Competence Matrix is: *"S/he is able to carry out actions aimed at maintaining the personal hygiene of the elderly client without supervision"*. This would be allocated to competence development step 3 within competence development area 1 in the NoBoMa matrix. Other skills currently not included in Competence Matrix are: *"S/he is able to perform actions aimed at handling incontinence of the client, and to administer and use related equipment and materials (pads, stomas)"*; *"S/he is able to perform actions and techniques of physiotherapy (e.g. healing baths, massage, rubbing etc.) for the elderly client"*; and "*S/he is able to perform actions and techniques of thromboembolism prophylaxis (compressions stockings, elastic bandage) for the elderly client"*, all of which would apply to competence development step 3 in competence area 2. *"S/he is able to maintain neat and tidy room conditions"* would be placed on competence development step 1 in competence area 3. *"S/he is able to clean the footwear and wash and iron the laundry of the client"*, could form part of competence development step 2 in competence area 3, and *"S/he is able to observe issues of confidentiality and to demonstrate respect for the intimacy of the elderly clients"* would be applicable to competence development step 2 in competence area 4. *"S/he is aware of the situation of*

elders and the society" and *"S/he is able to observe the social status of the elderly"* are also included in the ECVC and if allocated to the NoBoMa Competence Matrix could comprise part of competence development step 1 in competence area 6.

The following table shows the Organisational Profile of *Caritas Pécs* displayed in the NoBoMa Competence Matrix. Those parts of the NoBoMa Competence Matrix coloured in yellow indicate the competences acquired through the *Caritas Pécs* elderly care training programme.

Table 5: Organisational Profile *Caritas Pécs*

Competence area	Steps of competence development Basic level					Expert level
Professional skills and task related competences (competence areas 1 – 6)						
1 Planning and conducting daily care	S/he is able to support the client in domestic tasks (e.g. cooking, washing, etc.). S/he is able to maintain rituals and habits of clients. S/he is able to follow, adhere to, and apply legal requirements (e.g. client rights, ethical and moral standards, health law, knowing that s/he is only allowed to assist with basic care).	S/he is able to assist superiors in identifying the care needs of the client. S/he is, with guidance, able to develop care plans on the basis of identified care needs. S/he is able to consider the needs of clients by asking about individual sensitivities and assistance needs in an empathetic manner. S/he is able to report unforeseeable and modified situations to superiors and knows how and to whom to report (e.g. symptoms, accident hazards, family conflicts, crises, deterioration of nutritional status, pain). S/he is, with guidance, able to carry out basic body care procedures, personal hygiene, and daily activities. S/he is able to perform basic mobility actions with the clients (e.g. instruction how to use walking and standing aids, wheelchairs, etc.). S/he is able to deliver health care independently and regardless of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.	S/he is able to identify the care needs of the client and to conduct professional care interventions on the basis of identified care needs. S/he is able to develop care plans according to identified care needs. S/he is able to independently carry out body care procedures, personal hygiene, and daily activities. S/he is able to implement care processes that facilitate and promote the health and independence of the client (e.g. encouraging client independence or providing guidance for the personal well-being of clients). S/he is able to react adequately to unforeseeable and modified situations (e.g. by giving instruction on how to proceed). S/he is able to coordinate and plan with the client in an aim-oriented manner in order to provide appropriate care measures.	S/he is able to link theoretical concepts (according to the latest evidence-based guidelines) with practical observations. S/he is able to select and implement therapeutic interventions by reflecting theories and practical observations.	S/he is able to decide when a sub-division of tasks is necessary considering parameters such as relevance of needs, clinical situation, and qualification. S/he is able to plan, evaluate and, when necessary, to change resources which maintain quality of life, well-being, health and social integration (e.g. financial resources, physical assets and family/household resources, risk management, care in case of apoplectic stroke, injuries caused by falling). S/he is able to conduct special interventions based on evidence in the nursing process (e.g. being aware of professional guidelines and protocols, nursing scientific research, counselling in special situations). S/he is able to apply adequate care equipment (e.g. applying incontinence equipment, hearing and visual aids, mobility aids). S/he is able to supervise body care procedures. S/he is able to take responsibility for the implementation of care based on professional and legal requirements.	S/he is able to conduct research about care and nursing concepts, care utilities, nursing interventions. S/he is able to estimate the quality of the outcome (effectiveness of the research) and to ensure that the research results are applied in practice.
2 Planning and carrying out nursing activities	S/he is able to apply nursing instructions from superiors (e.g. measuring blood pressure, taking blood samples, etc.). S/he is able to support superiors in carrying out monitoring, provision of medication, and nursing of wounds with regard to basic hygiene rules. S/he is able to take care of, clean, and disinfect medical equipment. S/he is able to look for help in case of emergency and is able to call the ambulance, fire brigade, or police as necessary. S/he is able to consider current legislation and local standards regarding the workplace, medical instruments and contaminated waste, and health and safety measures, and is able to inform superiors in case of discrepancies.		S/he is able to make simple nursing diagnoses (e.g. change of skin colour or condition; identify an irregular health status). S/he is able to perform monitoring, provision of medication, and nursing of wounds with regard to basic hygiene rules. S/he is able to perform first aid.		S/he is able to recognise common disease patterns of elderly people (e.g. Cardiac problems, infectious diseases). S/he is able to respond immediately and appropriately to emergencies and to begin, if necessary, basic life support and other emergency measures. S/he is able to adhere to current regulations and local standards regarding the disposal of sharp medical instruments, contaminated waste in the workplace, and personal protective equipment, and is actively involved in the regular re-evaluation of the process. S/he is able to ensure adequate storage, handling, and recording of therapeutic substances.	S/he is able to create structural changes to prevent the spread of disease (e.g. coordinating and organising the distribution of infection control masks, manage health promotion and health care programmes, develop a hygiene guideline, and emergency actions). S/he is able to develop and implement emergency plans and to oversee coordination in case of emergencies.
3 Creating and	S/he is able to perform basic cleaning and environmental care procedures.		S/he is able to evaluate the safety conditions of the living environment by		S/he is able to avoid situations that might have a negative	S/he is able to arrange the environment of clients to

maintaining a health promoting and safe environment	S/he knows about psychological aspects of health and their impact, and is able to provide and support creative elements (e.g. singing, reading) in the care process. S/he is able to create and maintain a health promoting and safe environment.		following relevant criteria and is able to report potential dangers to colleagues or superiors. S/he adheres to applicable laws and local rules regarding the safety of the workplace. S/he is able to plan and carry out multiple social activities with the client at home and outside.	impact on the security of clients and colleagues. S/he is able to participate in arranging and furnishing residential areas which meet the requirements of clients, including provision of care utilities.		facilitate autonomy in the activities of daily living. S/he is able 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 a fall, taking measures to prevent infection). S/he is actively involved in the development of regulations in the work place (e.g. safety measures). S/he is able to choose instruments for the assessment of existing and potential security risks, to apply them, and to inform the relevant authorities.
4 Communicating with different stakeholders involved in the care process	S/he is able to build, maintain, and conclude verbal and nonverbal (e.g. through touch) interactions with empathy through interpersonal communication S/he is able to choose and apply appropriate methods of communication according to his/her institutional environment (e.g. home-care or nursing home). S/he is able to communicate with clients and relatives and provide information in an appropriate way.		S/he is able to explain simple medical diagnoses to the client and his/her family. S/he is able to provide information about the care process to clients and families and to inform the client about aspects of the care plan. S/he is able to recognise crises and inform superiors, and seek support from competent persons. S/he is able to network with professionals and ordinary persons (e.g. relatives of the client who support the care process).	S/he is able to identify communication barriers and conflicts, apply solutions, and perform mediation. S/he is able to professionally intervene in crises. S/he is able to initiate and terminate stakeholder-oriented relationships by using professional communication methods. S/he is able to plan and conduct counselling sessions. S/he is able to inform clients and verify that the information has been understood. S/he is able to lead and participate in consulting processes for the client and his/her social environment.		S/he is able to communicate effectively within the team and to develop, implement, and evaluate mechanisms for optimising the processes of professional cross-group collaboration. S/he is able to advocate for clients, families, or carers that request support, or have language barriers, or limited decision-making abilities. S/he is able to present and support positions of clients and colleagues in inter-professional teams and can manage negotiations.
5 Recording, evaluating and assuring the quality of the care process	S/he is able to assist superiors in creating care plans. S/he has a basic understanding of quality standards and quality criteria in care. S/he is able to conduct basic administrative work by using common computer-based documentation systems. S/he is, with guidance, able to plan and attend ward rounds (in nursing homes).	S/he is able to record the care process and report changes to her/his superior. S/he is able to gather health data and to transmit data for assessment by general care practitioners and specialists. S/he is able to conduct medical educational programmes for clients and relatives with an approved syllabus (e.g. hair care, oral care, bathing, use of medical aids, wound care, changing of incontinence pads , skin protection, stoma and PEG tube care, nutrition, hydration, mobilisation and positioning). S/he is able to evaluate and adapt care plans under supervision. S/he is able to apply quality standards and criteria in care during his/her work. S/he is able to report the outcomes of an intervention in a structured manner.	S/he is able to determine a care plan on the basis of a nursing diagnosis by using data from different sources. S/he is able to evaluate progress towards planned outcomes in consultation with clients, families, and/or professionals and to use evaluation data to modify the care plans. S/he is able to gather accurate and relevant objective and subjective data about the client through systematic health and nursing assessments (e.g. objective and subjective symptoms, physical, social, environmental, psychological factors, Norton Scale, Frohwein scale, MNA, descriptive personal profiles). S/he is able to document findings, interventions, and patient responses accurately, complying with professional standards and organisational policies (e.g. using the nursing documentation in effect).	S/he is able to apply critical thinking and clinical reasoning skills when developing a care plan. S/he is able to regularly review, revise, and adapt the care plan. S/he has specialised knowledge of systematic health and nursing assessments (e.g. professional guidelines, care protocols, application such as Braden Scale, Norton Scale, Frohwein Scale, MNA, Barthel-Index, and Mini mental state examination) and is able to apply it. S/he is able to order diagnostic tests and procedures permitted in the scope of specialist practice and legislation. S/he is able to involve clients in care planning, ensuring that they receive accurate, understandable information.	S/he is able to control care plans, evaluate them, and supervise other staff members in the care planning process. S/he is able to develop and maintain quality management systems in institutions or within the care process.	S/he is able to examine assessment instruments and to participate in the development and application of assessment instruments. S/he is able to introduce assessment tools into practice by considering the context of nursing sciences methods and to delegate the change of care interventions, if necessary.
6	S/he is able to instruct colleagues and		S/he is able to regulate processes and to collect individual		S/he is able to manage a care	

Managing the processes of elderly care	apprentices and to coordinate interprofessional teamwork e.g. by setting priorities.	resources and needs (e.g. assessing the physiological, safety, social, self-actualisation, self-esteem or mobility of clients). S/he is able to mobilise and coordinate resources and to take the lead role in managing the care process. S/he is able to apply the "case management" approach in the care process.		division and to make staff decisions. S/he is able to exchange information with other health occupations and to plan a common approach if necessary. S/he is able to continuously estimate the needs of clients and client groups as well as the available financial, material, and staff resources, and the requirements for organisational development. S/he is able to establish and manage research projects.
Personal attitudes of an elderly care giver (competence areas 7 – 8)				
7 Expanding and updating skills and knowledge	S/he is able to recognise his/her own training needs. S/he is able to motivate him-/herself for training. S/he is able to communicate his/her training needs to his/her supervisor. S/he is willing to frequently choose and attend formal education measures. S/he is able to apply up-to-date knowledge of legal regulations (e.g. familiarity with client rights, ethical standards, health law moral and ethical standards, first aid rules and their context). S/he is able to learn from her colleagues in practice (on-the job).	S/he is able to adapt existing skills to new technological developments. S/he is willing to specialise in a specific field of care (e.g. caring people with dementia or pain, etc.) S/he is able to support superiors in research projects.	S/he is able to communicate new empirical knowledge to colleagues. S/he is able to implement new empirical findings into daily practice. S/he is able to interpret and evaluate research findings critically. S/he is able to investigate new empirical knowledge and information in nursing science databases and peer reviewed journals.	S/he is able to create new empirical knowledge in the field of nursing sciences.
8 Reflecting and handling the impact of the job (job-related self-understanding)	S/he is able to take care of her/his own health to perform the job of a care giver. S/he can recognise her/his own limits and is able to acknowledge them. S/he is able to access methods of supervision and apply its results. S/he is able to recognise psychological impacts on her/his own health. S/he is able to carry out prevention and health promotion activities for care givers. S/he is able to maintain a healthy work-life-balance.	S/he is able to develop and apply individual coping strategies for clients. S/he is able to apply methods of burn-out prevention. S/he is able to pay attention to his/her own limits and maintain a professional distance from the clients. S/he can assist the elderly to address topics such as loneliness and death.	S/he is able to provide the elderly with tools to help them face chronic and terminal illness, loneliness, and death (e.g. establishing contacts, involvement in activities and events). S/he is able to apply special concepts and models in elderly care (e.g. chronic care model, patient-centred care).	

Author: Pál Csonka (Caritas Pécs, HU) with support from Tanja Bacher and Viktor Fleischer (3s research laboratory).

4.2 *Vinzentinum* Austria

The *Vinzentinum* in Linz (AT), in association with the UMIT (a private health University in Austria), offers a combined study programme known as "Combination Study Nursing Science" (*Kombistudium Pflegewissenschaften*) which leads to the award of a diploma certificate and a Bachelor's degree[14]. This programme combines a three year diploma degree course in "Nursing" (*Gesundheits- und Krankenpflege*), for which participants are awarded a Diploma of general nursing care, with a three year Bachelor's degree course in "Nursing Science" (*Pflegewissenschaften*), for which participants are awarded a "Bachelor of Science in Nursing", BscN.

The "Combination Study Nursing Science" lasts three and a half years and consists of 180 ECTS credits. In the first two terms (1 year of study) the study content is drawn from the "Nursing" diploma degree course. At the beginning of the third term (2 year of study) this is combined with the study content from the "Nursing Science" Bachelor's degree course. Therefore, the *Vinzentinum* offers a combination of professional and theoretical education with an academic research component.

The *Vinzentinum* Organisational Profile was developed by Markus Greger, a teacher at *Vinzentinum* Linz (Austria). The development of the Organisational Profile followed the procedure outlined above and the profile itself was validated by members of the teaching staff at *Vinzentinum* Linz.

The Organisational Profile of *Vinzentinum* Linz utilises almost all competence areas and competence development steps in the NoBoMa Competence Matrix, because basic education in the care profession is combined with a university degree. In the first two years of training the first and second competence development steps are reached, while the knowledge and skills relating to the third competence development step are primarily taught in the second and third year. Competence development steps 4 and 5 are primarily addressed during the bachelor studies and the final year of general nursing education. A number of skills and competences which do not form part of "Combined Study Nursing Science" programme can be acquired in the Austrian "Nursing Science" Master's programme. This Master's programme, however, is not offered at the *Vinzentinum*. These advanced skills and competences are found mainly in the final competence development step of competence areas 3, 5, 6, and 7 and consequently, these are not coloured in the matrix (because they do not form part of the Organisational Profile of the *Vinzentinum* programme). Elements of competence development step 4 in competence area 3, such as *"S/he is able to arrange the environment of clients to facilitate autonomy in the activities of daily living",* are part of the *Vinzentinum* training programme, but do not form part of the Organisational Profile because the majority of skills in this competence development level can only be achieved through the "Nursing Science" Master's degree.

While some parts of the NoBoMa Competence Matrix do not form part of the training programme at *Vinzentinum*, there are also some areas addressed within the *Vinzentinum* training

[14] http://www.vinzentinum-linz.at/index_html?sc=867593575 [26.02.2013].

curricula that are absent from the NoBoMa Competence Matrix. Firstly, Gerontology (Age Studies), the study of physical and mental changes in due to ageing, or diseases prevalent in older age, is not yet included in the matrix. Secondly, complementary care (music therapy, aromatherapy, wet packs and pads ...) and ethics comprise aspects of the training programme at *Vinzentinum*, but are not currently displayed in the NoMoBa matrix.

The following table shows the Organisational Profile of *Vinzentinum* displayed in the NoBoMa Competence Matrix. Those parts of the NoBoMa Competence Matrix coloured in yellow indicate the competences acquired through the "Combination Study Nursing Science" offered at the *Vinzentinum*.

Table 6: Organisational Profile *Vinzentinum* Austria

Competence area	Steps of competence development Basic level					Expert level
Professional skills and task related competences (competence areas 1 – 6)						
1 Planning and conducting daily care	S/he is able to support the client in domestic tasks (e.g. cooking, washing, etc.). S/he is able to maintain rituals and habits of clients. S/he is able to follow, adhere to, and apply legal requirements (e.g. client rights, ethical and moral standards, health law, knowing that s/he is only allowed to assist with basic care).	S/he is able to assist superiors in identifying the care needs of the client. S/he is, with guidance, able to develop care plans on the basis of identified care needs. S/he is able to consider the needs of clients by asking about individual sensitivities and assistance needs in an empathetic manner. S/he is able to report unforeseeable and modified situations to superiors and knows how and to whom to report (e.g. symptoms, accident hazards, family conflicts, crises, deterioration of nutritional status, pain). S/he is, with guidance, able to carry out basic body care procedures, personal hygiene, and daily activities. S/he is able to perform basic mobility actions with the clients (e.g. instruction how to use walking and standing aids, wheelchairs, etc.). S/he is able to deliver health care independently and regardless of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.	S/he is able to identify the care needs of the client and to conduct professional care interventions on the basis of identified care needs. S/he is able to develop care plans according to identified care needs. S/he is able to independently carry out body care procedures, personal hygiene, and daily activities. S/he is able to implement care processes that facilitate and promote the health and independence of the client (e.g. encouraging client independence or providing guidance for the personal well-being of clients). S/he is able to react adequately to unforeseeable and modified situations (e.g. by giving instruction on how to proceed). S/he is able to coordinate and plan with the client in an aim-oriented manner in order to provide appropriate care measures.	S/he is able to link theoretical concepts (according to the latest evidence-based guidelines) with practical observations. S/he is able to select and implement therapeutic interventions by reflecting theories and practical observations.	S/he is able to decide when a sub-division of tasks is necessary considering parameters such as relevance of needs, clinical situation, and qualification. S/he is able to plan, evaluate and, when necessary, to change resources which maintain quality of life, well-being, health and social integration (e.g. financial resources, physical assets and family/household resources, risk management, care in case of apoplectic stroke, injuries caused by falling). S/he is able to conduct special interventions based on evidence in the nursing process (e.g. being aware of professional guidelines and protocols, nursing scientific research, counselling in special situations). S/he is able to apply adequate care equipment (e.g. applying incontinence equipment, hearing and visual aids, mobility aids). S/he is able to supervise body care procedures. S/he is able to take responsibility for the implementation of care based on professional and legal requirements.	S/he is able to conduct research about care and nursing concepts, care utilities, nursing interventions. S/he is able to estimate the quality of the outcome (effectiveness of the research) and to ensure that the research results are applied in practice.
2 Planning and carrying out nursing activities	S/he is able to apply nursing instructions from superiors (e.g. measuring blood pressure, taking blood samples, etc.). S/he is able to support superiors in carrying out monitoring, provision of medication, and nursing of wounds with regard to basic hygiene rules. S/he is able to take care of, clean, and disinfect medical equipment. S/he is able to look for help in case of emergency and is able to call the ambulance, fire brigade, or police as necessary. S/he is able to consider current legislation and local standards regarding the workplace, medical instruments and contaminated waste, and health and safety measures, and is able to inform superiors in case of discrepancies.	S/he is able to make simple nursing diagnoses (e.g. change of skin colour or condition; identify an irregular health status). S/he is able to perform monitoring, provision of medication, and nursing of wounds with regard to basic hygiene rules. S/he is able to perform first aid.		S/he is able to recognise common disease patterns of elderly people (e.g. Cardiac problems, infectious diseases). S/he is able to respond immediately and appropriately to emergencies and to begin, if necessary, basic life support and other emergency measures. S/he is able to adhere to current regulations and local standards regarding the disposal of sharp medical instruments, contaminated waste in the workplace, and personal protective equipment, and is actively involved in the regular re-evaluation of the process. S/he is able to ensure adequate storage, handling, and recording of therapeutic substances.	S/he is able to create structural changes to prevent the spread of disease (e.g. coordinating and organising the distribution of infection control masks, manage health promotion and health care programmes, develop a hygiene guideline, and emergency actions). S/he is able to develop and implement emergency plans and to oversee coordination in case of emergencies.
3 Creating and	S/he is able to perform basic cleaning and environmental care procedures.	S/he is able to evaluate the safety conditions of the living environment by		S/he is able to avoid situations that might have a negative		S/he is able to arrange the environment of clients to

maintaining a health promoting and safe environment	S/he knows about psychological aspects of health and their impact, and is able to provide and support creative elements (e.g. singing, reading) in the care process. S/he is able to create and maintain a health promoting and safe environment.		following relevant criteria and is able to report potential dangers to colleagues or superiors. S/he adheres to applicable laws and local rules regarding the safety of the workplace. S/he is able to plan and carry out multiple social activities with the client at home and outside.	impact on the security of clients and colleagues. S/he is able to participate in arranging and furnishing residential areas which meet the requirements of clients, including provision of care utilities.		facilitate autonomy in the activities of daily living. S/he is able 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 a fall, taking measures to prevent infection). S/he is actively involved in the development of regulations in the work place (e.g. safety measures). S/he is able to choose instruments for the assessment of existing and potential security risks, to apply them, and to inform the relevant authorities.
4 Communicating with different stakeholders involved in the care process	S/he is able to build, maintain, and conclude verbal and nonverbal (e.g. through touch) interactions with empathy through interpersonal communication S/he is able to choose and apply appropriate methods of communication according to his/her institutional environment (e.g. home-care or nursing home). S/he is able to communicate with clients and relatives and provide information in an appropriate way.		S/he is able to explain simple medical diagnoses to the client and his/her family. S/he is able to provide information about the care process to clients and families and to inform the client about aspects of the care plan. S/he is able to recognise crises and inform superiors, and seek support from competent persons. S/he is able to network with professionals and ordinary persons (e.g. relatives of the client who support the care process).	S/he is able to identify communication barriers and conflicts, apply solutions, and perform mediation. S/he is able to professionally intervene in crises. S/he is able to initiate and terminate stakeholder-oriented relationships by using professional communication methods. S/he is able to plan and conduct counselling sessions. S/he is able to inform clients and verify that the information has been understood. S/he is able to lead and participate in consulting processes for the client and his/her social environment.		S/he is able to communicate effectively within the team and to develop, implement, and evaluate mechanisms for optimising the processes of professional cross-group collaboration. S/he is able to advocate for clients, families, or carers that request support, or have language barriers, or limited decision-making abilities. S/he is able to present and support positions of clients and colleagues in inter-professional teams and can manage negotiations.
5 Recording, evaluating and assuring the quality of the care process	S/he is able to assist superiors in creating care plans. S/he has a basic understanding of quality standards and quality criteria in care. S/he is able to conduct basic administrative work by using common computer-based documentation systems. S/he is, with guidance, able to plan and attend ward rounds (in nursing homes).	S/he is able to record the care process and report changes to her/his superior. S/he is able to gather health data and to transmit data for assessment by general care practitioners and specialists. S/he is able to conduct medical educational programmes for clients and relatives with an approved syllabus (e.g. hair care, oral care, bathing, use of medical aids, wound care, changing of incontinence pads , skin protection, stoma and PEG tube care, nutrition, hydration, mobilisation and positioning). S/he is able to evaluate and adapt care plans under supervision. S/he is able to apply quality standards and criteria in care during his/her work. S/he is able to report the outcomes of an intervention in a structured manner.	S/he is able to determine a care plan on the basis of a nursing diagnosis by using data from different sources. S/he is able to evaluate progress towards planned outcomes in consultation with clients, families, and/or professionals and to use evaluation data to modify the care plans. S/he is able to gather accurate and relevant objective and subjective data about the client through systematic health and nursing assessments (e.g. objective and subjective symptoms, physical, social, environmental, psychological factors, Norton Scale, Frohwein scale, MNA, descriptive personal profiles). S/he is able to document findings, interventions, and patient responses accurately, complying with professional standards and organisational policies (e.g. using the nursing documentation in effect).	S/he is able to apply critical thinking and clinical reasoning skills when developing a care plan. S/he is able to regularly review, revise, and adapt the care plan. S/he has specialised knowledge of systematic health and nursing assessments (e.g. professional guidelines, care protocols, application such as Braden Scale, Norton Scale, Frohwein Scale, MNA, Barthel-Index, and Mini mental state examination) and is able to apply it. S/he is able to order diagnostic tests and procedures permitted in the scope of specialist practice and legislation. S/he is able to involve clients in care planning, ensuring that they receive accurate, understandable information.	S/he is able to control care plans, evaluate them, and supervise other staff members in the care planning process. S/he is able to develop and maintain quality management systems in institutions or within the care process.	S/he is able to examine assessment instruments and to participate in the development and application of assessment instruments. S/he is able to introduce assessment tools into practice by considering the context of nursing sciences methods and to delegate the change of care interventions, if necessary.
6	S/he is able to instruct colleagues and		S/he is able to regulate processes and to collect individual		S/he is able to manage a care	

Managing the processes of elderly care	apprentices and to coordinate interprofessional teamwork e.g. by setting priorities.	resources and needs (e.g. assessing the physiological, safety, social, self-actualisation, self-esteem or mobility of clients). S/he is able to mobilise and coordinate resources and to take the lead role in managing the care process. S/he is able to apply the "case management" approach in the care process.		division and to make staff decisions. S/he is able to exchange information with other health occupations and to plan a common approach if necessary. S/he is able to continuously estimate the needs of clients and client groups as well as the available financial, material, and staff resources, and the requirements for organisational development. S/he is able to establish and manage research projects.
Personal attitudes of an elderly care giver (competence areas 7 – 8)				
7 Expanding and updating skills and knowledge	S/he is able to recognise his/her own training needs. S/he is able to motivate him-/herself for training. S/he is able to communicate his/her training needs to his/her supervisor. S/he is willing to frequently choose and attend formal education measures. S/he is able to apply up-to-date knowledge of legal regulations (e.g. familiarity with client rights, ethical standards, health law moral and ethical standards, first aid rules and their context). S/he is able to learn from her colleagues in practice (on-the job).	S/he is able to adapt existing skills to new technological developments. S/he is willing to specialise in a specific field of care (e.g. caring people with dementia or pain, etc.) S/he is able to support superiors in research projects.	S/he is able to communicate new empirical knowledge to colleagues. S/he is able to implement new empirical findings into daily practice. S/he is able to interpret and evaluate research findings critically. S/he is able to investigate new empirical knowledge and information in nursing science databases and peer reviewed journals.	S/he is able to create new empirical knowledge in the field of nursing sciences.
8 Reflecting and handling the impact of the job (job-related self-understanding)	S/he is able to take care of her/his own health to perform the job of a care giver. S/he can recognise her/his own limits and is able to acknowledge them. S/he is able to access methods of supervision and apply its results. S/he is able to recognise psychological impacts on her/his own health. S/he is able to carry out prevention and health promotion activities for care givers. S/he is able to maintain a healthy work-life-balance.	S/he is able to develop and apply individual coping strategies for clients. S/he is able to apply methods of burn-out prevention. S/he is able to pay attention to his/her own limits and maintain a professional distance from the clients. S/he can assist the elderly to address topics such as loneliness and death.	S/he is able to provide the elderly with tools to help them face chronic and terminal illness, loneliness, and death (e.g. establishing contacts, involvement in activities and events). S/he is able to apply special concepts and models in elderly care (e.g. chronic care model, patient-centred care).	

Author: Markus Greger (Vinzentinum) with support from Tanja Bacher and Viktor Fleischer (3s research laboratory).

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