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1 ABSTRACT

The Council and the European Parliament have placed a strong emphasis on the necessity to test the European Credit System for Vocational Education and Training in practice. Transparency, transferability and compatibility of professional qualifications are keys to increased mobility of students, teachers and qualified workers in Europe. Population ageing is generating a need and a demand for more and better jobs in long-term care. The challenges of the future are in skills anticipation of future HHCP by training of staff and /or new workers.

This report is referring the skill and competency needs in the homecare sector. The report based on findings of experiences of earlier ECVET projects, questionnaires of HHCP, structured interviews of older persons in CARESS project partner countries Italy, Spain and Finland as well comparing the skills gap with exiting curricula and the roles and competencies of HHCP. The report will compare HHCPs in Europe on the level of EQF, NQF and ESCP data. At the end this report will make conclusion of the situation and competence needs' based on the earlier reports 2.1, 2.2 and 2.3.

Comparing of the identified competences of earlier ECVET projects in elderly and home care sector highlights followed competences: communication and interdisciplinary teamwork; organisational and coordination skills; knowledge and skills in nursing and health care; evaluation skills and care planning; health promotion and safety, promotion well-being and rehabilitation by skills to use gerontechnology.

There are two side to the services provided at home care, health and/or social services, served by formal and/or informal carers. Homecare teams are at its best multidisciplinary teams including at least nurses, community nurses – nurse assistants and home helps, but also psysiotherapists, occupational therapists, professional educators, psychologists, social workers or social health operators etc. There are no specific specialization for graduated professionals in homecare. HHCPs can study in VET or high education, these occupations located in EQF classification on level 3–6. The biggest problem is need of more qualified staff and education for new skills needed in homecare sector.

Identification of HCCPs' training needs in terms of learning outcomes will list the skill gaps as well propose for each HCCP as set of learning outcomes grouped to possible units.

In the future people taken care by home care personnel have more severe conditions, more chronical diseases and have multi-diagnoses. HHCP need to have necessary skills, competence and knowledge of observing, nursing tasks, drugs and interaction. They also need to know the service structure and service producers. Palliative and terminal care needs at home is also increasing. Number of clients/patients with mental problems and addictive behavior has increased, which means increasing skill needs in that area. The review of earlier ECVET projects' results highlights communication and interdisciplinary teamwork; organisational and coordination skills; knowledge and skills in nursing and health care; evaluation skills and care planning; health promotion and safety, promotion well-being and rehabilitation by skills to use gerontechnology.

2 KEYWORDS:

ECVET, EQF, NQF, ESCO, Learning Outcomes, skill gap, training needs, new training methods, HHCPs

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6 INTRODUCTION: STRUCTURE AND AIMS OF THE DOCUMENT.

This report will introduce the skills and competences what will need in the home care sector. The aims of the document are:

1. To collect Best practices from earlier ECVET projects
2. To compare existing curricula identified in D2.3 with the HHCPs of D2.1. in terms of Role, Skills, and competencies
3. To compare existing curricula identified in D2.3 with the specific needs (in terms of Skills and Compentencies) identified in D2.2
4. To compare existing curricula identified in D2.3 with the ESCO classification
5. To identify HHCPs training needs in terms of Learning Outcomes according to ECVET

The founding of this documents will be the general preparation material, collecting and mapping background information for the design of the EU Framework (WP3), the design of national pilots (WP3) and their implementation (WP4 and WP5) and evaluation (WP6).

Chapter 7 gives a short summary about the earlier ECVET projects and collect the general findings and developing ideas for vision of the future in homecare sector.

Chapter 8 reviews analyses of skills and competency gaps compared to existing curricula with the roles and competencies of each HHCP. The describing of HHCPs' occupations in European countries based on EQF, NQF and ESCO classification.

Chapter 9 sums up and lists identified skills' gap in Italy, Spain and Finland. Identification of HCCPs' training needs in terms of learning outcomes will list the skill gaps as well propose for each HCCP as set of learning outcomes grouped to possible units.

Chapter 10 provides a summary and discussion of the outcomes of the collected material and results as well draws a number of conclusions for next work packages.

7 INTRODUCTION TO IDENTIFICATION OF GOOD PRACTICES IN HOMECARE SECTOR

The Council and the European Parliament have placed a strong emphasis on the necessity to test the European Credit System for Vocational Education and Training in practice. Among other initiatives, a series of transnational European pilot projects was established. ECVET ideas and documents are created, piloted and tested in many national and international projects. These projects are steps to implement ECVET and develop practical support in the form of guidelines and supporting tools. Such kind projects started already from 2004 and first of them was FINECVET, national ECVET pilot project in Finland. Finland was involved in the ECVET technical working group appointed by the European Commission right from the start in 2002.

Many projects have been developing and testing concepts and procedures to augment learners' mobility and set up templates for these periods. There are tested the different ways of describing qualifications in terms of unis and learning outcomes in terms of knowledge, skills and

competences. Some of projects are created a new transnational sectoral units and tested them. There are been compered assessment, created assessment criteria and forms as well proposing methods of assigning ECVET points. There are been developing ways of validation and transfer of these learning outcomes and set up templates for cooperation agreements in order to facilitate the establishment of lasting partnerships. Transparency, transferability and compatibility of professional qualifications are keys to increased mobility of students, teachers and qualified workers in Europe. Howerver, comparison is difficult and, at the moment, the complexity contributes to the near-impossibility of movement of skilled and qualified staff between countries. There is particular difficulty in movement from countries with less regulatory demands to those where the professional qualifications are more precise.

Based on the experience of previous projects, the Commission has developed a wider European toolkit for recognition and transparency of learning abroad, which includes the European Qualifications Framework (EQF), the Europass and the European Quality Assurance Reference Framework for VET (EQAVET).
There are some earlier projects in homecare sector, for example Community care in Europe. The Aged in Home Care project (AdHOC, 2004, http://www.ncbi.nlm.nih.gov/pubmed/15575119). The project compared outcomes of different models of community care using a structured comparison of services and a comprehensive standardised assessment instrument across 11 European countries.

The project Clinical continuity by integrated care (HOMECARE) inluded Poland, Portugal, Sweden, Denmark and the Netherlands The project aimed a comprehensive evidence-based assessment of integrated homecare in terms of a health technology assessment and focused on patients with stroke, heart failure and chronic obstructive pulmonary disease. The rsults of the project is a comprehensive evidence-based assessment of integrated homecare (IHC) in terms of a health technology assessment. http://www.integratedhomecare.eu

The project INNOCARE (http://innocare.edicypages.com/) funded by Central Baltic INTERREG IVA programme (2011 – 2013) investigated different technological solutions that are currently available for families and municipalities in home care service of elderly people in Estonia, Latvia and Sweden and aimed to improve quality of life and increased safety and security of elderly citizens living at their homes, which will be achieved through using innovative technology and methods in home care.

One big challenge will be the fact that the documents and outcomes of earlier projects will lose after ending of contracts of web pages, as well collected material will lose (EQUIP). Some outcomes and documents are only available in national languages and on the project's web-sites.

7.1 GENERAL INFORMATION AND EXPERIENCES OF EARLIER ECVET PROJECTS

The earlier ECVET projects worked with ECVET one of the central ideas underlying European lifelong learning policy is that international mobility should become a natural part of education

and training schemes. This helps learners improve their language skills and develop the "soft skills" which are crucial for a successful first step into the labour market.

FINECVET (four phases during 2004–2011) was a national project, supported by the Finnish National Board of Education piloting the credit transfer system for vocational education and training. The project tested ECVET's suitability for 9 different Finnish vocational qualifications, four further vocational qualifications and three specialist vocational qualifications. In total, 17 Finnish education providers or educational institutions and international partners from 11 different countries took part in the FINECVET subprojects. Many of the education providers in the project also had other ongoing ECVET projects like Omnia was involved in EVOC, HETA-ECVET, ECVET ASSET, ArtiCVET, Tool Tipls.

The publication *FINECVET as a Pioneer* focuses on the use of ECVET for trans-national mobility and supports the implementation of the credit transfer system in Finland (http://www.oph.fi/english/publications/publications/2012/finecvet_as_a_pioneer).
All experiences and results from different phases of the project have been compiled into the publication: describing learning outcomes by terms of knowledge, skills and competences; assessment criteria, ECVET points, validation and recognition of learning outcomes, ECVET documentation. The publication explains the benefits of using ECVET in mobility, describes the roles of Finnish actors and serves as a manual while going over the different stages of the ECVET process in terms of mobility. The same principles can use to individual study pathways in Finland.

HETA-ECVET project (2009 – 2012) founded by INTERREG IVA, was a large three years ECVET project between Finland and Estonia. The aims of the project were at enhancing the comparability, transparency and recognition of vocational qualifications in Estonia and Finland. The project aimed at increasing the knowledge of working life needs in both countries and comparing these needs to vocational education and training curricula, describing the learning outcomes of the seven chosen fields, comparing learning outcomes and assessment principles and criteria, and developing qualifications and curricula for Finland and Estonia. The project studied how to achieve a balance of skilled labour between Finland and Estonia, how to facilitate student mobility and how to recognize prior study and work experience.

Useful experiences during the project were:

1. Increasing knowledge about the partner's VET system, curricula and learning outcomes strengths the mutual trust between countries.
2. Building up mutual trust takes time, and will be followed by possible discussions about differences without being afraid of misunderstandings and hurt feelings. Trust can facilitate the acceptance of different methods in different cultures.
3. Understanding the ECVET idea was the biggest challenge: in the future, extended efforts should be made in the project set-up phase. Joint clarification of project targets and commitment to common operating principles and schedules is of great importance.

4. Learning how to create a unit, understanding ECVET and unit's concept. To be useful in transnational level description of unit have to be explicit and easily understandable for readers with different cultural and educational background.
5. Creativity, freedom to create new UNIT without a pre-defined framework was confusing.
6. Good experiences in how to work together with employers: moving curricula from teacher-centered to working life needs' centered in cooperation with employers;
7. By describing of learning outcomes it can be sometimes hard to pick out skills, knowledge, competences and attitudes
8. Not concentrating on the current situation, but planning development in view of future;

General challenges during the project included communication, language and cultural skills. Misunderstandings arose mostly from cultural differences in communication and working. The members of working groups determined that the periods between meetings were too long, more meetings are needed; but the project demanded too much personal time; the information flow and the sharing of responsibilities between different parties was weak.

Lesson learnt during HETA-ECVET cooperation:

- employers' representatives have been present in all ECVET projects and work groups;
- networking between various countries, sectors and different level participants breaks down boundaries;
- cooperation between various countries is possible, there are common qualification modules; no need for completely corresponding qualifications;
- assessment culture and criteria differ in different countries;

- there is a need of clearer definition of practices, tasks and responsibilities for mobility period; creating common instructions, assignments and aims (Learning Agreement);
- documentation should be in local languages;
- it is useful to have transnational students working in pairs at the same work placement facility;
- the group interview method is preferred for assessment;
- the participants need to be briefed on the assessment form and the unit;

The publication "**We have tried ECVET: Lessons from the first generation of ECVET pilot projects**" collected the best practice and examples from ECVET projects 2008 – 2012 (http://www.ecvet-projects.eu/Documents/Seminars/ECVET_Brochure_singlepages_allthesame.pdf).
The projects brought together partners from 21 countries, in different starting situation of ECVET, from various VET systems with different rules and practices regarding qualifications. The projects also represented a variety of sectors and professions. The projects had different motivations to engage in working with ECVET. The most common motivation for projects to test ECVET was to improve the transnational mobility of learners in initial VET (M.O.T.O., see more: http://www.ecvet-projects.eu/Projects/ProjectDetail.aspx?id=11) or to learn from the ECVET testing at system level (ECVET ASSET, see more: http://www.ecvet-projects.eu/Projects/ProjectDetail.aspx?id=9).

Different qualifications systems use different vocabulary and approaches to designing and describing their qualifications. In some countries and systems (Finland, France, Slovenia and Spain), units of learning outcomes were already an integral part of VET qualifications. Other countries started reforming VET systems to integrate the use of units and some countries do not design qualifications based on units (Germany). The ECVET pilot projects also differ in how they formulate learning outcomes that are grouped in a unit (for example in a holistic manner or in terms of knowledge, skills and competence). Most partners would agree that the use of ECVET supports flexibility in pedagogies as well in organising learning and supports individualised approaches.

One result was that the main added value of ECVET comes from the fact that it gives greater clarity to the learning aspects of mobility periods (learning outcomes/using Learning Agreement). Projects would put emphasis on learning outcomes rather than the curriculum and focusing on similarities and valorising differences. Through project discussions different level project partners improved each-others' understanding of foreign VET systems and overcame a number of barriers and strengthen trust.

LESSON LEARNT

1. There is no 'one-way' of using the ECVET principles and technical specifications at the core of this instrument.
2. There is no harm in developing different approaches as long as the principles of learning outcomes, transparency, documentation and mutual recognition, including assessment and validation, are respected.
3. Depending on the system-level conditions, the use of units of learning outcomes as part of ECVET testing differed.
4. Possibilities for validation and recognition 'units' differ.
5. Where units already exist in the national system, it may be possible to achieve a full unit abroad and to gain recognition for it on return. The other possibility is to achieve part of an existing unit in the host institution.
6. There are national systems where units do not exist as parts of qualifications and these countries can use the concept of a unit (*set of learning outcomes that can be assessed and validated*) for geographical mobility purposes.
7. The implications of carrying out assessment abroad for learners will vary (for example assessment during mobility can serve as a basis for the validation and recognition of units of learning outcomes when learners' credit is being transferred and accumulated or the assessment has a formative role and assessment can be considered as giving additional value to mobility).
8. ECVET-related documents (Memoranda of Understanding (MoUs), Learning Agreements (LA), and Transcripts of Records) are important elements for establishing mutual trust.

9. There are aspects of ECVET (recognition of assessment, ECVET points) that are difficult to apply in certain contexts and some were even contested. These issues depend highly on the national and systemic context.
10. ECVET progressive implementation takes place in parallel to other processes that reinforce the use of ECVET: development of qualifications frameworks, support of individualised pathways or the recognition of non-formal and informal learning. These reforms and developments of VET are also based on the use of learning outcomes and their assessment.

In addition to the ECVET pilot projects, other projects relating to the ECVET testing and development exist. Read more ADAM database for those projects. http://www.adam-europe.eu/adam/homepageView.htm#.VTZNr9Ltmko
The thematic network NetECVET brought together 14 National Agencies for the Lifelong Learning Programme Working together 2010-2013, LLP NA partners targeted continuing promotion of ECVET with a view to supporting the implementation of ECVET in mobility across the participating LLP countries.
http://www.adam-europe.eu/adam/thematicgroup/ECVET#.VTZFwtLtmko

7.2 GOOD PRACTICES FROM EARLIER ECVET PROJECTS IN SOCIAL AND HEALTH CARE AND/OR HOME CARE

7.2.1 GOOD PRACTICES FROM EARIER ECVET PROJCTS FROM FINLAND

HETA-ECVET
HETA-ECVET (2009 – 2012, INTERREG IVA) was a large multifield ECVET project between Finland and Estonia. The aims of the project were at enhancing the comparability, transparency and recognition of vocational qualifications in Estonia and Finland. The main idea was to promote the free movement of labour and population, continuing to intensify the cooperation which started in the HETA project and then integrating the HETA-ECVET comparisons and cooperation in the EQF and NQFs.

One of the seven fields described and tested in the project was social and health care. The transnational workgroup started with finding similarities and differences in curricula and job descriptions and chosen sub-module from social care (elderly work). They prepared questionnaires and interviewed both Finnish and Estonian social workers for more information of job descriptions. There was found some differences, for instance in Finnish institutions the pace of working with customers was not as important as in Estonian institutions, and in Finland all the workers were more involved in the planning of personal care activities.

At first, curriculum descriptions were prepared in three different tables to see the differences and similarities between Estonian and Finnish eldercare. The tables showed the similarities, which were combined into one new eldercare unit that described the learning outcomes as knowledge, skills and competences. Result of comparing structure of curricula showed that the Finnish curriculum was more step-by-step competence based, as the Estonian one was lifespan and

subject based. The theory behind the module is based on 12 activities of living, and the final eldercare unit consists of the following sub-modules: communication, professional ethics, working in a multicultural environment, gerontology and ageing history, elderly health and welfare services, activating, and safe working environment. The new unit was tested during student mobilities both in Finland and Estonia. The work group suggested total six ECVET points for established three sub modules.

The results of the social and health care work group in HETA-ECVET were the first comparation and description of Finnish qualification in social and health care (Practical Nurse, EQF 4) and Estonian qualification in social work (EQF 3), creating of the new unit in Elderly Care, testing the sub-unit Caring and Activation in the Elderly Sector and assessing them. All documents are available free on the project web-side: http://www.heta-ecvet.fi/englanti/unit_social.htm:

- Elderly Care Unit
- Tested Unit: Caring and Activation in the Elderly Sector
- Assessment Form

Next ECVET projects in social and health care sector (ProCaring and EFEC) are based on the experiences of HETA-ECVET work.

EFEF www.ecvetforec.eu

ECVET for Elderly Care (EFEC, 2013 – 2014) was one of the transnational partnerships called Sector Skills Alliances (SSA) proposed by the Commission of the European Union. Health and social work Alliance project EFEC addresses the elderly care sector in 6 countries (Estonia, Finland, Germany, Italy, Lithuania, United Kingdom) via 8 partners, member of EQAVET (subcontracted) and 5 associated partners. These partners represent 2 VET providers, 1 educational establishment, 1 research institute, and one researcher/expert, 3 bodies involved in education and training systems, one guidance body, 2 professional associations and 4 work placements/sector specific expertise. The EFEC project improves comparability, transparency and mutual recognition of qualifications and implements ECVET principles in the elderly care work. Project team collected a lot of material (60 intervies, background analyse, comparison of qualifications and learning outcomes in partner countries) and ideas for the next units and creating the EU elderly care worker qualification. The suggested units for elderly care worker qualifications are:

- Promote Inclusion and Participation in Elderly Care Practices (general unit)
- Awareness of Common Diseases and Pain
- Personal Care and Nutrition
- Rehabilitation
- Gerotechnology and ICT in the elderly care
- Service coordination and entrepreneurship
- Cultural Unit

Results and benefits

1. Research report about working life needs in the elderly care sector of partner countries: the report based on analyse of **the interviews (total 60)** were held in each partner country.
2. Descriptions and comparing of Learning Outcomes (curricula) in elderly care sector in partner countries

3. The work related competence list for Elderly care worker: The competence list based on the research and results of the working life interviews.
4. Creating the Basic Elderly Care UNIT. The UNIT based on the results of working life interviews, research report, collected **Competence list and Learning Outcomes** (LO).
5. The end version of UNIT package consists of an introduction (Situation in the field of care and support for older people in Europe, objective of the unit, target group, how the unit can be used and assessed, who wrote the unit and assessment, methodology, Why EFEC), Learning Outcomes with Knowledge-Skills-Competences, Guidelines for Assessment, Assessment, Information about the partners. In the work process it was decided between all partners not to focus on ECVET-points. The basic UNIT (recommendation EQF level 3/4), will work as A PART OF (different) national QUALIFICATIONS. This will be first step on the flexible study pathway. Students/workers can complete the UNIT, acquire the LO both in college and/or in companies.
6. Outcomes of EFEC project will be sustained by simplifying recognition and transparency of Learning Outcomes of students, voluntaries, new workers and employers. Workers free movement in EU will better guarantee sufficient competence workers in elderly care sector.

Lesson learnt:

- Cooperation and building trust will take time. There had to establish a very high level of confidentiality to be able to express ourselves in a totally open and open-minded way.
- The key partners of project are representatives of working life: getting the work life partners from each partner country. Participation of the labour market/sector specific partners is very important.
- There were partners with different background and experiences of international project.
- Partners from different country understand ECVET differently
- There will be increasing need for qualified staff and new skills and competences needed; new and different kind of services for elderly people. New and different education and training possibilities and methods (work based learning) are needed.
- There was mentioned one (general) UNIT in the application form and at least we agreed with one UNIT during this 2 years project.
- The aim to create a unit and assessment criteria was achieved. This unit concentrates on the basic ethical underlying principles of elderly care work and may be used not only on EQF-level 3, but also to emphasize and assess these principles for every profession in elderly care work, e.g. for ergo therapist, and nurses on levels 4-6.
- Assessment criteria, assessment form – various forms, flexible in use according to different settings and national standards
- Different language versions guarantee usefulness of the results both in VET organisations as well in labour
- Seminars and workshops in Brussels were very important during project lifetime: getting feedback, dissemination of the project results.
- Two years is quite short time for starting a new alliance, make background research/survey and create something new.
- The partners agreed to create one international UNIT and additional we did not agree to create a cultural unit for each partner country.

- Working with EQF and ECVET, dissemination of them ideas, documentations etc. need enough time and face to face meetings (better in national language).
- To come to a common sense about soft skills, values and attitudes towards the underlying ethical principles of care work is an extremely challenging but worthwhile process.
- Different to finding agreements about e.g. production processes these principles it is even more important to have face to face interactions and discussion forums. To establish a transnational partnership and gain the mutual trust needed for these designing tasks was challenging and more direct contact via extended international meetings would be recommended.

EQUIP I and II

EQUIP I: European Framework for Qualifications in Home Care Services for Older People (2007 – 2009)

EQUIP project was a large companionship of different actors (universities and providers of vocational education) in six countries Finland, Estonia, Spain, Denmark, the Netherlands and UK. It makes a sectoral implementation of EQF, concerning qualifications in home care services. It aims to develop tools for comparison of qualifications and education between the six countries in relation to home care services for older people, in terms of EQF and ECVET.

The main outcomes of the EQUIP project are e-tools: the home care competence test for e.g. individual job seekers, students and employers in the field. It gives feedback and advice; a database with search engine (comparable information on home care education, competences and work for educators and policy makers); a book desrcribing good practices in home care and the implementation process of EQF in home care sector.

The publication Home Care for Elder People. Good Practices and Education in Six European Countires (Salonen 2009, *julkaisut.turkuamk.fi/isbn9789522161178.pdf*) descriebes home care in Finland, Estonia, Spain, Denmark, the Netherlands and UK, analyses contents of home care work and occupational skills requirements for elderly care in the 21st century and compared education programmes for home care. The 8 home care study units based on rearch results and are created during the project. EQUIP main units are:

1. Nuring and health care
2. Communication and interaction
3. Organisation and administration
4. Promoting well-being and safe-quarding
5. Personal and professional development
6. Halth and safety in the workplace
7. Values of care
8. Personal and domestic support

EQUIP II (European Education, Competences and Qualifications in Home Care for Older People II) base on EQUIP –project. This partnership of researchers and vocational educators built a set of tools to enable the comparison of qualifications and competences among different EU countries in

relation to care services for older people in their own homes. It will contribute to the ECVET process and help implement the European Framework for qualifications (EQF).

The objectives of EQUIP II –project were:

- to disseminate the products and results of EQUIP-project to other European counties
- to establish the use of Home care competence –test in EQUIP-countries
- to compare home care education and training in different EU countries
- to increase mobility of students, teachers and home care workers
- to improve the quality of education of home care services.
- to contribute to appreciation of home care work
- to transfer the EQUIP-Home Care Competence -test to Bulgarian, Greek and Turkish

The project will assist with the implementation of the EQF and ECVET systems.

This project was targeted for students, teachers, trainees, practitioners, employers and policy makers who are concerned with care services for older people in their own homes. Students, employers, educators and practitioners will be able to use EQUIP- tool to assess and understand qualifications from other countries. The trainees and students can evaluate their own competence by the Home Care Competence-test. This partnership of researchers and vocational educators will continue to transfer the EQUIP- tools (Home Care Competence-test and a databace) to enable the comparison of qualifications and competence among Turkey, Greece, Bulgaria.

The results of EQUIP II- project are:

1. A Home Care Competence test in new participating countries, in Bulgarian, Greek and Turkish

2. Home care test updated in old EQUIP-countries

3. Information about education and qualifications about new Equip II –countries

4. A comparison of qualifications, education and good practices in home care

Two kinds of electronic tools based on the the research outcomes of the project: an electronic questionnaire, about match of users/fillers competences to the qualifications in different countries; and their training needs and lacks of competences.

The publication Good practices and visions of the future of home care work in Bulgaria, Finland and Turkey (Salonen–Kinos, 2012, http://www.adam-europe.eu/prj/6818/prj/EQUIPII_book%2020131].pdf) describes good practices and future visions of home care work in Bulgaria, Finland, Greece and Turkey.

EVOC:

Partners

OMNIA, the Joint Authority of Education in Espoo Region – Finland

Göteborg Stad, utbildning Studium - Sweden

Vocational School Center 7 – City of Nürnberg, Germany

City of München – Education Department, Vocational Schools and Further Education, Germany

EVOC – "ECVET-unit for Vocational Studies in Child Care" is a transfer of innovation project (2007 – 2009) under the Lifelong Learning Programme (2007 – 2013). The partners involved in the project, Finland, Germany and Sweden, all have differences in their national systems of qualifications. The aim of EVOC project was to develop a study unit for child care field, which could be transferred from one country to another.

The handbook produced in a project contains the main principles of ECVET and its implementation in child care studies. The handbook presents the Unit, the process of developing the Unit and the assessment forms. The handbook also contains information of the evaluation of the whole process. The comments of the students, teachers and instructors are essential part of the testing and the piloting and give important information about the application of ECVET.

EVOC project has increased the transparency of qualifications and mutual trust between the partners. It has strengthened the cooperation in student mobility between the partners in Sweden, Germany and Finland. It has helped us to understand the importance of ECVET system and proved the importance of developing the Vocational Education and training in Europe.
The produced Handbook was a good start, first European level ECVET project result. The partners learned that a lot of time is needed to open up the content of curricula and to find the common understanding of phenomena and vocabulary.
www.evoc.fi (not working any more)

ProCaring:

Partners
OMNIA, the Joint Authority of Education in Espoo Region - Finland
Kuressaare Ametikool – Estonia
Qualitas Forum – Italy
Vitalis College – the Netherlands

In ProCaring project the partners created together common learning units for Child Care and Elderly Care. The units were tested in each partner country by students' mobility periods. The work placements representatives had an important role in describing the skills needed in placements. ProCaring project had a focus in ECVET system and how it as an instrument promoted mutual trust and mobility in VET. By using the units of learning outcomes students could create an individual learning pathway abroad. The units have been described as Knowledge, Skills and Competences, following the EQF model.

In ProCaring project partner countries implemented first time the Learning Agreement document, which was on that time a draft version. Since that time the LA document has been developed a little bit further, but the basic structure is still the same and in use within the European ERASMUS+ Mobility.

www.procaring.fi (not working any more)

Trans-Finecvet – Implementation of the Finecvet model to the formal and non-formal education

www.trans-finecvet.eu

ERASMUS+ KA2 2014-2016

Partners
OMNIA, the Joint Authority of Education in Espoo Region- Finland
Fundatción Equipo Humano – Spain
Edukacja I Praca – Poland
Instytut Technologii Eksploatacji - Poland

The main project product and result is an ICT-Tool database for students, teachers and personnel of Social and Health Care field. The ICT-Tool contents a list of learning outcomes for Child Care and Elderly Care work (Child Care worker and Health Care assistant). It is possible to use the ICT-Tool also for students' self-assessment tool and for curriculum development. On top of ICT-Tool the project result was a book "Implementation of the Finecvet model to the formal and non-formal education" published by ITpib. The articles of the book are written by project partners.

Lessons learned: The differences between each countries' Educational systems and core content of curricula make it challenging to find a common understanding between the partner countries. It was very time consuming to find some kind of common understanding and find time for deeper discussions – part of that is the lack of English language among the staff and teachers in some partner countries.

Preparing to go abroad – Toolkit for VET

ERASMUS+ KA2 2015-2018

SOSU Nord, Social- og Sundhedsskolen I Nordjylland – Denmark
ROC West-Brabant, Vitalis College – the Netherlands
OMNIA, the Joint Authority of Education in Espoo Region – Finland
Kuressaare Ametikool – Estonia

One result in the project will be an open online Toolkit for students and personnel in Social and Health Care field. The Toolkit content are ECVET system principles, learning outcome units for child Care and Elderly Care, the national curricula (Social and Health care field) from each partner country, information for mobility periods and preparation material for it, cultural aspects of each country ext.

The partners will collect together the best practices for arranging student's mobility periods abroad and use ECVET system as a tool for recognizing the studies done during the preparation and the actual professional internship as part of student's qualification.

(www-pages not ready yet)

ELLAN
The project European Later Life Active Network (ELLAN, 2013 – 2016), founded by the European Commission of Lifelong Learning Programme, takes place with a consortium of 26 partners from 25 countries over Europe. ELLAN is the development of a competency profile for health and social workers in the care and support for older people. Direct target group of the project are educators and management at the partners and other higher education institutions in Europe, indirect are students, professional communities/societies and work places, older people themselves. The main aim of the project is to develop an agreed Core European Competencies Framework for working with older people. Additional aims are to positively influence health and social care professionals'

interest in working with older people and to gain insight how education should be organised to encourage students to choose to work with older people. The aims will be achieved by

- Research older people's thoughts on the knowledge, attitudes and behaviors of health and social care professionals.
- Research older people's ideas about the required and desired competencies of professionals working with the population in their later life.
- Explore professionals' views of desired competencies for all working with older people.
- Find out factors that influence health and social care students' views of older people and working with older people.
- Find out and share best practices of innovative teaching and learning methods.

Leaning on earlier studies and projects ELLAN project collected Multidisciplinary or core competences in the Care of Older Adults at the Completion of the Entry level of Health Professional Degree (http://ellan.savonia.fi/images/WP3_report_on_homepage.pdf):

Domain 1: Health Promotion and Safety
Domain 2: Evaluation and Assessment
Domain 3: Care Planning and Coordination across the Care Spectrum (Including End-of-Lige Care)
Domain 4: Interdisciplinary and Team Care
Domain 5: Caregiver Support
Domain 6: Healthcare Systems and Benefits
(Attachment 1-2 Appendix)

The outcomes of ELLAN project European Core Competences Framework for Health and Social Care Professionals Working with Older People (2016; http://ellan.savonia.fi/images/ECCF_final_version.pdf) focus both social and health care sector professionals (EQF 6) working with older people. There are identified seven different roles for health and social care professionals working with older people (expert, communicator, collaborator, organizer, health and welfare advocate, scholar and professional) and different required competences for these roles. Competences are defined as 'job related descriptions of an action, behavior or outcome that should be demonstrated in individual's performance' and include knowledge, skill and competence (http://ellan.savonia.fi/images/ECCF_final_version.pdf, 2016: 7). In the expert role competences are identified in five dynamic and interrelated phases (2016: 12; 22-28):

1. Assessment: collection of information in a systematic way;
2. Analysis, problem identification;
3. Planning;
4. Implementation/Intervention;
5. Evaluation.

http://ellan.savonia.fi/

7.2.2 GOOD PRACTICES OF EARLIER PROJECTS FROM ITALY

The Council and the European Parliament have placed a strong emphasis on the necessity to test ECVET (the European Credit System for Vocational Education and Training) in practice, in order to create a pool of information and experiences with the practical application of the tool at national

level, which would eventually feed back into future policy strategies – both at national and EU-level.

Among other initiatives, a series of transnational European pilot projects has been established.

Also in Italy, a lot of projects have been implemented in the fields of health and social care (as mentioned in the Deliverable 2.3, section 7.3), trying to give different answers to various needs.

CARE GIVER TALENTS

"Care giver talents" project aimed to transfer in the Italian and Bulgarian context the identification system (currently used in France), acknowledgement, and validation of the different competences developed and experienced by workers operating in elderly and disabled assistance.

In Italy, the model has been tested for the following figures: home helper and Social Health Operator (Operatore Socio Sanitario - OSS).

The project management was directed by an Italian non-governmental organization named "Anziani e non solo Società Cooperativa", with the assistance and support of three different partners: Interfor-Sia (France), Balkanplan Ltd (Bulgaria) and Enfap Emilia Romagna (Italy).

In particular, the project aimed to:

- Elaborate and study the French model, very structured and widely experimented, of validation of the developed experiences by workers operating in disabled assistance and elderly;

- Value its transferability in the Italian context, structuring, translating and adapting the instruments as referring procedures, exercises, grids and relative evaluation tests for the home caregiver career;

- Study and analyse how the validation outcomes could be used as a formative unit to capitalize for the training path of the home caregiver and healthcare and social worker;

- Experiment this model in the Italian system;

- Verify the conditions for the transferability of the model and tools in Bulgaria (a large part of the home caregivers working in Italy come from the Eastern Europe).[1]

I-CARE INFORMAL COMPETENCES ASSESSMENT AND RECOGNITION FOR EMPLOYMENT

I CARE project – Informal competences assessment and recognition for employment, based on the results of the project "TIPEIL – Transfer of an Innovative e-Portfolio to Evaluate Informal Learning", aimed at promoting procedures for the recognition and certification of competences acquired in informal and non-formal learning settings and for the transparency of qualifications especially referred to the "white jobs" (cares to disabled people, baby sitters, caregivers, etc.).

[1] http://www.adam-europe.eu/prj/4083/project_4083_en.pdf

TECLA Association was the promoting partner of the project. In addition other Italian, English and Dutch and Romanian partners were involved.

I CARE project aimed at transferring to the Employment Services Staff of the partner territories involved an innovative procedure for the recognition of informal and non-formal competences based on the methodology of the electronic portfolio that shows the competences of the person, stressing the different experiences and skills acquired in different contexts.

In addition, the project has promoted the development of this methodology in order to integrate with tools and methods currently used in the project territories and in line with the national classificatory system, the EQF and ECVET systems.[2]

COMETA EVOLUTION – CARE OPERATORS MOBILITY THROUGH ECVET

COMETA Evolution is a European project co-financed by the European Commission, DG Education and Culture, Lifelong Learning Programme.

The project aimed at developing and testing an agreement based upon ECVET for mutual acknowledgment of credits among partner organisations.

The project transferred the results of a previous Leonardo project "Highlight the competences", considered, at European level, a good practice on ECVET topic.

COMETA focused on geographical mobility (between partner countries and within regions in the same country) but also on professional mobility between different professional profiles of the social sector (from child care to elderly or disabled care).

It identified a set of soft skills common to a cluster of social profession and development of tools and means for mutual recognition.

COMETA promoted transparency, transferability, validation and recognition of learning outcomes acquired in formal, non-formal and informal contexts.

The Memorandum of Understanding based on ECVET for mutual acknowledgment of credits among partners was the main expected outcome of the project, giving a positive impact in the quality of mobility (geographical - among EU countries/regions - and professional) of workers, as well as on supporting the development of ECVET based practices in partners' countries.

The partnership was multiplayer and involved partners that, coming from different backgrounds, have developed specific skills on training of care workers and VET training policies and practices.[3]

MOBILITÀ NEI SERVIZI SOCIO-SANITARI (MOBILITY IN SOCIAL AND HEALTH SERVICES)

"Mobilità nei servizi socio-sanitari - Mobility in social and health services" project aimed to promote the student mobility in the social and health sector in Europe and in order to support the ECVET system.

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[2] http://www.icareplatform.eu/download/pdf/RESEARCH%20REPORT%20ICARE.pdf
[3] http://www.cometa-evolution.eu/

The project was addressed to the students that had more than 18 years old, in initial vocational training of social and healthcare sector (professional schools for social services) of Tuscany Region (Italy).

The project has foreseen the comparison and transfer of some ECVET units: one oriented to the care of the elderly, the other to childcare.

The students that have participated to the placement period abroad were evaluated on the basis of this system and they have received a certificate of competences.[4]

HANDLE ECVET IN THE FIELD OF HEALTH AND SOCIAL CARE – INVESTIGATING AND SHARING IMPLEMENTED INSTRUMENTS AND PRINCIPLES

"HANDLE ECVET in the field of health and social care – Investigating and sharing implemented instruments and principles" project has developed an overview about the different systems of VET concerning professions in health and social care The project was addressed to the students that had more than 18 years old, in initial vocational training of social and healthcare sector (professional schools for social services) of Tuscany Region (Italy).

The project has foreseen the comparison and transfer of some ECVET units: one oriented to the care of the elderly, the other to childcare.

The students that have participated to the placement period abroad were evaluated on the basis of this system and they have received a certificate of competences.[5]

HANDLE ECVET IN THE FIELD OF HEALTH AND SOCIAL CARE – INVESTIGATING AND SHARING IMPLEMENTED INSTRUMENTS AND PRINCIPLES

"HANDLE ECVET in the field of health and social care – Investigating and sharing implemented instruments and principles" project has developed an overview about the different systems of VET concerning professions in health and social care in the eight participating countries at EQF-level 2-5.

The main task was to share existing best- practice models concerning methods to describe qualifications, to define assessment standards, to compare qualifications and to recognize learning outcomes corresponding to ECVET instruments and principles.

The project has supported the mobility of skilled workers and helped to close the gap between staff supply and demand in the field of health and social care.

The partners have promoted the use of ECVET in the field of health and social care and supported the development of ECVET-partnerships by developing criteria for a memorandum of understanding, which were adapted to the specialities of this field.

[4] TRASPARENZA DELLE QUALIFICAZIONI E DELLE COMPETENZE – Sperimentazioni e pratiche di attuazione della Raccomandazione ECVET - ISFOL

[5] TRASPARENZA DELLE QUALIFICAZIONI E DELLE COMPETENZE – Sperimentazioni e pratiche di attuazione della Raccomandazione ECVET - ISFOL

The partnership project referred to the transfer of innovation project "PROPER CHANCE", which has been implemented by the coordinator (AFBB) as well as two other partners from Belgium and Italy.

Both projects were meant to support each other but could be accomplished successfully on their own as well.[6]

I CARE - IMPROVING MOBILITY AND CAREER PATHS FOR PERSONAL CARE AND SOCIAL WORKERS

I-CARE project was an experimental application of the ECVET system for the establishment of a recognition model in the field of personal care, with the aim of establishing a mutual trust area among partner countries (Italy, Germany, Poland, and Romania) and to further develop mutual recognition of training paths and qualifications.

The project activities focused on seven professional figures included in the Regional Framework for Professional Profiles (QRSP) of the Lombardy Region (Italy) and, in particular, in the qualification subsystem of Social Services and Personal Care.

Vocational qualifications were:

1. Family assistant/caregiver (personal care home workers; domestic workers and similar)
2. Dental assistant (dental assistants; dental hygienist)
3. Colf (domestic help and related, household cleaning; domestic workers and similar)
4. Assistant Associate Assistance – ASA
5. Care operator – OSS
6. Hygiene operator (cleaners in offices, hotels, and other buildings; workers not skilled in cleaning services in enterprises, public bodies and related)
7. Baby Sitter (employee of care services; supervision of children and similar).

The partnership was designed in order to guarantee broad representation and to ensure quality, dissemination and self-sustainability of outputs. In particular, it was characterised by the presence of the main public and private stakeholders of project results, the representation of potential intermediary and final users of products at the transnational level. The main impact envisaged concerned transparency of qualification system in personal care and social work services, as well as improvement of co-operation among partner countries.

Among the main objectives of the project there were:

- Adaptation of vocational qualifications (Regional Framework for Professional Profiles of Lombardy Region –QRSP) and their description in terms of learning outcomes units in order to make them comply with the ECVET technical specifications

[6] http://www.ausbildung-und-studium.de/projekte-in-dresden?id=1171#project-outline

- Development and application of a suitable methodology for assigning and applying ECVET points to the selected vocational qualifications in the personal care and social work field
- Adoption and development of a suitable common methodology for evaluating learning outcomes (including Validation of Prior Learning acquired in non-formal and informal contexts)
- Adoption, development and testing of a learning outcome transfer process among partner countries including evaluation, validation, accumulation and recognition of learning outcomes for the purpose of awarding qualifications, whatever the learning context (formal, non-formal and informal)
- Establishment of a stable consortium among partner institutions and definition of a joint work programme for the application of the learning outcomes transfer model

Linked to the above mentioned objectives, the project aimed to facilitate the recognition of competences gained in other contexts (countries, institutions or systems) and learning settings (formal, non-formal or informal ways of learning) for personal care and social workers travelling across Europe; to facilitate lifelong learning paths development in the personal care sector by adopting and developing tools and methodologies for the evaluation, transfer, validation and recognition of learning outcomes (and transition mechanisms from one qualification to another); to facilitate labour market integration and mobility for people willing to work (with a recognised qualification) in the personal care and social work sector throughout Europe.[7]

CO.L.O.R

CO.L.O.R. (COmpetency and Learning Outcomes Recognition for migrants) has adopted ECVET principles to meet specific needs of valorising competences and recognising learning outcomes of individuals with few qualifications, mostly "migrant workers" who must be able to qualify and re-qualify more easily in the current labour market context.

CO.L.O.R. was one of the eight pilot projects funded by the European Commission with the aim of:

- Setting up a sustainable network of Regional Authorities, stakeholders and practitioners;
- Pilot testing ECVET procedures for the evaluation, recognition and transfer of Learning Outcomes (LOs)

The project wanted to promote the recognition of the experience acquired in formal and informal contests by weak people. Two target sectors have been identified in the project: Healthcare (for women) and Construction (for men).

Two types of output have been defined:

A. Defined LO Units
B. Testing results of LO Units

The experimentation of the project has been based on qualifications (on both national and regional standards) at the EQF level 3, which represents the "basic" level of qualifications (the first

[7] http://www.icareproject.eu/

"achievement" in terms of competency) to enter the Italian labour market, for: Construction operator and Social help operator (OSS).

CO.L.O.R. put into practice ECVET mechanisms to achieve:

- qualifications adapted and tested (in terms of LO) on the basis of shared and tested transferable methods;
- defined assessment, validation and recognition processes;
- testing activities (including a Repertory of case studies) to assess the transferability of the recognition processes in a trans-sectorial dimension;
- a Memorandum of Understanding on ECVET-related issues among the Italian Regions involved aimed at promoting a wider use of the project results and transfer of its results into mainstream practices.

The expected results were in terms of innovative and concrete opportunities of LO recognition. This exercise of designing and adapting national and regional qualifications to the LO approach aimed at being transferred to other sectors/context/levels, while at the same time ensuring coherence with the overall system. The commitment of the competent regional Authorities involved in the project aimed to maximise the project impact at regional and national level.

The partners involved (Italy, Malta, Romania and the UK) have cooperated and had complementary roles. Italy mainly focused on the pilot testing of 11 qualifications, the UK played an important advisory role, being more advanced in referencing their systems to the EQF.

Five Italian regions were involved in the Project: Campania, Latium, Piedmont and Tuscany, Basilicata and associated partner. The authorities were responsible for assessment and recognition of qualifications and were committed to test ECVET-oriented mechanisms in the construction and healthcare sectors.

Local stakeholders and practitioners requiring successfully tested tools were targeted. Consequently, COLOR addressed the needs of disadvantaged workers, who typically have poor qualification records.[8]

7.3 VISION OF THE FUTURE IN HOMECARE SECTOR

There is a lot of different ECVET project about elderly care with some specific ideas about home care. Outcomes of these project will be sustained by simplifying recognition and transparency of Learning Outcomes of students, voluntaries, new workers and employers. Care of the aging population in Europe will be an important future issue not only for economic reasons but also because of citizens' rights to make choices about where to live. By results of EQUIP project nine out of ten people over 75 would like to live in their own home instead of an institution. As there is big gap between qualified worker free movement in EU will better guarantee sufficient

8 http://www.adam-europe.eu/adam/project/view.htm?prj=8026#.V6mHOPmLQdV

competence workers in elderly care and home care sector. New and different education and training possibilities and methods (work based learning) are needed.

Mostly there are the same findings, same ideas about learning outcomes and competences (see Attachments): projects would plan development in view of future, would pay more attention to working life need (skills gap), would put emphasis on learning outcomes rather than the curriculum and focusing on similarities and valorising differences. There is no 'one-way' of using the ECVET principles and technical specifications at the core of this instrument. By describing of learning outcomes it can be sometimes hard to pick out skills, knowledge, competences and attitudes. Learning (teaching) methods as well assessment methods (and credit points' system) differ. The new trend is collecting and describing global competences. These global competences in social and health care sector are very complex and a multidisciplinary team approach is absolutely necessary.

Developing of different approaches would be harmless and useful as long as the principles of learning outcomes, transparency, documentation and mutual recognition, including assessment and validation, are respected. Cooperation with representatives of labour market would be necessary. There are food experiences in how to work together with employers and moving curricula from teacher-centered to working life needs' centered in cooperation with employers.

The problem of the great variety of health and social care and the need for different types of professional can solve with a new or specific type of healthcare worker. Some competences as communication and multicultural competences, ethical competences and recognition of elderly abuse are needed. EFEC suggested 6 units for worker in elderly care field and EQUIP project suggested the 8 home care study units based on rearch results and are created during these project, ELLAN projecet indentified 6 domains for worker with older person (Table 1):

EFEC – units for elderly care worker (EQF levels 3 – 4)	ELLAN domains for worker with older persons (EQF 6)	EQUIP – 8 units for worker in home care
Promote Inclusion and Participation in Elderly Care Practices (general unit)	Care Planning and Coordination across the Care Spectrum (Including End-of-Lige Care)	Promoting well-being and safe-quarding
Awareness of Common Diseases and Pain	Evaluation and Assessment	Nursing and health care
Personal Care and Nutrition	Caregiver Support	Personal and domestic support
Rehabilitation		
Gerotechnology and ICT in the elderly care		
Service coordination and entrepreneurship	Healthcare Systems and Benefits	Organisation and administration
Cultural unit	Interdisciplinary and Team Care	Communication and interaction
		Personal and professional

		development
	Health Promotion and Safety	Health and safety in the workplace
		Values of care

Table 1 : The future competences in elderly care and home care by EFEC, EQUIP and ELLAN projects

The units and domains are not directly comparable as well are intended to different levels in care sector but these will confirm certain future trends in the care sector. Comparing of the identified competences (Table 1) highlights communication and interdisciplinary teamwork; organisational and coordination skills; knowledge and skills in nursing and health care; evaluation skills and care planning; health promotion and safety, promotion well-being and rehabilitation by skills to use gerotechnology.

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SEE ATTACHMENTS 1 and 2 at the end of the document

8 HCCPS' ROLES, SKILLS AND COMPETENCES

8.1 ANALYSIS OF HCCPs' ROLES, SKILLS AND COMPETENCES AND COMPARISON WITH EXISTING CURRICULA

8.1.1 Comparing existing curricula with HHCPs' roles, skills and competences in Italy

In Italy, some HHCPs involved in homecare should got a degree, while others should attend specific certified VET courses. In particular, nurses, physiotherapists, occupational therapists, psychologists and professional educators should get a degree (first or second level). All of these courses are provided by the Faculties of Medicine, with the exception of the Psychology course. The Ministry of Health defines the professional profiles to educate, while the content of the degree program is defined by the Ministry of University and Scientific Research (Legislative Decree, 502/1992).

In general, in Italy there's no specific specialization for graduated professionals in homecare. After a three-year academic degree (EQF6), compliant with the "European agreement on the instruction and education of nurses", Strasbourg, 25 October 1967 [Foreign and Commonwealth Office] nurses can provide public and private home nursing to older adults. Physiotherapists, after a three-year academic degree (EQF6), physiotherapists can provide public and private homecare to older adults. The same rule is valid for occupational therapists and professional educators. The profession of psychologist is described by Law n. 56 (18th February 1989); in order to practice this profession, including any psychological performance in the homecare setting, the following requirements are mandatory: a bachelor's degree in psychological science, a master's degree in psychology, the proper documentation attesting the completion of training in compliance with rules laid by the Ministry of Education, the qualification obtained by passing the state certification exam and the membership of the professional board.

Home aid professionals, such as Familiar Assistants, OSS and Social Guardians have to attend VET courses normally organized and defined by local authorities.

All of Italian medical professionals and operators should attend the **Medical Continuing Education Program (ECM Program)** provided for by law under the supervision of the Health Ministry. Each of them should get 150 formative credits[9] in 3 years. Aside to medical doctors, the ECM program involves: nurses, physiotherapists, occupational therapists, professional educators and psychologists. Home aid professionals are not obliged to follow any continuing education course by law.

In this Section a comparison will be provided between the Italian HHCPs current situation about roles, skills and competencies described in D2.1 and the existing curricula described in D2.3.

[9] One credit for each hour of attendance in case of courses with a maximum of 100 participants; if the ratio between teacher and participants is max 1:25, a participant can obtain 1,5 credits for each hour of attendance.

NURSES

Nursing education was introduced into Italian universities by the Law n.341 in 1990 "Reform of the university education systems" by setting up a new curriculum called "University Diploma in Nursing Sciences" including three different courses: general nursing, general paediatric nursing, and midwifery [Pascucci & Taormina, 2012]. The new structure of the educational courses is divided into two separate cycles: a three-year undergraduate degree and a two-year master's degree. In addition, universities can provide 1st and 2nd Level Specialisation Master courses, as well as advanced post-graduate courses (PhDs).

For the academic year 2015/2016, in Italy there are 221 Bachelor's Degree courses in Nursing in 42 Faculties of Medicine, for a total of 15.144 places available for students.
The bachelor of Science in Nursing has the purpose to ensure that students learn general scientific methods and contents. It envisages 180 Credits (1 credit = 30 hours) in 3 years. It is the entry-level qualification to practice nursing and substitutes the previous professional nursing titles and the University Diploma in Nursing Sciences. Once obtained this degree, a nurse can work in homecare, without any other specialization, both at public and at private level.
The Master of Science in Nursing (duration 2 years) allows for vertical career opportunities, such as becoming a nursing manager.
Specialization Masters can support nurses horizontal career development by increasing the professional scientific competencies, although there's no direct connection with status advancement in terms of career and salary. No specific Specialization Maters in the field of homecare have been identified, but some courses, such as the "*Master in Family and Community Nurse*", currently organized by different Universities at national level, could provide important competences to nurses involved in homecare, such as:

- knowing the concepts, theories and methodologies of community nursing;
- Knowing the institutional and legal structure of the social and healthcare services outside hospitals and their current status;
- knowing the role, aims and operational techniques for nurses in the field of occupational medicine;
- being aware of the most common healthcare issues in the community and the therapeutic and healthcare opportunities;
- acting ethically and analysing bioethical issues in contexts outside hospitals;
- Understand how to approach the assessment and promotion of health in families and the community.
- planning, conducting and assessing educational interventions and programs, and healthcare surveillance in home environments;
- ensuring prevention, educational, health surveillance, and caring services in the various territorial settings.

Comparing the existing curricula with the data concerning educational level of nurses we can identify important information. In the *Questionnaire targeting Home Healthcare Practitioners*[10] submitted for the CARESS Project context analysis to 214 HHCPs, 87 out of them were nurses who have worked in homecare in the last 5 years (82,76% public employed). About their professional education emerges that the 13,79% of them has lower-secondary school leaving diploma, about 34,48% of them have a Second Grade Secondary School degree and only about 53% of them have got a Bachelor Degree; about the 15% of the interviewed nurses has further specializations after the first degree. To the question "*do you have any additional professional qualification?*", the 88,51% answers no.

So one important emerging information is that about the half of the nurses answering to the questionnaire and working in homecare have no an academic education and probably no additional professional qualification. This is mainly due to the fact that nursing education was introduced into Italian universities by the law only in 1990. Nurses are now obliged by law to attend Medical Continuing Education Program (ECM Program) courses, but they are often organized by hospitals concerning specific diseases, while for private nurses they are often no-controlled and self-financed.

To the question "how many lifelong courses did you attend the last 5 years?" 60 out of 87 nurses answered "*more than five*". These data are coherent with the already mentioned ECM Italian Program duties.

Anyway, since there's no information about the contents of these courses, one of the emerging risks is that nurses providing homecare services have no updated competences about for examples new protocols, new services and new technologies. This risk becomes more important taking into consideration that about 9 million Italians pay to have a nurse in their homes. In 2015 8.7 million people turned to a private nurse in a year (17,2% of adult people) especially those who suffer from chronic diseases (2.8 million people) or those who are no longer self-sufficient [Colicelli, 2015]. The majority of the requested services were: injections (58.4%), perfusions, infusions and intravenous feeding (33.1%), general assistance (24.5%) medications and bandaging (24.4%) and night assistance (22.8%).

54% of this kind of assistance is unreported employment: 45% is completely unreported, 9% just for a small part. The economic crisis enables unreported employment because people can spend less. Other solutions are to turn to non-medical staff: in 2015 4.2 million people turned to homecare assistants or social health operators for several reasons also for health issues because a professional nurse is too expensive (33.7%) and because people think that in many cases it not necessary to hire a nurse (31.5%) [Colicelli, 2015]. In this case, the risk of an unqualified and ineffective service is very high.

The hypothesis of an unqualified and not-updated service provided by nurses is partially contradicted by the answers to the *CARESS Questionnaire targeting Home Healthcare Practitioners. In fact,* when asked about the activities normally carried out at the older person's

[10] See D2.1 for details

home the most selected answers were: evaluation of customers' needs, education in health management and lifestyle, prevention interventions, educational interventions for caregivers, team meetings and contacts with other professionals, in-home health exams and evaluation of health condition. In addition when asked about the competencies needed in homecare nurses specified an high number of competencies (with respect to other professionals) and when asked about their ability in managing those competencies the most of them declared to master them at high level. The 44,83% of nurses declares that he/she acquired those competences in formal education, but at the same time the 80,46% of them declares to have learnt such competencies by working practice.

PHYSIOTHERAPISTS

The physiotherapist is an health care professions of rehabilitation which requires a 3 years degree (180 credits).
Once got the Bachelor Degree in Physiotherapy a physiotherapist should have acquired knowledge, practical skills and interpersonal skills in following fields: care and rehabilitation; professional liability; therapeutic education, prevention; management; education and self-education; evidence based practice; communication and relationship [Bielli et al., 2011].

After the first academic degree, physiotherapist could attend the Master of Science in "Educational and Health Professions in Rehabilitation", which is not specific for their profession.

In order to practice in Italy, both on subordinated basis as well as a freelancer physiotherapist, isn't scheduled any certification of advanced skill in any field of physiotherapy. A research carried out by AIFI (Italian Physiotherapists Association) for the CARESS project over the Italian territory about the existence of specific University educational programs in order to ensure the acquisition of certificated competencies regarding Physiotherapy in older adults home care outlined that over the Italian territory there aren't high education educational programs about elderly homecare specifically designed for physiotherapists; specific courses organized in the framework of the Continuing Professional Educational Program of the Italian Health Ministry may present some contents regarding the field of older adults homecare but they usually don't certificate any advanced skill currently lacking in Italy.

As stated for nurses, some University Master (First Level – EQF7) or specific High Education Specialization Courses (EQF 7) can provide important competencies to physiotherapists working in homecare, but no specific initiative for homecare is known.

In the *Questionnaire targeting Home Healthcare Practitioners*[11] submitted for the CARESS Project context analysis to 214 HHCPs, 70 out of them were physiotherapists who have worked in homecare in the last 5 years. As to the educational level, about the 71% of them declared to have a Bachelor degree, about the 11% a Master Degree and about the 9% upper level education such as higher level specialization diploma or second level University masters. Only about the 8% has no Bachelor degree. Only the 30% of the declared to have further qualifications (such as other rehabilitation techniques), but no one in homecare sector.

[11] See D2.1 for details

About the 17% of the employed physiotherapists declared that they didn't attend any lifelong learning course in the last 5 years, although the Italian law envisages mandatory courses by the ECM program. This percentage is reduced to the 8% among freelance physiotherapists. About the 63% of freelance physiotherapists have attended 5 or more courses in the last five years, against the 37% of the employed ones. About the 87% of the physiotherapists answering to the questionnaire declared that lifelong learning have importance (about 25%) or extreme importance (about 61%) for them.

So, taking into account these data, it seems that physiotherapists have a general-basic academic education, in some cases integrated with high education paths; anyway sometimes the continuing education is not considered as much as the initial education, especially once employed by an institution, although in general lifelong learning is deemed an important resource for their profession.

As to the activities performed at older adults' homes, the most selected activities are: rehabilitation activities, positioning and support to mobility, evaluation of customer needs, educational interventions for caregivers, home environment assessment and evaluation of health conditions.

According to the physiotherapists answering to the questionnaire, the main needs they fulfil with their service (more than 70% of the answers) are:

- need to be supported and educated in proper positioning and postural changes to prevent physical disorders (about 93%)
- need to feel safe and secure in his/her surroundings including suitability of the home to prevent "static causes "of falls (about 88%)
- need to be informed about your state of health and the available treatment and care options (about 73%)
- need of assistance for transfers and mobilization at home (about 71%)
- need to a respectful treatment according to his/her dignity (about 70%).

The 91% of them in addition declared that they normally evaluate *in itinere* elderly needs in order to possibly refine the homecare plan according to changing situations and the 87% declared that while defining a homecare plan, they set their intervention in a more general personalized path for independent life and dignity. Only 5 out of 61 physiotherapists answered "No" to the question "*Do you think do you have the proper competencies to set your intervention in a more general personalized path for independent life and dignity?*", specifying that they lack psycho-social competencies and abilities to work in equip.

In general, the majority of physiotherapists declared that they need no other competences in addition to the ones they have to perform their activities in homecare service (about the 84%) and that no other user needs should be targeted in addition to the ones they target (about the 81%). So they feel confident with their competencies and roles.

One of the main problems emerging by the comments and the open questions and confirmed by the opinion of professional associations is the one related to the potential overlapping of roles and

tasks with other professional. This issue is particularly suffered by physiotherapists specially in the relation with nurses, occupational therapists and OSS.

Sometimes, mainly in the context of private homecare service, specific rehabilitation tasks are performed by nurses, OSS or familiar assistants in order to avoid to pay another professional. This fact can imply ineffective treatments and other problems. Due to this fact, professional associations in Italy are very firm about specific professional competencies and in the definition of what a professional can do in his/her practice.

OCCUPATIONAL THERAPISTS

The Occupational Therapist (OT) is an healthcare professional with a qualified university degree which operates in the framework of prevention, treatment and rehabilitation of patients with diseases and physical and psychic disorders with both temporary and permanent disability, using expressive, manual, recreational and daily activities.

In order to become an OT it is necessary to attend the first degree (EQF6) and got the Bachelor degree after three years within the University of Medicine. The final test has value as state examination, giving the qualification for the practice of the profession. The course also includes a compulsory traineeships that aims at providing the opportunity to apply the theories learned.

The title itself gives the right to exercise the profession, even if the education of the therapist can continue his studies with a Laurea Magistrale (second level degree), University Masters (First and second level), and PhD but not specifically referred to Occupational Therapy.

As stated for other graduated HHCPs, but no specific specialization courses for homecare are known.

The figure of OT is not so common and demanded in Italy like in other EU countries. Borders among physiotherapists' and OTs' tasks and roles are often under discussion with rigid positions assumed by the relative professional associations. Formal high education pathways don't help to solve this situation since they often target both of these figures; see for example the Master of Science, in Educational and Health Professions in Rehabilitation, or the University Masters (EQF7) *in Neuro-Cognitive Rehabilitation*[12] *or in "Taking charge of people with severe disability: clinical assistance, educational and management aspects"*[13]*,* or other High Education Specialization Courses (EQF 7) such as the one in *"Technologies for the autonomy and participation of people with disability"*[14] or the one in *"Technologies and devices for disability"*[15].

[12] Organized by the University of L'Aquila (http://www.mrnc.univaq.it/index.php)

[13] Organized by the University of Milan (http://w3.ordineaslombardia.it/?q=node/458)

[14] Organized in Milan by Centro IRCCS S.Maria Nascente in collaboration with Don Gnocchi IRCCS *(http://portale.siva.it/files/doc/library/ndrc2016_milano.pdf)*

[15] Organized by the Public Administration School of Umbria Region (http://www.aito.it/sites/default/files/ProgrammaTecnologieAusiliDisabilit%C3%A02016-2017.pdf).

PROFESSIONAL EDUCATORS

As defined by the Health Ministerial Decree n. 520 – 1998, the Professional Educator (PE) is the social and health worker which, in possession of a qualifying university degree, implements specific educational and rehabilitation projects, as part of a treatment plan developed by a multidisciplinary team, aimed at a balanced development of the personality with educational / relational objectives in a participation context and recovery to daily life.

A PE carries out his/her professional activities in public or private health and social and socio-educational facilities and services, in the territory, in residential and semi-residential facilities as employees or as freelancer.

PE training is provided through the Faculty of Medicine and Surgery in cooperation with the Faculty of Psychology, Sociology and Education sciences and takes place at health facilities of NHS and social and health facilities of public bodies. In order to practise this profession, it is necessary the three-years degree for Professional Educator. The degree program has a limited number, therefore it is necessary to pass an admission test.

The post-graduate seems particularly important for the PE. Almost three quarters decide to continue the studies, of various kinds: internships in particular (36%), but also postgraduate schools (25%) and internship within companies (17%) as well as vocational training and voluntary partnerships. Very often, however, the Professional Educator begins to work simultaneously to studies: 22% continues the same job also after graduation, 26%, instead, prefers to change[16].

In our knowledge there are no specific master courses or training in Older Adults Homecare for Professional Educator.

Aside from the information concerning PE training, an important contextual information about the PE which helps to understand the role played by this professional is that generally in Italy everybody can be an educator even if this person is not properly trained. This still happens even if there are two different degrees that should give these educators the proper training they need.

- the socio-pedagogical Professional Educator - Faculty of Education with a degree L19;
- the social health Professional Educator - Faculty of Medicine or inter-faculty courses with a degree LSNT / 02.

The Chamber of Deputies approved a bill to regulate the profession of educator. This bill needs to be passed by the Senate. This law will regulate working conditions for 100.000 people in Italy and it will also help to set clearly the kind of qualifications they need in order to work. A degree will be mandatory.
The crux of the matter is that this professional role can be accessed through two different educational paths and it even has two different official titles . Currently, some educators hold a degree in Education Science, while others, who are known as Professional Educators, graduated in Medicine. The aforementioned law suggests two new titles for these professionals.

[16] Almalaurea https://www.almalaurea.it/informa/news/2015/12/04/educatore-professionale-un-laureato-che-lavora

Edcuators L19 from now on will simply be known as educators (80% of professionals). They will work for social assistance, socio-educational and socio-sanitary hospital units to deal with educational, family, immigrant integration and sport matters.
Professional educators will be more healthcare-oriented and will be working in sanitary, socio sanitary units and homecare. Therefore, their education will be more focused on healthcare subjects. The bill sets a group of transition laws in order to protect all the educators who built a significant experience in this field even if they do not have the university degree that is requested by the new law but as long as they attend an intensive educational course that lasts at least a year. This new law will make a significant change in the field of educational training and it will provide all the educators who do not have a university degree with the proper skills they need. Furthermore, it will make it easier to distinguish between the two professions, in particular the educator who will have a Medicine degree will be the only worker who can deal with and be responsible for homecare assistance.

PSYCHOLOGISTS

The profession of psychologist in Italy is defined by Law n. 56, dated 18th February 1989. In order to practice this profession, including any psychological performance in a homecare setting, the following requirements are mandatory:

- a bachelor's degree in psychological science
- a master's degree in psychology,
- the proper documentation attesting the completion of training in compliance with rules laid by the Ministry of Education
- the qualification obtained by passing the state certification exam
- membership of the professional board.

So the training path to practice as psychologist, both as public or private employee and as a freelance professional, is long and complex. No specific training courses dedicated to train psychologist to provide homecare for older adults have been identified at Italian level. Despite this lack of knowledge there are several post degree courses dedicated to psycho-gerontology, psychogeriatric and psychology of aging, that define in detail the competences required to assist older adults. These training courses are not mandatory to perform work as psychologist in homecare for older adults. In addition, psychologists are required by law to take part in continuing education since they are involved in the Italian CME Program.

The report titled 'The State and Psychology Professionals in Italy', which was written by the Lab on Organisation and Consumption Culture of Università Cattolica in Milan, provides a snapshot of the psychology professions in Italy in 2012. It includes valuable information on trends and issues for lifelong education and training for psychologists. The survey was aimed at the psychologists who were members of the National Association in December 2011 (sample: 1500 cases); within this population a group of young psychologists - under 30 years of age – was selected (sample: 437 cases).

The report highlighted [CNOP, 2012]:

- a strong commitment to continuing education (an increase compared to 2008)

- a great variety of kinds of professional update and continuing education
- average-to-negative judgement of the educational offer provided by universities (both at bachelor's degree level and at the level of master's degree, PhD and specialty training) also when it comes to the transition into the workplace (placements and internships).

Young psychologists expect this educational off to be:

- highly methodological and centred around the design and implementation of interventions;
- embedded in professional context
- able to provide them with the necessary subject-related knowledge while getting their career started at the same time

In this respect, an urgent demand to provide less notion-based and more context-focused training and education arose clearly.

The continuing education offer is usually provided in non-academic settings [CNOP, 2012]. The question 'Have you undergone (or are you undergoing) any kind of post-graduate training? If so, what?' was answered positively by 98% of interviewees. Figure 1 offers the breakdown of the answers to this question.

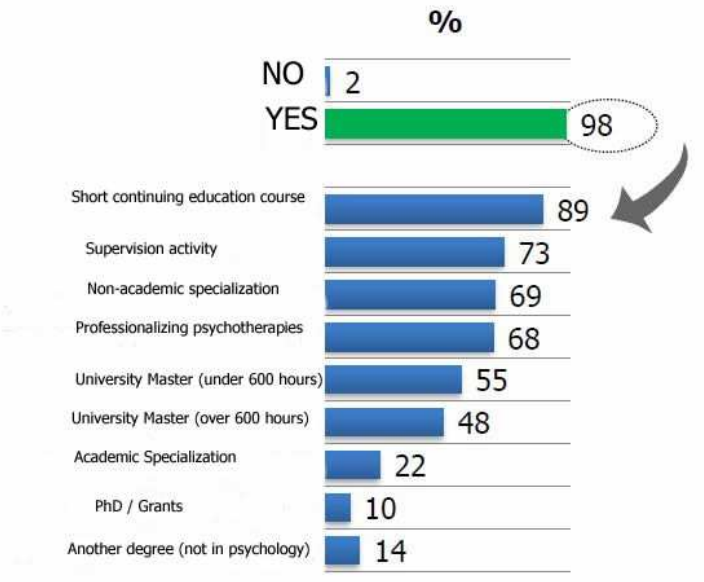

Table 2: Breakdown of the answers to 'Have you undergone (or are you undergoing) any kind of post-graduate training? If so, what?'

Although there is a very important request for psychological support to homecare in Italy, at present, the profession of psychologist is not very much involved in homecare like other professionals. A contributing factor is the document "New definition of home nursing", which in 2006 defined and updated the Essential Levels of health Assistance (LEA) [Ministry of Health, 2007]. This document defines three categories of home nursing care:

- occasional homecare assistance, it is requested by the Doctor who is in charge of the patient and it is meant to fulfil a simple healthcare need for those patients that are not able to reach the outpatient services;
- first and second level integrated homecare assistance: it is meant for those people that do not suffer from any serious disease but need constant assistance either for 5 (1st level) or 6 days (2nd level);
- third level integrated homecare treatments and homecare palliative treatments for terminally ill patients that need non-stop high-level assistance and highly qualified staff.

The psychological support for the patient and for the family and team supervision is envisaged only for palliative treatments. No specific reference to psychological support can be found in the description of the first two types of homecare.

Palliative Care Units usually work closely with the Diagnostics and Treatment Services from hospitals and are made up of: a doctor, a registered nurse, a social worker, a psychologist and possibly some volunteers.

All members need specific training to deal with this emotionally demanding work, which requires keeping in mind the patient's psychological and social needs

Psychologists'' role in a Palliative Care Unit is twofold: they are a vital member of the team as they look after the psychological and emotional well-being of the patient and of the patient's family; at the same time they also have an outsider's role when they take on their duty as supervisors during team meetings. Patients rarely ask for a psychologist's intervention (when they do, the psychologist go to the patient's home); more often, psychologists are asked to provide support for the patient's family and, sometimes, even by other team members.

SOCIAL HEALTH OPERATORS

The Social-Health Operator is a nurse-assisting professional figure working in the field of welfare and health assistance in the public health sector.

This profession has been established with an agreement signed on 22nd February 2001 by the Italian State-Regions Conference. It basically replaced a number of auxiliary health professionals who had been previously involved in healthcare assistance, namely Social Assistance Auxiliary (ASA), Technical Assistance Operator (OTA), Social Assistance Operator (OSA) and Homecare and Guardian Services Assistant (ADEST). Following the 2001 Conference, each region was meant to ratify the agreement into local legislations by specifying how to manage the necessary integrative professional training (normally about 300 hours) for those workers who already had ASA, OTA, OSA and ADEST qualifications in order to convert them into OSS qualifications. This issue has been managed at local level in different ways, and consequently at national level there's no homogeneous training pattern.

In the meanwhile Regions defined the OSS curriculum. Regional authorities are in charge of providing social-health operator training courses through accredited local healthcare agencies, hospitals and public or private organisations in compliance with the relevant rules and regulations.

The OSS qualification is obtained at the end of a 1000-hour training pathway including lessons (550 hours), traineeship (450 hours) and a final exam.

Some regional authorities has set up additional social health training courses of 300 hours (150 out of them devoted to traineeship), aimed at social-health operators with additional qualifications. In particular "Social-health operators with additional health assistance training", commonly named "Super-OSS", are specialised or rather "new" professional figures, if compared to social-health operators., who assist nurses and obstetric nurses. Their tasks differ from the traditional OSS since they can:

- administer the prescribed therapy, in compliance with the guidelines set by the supervising nurses/obstetric nurses;
- perform intramuscular and subcutaneous injections under the nurses/obstetric nurses' qualified supervision;
- provide therapeutic baths, medical compresses and frictions;
- detect and take note of the patient's vital parameters (heart rate, respiratory rate and body temperature).

Any health assistance task should be supervised by a nurse and should be under the nurse responsibility. Due to this fact, "Super-OSS" are mainly employed in public and private health institutions, while the additional health assistance training is normally not taken into account for homecare.

In the *Questionnaire targeting Home Healthcare Practitioners* submitted for the CARESS Project context analysis, only 12 HHCP (public or private employed, no-freelance) replying to the survey were OSS (6%), so their number couldn't be considered as representative for that figure. Anyway, some information could be taken into account such as:

- only the 58% of them has a secondary school degree,
- about the 66% of them declared to work in homecare since 10 to 20 years (and the 17% since more than 20)
- more than the 50% of the OSS, both public and private employed, declared to have attended more than five lifelong courses in the last 5 years;
- about the 87% of them consider important or extremely important lifelong learning.

As to the main activities performed at the older adults' home the most of them selected: personal hygiene, home environment assessment, evaluation of customer needs, team meetings and contacts with other professionals, educational interventions for caregivers; no one of them declared to provide pharmacological treatments.

Although the sample of OSS reached by the online questionnaire didn't report about specific nursing tasks, according to data collected by Censis (Centre for Social Investment Studies (www.censis.it), in 2015 4.2 million people in Italy turned to non-medical staff to ask for assistance, mainly to homecare assistants and OSS; the main explanations are: "because it is a reliable person that we know" (42%) or "because a professional nurse is too expensive" (33.7%)

and “because we think that in many cases it not necessary to hire a nurse” (31.5%) [Colicelli, 2015].

So generally the issue for Regions is to choose to invest in a clear distinction between nurses and OSS competencies and tasks or, taking into account the growing need for health assistance in private and public health facilities and the risk of unqualified services, investing in health specialization courses for OSS. Different Regions have different positions. Although the Regional Professional Repository[17] envisages the figure of “Social-health Operator with complementary training in health assistance”[18], Liguria Region , for instance, doesn’t envisage any course for them. The main declared reason is that currently there are no ways to distinguish between OSS and “Super-OSS” from a contractual (and salary) point of view, since the national collective agreement doesn’t envisage this distinction; so professionals are not encouraged to attend additional courses without any perspective of contractual and career improvement. This perspective doesn’t take into account the improvement of the quality of the service, the increasing number of non-medical staff working in home health assistance and the private market.

HOMECARE ASSISTANTS /HOME HELPER

Homecare Assistants in Italy are normally called Family Assistants and defined by the Civil Code (Chapter II, Articles 2240 to 2246) as professionals who cover the provision of services with domestic character; the Family Assistant has a vital role in providing much-needed assistance to old, disabled, and chronically ill populations within communities.

Since the Family Assistant figure is not nationally normed, reference is made to the regulation that may be present at regional level and training courses for them are defined at regional level, too. Not all Italian regions have accurately defined the terms and content of the training program for Family Assistant; courses guarantee a basic level of competence, ensure the territorial validity of the license and they offer a professional growth path. A Family Assistant Register has been created in some of the regions: the requirements differ from region to region, especially in terms of training, ranging from a minimum of 32 hours to a maximum of 300 hours, and the contents of the training differ in relation to the number of hours foreseen. Normally, training includes both theory (in classroom) and practical training, which could be substituted with a period of work at the client’s home with supervision.

In the *Questionnaire targeting Home Healthcare Practitioners* submitted for the CARESS Project context analysis, only 4 HHCP replying to the survey were Homecare Assistants, so their number couldn’t be considered as representative for that figure. Anyway, some information could be taken into account such as:

- one of them have a lower secondary school diploma while 3 of them a first grade secondary school diploma
- 3 of them declared to have attended only one lifelong course in the last 5 years;

Homecare Assistants are not obliged by law to attend lifelong learning courses since they are not included in the national ECM program.

[17] http://professioniweb.regione.liguria.it/
[18] http://professioniweb.regione.liguria.it/Dettaglio.aspx?code=0000000220

The main activities performed by Family Assistants are

- take care of cleaning, hygiene and reorganization of the house;
- take care and help the patient during his daily life activities at home (clothing and nutrition);
- support the patient in his personal hygiene, respecting customs and personal habits;
- collaborate in the administration of the house (laundry, cleaning, minor maintenance, custody of animals and plants, etc.);
- collaborate in the preparation and distribution of meals, observing food and hygiene standards;
- cooperate in activities related to nutrition services (supply, preparation and distribution of meals);
- accompany the patient outside in order to help him to access to services or other necessities (paperwork, leisure activities, etc.);
- provide companionship and help to the person, even in case of hospitalization or hospital care in place of the family;
- observe and report to the family (or to the assistance personnel) possible changes in the conditions of the patient;
- collaborate in activities aimed at providing the maintenance or recovery of social relationships.

In general, training courses for Family Assistants provide basic knowledge to face properly these tasks and envisage practical training to develop practical skills.

One of the biggest problems in Italy about Familiar Assistants is that most of them work in the private market and illegally (payed “under the table”); this fact limits the possibility to verify their competencies and the presence of a training certification. In many cases they are also foreigners, with some problems with the Italian language. So the priority in Italy should be to find the way to assure that a professional providing home aid has been formally trained to perform effectively the service and, in the meanwhile, is able to interact and communicate effectively in Italian with the client and the other caregivers.

When the service is publicly provided, the control on Familiar Assistant qualification is assured by the Municipalities and the agencies working in agreement with them. For the private sector, one possible solution can be identified in the increasing number of recruiting agencies. A control on the selection process carried out by these agencies can assure more control on the professionals’ qualification. Another important role to contrast unqualified services and the unreported work phenomenon can be played by the establishment of regional registers; by defining professionals’ profile and qualifications they could regulate the market and increase professionality. The possibility of linking all of the “home aid vouchers” provided to citizens by the Region to the employment of a professional enrolled in the regional register could give a further incentive to legal and qualified employment of Familiar Assistants.

In addition what has been stated for OSS in the previous section, can be reaffirmed for Familiar Assistants; in 2015 4.2 million people in Italy turned to non-medical staff to ask for assistance

[Colicelli, 2015]. Most domestic workers take care of people that are over 75 years of age, with an high risk for an unqualified service. Most of them live with the patient or with his family; so the assistant also get board and lodging. In this situation, when simple healthcare tasks are needed, families often turn to the family assistant instead of paying another professional.

SOCIAL GUARDIANS

As described in previous Deliverables, the Social Guardian figure has been described in CARESS project as representative of a number of different figures who operate in Italy providing services aimed at fostering older adults independent living, at monitoring situations of frailty and at empowering mental, physical and relational resources of the individual. In Italy regions manages autonomously social services and in particular interventions for older adults in community; interventions on independent living and frailty monitoring are managed locally through the involvement of specific figures, often identified and trained in the framework of specific initiatives, projects or funding.

Social guardians currently work in different areas in Italy. Naturally the duties and activities of social guardians vary on the basis of where they work, as each community has their own needs and organisation. In general, they make home visits or telephone calls, give support in mobility, accompany the older adult when going out (for shopping, visits or administrative tasks) and monitor his/her health status in order to avoid risky situations. The Social Guardian plays a complementary role with respect to the home aid provided by municipalities by monitoring frailty situations, activating territorial networks around lonely people and contributing to the reduction of improper institutionalizations. Since activities vary from one region or city to the other, also the professional profile of social guardians changes in various contexts. In some cases, social guardians are hired to match a particular profile and undergo specific training, while in other cases the figure is not regulated. Usually they come from voluntary associations or social cooperatives and are practically trained in very short courses to perform the envisaged tasks.

In the *Questionnaire targeting Home Healthcare Practitioners* submitted for the CARESS Project context analysis, only 10 HHCP replying to the survey were Social Guardian and all of them work in Genoa, so their answers couldn't be considered as representative for that figure. Anyway, some information could be taken into account such as:

- 7 of them have a second grade secondary school diploma, while the other 3 are graduated;
- 9 out of 10 declare to have no additional professional qualification;
- 5 of them declare to work in older adults' homecare since 5 to 10 years and 4 of them since 10 to 20 years;
- the 50% of them have attended any lifelong courses in the last 5 years.

As to the activities they usually perform, all of them declared: companionship, support and assistance in social relationship and support to daily activities (shopping, going to a medical appointment, etc.)

When asked about their competencies the majority of Social Guardians declared to have a high mastery concerning social-health services organization and networks; this competence has been

acquired mainly by working practice (70% of positive answers) and not in formal training courses. As shown in Table 3, according to them, other competencies they master have been acquired mainly by working practice.

Competences	Required competence	Acquired by working practice	Acquired by attending courses…
Procedures for monitoring healthy lifestyles	60%	70%	30%
Basics in older person's healthy lifestyles	80%	90%	50%
Managing errands	80%	70%	20%
Usage of reporting and monitoring tools	60%	60%	30%
Fostering customers social and familiar relations	60%	70%	30%
Providing the customer with contextualized and personalized information about the network of services he/she can rely on	80%	70%	30%

Table 3: Comparison between the answers of social guardians to the questions "is this competence required to perform the activity?" and "how did you acquire this competence?" for 5 Competences that they declare to master

The profile and the qualification of Social Guardians and the analogous figures in Italy suffer of scarce definition and formalization. Defined locally according to contingent needs, Social Guardian competences are difficult to be defined: this fact poses different problems for the identification of lifelong courses for updating these competences and for the transferability of their qualification in other contexts, not only abroad but in other Italian cities or regions, too. Thus, the first challenge for Social Guardians VET is a clear formalization of this figure's competencies and profile, recognized at national level. Then specific VET courses can be organized at local level in the framework of a national definition.

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8.1.2 Comparing existing curricula with HHCPs' roles, skills and competences in Spain

Since illness and death have forever existed, nursing has always been connected with care giving. Due to this fact, throughout history, different cultures has behaved in diverse ways with the sick. In prehistoric times, care giving had to do with survival or the preservation of life. During the Middle Ages the humanistic concept and the belief in the religious value of health was introduced. In Modern Times a secularization of caregivers' activity and their professionalization was produced. Nowadays, instruction at the highest level is reached.

The Spanish system has changed throughout times. Before 1986, resources were mainly found in the hospitals of large towns and their management was extremely centralized and full of red tape. With the enactment of the Constitution in 1978 many changes in the Health System took place when competences were transferred to the Autonomous Regions. In 1986, the Act on the General Health System promotes the creation of the General Health System. Through this act all the Spanish Autonomous Regions have created their own Health Services and they manage healthcare in their territories. To sum up, in Spain there is a Health National Policy coordinated by the Ministry of Health, Social Services and Equality, there is also a Health Autonomous Policy with 17 Health Regional Services and a Local Policy managed by the different city councils.

It is a fact that Spanish population is a progressively aging, since nowadays people tend to live to older ages, and this increases the number of long-term old age dependents.

There are two sides to the services provided at home to long-term old age dependents in Spain: health and social services.

Home nursing service. This is a group of activities –previously planned- developed by professionals who are part of a multidisciplinary nursing team.

Home Social Services care. This service is aimed at that group of the population with great limitations to do their daily chores, being this temporary or permanently. They help them in improving their personal autonomy and their quality of life within their environment.

In Spain, as already stated, we can classify HHCPs into two groups: informal practitioners (with no previous training) and formal practitioners (those who have previous training in care, the type of training raging from professional qualifications to university training).

The correlation of the Spanish framework with the EQF is done through the Spanish Framework of Qualifications (MECU) or National Qualification Framework (NQF), which includes all the levels, from level 1 (primary education) to level 8 (University Doctoral Studies).

As can be seen in the table, the MECU is the result of the addition of the CNCP and the Spanish Qualifications Framework for Higher Education (MECES).

These specifications are presupposed at level 3 of CNCP, corresponding with level 1 of MECES and with level 5 of EQF, establishing as Higher Education the one corresponding to the degree of Técnico Superior de Formación Profesional (VET Upper Level Technician).

NURSES

The degree of Nursing, in order to achieve all of the competencies provided will be required to complete 240 ECTS (each ECTS, by agreement of the Governing Council of the Uva, will have an equivalence of 25 hours), which will be distributed as follows: 60 ECTS for basic training, 84 ECTS for the compulsory subjects, 6 ECTS for elective courses, 84 ECTS for the practicum and 6 ECTS for the completion of a degree dissertation (Distribution in accordance with the guidelines of the RD 1393/2007).

For 2016/2017 there are 57 universities in Spain who's Faculties of Health Science, Faculties of Nursing, Faculties of Medicine or University Schools offer a Degree in Nursing, with 4750 new openings being offered.

Once the graduate Degree in Nursing has been achieved, you can either work as a nurse on your own, or continue with the specialization to a professional and / or academic level:

- Continuing with academic education obtaining the degree of Official University Master (studies aimed at academic or professional specialization of the student or an initiation in research activities), corresponding to an EQF-7. This type of Master enables students to pursue higher university education with a doctorate.
- The doctorate, EQF-8, is the third level of official university studies leading to a doctorate degree, which involves the acquisition of competencies and skills related to scientific quality research.
- Another level of specialization in nursing at professional level would be the completion of a Specialized Training program (Internal Nursing Resident, INR) under the authority of the Ministry of Health, Social Services and Equality, and not the Ministry of Education, Culture and Sport, with a duration of 2 years with the following specialties:
    - Obstetrics-Gynaecology Nursing
    - Mental Health Nursing
    - Occupational Health Nursing
    - Paediatric Nursing
    - Family and Community Nursing
    - Geriatric Nursing

The specialized health training system in Spain, shaped the profession of Geriatric Nursing as a nursing speciality, which appears in Royal Decree 450/2005, of 22 April, on nursing specialities and in paragraph 4 of Annex I of Royal Decree 183/2008, of 8 February, whereby health science specialities are determined and classified, and where also certain aspects of the specialized health training system are developed.

It is an official and formal training which aims to provide specialists with the speciality's knowledge, techniques, skills and attitudes: simultaneously to the gradual assumption by the interested person, with the inherent responsibility of the self-employed profession of geriatric nursing.

To obtain the qualification of the speciality of Geriatric Nursing, the residents will meet the training programme in multi-professional teaching units of geriatrics, over a full-time period of two years.

The overall objective of this programme is that, during the completion of the training period of two years, the resident nurse in Geriatric Nursing will have acquired the necessary skills for the appropriate exercise of their profession. These professional skills are divided into the following areas:

- Gerontology Foundations
- Experimental Gerontology
- Clinical Gerontology
- Psychological Gerontology
- Social Gerontology
- Health Education in the field of Gerontology
- Gerontological Nursing: Legal Framework and Health and Social Policies
- Bioethics in Gerontological Nursing
- Gerontological Nursing Research
- Gerontological Care and Service Management

Finally, with reference to continuous training courses, they were asked how many have been offered by their company in the last 5 years. 14% have been offered one and 57% more than five. 14% of respondents have not taken any of the courses they were offered while 86% have taken over five courses. When asked if they consider that continuous training is important for their profession, 72% think it is extremely important, 14% very important and 14% simply important.

6% was the rate of those nurses who answered our questionnaire and who had worked in elderly homecare in the last five years. Out of these, 57% are homecare providers working in a public institution, 14% work for a private company, 14% are self-sufficient and 14% indicated “other”.

Out of all the nurses interviewed, 57% hold an additional professional qualification and 43% do not. When asked how long have they been working a in elderly homecare, 57% have been between 1 and 5 years whereas 43% between 5 and 10 years.

Nursing main role is being responsible of healthcare in general. The main competences of nurses are:

- Being able to pay technical and professional sanitary attention to health needs.
- Planning and providing healthcare to people, families and groups.
- Knowing and applying theoretical and methodological basics of nursing.
- Understanding interactive behavior of people depending on their culture and social context.
- Designing care giving systems.
- Basing nursing procedures in scientific evidences.
- Understanding people considering their holistic appearance, avoiding prejudicing.

- Knowing the code of ethics.
- Promoting healthy life styles.

VET

In Spain, homecare services have been transferred to the Autonomous Regions, being carried out by their Social Services. The personnel of Social Services may directly provide it or this can be done by local entities after an agreement has been signed. Homecare is generally provided by City Councils, being these the institutions with a more direct contact with citizens and thus better knowing their needs.

Homecare professionals related to socio-sanitary activities (equivalent to Home Health Care) hold a VET degree ("*FormaciónProfesional*" -*FP*). They can be classified into three different groups, all of them EQF 2 or 3.

Before we describe these groups of professionals flaws and present and future needs of improvement in training, we should refer to another group. Domestic staff, are those workers who for many years had no formative regulation and that, after an adaptation period which will end in 2017, will need to mandatorily have a minimum qualification of EQF 1. INCUAL (Instituto Nacional de Cualificación) is the regulatory body in charge of supervising these qualifications.

This group of professionals does not have a socio-sanitary profile. They are in charge of the house chores but not of the people living in them. These workers will need to get accredited for some professional experience, and/or take a maximum of 150 hours of formative modules. It is interesting to include this information here because their work activity when employed in an elderly home may often overlap with that of VET professionals, as it would be the case of "administration of medication", but their qualification has not been not accredited. The reason for this increase in their chores may have to do with the proximity and familiarity of this activity as well as with the fact that they work in an environment in which the elderly of the household tend to have growing needs of help.

Anyhow, this is an area of study of future formative needs that should be payed attention to. Besides, changes in the profile of this activity have already been defended in different discussion forums and publications.

With reference to all VET categories

Different publications stress the fact that elderly homecare professionals, no matter what qualification they hold, should be highly motivated to be able to work with these people. That is, they should have a specific stimulus that helps them work in this field. They also indicate that those who only wish to work in this field for money reasons will probably fail. In this sense, fostering training in values would help improve this aspect. Expert opinions indicate that work placement –in elderly homecare- and desirable insurance that employees remain professionally active, would be easier if what prevails is human relations capacity, favorable disposition to understand elderly problems and a sincere and open attitude towards life, as well as other personal maturing conditions.

These opinions are in line with the answers given by elderly in the interview carried out. When asked what abilities or characteristics they considered should be fundamental for homecare professional to have, the most frequent answers could be grouped in concepts similar to “being well mannered”, “ability to chat” or “being goodnatured”. With reference to the aspects that elderly considerate have improved their quality of life since homecare professionals assist them, “not being alone at home or when going out” is the most frequent answer. Some other frequent answers are those referring to being helped with their mobility, e.g. assistance in fitting prosthetics.
A few number of training programs offer satisfactory partial answer to these needs.

To sum up, considering the facts here presented as well as conclusions of different publications and studies, we will now present a summary of the formative needs of HHCPs extracted from reputable publications.

PRACTICAL NURSE

- Socio-emotional needs
- Administrative operations and sanitary documentation
- Comunication
- Relations with the work equipment
- Environment and risk prevention in the workplace

HOMECARE ASSISTANT

- Homecare technologies
- Conflict management
- Communication
- Environment and risk prevention in the workplace
- Evaluation and quality management
- Professional values, attitudes and ethical behavior acquisition.

SOCIO SANITARY CARE TECHNICIAN

- Information treatment
- Service administrative Management
- Confidential information Management
- Public relations, Communications and professional abilities
- Environment and risk prevention in the workplace

PHYSIOTHERAPY

Physiotherapy assistance at home is a common practice for users with pathological processes both sub-acute and chronic. The public system offers these therapies “Primary Health Care” centers.
Acquired **competencies** necessary to develop the **activities** at the home of the elderly, are not taken account separately in the training programs of physiotherapy, so that the needs addressed

in this area are subordinated to those given in other areas. The physiotherapy activities are implemented in accordance with the programs of each health service.

Training programs in Spain are very uniform in all universities offering this matter. They share almost all the learning outcomes.

Some suggested new skills in several publications:

- Scope of home help service
- Administrative operations
- Environment and risk prevention in the workplace

OCCUPATIONAL THERAPY

Occupational Therapy is based on the study of human occupation and uses this one as intervention tool for the profit of its objectives, being it basic and fundamental objective to obtaining person's independence.

The competencies required to develop the activities at home are specifically acquired in training programs.

The Curriculum of different Spanish universities can vary significantly with respect to certain content in skills, knowledge and transversal competencies, which are influenced by the type of university center in which it is taught.

The level of coincidence between the needs and activities covered in the training programs and the established ones in our study is of the highest within the HHCP. However, it not happen the same with the skills and competencies because the objectives sought are different, as will be explained in the next section 8.2.2, entre

Some suggested new skills in several publications:

- Scope of home help service
- Sociocultural animation
- Communication with user
- Professional values, attitudes and ethical behavior
- Evaluation and quality management
- Environment and risk prevention in the workplace

SPEECH THERAPY

Speech therapy is a discipline with small presence in care services at all levels, despite they increasingly work in elderly home care. The competencies required to develop the activities at home are specifically acquired in training programs.

The level of coincidence between the needs and activities covered in the training programs and the established ones in our study is one of the lowest within the HHCP. Both general and specific competencies differ markedly from those suggested in our study. Many of them seem to be necessary to properly develop the profession in that environment. Training programs so far leave large gaps that need to be covered.

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8.1.3 Comparing existing curricula with HHCPs' roles, skills and competences in Finland

In Finland most usual home health care professional (HHCP), who's working in home health care sector is practical nurse. Practical nurses have upper secondary level qualification for social and health field. Practical nurses are health care professionals with a protected occupational title.

In Finland the results of HHCP survey indicated that majority of responders thought that almost all the competences included in questionnaire used in study are required in working in home health care. In self –evaluation of HHCPs skills and competences level, the responders evaluated their competence level satisfactory in knowledge of social- and health service system inc. social services and benefits client is entitled to Knowledge, skills and competences were also evaluated mostly in categories of satisfactory or good in procedures for providing physical therapies, fostering clients social and familiar relations, competences to support for coordinating the work of other practitioners, competences for evaluating clients mental health status and competences for caring clients with terminal illness and grief support.

Comparing the existing curricula with the data of the results of HHCP survey, we can notice that these themes and things are in curricula, but maybe students are not so interested in these themes. After some years in work, they noticed, that these are important things. There is only few lections about physical therapies, and likewise is with fostering clients social and familiar relations.

HHCPs had acquired competence mostly by working practice in following skills: basics in social-health services organizations and networks. This subject is in curricula, but not some much, only some hours and this is too little.

We can noticed that in curricula is quite many subjects, what practical nurses need in they work. In the achievement we emphasize other things.
Practical nurses answered that they need more knowledge about the main aids and devices for older and disabled people, procedures for fostering customers going out of home, providing the customer with contextualized and personalized information about the network of social services and benefits he/she can rely on, competences for collaboration with other practitioners and competences for evaluating customer needs and adapting the service.

In Finland the main laws as Law about Health service and Social service has been renovated very much in the year 2011 and 2015. The status of client is now different than before, for example a client is subject and he/she must be with when they are evaluating the clients situation and forming his/her care and service plan.

When comparing the skill gaps and existing curricula of practical nurse in Finland it implies that all of the skill needs are somehow covered in curricula but superficially and in quite general level and not necessary at all in home care aspect.

In the questationnaire did not asked if the responders have done recommended specialization: Care of elderly and especially the elective module Home care and nursing of the elderly. If the reponders have done these, so it is important that we develop the curricula and our teaching. If they did not done these, so it explains many of these answers and the skill gaps.

In Finland the Ministry of Education and Culture is doing just now a new curricula for practical nurses. The new curricula starts using in year 2018.

8.1.4 Analysis of HCCPs' roles, skills and competences in EU

By results of answering to the questionnaire half of the nurses working in homecare in Italy have got no academic education and probably no additional professional qualification. The results of questionnaires shows mostly the same direction in Spain: 72 % of answers consider that continues training is extremely important for their profession but just for 14 % have been offered one and 57 % more than five training courses by their company in the last 5 years. The results of HHCP survey in Finland indicated that majority of responders thought that almost all the competences included in questionnaire used in study are required in working in home health care.

However, depend countries and law, who can work in home (helath)care. Some countries accept only high educated nursing staff (EQF), the others try to solve the staff need by differentiate work for different actors on different qualification level. The lack of labour force can cause different problems like working in the private market and illegally (payed "under the table"); this fact limits the possibility to verify their competencies and the presence of a training certification. In many cases they are also foreigners, with some problems with official language. One of the priority in Italy should be to find the way to assure that a professional providing home aid has been formally trained to perform effectively the service and, in the meanwhile, is able to interact and communicate effectively in Italian with the client and the other caregivers.

Anyway, since there's no information about the contents of continues courses, one of the emerging risks is that nurses providing homecare services have no updated competences about for examples new protocols, new services and new technologies. However, comparing the skill gaps and existing curricula of practical nurse in Finland implies that all of the skill needs are somehow covered in curricula but superficially and in quite general level and not necessary at all in home care aspect. The one sub-part of the curricula is also recommended specialization: Care of elderly and especially the elective module Home care and nursing of the elderly.

By results of answering to the questionnaire in Spain HHCPs highlight the limitations in service administrative management and information treatment; evaluation and quality management; professional values, attitudes and ethical behavior acquisition; administrative operations and sanitary documentation; relations with the work equipment and homecare technologies; communication and conflict management; environment and risk prevention in the workplace.

Practical nurses in Finland answered that they need more knowledge about the main aids and devices for older and disabled people, procedures for fostering customers going out of home, providing the customer with contextualized and personalized information about the network of social services and benefits he/she can rely on, competences for collaboration with other practitioners and competences for evaluating customer needs and adapting the service.

8.2 IDENTIFICATION OF FUTURE TRAINING NEEDS BY COMPARING FUTURE SKILLS NEEDS WITH EXISTING CURRICULA

8.2.1 Comparing existing curricula with HHCPs' future skills needs in Italy

This section is dedicated to compare the results of primary and secondary data descripted in *D2.2 Identification of skill and competency needs in the home care sector* with the *Report on existing curricula, according to ECVET/learning outcomes, VET and career pathways concerning HHCP* (D2.3.2).

We will conduct a detailed analysis for each professional involved in Home Care in Italy, identifying skill gaps following also of the main EU and national guidelines and trend report on HHCP.

NURSES

The result of the analysis of data collected throught HHCP interviews show that nurses there are some gaps comparting them with the EU(EU SKILLS PANORAMA, 2014) and national levels guidelines, that identify the skills and competences that will be the key elements for the future homecare services delivery such as:

1. **"The homecare service should be focused on a global, multi-perspective and multidisciplinary view of the patient**, with the objective of improving his/her perception of the quality of life. To this end, the Individualized Assistance Plan should take into account all of the dimensions of the person and all of the possible services which could be activated to enhance the individual independence." (Deliverable 2.1)
4. "More detailed description of the roles that each HHCP should play within the homecare process should be provided, in order **to avoid gaps and overlapping in the integrated service provision**. "(Deliverable 2.1)
5. **Specific tools and documentation** should be identified and provided to professionals in order to report properly their activity, foster their collaboration and to support the creation of a unique set of information about the patient homecare, integrated with the National Health System databases; in particular, the integration of information from private and public homecare is crucial.

Regarding this area of competences, more than 80% nurses interviewed reported that the skills necessary to collaborate with other professions have been considered required to practice their job (81.38%). Above half of nurses interviewed consider himself/herself not be highly competent in this skills area(42.3%). From this data we could make some assumptions on Italian nurses competences profile:

- More than one third (35.63%) of the nurses interviewed consider not required the ability to use reporting and monitoring tools. This data let us suppose that in many cases tools like personal care plans or monitoring tools, are unused compared to the recommendations of EU commission.
- Mostly of the nurses interviewed consider themselves not highly competent about "the organization of services and service networks" and "the ability to provide patients

with detailed information on its requests"; despite they consider these skills required for their job.

	Basics in social-health services organizations and networks	Usage of reporting and monitoring tools	Providing the customer with contextualized and personalized information about the network of services he/she can rely on	Competences for collaborating with other practitioners	Competences for working in a group /equip /staff	AVERAGE
IS THE COMPETENCE REQUIRED?						
Required (A2)	*86,21%*	*63,22%*	*75,86%*	*89,66%*	*91,95%*	*81,38%*
Not Required (A1)	*12,64%*	*35,63%*	*24,14%*	*10,34%*	*8,05%*	*18,16%*
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE						
Low Mastery (A2)	*20,69%*	*4,60%*	*8,05%*	*6,90%*	*0,00%*	*8,05%*
Mean Mastery (A1)	*32,18%*	*29,89%*	*39,08%*	*44,83%*	*25,29%*	*34,25%*
High Mastery (A3)	*34,48%*	*29,89%*	*28,74%*	*36,78%*	*67,82%*	*39,54%*

Table 4: Nurses competences in team work and Usage of reporting and monitoring tools areas

If we compare these data with the three-year training course necessary to practice the nursing profession, as described in D2.3, we can assume that the educational objectives of the undergraduate program in nursing include aspects such as "maximum integration with other professions" and interdisciplinary subjects, that could compensate this skill gap. Despite this we have to consider that the autonomy of universities to plan their curricula, allows changes in training programs, especially for the learning outcomes that are not considered core competences, such as the skills needed to work in team or the ability to use of reporting tools. Within the community nurses competences profile proposal included in the CONSENSO project and described in the D2.3.2, these aspects of the profession profile have been considered particularly important that include the following skills:

- To know the national and international policies for healthcare and the regional and national laws on primary care
- He is able to contextualize his/her own intervention in regional and national politics
- To know the role played by the informal networks and FCN in primary care
- Being able to involve informal networks
- To be aware of FCN role in the primary care system
- He involves properly informal networks in personalized interventions

Another aspect that is emphasized as particularly relevant for future HHCP and future nurses are:

"Concerning specific competencies primary, secondary and tertiary care; a specific focus on primary care should be provided in their training in order to allow them to contribute, With Their specific service, to prevent and early diagnose diseases or health problems, in coordination with the GP and other HHCPs."

	Basic knowledge in medical assistance	Basic medical knowledge specifically related to my profession	Basics in anatomy and pathology	Basics in domestic safety and prevention	Basic procedures in medical assistance	Other specific basic medical procedures related to my profession	Procedures for providing medical therapies	Procedures for personal hygiene	AVERAGE
IS THE COMPETENCE REQUIRED?									
Required (A2)	86,21%	95,40%	96,55%	91,95%	94,25%	90,80%	90,80%	81,61%	86,59%
Not Required (A1)	12,64%	3,45%	3,45%	6,90%	5,75%	5,75%	8,05%	17,24%	12,01%
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE									
Low Mastery (A2)	0,00%	0,00%	2,30%	0,00%	0,00%	1,15%	1,15%	0,00%	1,40%
Mean Mastery (A1)	35,63%	36,78%	45,98%	13,79%	4,60%	31,03%	20,69%	13,79%	24,65%
High Mastery (A3)	51,72%	59,77%	47,13%	78,16%	89,66%	57,47%	70,11%	71,26%	61,43%

Table 5: Nurses competences in clinical area

According to the findings from the survey, it seems that the clinical skills required to nurse profession, to practice, are considered necessary and that professionals feel able to master the required skills. In most cases (always higher than 90%) these skills have been acquired either through training, or through work experience. Within the three-year training for certified nursing profession these skills are among the basic ones, so we can assume that overall the training course allows effective acquisition.

Also within the area of clinical expertise, the indications of the main European report on the topic (see D2.2) emphasize the importance of focusing on prevention and promote a healthy and active lifestyle.

	Environmental and personal hygiene basic concepts	Basics in dietetic	Basics in older person's healthy lifestyles	Procedures for personal hygiene	Procedures for monitoring healthy lifestyles	Competences for empowering the customer	Competencies for supporting the customer in building up an independent living path	AVERAGE
IS THE COMPETENCE REQUIRED?								
Required (A2)	*91,95%*	*80,46%*	*91,95%*	*81,61%*	*62,07%*	*58,62%*	*45,98%*	*73,23%*
Not Required (A1)	*6,90%*	*17,24%*	*6,90%*	*17,24%*	*37,93%*	*41,38%*	*52,87%*	*25,78%*
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE								
Low Mastery (A2)	*0,00%*	*2,30%*	*1,15%*	*0,00%*	*2,30%*	*2,30%*	*2,30%*	*1,48%*
Mean Mastery (A1)	*13,79%*	*44,83%*	*31,03%*	*13,79%*	*25,29%*	*27,59%*	*26,44%*	*26,11%*
High Mastery (A3)	*78,16%*	*35,63%*	*60,92%*	*71,26%*	*35,63%*	*28,74%*	*17,24%*	*46,80%*

Table 6: Nurses competences in prevention area

In relation to these competencies, as evidenced from the data shown in the D2.2, the nurses surveyed consider that some of these are not particularly relevant for their profession (Procedures

for monitoring healthy lifestyles; Competences for empowering the customer; Competencies for supporting the customer in building up an independent living path).

They seem to point that it is more required by their profession prevention skills linked to hygiene _, in which the main actor is the health care worker and not the patient. The skills related to the promotion and monitoring of a style of active and independent healthy life, in which the patient is the protagonist of his health path, seem to be mastered only by a small percentage of professionals (35.63%). Comparing these data with the degree program in Nursing, arise that, although the skills related to prevention are among the basic educational objectives (general hygiene and applied), there is not much study on a patient empowerment approach. Within the proposed educational goals related to professional nurse community (D2.3.2 Caress project), it is given special importance to the concept of Active Aging and Healthy and prevention based on the Early diagnosis ; In fact, within the competence included within the formative objectives have been included:

- To know what fragility is and being able to evaluate the fragility levels of the elderly, the prevention strategies and the methods and tools to recognize the early fragility of the patient
- Being able to use specific measurement methods to carry out an early diagnosis of the fragility of the patient
- The basics on how much one's lifestyle can affect the outbreak of chronic disease and their complications
- To know the principles and methods used to teach people the principles and the methods of healthcare and therapeutic education Nutrition and healthcare; Tobacco use and abuse prevention ; Physical training and health; Home safety
- Being able to set up a therapeutic educational project

Considering the skills "to use new ICTs supporting telecare, primary care and remote health monitoring." as suggested by EU and national reports, as described in D2.2, we can find that more than half of the subjects believe that the use of ICT in their profession is not required and they have not mastered the skills required.

	Using ICT for social participation	**Using ICT for health status monitoring**	**AVERAGE**
IS THE COMPETENCE REQUIRED?			
Required (A2)	*26,44%*	*49,43%*	37,93%
Not Required (A1)	*73,56%*	*50,57%*	62,07%
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE			
Low Mastery (A2)	*3,45%*	*3,45%*	3,45%
Mean Mastery (A1)	*17,24%*	*26,44%*	21,84%
High Mastery (A3)	*8,05%*	*20,69%*	14,37%

Table 7: Nurses competences in ICT area

Comparing these data with the degree courses in nursing, there is clearly a need for skills training in the ICT sector, in particular on the application of these in the profession.
Within the training course offered by community nurses in the project CONSENSO have been included the following competences:

- To know the main tools and methods to grant remote assistance and the Ambient Assisted Living
- Being able to use all the IT tools to grant remote assistance.
- Being able to record and transmit medical data using technological tools

As defined by the Ministerial Decree of 14 September 1994, the participating nurses identify the health needs of the people and plans and implements assistance interventions, including the field of mental health. So as it noted within the D2.2 both at Community than Italian level, the competent authorities have repeatedly stressed the importance of skills related to psychology and mental health for the professions working in home care.

"Patients and their Families demand 'more and more for psychological assistance and are often unsatisfied by the service provided. According to Cittadinanzattiva report [2006], psychological assistance is envisaged by the 63.2% of the Local Health Agencies, but actually provided to the 16% of the families. "

Resuming the analysis of the results of the responses to the questionnaire carried out the D2.2_ arise that the majority of nurses surveyed (65.29%) consider that such skills are required to practice their profession,_ in particular psychology Basic elements (81.61%) and competences for evaluating customer mental health status (77.01%). Investigating the perceived level of mastery of these skills_ arise that only a quarter (25. 52%) feels to master the required skills.

	Basic psychology elements	**Fostering customers social and familiar relations**	**Competences for managing conflicts**	**Competences for evaluating customer mental health status**	**Grief support**	**AVERAGE**
IS THE COMPETENCE REQUIRED?						
Required (A2)	*81,61%*	*57,47%*	*44,83%*	*77,01%*	*65,52%*	*65,29%*
Not Required (A1)	*16,09%*	*42,53%*	*54,02%*	*21,84%*	*33,33%*	*33,56%*
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE						
Low Mastery (A2)	*13,79%*	*11,49%*	*11,49%*	*6,90%*	*8,05%*	*10,34%*
Mean Mastery (A1)	*45,98%*	*21,84%*	*20,69%*	*32,18%*	*33,33%*	*30,80%*
High Mastery (A3)	*22,99%*	*24,14%*	*16,09%*	*39,08%*	*25,29%*	*25,52%*

Table 8: Table 8 Nurses competences in psychology area

Verifying the presence of these skills within the educational objectives of the educational paths for nurses_ you can observe how_ although they are present among the basic training activities (elements of psychology); mental health and interventions to promote it find little space 'inside of

the training courses for nurses. This finding is also confirmed by the answers given by respondents. In fact_ many of them report that as well if they have a medium or high mastering of a certain expertise in the mental health sector, for example, support in case of bereavement (58.62%)_ this competence has been learned through practice (63.22%) and not through training courses (44.83%).

Another aspect that arises from the analysis of the interview data is connected to terminal illness Competencies for support._ Regarding it there is not a defined Majority identifying if this competence Has Been acquired attending courses at or not (50% equally distributed). More over this has no competence to Majority clear on the question related to if the professions manage it_ in fact 25% Answered low mastery_ 25% Answered average mastery_ 37.5% Answered high mastery and 12.5% preferred to avoid answering.

As reported the D2.2 the 95, 40% of the respondents reported that there are no additional skills required.

PHYSIOTHERAPISTS

In this section we will compare the results from the analysis of the skills and competency needs, reported in the deliverable D2.2, with training courses for physiotherapists currently conducted and already presented in the deliverable D2.3.1 and D2.3.2, in order to identify any skill gaps and to suggest any possible professional learning paths and outcomes.

Resuming the analysis of the skills of physiotherapists shown in D2.2, 70 professionals who answered the questionnaire:

Considering basic clinical skills of the profession of physiotherapist,

- with the only exception for the competence "Other specific basic medical procedures related to my profession", physiotherapists consider necessary (86.9%) all the clinical skills listed, including Basic knowledge in medical assistance, Basic medical knowledge specifically related to my profession, Basics in anatomy and pathology, Procedures for providing physical therapies, Procedures for customer moving.
- Investigating the degree of self-assessed mastery of the skills required, we can note that in some clinical aspects except for “Procedures for providing physical therapies”, physical therapists perceive a high mastery level (> 80%).
- By analyzing the data concerning to the way the competences have been acquired, physiotherapists seem to acquire them both through training and through the clinical practice.

	Basic knowledge in medical assistance	Basic medical knowledge specifically related to my profession	Basics in anatomy and pathology	Other specific basic medical procedures related to my profession	Procedures for providing physical therapies	Procedures for customer moving	AVERAGE
IS THE COMPETENCE REQUIRED?							
Required (A2)	*74,29%*	*84,29%*	*94,29%*	*50,00%*	*80,00%*	*98,57%*	*83,45%*
Not Required (A1)	*24,29%*	*14,29%*	*5,71%*	*45,71%*	*18,57%*	*1,43%*	*15,33%*
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE							
Low Mastery (A2)	*2,86%*	*1,43%*	*0,00%*	*4,29%*	*11,43%*	*1,43%*	*2,68%*
Mean Mastery (A1)	*34,29%*	*15,71%*	*12,86%*	*20,00%*	*21,43%*	*11,43%*	*16,76%*
High Mastery (A3)	*37,14%*	*70,00%*	*82,86%*	*27,14%*	*51,43%*	*87,14%*	*65,44%*
COMPETENCE ACQUIRED ATTENDING A SCHOOL, A TRAINING COURSE OR AN ACADEMIC COURSE							
No (A2)	*8,57%*	*5,71%*	*0,00%*	*8,57%*	*7,14%*	*4,29%*	*5,71%*
Yes (A1)	*61,43%*	*80,00%*	*95,71%*	*38,57%*	*75,71%*	*94,29%*	*74,29%*
COMPETENCE ACQUIRED BY WORKING PRACTICE							
No (A2)	*7,14%*	*4,29%*	*12,86%*	*1,43%*	*12,86%*	*4,29%*	*7,14%*
Yes (A1)	*65,71%*	*81,43%*	*77,14%*	*47,14%*	*65,71%*	*92,86%*	*71,67%*

Table 9 Physiotherapist competences in clinical and medical knowledge

Comparing these data with the results of the D2.3.2 describing training courses existing, one of the main specific educational objectives of the Bachelor Degree in Physiotherapy are the medical skills related to the profession. There is no indication, therefore, within this area, particular skill gaps and learning needs.

As we reported previously, in the deliverable D2.2,

“Another important resource can be remote patient monitoring technologies, which enables patients with severe chronic diseases or conditions to monitor their blood pressure and other health factors from their homes and share this information electronically with their physicians and other healthcare providers. Italian regions are investing at different levels in remote health monitoring, but in general it is limited to experimental initiatives involving a limited number of users.”

So one of the learning objectives for the future home care professional path will be the competences in using new ICTs supporting telecare, primary care and remote health monitoring.

Analyzing the outcomes of physiotherapist’s answers regarding these skills area, we can note that:

- Almost 90% of professionals believe that these skills are not required by their profession; this confirms that actually using them is really very limited, and as reported in D2.1 Italian regions are investing at different levels in remote health monitoring, but in general it is limited to experimental Initiatives Involving a limited number of users.

- the level of mastery of these skills seems to be very low. Within the total number of response, more than 90% of respondents perceive a medium / low mastery level.
- regarding the methods by which these skills have been acquired, despite the small number of responses, we can deduce that it is dedicated within the training small space (only 11% of physiotherapists, reports of them acquired during a course).

	Using ICT for social participation	Using ICT for health status monitoring	AVERAGE
IS THE COMPETENCE REQUIRED?			
Required (A2)	*7,14%*	*5,71%*	*6,43%*
Not Required (A1)	*88,57%*	*90,00%*	*89,29%*
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE			
Low Mastery (A2)	*10,00%*	*7,14%*	*8,57%*
Mean Mastery (A1)	*4,29%*	*4,29%*	*4,29%*
High Mastery (A3)	*1,43%*	*0,00%*	*0,71%*
COMPETENCE ACQUIRED ATTENDING A SCHOOL, A TRAINING COURSE OR AN ACADEMIC COURSE			
No (A2)	*12,86%*	*8,57%*	*10,71%*
Yes (A1)	*1,43%*	*1,43%*	*1,43%*
COMPETENCE ACQUIRED BY WORKING PRACTICE			
No (A2)	*8,57%*	*5,71%*	*7,14%*
Yes (A1)	*7,14%*	*4,29%*	*5,71%*

Table 10 Physiotherapist competences in ICT area

By comparing these data with the existing training courses we can recognize that currently the Bachelor degree in physical therapy does not include the use of ICT for servicing and monitoring within the educational objectives, with the exception of basic computer skills area.
The lack of use of ICT tools in the clinical practice and the lack of skills of professionals in the field, highlight a skill gap, which should be the subject of learning objectives, but only if it is accompanied by a greater implementation and service innovation.

As reported previously in the D2.2, one of the points of development of the health professions trend will be:

"Normally the health homecare service replies to assistance and care problems in crucial phases of specific diseases; normally the indicator for the need of an homecare service is not the disease itself, but the problems taken by the disease (bedsores, need for mobilization, etc.). Homecare should be considered as a fundamental instrument not only for secondary and tertiary prevention, but also for primary prevention, aiming to prevent diseases or injuries before they ever occur".

So in the next future also Physical therapists:

- *"…should have specific competencies concerning the main objectives and aims of primary, secondary and tertiary care; a specific focus on primary care should be provided in their*

training in order to allow them to contribute, with their specific service, to prevent and early diagnose diseases or health problems, in coordination with the GP and other HHCPs" (D2.2)

Analyzing the outcomes of responses to the questionnaire physiotherapists we can conclude that:

- Key competencies in the field of primary prevention for the physiotherapist profession, have not been considered as required by the profession themselves. In particular with the exception of "Environmental and personal hygiene Basic Concepts" and "Basics in dietetic", all other competencies in this area are considered required by less than 50% of subjects.
- 30% of the subjects consider to have acquired an high/mean level of competencies in the field of prevention, but level of mastery perceived about skills related to 'older person's healthy lifestyles, Competences for empowering the customer, Procedures for personal hygiene (latter's more to the prerogative of other professionals) are below the average.
- the skills related to primary prevention are learned most during the experience in training, this emerges particularly for "Competences for empowering the customer" and "Competencies for supporting the customer in building up an independent living path".
- Almost all the physiotherapists believe that there are no additional skills respect to those mentioned in questionnaire, which are required by the profession.

	Environmental and personal hygiene basic concepts	Basics in dietetic	Basics in older person's healthy lifestyles	Procedures for personal hygiene	Procedures for monitoring healthy lifestyles	Competences for empowering the customer	Competencies for supporting the customer in building up an independent living path	AVERAGE
IS THE COMPETENCE REQUIRED?								
Required (A2)	78,57%	94,29%	44,29%	27,14%	48,57%	44,29%	55,71%	54,46%
Not Required (A1)	21,43%	5,71%	55,71%	72,86%	51,43%	55,71%	42,86%	45,36%
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE								
Low Mastery (A2)	0,00%	2,86%	5,71%	2,86%	2,86%	2,86%	5,71%	3,14%
Mean Mastery (A1)	31,43%	34,29%	28,57%	12,86%	24,29%	25,71%	21,43%	27,92%
High Mastery (A3)	48,57%	55,71%	20,00%	21,43%	30,00%	22,86%	32,86%	33,38%
COMPETENCE ACQUIRED ATTENDING A SCHOOL, A TRAINING COURSE OR AN ACADEMIC COURSE								
No (A2)	20,00%	22,86%	22,86%	20,00%	21,43%	31,43%	32,86%	24,49%
Yes (A1)	55,71%	68,57%	28,57%	14,29%	32,86%	15,71%	21,43%	33,88%
COMPETENCE ACQUIRED BY WORKING PRACTICE								
No (A2)	2,86%	7,14%	5,71%	7,14%	7,14%	5,71%	7,14%	6,12%
Yes (A1)	75,71%	82,86%	44,29%	31,43%	47,14%	44,29%	45,71%	53,06%

Table 11 Physiotherapist competences in prevention area

Comparing these data with the results of the D2.3.2 on the degree courses in physiotherapy, we can recall that:

- The physiotherapist shall be able to carry out preventive activities in relation to individuals and the community, both healthy and with problems and disabilities related to physical and / or mental condition; will promote the actions needed to maintain health with particular attention to ergonomic principles, advice on lifestyle, motivating the person to be responsible and to actively cooperate to promote their physical and social well-being. In particular, this area considers a commitment in activities pointed to the recognition and the elimination of potentially harmful situations for the individual and the community, through: the identification of health needs and disability preventing, promotion of the necessary actions to maintain health and to overcome disability, prevention of further aggravation of the disability.

We can conclude that despite the prevention is present inside of the stated educational goals of the designed degree, it seems to be underutilized than advocated by international guidelines, and that learning them during the training course does not encourage high level of mastery.

One of the other elements that international guidelines suggest / hope as the future development of the home care professions is a progressive integration of interventions and coordiantion, to avoid duplication and waste. To do this it will be necessary the implementation of evaluation and monitoring tools that foster coordination between professionals.
In particular:

- The homecare service should be focused on a global, multi-perspective and multidisciplinary view of the patient
- Home care should be provided actually in an integrated way, by formulating, monitoring and evaluating a unique individualized plan, where both public and private, both social and health care are taken into account;
- Specific tools and documentation should be identified and provided to professionals in order to report properly their activity, foster their collaboration and to support the creation of a unique set of information about the patient homecare,

The above mentioned Italian contextual elements imply important consequences on HHCPs skill and competency needs, which can be summarized in the following points:

- HHCPs should get specific competencies for working in equip, both if they work in health and in social homecare; they should be able to build, monitor and evaluate a Personalized Assistance Plan.
- HHCP should be able to manage specific tools, report models and documentation, even supported by ICTs

If we consider the analysis of the responses of the physiotherapists, we can to verify that more than 60% the subjects consider these skills, required by their profession, in particular those related

to teamwork and knowledge of network services. Conversely, 14% of physiotherapists responded to the questionnaire considering unnecessary the use of monitoring tools and reports. This suggests that there is little use of these tools in the clinical practice.
If we analyze the perception of mastery of these skills, except for Usage of reporting and monitoring tools (for the reasons mentioned above), it seems that physiotherapists perceive an average high level of expertise in this area. In particular seems to be a lack of mastery in the Basics social-health services organizations knowledge and networks and Competences for working in a group / equip / staff, and that these competencies are not learned in the training courses but during the work experience.

	Basics in social-health services organizations and networks	Usage of reporting and monitoring tools	Providing the customer with contextualized and personalized information about the network of services he/she can rely on	Competences for collaborating with other practitioners	Competences for working in a group /equip /staff	AVERAGE
IS THE COMPETENCE REQUIRED?						
Required (A2)	75,71%	32,86%	51,43%	88,57%	88,57%	67,43%
Not Required (A1)	24,29%	67,14%	48,57%	11,43%	11,43%	32,57%
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE						
Low Mastery (A2)	24,29%	5,71%	7,14%	1,43%	1,43%	8,00%
Mean Mastery (A1)	32,86%	17,14%	25,71%	35,71%	28,57%	28,00%
High Mastery (A3)	21,43%	12,86%	20,00%	50,00%	58,57%	32,57%
COMPETENCE ACQUIRED ATTENDING A SCHOOL, A TRAINING COURSE OR AN ACADEMIC COURSE						
No (A2)	60,00%	15,71%	35,71%	31,43%	21,43%	32,86%
Yes (A1)	14,29%	20,00%	12,86%	50,00%	17,14%	22,86%
COMPETENCE ACQUIRED BY WORKING PRACTICE						
No (A2)	8,57%	5,71%	2,86%	4,29%	2,86%	4,86%
Yes (A1)	67,14%	28,57%	51,43%	80,00%	40,00%	53,43%

Table 12 Physiotherapist competences in Usage of reporting and monitoring tools and working in a group area

The three-year degree course in physiotherapy includes the following learning objectives:

- Competence requires knowledge and skills in ethics, law, management skills, social skills, cooperation and interprofessional in networked relationships, planning, organization and articulation of the treatment program. In this area are framed all procedures and tools that enable the future professional to organize its work in the overall sense of the term.

Comparing these data with the results of the questionnaires, we can deduce that there is:

- A skill gap in the Usage of reporting and monitoring tools, caused in part by the low use of the that and low level of coordination between the existing local services, and partly by the poor training of their use within the curriculum.

- A skill gap in the Basics competencies in social-health services organizations knowledge and networks Competences for working in a group / equips / staff; that are learned much more at work, than during the training.

Another item stressed as important for the improvement and development of the effectiveness of homecare services is the answer to a growing demand for psychological assistance, often unmet. The basic skills of psychology and conflict management are included in the educational goals of a physical therapist.

- Analyzing the results of the questionnaire, as reported in D2.2, it seems that physical therapists consider that only the basic knowledge of psychology are required by the profession.
- Are not considered relevant for the profession Competences for managing conflicts; Grief support.
- The overall level of mastery of these competencies appears to be low, only 40% feel a high average mastery level.

	Basic psychology elements	Fostering customers social and familiar relations	Competences for managing conflicts	Grief support	AVERAGE
IS THE COMPETENCE REQUIRED?					
Required (A2)	87,14%	41,43%	40,00%	24,29%	50,00%
Not Required (A1)	12,86%	58,57%	60,00%	72,86%	49,43%
SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE					
Low Mastery (A2)	10,00%	7,14%	1,43%	11,43%	8,29%
Mean Mastery (A1)	41,43%	20,00%	28,57%	12,86%	26,00%
High Mastery (A3)	34,29%	24,29%	10,00%	7,14%	19,71%
COMPETENCE ACQUIRED ATTENDING A SCHOOL, A TRAINING COURSE OR AN ACADEMIC COURSE					
No (A2)	11,43%	37,14%	24,29%	25,71%	22,29%
Yes (A1)	74,29%	10,00%	14,29%	2,86%	29,14%
COMPETENCE ACQUIRED BY WORKING PRACTICE					
No (A2)	11,43%	4,29%	2,86%	7,14%	6,57%
Yes (A1)	72,86%	42,86%	34,29%	22,86%	45,14%

Table 13 Physiotherapist competences in psychological area

The educational goals of the degree course in physiotherapy include learning the management of relational aspects in particular:

" in the case of health professional and not only that, the primary dimension of social life, and the vehicle through which to establish the relationship with the care recipient with particular reference to its take on responsibility; furthermore the communication plays a key role in relations with other professionals, with family and caregivers. The communication and relationship skills are therefore considered to be a professional competence of the health professional attributes with full rights. This area defines the sub-relational layer through which the Physiotherapist graduate will apply its professional practice in the overall context, through: communication and building a profitable relationship with patients and caregivers; communication and obstruction of a constructive inter-professional collaboration, negotiation and management of interpersonal conflicts."

Comparing The questionnaire data with the proceeds from the analysis of the training courses, we can conclude that the professionals do not consider required many psychological competencies, but they are included in both international guidelines and in training plans, although the latter are perceived by physiotherapists not effective in improving skills in psychology, which instead are learned far more frequently in clinical practice.

SOCIAL HEALTH OPERATORS

As described above in the D2.2, only 12 SHO (public or private employed, no-freelance) replied to the survey (6%), so their number couldn't be considered as representative for that figure.

Despite this low number we can draw some thoughts from the responses received. The skills that professionals consider to be most in demand within the profession include: (1) Knowledge about the main aids and devices for older and disabled people, (2) Basics in older person's healthy lifestyles e (3) Environmental and personal hygiene basic concepts. These data are consistent with the definition of the professional profile that includes activities aimed at meeting the basic needs of the person, within their areas of expertise, both in a social context that health, promoting wellness and user autonomy, as defined by the Laboratory of professions published by the region of Liguria (http://professioniweb.regione.liguria.it/Dettaglio.aspx?code=0000000120).

HOMECARE ASSISTANTS

In the *Questionnaire targeting Home Healthcare Practitioners* submitted for the CARESS Project context analysis, only 4 Homecare assistants replied to the survey. The number of responders couldn't be considered as representative for that figure.

Assessing the answers received also their ability in managing the competences as mastered appropriately and almost all the item recognized as required has been declared managed with high mastery. The competences resulted has been acquired, by the majority of the responders, both "attending a school, a training course or an academic course" then "working practice". HHCP questionnaire shows that all the Home Care Assistant answer negatively to the possibility to address other needs of old adults with their activity (100%). Older people interviewed reported that they being generally satisfied with support received, however, refer to have some unmet needs such as social isolation. Older adults interviewed reported that they feel like they need support in carrying out daily activities to meet priority and need to support in maintaining a healthy lifestyle.

As described in the section 8.1.1 related to Homecare assistant a Family Assistant Register has been created in some of the regions and the requirements are different in the different regions, included for training. We refer to the previous section for more information on training courses.

Ass described above, also the roles and responsibilities of the Homecare assistant is going to change in the next years.

This profession that falls into the category HOMECARE, described in D2.1 and will face in the coming years some problems related mainly to aspects of labor and social, that training. In fact, the main problem of this profession is not the presence of unmet needs of the population or the need to define a new competence profile, but the respect of professional quality criteria providing for that the practice of Homecare assistant profession.

There are 1.5 million personal careers at home (private home assistants (calf and "badante"), 72% of who are immigrants (CENSIS, 2009). Domestic aids are often migrants, without contract and unregulated, but the Law Bossi Fini (189/2002) has increased regulation. Nevertheless, the most recent "legalization campaign" for foreign domestic aids (Law 102/2009), during September 2009, recorded only 114,000 requests (less than expected). It is of note that in case of co-residence, "badante", care for clients, the "regular" expense for the family is 30–50% higher than the corresponding sum in a black market. So far as working conditions are concerned, private care supply is associated with a low qualification and a weak position of workers, and a much reduced professional protection (Pesaresi 2007a). As described by EURHOMCARE, the main challenge the for the homecare assistant of sector will be the Integration of the foreign private assistants within the network of local services, through coordination and collaboration between local and national levels of governance (Lamura, Principi, 2009a).

SOCIAL GUARDIANS

Analyzing the results of the responses of the surveyed professionals about their competencies, it appears that:

The item Basics in social-health services organizations and networks has recognized as required by the 80% of Social Guardians and the 70% of them declared to master it with a High Mastery level. At the same time they declared that this required competence has been acquired mainly by working practice (80%) and not learned during training course (30%). At the same time Social Guardians differences their answers from the general trend also for other 6 competences. Those competences are recognized as required, but in all the cases the acquisition of these competences happens mainly by working practice instead of school or courses.

Older people reported that they are generally satisfied about support received, however, refer to as unmet such as preventing and avoiding situations of loneliness and isolation and facilitate family and social relationships (3.75%). Moreover they highlight that it would be a comfort element if the social guardian could support them:

- when they go out from home (55%)
- in particular health conditions that require specialists such as skin lesions, technical help in managing medical tools, assumption and management of therapy (27%)
- support in prevention from any health risk (including home suitability) and maintenance of healthy lifestyle (18%).

As previously described social guardian is a newly established professional and still without a clear legal definition about the skills. Is, therefore, difficult to identify the specific training needs of a

skill gap. Thus, the first challenge for Social Guardians VET is a clear formalization of this figure's competencies and profile, Recognized at national level. Then specific VET courses can be organized at local level in the framework of a national definition.

8.2.2 Comparing existing curricula with HHCPs' future skills needs in Spain

In Spain, homecare services have been transferred to the Autonomous Regions, being carried out by their Social Services. The personnel of Social Services may directly provide it or this can be done by local entities after an agreement has been signed. Homecare is generally provided by City Councils, being these the institutions with a more direct contact with citizens and thus better knowing their needs.

Homecare professionals related to sociosanitary activities (equivalent to Home Health Care) hold a VET degree (*"Formación Profesional" -FP*). They can be classified into three different groups, all of them EQF 2 or 3.

Before we describe these groups of professionals' flaws and present and future needs of improvement in training, we should refer to another group. Domestic staff, are those workers who for many years had no formative regulation and that, after an adaptation period which will end in 2017, will need to mandatorily have a minimum qualification of EQF 1. INCUAL (Instituto Nacional de Cualificación) is the regulatory body in charge of supervising these qualifications.
This group of professionals does not have a socio-sanitary profile. They are in charge of the house chores but not of the people living in them. These workers will need to get accredited for some professional experience, and/or take a maximum of 150 hours of formative modules. It is interesting to include this information here because their work activity when employed in an elderly home may often overlap with that of VET professionals, as it would be the case of ……; but their qualification has not been not accredited. The reason for this increase in their chores may have to do with the proximity and familiarity of this activity as well as with the fact that they work in an environment in which the elderly of the household tend to have growing needs of help.
Anyhow, this is an area of study of future formative needs that should be payed attention to. Besides, changes in the profile of this activity have already been defended in different discussion forums and publications.

NURSE:
The Degree in Nursing includes very few practical work in the area of homecare due to the fact that most of the abilities and skills practiced during the Degree are aimed at instruction. Besides, in practice, most of the tasks in homecare are carried out by auxiliary staff, with no university degree, since in Nursing there is a tendency to delegate tasks. Despite this, nurses also work in elderly homecare mainly in terms of healthcare and autonomy.

The mission of nurses is to contribute to the protection and improvement of the population's health and welfare, preventing illnesses and their consequences, as well as favoring the preservation of the Health System and the environment pursuing the population's health.

The body of specific knowledge of Nursing has become historically established and supported by an ample and growing research activity: Theories, models transferred to praxis and care giving evolution.

The tasks more often carried out by nurses in homecare are, among others: evaluating the client's needs, home sanitary tests (e.g., blood samples), supervision in keeping healthy life styles, team meetings and contacts with other professionals related with elderly care.
71% of nurses remain at each home between 15-30 minutes whereas 14% of them remain from 30 minutes to 1 hour. 71% of the nurses usually visit every person once a week whereas 14% visit them 2-3 times per week.

The main tasks of nurses are:

- Comprehensive geriatric assessment: physical, mental, social and spiritual assessment and ability for its implementation.
- Major scales and multidisciplinary assessment instruments management.
- Skills to develop a medical life history.
- Ability for the selection and implementation of healthy-ageing promotion theories.
- Ability to promote prevention programs.
- Ability to assess the medical condition, basic needs and identify risk factors.
-

Nurses formative needs are:

- **Knowledge:**
    - Need to be familiar with and know how to use drugs and medicines for chronic treatments.
    - Need to be familiar with and know how to use drugs and medicines for pressure ulcers.
    - Need to know about risk factors determining health or illness in the different stages of the life cycle.
    - Need to know about the most frequent health problems of elderly people.
    - Need to know about palliative care and pain control in order to provide better care to relieve the situation of terminal phase or acute patients.

- **Skills:**
    - Need of establishing an empathetic and respectful relationship with the patients and their families which are in accordance with the person's situation, health problems and their stage of development.
    - Capacity for identifying life-threatening situations and being capable of carrying out basic and advanced life support techniques.
    - Capacity to identify the care giving needs derived from health problems.
    - Capacity to select care giving needs aimed at treating or preventing health problems and adapting them to the daily routine using proximity and elderly support resources.

- **Abilities:**
  - Need to promote knowledge about elderly health problems among care givers.

VET: PRACTICAL NURSE, HOME CARE ASSISTANT, SOCIOSANITARY CARE TECHNICIAL

The competences the majority of HHCP considered "necessary in order to do their job", were acquired in regulated courses.

More or less 50% of the respondents have some additional qualification within their learning path. Also this same percentage of respondents considered that their daily work had also had a formative value. As it was expected, those who considered that their training courses had not been ideal, gave more importance to their job as a source of training.

- ✓ Their proficiency level in these competences was graded as medium-high.
- ✓ All the competences in the questionnaire are included in the specific training professional programs, although an irregular development in various programs -with some aspects clearly underdeveloped -is appreciated.
- ✓ In order to obtain a higher utility of surveys:
  Tasks more frequently executed, are well reflected in training programs. Those that are partially done or with to a small number of users are those that can indicate where to find the major holes in the training programs.

PRACTICAL NURSE:

- ✓ It is necessary to pay special attention to the little importance that respondents gave to the following aspects as well as the low level of instruction received:
  - Home Economy
  - Kitchen
  - Runningerrands

  A possible explanation to this could be the "false feeling" that workers may have in the sense that these are too elementary tasks, hardly professional or of a lesser value. All this would indicate the need to improve training in attitudes and behaviors. Further training in Ethics would definitely help overcome these real deficiencies.
- ✓ The training received in the following sections, seems to be too low or incomplete, thus it could be definitely improved:
  - Basic knowledge about social and health services organizations and networks.
  - Basic knowledge of legal framework and human rights.
  - Use of information and monitoring tools
  - Use of computer systems for social participation
  - Use of computer systems for health monitoring
  - Information to customers about reliable service networks
  - Competences to coordinate other professionals' tasks.
  - Competence for mental health assessments
  - Competencies for user empowerment

- Support in depression or despair cases

Being the range of items presented so thorough, makes the majority of respondents think that it is not necessary to mark any other complementary goals or competences to achieve an ideal homecare environment. A small percentage of the people interviewed pointed at their need of support to operate technological devices for home health monitoring. Others also expressed the need to support users in the self-management of his/her mental health..

- ✓ With reference to the user, they highlight the limitations found when trying to help users maintain social and family relations. Also, they have trouble solving daily problems or knowing where to seek for help.
- ✓ As for their capacity to plan actions, it seems there is a great variety of opinions here, prevailing those who indicate that a major improvement in coordination is required; these opinions agree with the survey results, i.e. those activities that are considered hardly ever done by most HHCPs:
  - Meetings with health teams, and keeping in touch with other professionals who also deal with elder care.
  - Reports on the activities carried out

  It is also necessary to *promote the following activities*
  - Personal assistance Planning
  - Preventive interventions

HOMECARE ASSISTANT:

- ✓ Tasks related to homecare that most professionals in this group perform can be found in the basic training programs. This is the case of direct user-care tasks, such as “household tasks”, “support to treatment adherence” or “preparation of medication”.
- ✓ While 50% of respondents support the "need of a respectful treatment according to the user's dignity", this percentage decreases when it comes to "the need for protection of user’s privacy and intimacy". Affirmative responses decrease even further when it comes to “the need to make elderly feel protected and supported in their own interests”, or to “the need of a deep respect towards their own values (such as religious beliefs, etc.)” or to the caregiver’s competencies “towards the user’s empowering”. This last question is considered almost unnecessary in the caregiver’s daily routines. Education and training in all these aspects is generally very unsatisfactory in formative programs. On the other hand, when the question posed is too direct, as in: “I consider that my work respects the way of living and routines of users”, most respondents totally agree with it and very few simply agree or doubt it. Nobody disagrees with it. This lack of balance shows that education and training in ethical aspects and values should be reformulated or promoted since in most programs it is not even considered.
- ✓ Aspects related with communication needs and competencies are very inconsistently valued. In the daily routine, “the need of support and assistance for an efficient communication” is considered inconsequential. This is also true for the “need of being informed about their health” or the “ability to work in groups/teams”. Nevertheless, a very high percentage of respondents value the mastery of “competencies to be able to cooperate with other

professionals". They mainly acquired these competencies during their professional career and it is hardly ever included in the different programs. It is a fact that "training in communication" both with the user and with the rest of the team, and "communication and information systems" are aspects that should be promoted.

- ✓ Aspects referring to "quality management" are neither valued nor taken care of. There is a complete lack of these aspects in the training programs. If training of professionals in this are aware promoted, a proactive and professional attitude would also be promoted, as well as an improvement in the areas of communication, environment, and the like, as well as the already mentioned direct attention.
- ✓ One third of the respondents highly value "the need to support and manage behavior disorders associated with dementia". Even though one third may not seem a very high rate, it really is if we keep in mind the prevalence of this pathology and the frequency with which users with associated behavior disorders are institutionalized and not living at home -this situation should be reverted. On the other hand "competence to handle conflicts" is not considered important, despite the fact that respondents admit to have an average training, acquired during their professional career. It seems that the competence to handle conflicts is not sufficiently covered in the training programs, and itis necessary in the daily routine.
- ✓ Finally we can also emphasize, with a rate lower than 25%, "the need of support in handling technological appliances for monitoring health at home", "the use of information systems for social participation" and "competencies to provide clients with contextualized and personalized information about reliable service networks". The special care of the environments also an important aspect. And doing it with advanced technological resources seems basic for the future development of primary healthcare. The use of technology and instruction in this field is therefore an important requirement.

SOCIO SANITARY CARE TECHNICIAN

- ✓ This groups gives more importance to procedure needs, to administrative management ,to aspects related to quality and improvement, to internal communication (among professionals) and to communication with users and their environment. Training in all these aspects is not considered deficient or very deficient but it could clearly improve.
- ✓ Basic aspects related to the direct care of patients are not considered essential for the activity of these workers due to their administrative profile. On the contrary, they do consider social and family relationships important, as they also do with being respectful of the way and type of life of patients.

PHYSIOTHERAPIST

Home physiotherapist attention is a current practice for users with pathological processes which are both subacute and chronic. Coordinated collaboration with family and/or assistants is basic for a successful intervention.

- ✓ In the survey carried out, numerous activities which are extremely important and which are currently carried out at the patient's home have been included. These are included in the formative programs as well.

- ✓ Other activities which are also extremely important are often not included in the formative programs; or, if included, they are not given the required importance. These are, “educational interventions for caregivers” or “Prevention of skin lesions through proper hygiene, postural changes and specific skin care”.
- ✓ Respondents believe that there is hardly ever a “need of support in mobility out of home”. This activity is not included in the formative programs but it could be useful to consider this ability for a future improvement of caregiving.
- ✓ A future challenge could be the adequate training in giving “technical support with external devices: Oxygen, NIMV (non-invasive mechanical ventilation), feed pumps, infusion pumps, home peritoneal dialysis, etc…” None of these aspects are considered in the formative programs, so when caregivers have to face them in their daily routine, they may feel overwhelmed.
- ✓ They show a great interest in and find that they “need to be supported and educated in proper positioning and postural changes to prevent physical disorders”. These professionals worry a lot about the consequences of patients’ bad posture. Despite this, these contents are not included in the formative programs. In line with this, we find the “need of support and rehabilitation in toilet habits” in the formative programs, although not very well developed.
- ✓ Among the competencies which are very useful for homecare and which are not included in the formative programs we find the “knowledge about the main aids and devices for older and disabled people” and the “competencies for terminal illness support”.
- ✓ Training in communications should be improved since “competences for collaborating with other practitioners” and “competences for working in a group /equip /staff”, have been very little developed in the formative programs. Also “basics in older person’s healthy lifestyles“ have been hardly developed.

SPEECH THERAPIST

Speech therapy is a discipline with small presence in care services at all levels, despite they increasingly work in elderly home care.

The design of the questionnaire carried out in Spain does not permit a differentiation in this group of HHCPs, therefore we carried out several directed interviews, and we concluded the following:

- ✓ None of the tasks mentioned in the questionnaire are specific or basic for the practice of their profession, except for "rehabilitation activities (walking, exercises, etc.)"
- ✓ The activities of "evaluation of customer needs" and " personal assistance planning" are only partially carried out. As for the formative programs, these are not included.
- ✓ Some of the main objectives of these professional´s work are the "educational interventions for caregivers" and "team meeting and contacts with the other professionals involved in older person’s assistance", so that there is a continuity of the treatment. On the contrary, formative programs do not cover these aspects and, even less, the difficulties that can be found in their application.
- ✓ Within the professional competencies required to carry out homecare included in the questionnaire, we can highlight: " Basics in dietetic"; here we should keep in mind that speech therapists who hold a Master’s Degree in Dysphagia, use and manipulate food, being capable of modifying its texture. Despite this, there is no recognition given to dietary instruction in the

programs. "Basics in social-health services organizations and networks" are also not included in the programs, and these are basic abilities to acquire an aptitude to follow treatments.

- ✓ There is a total lack of "basics in law and human rights frameworks" and "competences for caring with dignity" in the formative programs. This is also true for the "need to a respectful treatment according to his/her dignity", "need for protection of user privacy and intimacy" , "need to feel defended and to be supported in his own interests", "need to feel a deep respect regarding values (including religious beliefs and spiritual needs)"

  With reference to what we have just stated, respondents believe that these are essential in caregiving to people in need. Besides, these people often are in social or economic risk. It is also interesting to note that the existing generation gap between the elderly and their caregivers makes the inclusion of formal contents in this field necessary and very important.

OCCUPATIONAL THERAPIST

As is the case of previous group, data about the activity of occupational therapists in elderly home were obtained by complementary interviews.

Occupational Therapy (OT) is an academic field clearly in expansion, its scope reach very different policy areas. Curricula in OT of different Spanish universities can vary significantly with respect to certain content, skills, knowledge and competencies. All of them rest upon a common knowledge central body, shared by all. The outcomes that came out of the compared study, may be influenced by the fact mentioned.

Difficulty in to compare results: Tasks listed in the survey, are in fact, in a vast majority, carried out by OT, in a more or less extensive way , All of them are included in different proportions in training programs, although with significant differences in application goals

An example is the task of "companionship" which is performed, not as an end in itself, but as exercise and training in some other task or objective. Same thing happens with all the tasks under epigraph "Need for BASIC PERSONAL attention".. The OT is involved in all of them, with no objective of support or assistance, but of retraining

- ✓ As to the OT curriculum, seem to have a deficient training in the following aspects: the "support and assistance in social relationships". Also in what refers to "Formalize in a sheet, a chart or to report the initial evaluation of older person's needs"
- ✓ Improving training is necessary in respect to : "Basics in older person's healthy lifestyles", "Basics in social-health Services Organizations and networks", "Basics in law and human rights frameworks", "Procedures for monitoring healthy lifestyles", "Using ICT for social participation "
- ✓ Expanded and modifying training in: "Competencies for managing conflicts", "Competences for coordinating the work of other practitioners". "Competences for evaluating customer mental health status".

It must highlight that Occupational Therapists are the professionals who gave more importance to the "Competencies for supporting the customer in building up an independent living path", what gives a clear idea of the sense of their profession.

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8.2.3 Comparing existing curricula with HHCPs' future skills needs in Finland

In Finland the results of HHCP survey indicated that majority of responders thought that almost all the competences included in questionnaire used in study are required in working in home health care. In self –evaluation of HHCPs skills and competences level, the responders evaluated their competence level satisfactory in knowledge of social- and health service system inc. social services and benefits client is entitled to Knowledge, skills and competences were also evaluated mostly in categories of satisfactory or good in procedures for providing physical therapies, fostering clients social and familiar relations, competences to support for coordinating the work of other practitioners, competences for evaluating clients mental health status and competences for caring clients with terminal illness and grief support.

HHCPs had acquired competence mostly by working practice in following skills: basics in social-health services organizations and networks, knowledge about the main aids and devices for older and disabled people, procedures for fostering customers going out of home, providing the customer with contextualized and personalized information about the network of social services and benefits he/she can rely on, competences for collaboration with other practitioners and competences for evaluating customer needs and adapting the service. Competences in basics in anatomy and pathology, basic procedures in medical assistance (eg. make injection, provide drugs, change medication) HHCPs have gained mostly by attending a school, training course or academic course.

HHCP didn't take a part of the first evaluation and forming a clients' care and service plan. This is probably the reason why they evaluated their knowledge of social services and benefits lower than expected. However HHCPs were involved in modifying and assessing clients care plans in continued care. Yet they thought that they could have competences to do it, if given time, education and authorization. It seems that in division of tasks in home care doing the care plans especially on beginning of the care of the new client is done by the registered nurses or registered public health nurses

In Finland the elderly clients' interview results showed that in the future, HHCPs education needs has to be considered in the categories of administration and assessing medications and ethical skills. Also interaction skills as well as the HHCPs ability to plan the care needs individually and giving enough time for the client, are important aspects in all three countries. In Finland spent on average from 30 minutes to one hour in client`s home. This in some way may reflect the clients` need of the discussions with HHCP`s. Furthermore the stability of the staff should also be considered.

When comparing the skill gaps and existing curricula of practical nurse in Finland it implies that all of the skill needs are somehow covered in curricula but superficially and in quite general level and not necessary at all in home care aspect. Continuing education for practical nurses are mostly provided by different educational institutions or private education centers which are selling out various different courses.

8.2.4 Conclusions

The result of the analysis of data collected through HHCP interviews show that there are some gaps comparting them with the EU(EU SKILLS PANORAMA, 2014) and national levels guidelines, that identify the skills and competences that will be the key elements for the future homecare services delivery: focusing on a global, multi-perspective and multidisciplinary view of the patient/client (improving his/her perception of the quality of life), descripting in detail the roles of each HHCP in order to avoid gaps and overlapping in the integrated service provision and identifying specific tools and documentations of HHCPs' activity.

8.3 HHCPs' ROLES, SKILLS AND COMPETENCES ACCORDING TO ESCO EQF CLASSIFICATIONS

The EQF recommendation of 2008 stems from European countries' determination to retain oversight of all educational activity and all forms of certification. Countries agreed that basing qualifications frameworks on learning outcomes would achieve this oversight better than simply registering learning inputs. First tree countries which had been set up the national qualifications frameworks (NQF) were Ireland, France and the UK (before 2005). In 2015, frameworks have been, or are being, developed in all 38 countries cooperating on the European qualifications framework (EQF) (Cedefop 2015: *National qualifications framework developments in Europe – Anniversary edition* Luxembourg).

European Skills/Competences, Qualifications and Occupations (ESCO) is a multilingual classification and useful as a joint European " Dictionary " between different classifications. ESCO identifies and categories skills, competences, qualifications and occupations relevant for EU labour market and education and training. It shows systematically the relationships between the different concepts. ESCO has been developed in an open IT format, is available for use free of charge and can be accessed via ESCO portal. Today, DG Employment, Social Affairs and Inclusion - supported by the European Centre for the Development of Vocational Training (Cedefop) – coordinates the development of ESCO. Stakeholders are closely involved in the development and dissemination of ESCO.

ESCO classification based on EURES and gives ISCO links but is not related to EQF. EURES – The European Job Mobility Portal includes proposal on ESCO: European Skills, Competences, Qualifications and Occupations. Commission proposed amendments to make EURES more efficient, recruitments more transparent and cooperation among Member States stronger. Benefit of ESCO based on economic crisis and unemployment: employees need better training and employment support services, employers are more interested in real skills and competences (learning outcomes) of employees. ESCO classifieds occupations by listing skills and competences. ESCO builds bridge between education and labour market and improve equivalence of education and training to working life. The aim of ESCO is to link the three 'pillars' in such a way that the profiles of occupations show the relationships between skills/competences and qualifications. Such a way ESCO will allow free movement of labour force and benefit CV as well job seeking on EU level.

Finland (FNBE) was represented in the Ref. Human Healthcare and Social work activities Group of (2013-2015). This group described about 100 different occupations (Nursing, Heath Care, (Registered) ja Social Worker, Social Services, Social Care). They did not identify occupations in homecare sector. There are some challenges with translations (Finnish 'lähihoitaja' and English 'Health Care Assistants'), there are available some old occupations (not any more exciting qualifications like Finnish 'kodinhoitaja') and missing some new occupations (Finnish 'hoiva-avustaja' 'care worker'). Social and health care is in changes, in some countries (Estonia and Germany) the new law will change the service system and (vocational) qualifications (Finland).

CARESS project will propose a new description of HHCPs (occupations, skills and competences) for ESCO. Followed material based on literature descriptions of D2.1 about HHCPs occupations described by terms of EQF, NQF and ESCO as much as the date was available. First, there will tables of project partner's, Italy, Spain and Finland, after that other countries in alphabetic order.

References

Cedefop 2015: *National qualifications framework developments in Europe – Anniversary edition* Luxembourg: Publications office of the European Union.Cedefop information series.
https://ec.europa.eu/esco/portal/alphabeticalBrowser

ITALY

Italy has a complex system governed by regional and national authorities in designing and awarding qualifications and has not a NQF for lifelong learning in place yet. Nevertheless, Italy has referenced most formal qualifications to the eight EQF levels using the related descriptors.

The following tables allocate the EQF levels and ISCO code to the HHCPS: nurse[19], physiotherapist[20], psychologist[21], professional educator[22], occupational therapist[23], social health operator (OSS)[24], home care assistant / home helper[25] and social guardian.

NQF Table

HHCPS IN ITALY	NQF LEVEL
NURSE	/
PHYSIOTHERAPIST	/
PHSYCOLOGIST	/
PROFESSIONAL EDUCATOR	/
OCCUPATIONAL THERAPIST	/
SOCIAL HEALTH OPERATOR (OSS)	/
HOME CARE ASSISTANT /	/

[19] http://fabbisogni.isfol.it/scheda.php?id_menu=11&id=3.2.1.1.1&limite=1
[20] http://fabbisogni.isfol.it/scheda.php?id_menu=11&id=2.5.3.3.2&limite=1
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[25] http://www.qualificare.info/upload/Allegato_A.pdf
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HOME HELPER	
SOCIAL GUARDIAN	/

It is not possible to fill in the table above because in Italy the NQF classification is still under construction. For this reason, it has been filled in only the EQF table[26].

EQF Table

HHCPS IN ITALY	EQF LEVEL
NURSE	6
PHYSIOTHERAPIST	6
PHSYCOLOGIST	7
PROFESSIONAL EDUCATOR	6
OCCUPATIONAL THERAPIST	6
SOCIAL HEALTH OPERATOR (OSS)	3
HOME CARE ASSISTANT / HOME HELPER	2
SOCIAL GUARDIAN	2

ESCO Table

HHCPS IN ITALY	ESCO CLASSIFICATION
NURSE	See ISCO code 2221 - Nursing professionals (Home care nurse)
PHYSIOTHERAPIST	See ISCO code 2264 - Physiotherapists
PHSYCOLOGIST	See ISCO code 2634 - Psychologist
PROFESSIONAL EDUCATOR	See ISCO code 32 - Health Associate Professionals, 325 Other Health Associate Professionals
OCCUPATIONAL THERAPIST	See ISCO code 32 - Health Associate Professionals, 325 Other Health Associate Professionals
SOCIAL HEALTH OPERATOR (OSS)	See ISCO code 3221 - Nursing Associate Professionals
HOME CARE ASSISTANT / HOME HELPER	See ISCO code 5322 - Home-based Personal Care Workers

[26] Cedefop (2015). National qualifications framework developments in Europe – Anniversary edition Luxembourg: Publications Office of the European Union, Cedefop information series, pp. 50-51.

SOCIAL GUARDIAN	See ISCO code 9111 – Domestic cleaners and helpers, See ISCO code 5152 – Domestic Housekeepers See ISCO code 5162 - Companions and Valets

SPAIN

The correlation of the Spanish framework with the EQF is done through the Spanish Framework of Qualifications (MECU) or National Qualification Framework (NQF), which includes all the levels, from level 1 (primary education) to level 8 (University Doctoral Studies).

The MECU, therefore, is the result of the addition of the Professional Qualifications National Catalogue (CNCP) and the Spanish Qualifications Framework for Higher Education (MECES).

These specifications are presupposed at level 3 of CNCP, corresponding with level 1 of MECES and with level 5 of EQF, establishing as Higher Education the one corresponding to the degree of *Técnico Superior de Formación Profesional* (VET Upper Level Technician).

HHCPS' IN SPAIN	EQF LEVEL
NURSE	6
SPEECH THERAPIST	6
PHYSIOTHERAPIST	6
PHSYCOLOGIST	6
PROFESSIONAL EDUCATOR	2
OCCUPATIONAL THERAPIST	3
SOCIALAND HEALTH CARE FOR PEOPLE AT HOME	4
OCCUPATIONAL THERAPY	6

HHCPS' IN SPAIN	ESCO CLASSIFICATION
NURSE	See ISCO 2008 Broad Match 3221 Nursing associate professionals . See ISCO 1988 Broad Match 3231 Nursing associate professionals.
SPEECH THERAPIST	See ISCO 2008 Broad Match 2352 Special needs teachers . See ISCO 1988 Broad Match 2340 Special education teaching professionals. 3330 Special education teaching associate professionals.
PHYSIOTHERAPIST	See ISCO 2008 Broad Match 2264 Physiotherapists. See ISCO 1988 Broad Match 3226 Physiotherapists and related associate professionals.
PHSYCOLOGIST	See ISCO 2008 Broad Match 2634 Psychologists. See ISCO 1988 Broad Match 2445 Psychologists.
PROFESSIONAL EDUCATOR	see ISCO code - 32 Health Associate Professionals, 325 Other Health Associate Professionals
OCCUPATIONAL THERAPIST	see ISCO code 32 - Health Associate Professionals, 325 Other Health Associate Professionals
SOCIALAND HEALTH CARE FOR PEOPLE AT HOME	see ISCO 2008 Broad Match 3221 Nursing associate professionals See ISCO 1988 Broad Match 5133 Home-based personal care workers. Nursing associate

	professionals See ISCO 1988 Broad Match 5132 Institution-based personal care workers. Nursing attendant.
OCCUPATIONAL THERAPY	Not available.

FINLAND

TABLE 1 –NQF LEVEL

HHCPS' IN FINLAND	NQF LEVEL (if available)
REGISTERED NURSE	/ (6)
PUBLIC HEALTH NURSE	/ (6)
PHYSIOTHERAPIST	/ (6)
PRACTICAL NURSE	/ (4)
CARE ASSISTANT	/ (3)

the NQF are still under construction.

TABLE 2 – EQF LEVEL

HHCPS' IN FINLAND	EQF LEVEL
REGISTERED NURSE	6
PUBLIC HEALTH NURSE	6
PHYSIOTHERAPIST	6
PRACTICAL NURSE	4
CARE ASSISTANT	3

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN FINLAND	ESCO Occupations
REGISTERED NURSE	see ISCO code 3221 - Geriatrics nurse Nurse (geriatric care)
PUBLIC HEALTH NURSE	not available
PHYSIOTHERAPIST	see ISCO code 2264 -Fysioterapeutti Physiotherapists, ISCO 2008 3226 Physiotherapists and related associate professionals
PRACTICAL NURSE	see ISCO code 2008 - 'Lähihoitaja' (Health care assistants) see ISCO 5321 - Lähihoitajat – perushoitaja: (Personal care worker in health services)
CARE ASSISTANT	not available

OTHER EUROPEAN COUNTRIES

AUSTRIA

Austria NQF has still to reach operational stage and has not any regulatory functions. It is divided in eight levels, defined in terms of knowledge, skills and competence that maps the national qualifications from all education and training subsystems and aids the validation of non-formal and informal learning. A 'Y structure' has been adopted as the levels 6 to 8 remain open to VET qualifications, acquired outside the Bologna strand, and to higher education. Its implementation is structured in three procedural corridors: allocation of levels to qualifications awarded within formal education and training; development of quality assured procedures for inclusion of qualifications from the non-formal sector; development of approaches to validate learning outcomes acquired through informal learning[27].

Not being operational the NQF, at present, the official classification used in Austria is the International Standard Classification of Education (ISCED). As a result, the following table represents the levels associated to each HHCP analysed in the previous deliverables.

ISCED Table

HHCPS IN AUSTRIA	ISCED LEVEL
HOME HELPER	NA
SOCIAL CARE WORKERS SPECIALISED IN SERVICES FOR ELDERLY PERSONS	3-4[28]
QUALIFIED SOCIAL CARE WORKERS SPECIALISE DIN SERVICES FOR ELDERLY PERSONS	5[29]
NURSE ASSISTANT	3-4[30]
NURSE	4[31]

Even if the NQF is not operational at present, Austria has referenced it to the EQF. As a result, considering the ISCED classification, methodologically it has been used a deductive logical process in order to allocate the levels of the different HHCPS to the EQF.

EQF Table

HHCPS IN AUSTRIA	EQF LEVEL
HOME HELPER	NA
SOCIAL CARE WORKERS SPECIALISED IN SERVICES FOR ELDERLY PERSONS	4[32]
QUALIFIED SOCIAL CARE WORKERS SPECIALISED	6[33]

[27] Cedefop (2015). National qualifications framework developments in Europe – Anniversary edition Luxembourg: Publications Office of the European Union, Cedefop information series, pp. 18-19

[28] www.edusystem.at

[29] www.edusystem.at

[30] www.edusystem.at

[31] www.edusystem.at

[32] For more information, see Social Service Professions Towards Cross-European Standardisation of Qualifications, Aila-Leena Matthies, Professor of Social Work, University of Jyväskylä, Finland, Social Work and Society International Online Journal (http://www.socwork.net/sws/article/view/9/31) and TAKE CARE Project, Final Common Report 2014, pp. 50-51 (http://www.takecare-project.eu/dwnd/CommonReportFinal-it.pdf)

[33] For more information, see Social Service Professions Towards Cross-European Standardisation of Qualifications, Aila-Leena Matthies, Professor of Social Work, University of Jyväskylä, Finland, Social Work and Society

IN SERVICES FOR ELDERLY PERSONS	
NURSE ASSISTANT	5[34]
NURSE	5[35]

ESCO Table

HHCPS IN AUSTRIA	ESCO CLASSIFICATION[36]
HOME HELPER	See ISCO code 5322 - Nursing aide –such as (Home care aide) – (Home-based personal care workers)
SOCIAL CARE WORKERS SPECIALISED IN SERVICES FOR ELDERLY PERSONS	See ISCO code 2635 - Social worker and counselling professionals See ISCO code 3412 - Social work associate professionals – such as (Welfare support worker)
QUALIFIED SOCIAL CARE WORKERS SPECIALISED IN SERVICES FOR ELDERLY PERSONS	See ISCO code 2635 - Social worker and counselling professionals See ISCO code 3412 - Social work associate professionals – such as (Welfare support worker)
NURSE ASSISTANT	See ISCO code 3221 - Home based personal care workers – such as (Home care aid) – (Nursing aide home)
NURSE	See ISCO code 2221 - Nursing Professional
SOCIAL CARE WORKERS SPECIALISED IN SERVICES FOR ELDERLY PERSONS	See ISCO code 2635 - Social worker and counselling professionals See ISCO code 3412 - Social work associate professionals – such as (Welfare support worker)
QUALIFIED SOCIAL CARE WORKERS SPECIALISED IN SERVICES FOR ELDERLY PERSONS	See ISCO code 2635 - Social worker and counselling professionals See ISCO code 3412 - Social work associate professionals – such as (Welfare support worker)
NURSE ASSISTANT	See ISCO code 3221 - Home based personal care workers – such as (Home care aid) – (Nursing aide home)
NURSE	See ISCO code 2221 - Nursing Professional

BELGIUM

TABLE 1 –NQF LEVEL

HHCPS' IN BELGIUM	NQF LEVEL (if available)
NURSING AUXILIARY	
NURSE	
SOCIAL ASSISTANT	
FAMILY HELPER	

International Online Journal (http://www.socwork.net/sws/article/view/9/31) and TAKE CARE Project, Final Common Report 2014, pp. 50-51 (http://www.takecare-project.eu/dwnd/CommonReportFinal-it.pdf)

[34] TAKE CARE Project, Final Common Report 2014, pp. 50-51 (http://www.takecare-project.eu/dwnd/CommonReportFinal-it.pdf)

[35] TAKE CARE Project, Final Common Report 2014, pp. 50-51 (http://www.takecare-project.eu/dwnd/CommonReportFinal-it.pdf)

[36] https://ec.europa.eu/esco/portal/alphabeticalBrowser

TABLE 2 – EQF LEVEL

HHCPS' IN BELGIUM	EQF LEVEL
NURSING AUXILIARY	
NURSE	6
SOCIAL ASSISTANT	
FAMILY HELPER	-

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN BELGIUM	ESCO Occupations
NURSING AUXILIARY	see ISCO code 3221 – nursing assistant
NURSE	see ISCO code 3221 - nurse
SOCIAL ASSISTANT	see ISCO code 2635 – welfare officer
FAMILY HELPER	see ISCO code – 9111 – Domestic helper

DENMARK

TABLE 1 –NQF LEVEL

HHCPS' IN DENMARK	NQF LEVEL (if available)
SOCIAL- AND HEALTH SERVICE ASSISTANTS	4
SOCIAL- AND HEALTH SERVICE HELPER	3

TABLE 2 – EQF LEVEL

HHCPS' IN DENMARK	EQF LEVEL
SOCIAL- AND HEALTH SERVICE ASSISTANTS	4
SOCIAL- AND HEALTH SERVICE HELPER	3

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN DENMARK	ESCO Occupations
SOCIAL- AND HEALTH	Social- og sundhedsassistent

SERVICE ASSISTANTS	not available
SOCIAL- AND HEALTH SERVICE HELPER	Social og sundhedshjælper not available

Danish material is not available in ESCO.

ESTONIA

The systems both of health and social care as well homecare are in change process in Estonia. Mostly, homecare services are quite new and mainly social services. The Social Welfare Act (Sotsiaalhooldekande seadus RT I, 30.12.2015, 5)[37] the provision of home care services which are defined as being services provided to persons in their homes which help them cope in familiar surroundings. By guidelines of Ministry of Health following HHCPs are work ih home care team: home care nurse, care worker and nurse (planner and organizer)[38]. However, there are more occupations named in ESCO (in Estonian): koduterapeut, toetusabiline, isiklik abi, puudega inimese abistaja, puudega inimese hooldusõde, koduhooldaja, igapäevaelu toetamise abiline, koduabistaja, tugiisik, koduhooldaja abi.

An anticipation group is working during 2016 and looking for new needs in homecare sector in Estonia[39]. They are mapping the new skills in socia care: change in attitude (humanity and equality), customer centred care and support, language skills (Estonian and sother languages), organisatoric skills (planning time, knowing laws and rules), cultural differences, communication and team work skills, ability to analyse own work and creativness, personal developing of care workers. Experts hightlight customer centered planniong and coaching, guiding and coaching in home planning (safety environments) and using new technology.

TABLE 1 –NQF LEVEL

HHCPS' IN ESTONIA	NQF LEVEL (if available)
NURSE	6
HOME CARE NURSE/CARE WORKER	4
CARE WORKER	3
	/

TABLE 2 – EQF LEVEL

HHCPS' IN ESTONIA	EQF LEVEL

[37] https://www.riigiteataja.ee/akt/130122015005

[38] http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervishoiususteem/koduoenduse_tegevusjuhend.pdf

[39] Valdkondlikülevaade tööturu olukorrast, tulevikuarengutest, tööjõu- ja oskuste vajadustest ning sellest tulenevat koolitusvajadusest, Kutsekoda 2016 – coming soon

NURSE	6
HOME CARE NURSE/CARE WORKER	4
CARE WORKER	3

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN ESTONIA	ESCO Occupations
NURSE	see ISCO code 3221 Staff nurse (Nursing associate professionals) see ISCO code 5322 Disabled person's nurse (Health/home nursing) …
HOME CARE NURSE/CARE WORKER ***Koduhooldusõde***	see ISCO code 2221 Home based personal care worker (Home-based personal care workers)
CARE WORKER ***Hooldustöötaja (avahooldus)***	**see ISCO code 2008** **Home care assistant (institution-based personal care workers)** **Supporter of residence outside of institutions** Home help assistant (Home-based personal care workers) see ISCO code 1988 Social work associate professionals
Social worker ***Sotsiaaltöötajad ja nõustajad***	see ISCO code 2635 see ISCO code 3412
Daily life assistant ***Igapäevaelu toetamise abiline***	see ISCO code 5322 Activities of daily life assistant (Home-based personal care workers)

FRANCE

NQF Table

HHCPS IN FRANCE	NQF LEVEL
Employé à domicile/aide à domicile (home helper/home aid)	V
Auxiliaire de vie sociale (home care assistant)	IV
Aide soignant (nurse assistant)	V

EQF Table

HHCPS IN FRANCE	EQF LEVEL
Employé à domicile/aide à domicile (home helper/home aid)	3
Auxiliaire de vie sociale (home care assistant)	4
Aide soignant (nurse assistant)	3

ESCO Table

HHCPS IN FRANCE	ESCO CLASSIFICATION
Employé à domicile/aide à domicile (home helper/home aid)	See ISCO code 9111 - Aides de ménage à domicile
Auxiliaire de vie sociale (home care assistant)	See ISCO code 3412 - Professions intermédiaires du travail social
Aide soignant (nurse assistant)	See ISCO code 3221 - Personnel infirmier (niveau intermédiaire)

GERMANY

The remaining staff represents different professions such as family care and social work, with 6.4% in vocational training. Mostly formal home care workers are so called nurse/carer for older people 'Altenpfleger' (EQF4) and careworker for older people 'Altenpflegehelfer' (EQF3). There is clear specialist deficiency in home care: there needed already more specialists/ skilled workers. There are different changes in social and health care system in Germany.

Levels of home care staff in Germany[40]:

Level 1 takes responsibility for delegated daily routine attendance
Level 2 lower than Assistance (for example Services under instruction) takes responsibility for delegated personal assistance
Level 3 Assistance of the skilled worker takes responsibility for delegated tasks in care
Level 4 skilled worker takes responsibility for controlling individual care processes
Level 5 takes responsibility for groups of clients with special needs
Level 6 takes responsibility for groups of clients with complex tasks, and team leader
Level 7 takes responsibility for leading the institution
Level 8 takes responsibility for control of scientific functions

TABLE 1 –NQF LEVEL

HHCPS' IN Germany	NQF LEVEL (if available)
NURSE/CARER FOR OLDER PEOPLE (Altenpfleger)	4
CAREWORKER	3

[40] Nowack – Boldajipour, 2013.

(Altenpflegehelfer)	
(HEALTH) CARE PROFESSIONALS (Gesundheits- und Krankenpfleger Gesundheitspflege)	2-3

-
- **TABLE 2 – EQF LEVEL**

HHCPS' IN Germany	EQF LEVEL
NURSE/ CARER FOR OLDER PEOPLE (Altenpfleger)	4
CAREWORKER (Altenpflegehelfer)	3
(HEALTH) CARE PROFESSIONALS (Gesundheits- und Krankenpfleger Gesundheitspflege)	?

-
- **TABLE 3 – ESCO SKILLS/COMPETENCES**

HHCPS' IN Germany	ESCO Occupations
NURSE/ CARER FOR OLDER PEOPLE	see ISCO code 3221 Altenpfleger' – Geriatrics nurse (Nursing associate professionals)
CAREWORKER	Altenpflegehelfer' not available in ESCO
nurses/health care professionals	see ISCO code 5321 Gesundheits- und Krankenpfleger Gesundheitspflege – Health care, professional guidance Krankenpfleger – Assistant nurse ISCO 5321

ICELAND

Home care in Iceland includes health care and social services. The main actors in homecare are nurses, personal carers and home helps. Only 1/3 of employees of nursing homes in Iceland are Practical nurses. 2/3 are unskilled workers or staff who have few courses from Union Promotion (Efling) or low levels of educations. A large part of unskilled workers are foreigners who have moved to Iceland to get work and speak very poor Icelandic if any.

The primary nursing degree in Iceland is a four-year university course. Community (home) nurses provide care in the home including a full range of nursing care. Health care assistants provide basic personal care services. Home help staff provide domestic aid to people in the community and in

step-up care housing. There is no formal task differentiation between home nursing and home help grades, except that nurses must hold professional registration.[41]

TABLE 1 –NQF LEVEL[42]

HHCPS' IN ICELAND	NQF LEVEL (if available)
NURSE	5?
PERSONAL CARER	3?
HOME HELP	2-3?

TABLE 2 – EQF LEVEL

HHCPS' IN ICELAND	EQF LEVEL
NURSE	6
PERSONAL CARER	4?
HOME HELP	3-4?

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN ICELAND	ESCO Occupations
NURSE	
PERSONAL CARER	
HOME HELP	

IRELAND

There are a wide variety of criteria for homecare according to the different regions, due to the lack of a national standardization. Home help and the personal care delivery is widespread in Ireland. There is a range of professional actors providing domiciliary home care. A typical team include General Practitioners and practice nurses, a social worker, occupational therapist and physiotherapist, community nurse and community nursing assistant and public health nurse.[43]

TABLE 1 –NQF LEVEL[44]

HHCPS' IN IRELAND	NQF LEVEL (if available)
NURSE	
SOCIAL WORKER	

[41] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf

1.1.1 [42] **Iceland - European inventory on NQF 2014**
EN

[43] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf

[44] http://www.nfq-qqi.com/

OCCUPATIONAL THERAPIST	
PHYSIOTHERAPIST	
COMMUNITY NURSE	
PUBLIC HEALTH NURSE	
COMMUNITY NURSING ASSISTANTS	
HEALTH CARE ASSISTANTS	

TABLE 2 – EQF LEVEL

HHCPS' IN IRELAND	EQF LEVEL
NURSE	6
SOCIAL WORKER	3-4
OCCUPATIONAL THERAPIST	3-4
PHYSIOTHERAPIST	
COMMUNITY NURSE	
PUBLIC HEALTH NURSE	
COMMUNITY NURSING ASSISTANTS	
HEALTH CARE ASSISTANTS	

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN IRELAND	ESCO Occupations
NURSE	
SOCIAL WORKER	
OCCUPATIONAL THERAPIST	
PHYSIOTHERAPIST	
COMMUNITY NURSE	
PUBLIC HEALTH NURSE	
COMMUNITY NURSING ASSISTANTS	
HEALTH CARE ASSISTANTS	

LATVIA

Latvia

Since regaining independence in 1990, Latvia changed a health care system and built a structured social insurance system. Organising of planned homecare is quite new in Latvia. Activities of home care providers are limited by volume of health care budget. For the patient it is cheaper to stay in an institution. According of the report 2.1 there are following practitioners working in home care services in Latvia: carer, social carer, social worker and certified nurses or doctor's assistants. There is a lack of both informal carers and formal carers in Latvia.

TABLE 1 –NQF LEVEL

HHCPS' IN LATVIA	NQF LEVEL (if available)

NURSE/DOCTOR'S ASSISTANCE	6?
SOCIAL WORKER	6?
SOCIAL CARER	3?
CARER	/

TABLE 2 – EQF LEVEL

HHCPS' IN LATVIA	EQF LEVEL
NURSE/ DOCTOR'S ASSISTANCE	6
SOCIAL WORKER	6
SOCIAL CARER	3
CARER	-

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN LATVIA	ESCO Occupations
NURSE/ DOCTOR'S ASSISTANCE	Medicīnas māsas ISCO 3221 see ISCO code 3221 - Nursing associated professionals (Medically responsible nurse, Nurse, geriatric care)
SOCIAL WORKER	not available
SOCIAL CARER	not available
CARER	not available

LITHUANIA

Homecare in Lithuania is quite new and in developing. There are followed HHCPs working in homecare in Lithuania: carer, social worker, community nurse, red cross nurse and volunteers. Nurses have a university bachelor's qualifying degree in nursing. Social workers are trained in colleges (higher education, professional qualification of social worker) and universities (Bachelor or Master degree and professional qualification)[45]. Other domestic aid is provided more seldom, by neighbors, friends or volunteers.

TABLE 1 –NQF LEVEL

HHCPS' IN LITHUANIA	NQF LEVEL (if available)
NURSE	6
COMMUNITY NURSE	6
SOCIAL WORKER	6
RED CROSS NURSE	-
CARER	-

TABLE 2 – EQF LEVEL

[45] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf

HHCPS' IN LITHUANIA	EQF LEVEL
NURSE	6
COMMUNITY NURSE	6
SOCIAL WORKER	6
RED CROSS NURSE	-
CARER	-

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN LITHUANIA	ESCO Occupations
NURSE ***Slaugytoja/seselė - geriatrinė priežiūra Slaugytojas***	see ISCO code 3221 Nurse, geriatric care (Nursing associate professional) Nursing attendant
COMMUNITY NURSE ***Sveikatos priežiūros specialistai***	ISCO code not available Health professionals
SOCIAL WORKER ***Socialiniai darbuotojai ir konsultantai***	ISCO code not available Social work and counselling professionals
RED CROSS NURSE	not available
CARER	not available

LUXEMBOURG

There are following main occupations of homecare in Luxembourg: 'Aide ménagere' (domestic aid - no qualification needed); 'Aide socio-familiale' - personal carer1 (2 years certificate); 'Auxiliaire de vie' - personal carer2 (3 years certificate); 'Aide-soignant' - nursing aid (3 years certificate, 'comprehensive assistance'); general qualified nurse (diploma for 3 years education); specialised nurse; e.g. palliative care nurses.

Comprehensive assistance works with nursing tasks (e.g. help with stomach bags, prosthesis; protection of the skin) and supervision of clients, by checking their temperature and heart rhythm. General nurse works in nursing e.g. injections, disinfecting wounds and preventing bedsores, help with a feeding tube, taking blood and perfusion) and for case management.[46] Description of NQF (CLQ)[47] and EQF based on the written documents Vocational education and Training in Luxembourg.[48]

TABLE 1 –NQF LEVEL

HHCPS' IN LUXEMBOURG	NQF LEVEL (if available)
SPECIALISED NURSE	6
GENERAL QUALIFIED NURSE	6

[46] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf

[47] https://ec.europa.eu/ploteus/sites/eac-eqf/files/Referencing%20report.pdf

[48] http://www.lifelong-learning.lu/bookshelf/documents/vocational-education-and-training-in-luxembourg.pdf

AIDE-SOIGNANT	3?
AUXILLIAIRE DE VIE	3?
AIDE SOCIO-FAMILIALE	2?
AIDE MENAGERE	-

TABLE 2 – EQF LEVEL

HHCPS' IN LUXEMBOURG	EQF LEVEL
SPECIALISED NURSE	6
GENERAL QUALIFIED NURSE	6?
AIDE-SOIGNANT	3?
AUXILLIAIRE DE VIE	3?
AIDE SOCIO-FAMILIALE	2?
AIDE MENAGERE	

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN LUXEMBOURG	ESCO Occupations
SPECIALISED NURSE	see ISCO 3221 Infirmier, infirmière en gériatrie Geriatric nurse (Nursing associate professionals)
GENERAL QUALIFIED NURSE	see ISCO code 3221 Infirmiere Nurse (Nursing associate professionals)
AIDE-SOIGNANT	see ISCO code 3221 Nursing assistant (Nursing associate professionals)
AUXILLIAIRE DE VIE	(Auxilliaire de vie – not available) see ISCO code 5322 Aide à domicile (personnel de compagnie et valets de chambre, aides soignants à domicile) Home care assistant (companions, valets and home-based personal care workers)
AIDE SOCIO-FAMILIALE	ISCO code not available Home-based personal care workers (Personal care workers in health services)
AIDE MENAGERE	not available

MALTA

Since 2009, Malta qualification framework is linked to the EQF. It is a comprehensive national framework for lifelong learning structured in eight-level learning-outcomes-based framework defined in terms of knowledge, skills and competence. The National Commission for further and higher education (NCFHE) is the main body in charge of MQF implementation[49].

NQF Table

[49] Cedefop (2015). National qualifications framework developments in Europe – Anniversary edition Luxembourg: Publications Office of the European Union, Cedefop information series, pp. 60-61

HHCPS IN MALTA	NQF LEVEL
NURSE – Diploma in Health Science (Nursing Studies)	5
NURSE – Certificate in Clinical Nursing Practice (Elderly Care)	5
NURSE – Bachelor of Science (Honours) Community Nursing	6
PHYSIOTERAPIST	6
OCCUPATIONAL THERAPIST	6
SOCIAL WORKER	6
HOME HELPER	Not required level of education[50]

EQF Table

HHCPS IN MALTA	EQF LEVEL
NURSE – Diploma in Health Science (Nursing Studies)	5
NURSE – Certificate in Clinical Nursing Practice (Elderly Care)	5
NURSE - Bachelor of Science (Honours) Community Nursing	6
PHYSIOTERAPIST	6
OCCUPATIONAL THERAPIST	6
SOCIAL WORKER	6
HOME HELPER	Not required level of education[51]

ESCO Table

HHCPS IN MALTA	ESCO CLASSIFICATION[52]
NURSE - Diploma in Health Science (Nursing Studies)	See ISCO code 2221 - Nursing Professional
NURSE - Certificate in Clinical Nursing Practice (Elderly Care)	See ISCO code 2221 - Nursing Professional
NURSE - Bachelor of Science (Honours) Community Nursing	See ISCO code 2221 - Nursing Professional
PHYSIOTERAPIST	See ISCO code 2264 - Physiotherapist
OCCUPATIONAL THERAPIST	See ISCO code 2269 - Health professionals not elsewhere classified – such as (Occupational Therapist)
SOCIAL WORKER	See ISCO code 2635 - Social worker and counselling professionals See ISCO code 3412 - Social work associate professionals – such as (Welfare support worker)
HOME HELPER	See ISCO code 5322 - Home based personal care workers - such as (Home care aid) – (Nursing aide home)

[50] Home Care across Europe, Case studies, Edited by Nadine Genet, Wienke Boerma, Madelon Kroneman, Allen Hutchinson, Richard B Saltman, European Observatory on Health Systems and Policies, World Health Organization, 2013, page 190

[51] Idem

[52] https://ec.europa.eu/esco/portal/alphabeticalBrowser

THE NETHERLANDS

Referenced to the EQF since 2011, the NLQF is a comprehensive framework structured in eight-levels with an entry level (lower than EQF level 1). It covers all levels and types of qualifications: general education, vocational and higher education. Based on learning outcomes approach, the level description is in terms of knowledge, skills, responsibility and independence, supplemented by context descriptor[53].

The following tables allocate the NQF and EQF levels and the ISCO code to the HHCPS: zorghulp – auxiliary helps / care assistant, helpende - home helper / health and welfare assistant, verzorgende - individual health carer, mbo-verpleegkundige, hbo-verpleegkundige and verpleegkundig specialist: master of advanced nursing practice (MANP).[54]

NQF Table

HHCPS IN THE NETHERLANDS	NQF LEVEL
ZORGHULP – AUXILIARY HELPS / CARE ASSISTANT	1
HELPENDE - HOME HELPER / HEALTH AND WELFARE ASSISTANT	2
VERZORGENDE - INDIVIDUAL HEALTH CARER	3
MBO-VERPLEEGKUNDIGE	4
HBO-VERPLEEGKUNDIGE	6
VERPLEEGKUNDIG SPECIALIST: MASTER OF ADVANCED NURSING PRACTICE (MANP)	7

EQF Table

HHCPS IN THE NETHERLANDS	EQF LEVEL
ZORGHULP – AUXILIARY HELPS / CARE ASSISTANT	1
HELPENDE - HOME HELPER/HEALTH AND WELFARE ASSISTANT	2
VERZORGENDE - INDIVIDUAL HEALTH CARER	3
MBO-VERPLEEGKUNDIGE	4

[53] Cedefop (2015). National qualifications framework developments in Europe – Anniversary edition Luxembourg: Publications Office of the European Union, Cedefop information series, pp. 62-63

[54] http://www.platformzorglandschaplimburg.be/Uploads/zorglandschap/Euregional%20Framework_Salmon_VF_13.pdf
https://www.hanze.nl/assets/corporate/Documents/Public/Degreeprogrammeprofilenursing.pdf
http://www.platformzorglandschaplimburg.be/Uploads/zorglandschap/TOTAL%20TEMPLATE%20OF%20ACTION%202.pdf
https://www.cbs.nl/NR/rdonlyres/0A179A27-64E4-4A6D-9DC9.../codelijstenisco08.xls
ISCO-08 unit group - CBS
https://www.cbs.nl/NR/rdonlyres/0A179A27-64E4-4A6D-9DC9.../codelijstenisco08.xls

HBO-VERPLEEGKUNDIGE	6
VERPLEEGKUNDIG SPECIALIST: MASTER OF ADVANCED NURSING PRACTICE (MANP)	7

ESCO Table

HHCPS IN THE NETHERLANDS	ESCO CLASSIFICATION
ZORGHULP – AUXILIARY HELPS / CARE ASSISTANT	See ISCO code 5321 - Health Care Assistants
HELPENDE - HOME HELPER/HEALTH AND WELFARE ASSISTANT	See ISCO code 5322 - Home-based personal care workers
VERZORGENDE - INDIVIDUAL HEALTH CARER	See ISCO code 5322 - Home-based personal care workers
MBO-VERPLEEGKUNDIGE	See ISCO code 3221 - Nursing associate professionals
HBO-VERPLEEGKUNDIGE	See ISCO code 2221 - Nursing professionals
VERPLEEGKUNDIG SPECIALIST: MASTER OF ADVANCED NURSING PRACTICE (MANP)	See ISCO code 2221 - Nursing professionals

NORWAY

There are three main personnel groups working in the home care sector (read more D 2.1): nurses, practical nurses and assistants (workers without training within health services). The nurses and to some degree the practical nurses have quite an independent professional role in the health- and care services in patients homes. Older report[55] identified followed HHCPs in homecare sector in Norway: registered nurse (a three year university or college degree; assistant nurse (a three year upper secondary school education); health worker (a three year upper secondary school education which is based on the education of an assistant nurse and that of the former care workers); care worker and personal assistant (no further education requirements).

TABLE 1 –NQF LEVEL

HHCPS' IN NORWAY	NQF LEVEL (if available)
REGISTERED NURSE	6
PRACTICAL (ASSISTANT) NURSE	4
ASSISTANTS – HEALTH WORKER	

TABLE 2 – EQF LEVEL

[55] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf

HHCPS' IN NORWAY	EQF LEVEL
REGISTERED NURSE	6
PRACTICAL (ASSISTANT) NURSE	4
ASSISTANTS – HEALTH WORKER	3

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN NORWAY	ESCO Occupations
REGISTERED NURSE	not available material in Norwegian
PRACTICAL (ASSISTANT) NURSE	not available material in Norwegian
ASSISTANTS – HEALTH WORKER	not available material in Norwegian

POLAND

The Poland Qualification Framework was referenced to the EQF in 2013. It is comprehensive and structured in eight-levels covering all levels and types of qualifications from general education, VET and higher education. The levels are described in terms of knowledge, skills and social competence. The PQF is open to qualifications from the private and non-formal sectors that meets quality criteria.

NQF Table

HHCPS IN POLAND	NQF LEVEL
PRIMARY CARE NURSE	6
LONG TERM HOME CARE NURSE	6(7)

EQF Table

HHCPS IN POLAND	EQF LEVEL
PRIMARY CARE NURSE	6
LONG TERM HOME CARE NURSE	6(7)

ESCO Table

HHCPS IN POLAND	ESCO CLASSIFICATION
PRIMARY CARE NURSE	See ISCO code 2221 - Nursing Professional
LONG TERM HOME CARE NURSE	See ISCO code 2221 - Nursing Professional

SLOVENIA

Slovenians attach much value to informal care and homecare is not so popular. At home 44% find care a task for close relatives even if this would affect career perspectives. Homecare is still scarce and it is not equally accessible around the country.

Homecare team includes professional workers, home helpers and family assistants. The Social Chamber decides about the educational requirements for them. Professional workers will have a higher or high degree schools for social work or university degree with one year social welfare work experience (nursing assistants - three year secondary vocational education; nurses with higher non-university education - community nurses; nurses with a university degree specialized in community nursing care). They coordinate social care at home; provides counselling and helps with social problems. Home assistants (professional assistants by law 'National Vocational Qualification Social Home Care Worker' – 120 hours training) help with meals, basic cleaning of the house, dressing; washing; help with catheter; etc.) and maintaining social network, contact with volunteers and family; accompanying a client; liaison to institutions. Family (home care) assistants' training stipulated by the Social Chamber; help with meals, basic cleaning of the house, dressing; washing). Laymen (without required qualification) is assisting professionals.[56]

TABLE 1 –NQF LEVEL[57]

HHCPS' IN SLOVENIA	NQF LEVEL (if available)
NURSE	6?
COMMUNITY NURSE	5?
NURSING ASSISTANTS	4?
FAMILY (HOME CARE) ASSISTANTS	3?
HOME ASSISTANTS	/

TABLE 2 – EQF LEVEL

HHCPS' IN SLOVENIA	EQF LEVEL
NURSE	6?
COMMUNITY NURSE	4?
NURSING ASSISTANTS	3?
FAMILY (HOME CARE) ASSISTANTS	3?
HOME ASSISTANTS	/

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN SLOVENIA	ESCO Occupations
NURSE	not available

[56] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf

[57] http://www.nok.si/en/

COMMUNITY NURSE	not available
NURSING ASSISTANTS	not available
FAMILY (HOME CARE) ASSISTANTS	not available
HOME ASSISTANTS	not available

Slovenic language not available

SWEDEN

The aim with regard to Swedish home care is that all staff should be trained. There are following professionals acting in homecare in Sweden: registered nurse (a three-year education on university/advanced level); primary nurse (a four year education on university/advanced level, including a certificate to prescribe drugs from a limited list); home help officer (a three year education at university level including education in management and service assessment); assistant nurse (a three year upper secondary school education); home help assistant (a three year upper secondary school education; personal assistant (at least a short course focused on the role of being a personal assistant but often the person has a three year upper secondary school education)[58]. The three year upper secondary school education (Slutbetyg Från Gymnasieskola) will give NQF level 4[59]. Swedish home care, as a universal welfare service, is now under threat and may become increasingly dominated by groups with less education and lower income which, in turn, could jeopardise the quality of care[60]

TABLE 1 –NQF LEVEL

HHCPS' IN SWEDEN	NQF LEVEL (if available)
PRIMARY NURSE	6
REGISTERED NURSE	6
HOME HELP OFFICER	6
ASSISTANT NURSE	4
HOME HELP ASSISTANT	4
PERSONAL ASSISTANT	2-4

TABLE 2 – EQF LEVEL

HHCPS' IN SWEDEN	EQF LEVEL
PRIMARY NURSE	6
REGISTERED NURSE	6
HOME HELP OFFICER	6
ASSISTANT NURSE	4
HOME HELP ASSISTANT	4
PERSONAL ASSISTANT	-/4

[58] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf

[59] www.seqf.se

[60] https://www.researchgate.net/publication/51853030_Home_care_for_older_people_in_Sweden_A_universal_model_in_transition

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN SWEDEN	ESCO Occupations
PRIMARY NURSE	Sjuksköterska, äldresjukvård see ISCO code 3221 Nurse (geriatric care)
REGISTERED NURSE 3V	Sjuksköterska, äldresjukvård see ISCO code 3221 Nurse (geriatric care)
HOME HELP OFFICER ***Hemtjänstinspektör***	see ISCO code 3257 Home-help inspector (Environmental and occupational health inspector and associates)
ASSISTANT NURSE 3V ***Vårdare, vårdhem***	Sjukvårdsassistenter ISCO code not available Medical assistants, Other health associate professionals Hemsjukvård, vårderfarenhet Home nursing, Health ISCO code not available Vårdare, vårdhem see ISCO code 3221 Nursing assistant (nursing home)
HOME HELP ASSISTANT ***Hemtjänstassistent*** ***Hemvårdsassistent***	see ISCO code 5322 Home-help assistant (Home-based personal care workers) see OSCO code 3412 Home-care assistant (social work professionals adn modern health professionals except nursing)
PERSONAL ASSISTANT ***Hemvårdsbiträden, personliga assistenter m.fl.***	ISCO code not available Home-based personal care workers (Personal care workers in health services) Hemtjälp, see ISCO code 9111 Domestic helper

http://www.ancien-longtermcare.eu/sites/default/files/ENEPRI%20_ANCIEN_%20RR%20No%2089%20Sweden.pdf
https://ec.europa.eu/esco/portal/alphabeticalBrowser
http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf
www.seqf.se
http://sci.se/educations/list-of-educations/

SWITZERLAND

Homecare in Switzerland is not officially regulated (by report D2.2). Practically, at the level of the cantons and even if some variation may exists, it appears that informal carers are considered more as co-workers than as clients with needs to be addressed by home workers and nurses. The family is "morally" supposed to care for their elderly relatives but is not legally forced to put "hands on care" as it is legally up to the local authority to plan and provide professional services to the elderly citizen, based on their needs.

TABLE 1 –NQF LEVEL

HHCPS' IN SWITZERLAND	NQF LEVEL (if available)
NURSE	6?
HOME HELP	

TABLE 2 – EQF LEVEL

HHCPS' IN SWITZERLAND	EQF LEVEL
NURSE	6
HOME HELP	?

TABLE 3 – ESCO SKILLS/COMPETENCES

HHCPS' IN SWITZERLAND	ESCO Occupations
NURSE	
HOME HELP	

9 IDENTIFICATION OF HHCPS' TRAINING NEEDS IN TERMS OF LEARNING OUTCOMES

9.1 Identification of Italian HHCPs' training needs in terms of learning outcomes

9.1.1 Italian HHCPs' skill gap

This section will sum up the results of the analysis carried out for the Italian context in Sect 8.1.1, comparing existing curricula with HHCPs' roles, skills and competences, and in Sect 8.2.1, comparing existing curricula with HHCPs' future skills needs. It also takes into account the main general issues concerning the homecare Italian context presented in D2.1 and D2.2. This conclusive analysis is aimed at identifying specific skill gaps of Italian HHCPS' in order to pose the basis for the design of possible compensative training modules.

The homecare context in Italy is characterized by several problems which influence the quality of the service itself. **Some skill gaps in the field oh homecare which can be identified horizontally with respect to different HHCP can be partially due to these problems**.

The Integrated Home Care (ADI – Assistenza Domiciliare Integrata) is the most important model of assistance, both for its intrinsic organizational complexity and for its potential in fitting end-users needs [Pesaresi, 2007]. As a matter of fact, it envisages an **integration of different professional competencies and, above all, the integration of two institutional levels** (national and local) since social and health services are managed respectively by Municipalities and Regions, often in a "organ-pipe" separation model. In this context, the relation between the healthcare system and the social system as disciplined by law is not even and this fact prevents a real integration. An example of this complexity is the presence of a dual PIC[61] process (health and social PIC, managed by regions and municipalities). Another problem is **the integration between public and private homecare;** together with the inadequate integration of social and health services, it causes a **scarce integration of homecare information about a single patient** and the difficulties of formulating an effective Individualized Assistance Plan, without taking into account all of the older adults needs and the carers who fulfil them.

As a consequence of this situation HHCPs often lack of:

- knowledge about rules and laws on homecare at regional and national level and know-how about the **actual role and responsibilities of their own professional figure** in a scarcely integrated system;
- Knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status;

[61] PIC (presa in carico), which is the administrative process for the access/admission of a patient with a social or health problem to an institutional/public care process.

- **competencies for working in equip**, both if they work in health and in social homecare, both if they are public-employee and they are free-lance, in order to compensate the difficulties generated by a scarcely integrated system;
- **competencies for managing specific tools, report models and documentation**, even supported by ICTs, in order to effectively report their activity and share information about the patient homecare with other professionals.
- competencies for collaborating and cooperating with other professionals in order to **build, monitor and evaluate a Personalized Assistance Plan**, contributing for their specific part, but taking into account the whole objective of improving the older adults quality of life.

Another issue of Italian context is that normally the focus of health homecare service is not on the general frailty status (physical, psychological, social, etc.), but on a specific disease or (worse) on the problems taken by a disease (bedsores, need for mobilization, etc.). Co-morbidity, which is naturally spread in older adults population, and the general perspective of a bio-psycho-social approach to health status are often overlooked; the most provided homecare services are often the simplest, connected to a single performance which don't take into account the whole complexity of the patient context. So, secondary and tertiary prevention clearly prevail on primary prevention.

As a consequence, HHCPs often lack of:

- **knowledge about what frailty is and skills about how to detect and prevent it**, in the **new bio-psycho social paradigm** which defines frailty as "a dynamic state affecting individuals with losses through one or more functional domains (physical, psychological and social), increasing overall the risk of adverse outcomes"; this approach requires an overall holistic viewpoint of patients and their predicament by taking into account, the medical, environmental, educational, economical and psychological factors[62].
- knowledge and skills about how to detect and manage **multimorbidity in older adults**, with a focus on the role of the specific professional; frailty and multimorbidity need to be considered with a more holistic approach, requiring an integrated, multi-sectoral and multi-professional strategy, focusing on community based settings and primary care services[63].
- competencies about the **role of homecare in primary care** with a specific focus on their professional figure;
- competencies about how to manage (in the framework of their roles and professionality) general **needs of the patient such as independence, social participation and self-realization**;
- **psychological and relational competencies** in order to support older adults and their families with basic psychological support and social participation, as demanded by end-user (*see results of CARESS D2.2*)

[62] SUNFRAIL Project (funded by the European Union's Health Programme 2014-2020) Website http://www.sunfrail.eu/what-is-frailty/

[63] SUNFRAIL Project (funded by the European Union's Health Programme 2014-2020) Website http://www.sunfrail.eu/what-is-frailty/

Another issue can be identified in the actual integration of ICT-based solution for remote monitoring and rehabilitation in the National Healthcare protocols, as well as in private ones. A number of ICT solutions for tele-monitoring and tele-rehabilitation are currently available on the market, but their implementation in daily healthcare in public healthcare is limited to local experimentations. The introduction of these solutions should find HHCPs ready to effectively select, use and evaluate them. So another HHCPs' skill gap can be identified in the

- knowledge of the main ICT-based tool for remote monitoring and/or rehabilitation and the skills for using them effectively to monitor older adults in their own home, also with the support of caregivers

Another important contextual element which conditions the competency level of HHCPs is related to the **criteria for career progression**. Today in Italy there is surely the need to build new career paths for health professions, especially in the field of nursing. In this historical moment, the most important step is definitely to push for a new National Collective Agreement that redesigns the career progression pathways of health professionals, by identifying wider roles, functions and responsibilities, extending the career ladders linked to a wider range of wage levels proportional to the complexity of the professional role. At present, a specialization in homecare (a university master or a specialization course) for graduated HCCPs (nurses, physiotherapists, psychologists, professional educators, occupational therapists) wouldn't assure them any advantage for career progression, at least in public sector.

Aside to the above mentioned skill gaps in the field oh homecare which can be identified horizontally with respect to different HHCP, in the analysis carried out within WP2 we've also identified specific skill gaps which characterized the different professionals.

In the following table we summarize for each analyzed HHCP the main skill gaps we've identified, including both "horizontal" homecare skill gaps and the ones specific for the profession.

NURSES skills gap
HORIZONTAL HOMECARE SKILLS GAP • knowledge about rules and laws on homecare at regional and national level; • Knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status; • know-how about nurses actual role and responsibilities in homecare; • competencies for working in equip and for collaborating and cooperating with other professionals; • competencies for managing specific tools, report models and documentation, even supported by ICTs, in order to effectively report their activity and share information about the patient homecare with other professionals; • knowledge about what frailty is and skills about how to detect and prevent it; • knowledge about in the new bio-psycho social definition of health status; • know-how about detecting and managing multimorbidity in older adults; • competencies about the role of nurses in the community primary care; • psychological and relational competencies in order to support older adults and their families with basic psychological support and social participation; • knowledge of the main ICT-based tool for remote monitoring and rehabilitation; • know-how about the effective use of the main ICT-based tool for remote monitoring and rehabilitation.

PROFESSIONAL SPECIFIC SKILLS GAP

- knowledge about the guidelines, the clinical pathways and the epidemiology for the main chronic diseases;
- knowledge about the basics on how much one's lifestyle can affect the outbreak of chronic disease and their complications;
- know-how about promotion of health in families and the community;
- know-how about promotion and monitoring of a style of active and independent healthy life;
- knowledge about the concepts, the theories and the methodologies of community nursing;
- knowledge about the role, aims and operational techniques for nurses in the field of occupational medicine;
- being aware of the most common healthcare issues in the community and the therapeutic and healthcare opportunities;
- know-how about planning, conducting and assessing educational interventions and programs in home environments;
- knowledge about the role played by the informal networks and community nurses in primary care and know-how about how to involve informal networks in personalized interventions;
- know-how about recording and transmitting medical data using technological tools

Need for practical traineeship in older adults homecare

PHYSIOTHERAPISTS skills gap

HORIZONTAL HOMECARE SKILLS GAP

- knowledge about rules and laws on homecare at regional and national level;
- knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status;
- know-how about physiotherapists actual role and responsibilities in homecare;
- competencies for working in equip and for collaborating and cooperating with other professionals;
- competencies for managing specific tools, report models and documentation, even supported by ICTs, in order to effectively report their activity and share information about the patient homecare with other professionals;
- knowledge about what frailty is and skills about how to detect and prevent it;
- knowledge about in the new bio-psycho social definition of health status;
- know-how about detecting and managing multimorbidity in older adults;
- competencies about the role of physiotherapists in the community primary care;
- basic psychological and relational competencies;
- knowledge of the main ICT-based tool for remote rehabilitation;
- know-how about the effective use of the main ICT-based tool for remote rehabilitation.

PROFESSIONAL SPECIFIC SKILLS GAP

- knowledge about all the theories and methodologies on therapeutic exercises which can be made at home in order to help the elderly in their rehabilitation process;
- practical skills about therapeutic exercises which can be made at home in order to help the elderly in their rehabilitation process;
- knowledge about the guidelines, the clinical pathways and the epidemiology for the main chronic diseases;
- knowledge about the main scientific evidence on chronical and degenerative diseases in older adults;
- know-how about promotion of active and independent living style;
- know-how about tools for measuring vital signs and for recording and transmitting medical data;
- competences for empowering the customer and for supporting the customer in building up an independent living path.

Need for practical traineeship in older adults homecare

OCCUPATIONAL THERAPISTS skills gap

HORIZONTAL HOMECARE SKILLS GAP

- knowledge about rules and laws on homecare at regional and national level;
- knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status;
- know-how about occupational therapists actual role and responsibilities in homecare;
- competencies for working in equip and for collaborating and cooperating with other professionals;
- competencies for managing specific tools, report models and documentation, even supported by ICTs, in order to effectively report their activity and share information about the patient homecare with other professionals;
- knowledge about what frailty is and skills about how to detect and prevent it;
- know-how about detecting and managing multimorbidity in older adults;
- competencies about the role of occupational therapists in the community primary care;
- basic psychological and relational competencies;
- knowledge of the main ICT-based tool for remote rehabilitation;
- know-how about the effective use of the main ICT-based tool for remote rehabilitation.

PROFESSIONAL SPECIFIC SKILLS GAP

Focus on specific issues of older adults homecare

Need for practical traineeship in older adults homecare

PROFESSIONAL EDUCATORS skills gap

HORIZONTAL HOMECARE SKILLS GAP

- knowledge about rules and laws on homecare at regional and national level;
- knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status;
- know-how about professional educators actual role and responsibilities in homecare;
- competencies for working in equip and for collaborating and cooperating with other professionals;
- competencies for managing specific tools, report models and documentation, even supported by ICTs, in order to effectively report their activity and share information about the patient homecare with other professionals;
- what frailty is and skills about how to detect and prevent it;
- competencies about the role of professional educators in the community primary care.

PROFESSIONAL SPECIFIC SKILLS GAP

Focus on specific issues of older adults homecare

Need for practical traineeship in older adults homecare

PSYCHOLOGISTS skills gap

HORIZONTAL HOMECARE SKILLS GAP

- knowledge about rules and laws on homecare at regional and national level;
- Knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status;
- know-how about psychologists actual role and responsibilities in homecare;
- competencies for working in equip and for collaborating and cooperating with other professionals;
- competencies for managing specific tools, report models and documentation, even supported by ICTs, in order to effectively report their activity and share information about the patient homecare with other professionals;
- knowledge about what frailty is and skills about how to detect and prevent it;
- knowledge about in the new bio-psycho social definition of health status;
- competencies about the role of psychologists in the community primary care;

PROFESSIONAL SPECIFIC SKILLS GAP

- specific competencies for providing psychological support for the patient and for the family in palliative treatments
- knowledge about how Palliative Care Units usually work

Focus on specific issues of older adults homecare

Need for practical traineeship in older adults homecare and context-focused training.

OSS skills gap

HORIZONTAL HOMECARE SKILLS GAP

- knowledge about rules and laws on homecare at regional and national level;
- Knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status;
- know-how about OSS actual role and responsibilities in homecare;
- competencies for working in equip and for collaborating and cooperating with other professionals;
- competencies for managing specific tools, report models and documentation, even supported by ICTs, in order to effectively report their activity and share information about the patient homecare with other professionals;
- knowledge about what frailty is and skills about how to detect and prevent it;
- knowledge about in the new bio-psycho social definition of health status;
- know-how about detecting and managing multimorbidity in older adults;
- competencies about the role of OSS in the community primary care;
- psychological and relational competencies in order to support older adults and their families with basic psychological support and social participation;
- knowledge of the main ICT-based tool for remote monitoring and rehabilitation;
- know-how about the effective use of the main ICT-based tool for remote monitoring and rehabilitation.

PROFESSIONAL SPECIFIC SKILLS GAP

- knowledge about the epidemiology of chronical disease and the impact that a person's lifestyle has on the outbreak of chronical diseases and related complications;
- basic knowledge about pathophysiology and know-how to prevent and treat the main chronical diseases;
- knowledge about the formal and informal networks in the area and know-how to interact with the various local social and healthcare networks in the community;
- knowledge about the basics of primary, secondary and tertiary prevention;
- knowing the basics of counselling and empowerment techniques and know how to apply them;
- knowing the basics of healthy ageing education (nutrition, physical exercise and social participation) and know how to apply them in homecare;
- knowing the main IT aids and devices available for the elderly.

HEALTH ASSISTANCE SKILLS GAP with reference to the Italian State-Regions Conference agreement signed on 22nd February 2001

- know-how to administer the prescribed therapy, in compliance with the guidelines set by the supervising nurses/obstetric nurses;
- know-how to perform intramuscular and subcutaneous injections under the nurses/obstetric nurses' qualified supervision;
- know-how to provide therapeutic baths, medical compresses and frictions;
- know-how to detect and take note of the patient's vital parameters (heart rate, respiratory rate and body temperature).

Need for practical traineeship in older adults homecare

HOMECARE ASSISTANT skills gap

HORIZONTAL HOMECARE SKILLS GAP

- knowledge about rules and laws on homecare at regional and national level;

- knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status;
- know-how about Homecare Assistant actual role and responsibilities in homecare;
- competencies for working in equip and for collaborating and cooperating with other professionals;
- knowledge about what frailty is and skills about how to detect and prevent it;
- psychological and relational competencies in order to support older adults and their families with basic psychological support and social participation;

PROFESSIONAL SPECIFIC SKILLS GAP

- competencies for fostering elderly or disabled users' independence;
- competencies for promoting inclusion (self-realization and self-planning);
- competencies for early detect signs of need for psychological support;
- know-how to implement the main techniques for managing a helping relationship;
- know-how to implement the main motivational and active listening techniques;
- know-how to implement the main psychological counselling and guidance techniques;
- knowledge about the local network of social services;
- knowledge about the main tools to document social assistance interventions;
- knowledge about the administrative procedures for social and healthcare cases;
- basic knowledge in domestic economy.

Need for practical traineeship in older adults homecare

SOCIAL GUARDIAN skills gap

HORIZONTAL HOMECARE SKILLS GAP

- knowledge about rules and laws on homecare at regional and national level;
- knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status;
- know-how about Social Guardian actual role and responsibilities in homecare;
- competencies for working in equip and for collaborating and cooperating with other professionals;
- knowledge about what frailty is and skills about how to detect and prevent it;
- psychological and relational competencies in order to support older adults and their families with basic psychological support and social participation;

PROFESSIONAL SPECIFIC SKILLS GAP

- competencies for fostering elderly or disabled users' independence;
- competencies for promoting inclusion (self-realization and self-planning);
- competencies for early detect signs of need for psychological support;
- knowledge about the local network of social services;
- knowledge about the main tools to document social assistance interventions.

Need for practical traineeship in older adults homecare

9.1.2 Learning outcomes overcoming Italian HHCPs' skill gap

Starting from the issues presented in the previous section, here we propose possible learning units, expressed in terms of learning outcomes, which could fill the skill gaps identified in Italian HHCPs concerning older adults' homecare. In particular, we focus on the Italian professionals for which we retrieved more information and for which professional associations or institutional agencies could give us feedbacks and advices about the proposal itself.

NURSES

The work carried out in collaboration with the Faculty of Nursing - University of Genoa within the WP2 brings to light the important role which could be played by specialization courses targeting graduated nurses, but also nurses that has got the professional certification before the introduction of the academic degree in nursing. The Master in "Family and Community Nurse", organized by different universities at national level (University of Milano-Bicocca, University of Turin, University of Novara, etc.) is the one that better fits with the skill gaps identified in the previous section.

In general it pursues learning outcomes in community care, such as:

- knowledge about the role, aims and operational techniques for nurses in the field of occupational medicine
- knowledge about the concepts, theories and methodologies of community nursing. Identify the profile of a public health, family and community nurse. Act ethically and analyse bioethical issues in contexts outside hospitals;
- knowledge about the institutional and legal structure of the social and healthcare services outside hospitals and their current status. Understand the organizational context of the services available in the community. Knowing the competences and responsibilities of nurses within the community healthcare team;
- identify the priority areas of investigation of family and community nursing. Knowing about evidence based practice (EBP) and how it relates with clinical practice.
- understand how to approach the assessment and promotion of health in families and the community. Plan, conduct and assess educational interventions and programs, and healthcare surveillance in work and home environments. Knowing and disseminating self-care and community-care;
- be aware of the most common healthcare issues in the community and the therapeutic and healthcare opportunities. Identify the healthcare needs of sick people, plan and perform nursing interventions, and monitor the primary care outcomes. Set healthcare priorities and aims, also in relation to self-care skills of individuals, families or the community.

A particular edition of the in "Family and Community Nurse" Master has been designed within the framework of CONSENSO (COmmunity Nurse Supporting Elderly iN a changing Society) PROJECT[64] (see D2.3 for details). In this context the Family and Community Nurse (FCN) is expected to become a key actor in a new social-health services model which aims to allow the elderly to live at home as long as possible.

Drawing inspiration from these initiatives, he we present a selection of learning units, articulated by competence-based learning outcomes, which could characterized compensative learning paths for nurses in the field of older adults' homecare.

[64] CONSENSO PROJECT is co-financed through the European Regional Development Fund (ERDF) under the Interreg Alpine Space Programme (December 2015 – December 2018). It is aimed at developing a care model that puts the elderly at the center of health and social services, built on the pivotal role of the Family and Community Nurse.

The following learning outcomes could be furtherly selected and simplified in order to design specific specialization courses for nurses who has not the academic degree and thus cannot participate in University Masters.

POSSIBLE LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	SKILLS	COMPETENCES
NURSING IN PRIMARY CARE	To know the national and international policies for healthcare and the regional and national laws on primary care		
	To know the role played by the informal networks and nurses in primary care	Being able to involve informal networks	To be aware of nurse role in the primary care system
	To know the role played by demographical, cultural economic and social factors and their impact on the healthcare system in all the different territories.		
MASTERING THE RESEARCH METHODOLOGY	To know the main databases	Being able to carry out a bibliographical research: definitions, aims and methods Being able to critically read a scientific article Being able to use guidelines, systematic revisions, metanalysis	
HEALTH EDUCATION AND COMMUNICATION	To know the principles and methods used to teach people the principles and the methods of healthcare and therapeutic education • Nutrition and healthcare • Active ageing • Physical training and health • Home safety	Being able to set up a therapeutic educational project	
	To know the main principles of family counselling	Being able to carry out family counselling	
	To know the main principles of psychological, organizational, social and community empowerment	Being able to empower the knowledge of the patient through prevention and promotion policies Being able to use all the necessary tools and methods to evaluate the empowerment following the prevention and promotion actions previously taken	He's able to confront himself with other professionals when it comes to dealing with the empowerment within a prevention and promotion programme Being able to evaluate the empowerment level
	To know the relationship between the efficiency of the therapeutic practices and the methods and tools to boost them.	His actions are aimed at increasing the therapeutic performances and their resilience	
MASTERING THE UNDERTAKING	To know the tools and the methods to perform a first visit at the patient's home: the first approach	Being able to use all the tools and methods to perform a visit at home.	Listen to the patient

POSSIBLE LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
	To know the methods and the tools to carry out a nursing assessment	Being able to use all the methods and evaluation tools needed to carry out the nursing assessment	
	To know the theories and the procedures related to the nursing case management	Being able to carry out a nursing case management	
COMMUNICATION WITH THE OLDER ADULT	To know the main steps and characteristics of: • A phone interview • A follow-up phone call • A motivational speech	Being able to carry out: • a phone interview • a follow- up phone call • a motivational speech	Being able to effectively deal with the patient in order to carry out an interview
		Being able to draw the medical record of the patients	Being able to efficiently interact with the patient in order to draw his medical record
CHRONICLE DISEASES PREVENTION AND MANAGEMENT	To know what frailty is and being able to evaluate the frailty levels of the elderly, the prevention strategies and the methods and tools to recognize the early frailty of the patient	Being able to use specific measurement methods to carry out an early diagnosis of the frailty of the patient	He's able to evaluate the frailty level
	The basics of pharmacology in the elderly		
	The basics on how much one's lifestyle can affect the outbreak of chronic disease and their complications		
	To know the guidelines and the clinical pathway for the main chronic diseases	Being able to use the Guidelines and the Clinical Pathway of the main chronic diseases	
ICT TOOLS SUPPORTING REMOTE ASSISTANCE AND AMBIENT ASSISTED LIVING	To know the main tools and methods to grant remote assistance and the Ambient Assisted Living	Being able to use the main IT tools to grant remote assistance. Being able to record and transmit medical data using technological tools	Being able to establish when it is necessary to turn to technology to support home care assistance
		Being able to properly train the caregivers to support the older adult home care assistance	

Table 14: Possible learning outcomes filling NURSES skills gaps in older adults' homecare

PHYSIOTHERAPISTS

Results presented in WP2 deliverables about physiotherapists working in older adults' homecare have been reached by Italian partners working in team with the Physiotherapy Faculty of the University of Genoa and the Italian Association of Physiotherapists (AIFI). This team, representing different stakeholders, starting from the skill gap emerging from the previous deliverables, outlined a list of possible learning units, structured into competence-based learning outcomes, which could fill the main gaps of physiotherapists working in older adults' homecare.
These learning units could be formalized in a Specialization course of about 300-400 hours, including traineeship at older adults' home, targeting professional with the first or second academic degree.

Possible LEARNING UNITS	**LEARNING OUTCOMES**		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
PROFESSIONAL RESPONSIBILITY	Knowing the code of conduct and the legislation for homecare physiotherapists		
	Knowing the formal and informal networks in the area		Being capable of interacting with the various local social and healthcare networks in the community
THERAPIES AND REHABILITATION – internal medicine area	Having an in-depth knowledge of all the necessary tools to measure vital signs		
	Knowing emergency procedures		Being able to act in case of emergency
THERAPIES AND REHABILITATION – rehabilitation area	Knowing all the theories and methodologies on therapeutic exercises which can be made at home in order to help the elderly in their rehabilitation process	Being able to apply all the theories and methodologies needed to carry out therapeutic exercises at home in order to help the elderly in their rehabilitation process	
NEW TECHNOLOGIES TO SUPPORT THERAPIES AND REHABILITATION TREATMENTS	Knowing the basics to support remote rehabilitation such as software, movement analysis tools and movement performance monitoring tools	Being able to use all the available tools to support remote rehabilitation.	Being able to establish when it is necessary to turn to technology to support home care assistance and remote rehabilitation
		Being able to properly train the caregivers to support the older adult in carrying out the exercises he/she has to do independently.	
	Knowing the main technological tools for the elderly and the disabled	Being able to use the main technological tools for the elderly and the disabled	
PREVENTION	Knowing the basics of primary, secondary and tertiary prevention		Effectively promote the necessary actions to be taken in order to preserve a person's health in accordance with his/her lifestyle
	Knowing the role played by the physiotherapist in the primary care		

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	SKILLS	COMPETENCES
	Knowing the demographic, cultural economic and social factors and their impact on healthcare in the different areas		
	Knowing the epidemiology of chronical disease and the impact that a person's lifestyle has on the outbreak of chronical diseases and related complications		
	Knowing what frailty is and its main signs		Being able to evaluate how weak an elderly person is
EVIDENCE BASED PRACTICE	Knowing the main scientific evidence on chronical and degenerative diseases in the elderly	Being able to look for the scientific evidence on chronical and degenerative diseases in the elderly	
COMMUNICATION AND RELATION – communication area	Knowing the main communication strategies to be used with the caregivers, the family and all the medical staff		Being able to use the main communication strategies with the caregivers, the family and all the medical staff
	Knowing the basics of psychology in order to help the patients in their rehabilitation programme		Being able to apply the basics of psychology in order to help the patients in their rehabilitation programme
COMMUNICATION AND RELATION – evaluation, diagnosis and prognosis area	Knowing the main tools to handle and share the information with and from the different professionals looking after the patient	Being able to use the main tools to handle and share the information with and from the different professionals looking after the patient	
			Being able to work in an interdisciplinary team

Table 15: Possible learning outcomes filling PHYSIOTHERAPISTS skills gaps in older adults' homecare

SOCIAL HEALTH OPERATORS

The OSS qualification is defined by an agreement signed on 22nd February 2001 by the Italian State-Regions Conference. The OSS qualification can be obtained at the end of a 1000-hour training pathway which includes lessons (550 hours), an internship (450 hours) and a final exam. Attendance is mandatory for the 1000-hour training and is an essential condition to guarantee that the qualification is valid at a national level.

This agreement includes additional training courses up to a maximum of 200 hours. 100 hours will be entirely dedicated to an internship.

The modules are meant for specific users and specific operational contexts such as: the elderly, the disabled, patients suffering from mental disorders, terminally-ill patients, homecare treatment, hospitals, daily care, nursing homes and so on. This training programme is divided into two different modules on adult homecare. These modules could be organized as follows:

- 100 hours of practical and theoretical training on specific professional subjects;

- 100 hours of internship in the field of social and medical homecare assistance;

The following chart shows some possible learning outcomes divided into different learning units which could easily be part of the modules on the OSS adult homecare.

POSSIBLE LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	SKILLS	COMPETENCES
PROFESSIONAL RESPONSIBILITY	Knowing the code of conduct and the legislation for OSS in homecare		
	Knowing the formal and informal networks in the area		Being capable of interacting with the various local social and healthcare networks in the community
PRIMARY CARE	Knowing the basics of primary, secondary and tertiary prevention		
	Knowing the role played by the OSS figure in primary care		
	Knowing the demographic, cultural economic and social factors and their impact on healthcare in the different areas	Being able to determine which factors have an impact on the healthcare system in a specific local area	
	Knowing what characterizes healthcare according to the WHO		
		Being able to determine which kinds of habits must be corrected	
COMMUNICATION AND HEALTCHARE EDUCATION	Knowing the basics of counselling		
	Knowing the main principles and methods on health care training in order to help the elderly to boost their knowledge in this matter	Knowing how to apply the principles and the methods on health care training in order to help the elderly to boost their knowledge in this matter	Being able to teach the elderly how to change the habits which need to be changed
	Knowing empowerment techniques	Being able to apply empowerment techniques on the elderly	
	Knowing the basics on healthcare education and ageing related to nutrition, physical exercise and social activities		
	Knowing the basics on home safety		
	Knowing the basics of psychology with a specific reference to older adults, active ageing and independent living		Being able to apply the basics of psychology in order to give the patients basic psychological support
PREVENTION AND HANDLING OF CHRONICAL DISEASES	Knowing the epidemiology of chronical disease and the impact that a person's lifestyle has on the outbreak of chronical diseases and related complications		

POSSIBLE LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	SKILLS	COMPETENCES
	Knowing what frailty is and its main signs		Being able to evaluate how weak an elderly person is
	Brief notes on Pathophysiology and how to prevent and treat the main chronical diseases		
	The basics on COPD , cardiac deficiency, diabetes, hypertension and dementia		
ICT-BASED REMOTE MONITORING	Knowing the main IT tools to monitor an elderly patient in his/her own house in order to make sure that he/she is always connected with healthcare and care facilities	Being able to use the main IT tools to monitor the an elderly patient in his/her own home	
		Being able to properly train the caregivers to support the older adult in procedures for health remote monitoring	
DEVICES	Knowing the main IT aids available for the elderly	Being able to use the main IT aids for the elderly	

Table 16: Possible learning outcomes filling OSS skills gaps in older adults' homecare

HOMECARE ASSISTANTS

PRO.VI. Technical Professional Hub is an association of SMEs, professional schools, university departments and VET providers aimed at creating functional connections between training (at all levels) and businesses sectors in the field of healthcare in Liguria. In 2015 *PRO.VI. Technical Professional Hub* carried out an analysis on the Homecare Assistant figure competencies and their possible integration. The aim of the analysis was to overcome the mismatch between demand and supply in the job market.

Thanks to the contribution of all of the partners of the hub, representing different stakeholders (professionals, employers, end-users and public bodies), a report has been produced in order to support the design of possible VET courses for Homecare Assistants in Liguria.

According to this report, the figure of Homecare Assistant needs to learn new skills in order to fit within Regione Liguria's new policies on active ageing and independent living for the elderly and the disabled. These new policies include the possibility of using cheques to pay professionals to assist the elderly or the disabled and help them to live independently at home or in communal living solutions. As a consequence, the new policies require professionals to refresh their skills and learn new ones. Specifically, Homecare Assistants should acquire, alongside their own skills (as described in Regione Liguria's List of Professions), skills that are typically associated with other professions (which are described in the List as well), such as those of social workers, social facilitators, social-educational animators and members of the guidance counselling services for the disabled and people from disadvantaged backgrounds.

Thanks to these new skills, Homecare Assistants could carry out the following tasks:

- Helping elderly or disabled users make their life plan happen
- Facilitating and strengthening elderly or disabled users' independence
- Promoting inclusion (self-realization and self-planning)
- Helping with daily life planning (including meal planning), on a daily, weekly and monthly basis, in order to encourage the user to plan independently
- Ensuring health and socio-health monitoring
- Being on the lookout for signs of regression or psychiatric issues on the part of the user

The following table sums up the possible Learning Outcomes of the integrated educational training paths outlined in this analysis. We deem these objectives consistent and in keeping with the training needs that were brought to light by the CARESS project so far. Alongside these objectives specific learning units could be created to improve and increase Homecare Assistants' specific skills, which are already dealt with in basic training.

Possible LEARNING UNITS	**LEARNING OUTCOMES**		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
SUPPORT FOR SOCIAL ASSISTANCE INTERVENTION (*SKILLS SHARED WITH SOCIAL WORKERS*)	Basic notions of psychology and counselling	Being able to put into practice psychological counselling and active listening techniques	
	Social and healthcare intervention methods	Being able to implement targeted social interventions, working in a team or independently	
	Being familiar with the main tools to document social assistance interventions	Being able to write up and update the documents that are necessary for social and healthcare interventions	Being able to work with the other professionals who follow the patient
	Being familiar with the administrative procedures for social and healthcare cases	Being able to implement administrative procedures for social and healthcare cases	
	Basic notions of national law on healthcare, social and educational services and regional law on social services and social and healthcare services.		
	Being familiar with the community network for integration	Being able to get the local community network working for the integration of a user, working with local services and agencies	Being able to work with the members of the network
SUPPORT FOR SOCIAL REHABILITATION INTERVENTIONS IN THE HOME	Basic elements of psychology of communication, psychology of disability and rehabilitation and of social psychology	Being able to provide adequate psychological support for the user	
	Being familiar with the main methods of psychological counselling and guidance	Being able to help the user plan their time	

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
(*SKILLS SHARED WITH SOCIAL FACILITATORS*)	Being familiar with the main techniques for managing a helping relationship		
	Being familiar with the local network of social services	Being able to guide the user in his/her dealing with the social/service network as needed	
		Being able to liaise with the other professionals who follow the user	
		Monitoring daily the user, carrying out the actions decided with the social-healthcare team on the basis of the user's discomfort and his/her history and life	
SUPPORT FOR ANIMATION INTERVENTIONS AIMED AT IMPROVING QUALITY OF LIFE (*SKILLS SHARED WITH SOCIAL ANIMATORS*)	Being familiar with the main techniques to carry out individual or group interventions to improve quality of life	Being able to lead or support individual or group interventions to improve quality of life	
	Being familiar with the main motivational and active listening techniques	Being able to implement the main motivational and active listening techniques	
	Being familiar with how the network can be activated for an individualised project	Being able to activate a the network for an individualised project	
	Being familiar with the main tools for social animation	Being able to use the main tools for social animation	
	Being familiar with the main techniques for developing and strengthening interpersonal relationships	Facilitating the development and maintenance of social and family relationships	
	Being familiar with the main techniques for developing self-building	Promote self-determination in daily life	
SUPPORT FOR GUIDANCE (*SKILLS SHARED WITH MEMBERS OF THE GUIDANCE COUNSELLING SERVICES FOR DISABLED PEOPLE AND PEOPLE COMING FROM DISADVANTAGED BACKGROUNDS*)	Being familiar with the techniques to help elderly users build independence into their life	Being able to help elderly users build independence into their life	
	Being familiar with the main different methods of psychological intervention for different social, organisational and working contexts	Being able to identify distressing or negative situations felt by the user within the agreed plan	
	Being familiar with the main different methods of psychological intervention for services to individuals and to the community	Being able to assess which actions the user can take independently and which actions require assistance	
	Being familiar with the main techniques for developing interventions to deal with psychological distress	Being able to monitor the project outcomes while involving all partners in the project	Being able to interact effectively with all partners in the project

Table 17: Possible learning outcomes filling ASSOCIATED PARTNERS skills gaps in older adults' homecare

9.2 Identification of Spanish HHCPs' training needs in terms of learning outcomes

9.2.1 Spanish HHCPs' skill gap

The Home Nursing Service is a group of activities –previously planned- developed by professionals who are part of a multidisciplinary nursing team. The aim of this team is to provide health services by means of a series of activities which have to do with promotion, protection, healing and rehabilitation. These services are provided within a frame of joint responsibility of the patients and/or their family with the professionals of the nursing team. They are provided at the patient's home when, due to their health conditions or to other criteria previously established by the team, they cannot get about.

PRACTICAL NURSE

- Socio-emotional needs
- Administrative operations and sanitary documentation
- Communication
- Relations with the work equipment
- Environment and risk prevention in the workplace

- ✓ Training in Ethics
- ✓ Basic knowledge about social and health services organizations and networks.
- ✓ Basic knowledge of legal framework and human rights.
- ✓ Use of information and monitoring tools
- ✓ Use of computer systems for social participation
- ✓ Use of computer systems for health monitoring
- ✓ Information to customers about reliable service networks
- ✓ Competences to coordinate other professional's tasks.
- ✓ Competence for mental health assessments
- ✓ Competencies for user empowerment
- ✓ Support in depression or despair cases

- ✓ The need of support to operate technological devices for home health monitoring.
- ✓ The need to support users in the self-management of his/her mental health.
- ✓ maintain social and family relations
- ✓ Solving daily problems or knowing where to seek for help.
- ✓ major improvement in coordination capacity to plan actions
- ✓ Meetings with health teams, and keeping in touch with other professionals who also deal with elder care.
- ✓ Reports on the activities carried out
- ✓ Personal assistance Planning

- ✓ Preventive interventions

HOMECARE ASSISTANT

- Homecare technologies
- Conflict management
- Communication
- Environment and risk prevention in the workplace
- Evaluation and quality management
- Professional values, attitudes and ethical behavior acquisition.

- ✓ “communication and information systems”.
- ✓ “the need of support in handling technological appliances for monitoring health at home”,
- ✓ “the use of information systems for social participation”
- ✓ “competencies to provide clients with contextualized and personalized information about reliable service networks”.
- ✓ “the need to support and manage behavior disorders associated with dementia”. “competence to handle conflicts”
- ✓ "need of a respectful treatment according to the user's dignity",
- ✓ "the need for protection of user’s privacy and intimacy".
- ✓ “the need to make elderly feel protected and supported in their own interests”,
- ✓ “the need of a deep respect towards their own values (such as religious beliefs, etc.)”
- ✓ “the need of support and assistance for an efficient communication”
- ✓ “need of being informed about their health”
- ✓ “training in communication”
- ✓ “quality management”.
- ✓ “ability to work in groups/teams”.
- ✓ “competencies to be able to cooperate with other professionals”.

SOCIO SANITARY CARE TECHNICIAN

- Information treatment
- Service administrative Management
- Confidential information Management
- Public relations, Communications and professional abilities
- Environment and risk prevention in the workplace

- ✓ Procedure needs,
- ✓ administrative management

- ✓ aspects related to quality and improvement,
- ✓ internal communication (among professionals) and
- ✓ communication with users and their environment.
- ✓ Basic aspects related to the direct care of patients are not considered essential for the activity of these workers due to their administrative profile. On the contrary, they do consider
- ✓ social and family relationships important, as they also do with being respectful of the way and type of life of patients.

PHYSIOTHERAPIST

- Scope of home help service
- Administrative operations
- Evaluation and quality management
- Environment and risk prevention in the workplace

- ✓ "educational interventions for caregivers"
- ✓ "Prevention of skin lesions through proper hygiene, postural changes and specific skin care".
- ✓ "need of support in mobility out of home".
- ✓ "technical support with external devices: Oxygen, NIMV (non-invasive mechanical ventilation), feed pumps, infusion pumps, home peritoneal dialysis, etc…"
- ✓ "need to be supported and educated in proper positioning and postural changes to prevent physical disorders".
- ✓ "need of support and rehabilitation in toilet habits"
- ✓ "knowledge about the main aids and devices for older and disabled people"
- ✓ "competencies for terminal illness support".
- ✓ "competences for collaborating with other practitioners"
- ✓ "competences for working in a group /equip /staff", have been very little developed in the formative programs. Also "basics in older person's healthy lifestyles"

OCCUPATIONAL THERAPIST

- Scope of home help service
- Sociocultural animation
- Communication with user
- Professional values, attitudes and ethical behavior
- Evaluation and quality management
- Environment and risk prevention in the workplace

- ✓ "support and assistance in social relationships".
- ✓ "Formalize in a sheet, a chart or to report the initial evaluation of older person's needs"

- ✓ "Basics in older person's healthy lifestyles"
- ✓ "Basics in social-health Services Organizations and networks"
- ✓ "Basics in law and human rights frameworks"
- ✓ "Procedures for monitoring healthy lifestyles"
- ✓ "Using ICT for social participation "
- ✓ "Competencies for managing conflicts"
- ✓ "Competences for coordinating the work of other practitioners"
- ✓ " Competences for evaluating customer mental health status".

SPEECH THERAPIST

- ✓ "evaluation of customer needs" and
- ✓ " personal assistance planning"
- ✓ "educational interventions for caregivers"
- ✓ "team meeting and contacts with the other professionals involved in older person's assistance",
- ✓ " Basics in dietetic"
- ✓ "Basics in social-health services organizations and networks"
- ✓ "basics in law and human rights frameworks"
- ✓ "competences for caring with dignity"
- ✓ "need to a respectful treatment according to his/her dignity"
- ✓ "need for protection of user privacy and intimacy"
- ✓ "need to feel defended and to be supported in his own interests"
- ✓ "need to feel a deep respect regarding values (including religious beliefs and spiritual needs)"

9.2.2 Learning outcomes overcoming Spanish HHCPs' skill gap

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
• Biological, structural and functional changes in the aging process. • Elderly psychosocial changes. • Elderly social changes. • Geriatric evaluation. • Nursing care applied to elderly and their families. • Characteristics of the process of becoming sick in the elderly. • Mental illnesses in elderly people. • Geriatric syndromes. • The importance of mediation in elderly people. • Abuse of elderly people. • Nutrition in elderly people.	• Know and identify the structure and function of the human body. • Understanding the molecular and physiological bases of cells and tissues. •		
	• Understand the use and indications of health products linked to nursing care. • Know the pathophysiologic processes and its • symptoms and risk factors that determine health status and diseases in the different stages of the life-cycle. • Know and apply the principles based on comprehensive nursing care. • Identify people's psychosocial response to different health situations (in particular, disease and suffering), choosing the adequate actions to provide help in them. • Know the most relevant mental health issues in the different stages of the life cycle, providing comprehensive and effective care within nursing. • Know the palliative care and pain control to provide care that alleviates the condition of advanced and terminally ill patients.	• Identify the people's psychosocial to different health situations (in particular, disease and suffering), choosing the adequate actions to provide help in them. • Establish an emphatic and respectful relationship with the patient and family, consistent with the person's situation, health issue and development stage. • Use strategies and skills allowing an effective communication with patients, families and social groups, as well as expressing their concerns and interests. • Recognise life-threatening situations and know how to perform basic and advanced life support maneuvers. • Manage, assess and provide comprehensive nursing care for the individual, the family and the community. • Promote the involvement of people, families and groups in the health-disease process. • Identify the factors associated with the health and environmental issues to care for people in health-disease conditions as members of a community. • Identify and analyse the influence of internal and external factors in the level of health of individuals and groups. • Identify the care needs derived from health problems.	• Ability to apply critical thinking. • Capacity for analysis and synthesis. • Ability to solve problems and make decisions. • Ability to solve problems and make decisions. • Ability to work on the basis of quality criteria. • Ability to develop creativity. • Ability to develop initiatives and entrepreneurial spirit. • Ability in leadership. • Ability to learn. • Ability to plan and evaluate. • Ability to adequately use IT resources and emerging technologies. • Ability to demonstrate research skills. • Ability to develop information management skills. • Ability to communicate in the mother tongue. • Ability to communicate in a second language.
	• Know the different groups of medicine, their authorization principles, the use and guidelines, and their action mechanisms.	• Use of medication, evaluating the expected benefits and the associated risks and/or effects of its administration and consumption.	
	• Know and asses the nutritional needs of healthy people and people with health		

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
	problems throughout the life cycle, to promote and strengthen guidelines/patterns of healthy eating behavior. • Identify nutritional problems of higher prevalence and choose the appropriate dietary recommendations. • Identify the nutrients and the food.		
	• Understand the changes connected to the process of ageing and its impact on health. • Know the health issues that are more common in elderly people.	• Identify structural, functional and psychological changes and ways of life associated with the process of ageing. • Choose the carers intervention aimed at treating or preventing health problems and their adaptation to daily life by proximity and support resources for the elderly person.	
	• Know the Spanish healthcare system. • Know the applicable law and the Spanish nursing code of ethics ad conduct, inspired in the code of ethics and conduct for European nursing.	• Ability to describe the health primary level bases and the activities to be developed to provide comprehensive nursing care for the individual, the family and community.	• Capacity to assume an ethical commitment.
	• Identify the different characteristics of women in the different stages of the reproductive cycle, the climacteric and the alterations that may occur providing the necessary need at each stage. • Know and identify physical and psychological problems derived from gender-based violence in order to train the student in prevention, early diagnosis, assistance and rehabilitation to victims of this form of violence.		

Possible LEARNING UNITS	LEARNING OUTCOMES			ASSESSMENT OF THE VOCATIONAL QUALIFICATION
	KNOWLEDGE	**SKILLS**	**COMPETENCES**	
• biological, structural and functional changes the aging process. • Psychosocial changes in the elderly. • • Social changes in the elderly. • Geriatric assessment. • Nursing care applied to the elderly and their families. • The characteristics of the process nurse in the elderly. • The elderly own mental illness. • geriatric syndromes. • The importance of medication in the elderly. • The elder abuse. • The nutrition in the elderly.	• Know and identify the structure and function of the human body. • Understanding the molecular and physiological bases of cells and tissues.			
	• Understand the use and indications of health products linked to nursing care. • Know the pathophysiologic processes and its • symptoms and risk factors that determine health status and diseases in the different stages of the life-cycle. • Know and apply the principles based on comprehensive nursing care. • Identify people's psychosocial response to different health situations (in particular, disease and suffering), choosing the adequate actions to provide help in them. • Know the most relevant mental health issues in the different stages of the life cycle, providing comprehensive and effective care within nursing. • Know the palliative care and pain control to provide care that alleviates the condition of advanced and terminally ill patients.	• Identify the people's psychosocial to different health situations (in particular, disease and suffering), choosing the adequate actions to provide help in them. • Establish an emphatic and respectful relationship with the patient and family, consistent with the person's situation, health issue and development stage. • Use strategies and skills allowing an effective communication with patients, families and social groups, as well as expressing their concerns and interests. • Recognise life-threatening situations and know how to perform basic and advanced life support maneuvers. • Manage, assess and provide comprehensive nursing care for the individual, the family and the community. • Promote the involvement of people, families and groups in the health-disease process. • Identify the factors associated with the health and environmental issues to care for people in health-disease conditions as members of a community.	• Ability to apply critical thinking. • Capacity for analysis and synthesis. • Ability to solve problems and make decisions. • Ability to solve problems and make decisions. • Ability to work on the basis of quality criteria. • Ability to develop creativity. • Ability to develop initiatives and entrepreneurial spirit. • Ability in leadership. • Ability to learn. • Ability to plan and evaluate. • Ability to adequately use IT resources and emerging technologies. • Ability to demonstrate research skills. • Ability to develop information management skills. • Ability to communicate in the mother tongue. • Ability to communicate in a second language.	• Demonstrates ability to communicate properly. • Solves problems and makes decisions effectively. • Work accurately applying the nursing process. • Evaluates effectively the life-threatening situations. • Performs effectively resuscitation. • Demonstrates ability to support and education to community members. • Demonstrates knowledge about mental health problems. • Effectively promotes the participation of individuals and families in sickness.

Possible LEARNING UNITS	LEARNING OUTCOMES			ASSESSMENT OF THE VOCATIONAL QUALIFICATION
	KNOWLEDGE	SKILLS	COMPETENCES	
		• Identify and analyse the influence of internal and external factors in the level of health of individuals and groups. • Identify the care needs derived from health problems. •		
	• Know the different groups of medicine, their authorization principles, the use and guidelines, and their action mechanisms.	• Use of medication, evaluating the expected benefits and the associated risks and/or effects of its administration and consumption.		• Effective implementation of drug therapy.
	• Know and asses the nutritional needs of healthy people and people with health problems throughout the life cycle, to promote and strengthen guidelines/patterns of healthy eating behavior. • Identify nutritional problems of higher prevalence and choose the appropriate dietary recommendations. • Identify the nutrients and the food.	•	•	•
	• Understand the changes connected to the process of ageing and its impact on health. • Know the health issues that are more common in elderly people.	• Identify structural, functional and psychological changes and ways of life associated with the process of ageing. • Choose the carers intervention aimed at treating or preventing health problems and their adaptation to daily life by proximity and support resources for the elderly person.	•	• effectively promotes the participation of families and the elderly. • Provides individualized care effectively. • Identify the psychosocial responses of the elderly.
	• Know the Spanish healthcare system. • Know the applicable law and the Spanish	• Ability to describe the health primary level bases and the	• Capacity to assume an ethical commitment.	• Demonstrates knowledge of the Spanish Health System.

Possible LEARNING UNITS	LEARNING OUTCOMES			ASSESSMENT OF THE VOCATIONAL QUALIFICATION
	KNOWLEDGE	SKILLS	COMPETENCES	
	nursing code of ethics ad conduct, inspired in the code of ethics and conduct for European nursing.	activities to be developed to provide comprehensive nursing care for the individual, the family and community.		• Demonstrates knowledge of the code of ethics and laws and code of ethics.
	• Identify the different characteristics of women in the different stages of the reproductive cycle, the climacteric and the alterations that may occur providing the necessary need at each stage. • Know and identify physical and psychological problems derived from gender-based violence in order to train the student in prevention, early diagnosis, assistance and rehabilitation to victims of this form of violence.			

PRACTICAL NURSE				
Possible LEARNING UNITS	**LEARNING OUTCOMES**			**ASSESSMENT OF THE QUALIFICATION**
	KNOWLEDGE	**SKILLS**	**COMPETENCES**	
User care in their emotional and social needs.	• Basics in strategies of social support. • Basics in personal support strategies. • Basic knowledge about social and health services organizations and networks	• Identify user social needs • Initial assessment of affective needs • Recommend basic actions to compensate deficiencies • Solving daily problems or knowing where to seek for help.	• Competence in support to social needs of the user • Competence in support to emotional needs of the user.	Effectively provides emotional an social support
Administrative operations, and health documents.	• C. básico en administración • C. en manejo de documentación sanitaria pertinente	• Relevant-health documentation Management	• Competence in effective administrative support	Effectively carries out administrative management
Professional values and ethical behavior.	• Basic knowledge in Professional Ethics • Basics in in preserving the dignity and privacy, and confidentiality of information	• To adopt dialoguing attitude • Development of empathetic attitude • Decision making	• Competence in Values and Ethics	Apply professional values and ethical principles in daily practice
Communication	• Verbal communication and paraverbal	• Communication in sensory disorders • Communication in aphasia	• Competence in Communication	Conducts effective communication
Team Working	• Pathways between professionals • Troubleshooting Techniques • Capacity to plan actions	• Coordination with other professionals • Empathy • Commitment to fill reports on the activities carried out	• Competence in Working in group	Achieves effective collaboration within the team

Occupational hazards and the Quality of Care	• Knowledge of risk own labor job • Knowledge of risk to users by malfunctions in their environment • Basics in quality. The PDCA cycle	• Identify risks associated with jobs. • Identify areas for improvement • Basic propose corrective measures • Communicate the facts to higher authorities	• Competence in Risk management • Competence in Quality of care	Shows ability to propose a safe environment, by analysing and proposing improvements
Information systems	• Knowing how to use computer systems and home applications • knowing how to work in equip, by using informatics tools	• Using computer systems for health monitoring • Use of information and monitoring tools	• Competence in applying information tools at home	Shows ability with information tools

HOMECARE ASSISTANT				
Possible LEARNING UNITS	**LEARNING OUTCOMES**			**ASSESSMENT OF THE QUALIFICATION**
	KNOWLEDGE	**SKILLS**	**COMPETENCES**	
Technologies associated with the home support.	• Knowledge of equipment devices that can be used in care. • Knowledge the use of information systems for social participation	• Being able to adapt new technologies to the needs of the home. • Handling technological appliances for monitoring health at home	• Competence in applying information tools at home	Shows ability with information tools
Conflict management	• Knowledge of the techniques of conflict management. • Basic knowledge of behavior disorders in dementia basics in how to ensure the physical and psychological well-being	• Initial handling of confrontational situations. • It recognizes conflict situations that require specialized intervention • Manage of behavior disorders associated with dementia • Detect abuse	• Competence to handle conflicts • Competence in comunication	Effective at solving problems and making decisions
Professional values and ethical behavior.	• Basic knowledge in Professional Ethics • Basics in in preserving the dignity and privacy, and confidentiality of information	• To adopt dialoguing attitude • Development of empathetic attitude • Decision making	• Competence in Values and Ethics	Apply professional values and ethical principles in daily practice
Communication	• Verbal communication and paraverbal	• Communication in sensory disorders • Communication in aphasia	• Competence in communication • Competence in communication with Working group	Conducts effective communication
Evaluation and quality management	• Basics in quality	• Environment analysis • Identification of areas for improvement • knows handling the PDCA cycle	• Competence in Quality of care	Effectively analyzes and promotes improvements
Environment and Occupational Risk Prevention	• Knowledge of risk own labor job • Knowledge of risk to users by	• Identify risks associated with jobs and those for the patient	• Competence in Risk management	Shows ability to propose a safe environment, by analysing and proposing improvements

	malfunctions in their environment	• Basic propose corrective measures • Communicate the facts to higher authorities		

SOCIO SANITARY CARE TECHNICIAN				
Possible LEARNING UNITS	**LEARNING OUTCOMES**			**ASSESSMENT OF THE QUALIFICATION**
	KNOWLEDGE	**SKILLS**	**COMPETENCES**	
Information processing.	• Knowing managing databases, methodologies for data processing. • Information management techniques and bioethics. • Deep knowledge of confidentiality protocols • knowledge in administrative management	• Ability to manage information appropriately and ethically. • Being able to identify sensitive information. • Taking measurements of user satisfaction • Development of relevant reports	• Management of information systems • Management of confidential information. • Competence in Values and Ethics • competencies for the exploitation of information	He shows effectiveness in managing information, and in accomplishing confidentiality protocols
Acquisition of professional values, attitudes and ethical behavior.	• Basic knowledge in Professional Ethics • Basics in in preserving the dignity and privacy, and confidentiality of information	• Knowing the ethical implications and attitudes treatment to users. • Development of empathetic attitude • Decision making	• Competence in Values and Ethics	Apply professional values and ethical principles in daily practice
Public relations, communication and professional skills	• Techniques oral, written and alternative for people with specific needs in communication • Motivation and teamwork.	• Appropriate interaction with work teams, users and families	• Competence in Communication	Conducts effective communication
Evaluation and quality management	• Deep knowledge in quality process • knows handling the PDCA cycle	• Identification of areas for improvement • Broadcast the quality objectives • Encourage for using quality process	• Competence in Quality of care	Effectively analyzes and promotes improvements
Environment and Occupational Risk Prevention	• Knowledge of risk own labor job	• Identify risks associated with jobs • Basic propose corrective measures • Communicate the facts to higher authorities	• Competence in Risk management	Shows ability to propose a safe environment, by analysing and proposing improvements

PHISIOTHERAPIST				
Possible LEARNING UNITS	**LEARNING OUTCOMES**			**ASSESSMENT OF THE QUALIFICATION**
	KNOWLEDGE	**SKILLS**	**COMPETENCES**	
Scope of home help service	• Physiotherapy performances limits • Performance of collaborative Professionals	• Detect social needs of patients • The Support search	• Competence in Organization of care at home	He Shows to know the limits and line of action at home
Administrative operations	• Administrative operations taking place in the workplace	• Document Management • Formalize tracking sheets and reports	• Process management	Effectively carries out administrative management
Evaluation and quality management	• Basics in quality	• Environment analysis • Identification of areas for improvement • knows handling the PDCA cycle	• Competence in Quality of care	Effectively analyzes and promotes improvements
Environment and risk prevention in the workplace	• Healthy and safe environment • Characteristic labor risks of the job • Knowledge about risk pathologies of patients	• Recognition of risk environment • Identify associated risks • Warn of risks • Initiate corrective actions	• Competence in Risk management	He Shows ability to propose a safe environment
Medical conditions	• Adequacy of therapeutic effort (limitation of therapeutic efforts) • Basics in major assistive devices for the elderly • Basics in technical support with external devices	• Adaptation of therapeutic interventions • Adaptation of therapeutic interventions • Adaptation of therapeutic interventions	• Competence in Care for the terminally ill • Competence in Management of patients with specific diseases	He works accurately, adapting to users
Training caregivers and family	• Basics in prevention of skin lesions • Postural hygiene • Proper positioning and postural changes	• Adapt therapeutic measures • Empathy • Communication skills	• Competence in Training in the prevention of physical disorders	He Shows ability in education and support to relatives and caregivers
Specific support the healthy and sick user at home.	• Basics for Healthy Lifestyle in elderly at home	• Mobility outside the home. • Rehabilitation and support	• Competence in Care of the elderly	He Showed knowing needs of elderly and how to support them

		in grooming habits		
Team work	• Pathways between professionals • Troubleshooting Techniques	• Coordination With other professionals • Empathy	• Competence in Working in a group	Achieves effective collaboration within the team

OCUPATIONAL THERAPIST				
Possible LEARNING UNITS	**LEARNING OUTCOMES**			**ASSESSMENT OF THE QUALIFICATION**
	KNOWLEDGE	**SKILLS**	**COMPETENCES**	
Scope of home help service	• Ocupational Therapist performances limits	• Detect social needs of patients • The Support search	• Competence in Organization of care at home	He Shows to know the limits and line of action at home
Support and assistance in social relations	• Knowledge of social resources of the environment . • Basics limitations of users	• Ability to encourage users	• Competence in sociocultural animation	It shows ability to foster healthy habits
	• Adaptive and maladaptive attitudes	• the Initial focus for activity in users with mental disorder known	• Competence in Conflict management	Shows ability in handling of behaviors
Communication	• Verbal communication and paraverbal	• Communication in sensory disorders • Communication in aphasia	• Competence in Communication	Conducts effective communication
Professional values,	• Basics in ethics in current practice	• Adopt dialoguing attitude • Show Empatia • Show respect • Ensure confidentiality	• Competence in Values and Ethics	Apply professional values in daily practice
Administrative operations	• Administrative operations taking place in the workplace	• Document Management • Formalize tracking sheets and reports	• Competence in Competence in Process management	Effectively carries out administrative management
Evaluation and quality management	• Basics in quality	• Análisis del entorno • Identificación de áreas de mejora	• Competence in Quality of care	Effectively analyzes and promotes improvements
Environment and risk prevention in the workplace	• Healthy and safe environment • Procedures for monitoring healthy lifestyles	• Recognition of risk environment	• Competence in Risk management	He Shows ability to propose a safe environment
	• Characteristic labor risks of the job • Knowledge about risk pathologies of patients	• Identify associated risks • Warn of risks • Initiate corrective actions		
Team Working	• Pathways between professionals • Troubleshooting Techniques	• Coordination with other professionals • Empathy	• Competence in Working in group	Achieves effective collaboration within the team

SPEECH THERAPIST				
Possible LEARNING UNITS	**LEARNING OUTCOMES**			**ASSESSMENT OF THE QUALIFICATION**
	kNOWLEDGE	**SKILLS**	**COMPETENCES**	
Conocimientos en dietética	• Basics in dietetic"	• Changing diets	• Competence in Adapting diets	It shows skill in handling diets
Educational interventions for caregivers	• Speech Therapy Techniques	• Communication skills	• Competence in Training	He teaches effectively to relatives and caregivers the right way to support the user
Scope of home help service	• Speech Therapist performances limits	• Planning of personal assistance • The Needs Assessment	• Competence in Organization of care at home	He Shows to know the limits and line of action at home
Training in ethics and values	• Basic knowledge in Ethics • Defense of values: Dignity, privacy, intimacy • Basics knowledge in human law and human rights	• Adopt dialoguing attitude • Show respectful treatment • Ensure confidentiality Defend and support user interests	• Competence in Values and ethics	Apply professional values in daily practice
Working in a equip	• Pathways between professionals	• Coordination with other professionals • Empathy	• Competence in Working in group	Achieves effective collaboration within the team

9.3 Identification of Finnish HHCPs' training needs in terms of learning outcomes

9.3.1 Finnish HHCPs' skill gap

The questionnaire of HHCP was sent to 2550 persons, practical nurse working in home care and with at least the VET education on EQF4 level. The survey was conducted by Survey Pal. A total of 433 individuals (practical nurses/members/persons) responded to the survey and the response rate was 17 %.The survey reveals that the practical nurses working in home care recognized lack of their skills especially in these areas: Basics in social-health services organizations and networks, Basics in law and human rights frameworks, Procedures for providing physical therapies, Providing the customer with contextualized and personalized information about the network of services he/she can rely on, Competences for coordinating the work of other practitioners, Competences for evaluating customer´s mental health status, Grief support and Competencies for terminal illness support.

The results of the interviews done for (n=9) elderly home care clients showed, that administering and assessing medications was one of the activities that HHCPs routinely carried out in the elderly clients´ home. Administration and assessing medications was also brought up as the most important priority care need to the clients in their own opinion. Concerning result was that, in this activity clients assessed the HHCPs competence level only satisfactory or even poor. Weak interaction skills and ethical skills as some HCCPs appearing intimidating and not listening elderly clients' needs and wishes was also a result that should be taken into consideration in health care organizations and education

In the future people taken care by home care personnel have more severe conditions, more chronical diseases and have multidiagnoses. Hence practical nurses need to have necessary skills, competence and knowledge of observing, nursing tasks, drugs and interaction. They also need to know the service structure and service producers. Palliative and terminal care needs at home is also increasing. Number of clients/patients with mental problems and addictive behavior has increased, which means increasing skill needs in that area.

There is already a solution exciting for previously mentioned lacking knowledge of service structure. Project led by Finnish Ministry of Social Affairs and Health (MSAH) is developing service centres for regions. These centres will be serving also home care.

In addition to skill needs there has to be enough resources available to actually deliver services. At the moment home care is lacking personnel/practical nurses and the clients do not receive the service which they are entitled (after their needs have been assessed). This causes ethical burden for home care workers/practical nurses, restricts use of existing professional skills and most importantly, is diminishing the quality of home care services.

9.3.2 Learning outcomes overcoming Finnish HHCPs' skill gap

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Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
1 **Communication and interaction:** Using his/her vocational interaction and guiding skills in working with the elderly and their families	**The learner knows and understands** The different forms of communication (verbal (inc paralanguage), non verbal, body language) Common barriers to communication (language, disease, aging, environment) Develop verbal and nonverbal communication strategies to overcome potential sensory, language, and cognitive limitations in older adults.	**The learner is able to** Use appropriate communication to establish a therapeutic relationship with the service user, family, carer and others. Develop verbal and nonverbal communication strategies to overcome potential sensory, language, and cognitive limitations in older adults. use his/her vocational interaction skills in a natural manner in working with clients. expresses him-/herself professionally, appropriately and clearly both orally and in writing	**The learner is competent in** Applying different forms and methods of communication in response to varying situations. Providing support to individuals to develop their communication skills Using different forms of communication to promote independence and recovery.
	Group dynamic, Triggers to challenging behaviour.	guide and support the elderly in daily activities, adopting a rehabilitative approach actively cooperate with the client's family and immediate community, regarding them as a meaningful resource for the client and the nurse's work. cooperate with the client's family caregiver, relatives and network Develope favourable conditions for finding solutions to overcome real or potential barriers to communication Actively support the clients and their families solve everyday problems and acts in surprising situations in the client's home	guiding the elderly and their families in promoting health (making healthy lifestyle possible, preventing difficulties and diseases, care and rehabilitation) in social and mental problems, and in applying for and using different services guides activity groups for clients of different ages and functional abilities, promoting interaction between and participation of the group members Using communication channels to deal with conflict and challenging behaviour. finding positive solutions to challenging situations using his/her vocational interaction skills in a natural manner in working with clients, also in challenging situations.
	The value of observation.	Use effective observation skills to promote recovery and independence. guides groups of elders with different functional abilities	justifies his/her decisions and actions with his/ her knowledge of the significance of the client's life history and the connection of Finnish history for the present situation in life. exploits his/her language skills in customer service

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
	Legislation relating to data protection.	Apply appropriate legislation abides with the principles, regulations and provisions concerning the field of social and health care, when working in the client's home	Respect the privacy, habits, customs and property of the client who lives in his/her own home Decision-making and problem solving skills
	Customer service and information processing.	acts responsibly as a client's primary nurse, in cooperation with a team. actively cooperates with other employees and service providers Organise information to be reported to team members and different agencies.	Sharing appropriate information with health professionals, other team members and key stakeholders. caregiver support, personal and domestic support cooperates with the client's family caregiver, relatives and network

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
2 **Medical care and pharmacies**	**The learner knows and understands** medical know-how (provision of medicinal products)	**The learner is able to** handle, dispense and administer pharmaceuticals correctly and safely to the client	**The learner is competent in** Guides the client and his/her family in the use of pharmaceuticals, in their storage and disposal and in renewing prescriptions
	Apply knowledge of the indications and contraindications for, risks of, and alternatives to the use of physical and pharmacological restraints with older adults.	monitors the effects and combined effects of pharmaceuticals and recognizes the most common adverse and side effects, as well as the signs of abuse of medication	justifies his/her actions with his/her knowledge of the basics of pharmacotherapy to the elderly
	Recognize the principles and practices of safe, appropriate, and effective medication use in older adults	handles, dispenses and administers pharmaceuticals correctly and safely to the client. Actively guides the client and his/her family in the use of pharmaceuticals, in their storage and disposal and in renewing prescriptions.	justifying his/her actions with knowledge and skills in pharmacotherapy

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
3. Ethical principles Abiding with the ethical principles and quality recommendations in the care for the elderly and develops care for the elderly	**The learner knows and understands** the ethical principles and quality recommendations in the care for the elderly	**The learner is able to** apply all aspects of equality and diversity respect the individual, their life experience, preferences and choices demonstrate a willingness to accept responsibility for their actions, professional standards and continuing development	**The learner is competent in** promoting the rights and diversity of individuals
	professional ethics, ethical issues in care of the elderly	plans his/her work, complying with the ethical principles, statutes and regulations of the care for the elderly and perceives his/her work as a whole to fit the activities in his/her work unit work within ethical parameters	respects the privacy, habits, customs and property of the client who lives in his/her own home making and maintaining professional boundaries
	the equality and diversity	apply the values that underpin quality care; dignity, respect, choice, privacy, confidentiality attends to the client's pain relief independently and as a team member	following the principles of quality and sustainable professional development and lifelong learning
	the values that underpin quality care provision professional accountability and limitation of practice	comply with the principles of sustainable development and the quality recommendations of the work unit.	abides with the ethical principles and quality recommendations in the care for the elderly and develops care for the elderly
	the effect that prejudice, stereotyping and discrimination ha e on the individual the importance of trust and confidentiality	supports the client's continence, assists and guides in problems of incontinence recognise abuse and reports accordingly.	identifying own values and principles and the affect that these may have on the individual in care practising within the legal and ethical boundaries of their profession
4 Service system, organisation and administration, planning care and services:	**The learner knows and understands** service system, service coordination	**The learner is able to** surveys, in a resource-based manner, the client's functional abilities, customs and habits, life history and potential social problems, as well as the need for care and services, exploiting different functional ability scales.	**The learner is competent in** contributes, as a team member, to proper oral information and documentation of client records

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
Planning, implementing and assessing the care of and services to the elderly, taking their resources and participation into account	the process of assessing needs and planning care. justifies his/her actions extensively with his/her knowledge of the services and social benefits available to home care clients and family caregivers.	as a team member, drawing up and updating, together with the client and the client's representative, a plan which supports the client's participation and which the nurse implements and assesses in a variety of ways. Develop advanced care plans based on older adults' preferences and treatment/care goals, and their physical, psychological, social, and spiritual needs. Recognize the need for continuity of treatment and communication across the spectrum of services and during transitions between care settings, utilizing information technology where appropriate and available.	planning and assessing the care of and services the clients living at home, taking their resources and participation into account planning his/her visit in the client's home according to the client's care and service plan, paying extensive attention to the client's habits, customs and privacy. Acting flexibly and in exceptional situations and assesse and justifies his/her actions.
	Serve as an advocate for older adults and caregivers within various healthcare systems and settings	supports the client and his/ her family in coping with different social problems and intervenes as early as possible as a team member. Guides the client to seek required expert help in e.g. substance abuse or crisis clinics	acting responsibly as a client's primary nurse, in cooperation with a interdisciplinary team. actively cooperates with other employees and service providers
	information to older adults and their caregivers about the continuum of long-term care services and supports – such as community resources, home care, assisted living facilities, hospitals, nursing facilities, sub-acute care facilities, and hospice care	promote and monitor the client's vital functions as well as sleep-wake pattern. Intervenes as early as possible in the case of declining health and functional abilities observational skills monitors changes in the client's physical, mental and social well-being and abilities and prevents the factors that have a detrimental effect	guides and supports clients in the different phases of the care chain (e.g. junction between institutional and home care, memory loss and substance abuse problems) Provide information to older adults and their caregivers about the continuum of long-term care services and supports – such as community resources, home care, assisted living facilities, hospitals, nursing facilities, sub-acute care facilities, and hospice care
	Knowledge related to the older person's immediate environment and the services available assessment tools to determine needs and plan care.	assesses the client's nutritional status, fluid balance and use of alcohol, and guides and assists the client in eating or preparing food and in eating habits, paying attention to special diets. use assessment tools to determine needs and plan care. applies this information individually to the client and his/her	plans the productisation of his/her competence works in an enterprising, conscientious, economical and effective manner. using assessment tools appropriately.

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
		family	
5 **Geriatric nursing, common diseases and memory diseases**	**The learner knows and understands** knowledge of the biological, physical, cognitive, psychological, and social changes commonly associated with aging; person centred care, physical and psychosocial changes of aging, significance and main principles of: nutrition; personal hygiene; aesthetics in the environments; mobility. Client –specific knowledge pertaining to the older persons person	**The learner is able to** basic care tasks nursing (geriatric nursing) care work (nutrition, hygiene, errands) evaluation of health (ability to function) and its maintenance; apply the principles of person centred care. in his/her work, takes account of and reflects on the significance of different conceptions of old age as well as on his/her thoughts, attitudes and values regarding his/her own ageing. advocate to older adults and their caregivers interventions and behaviors that promote physical and mental health, nutrition, function, safety, social interactions, independence, and quality of life;	**The learner is competent in** justifying his/her decisions and actions extensively and in a client-based manner with his/her knowledge of physical and mental changes related to ageing, the most common physical and mental diseases of home care clients and their treatment justifies his/her actions with his/her knowledge of the impact of physical, mental and social ageing and changes on the elder's life
	Common Diseases and Pain, memory diseases Identify and inform older adults and their caregivers about evidence-based approaches to screening, immunizations, health promotion, and disease prevention. Actively searches for further information	nursing and health care; providing first aid and basic resuscitation monitoring, recognising and anticipating changes and the need for support in the client's physical, mental and social well-being in many ways, and seeks for solutions in a multi-disciplinary home care team together with the client and his/her family. Through his/her actions, prevents factors which reduce the client's well-being making healthy lifestyle possible, preventing difficulties and diseases, care and rehabilitation guides and supports the client and his/her family in maintaining and promoting physical, mental and social well-being and abilities	guides and supports clients in the different phases of the care chain (e.g. junction between institutional and home care, memory loss and substance abuse problems) justifies his/her decisions and actions with his/her knowledge of memory loss and the care for people suffering from memory loss justifies his/her actions extensively with his/her knowledge of the basics of nursing and care justifies his/her actions with his/her knowledge of the services and social benefits available to the elderly and/or people with memory disorders

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
	importance of wellbalanced nutrition, relevant to the client's age, and of meal services	help the client take care and/or take care of the client's meals and nutrition; in his/her work, exploit his/her knowledge of wellbalanced nutrition, relevant to the client's age, and of meal services and acts flexibly depending on the client's situation.	justifying his/her decisions and actions with his/her knowledge of the basics and special problems in oral & dental, skin and foot care.
	how to maintain a safe working environment. safeguarding and recognition of abuse	task supporting basic care home care tasks other home care skills assists and guides the client in tending to personal hygiene and dressing and recognizes special problems encourage participation, self determination with the individual. create and maintain an safe care environment. personal care applying moving and positioning techniques, infection prevention strategies	justifies his/her actions with his/her knowledge of the elders' accident risks and of how to act in first aid cases; promoting safeguarding and how to promote the safety of individuals in your care; implementing the process of risk assessment. works in an ergonomically correct way and prevents work-related accidents and injuries
		promotes meaningful everyday living and the pleasantness and aesthetic aspects of the environment as a natural part of daily care and nursing of the client	compliyng with the principles of aseptics, using the correct work practices, and prevents the spreading of infections.
6 **Rehabilitative approach and rehabilitation:** Guiding and supporting the elderly in daily activities, adopting a rehabilitative approach	**The learner knows and understands** Knowledge related to the maintenance of health and functional abilities of the older persons person and rehabilitation	**The learner is able to** apply a rehabilitative approach in daily activities, in order to maintain the client's functional abilities.	**The learner is competent in** promoting inclusion and participation of clients in daily practices
	assessing specific risks and barriers to older adult safety, including falls, elder mistreatment, and other risks in community, home, and care environments.	motivate and guide the elderly to take up physical exercise and to maintain muscle strength	making healthy lifestyle possible, preventing difficulties and diseases, care and rehabilitation
		help the client take care and/or takes care of daily tidiness and/or cleaning and	promotes the elder's life quality, paying attention to his/her unique situation and

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
		laundry in the client's home runs errands for the client outside their home and/or assists the client in running errands	history
		assists and guides the client in tending to personal hygiene and dressing and recognizes special problems	promoting advocacy and mobility, personal care, activities of living and social interactions with individuals.
7 **Palliotive care** Participating in the care of a dying elder	**The learner knows and understands** accepting death as part of life and is able to talk about death and related issues naturally with the elder and his/her family	**The learner is able to** accept death as part of life and is able to talk about death and related issues with the elder and his/her family	**The learner is competent in** as a team member, participating in the care of a dying elder in every respect
	legal issues are living will, client's attorney and testament	as a team member, participate in the care of a dying elder	instructing the client and his/her family
		justify his/her actions extensively with his/her knowledge of special legal issues related to old age and memory loss.	
8 **Welfare technology and gerotechology** Competence and skills to introduce, bring in to use and guide clients to use Welfare technology	**The learner knows and understands** social and health care technology, ethical issues by using ICT and tele-care	**The learner is able to** exploit the physical and psychosocial environment as well as gerotechnology to promote the client's functional abilities, meaningful everyday living and safety.	**The learner is competent in** guiding and motivating the client in the acquisition and use of aid-devices and gerotechnology
	electronic health records, Electronical referrals and patient records (eHealth, healthcare ICT)	maintain and improve health and capability of physical, psychological and social functioning and condition by using technology and ICT	improving the technology, ICT and new mobile solutions
	services supported by ICT solutions	use technology on basic level and is interested and able to learn more use existing technology in new ways.	promoting well-being and safe-guarding
	electro devices, medical aids, medical furniture, health promotion and consumer products	guide to use technology, to guide to find welfare technology services	motivating the courage and open-mindedness of professionals to use welfare technology

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	**SKILLS**	**COMPETENCES**
	mobile solutions for measurements and monitoring of health, tele-care methods	assess clients' needs; guide, motivate and encourage clients and their families to use technology highlight clients' viewpoints how technology can bring added value and improve the quality of people's life; usability and user-friendliness of technology exploit tools and technology related to safety, social interaction, information and statistics in the client's home and guides the clients and their families in their use	promote clients and their families by using welfare technology in supporting independent life, in maintaining and increasing safety, in evaluating and monitoring health and capability and in improving social interaction, involvement and participation
9 **Multicultural care and services** Working in multicultural environments with clients and co-workers from different cultures	**The learner knows and understands** how to seek and find knowledge about transcultural approach; cultural competence in a different aspects: self-awareness, ethics, assessment, engagement, treatment, folk healing and general multicultural consciousness	**The learner is able to** work in multicultural environments and with clients from different cultures and develops his/her cultural awareness	**The learner is competent in** acting in a new situation and with a new multicultural client, takes the customer's life history into account and acts accordingly
	importance to develop verbal and nonverbal communication strategies	attend to clients in appropriate language and manage service situations in one foreign language; use verbal and nonverbal communication strategies in case of the lack of a common language; expresses presence and care in actions and words (verbally and non-verbally)	communication and collaboration with older adults, their caregivers, healthcare professionals, and direct-care workers to incorporate discipline-specific information into overall team care planning and implementation.
	basic knowledge on demography trends and cultural background of potential users/clients; limitations of different cultures, rituals	take into account the limitations of different cultures guide and support the multicultural client by descriptions of cultural traditions, living environments and service opportunities in a new country	accepting practices and limitations of different cultures and religions

Possible LEARNING UNITS	LEARNING OUTCOMES		
	KNOWLEDGE	SKILLS	COMPETENCES
	delivering services to support and strengthen our culturally diverse community; sexuality and shame; hygiene; ethics and cultural traditions.	understand the sense of community and interacts with the family and friends of the client, take the client's wishes into consideration Guide and support the person in need in expressing his sexuality (e.g communicating with the opposite sex).	assists and guides the client in tending to personal hygiene and dressing and recognizes special problems

10 CONCLUSIONS

This report is referring the skill and competency needs in the homecare sector. The report based on findings of experiences of earlier ECVET projects, questionnaires of HHCP, structured interviews of older persons in CARESS project partner countries Italy, Spain and Finland as well comparing the skills gap with exiting curricula and the roles and competencies of HHCP. The report will compare HHCPs in Europe on the level of EQF, NQF and ESCP data. At the end this report will make conclusion of the situation and competence needs' based on the earlier reports 2.1, 2.2 and 2.3.

The result of the analysis of data collected through HHCP interviews show that there are some gaps comparting them with the EU(EU SKILLS PANORAMA, 2014) and national levels guidelines, that identify the skills and competences that will be the key elements for the future homecare services delivery: focusing on a global, multi-perspective and multidisciplinary view of the patient/client (improving his/her perception of the quality of life), descripting in detail the roles of each HHCP in order to avoid gaps and overlapping in the integrated service provision and identifying specific tools and documentations of HHCPs' activity.

Chapter 8 reviews analyses of skills and competency gaps compared to existing curricula with the roles and competencies of each HHCP. Human Healthcare and Social work activities Group of (2013-2015) in ESCO described about 100 different occupations (Nursing, Heath Care, (Registered) Social Worker, Social Services, Social Care). However, they did not identify occupations in homecare sector. There are some challenges with translations and some new occupations are missing. Social and health care system is in changes, in some countries the new law will change the service system and (vocational) qualifications. CARESS project will propose a new description of HHCPs (occupations, skills and competences) for ESCO. The describing of HHCPs' occupations in European countries based on EQF, NQF and ESCO classification and will be in process during next years.

Chapter 9 sums up and lists identified skills' gap in Italy, Spain and Finland. Identification of HCCPs' training needs in terms of learning outcomes will list the skill gaps as well propose for each HCCP as set of learning outcomes grouped to possible units. Italians partners focus on the Italian professionals for which they retrieved more information and for which professional associations or institutional agencies could give feedbacks: Nurse, Physiotherapists and Social Health Operators, Homecare Assistants. Spanish partners focus HCCPs who are part of a multidisciplinary nursing team: Practical nurse, Homecare assistant, Socio sanitary care technician, Physiotherapist, Occupational therapist and Speech therapist.

In Finland most usual home health care professional (HHCP), who's working in home health care sector is practical nurse and Finnish partners described new units/learning outcomes for practical nurse.

11 ATTACHMENTS

11.1 APPENDIX 1.Multidisciplinary or core competences in the Care of Older Adults at the Completion of the Entry level of Health Professional Degree

	Domains
	Domain 1: Health Promotion and Safety
1	Advocate to older adults and their caregivers interventions and behaviours that promote physical and mental health, nutrition, function, safety, social interactions, independence, and quality of life.
2	Identify and inform older adults and their caregivers about evidence-based approaches to screening, immunizations, health promotion, and disease prevention.
3	Assess specific risks and barriers to older adult safety, including falls, elder mistreatment, and other risks in community, home, and care environments.
4	Recognize the principles and practices of safe, appropriate, and effective medication use in older adults.
5	Apply knowledge of the indications and contraindications for, risks of, and alternatives to the use of physical and pharmacological restraints with older adults.
	Domain 2: Evaluation and Assessment
1	Define the purpose and components of an interdisciplinary, comprehensive geriatric assessment and the roles individual disciplines play in conducting and interpreting a comprehensive geriatric assessment.
2	Apply knowledge of the biological, physical, cognitive, psychological, and social changes commonly associated with aging.
3	Choose, administer, and interpret a validated and reliable tool/instrument appropriate for use with a given older adult to assess: a) cognition, b) mood, c) physical function, d) nutrition, and e) pain.
4	Demonstrate knowledge of the signs and symptoms of delirium and whom to notify if an older adult exhibits these signs and symptoms.
5	Develop verbal and nonverbal communication strategies to overcome potential sensory, language, and cognitive limitations in older adults.
	Domain 3: Care Planning and Coordination Across the Care Spectrum (Including End-of-Lige Care)
1	Develop treatment plans based on best evidence and one person-centred and directed care goals.
2	Evaluate clinical situations where standard treatment recommendations, based on best evidence, should be modified with regard to older adults' preferences and treatment/care goals, life expectancy, co-morbid conditions, and/or functional status.
3	Develop advanced care plans based on older adults' preferences and treatment/care goals, and their physical, psychological, social, and spiritual needs.
4	Recognize the need for continuity of treatment and communication across the spectrum of services and during transitions between care settings, utilizing information technology where appropriate and available.
	Domain 4: Interdisciplinary and Team Care
1	Distinguish among, refer to, and/or consult with any of the multiple healthcare professionals who work with older adults, to achieve positive outcomes.
2	Communicate and collaborate with older adults, their caregivers, healthcare professionals, and direct-care workers to incorporate discipline-specific information into overall team care planning and implementation.
	Domain 5: Caregiver Support
1	Assess caregiver knowledge and expectations of the impact of advanced age and disease on health needs, risks, and the unique manifestations and treatment of health conditions.
2	Assist caregivers to identify, access, and utilize specialized products, professional services, and support groups that can assist with care-giving responsibilities and reduce caregiver burden.
3	Accurately identify clinical situations where life expectancy, functional status, patient preference or go Know how to access and explain the availability and effectiveness of resources for older adults and caregivers that help them meet personal goals, maximize function, maintain independence, and live in their preferred and/or least restrictive environment.
4	Evaluate the continued appropriateness of care plans and services based on older adults' and caregivers' changes in age, health status, and function; assist caregivers in altering plans and actions as needed.

	Domain 6: Healthcare Systems and Benefits
1	Serve as an advocate for older adults and caregivers within various healthcare systems and settings.
2	Know how to access, and share with older adults and their caregivers, information about the healthcare benefits of programs such as Medicare, Medicaid, Veterans' services, Social Security, and other public programs.
3	Provide information to older adults and their caregivers about the continuum of long-term care services and supports – such as community resources, home care, assisted living facilities, hospitals, nursing facilities, sub-acute care facilities, and hospice care

11.2 APPENDIX 2. European Framework for Qualifications in Home Care Services for Older People

Home care work contents and skills	Knowledge areas	**Personal attributes**
A. Basic Care tasks nursing (geriatric nursing) medical know-how (provision of medicinal products) care work (nutrition, hygiene, errands) evaluation of health (ability to function) and its maintenance B. Tasks supporting basic care home care tasks other home care skills	Client –specific knowledge pertaining to the older persons person Knowledge related to the maintenance of health and functional abilities of the older persons person and rehabilitation Knowledge related to the older person's immediate environment and the services available Knowledge about professional ethics	Interest in working with older persons social (interpersonal skills) e.g. communication skills Observational skills organisational skills Decision-making and problem solving skills