Educational Gerontology

Routledge
Taylor & Francis Group

ISSN: 0360-1277 (Print) 1521-0472 (Online) Journal homepage: http://www.tandfonline.com/loi/uedg20

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To cite this article: Bea Dijkman, Lidwien Reehuis & Petrie Roodbol (2017): Competences for working with older people: The development and verification of the European core competence framework for health and social care professionals working with older people, Educational Gerontology, DOI: 10.1080/03601277.2017.1348877

To link to this article: http://dx.doi.org/10.1080/03601277.2017.1348877

Accepted author version posted online: 28 Jun 2017.
Published online: 28 Jun 2017.

EDUCATIONAL GERONTOLOGY
https://doi.org/10.1080/03601277.2017.1348877

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Competences for working with older people: The development and verification of the European core competence framework for health and social care professionals working with older people

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ABSTRACT

Universities of applied sciences in Europe face the challenge of preparing students in health and social care for working with older people and contributing to the innovations needed in light of the ageing of society, along with changes in the health and social care systems in many countries. Dealing with the special needs of older people and the increasing burden of chronic diseases requires specific competencies for health and social care professionals, as well as an integrated approach to health and social care. Research has found that many educational programs lack adequate preparation for students in health and social care when it comes to the correct competences. To identify the competences needed for all health and social care professionals in Europe, who work with older people, the European Later Life Active Network (ELLAN) has conducted research and developed a verified competence framework. This "European core competences framework for health and social care professionals working with older people" describes roles and competences that students in health and social care programs need to learn in order to provide good care and support for older people. Within the ELLAN consortium, 26 universities of applied sciences from 25 European countries collaborated in this research and development process. The framework has been verified by two Delphi rounds among a group of 21 experts and a group of 21 researchers from 19 countries. The framework includes awareness of diversity and different cultural backgrounds. This makes it a useful document for educational purposes all over Europe.

Introduction

The World Health Organization (WHO, 2017) emphasizes that all countries need to be prepared to address the consequences of demographic trends. In the European region, the proportion of older people aged 65 is already 18% and will increase further to 25% by 2050. The relative importance of the very old is growing at a faster pace than any other age segment of the EU population. The percentage of those aged 80 years or above in the EU-28's population is projected to more than double between 2015 and 2080, from 5.3% to 12.3% (Eurostat, 2016). Ageing populations provide a challenge for both public health and social care systems. The increase in the ageing population means an increase in the number of frail people who are unable to care for themselves. This increased need to provide care for older people covers a wide range of services including residential care settings, health and community services, and hospitals. This growing demand is set against a background of a global shortage

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of skilled healthcare professionals and a lack of interest or desire on the part of these professionals to work within the ageing context (Coffey et al., 2015).

The findings suggest that most students in health and social care programs place working with older people low on their preferred list of future careers (Coffey et al., 2015). However, most students in health and social care programs will be working with older people after they graduate, even if they do not explicitly choose a career in gerontology. Older people have become the largest population in the various care settings: at home, in the community, in hospitals, and in long-term care settings. For example, Holroyd et al. (2009) estimated that, by 2020, 75% of all care delivered by nurses will be for people 65 and older. In addition, other health and social care professionals will also find that they have older people as their main target group. Attitudes toward ageing and lack of interest in working with older people not only diminishes the numbers of health and social care professionals working with this population but may also affect the quality of care older people receive. Healthcare professionals need to have the right skills to manage a more demanding role in the future in order to offer effective services for older people (Engstrom & Fagerberg, 2011).

Various studies recommend educational interventions to enable individuals to develop accurate knowledge about the ageing process. Increased knowledge about older people through education was found to decrease ageist attitudes and responses, resulting in increased interest in working with older people (Coffey et al., 2015; Baumbusch, Dahlke, & Phinney, 2012; Boswell, 2012). Education is clearly able to influence students' competences in terms of working with older people (Koskinen et al., 2015).

Nevertheless, many of the educational curricula for health and social care professionals lack gerontological content (Baumbusch et al., 2012; Schuurmans, Habes, & Strijbos, 2012).

Taking this situation into account, the ELLAN consortium decided to investigate the competences needed in healthcare and social care, to work with older people, and which needed to be addressed in the curricula for these groups of students. The aim was to identify those competences that all health and social care students should learn during their training at the Bachelor's level. The consortium, 26 partners from 25 European countries, was funded by the Erasmus Lifelong Learning Program to conduct research and to develop a verified competences framework. The framework needed to be suitable for all the health and social care professions in European countries. Developing a competence framework for working with older people in general was not easy, but doing so for multidisciplinary professions and in a European context was a real challenge. Healthcare systems vary from country to country, and there are cultural differences in dealing with health and older people. This was taken into account by formulating competences and performance indicators. Cultural sensitivity was included in the framework. In addition, we had to verify the competence framework in the various countries. This article describes the development of this competence framework and verification process. The main research question was: "What are the competences that all health and social care professionals at the Bachelor's level need to have in order to work with older people?"

Background

For the purposes of our project, a professional in health and social care for older people was defined as a person who systematically provides direct and indirect professional care and support to individuals or communities of people aged 65 and older, and their families. Health and social care is a generic term used to refer to the whole of the health and social care infrastructure in the public and private sectors. These constitute care and support services in various settings: promotional, preventive, supportive, disease managerial, rehabilitative, palliative and terminal care, and short-term and long-term care. Health and social care professionals are able to handle increasing levels of support, with transitions if necessary across various care settings.

Older people, and especially frail older people, may have problems that interact with each other, such as cognitive restrictions, handicaps, psychosocial problems, multi-morbidity, poly-pharmacy, and social isolation. "The changed pattern of disease and the sheer increase in the numbers of older people results in many more frail older people who live with multiple conditions. This requires either

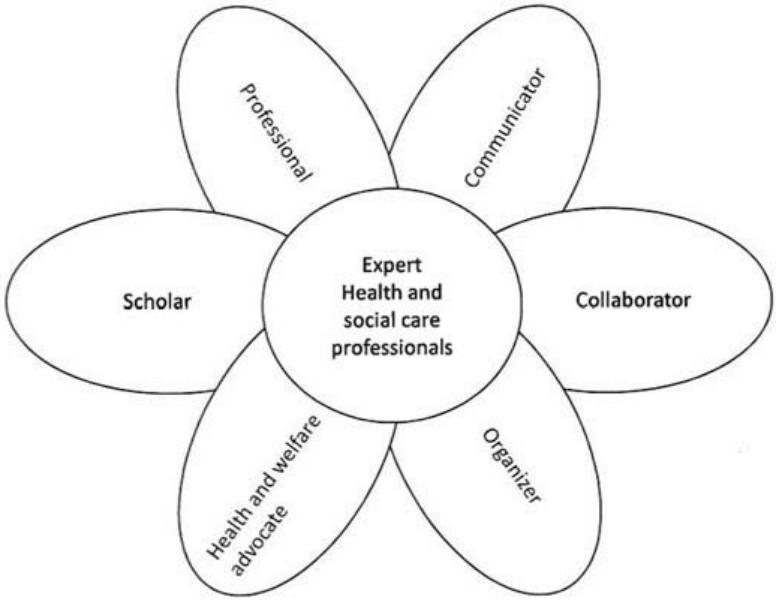

Figure 1. Role model for health and social care professionals working with older people.

health or social care or, very often, both" (Barker et al., 2014). Far better integration of health and social care also requires the professionals working with these older people to have specific competencies built around the older person's needs—not strictly segregated by the professional boundaries dividing health and social care.

For the purposes of our project, the CanMEDs role model was used for organizing the competences into different roles. The CanMEDs role model consists of seven roles: (Medical) Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar, and Professional (Royal College of Physicians and Surgeons Canada, 2005). This role model was modified for health and social care professionals working with older people (see figure 1). Worldwide, the CanMEDs has been used in a modified way for other professionals as well, such as occupational therapist, midwives, nutrition counselors, registered nurses, and other professionals (Sottas, 2011).

Competences working with older people: Literature review

The ELLAN consortium began by conducting an extended literature review in the scientific and gray-area literature in eleven European languages. The research question for the literature search was: "For the care and support of older people, which competences of health and social care professionals (nurses, physiotherapists, mouth hygienists, nutrition/dietician, social and occupational workers) are needed for professionals working at the Bachelor level?" In total, 228 studies were included, and the information about competences was systematically analyzed using the CanMEDs role model (Roodbol et al., 2016).

Furthermore, several complete competence sets for working with older people were found. Witt and colleagues (2014) identified and analyzed the necessary generic competences in primary healthcare when caring for older adults in Brazil. They arrived at twenty-eight competences by consensus, and these were classified into twelve domains: clinical thinking, communication, assessment, technical skills, health promotion/risk reduction/disease prevention, illness and disease management, information and healthcare technology, ethics, healthcare systems and policy, providers of care, designer/manager/coordinator of care, and member of a profession. These domains are found in the CanMEDs terms: expert, communicator, organizer, health advocate, and professional. The American Geriatrics Society set up the Partnership in Ageing (PHA) working group (2010) and developed the set of "Multidisciplinary Competencies in the Care of Older Adults at the Completion

of the Entry-level Health Professional Degree," a baseline for geriatric and gerontology training in any healthcare discipline that contributes to the care of older people. The PHA consists of ten different health disciplines (Dentistry, Medicine, Nursing, Nutrition, Occupational Therapy, Pharmacy, Physical Therapy, Physician Assistants, Psychology, and Social Work). They identified six domains of competences: health promotion and safety, evaluation and assessment, care planning and coordination across the care spectrum (including end-of-life care), interdisciplinary and team care, caregiver support, and healthcare systems and benefits. These domains accord with the CanMEDs roles of communicator, collaborator, health advocate, manager, and professional. Taipale-Lehto and Bergman (2013) stated that common competences and skills needed in future work with older people—according to various scenarios, sub-fields, and professions—were the following: (1) skills in client-centered action and quality thinking, (2) interdisciplinarity and multi-professionality (service coordination), (3) innovation skills (skills in developing one's own work), (4) ethical competence and accountability/responsibility, (5) holistic knowledge of human functions, (6) competence in multiculturality, and (7) knowledge of guidelines, rules, and legislation. These competences are encompassed by the CanMEDs roles of expert, collaborator, and professional, with special attention paid to multiculturality and ethical competences, as well as accountability. The European Framework for Qualifications in Home Care Services for Older People—EQUIP and EQUIPII projects (Salonen, 2009) used online tools (a database and the Home Care Competence Test) in order to compare home care qualification requirements, training, and good practices in Denmark, Estonia, Finland, Great Britain, the Netherlands, Spain, Bulgaria, Greece, and Turkey. As part of this project, a report entitled "Home Care for older people—Good practices" identified the contents of home care work and occupational skills required for the care of older people in the twenty-first century. Based mainly on Finnish research, they addressed three main domains, namely skills, knowledge, and attitudes, which were considered essential competences for formal home care for older people, whose content was comparable with the CanMEDs roles of expert, communicator, health advocate, manager, and professional. Nederland and Van Vliet (2009) developed evidence-based directions for health promotion for the care of the older people in the European Union. They emphasized the empowerment of the elderly (health advocacy), health promotion through working in an interdisciplinary way (collaborator), good (financial) management (manager), and evidence (professional). Roodbol and colleagues (2016) concluded that the care and support of older people was very complex. Sometimes communication with older people required special skills. A multi-disciplinary team approach was absolutely necessary. Collaboration and communication were essential competences needed not only to optimize the team approach but also to address the individual needs (including prevention and health advocacy) of older people. Collaboration with the older person and other informal caregivers was important as well.

Competences for professionals from the perspective of older people

When developing a competence framework for working with older people, the perspective of older people themselves is also important. Although the amount of literature about this is not abundant, several studies have underlined the importance of person-centered relationships, focused on individuals and on personalized care (Soares & Marques et al., 2015). For instance, in relation to nursing, Van der Elst, Dierckx de Casterle, and Gastmans (2012) concluded that, even though participants found technical knowledge and skills shown during physical care to be important attributes, these seemed to be interconnected with the nurse's attitudes in such a way that the former could not be performed adequately without the latter. It seems that the relational aspects of care and the psychosocial characteristics of carers are more often mentioned by older people as being important, when compared to technical aspects of competence (Soares & Marques et al., 2015). These results were confirmed in a research project conducted within the ELLAN consortium. In six countries (Austria, Finland, Lithuania, Portugal, Turkey, and the UK) a qualitative research project was conducted to explore older people's perceptions and ideas about the required and desired

competences of professionals working with older populations in different European countries. Specifically, it aimed at identifying and analyzing the meaningful dimensions emphasized by older European citizens, considering their their personal experiences with health and social care professionals. Each of the six partner countries selected a convenience sample of 16 participants, making 96 older people in total. Globally, participants were living either alone/with family or were institutionalized, without cognitive impairments, and experienced differing health conditions. According to the interviewees, this acknowledgment can be achieved through means of communication and positive relationships between professionals and service users. The participants expressed their desire to be cared for by professionals who were experts and experienced in their field of work, skilled in technical procedures, with specific knowledge about ageing processes, and who were able to work in teams. Personal vocation and commitment to the profession, compliance with the professional code of ethics (in terms of values, attitudes, and behaviors) were also relevant within the context of care (Soares & Marques et al., 2015).

When comparing these findings with the CanMEDs roles, personal and interpersonal aspects of care were found to be broadly reflected in the roles of communicator and health advocate, while technical/professional dimensions appeared to be more associated with the expert, collaborator, manager, scholar, and professional roles. When describing the desired relationship with professionals, older people highlighted emotional aspects that they valued highly during the provision of care, namely kindness, friendliness, and compassion. Descriptions of these affective and emotional aspects have also appeared in other studies (Rodriguez-Martin, Martinez-Andres, Cervera-Monteagudo, Notario-Pacheco, & Martinez-Vizcaino, 2013) and seem to mirror an important component of care for this target group.

The competence framework

The findings of the literature review, together with the information from the interviews with older people themselves, were used to develop the competence framework. The competence framework describes the outcomes that professionals working with older people in different roles are expected to achieve and be able to demonstrate. The competence framework contains role descriptions of professionals working in health and social services, based on the seven adjusted CanMED roles (Royal College of Physicians and Surgeons Canada. CanMEDs, 2005). For each role, competences were formulated, making 18 in total. Each competence was elaborated in performance indicators, with 182 in total.

Within this framework, competences are defined as job-related descriptions of an action, behavior, or outcome that should be demonstrated in an individual's performance. Competences are person orientated, referring to a person's underlying characteristics and qualities, which lead to effective professional performance (McMullan et al., 2003). Performance indicators, in the context of the competences, are defined as skills, behaviors, or practices that demonstrate the existence of the competence. For each competence, the performance indicators are described in terms of active verbs. The ability of an individual to deal with complexity, unpredictability, and change determines his or her level of competence. The competence framework aligns with the Bachelor's level, the European Qualifications Framework (EQF) level 6 (Bologna Working Group on Qualifications Frameworks, 2005).

Roles and competences

The seven roles for professionals in health and social care, and services working with older people, are defined as: Expert, Communicator, Collaborator, Organizer, Health and Welfare Advocate, Scholar, and Professional. The major difference between the original CanMEDs and the description of the seven roles for health and social care professionals working with older people is an autonomous understanding of the role of the expert. While in the CanMEDs framework the role of the

expert is understood as an integration of (or the resulting performance in) all the other roles, in this case, it is described as profession-specific competences. The term "expert in…" is based on professional knowledge and skills acquired during formal education. It enables the expert to act professionally and autonomously in his/her professional practice and in specific situations. The role of the expert is specific to each profession, and it entails reflecting the function and role as well as the positioning of the specific profession in a given societal and health policy context. One can be called an "expert in…" when the professional knowledge involved makes an independent assessment in a specific field of expertise possible. The depth and the breadth of knowledge and skills vary depending on the profession, but they are always present and comply with the requirements for professional qualification. The expert role, in this competence framework, includes those competences that are needed for all professionals who work in health and social care, and who specifically work with older people.

The central role, based on professional expertise, is strengthened by other supportive roles or competence areas, which are more or less equal for all health and social care professionals but with divergent focuses or emphases.

1. Expert

The health and social care of professionals involves a defined body of knowledge, along with disciplinary and procedural skills and attitudes, which are directed toward effective support of older people, centered on wellbeing and health. These professionals understand into the ageing process, the diversity of the older population, and their health and social needs. The care and support for the older person is not only characterized by the maintenance of his/her physical and mental state but also by autonomy and participation despite the ageing process. The older person is seen as a unique, complex, and unitary person in his or her system (personal situation), and as a partner in the health and care, as well as the services, provided by professionals. This vision of the professional is holistic, person-centered; he/she forms a collaborative relationship with the older person and his/her supportive family, along with—as a major added value—their individual autonomy. Family-support interventions benefit older people's wellbeing, while improving service access and satisfaction (Heller, Gibbons, & Fisher, 2015). Professionals apply to collect, interpret, and analyze information; make appropriate decisions and plans; and carry out diagnostic and (therapeutic) interventions and supportive methodologies within the context of their profession, and evaluate their effectiveness. This means providing support (information, emotional support, tangible help, or integration) and, if indicated, providing care (prevention, self-care support, disease management, highly complex care) for older people in all conceivable situations, including palliative and terminal conditions. They do so within the boundaries of their discipline, taking into account the narrow connection between health and social care. They are aware of their own personal expertise, the setting, and the older person's preferences, potentials, and context.

The competences required for this role are:

(a) Assessment: Conduct an appropriate assessment and collect data in a systematic way from the older person and, when necessary, from his/her family or caregivers about the physical and mental wellbeing, housing conditions, and social participation of the older person, as well as identifying his/her needs and wishes.
(b) Analysis and problem identification: Analyze the data collected from the assessment. Identify the problems and the risk factors for the older person and his/her family. Formulate a conclusion or, when applicable, a diagnosis.
(c) Planning: Develop a clear, timely, and appropriate individual plan with measurable objectives for the care and support of the older person and his/her family with a focus on optimum health, wellbeing, and quality of life. Use the techniques for shared decision-making.
(d) Carry out interventions based on professional standards: Provide care, help, and support to the older person and his/her family in order to improve or prevent further decline in mental

and physical wellbeing, housing, and living conditions and social participation. Carry out interventions based on professional standards.
(e) Evaluation: Re-evaluate and adjust service or care plans for the older person on a continuing basis, with the goal of providing optimum care and support for the wellbeing of the older person and his/her family.

2. Communicator

Professionals in health and social care facilitate communication centered on older people in formal and informal situations through shared decision-making and effective interactions/methodologies with older people themselves, and their family and informal supporters. They work within the context of the personal situation and living conditions, and take into account the level of support needed, the level of literacy, and the sensory possibilities. The competences of this role are essential for establishing rapport and trust, formulating a diagnosis and goal interventions, delivering information, striving for mutual understanding, and facilitating a shared plan of (increasing levels) of support. The application of these communication competences, along with the nature of the professional health and social care and services involved in the relationship with older people, varies according to different occupations and forms of practice, both formal and informal. The competences required for the communicator role are:

(a) Maintaining relationships and effective communication: Form strong positive relationships with older people and their families, based on empathy, trust, respect, and reciprocity. Communicate in a clear and effective way, while taking into account the older person's individuality, dignity, personal and social background, and needs.
(b) Empowerment: Promote capacities and resources in older people and their families so that they can regain control over their lives and achieve their own goals according to their needs and expectations. Contributing to the improvement of the older person's autonomy, independence, wellbeing, and quality of life.
(c) Coaching: Stimulate, motivate, and coach the older person in terms of self-management, self-reliance, and co-reliance.

3. Collaborator

Professionals in health and social care effectively work together with other professionals to achieve optimum support and care, if needed, for older people, with as goal optimizing their health and wellbeing and quality of life in multiple locations. It is essential to collaborate effectively within the multidisciplinary team that provides the care and services for the older person and their family. Professionals in health and social care also work together with people outside the framework of organized, paid, professional work. Informal care and support have increased in many countries, with the adoption of community care policies that increasingly rely on care provided by family, relatives, and friends, often women. Collaboration is a relationship-centered process based on trust, respect, and shared decision-making. This can occur in a team with informal caregivers or a professional team, as well as together with municipal and governmental institutions. It involves sharing knowledge, perspectives, and responsibilities, along with a willingness to learn together. This requires understanding the roles of others, pursuing common goals and outcomes, and managing differences. The competences required for the collaborator role are:

(a) Integral cooperation and integrated services: Work effectively together with other professionals for integrated care and support. Multi- and inter-professional cooperation to achieve optimum support and care for older people, with the goal of optimizing their health and wellbeing, as well as quality of life in multiple locations.

(b) Informal care and support: Work together with older people's supportive families, informal caregivers, and their social network, and stimulate informal care and support.

4. Organizer

Professionals in health and social care organize and manage care and services for older people. Particularly during transitions, they focus on integral connectivity, and continuity of care and support for older people. They actively plan and coordinate. They are able to demonstrate leadership in the team and are able to chair meetings. They contribute to the improvement of care and services for older people in teams, organizations, and systems. They interact with their social and health systems locally, regionally, and nationally. They take an active part in developing, adapting, and implementing long-term policy actions for the care and services of older people on a national, regional, local, or organizational level. The competences element of the Organizer role are:

(a) Integral cooperation and integrated services: Work effectively together with other professionals for integrated care and support. Multi- and inter-professional cooperation to achieve optimum support and care for older people, with the goal of optimizing their health and wellbeing, as well as quality of life in multiple locations.
(b) Informal care and support: Work together with older people's supportive families, informal caregivers, and their social network, and stimulate informal care and support.

5. Health and welfare advocate

As a health and welfare advocate, professionals try to influence and improve the health and well-being of older people and their families/networks. They focus on individuals, groups, communities, or the populations they serve in order to determine and understand needs and develop partnerships. They speak on behalf of older people, when necessary. This encompasses prevention, health promotion, and health protection, whereby individuals and populations can reach their full health potential without being disadvantaged by race, ethnicity, religion, gender, sexual orientation, age, social class, economic status, or level of education. It also involves efforts to change specific practices or policies on behalf of older people, and to decrease the negative effects of the ageing process through education and stimulation of active ageing. As a health and welfare advocate, professionals in health and social care use their expertise and influence to assist older people and their families in navigating the health and social care systems in order to find the appropriate facilities for the individual or population in a timely fashion. Advocacy requires partners and networks. Professionals work together with older people and their families, along with support networks, community agencies, and organizations, in order to influence the determinants for health and wellbeing. They know how to reach the target groups and are able to use social media for this, when appropriate. The competences required are:

(a) Collective prevention and health promotion: Advocate for health with and on behalf of older people and their families, communities, and organizations in order to improve their health and wellbeing and to build the capacity for health-promoting activities.
(b) Social map and social networks: Access and share information about the social map, health-care benefits, social support, and public programs with older people, their families, and their caregivers.

6. Scholar

As scholars, health and social professionals pursue excellence by continually evaluating the processes and the outcomes of their daily work, sharing and comparing their work with that of others, and actively seeking feedback in the interest of the quality of care and support for older people and their families, as well as on the organizational level. As lifelong learners, they implement a planned approach to learning in order to achieve improvement in each of the roles (the 7 CanMeds-based

roles). They employ multiple ways of learning. They demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application, and translation of knowledge about older people, as related to their occupation and domain of expertise. The aim is to increase the quality of support, and care and services, through the implementation of new evidence-based practice and knowledge dissemination. Competences are:

(a) Expertise: Expand their own professional expertise in terms of their own professional practice, one that involves working with older people and their families. Spread relevant new evidence-based research among fellow professionals and other professionals in health and social care and services.
(b) Innovation of care and support: Interpret the evidence-based results of research and contribute to the development of knowledge and practical research in applied science in relation to the provision of care and support for older people and their families. Implement and apply new insights, protocols, standards, procedures, and technologies within the context of promoting the quality, efficiency, and effectiveness of the care and services provided to older people and their families.

7. Professional

In the role of "professional," professionals in health and social care are committed to the wellbeing of older people individually and in a societal context, through ethical practice, profession-led regulation, and high personal standards of behavior. The professional role is guided by codes of ethics and a commitment to the state of the art of their profession, along with embracing appropriate attitudes and behaviors, integrity, altruism, and personal wellbeing. These commitments form the basis of a social contract between the health and social professional, and older people and their supportive families. The competences required are:

(a) Professional ethics: Demonstrate commitment to best practices in terms of the health and wellbeing of individual older people, their families, and society through adhering to ethical standards and profession-led regulation and by showing high personal standards of behavior.
(b) Professional commitment and personal awareness: Reflect on one's own actions, and improve and innovate one's professional behavior in order to attain the highest quality of care and support possible for older people and their families. Demonstrate commitment to the health and wellbeing of older people and their families. Display an awareness of diversity and cultural differences.

Method for verification

The Delphi technique was chosen for verification of the competence framework. The Delphi method is based on the results of several rounds of anonymous questionnaires sent to a panel of experts. Because the draft competence framework was based on an extensive literature review and actual research outcomes, two rounds of Delphi questionnaires were enough for verification. The objects of the questions were the 18 competences and the performance indicators. The level of consensus used was 70% (Hassan, Keeney, & McKenna, 2000). Items with a lower level of consensus were removed from the competence framework.

The respondents were asked to give their opinion anonymously on the importance of the 18 competences on a 5-point Likert scale. The question for each competence was: "Is the competence important for professionals in health and social care working with older people?" For counting the consensus level on the competences, the numbers on the answers "very important" and "extremely important" were combined.

The 18 competences were elaborated in performance indicators, with 182 in total. For the 47 performance indicators that were part of the assessment of competence, the request was: Please check the box for those items the professional should be able to include in the assessment about mental wellbeing, physical wellbeing, housing and living conditions, or social participation and functioning. For the other 135 performance indicators, we asked about the respondents to check off those performance indicators that were important. The request was: "Please check the box for those performance indicators that the professional in health and social care should be able to demonstrate." The respondents were asked to add indicators for each competence performance that was missing and to make additional remarks, if desired.

Respondents

Two different groups of respondents were selected for the Delphi research: a group of professional experts and a group of researchers. Experts were chosen in eight countries spread over Europe: the Netherlands, Ireland, Poland, Portugal, Belgium, Finland, Austria, and Greece. For these eight countries, three experts were selected: one from the nursing discipline, one from the discipline of social work, and one from another relevant healthcare discipline (see Table 1). All experts needed to meet the following criteria: a professional background with educational level EQF 6 or 7 both in one of the professions and in care for older people, actual work experience in professional practice in working with older people for at least five years, a good level of English, and a willingness and ability to spend at least one hour filling in the questionnaire in the first and second round. In seven countries, three experts filled in the questionnaires; only Ireland was missing, due to organizational circumstances. The response was 21 out of 24 (88%) in the first round. In the group of experts the response rate in the second round was 20 (95%) spread over seven countries.

From each university of applied sciences involved in the ELLAN project, one researcher working with older people was selected from the field of health and social care. To make sure that the researchers were approximately equally spread over the different disciplines and over different parts of Europe, the available researchers were identified. The research team made a sample of 25 researchers in the nursing discipline, in the discipline of social work, and in one other relevant healthcare discipline. In total, 21 of the 25 researchers filled in the questionnaire in the first round, a response rate of 84%. The response rate of the second round in the group of researchers was 18 (86%), spread over 18 countries. The largest group of respondents came from the nursing discipline. In the group of other professions, there were, for example, gerontologists, dieticians, and oral hygiene therapists.

Results of the Delphi research

The level of agreement was high. Already in the first round, all competences had a consensus level of 70% or higher in both groups (see Table 2). There was only one exception, that is, the competence involving "Access and share with older people, their families and their caregivers, information about the social map, healthcare benefits, social support, and public programs." The experts scored this as only 66% important, while researchers gave it an 86% score for importance. Because all performance

Table 1. Field of profession of the respondents.

Field of profession of the respondents	Experts (n = 21)		Researchers (n = 21)	
Nursing	8	38.1%	6	28.6%
Social Work	5	23.8%	2	9.5 %
Physiotherapy	4	19.0%	3	14.3 %
Occupational therapy	1	4.8%	2	9.5%
Other	3	14.3%	8	38.1%

Table 2. Competences and level of consensus—results of Delphi research round 1.

		Level of consensus experts (n = 21)		*Level of consensus Researchers (n = 21)*		*Average consensus level*
Role	*Competence*	*n* (agree)	%	*n* (agree)	%	
1. Expert	Assessment	20	95.2	21	100	97.60%
	Analysis and problem identification	19	90.5	21	100	95.25%
	Planning	18	85.7	20	95.2	90.45%
	Carry out interventions based on professional standards	16	76.2	19	90.5	83.35%
	Evaluation	19	90.5	21	100	95.25%
2. Communicator	Maintaining relationships and effective communication	20	95.2	21	100	97.60%
	Empowerment	21	100	19	90.5	95.25%
	Coaching	19	90.5	20	95.2	92.85%
3. Collaborator	Integral cooperation and integrated services	20	95.2	21	100	97.60%
	Informal care and support	18	85.7	20	95.2	90.45%
4. Organizer	Planning and coordination of care and services	20	95.2	21	100	97.60%
	Program of care	16	76.2	19	90.5	83.35%
5. Health and welfare advocate	Collective prevention and health promotion	18	85.7	20	95.2	90.45%
	Social map and social networks	14	66.7	18	85.7	76.20%
6. Scholar	Expertise	18	85.7	21	100	92.85%
	Innovation of care and support	19	90.4	21	100	95.20%
7. Professional	Professional ethics	20	95.2	21	100	97.60%
	Professional commitment and personal awareness	20	95.2	21	100	97.60%

indicators that belong to this competence were noted as being important, and the average between the two groups was 76.2%, we decided to include this competence in the framework.

The group of researchers showed a slightly higher level of consensus than the group of experts. The average importance of the competences was 97% for the group of researchers and 88% for the experts.

Table 3. Performance indicators with low consensus level.

	Level of consensus by the group of experts				Level of consensus by the group of researchers			
	First round n = 21		*Second round n = 20*		*First round n = 21*		*Second round n = 18*	
Performance indicator	*n* (agree)	%	*n* (agree)	%	*n* (agree)	%	*N* (agree)	%
Part of the assessment of mental wellbeing: Signs and symptoms of delirium	15	71.4	20	100	14	66.7	15	83.3
Part of the assessment of mental wellbeing: Spirituality, religion	10	47.6	12	60.0	14	66.7	12	66.7
Part of the assessment of physical functioning and wellbeing: Diseases such as pneumonia and flu	12	57.1	18	90.0	15	71.4	12	66.7
Part of the assessment of social participation and functioning: Use of computer/Internet/social media	14	66.7	14	70.0	20	95.2	15	83.3
Write the plan according to the standards and regulations of the organization and the profession.	14	66.7	18	90.0	19	90.5	17	94.4
Apply IT and ambient assisting living technologies effectively and safely.	13	61.9	18	90.0	18	85.7	14	77.8
Demonstrate leadership in the team and an ability to chair meetings.	13	61.9	17	85.0	16	76.2	14	77.8
Participating in policy meetings.	11	52.4	11	55.0	10	47.6	10	55.6

Table 4. Performance indicators to add to the competence framework.

It is important for professionals in health and social care to be able to include the following items in the assessment, as stated below	*Level of consensus Experts n = 20*		*Level of consensus researchers n = 18*	
	n (agree)	%	*n* (agree)	%
Feelings about the future (death anxiety)	17	85.0	17	94.4
Oral health, chewing, and swallowing	19	95.0	17	94.4
Sleeping habits and problems	19	95.0	18	100
Fainting and dizziness	16	80.0	15	83.3
Frailty	17	85.0	14	77.8
Adequate use of aids, devices, and prostheses	18	90.0	16	88.9
Sleeping habits and problems	18	90.0	18	100
Transport facilities	16	80.0	14	77.8
Use of assistive technology	16	80.0	17	94.1
Availability of resources in the neighborhood (stores, etc.)	18	90.0	16	88.9
Coaching competence (being aware of feelings of uncertainty and encouraging the older person, if necessary)	20	100	17	94.4

Out of the 182 performance indicators that were part of the first round of the Delphi research, there were 8 performance indicators with a level of agreement lower than 70%, as scored by one of the two groups of respondents (see Table 3).

Out of these eight items, only two performance indicators were found to be less important by both the group of experts and researchers. These were: "Include spirituality and religion in the assessment" and "participate in policy meetings." In the second round, the same questions were asked for these two performance indicators. Although the level of consensus was slightly higher, it still did not meet the criterion level of 70%. The other six performance indicators were rated at a level of importance lower than 70% by only one of the two groups. In the second round, we again asked both groups the same question about these performance indicators, together with providing information from answers from the first round. Then all the six performance indicators were rated with a higher level of consensus by both groups. We made an exception for the performance indicator about pneumonia and flu, because the level of consensus was so close to 70% and the average of the two groups was far above 70%.

The respondents were also asked to provide comments about and add suggestions for performance indicators for each competence. After analyzing these comments, we suggested adding nine performance indicators to the competence "assessment" (see Table 4). These involved the assessment of mental wellbeing: feelings about the future (death anxiety), and sleeping habits and problems; in the assessment of physical functioning and wellbeing: oral health/chewing and swallowing, fainting and dizziness, frailty and adequate use of aids, devices, and prostheses; and in the assessment of housing and living conditions: transport facilities, use of assistive technology, and availability of resources in the neighborhood (stores, etc.). In addition, one performance indicator was added to the coaching competence: "confirmation and acceptance."

Discussion

The strength of the development and verification of the competence framework is the international collaboration between 26 universities of applied sciences, coming from 25 European countries. The framework provides a complete overview of the competences, since it is built upon an extensive literature review in eleven languages, along with findings from interviews with older people themselves in six countries. The framework is not only verified by nursing professionals but also by experts and researchers from the field of social work and other allied healthcare disciplines. The framework combines specifications of current best practice with realistic future expectations.

One weakness was the use of the five-point Likert scale in the first Delphi round for the questions about the importance of the competences. This could have been improved by using a three-point or even a two-point scale. There was no added value in differentiating between "agree" and "totally agree" in terms of the competence framework. Therefore, the answers "agree" and "totally agree" were combined, and viewed as one and the same answer in our analysis of the results.

Another limitation of the competence framework is that spirituality and religion were not included. Both groups, experts and researchers alike, rated this performance indicator (part of the competence assessment of mental wellbeing: "spirituality and religion") with a consensus level lower than 70%. Although the consensus level increased from 48% in the first round to 67% in the second round for the experts, it still did not reach consensus level. The researchers rated this performance indicator as being important in both rounds with 67% consensus, which was also lower than 70%. Therefore, it was left out of the competence framework. It is questionable whether this was the right decision. Elderly people have different spiritual needs, and their assessment can help in finding the necessary solutions or resources, such as counseling, spiritual support from a given religious group, participation in religious activity, and contacts with members of the community. However, spirituality and religion, and their impact on health, and also the competencies of health care and social workers in this field, have all pretty much been neglected (Wallace & O'Shea, 2007). In this study of professionals' views on competences needed for working with older people also revealed that most professionals believed that they did not have sufficient knowledge on how to meet spiritual needs; according to these professionals, questions about faith could be awkward. (Felsmann & Andruszkiewicz et al., 2016). Huber and colleagues (2016) found in their research about a patient-centered operationalization of a new dynamic concept of health that there were different views on the part of patients themselves, health care providers, and researchers. They investigated six dimensions comprising bodily functions, mental functions and perceptions, the spiritual dimension, quality of life, social life and social participation, and daily functioning. When it came to the dimension of spirituality, they found that patients themselves rated this as being significant and more important than did healthcare providers and researchers. We might have found different outcomes had we included a group of older people in the Delphi research.

Although many countries were involved, another limitation is that not all European countries were involved; for example, France did not participate in the Ellan project.

Most of the research about competences for working with older people was conducted in the field of nursing. Although different professions were included in our verification research, the largest group of experts also came from the field of nursing. It might be interesting to verify this research, using a more diverse group of experts, and including research from the fields of allied healthcare and social work.

Conclusion

The verification study showed high levels of consensus concerning the competences and performance indicators in terms of both groups: the group of experts and the group of researchers. Therefore, we can conclude that the framework describes the minimum set of competences that constitute a common baseline for all health and social care professionals working with older people in different roles. The competences encompass engaging and working with older people and their families within the context of their environment, that is, the home, community-based settings, and institutions. The competences and performance indicators were worded in such a way that they were applicable in different European countries and in different cultures. This has been confirmed in the verification research with respondents coming from 19 different European countries. This makes the framework a practical instrument to use in an educational context all across Europe. It may help educational institutions improve their education for health and social care professionals. Implementing these competences in the education they offer might also increase the number of students choosing a career in working with older people.

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