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ORIGINAL INVESTIGATION

Older people's views and expectations about the competences of health and social care professionals: a European qualitative study

Célia Casaca Soares[1,2] · António Manuel Marques[1,2] · Pat Clarke[3] · Regina Klein[4] · Liisa Koskinen[5] · Daine Krasuckiene[6] · Evelina Lamsodiene[6] · Viktorija Piscalkiene[6] · Özlem Küçükgüçlü[7]

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Abstract
Adapting and providing quality services for people as they age is a common challenge across Europe. The perspective of older people is fundamental in a person-centred care approach. Expanding research at the European level that explicitly includes their views can offer a relevant contribution to the development of evidence-based guidelines that can be shared in education and training across health and social care professions. This study aimed to identify common meaningful dimensions of professional competence in health and social care emphasised by older people from six countries in different regions of Europe according to their experiences. A qualitative approach was chosen with a total of 95 semi-structured interviews conducted in Austria, Finland, Lithuania, Portugal, Turkey and UK, following a common topic guide. Participants in this study were aged 60 and above, and recruitment considered age, gender, level of education and living arrangements. Results identified a set of universal skills and practices that according to older people, health and social care professionals should meet. Competences at the interpersonal level were central in older people's discourses, and its core dimensions are anchored in relational, communication and socio-emotional skills of professionals. These findings reinforce the aspiration of establishing best practices in care that relies on the harmonisation of a competence framework that can be shared in the training and education of health and social care professionals across Europe and that voices older people's preferences, expectations and needs.

Keywords Health and social care · Professional competences · Older people · Europe · Qualitative research · Person-centred care

Background

Healthy ageing has become a challenge that all modern societies must try to address (United Nations 2009). Living longer healthy and promoting autonomy and participation (World Health Organization 2012) provide a positive vision for the future of populations but also can place additional demands on the need for health and social care. Health and social care systems differ across Europe, however, providing quality services for older people is a common concern. The Strategic Plan of the Steering Group of the European

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✉ Célia Casaca Soares
celia.soares@ess.ips.pt

[1] Department of Social Sciences and Humanities, School of Health, Centre for Interdisciplinary Applied Research in Health, Instituto Politecnico de Setúbal, Campus do IPS, Estefanilha, Setúbal 2910-761, Portugal

[2] Centro de Investigação e Intervenção Social (CIS-IUL), Instituto Universitário de Lisboa (ISCTE-IUL), Av. das Forças Armadas, Lisboa 1649-026, Portugal

[3] School of Nursing and Allied Health, Liverpool John Moores University, Henry Cotton, 15/21 Webster St., Liverpool L3 2ET, UK

[4] Department Health + Social Care, Carinthia University of Applied Sciences, Hauptplatz 11, 9560 Feldkirchen, Austria

[5] School of Health Care, Savonia University of Applied Sciences, PL 6 (Microkatu 1), 70201 Kuopio, Finland

[6] Faculty of Medicine, Kaunas University of Applied Sciences, Pramones pr. 20, 50468 Kaunas, Lithuania

[7] Department of Internal Medicine Nursing, Dokuz Eylul University, Inciralti, İzmir, Turkey

Innovation Partnership on Active and Healthy Ageing (2011) outlined the importance of pursuing a holistic, multidisciplinary approach in care with an emphasis on the active engagement of older people. The inclusion of older people in care will help us to understand their aspirations, values and decisions, supporting health and social care professionals to agree on the appropriate care for the individual (Bastiaens et al. 2007; Tinetti et al. 2012).

The quality of education and training of health and social care professionals working with older people is a central requirement to fulfil such principles. Higher Education Institutions (HEIs) in addition to professional regulators play a pivotal role in the development of innovative expertise related to the promotion of positive ageing (Bardach and Rowles 2012). Within this context, and seeking to make a contribution towards Positive Ageing on Higher Education in Europe, the ELLAN project (European Later Life Active Network) was undertaken between 2013 and 2016.[1] The overarching aim of this project was to develop an agreed European Core Competences Framework (ECCF) for health and social care professionals working with older people across Europe (Dijkman et al. 2016). Results from this project will be used in curricula development across twenty-six HEIs covering a wide number of European countries. The ECCF was developed within a pan-European perspective and seeks to influence education for health and social care professionals at an international level. Hence, this is a promising initiative to foster exchange and cooperation for education and research training in gerontology across Europe (Wahl et al. 2013) considering the interplay of health and social care.

This study was part of the wider ELLAN project and involved six European countries. It aimed to expand research at the European level and offer a relevant contribution to the development of common evidence-based guidelines that can be shared in education and training of health and social care professionals. Considering that care delivered to older people should be underpinned by research that explicitly includes their voice (FUTURAGE 2011), our main aim was to explore the views and expectations of older people about the competences of health and social care professionals. Understanding the views and expectations of older people is fundamental in person-centred care since respect for individual diversity is a basic pillar in this approach (Silva 2014; World Health Organization 2008). Thus, including older people's perspectives in curricula used in education and training of professionals is an effective strategy to ensure it meets their needs.

There are many approaches that seek to identify the competences, according to a set of outcomes, that health and social care professionals need to develop and demonstrate during care. We highlight those related to medicine (e.g. CanMEDS Framework 2005; Epstein and Hundert 2002), nursing (e.g. CGNA 2010), physiotherapy (e.g. Wong et al. 2014), social work (e.g.; NASW 2010) and occupational therapy (e.g. COTEC 2010). On the other hand, research grounded in the experiences of older people about the components of care, and on how these should be expressed by professionals, has started to flourish. Overall, results suggest that older people want personalised care (Bridges et al. 2010; Manthorpe et al. 2008).

Analysis of the literature shows that the preferences of older people in different health and social care contexts can be organised under two main themes: skills and behaviours directly linked to treatment or care (e.g. medication information or specific interventions), and those associated with the nature of relationships and care driving processes (e.g. involvement in decision-making and communication styles) (Lindhiem et al. 2014; Street et al. 2012).

The first dimension emphasises technical and task-oriented aspects of professional competence, which include the ability and expertise manifested during care (Bridges et al. 2010), training in geriatrics and gerontology (Rodriguez-Martin et al. 2013) and specific procedural skills (Van der Elst et al. 2012). In different contexts of intervention, older people value time spent by professionals to give suitable information about issues related to their care and wish to receive clear explanations with patience (Peck 2011).

The second dimension found in the literature is anchored in relational and socio-emotional components of competence in care. The ability to promote positive and reciprocal relationships with older people is central in person-centred care (Berkelmans et al. 2010; McIntyre and Reynolds 2012). Positive relationships require availability of professionals and imply the possibility of shared decision-making (Berkelmans et al. 2010; Janssen et al. 2011). Caring characteristics of professionals such as friendliness and sense of humour, affection, kindness and providing support are also highlighted by older people (Rodriguez-Martin et al. 2013) and contribute to higher levels of satisfaction (Peck 2011).

In general, international literature on health and social care is uni-professional. However, one challenge of conducting research within a specific field of practice is having opportunities to share it across teams, specialties, systems and organisations (McCance et al. 2011). This can lead to a lack of common and shared understanding between different professional groups. Even if each professional group grounds its practice into a set of specific competences and skills, there are many components of care that are common across professional groups working with older people that can be harmonised to pursue higher levels of quality and effectiveness. Conversely, most of the research related to health and social care delivered to older people has a

[1] http://ellan.savonia.fi.

Table 1 Participants' characteristics by country

Country	Age groups			Gender		Level of education			Living arrangements	
	60–69	70–79	≥ 80	Male	Female	Elementary	Secondary	University	Home	Skilled nursing facility
Austria	4	5	6	4	11	6	8	0	10	5
Finland	4	8	4	4	12	*	*	*	16	0
Lithuania	6	8	2	8	8	7	3	6	14	2
Portugal	3	6	7	6	10	14	0	2	12	4
Turkey	4	8	4	8	8	7	5	4	8	8
UK	8	6	2	8	8	*	*	*	16	0
Total	29	41	25	38	57	34	16	12	76	19

*Data not recorded

national or regional character (e.g. Manthorpe et al. 2008; Marcinowicz et al. 2014). Consequently, findings of such studies are related to specific context factors of health and social care of such countries or regions (on the micro, meso and/or macro levels) and can't be fully accounted in a comprehensive, integrated model of interdisciplinary and multiprofessional care for older people in Europe. Additionally, increasing demand for health and social care professionals in some countries and current migration and mobility within Europe may result in qualified human resources moving across borders (Hussein et al. 2013). Therefore, creating a pan-European approach for education and training of health and social care professionals can enhance the quality of care services delivered to older people across Europe, alongside research in this area.

Research aim

This study was part of the ELLAN project and reflects the work developed in the work package 'Older people's views on professional competences'. The aim was to explore older people's views and expectations about the competences of health and social care professionals based on their experiences with a range of professionals. Specifically, it aimed to identify common meaningful dimensions of professional competence in health and social care emphasised by older people from six countries in different regions of Europe.

Methods

To achieve the aim of this study, a qualitative approach was chosen (Howitt 2010). Interviews were conducted in Austria, Finland, Lithuania, Portugal, Turkey and UK to explore the diversity of experiences of older people from different demographic regions of Europe covering North, South, East, West and Central Europe.

Participants

A purposive sample of people aged 60 and above was recruited for this study. Taking account of biopsychosocial diversity during late adulthood, recruitment was based on broad socio-demographic criteria that could be applicable in all countries: old age groups (between 60–69, 70–79 and ≥ 80 years),[2] gender (female, male) and level of education (Elementary, Secondary, University). The sampling criteria also included living arrangements (home, skilled nursing facility) to cover views about care that may be associated with different levels of autonomy, independence or frailty.

The recruitment process varied from country to country. Overall it included contacts with managers of private or public skilled nursing facilities and municipal or local associations providing services for older people and working closely with the HEIs involved in this study. The details about the study were shared in each setting, and people interested in the research topic volunteered themselves as participants. People living at their homes were also approached by contacts of some researchers and through a municipal association of older people (in the Finnish sample) using a snowball sampling method.

In each country a sample of around sixteen participants was selected after receiving clear information about the aims of the study and signing an informed consent. Ninety-five people in total were interviewed in this study. Characteristics of the participants by country are illustrated in Table 1. The mean age of the total sample was

[2] Definition of age groups based on National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services & World Health Organisation (2011).

Table 2 Interview topic guide

Warming-up:
When you think about health and social care professionals in a general way, how would you describe these professionals?
Central Questions
A. Relational and communicational aspects
When you think about the meetings you have had with health and social care professionals, how would you describe this experience in terms of:
The ways professionals relate with you?
The ways professionals communicate with you?
(Ask for positive/negative experiences if interviewee only focus on one aspect spontaneously)
(These questions can be related with or in sequence to some episodes mentioned before)
B. Self-management in daily life
Now please think about your everyday life.
How do you make decisions about issues that are relevant to you?
(Activities of daily life and health)
(*Ask about the role/action of health and social care professionals in this area if not mentioned spontaneously*)
Closing questions:
If you think about your present and future what do you expect from health and social care professionals?
If you think about the education of future health and social care professionals who will work with people like you, which aspects would you value the most in their university studies?
How would you describe the ideal health professional?
How would you describe the ideal social care professional?

74,3 years (SD = 7,4), ranging from 61 to 94, and 60% of participants were female. 83% of our participants lived in their own homes.

This study was approved in the leading country by the Ethics Committee for Research, School of Health, Instituto Politécnico de Setúbal (reference 08-2014/ELLAN) and also in other partner countries where approval was required (Turkey—reference 2014/25-02; and UK—reference 14/EHC/031—ELLAN—European Later Life Active Network 10/04/2014).

Data collection

Semi-structured interviews were conducted in all countries using a common topic guide that was agreed upon beforehand by all researchers (Table 2). While the topic guide could be followed for each interview, participants were encouraged to express their views and experiences around professional practice in health and social care during later adulthood in a free and spontaneous way. These experiences could be related to care they received themselves but also to experiences of being a relative to someone receiving care.

Data collection was undertaken between May and July 2014 in each country, either in the participants' home or in other settings such as skilled nursing facility, day centre or occupational activities centre. The length of interviews varied between 24 min and a maximum of 1 h and 55 min. All interviews were audio-recorded and fully transcribed in the original language.

Data analysis

Using the approach of Braun and Clarke (2006), transcripts of interviews were analysed thematically in two stages. The main goal of this thematic analysis was to identify and describe significant common dimensions of professional competences across the six countries. For this reason, data analysis followed a realistic method, which focused on the descriptions of reality given by the participants of this study (Braun and Clarke 2006).

The first stage of analysis was conducted at the national level when an initial set of codes was generated in each country, with illustrative quotes translated into English. To guarantee a common frame and consistent structure in this process of initial coding, a guide was developed in Portugal (scientific coordinator of this study) and shared with the other countries. This guide provided a step-by-step description for first level data analysis (1. familiarisation with data: transcription, full reading and identification of meaningful discourses; 2. coding and translation of quotations into English); and also the structure to be followed on the presentation of national results (main questions, quotations and generated codes). This guide was illustrated with the contents of one interview collected by the coordinating partner. To reach agreement on the primary analysis conducted in each country, the process of initial coding was then fully reviewed by the Portuguese team, discussed and confirmed with each partner on a qualitative basis.

The next stage involved the lead country conducting a secondary analysis on the initial codes derived from the six countries; these were collated into potential themes and

subthemes. The final themes and subthemes were reached following an iterative process. A structured report with the interpretation of the final themes, subthemes and illustrative quotes was prepared by the leading team and then shared and agreed between the countries.

To ensure the credibility and trustworthiness of our qualitative research, and based on the criteria proposed by Creswell and Miller (2000) and Patton (2002), several strategies were used in this study: a semi-structured interview format based on a common topic guide was followed in all countries; a model of analysis oriented the process of primary analysis conducted in each country; the process of initial coding was fully reviewed by the leading team and discussed with each partner to reach agreement; the secondary analysis was undertaken independently by two researchers of the leading team, who have discussed and reached a consensus of the themes and subthemes. The interpretation of final themes, subthemes and illustrative quotes was checked and confirmed by all countries.

Results

Four themes have been identified across interviews: recognising the person I am; connecting the space between us; fulfilling your expert knowledge and technical skills; and disclosing professionalism in you.

Recognising the person I am

This theme addresses the topic of personhood and focuses on the importance of being known as an individual with a particular identity, history and background. Recognition of older people's individuality and dignity is its core values. Being known and understood as an individual and having personalised and adapted care is appreciated. Professionals must be aware of diversity and personal differences and should avoid making generalisations during care. To achieve such goal, they must be well aware of the individual client.

> You're not just another number in a book (…) they are genuinely interested in you as a person. (Male, British, aged 76)

To attain customised care, professionals should rely on a deep understanding of older people's specific needs and limitations.

> First, you should know the person's needs, to be able to identify it (…) and once the person is understood, it may be a way to help her to overcome its difficulties or problems. (Male, Portuguese, aged 90)

Recognising the person is also being aware of his/her life conditions, available resources and social contexts; otherwise, the understanding of professionals will be disconnected from the social belonging and contextual reality of the older person.

> They should just pay more attention to the living situation because some people don't have opportunities to, for example, reach the hospital or any other institution. (Female, Lithuanian, aged 67)

To reach a comprehensive perspective about the social belonging of the person, different intervention methods or strategies can be used, such as making appointments or house visits.

> This requires that professionals do home visits. This cannot be assessed only through talking. This gives much information if the professional sees the home environment. (Female, Finnish, aged 70)

A broad understanding about older people's contextual reality and life conditions also needs to include the family situation. Professionals should be aware about the family composition, the nature of family relations and the type of support provided by the relatives as well.

> They need to know the family and understand the reason why he is depressed, why he has so few visits. I think it's very important to establish that connection with the family (Female, Portuguese, 78)

To promote self-affirmation and the integrity of the person, professionals must respect personal wishes and individual choices of older people.

> It is important that concern with what a person wants and that a person would not be taken into situations that are uncomfortable or bad and depressive. (Female, Finnish, aged 74)

Dignity is relevant for the recognition of self and comes intertwined with a sense of lifelong continuity, despite the particular conditions or limitations that the person may have to face in the present life. Identity is built upon this sense of continuity, and older people have reflected on how conceptions of self and self-esteem may be negatively influenced by restrictive approaches to personhood.

> Well, a lot about respect for the elder, and not just see a poor man who can't wee properly. Respect that this gentle man was a fine young man and he never thought he was going to end up… (Female, British, aged 68)

Connecting the space between us

The second theme is related to interpersonal skills and interpersonal exchange in situations of care. Communication and relational aspects of professional competence represent its

core dimensions and reflect the two subthemes included in this theme: *Communicate with me* and *Involve me with (in) care*.

Communicate with me

Communication skills used by professionals were reiterated throughout interviews. Communication and dialogue must be promoted so that older people feel safe to express themselves and share relevant information in different situations.

> 'Did you tell him about such and such?' (…) And that was her main problem, she'd never mentioned it, because he didn't ask her. (Male, British, aged 79)

Professionals must be aware of the language they use and adapt it to meet the needs of the older person. Technical terms or 'jargon' hinders comprehension of what is being told.

> If they tell me in medical terms, then I have to ask for explanations. But then they straighten things out right away and explain everything in a way that I can understand". (Female, Lithuanian, aged 72)

During any intervention, professionals are expected to listen, to give feedback and to exhibit signs of understanding about what is being said by the older person.

> That they let me finish speaking, that they understand me and listen to me, that they really listen to me and try to understand. (Female, Austrian, aged 75)

Communication skills of professionals also include non-verbal communication such as eye contact and showing signs of attention during the encounters with older people.

> Many of them [doctors] did not even look at my face, the way they were talking without looking at my face did hurt me indeed. (Female, Turkish, aged 76)

Professionals are also expected to communicate bad news in an adjusted way and to be sensible to the amount of information that the person is prepared to receive, particularly in situations of vulnerability.

> They say it directly towards the face and may hurt the patient, in particular if he/she is severely ill. (Female, Finnish, aged 71)

This subtheme is also associated with technical aspects of communication, which are relevant for giving information, promoting health and empowering older people. They wish to understand what is happening in their particular situation in a clear way.

> Before tests and examinations they don't clarify why do we even need it (…) sometimes I start doubting if I even need it (…) they really don't clarify (…) how it works or if there could be some side effects afterwards. (Female, Lithuanian, aged 67)

Older people recognise the role of professionals in terms of education for self-management. However, this requires time and professionals must avoid strategies that reinforce passivity of those who are being cared. They should focus on enhancing autonomy and independence of older people.

> To give their client the power to try and do better, without being domineering but try and encourage them to do better. (Male, British, aged 76)

Involve me with (in) care

This subtheme focuses on the nature and inner quality of relationships. Openness, symmetry, trust, warmth and support constitute key aspects contributing to relational and emotional skills of professionals. Older people expect positive relationships with professionals, rooted in symmetry, reciprocity and mutual acceptance.

> How you approach a person is how that person reacts back to you. (Female, British, aged 80)

Participated discussions and shared decision-making related to the nature, conditions and procedures of care are also relevant for avoiding vertical and unbalanced relationships between professionals and older people.

> My desire is naturally that the patients would be heard and considered in the arrangements of treatments and care. (Male, Finnish, aged 69)

The same type of balance should happen when a family member has an active role in caring for the older person. In these circumstances, professionals need to involve carers in any decisions related to the particular situation of the person who is being cared.

> I'm thinking of an occasion with a social worker… I just got the overall feeling that she had, sort of, made a decision about my mum's care before she'd actually asked any questions. (Female, British, aged 63)

There is also the expectation that professionals have the ability to show compassion, provide support, comfort and reassurance to older people, in each particular situation. In fact, warmth of professionals was highly valued across interviews.

> They [professionals] can also talk in the right way, touch, be compassionate and give people the feeling they are not alone. That people have the feeling that they are 'in the right hands and nothing bad can happen to you now'. (Male, Austrian, aged 73)

Older people also discussed how friendliness and kindness of professionals are important for developing collaborative relationships during care. Again, this emphasises the relevance of affection and other emotional dimensions in health and social care.

> It's being kind and always trying to help, so that we can collaborate with them. (Female, Portuguese, aged 68)

Undoubtedly, relational skills require the availability of professionals; however, older people do recognise and understand the difficulties that come associated with the workload in health and social care.

> A little bit of talking, taking their time for the older people, well, yes… there's never time for that. (Female, Austrian, aged 61)

Fulfilling your expert knowledge and technical skills

The relevance of technical knowledge and skills has been stressed, and how these contribute to the adaptation to health/illness and to social integration. Older people value professionals who have specialised training in their field of work, showing confidence and ability during their performance.

> Yes, that they could identify the situation and do the right thing based on their knowledge and training. (Male, Austrian, aged 73)

Professional expertise was also underpinned by specialised knowledge about older people and ageing processes. Thus, education and training need to emphasise developmental and other specific features of this target population.

> They have to have the understanding of the elders as a group (…) understanding of the elders and how they function. (Female, British, aged 67)

Participants also mentioned many tasks and specific procedures that had been delivered by health and social care professionals. Financial help, promoting cultural activities, diagnosis, prescription of exams, medication administration and helping in personal hygiene reflect some examples. Overall, older people are pleased with the action of professionals; they think it's appropriate to their condition.

> About the doctors, they check, they examine, if we get sick they take us to the hospital; every morning they come to visit us and check. (Female, Turkish, aged 75)

Even if older people are satisfied with technical procedures and interventions, some have claimed that the quality of services is influenced by professional's age and experience.

> Like in that laboratory, there is an older nurse who is remarkably good with blood tests! The youngest one… god should forbid her! (Male, Portuguese, aged 73)

Quality of care is also related with the co-action of multidisciplinary teams and coordination of the available resources as well.

> It is also essential that the doctor and the nurse collaborate and that there are no authorities or superiority (…) that each staff member has their own role and exchange information. (Female, Finnish, aged 66)

Disclosing professionalism in you

Professionalism is seen as an essential requirement for working in health and social care professions. Older people's discourses are anchored in representations about vocation, commitment and ethics. Professionals working in the field of care must feel an inner personal orientation for their job. A sense of vocation is needed for those who embrace these professions.

> This is something personal, that you are born with… you have that instinct and you have that ability to work with older people. (Male, Portuguese, aged 73)

Older people value professionals who are available for helping them with any needs they may have, acting in a skilled and committed manner.

> Yes, but there have been several people, quite good doctors, also good nurses who really had a lot of commitment; they wholeheartedly did everything they could to help me get well again. (Male, Austrian, aged 73)

In addition to commitment, professionals must be conscious about moral conduct and professional code of ethics. These must be respected and guide professional action during care.

> [An ideal doctor?] (…) Well I should trust that he is definitely not going to tell that to anyone, he should be like a priest, keep my secrets. (Female, Lithuanian, aged 67)

If the previous dimensions are not part of professionals' attitudes and behaviours, the risk of neglect increases. Older people will lose confidence in the care they are receiving and may experience lack of compliance with their requests and needs.

> I said to her, 'oh, you haven't eaten your lunch'. And she said, 'I couldn't get at it'. And I said, 'didn't someone come to see?' She said, 'no, they just put the meal on the side and it's been there ever since'. (Male, British, aged 92)

Professionalism is threatened by the expression of ageist attitudes within the context of health and social care. Older people have reflected on the loss of social value they are facing nowadays. Age-based discrimination in care may lead to perceptions of inequality and disinvestment.

> Sometimes I get the feeling 'Well, she is retired, not productive'; the only importance is to get rid of the client quickly. This I also hear from others often, elders are not taken seriously. (Female, Finnish, aged 72)

Condescending and infantilising behaviours expressed by professionals represent other forms of age-based discrimination that undermine older people and compromise the quality of care.

> This young lady that was my breast cancer nurse was very condescending and talking down to you, and very sort of made me feel worse than I was. (Female, British, aged 75)

Discussion

The themes and subthemes identified have provided an insight into older people's views and expectations about the competences of health and social care professionals. It was possible to identify a clear pattern of convergence in the discourses collected in six different European countries, describing a set of common skills and professional practices desired by older people when they speak about experiences related to care. Overall, competences at the interpersonal level were central in older people's discourses and its core dimensions are anchored in relational, communicational and socio-emotional skills of professionals.

The relevancy of a person-centred approach in care has been stressed throughout interviews. Older people have argued that being known and recognised as individuals is essential to achieve personalised and adapted care. From this point of view, professionals should be aware that the context of the older person's biography is relevant to further develop this approach in care (Clarke et al. 2003). Accounts of a person's previous life, habits and routines can offer important cues for his/her present behaviour and wishes (Edvardsson et al. 2008). Moreover, it can promote the understanding of the person's present needs and limitations (Bayliss et al. 2008; Bridges et al. 2010). Thus, recognising the individuality and identity of the older person is a key element for interpersonal competences of professionals.

Interpersonal competences are also reflected on the nature of user-professional relationship. Older people claimed that the promotion of trustful, supportive and reciprocal relationships (Janssen et al. 2011) and shared decision-making (Berkelmans et al. 2010; van de Pol et al. 2015) constitute fundamental elements of competences in health and social care. Emotional aspects valued during care situations, such as kindness, friendliness and compassion, were also emphasised. Descriptions of these affective and emotional aspects seem to mirror an important component of care for older people and might influence their satisfaction as well as the subjective feeling of healthiness and well being (Marcinowicz et al. 2014).

Another relevant finding is the undoubted awareness that older people have about the role of communication in care experiences with different professionals. They believe that positive communication styles have a significant impact on the way people perceive the quality of care (van de Pol et al. 2015). But communicational skills of professionals are also intertwined with technical and task-oriented aspects of care since exchange of reliable information depends on the type of language adopted by professionals (Holm and Severinsson 2013; Yorkston et al. 2010). Effective health education strategies that promote autonomy and independence of older people rely on the quality of communicational and educational strategies used by professionals and must be integrated and adapted to the present situation of the person.

Technical and task-oriented dimensions of competence are also linked to specialised knowledge and skills, particularly in terms of gerontology and healthy ageing (van de Pol et al. 2015). In our study, older people claimed that there is a lack of specialists in these domains, reflecting the need to engage professionals and students in specialised training to improve the quality of care (Rodriguez-Martin et al. 2013). This finding suggests that a deeper investment on the field of ageing studies and training in gerontology can be a way to improve the attractiveness of older people's care components in the European care education.

During interviews older people have also spoken about their negative experiences in care situations, which they perceived as expressions of negative attitudes and discriminating behaviours of professionals based on age categorisation. In fact, this finding has enlightened the potential consequences of age-based perceptions and attitudes on how people relate with ageing processes and treat older adults (Abrams et al. 2011). Research shows that age discrimination has increased over the last 20 years, when compared to gender or ethnicity (Eurobarometer 2010; van den Heuvel and van Santvoort 2011). Competences at this level can be interpreted according to a dialogic relation between personal/professional attitudes and values of care workers towards ageing and older people. Hence, developing both personally and professionally may encompass a process of (self) reflection about the interplay of personal and cultural ageing conceptions and how this can influence the experiences of caregivers and caretakers.

Finally, it is worthwhile to reflect on the cultural inscription of our research and findings. This study was conducted

in six countries with a large number of researchers. Even if transcultural and multilingual requirements for translation and cross-cultural adaptation have been followed during the construction of the interview topic guide and data analysis, some meanings and cultural nuances of language could have been missed during translation from each national language to English. Hence, the issue of translation reflects a constant challenge faced by international teams conducting qualitative research.

The focus of our analysis was to explore common significant dimensions of professional competence across the six countries. Findings suggest that there are two main domains (relational and socio-emotional, technical and task-oriented) that can be seen as overarching themes of professional competence. These are cross-cultural enabling an understanding of the views and expectations of older people in relation to the quality of health and social care provided during later adulthood. In our view, this is the major contribution of this study. However, considering our methodological options we cannot argue that these findings are transferable to the different European countries. There are some expectations that may differ from country to country, depending on cultural expectations, professional regulation requirements or professional structures. The economic restrictions that Europe is facing can be more challenging to the care systems of some countries. Additionally, some skills are context related and in some situations professionals need to be flexible and able to keep the older person at the centre of care. To achieve a deeper understanding about the cross-cultural validity of these findings, a large-scale survey-based research can be conducted in the 25 countries involved in ELLAN project.

Conclusions

According to our findings, professional competences in health and social care combine the recognition of the unique and complex history of older people with professionalism, expert knowledge and technical skills. Interpersonal skills of health and social care professionals influence the way older people perceive and experience care. If interpersonal awareness and sensitivity of professionals represent core dimensions of person-centred care, according to our research, some changes may be necessary to improve the quality of care provided to people in late adulthood. In our view, these findings reinforce the aspiration of establishing best practices in Europe that rely on the harmonisation of a competence framework underpinned by common evidence-based guidelines such as ELLAN's European Core Competences Framework (ECCF). This framework can be incorporated in the training and education of different health and social care professionals leading to the reinforcement of interpersonal competences, which were explicitly voiced by older people considering their lived experiences related to care.

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