



European Core Competences Framework for Health and Social Care Professionals Working with Older People



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1. Introduction

The number of older people in Europe is increasing and the demand for care and support is changing. All over Europe there is a need to educate students and professionals in health and social care with the right competences to work with older people. Therefore this European Core Competence Framework for health and social care professionals working with older people is developed in the context of international cooperation between 26 universities and universities of applied sciences as part of the European Later Life Active Network (ELLAN). The ELLAN is a Lifelong Learning Programme project funded by the European Commission for the period September 2013 – September 2016. The consortium included 26 partners from 25 countries in Europe.

The ELLAN project promotes European cooperation and exchange of innovation and good practice related to the ageing population and to the educational preparation of those professionals in health and social care that work with older people. The desired outcome of the ELLAN project is a better quality of higher education related to the care and services of people in later life. The main result is this European Core Competences Framework for health and social care professionals working with older people. The project directly targets educators and management staff at the partner organizations and other higher education institutions in Europe. The indirect target groups are the students, professional communities and older people themselves.

The consortium conducted analyses of competences required by professionals working with older people from the viewpoint of literature, from qualitative research among older people themselves in six different countries and from quantitative research among professionals. These research studies were used to develop this European Core Competences Framework. The competences are described according to the CanMEDS roles¹. The competence framework is verified by two rounds of Delphi research among a group of 21 experts and a group of 21 researchers from different countries all over Europe.

In addition, within the ELLAN project research was also conducted on the attitude of students to ageing and working with older people and also on innovative educational approaches to gerontology that influence the attitude of students. More information about the ELLAN project and the different research reports can be found on <http://ellan.savonia.fi/>.

In this document the terms and concepts used are first defined, then the CanMEDS roles are described for health and social care professionals working with older people. For each role, competences are defined. The 18 competences are elaborated in performance indicators.

¹ <http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e> (1996, updated 2005 and 2015)

2. Terms and concepts

2.1 Older person

Older person is defined as someone of 65+. The age of 65, is roughly equivalent to the retirement age in most developed countries, and are said to be the beginning of old age. This is disputable because of the heterogeneity of the older population. Today's persons of 65 are not the same as yesterdays as a result of different lifestyle, social and economic circumstances.

Growing older affects a person's physiological condition and may result in changes in functioning. Bones may lose density and make them vulnerable to fractures. Falls may result in increasing mobility problems. (Minor) problems with memory are common in older persons. Dementia is an overall term for diseases characterized by a decline in memory that finally affects a persons daily activities. Alzheimers disease is the most common type with a prevalence increasing by age from 4% between 65-75 years up to 38% in 85+. Deficits in immunity may cause infections and result in susceptibility for influenza and other complications. Sensory problems e.g. with hearing and vision are responsible for functional decline. Difficulties with bowel and bladder control may occur, resulting in incontinence (involuntary loss of faeces or urine). In older age there is a 70% prevalence of one or more somatic age-related diseases like cardiovascular disease, cancer, COPD, diabetes, high blood pressure with 35% having more than one of these conditions (WHO)². The association of ageing with psychological problems is complex. The prevalence of depression is 15% and other psychological and social problems like anxiety, fear, loneliness, occur more often in older people. A combination of problems is typical for the older old person and can result in frailty. Frail older persons are weak, often have many complex medical problems, have a lower ability for independent living, may have impaired mental abilities, and often require assistance for daily activities such as dressing, eating, toileting and mobility (Torpy et al., 2006)³.

2.2 Health and social care professionals

Health and social care professionals working with older persons are defined as persons who provides systematically direct and indirect professional care and support to individuals or communities of 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 and services provision; infrastructure, public and private. This represents care and support services in different settings and includes: promotional, preventive, supportive, disease managerial, rehabilitative, palliative and terminal care, short term and long term care. The health and social care professionals handle increasing levels of support, with transitions if necessary across different care and service settings. Usually the social and health domains are separated in different professions. The changed pattern of disease and the sheer increase in the numbers of older people mean that there will be many more frail older people who live with multiple conditions. This requires either health or

² <http://www.who.int/topics/ageing>

³ Torpy, M.J. et al. (2006). Frailty in older adults. The Journal of the American Medical Association. 296 (18).

social care or, very often, both (Barker et al., 2014)⁴. Better integration of health and social care also requires that the professionals working with older people have specific competences built around older persons needs and not strictly segregated by professional boundaries dividing health and social care and services. The competences developed here are focused on, and are generally applicable for health and social care professionals working with older people and with some suggestions for refinements for the specific professional domains.

In addition, the role of professionals working in health and social care varies across European countries and their professions often have a different national history, culture and codes of practice. Nevertheless the health and social care needs of older people are similar across countries. Older people, and especially frail old people, may have problems that interact with each other like cognitive restrictions, functional restrictions, psychosocial problems, multi morbidity, poly pharmacy and social isolation. These problems require an integrated approach to health and social care.

2.3 Cultural differences

Although great progress has been made in the political exposure of Europe as an unity, there remains diversity between and even within countries. This is also applicable in health and social care systems. The wide variety in health and social care systems has consequences for the accessibility. There are differences in responsibility for the provision of care and support needed by older people: whether it is the government, the family or a combination that provides the care and whether informal care is dominating or whether care and services are publicly funded. In countries with a focus on informal care, there is less institutional care in contrast to countries where the government takes the responsibility. Health and social care organizations can be centralized on a national, regional or on a local level and the services they deliver can be comparable or not. This all has implications for the number of health and social care workers needed and the required competences.

There are also striking differences between the European regions in relation to behavioural adjustments that can promote health (like smoking). In addition to health characteristics, characteristics such as sex, age, marital status, education level and income, can play a role in differences between countries and the amount of care available to for the older persons. Perception of ageing is seen as a primarily medical problem or a more societal problem also causes differences in the approach of services for older persons. Care and services can be mainly focused on promotion of independence of older persons and guidance or can have a more protective approach. This may have consequences for the recognisability of certain health or social problems, their frequency, and also for the type of health and social care workers needed and their competences.

On the individual level, health and social care professionals today are more likely to work with older people that are originally from other cultures. This may be a result of an increase in refugees entering Europe or as a result of increased mobility of professionals.

⁴ Barker, K. et al. (2014). A new settlement for health and social care. Interim report. Commission on the future of health and social care in England.

The competences of the health and social care professionals need to meet the challenges of providing care and services in the growing multi-cultural world. However it has been noted that the health and social care professionals strive to achieve the ability of effectively working within the cultural context of the older person (individual, family, community, national)⁵. This competence framework is worded in such a way that it is applicable in different European countries and different cultures. This cultural competence is integrated within different roles and explicitly mentioned in the role of the Professional.

2.4 The competence framework

The competence framework describes the outcomes that professionals working with older people in different roles are expected to achieve and able to demonstrate. The framework combines specifications of current best practice with realistic future expectations. The framework is based on a literature research and on qualitative and quantitative studies. The framework is verified by two rounds of Delphi research among a group of 21 experts and a group of 21 researchers from different countries all over Europe.

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 persons and their families within the context of their environment -the home, community-based settings, and institutions.

The competence framework has the following structure:

- **Role descriptions** of professionals working in health and social services, based on the 7 CanMEDS roles⁶
 - For each role several **competences** are formulated – 18 in total.
 - Each competence is elaborated in **performance indicators**
 - For each competence the **outcome** is described.

2.4.1 Definition of competence

There are many different definitions of competences. In this framework we use the following definition:

“Competences are job related descriptions of an action, behaviour or outcome that should be demonstrated in individual’s performance.” Competences are person orientated referring to person’s underlying characteristics and qualities that lead to an effective professional performance. (McMullan 2003⁷, TRACE project).

Competence includes: i) cognitive competence involving the use of theory and concepts, as well as informal tacit knowledge gained experientially; ii) functional competence (skills or know-how), i.e. those things that a person should be able to do when they are functioning in a given area of work, learning or

⁵ Camphina-Bacote, J. (2002). The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. Journal of Transcultural Nursing. 13 (3), 181-184.

⁶ <http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e> (1996, updated 2005 and 2015)

⁷ McMullan, M. et al. (2003). Portfolios and Assessment of Competence: A Review of the Literature. Journal of Advanced Nursing, 41(3), 283-294

social activity; iii) personal competence involving knowing how to conduct oneself in a specific situation; and iv) ethical competence involving the possession of certain personal and professional values.⁸

The concept of competences is used in an integrative manner; as an expression of the ability of individuals to combine – in a self-directed way, tacitly or explicitly and in a particular context – the different elements of knowledge and skills they possess. This aspect of self-direction is critical to the concept as this provides a basis for distinguishing between different levels of competence.

Performance indicators, in the context of the competences, are defined as skills, behaviours, or practices that demonstrate the existence of the competence. For each competence the performance indicators are described in active verbs.

2.4.2 Level of competence

Acquiring a certain level of competence can be seen as the ability of an individual to use and combine his or her knowledge, skills and wider competences according to the varying requirements posed by a particular context, situation or problem. Put another way, the ability of an individual to deal with complexity, unpredictability and change defines/determines his or her level of competence.

The competences framework aligns with the European Qualifications Framework (EQF) level 6 (bachelor)⁹. This level of complexity is described in terms of autonomy by¹⁰:

- Knowledge: Advanced knowledge of a field of work or study, involving a critical understanding of theories and principles
- Skills: Advanced skills, demonstrating mastery and innovation, required to solve complex and unpredictable problems in a specialised field of work or study
- Competence: Managing complex technical or professional activities or projects, taking responsibility for decision-making in unpredictable work or study contexts; taking responsibility for managing professional development of individuals and groups.

⁸ TRACE Project. (2005). Overview of European competences frameworks. <http://www.menon.org/wp-content/uploads/2012/11/9.-TRACE-Overview-of-EU-competency-frameworks1.pdf>

⁹ Bologna Working Group on Qualifications Frameworks. (2005). A framework for Qualifications of the European Higher Education Area. 3.3 Descriptors of learning outcomes including competences. Ministry of Science, Technology & Innovation, Copenhagen.

¹⁰ <https://ec.europa.eu/ploteus/en/content/descriptors-page>

3. Roles for health and social care professionals

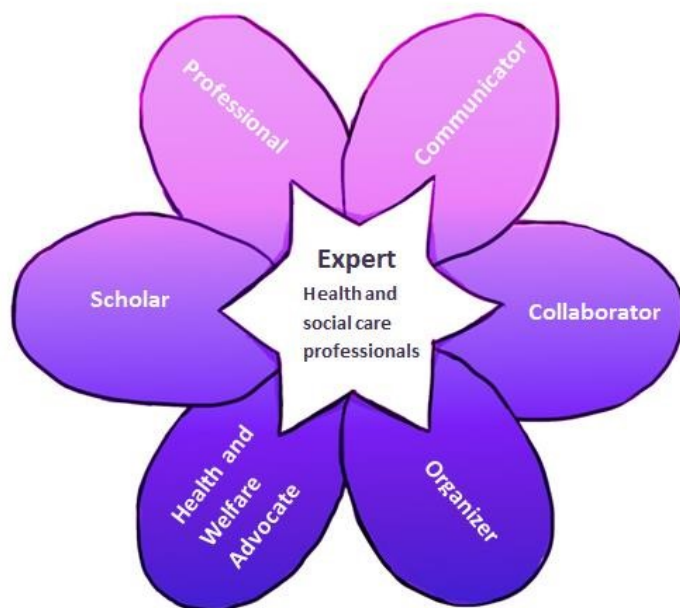
Each professional performs tasks specific to different roles. Each of these roles requires different competences. For this set of European Core Competences for working with older people, we agreed to use the CanMEDS Physician Competency Framework for describing the different roles of professionals in health and social care ¹¹. The CanMEDS framework is developed by the Royal College of Physicians and Surgeons of Canada. This framework describes the knowledge, skills and abilities that specialist physicians need for better patient outcomes. It consists of seven roles: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar, and Professional. The roles and competences in the framework are based on empirical research, educational design and college consensus. All seven roles are needed to perform as a medical professional. The Royal College Governing Council approved the framework in 1996 and it is the basis for all specialty specific training objectives recognized by the College. World-wide, the CanMEDS has been used in a modified way for other professionals as well (Sottas B, 2011)¹², for example: occupational therapy midwifery, nutrition counselling, registered nurses and other professionals.

The major difference between the original CanMEDS and this competence framework is the understanding of the role of the Expert. In the CanMEDS framework the role of the Expert is understood as an integration of (or the resulting performance in) all the other roles. However, in our case, we describe it as profession-specific competences. After graduation a physiotherapist, for example, will be “expert in physiotherapy”. The term “expert in...” is based on professional knowledge and skills acquired during formal education. It enables the individuals to act professionally and autonomously in their professional practice and in specific situations. The role of the Expert is specific to each profession and it allows reflection on 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 “expert in...” when the professional knowledge allows the individual to make an independent assessment in a specific field of expertise. The depth and the width of knowledge and skills vary depending on the profession, but they are always present and comply with the requirements for professional qualification. Within this competence framework, the competences described for the expert role are those needed for all professionals working in health and social care, and in services working with older people.

The seven roles for health and social care professionals working with older people are: Expert, Communicator, Collaborator, Organizer, Health and Welfare Advocate, Scholar and Professional.

¹¹ <http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e> (1996, updated 2005 and 2015)

¹² Sottas, B. (2011). Learning outcomes for health professionals. GMSZ Ausbild. 28(1).



CanMEDS Role model, adapted for health and social care professionals

The central role of Expert, based on professional expertise, is strengthened by other supportive roles and competences which are more or less equal for all health and social care professionals but with diverse focus or emphasis. Considering efforts to stimulate integrated care and services, and in working with the same group of people (older persons), the other supportive roles are comparable.

The Role of Expert is central to health and social care professional and draws on the competences included in the roles of Communicator, Collaborator, Organizer, Health and Welfare Advocate, Scholar and Professional. In the role of Expert the professional is working directly with the older person and his or her family and social network. For most professionals in health and social care this will be the main role. However, some professionals might have one of the other roles as their main role, for example the role of Health and Welfare Advocate for social workers, with a more population based approach than an individual focus.

In the next paragraphs the role descriptions are specified for health and social care professionals working with older people.

3.1 Expert



Health and social care professionals possess a defined body of knowledge, disciplinary and procedural skills and attitudes, which are directed towards providing optimal person-centred support for wellbeing and health. These professionals possess insight 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 characterized by the maintenance of his/her physical and mental state but also by promoting autonomy and participation in spite of the ageing process. The older person is seen as a unique and complex person within her/his system (personal situation) and as a partner of the health and social care professionals. The vision of the professional is holistic, person-centered and he/she forms a collaborative relationship with the older person and their family with individual autonomy as an important value. Family-support interventions benefit older people's wellbeing, improve access to services and promote satisfaction (Heller et al., 2015)¹³. Additionally, family may play a supportive role in the care of older people. Furthermore, an older person may have an older partner who may also have health and social needs, particularly when his or her partner becomes frail or develops complex needs.

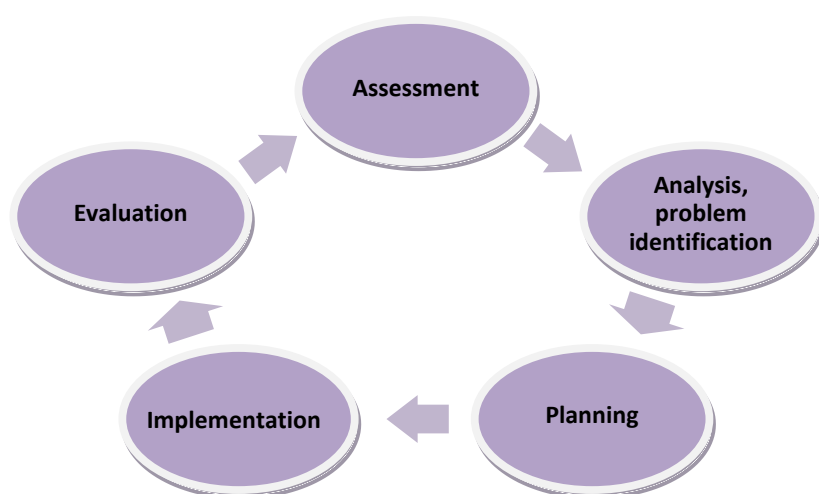
Professionals apply competences in order to collect, interpret and analyse information; make appropriate decisions and plans; carry out diagnostic and (therapeutic) interventions / supportive methodologies within the context of their profession and evaluate effectiveness of interventions. This support may be informational, emotional support, tangible help or integration, and if indicated care (prevention, self-care support, disease management, high complex care) is provided for the older persons in all situations, including palliative and terminal conditions. Professionals do so within the boundaries of their discipline, taking into account the connection between health and social care. They are aware of their own personal expertise, the setting and the older persons' preferences, possibilities

¹³ Heller, T. et al. (2015). Caregiving and family support interventions: Crossing networks of ageing and developmental disabilities. *Intellectual and Developmental Disabilities*. 53(5), 329-45.

and context. The focus of support and care is on quality of life and wellbeing: physical, mental, emotional, relational, social (participation and activities), spiritual and living conditions.

In the expert role the components of health and social care processes consists of five dynamic and interrelated phases:

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



Health and social care processes

These processes are part of the professional role and not specific for older persons. However, the competences (and knowledge, skills and attitudes) need to be specified for this target group in all phases of this process.

Assessments are made initially and continuously throughout the care and support process. The remaining phases of the process depend on the validity and completeness of the initial data collection. Early recognition of risks is crucial. If applicable professionals should choose standardized assessment and diagnostic tools for comprehensive assessment that are applicable for all health and social care professionals. Assessment is part of each activity done for and with the older person, systematically and continuously. Results are **analysed and the problems are indicated**. Based on knowledge and depth of understanding of the problems by a thorough assessment of the older person, a health or social care professional can construct **plans**, make **decisions regarding interventions** or advise in order to promote functioning and participation. Where possible this should occur together with the older person him/herself and/or his family or caretaker (i.e. shared decision making). **Interventions** are focused on independence and optimising functioning in all domains (physical, mental, social and spiritual), in order to prevent a combination of problems across domains. The older person and the family receive the best

care and support possible. The care and support plans and interventions are re-**evaluated** on a regular basis and changes are made when necessary.

Competences, as part of the Expert role, are related to the five phases and in all phases are linked to physical & mental wellbeing, social participation & activities and living conditions.

3.2 Communicator



Health and social care professionals enable older person-centred communication in formal and informal situations. This is achieved through shared decision-making and effective interactions with the older person, their family and informal supporters. Health and social care professionals work within the context of the older person's individual situation and living conditions, and take into account the level of support required, and factors such as the individual's level of literacy and sensory abilities. The competences required for this role are essential for establishing rapport and trust, formulating a diagnosis and planning interventions, delivering information, achieving mutual understanding, and constructing a shared plan of support. The application of these communication competences and the nature of the different health and social care professions vary for different occupations and forms of practice, and may be formal and informal.

Competences of the Communicator role are related to interviewing, listening, interpersonal communication skills, maintaining relationships, empowerment, coaching, and effectively addressing, explaining and summarizing information.

3.3 Collaborator



Health and social care professionals work together to achieve optimal support and care for the older persons with a shared goal of optimising health, wellbeing and quality of life. It may be necessary for this to occur across multiple locations. It is essential to collaborate effectively within the multidisciplinary team which provides care and services to older people and their families. Health and social care professionals also work collaboratively with persons outside the framework of organized, paid, professional work. Informal care and support has increased in many countries with the adoption of community care policies, and with increasing reliance on care provided by family, relatives, and friends. Collaboration is a relationship-centred process based on trust, respect and shared decision-making. This may be in a team with informal caregivers or a professional team, or together with municipal and governmental institutions. It involves sharing knowledge, perspectives and responsibilities and requires willingness to learn together. This requires understanding the roles of others, pursuing common goals and managing differences.

Competences of the Collaborator role are directed towards cooperation with other professionals and with informal care and support givers.

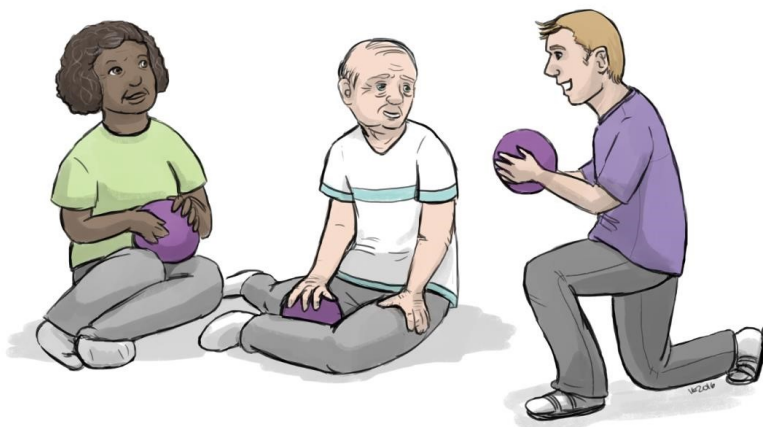
3.4 Organizer



Health and social care professionals organize and manage care for older people. During transitions in particular, they focus on promoting the integration and continuity of care required for optimal support of older people. They will actively plan and coordinate tasks, and should be able to demonstrate leadership in the team. Health and social care professionals contribute to the improvement of care and services for older people in teams, organizations and the overall health and social care systems. They must therefore interact with their social and healthcare systems locally, regionally and nationally. Furthermore, they actively take part in developing, adapting and implementing long-term policy actions for care and services for older people on a national, regional, local or organizational level.

Competences which form part of the Organizer role are related to planning, arranging, and coordinating the care and services for older people, which are provided by a variety of formal and informal care and support workers.

3.5 Health and welfare advocate



As a health and welfare advocate professionals try to improve health and wellbeing of older people and their families or networks. They focus on individuals, groups, communities, or populations they serve in order to determine needs and develop partnerships. They speak on behalf of older people when needed and support efforts to effect change. This includes prevention, health promotion and health protection, whereby individuals and populations 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 by provision of client education and promotion of active ageing.

As a health and welfare advocate, health and social care professionals use their expertise and influence to assist older people, and their families to navigate the health and social care systems and to find appropriate resources in a timely manner.

Advocacy requires partners and networks. Professionals work together with older people, their families and support networks, community agencies and other organizations to positively influence determinants of health and wellbeing. Professionals must know how to reach target groups and should be able to use social media for this when appropriate.

Competences for advocacy are related to health promotion and illness prevention and focus on the individual's social map and networks.

3.6 Scholar



As a Scholar, the health and social care professionals pursue excellence by continually evaluating the processes and outcomes of their daily work, comparing their work with that of others, and by actively seeking feedback to improve the quality of care and support they provide for the older person and their family. Feedback on their work from an organizational level should also be sought. As lifelong learners health and social care professionals must implement a planned approach to learning in order to achieve improvement in each role (i.e. all 7 CanMed based roles). They must therefore use multiple ways of learning and should 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 own occupation and domain of expertise. The aim is to increase the quality of support and care by implementing new forms of evidence-based practice and knowledge dissemination.

Competences for this role are related to life long learning, improving expertise and innovation of care and services.

3.7 Professional



In the role of Professional, health and social care professionals are committed to the well being of older persons individually and socially, through ethical practice, profession-led regulation, and high standards of behaviour. The Professional role is guided by codes of ethics and a commitment to the standards of the profession. Furthermore, the professional must embrace appropriate attitudes and behaviours, such as integrity, altruism, and personal wellbeing. These commitments form the basis of a social contract between the health or social professional, and the older person and their family.

Competences for the Professional role are related to demonstrating professional ethics, professional commitment and personal awareness.

3.8 Competences per role – an overview

Based on the descriptions for each role, competences are formulated. This paragraph/ table gives a short overview of the competences. In the next paragraphs the competences are elaborated on in the form of performance indicators and outcomes.

Role	Competence
1. Expert	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 physical and mental wellbeing, housing conditions and social participation. Identify the needs and wishes of the older person.
	b) Analysis and problem identification Analyse 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 for the older person and his/her family with the focus on optimal health, wellbeing and quality of life. Use appropriate 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 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 purpose of providing optimal care and support for the wellbeing of the older person and his/her family.
2. Communicator	a) Maintain relationships and effective communication Form strong positive relationships with older persons and their families, based on empathy, trust, respect and reciprocity. Communicate in a clear and effective way considering 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 gain 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 Encourage, motivate and coach the older person and relevant others in relation to self-management, self-reliance and co-reliance.

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3. Collaborator	a) Integral cooperation and integrated services Work effectively together with other professionals for integrated care and support. Multi- and inter professional cooperation to achieve optimal support and care for the older persons with the goal of optimising their health and wellbeing and 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 to encourage appropriate informal care and support.
4. Organizer	a) Planning and coordination of care and services Plan, arrange, and coordinate the care and services provided by formal and informal health and social care workers, across different organizations, to provide the best-personalized care and support for the older person and their family.
	b) Programme of care Contribute to the organization of existing care and services within the region, which can be offered to groups of older people and their families. Take an active part in developing, adapting and implementing long term policy actions relating to care and services for older people on a national, regional, local or organizational level.
5. Health and welfare advocate	a) Collective prevention and health promotion Advocate for health with, and on behalf, of older persons and their families, communities and organizations in order to improve health and wellbeing and build capacity for health promotion.
	b) Social map and social networks Access and share information or resources with older persons, their families and their caregivers, regarding the social map, healthcare benefits, social support and public programs.
6. Scholar	a) Expertise Expand professional expertise for their own professional practice in relation to working with older people and their families. Spread relevant new evidence based research among fellow professionals and other professionals in health and social care services.
	b) Innovation of care and support Interpret evidence based results of research and contribute to the development of knowledge and practical research in relation to the provision of care and support of older people and their families. Implement and apply new insights, protocols, standards, procedures, and technologies with the aim of promoting the quality, efficiency and effectiveness of care and services provided to older people and their families.
7. Professional	a) Professional ethics Demonstrate commitment to best practices for the health and wellbeing of older people, their families and society through adhering to ethical standards and professional-led regulation and by showing high personal standards of behaviour.
	b) Professional commitment and personal awareness Reflect on one's own actions and improve and innovate own professional behaviour to 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. Show awareness of diversity and cultural differences.

4. Competences Expert role

The role of the Expert is specific to each profession and reflects the function and role of the professional as well as the position of the specific profession within a given societal and health policy context. The depth and the width of knowledge and skills vary depending on the profession, but they are always present and must comply with the requirements for professional qualification. Within the Expert role of this competence framework, the competences described are those required for all health and social care professionals working with older people.

Competences included in the Expert role are related to the five phases; Assessment; Analysis and problem identification; Planning; Implementation/Interventions; and Evaluation. In all phases health and social care professionals focus on physical and mental wellbeing, social participation & activities and housing and living conditions.

4.1 Assessment: collecting information in a systematic way

Role: Expert

Competence

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 individual's physical and mental wellbeing, housing conditions and social participation. Identify the needs and wishes of the older person.

Performance indicators

- Choose the appropriate (validated, personalized, standardized) assessment instruments.
- Obtain basic information before the visit. Encourage patients to bring in written lists of concerns as well as all medication. If applicable, request previous (medical) records from other professionals.
- Take time for the assessment; be patient, interested and reliable.
- Inform the older person (and when necessary, the family/carer) about the purpose and process of the assessment.
- Collect data by observing and interviewing the older person and/or the family network. Some health and social care professionals also collect data by physical examinations.
- Use alternative sources of information when the older person is unable to respond physically or to communicate.
- Consider a life history.
- Gather information about mental wellbeing.
- Gather information about physical wellbeing and physical functioning.

- Gather information about housing and living conditions. The focus is on the living environment as it relates to functional, physical, cognitive, psychological, and social care needs of the older person.
- Gather information about social participation and functioning.
- Discuss the results of the assessment with the older person, the expectations and the further process.
- Present well documented assessments and recommendations in written and oral form.
- Complete documentation accurately and in timely fashion.

- Perform the assessment appropriately and gather information about **mental wellbeing**, including:
 - Cognition and memory
 - Mood, with special attention for depression, loss and grief, and stress factors
 - Signs and symptoms of delirium
 - Signs and symptoms of dementia
 - Quality of life and life satisfaction
 - Relationships
 - Feelings of loneliness
 - Feelings about the future (death anxiety)
 - Coping abilities
 - Self management and self-reliance
 - Factors of personal history transitions, and adaptations to changes over the life cycle influencing mental wellbeing
 - Life goals, personal preferences and wishes
 - Recent changes in behaviour

- Perform the assessment appropriately and gather information about **physical wellbeing and physical functioning**, including:
 - Activities of Daily Living (ADL)
 - Instrumental activities of daily living (IADL's)
 - Main physical complaints
 - Endurance and fatigue
 - Pain and coping with pain
 - Chronic diseases such as cardio-vascular disease, cancer and diabetes
 - Respiratory diseases such as pneumonia and the flu
 - Incontinence
 - Musculoskeletal problems such as arthritis
 - Hearing problems
 - Eyesight problems
 - Oral health, chewing and swallowing

- Sleeping habits and problems
 - Fainting and dizziness
 - Frailty
 - Mobility
 - History of falling
 - Use of medicine, adherence and poly pharmacy
 - Health history
 - Adequate use of aids, devices and prostheses
- Gather information about **housing and living conditions**. The focus is on the living environment as it relates to functional, physical, cognitive, psychological, and social needs of older persons, and includes:
 - The ability to live independently, taking into account limited mobility, frailty and other physical or mental health problems
 - Eating habits
 - Smoking
 - Consumption of alcohol
 - Exposure to toxic substances
 - Safety issues (e.g. fire hazards and risks for accidents)
 - Fall prevention
 - Actual or potential mistreatment (physical, mental or financial abuse and/or self neglect)
 - Support network
 - Informal caregivers/family knowledge of skills necessary to deliver care and help
 - Family/caregivers' needs and level of stress
 - Financial resources and who administers the same
 - Transport facilities
 - Availability of resources in the neighborhood (shops etc)
 - Use of assistive technology
- Gather information about **social participation and functioning**, including:
 - Social history/ background
 - Contacts with family, friends and neighbours
 - Activities in community centres and neighbourhood
 - Hobbies
 - Use of computer/ internet /social media
 - Self efficacy
 - Network of help and social support

Outcome

The assessment is complete and contains all necessary information about the older person's mental and physical wellbeing, social participation and housing and living conditions. The assessment is well documented according to the regulations of the organization. The older person is well informed about the further process.

4.2 Analysis, and problem identification

Role: Expert

Competence

Analyse 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.

Performance indicators

- Apply professional knowledge to analyse, understand and interpret the information gathered.
- Identify and understand the relationships between physical, mental and social problems of the older person in his/her environment.
- Identify risk factors in mental wellbeing like recent behavioural changes.
- Identify risks in physical wellbeing and physical functioning like activity limitations, frailty, multi morbidity, poly pharmacy.
- Identify risks about housing and living conditions and the ability to take care of him/her self
- Identify risks in relation to social participation.
- Explore and discuss information to help work out what is most important for the older person and the family. Set priorities.
- Notify family/caregivers if an older adult exhibits risk signs and symptoms.
- Identify main problem(s) and formulate conclusion together with the older person and his/her family.

Outcome

Risk factors are identified and clearly described and when applicable a conclusion and/or diagnosis is formulated. Priorities are set. If necessary the older person, their family and other caretakers are informed about the risks.

4.3 Planning

Role: Expert

Competence

Develop a clear, timely, and appropriate individual plan with measurable objectives for the care and support for the older person and his/her family with the focus on optimal health, wellbeing and quality of life. Use appropriate techniques for shared decision making.

Performance indicators

- Based on analysis of the assessment results, formulate goals and objectives for further care based on older person's preferences and needs.
- Use consultation techniques for shared decision making and work together with the older person and his/her family to set objectives, define outcomes and select treatment, interventions and help needed.
- Develop plans based on health situation, functional status, life goals, symptoms management, and financial and social supports of the older person and his/her family.
- Explain the availability and effectiveness of resources for the older person and his/her family.
- Develop a clear, timely, realistic and appropriate individualized plan with measurable objectives for the treatment and support for the older person and his/her family. This plan should be person-centred and based on best evidence.
- Develop a plan that includes the interventions/actions from the profession's own discipline, and when necessary, referrals to a multidisciplinary team and other professionals.
- Write the plan according to the standards and regulations of the organization and the profession.

Outcome

A clear, complete and realistic plan providing the best support to the older person and his or her family. The plan is written and communicated about according to the standards and regulations of the organization and the profession.

4.4 Carry out interventions based on professional standards

Role: Expert

Competence

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.

Performance indicators

- Facilitate the older person's active participation in all aspects of his/her own health and wellbeing.
- Deliver care and support to the older person and his/her family with respect to cultural and spiritual beliefs, and making health care resources available.
- Carry out approved professional procedures, demonstrating knowledge and skills in the use of aids and equipment available.
- Prevent or reduce common risk factors that contribute to functional decline, impaired quality of life and excessive disability in the older person.
- Involve, educate, and when appropriate, supervise family, friends and assistive personnel in implementing best practices for the older person.
- Access and manage an emergency/critical event ensuring prompt, effective care and referral where appropriate.
- Apply ICT and ambient assisting living technologies effectively and safely.
- Develop and implement a tailor made rehabilitation programme.

Outcome

The older persons and their supportive families receive care and support in all the areas they agreed on: mental and physical wellbeing, housing and living conditions and social participation to optimize their well being and to prevent further decline. The interventions and treatments are carried out according to professional standards and contribute to the mental and physical wellbeing of the older person.

4.5 Evaluation

Role: Expert

Competence

Re-evaluate and adjust service or care plans for the older person on a continuing basis with the purpose of providing optimal care and support for the wellbeing of the older person and his/her family.

Performance indicators

- Monitor the situation of the older person and his/her family on a regular basis.
- Re-evaluate and adjust the plans and interventions for older adults on a continuing basis.
- Evaluate the continued appropriateness of the interventions, care plans and services based on the older person's and families'/caregivers' changes in age, status of health and wellbeing, and function.
- Adjust and change plans and interventions when necessary or desirable.

Outcome

The older person and his/her supportive family receive the best care and support possible, and as agreed on. The plans and interventions are re-evaluated on a regular basis and changes are made when necessary.

5. Competences Communicator role

5.1 Maintaining relationships and effective communication

Role: Communicator

Competence

Form strong positive relationships with older persons and their families, based on empathy, trust, respect and reciprocity. Communicate in a clear and effective way considering older person's individuality, dignity, personal and social background, and needs.

Performance indicators

- Understand the older person's individuality, identity, background, developmental path, expectations and needs.
- Respect individual and cultural diversity in care and services, including diversity of attitudes and beliefs about ageing and wellbeing. Be aware of, and avoid cultural biases during care.
- Promote positive, trusting and symmetrical relationships.
- Adjust the form of communication depending on the characteristics of the older person.
- Assess possible barriers to the older person receiving, understanding, and giving information.
- Use active listening during different situations of care and support.
- Listen to older person's concerns and allow extra time when needed.
- Be aware of the nature of relationships of the older person with his/her family/caregivers, and of the possible (positive/negative) effects in care and support.
- Be able to relate and communicate with the older person and his/her family/caregivers individually and in small groups.
- Use diplomacy and tact in fraught situations and handle tense situations. Address conflict situations positively, show respect, listen to the involved parties and achieve common ground whenever is possible.

Outcome

Establish rapport and maintain an effective working relationship with the older person and his/her family members. Positive and trusting relationships and effective communication between professional(s) and older people and their family members/caregivers positively influences health and social care and support.

5.2 Empowerment

Role: Communicator

Competence

Promote capacities and resources in older people and their families so that they can gain control over their lives and achieve their own goals according to their needs and expectations. Contribute to the improvement of older person's autonomy, independence, wellbeing and quality of life.

Performance indicators

- Adapt educational approaches to enhance older person's coping capacities and wellbeing.
- Respect personal choices of the older person in the activities he/she wants to perform despite the time needed.
- Promote shared decision making with the older person and/or families/caregivers for maintaining autonomous everyday living, health and wellbeing.
- Encourage the older person to voice his/her wishes, expectations and concerns.
- Ask the older person if and how they want his/her family to be involved in care and support.

Outcome

The older person and the supportive family feel that they are able and powerful enough to take part in decision making and gain control over their own life.

5.3 Coaching

Role: Communicator

Competence

Stimulate, motivate and coach the older person and related others regarding self-management, self-reliance and co-reliance.

Performance indicators

- Inform the older person and his/her family about their particular situation and condition, and explaining interventions, procedures, benefits and/or risks in a clear and detailed way.
- Stimulate social participation of the older person according to his/her personality and needs.
- Be aware of feelings of uncertainty and reassure the older person if necessary.
- Discuss possibilities and stimulate self-management, self-reliance and co-reliance.
- Use of group interventions with the older person and his/her family and/or caregivers.

- Mediate conflict or hostile situations with the older person and family/caregivers.

Outcome

The older person and their families are informed, encouraged and motivated regarding the best possible self-management, self-reliance and co-reliance in care and services.

6. Competences Collaborator role

6.1 Integral cooperation and integrated services

Role: Collaborator

Competence

Work effectively together with other professionals for integrated care and support. Multi- and inter-professional cooperation to achieve optimal support and care for the older persons with a goal of optimising their health, wellbeing and quality of life in multiple locations.

Performance indicators

- Demonstrate a positive disposition and commitment towards working together. Foster positive team-working and maximize the potential of staff in providing high standards of care and services.
- Demonstrate knowledge of the roles and responsibilities of the members of the multidisciplinary team who provide care for older persons and of the roles of different categories of the support staff.
- Anticipate to the needs of other professionals; adjust to each other's actions, and have a shared understanding of what should happen.
- Engage in effective and respectful shared decision-making with inter- and intra-professional care and support providers, sharing knowledge, perspectives and responsibilities and willingness to learn together.
- Define the purpose and components of an interdisciplinary, comprehensive assessment and the roles individual disciplines play in conducting and interpreting a comprehensive assessment.
- Refer to, and/or consult with any of the multiple health and social care professionals who work with older persons, to achieve positive outcomes.
- Demonstrate effective and safe handover, both verbal and written, during transition of the older person to a different setting or during a transition of responsibility for the care and support.
- Maintain and promote a culture of collegiality and respect in professional relationships.

Outcome

Health and social care professionals effectively work together with other professionals for good integrated care and support for older persons and their families. Multi- and interprofessional cooperation in order to achieve optimal support and care for the older person with a goal of optimising their health, wellbeing and quality of live in multiple locations.

6.2 Informal care and support

Role: Collaborator

Competence

Work together with older people's supportive family, informal caregivers and their social network to encourage appropriate informal care and support.

Performance indicators

- Work effectively with the supportive family and informal caregivers on a basis of respect and equality.
- Coach informal caregivers on instrumental and emotional care to older people.
- Assist informal caregivers to reduce their stress levels and maintain their own mental and physical health.
- Assist informal caregivers to identify, access, and utilize specialized products, professional services, and support groups that can assist with care-giving responsibilities and reduce caregiver burden.

Outcome

Professionals work effectively with the supportive family, the informal caregivers and together they provide optimal care and support for older persons and their families.

7. Competences Organizer role

7.1 Planning and coordination of care and services

Role: Organizer

Competence

Plan, arrange, and coordinate the care and services provided by formal and informal health and social care workers, across different organizations, to provide the best personalized care and support for the older person and their family.

Performance indicators

- Provide care management to link older persons and their supportive families to resources and services, and to conduct long-term planning.
- Arrange and coordinate the care provided by informal care and various care organizations and services around the older persons.
- Recognize and respect the variations of needed care and support, the increased complexity, and the increased use of healthcare resources inherent in caring for older people.
- Facilitate safe and effective transitions across levels of care and support, including acute, community-based care and services, and long-term care (e.g., home, assisted living, hospice, nursing homes) for older people.
- Demonstrate leadership in the team and ability to chair meetings.
- Contribute to quality improvement and safety of older persons using the best available knowledge and practice.
- Use health informatics and other data to improve the quality of care and services for older people and their families.
- Prioritize, execute tasks collaboratively with colleagues, and make systematic choices when allocating scarce healthcare resources. Allocate resources for optimal care and support for older people and their families.
- Liaise with relevant disciplines in order to maintain and/or improve organizational, managerial and professional practice in order to ensure a safe environment for both the professionals and the older people.

Outcome

Care and services are planned and organized smoothly, including during transitions. Older people receive personalized care and services which considers their health and wellbeing, social participation and housing conditions in order to optimize their quality of life.

7.2 Programme of care and services

Role: Organizer

Competence

Contribute to the organization of the existing care and services within the region, which can be offered to groups of older people and their families. Take an active part in developing, adapting and implementing long term policy actions relating to care and services for older people on a national, regional, local or organizational level.

Performance indicators

- Identify how policies, regulations, and programmes impact older people, their families and their caregivers, particularly vulnerable groups of older people.
- Identify methods of outreach to older persons and their families to insure appropriate use of the service continuum (e.g., health promotion, long term care, mental health). This includes understanding the diversity of older people's attitudes toward the acceptance of services.
- Identify the need of new kind of services for older persons and their families, and take the initiative to develop these.
- Participate actively in developing, adapting and implementing long term policy actions on a national, regional, local or organizational level.
- Integrate relevant theories and concepts- where possible, evidence based with the focus on wellbeing and quality of life of older people.
- Evaluate the effectiveness of practice and programs in achieving intended outcomes for older persons.
- Apply evaluation and research findings to improve practice and program outcomes.
- Identify the availability of resources and resource systems for older persons and their families.
- Identify the major sources of funding for meeting the needs of older people.

Outcome

Health and social care professionals optimally influence policy development processes on a local, regional and national level for the best care and services possible for older people and their families, with the focus on health, wellbeing and quality of life.

8. Competences Health and welfare advocate role

8.1 Collective prevention and health promotion

Role: Health and welfare advocate

Competence

Advocate for health with, and on behalf, of older people and their families, communities and organizations, to improve health and wellbeing and build capacity for health promotion.

Performance indicators

- Use advocacy strategies and techniques that reflect health promotion principles.
- Engage with and influence key stakeholders to develop and sustain health promotion actions.
- Raise awareness of and influence public opinion regarding health and wellbeing issues which affect older people.
- Advocate to older persons, their families and their caregivers regarding interventions and behaviours.
- Promote physical and mental wellbeing, social participation, safe and comfortable housing and living conditions.
- Use educational strategies to provide older persons and their families with information related to wellness and disease management (e.g., Alzheimer's disease, end of life care).
- Use social media for the purpose of promoting self reliance, co reliance and quality of life of older people.

Outcome

Serve as an advocate for older people, their families and caregivers within communities and various healthcare systems and settings.

8.2 Social map and social networks

Role: Health and welfare advocate

Competence

Access and share information with older persons, their families and their caregivers, regarding the social map, healthcare benefits, social support and public programs.

Performance indicators

- Increase transparency and strengthen the informal social networks around older persons and their families.
- Initiate the formation of informal social networks for older persons in situations where these are lacking.
- Providing insight into all the agencies, organizations and facilities aimed at promoting self reliance, co-reliance and quality of life of older people, and also enable cooperation with those authorities.
- Provide information to older people and their families/caregivers about the continuum of long-term care services.
- Advocate and organise with service providers, community organizations, policy makers, and the public to meet the needs and issues of the growing ageing population.

Outcome

Older persons have information about and access to the right facilities for their personal situation in order to increase their quality of life, considering their health, social support, and families.

9. Competences Scholar

9.1 Expertise

Role: Scholar

Competence

Expand professional expertise for their own professional practice in relation to working with older people and their families. Spread relevant new evidence based research among fellow professionals and other professionals in health and social care.

Performance indicators

- Evaluate the processes and the outcomes of their daily work, sharing and comparing their work with that of others, and actively seeking feedback in relation to the quality of health and social care for older people and their families.
- Use multiple ways of learning in order to achieve improvement in each role (i.e. all 7 CanMEDS based roles).
- Increase their knowledge, understanding, and skills with respect to working with older persons through continuing education, training, supervision, and consultation.
- Relate concepts and theories of biological, psychological and social ageing to health and social work practice and understands the effects of cohort and generational experiences on older persons, the normal ageing processes, and the life course perspective.
- Contribute to the dissemination and/or creation of knowledge and practices applicable to health and well-being of the ageing population.
- Recognize how their attitudes and beliefs about ageing, about older persons, and about diversity may be relevant to their assessment and treatment of older persons, and to seek consultation or further education about these issues when indicated.
- Identify any area of need for information and initiate, using research-based evidence, an information service for older persons and their families or caregivers.
- Summarize and communicate to professional and lay audiences, including older persons and their families, the findings of applicable studies and reports about healthy ageing and an ageing population.

Outcome

As life-long learners, health and social care professionals strive to master their profession and share their knowledge with the aim of improving the quality of care and support for older people and their supportive families. They are adequately equipped to perform the right evidence based care and social support for older persons by the latest best practice and research findings.

9.2 Innovation of care and services

Role: Scholar

Competence

Interpret, evidence based results of research and contribute to the development of knowledge and practical research in relation to the provision of care and support of older people and their families. Implement and apply new insights, protocols, standards, procedures, technologies with the aim of promoting the quality, efficiency and effectiveness of care and services provided to older people and their families.

Performance indicators

- Keep up with relevant professional literature with the focus on improvement of the care and services for older people and their families.
- Analyse research articles on aspects such as reliability and validity.
- When applicable translate research findings and recommendations to one's own practice to improve care and support for older people and their families.
- Analyse innovations and adopt appropriate actions into one's own practice.
- Develop protocols, standards and procedures in the context of promoting the quality, efficiency, and effectiveness of care provided to older people based on evidence-based knowledge.
- Apply technological innovations when suitable and available, and contribute to the health and wellbeing of older people and their families.
- Contribute to, and conduct practical research.

Outcome

Good quality of care and services for older people and their families that are up to date. Implementation of evidence based innovative practices.

10. Competences Professional role

10.1 Professional ethics

Role: Professional

Competence

Demonstrate commitment to best practices for the health and wellbeing of individual older people, their families and society through adhering to ethical standards and professional-led regulation and by showing high personal standards of behaviour.

Performance indicators

- Apply ethical and legal principles to the complex issues that arise in care and services of older people.
- Adhere to laws and public policies related to older persons. Apply knowledge of patients' rights in professional clinical practice.
- Apply ethical principles to decisions on behalf of all older people with special attention to those with limited decisional capacity. This includes the older person's self-determination, end of life decisions and family conflicts.
- Respect and promote older person's right to dignity and self-determination within the context of the law and safety concerns.
- Respect diversity among older people, families, and professionals (e.g., class, race, ethnicity, gender, and sexual orientation) and understand how diversity relates to variations in the ageing process.
- Respect the cultural, spiritual, and ethnic values and beliefs of older people and their families.
- Recognize and manage conflicts of interest.
- Recognize and respond to unprofessional and unethical behaviours in others.

Outcome

Appropriate professional behaviours and relationships with older persons and their families in all aspects of practice, reflecting honesty, integrity, commitment, compassion, respect, altruism, respect for diversity and maintenance of confidentiality.

10.2 Professional commitment and personal awareness

Role: Professional

Competence

Reflect on one's own actions and improve and innovate own professional behaviour to 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. Show awareness of diversity and cultural differences.

Performance indicators

- Demonstrate a commitment to high-quality care and support of their older persons and their families.
- Demonstrate an empathetic attitude and interest in the individual situation of the older person.
- Identify and assess one's own values and biases regarding ageing and, as necessary, take steps to dispel myths about ageing.
- Show awareness of diversity and cultural differences and ability to work with older people from other cultures with tact and respect, and within the boundaries of their own profession.
- Exhibit self-awareness and effectively manage the influences on personal wellbeing and professional performance.
- Reflect on, and critically evaluate her/his professional practice. Professional is open to feedback, seeks feedback and is able to change behaviour accordingly.
- Demonstrate accountability to patients, society and the professional by recognizing and responding to societal expectations of the profession.
- Carry out professional duties in the face of multiple competing demands.

Outcome

Committed health and social care professionals with self awareness and willingness to learn striving to contribute to the health and wellbeing of older people.