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Elderly care worker new

JOB PROFILE AND COMPETENCE TOOL

This report was developed in the framework of the Erasmus+ Tenderness for life[1] partnership, under the leadership of Cyprus University of Technology.

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[1] To learn more: https://www.tender4life-project.org/

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Introduction

TENDERNESS FOR LIFE is an European project funded under the Erasmus+ KA2 programme.

The project aims to enable care providers to implement a set of tools to enhance professional qualification of low-level elderly care workers, as well as to increase their competencies that can directly influence their self-esteem, leading to higher levels of motivation.

Adequate qualification and training lead to better preparation for elderly care workers to deal with contemporary situations. The model to be developed aims to be a mixed training approach between a person-centered approach with high-quality and technical skills (interpersonal, digital). It will innovate in terms of providing new curricula, work-based learning, and practical exercises, instead of the old-fashioned way of theoretical modules, which have been often led to skills and expectations mismatching and thus, job quitting and labor market instability.

Person-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. Recent research of WHO indicates that person-centred approaches are associated with better clinical outcomes and improved cost-effectiveness and thus, supporting the pressure that EU is facing in welfare systems for social and health care. The person-centred care, for instance, sustains the relevance of the role of a carer of an elderly customer in his health and wellbeing. The use of a humanistic approach in delivering services to elderly people is seen as a strategic solution to address the challenges in an ageing population. This kind of humanistic approaches sees customers as “unique individuals”, taking in consideration their perspective and will in the decision-making process, by respect, courtesy, availability, communication, etc. These approaches provide an increase in job satisfaction and improvements in efficiency of services.

The “Elderly care worker new job profile and competences tool” is the first intellectual output of the project. It includes:

- A summary[2] of the results of focus groups conducted with care professionals and older persons in all partner countries to explore the profile of the elderly, the needs of the elderly, the competences should care workers have;
- The description of the competences identified from the focus groups, in terms of knowledge, skills and attitudes;
- An assessment tool, aimed for care professionals to self-assess the possession of the identified competences.

[2] The full report is available from: https://www.tender4life-project.org/uploads/1/2/3/6/123661942/io1_full_report.pdf

Executive summary of the outcomes of the focus groups

Background and methodology

- During December – March 2019, 18 focus group discussions were organized by the members of the Tenderness4life partnership to explore the profile of the elderly, the needs of the elderly, the competences should care workers have.
- 12 focus groups consisted of elderly and 6 of care workers were organized in Italy, Portugal, Finland, Romania, UK and Cyprus. More specifically, 69 old persons (aged 65+) participated and 41 care workers (aged 25 +)
- Each partner was responsible to organize the focus group discussions in their country; however, all followed the research protocol prepared by the CUT team. All partners analyzed the data emerged from the discussions while the final analysis was performed by the CUT team. Results of the FG were analyzed according to Krueger and Casey (2014) framework.

The "modern old person" according to older participants

- The participants had a wide knowledge and understanding how to describe themselves. They **refused** that people in the **age of 65-70** should call them **'elderly people'** and they insisted that there were **no special needs at this age** (CY/IT). The majority of the participants (group of elderly) described the elderly with the following characteristics:
- 'There are **several types of elderly**; the ones who are **totally independent** and those who **need a lot of help** and maybe live in **Nursing homes**' (participant 2) FIN
- I think in the past there was only one concept of 'older person', now it really depends on **how you feel** rather than **on your age**' (participant 8) IT2

Identification of the characteristics of new customers (both groups)

- **A modern retiree: independent/more autonomous:** interested in working - to use his mind - to take care of himself - not to be left, take decisions for himself – more open minded to new relationships - not to marginalize himself – **caring for family members**
- **Free time for him/herself:** relax, cooking, house works, take care of grand-children, **caring about family**
- **Active/ aware of fitness and health:** hobbies (hunting, gymnastics, dance, craft courses, aerobics), household, **3 participants still working and some others express the need to work** for socialization and to earn money (ROM/CY), they meet their friends for walks or go shopping together
- **Involved in the social life/social awareness/volunteer:** social interactions, traveling, excursions, meet their friends
- **Use of social media/Need help to use ICT:** Facebook, internet, WhatsApp and Instagram
- **Emotionally vulnerable:** changes in behavior/change mood/anxiety
- **Loneliness/Abandonment**
- Perceived **ageism and lack of respect**

What does society expect from them? (both groups)

- **Providing care and support within the family**

- *'My mother is 98 and I must be by her side' (participant 3) ROM 1*
- *'They expect you to help the younger generations, for example to take care of grandchildren'IT2*
- *'Take care of grandchildren'(participant 5) UK*

- **Moral Compass/Respected:**

- *'To be a good example for our children' (participant 3) ROM 1*

- **Remain Active/Independent financially/Autonomy:**

- *'To be independent and take care of themselves' (participant 1) FIN*
- *'Remaining active in the society' (participant 4) IT1*
- *'Doing their hobbies' (participant 1) UK2*

▶ **Volunteering:**

- '*There is an expectation for older persons to volunteer and there is a need for this, but the current volunteering opportunities are not suitable for us [meaning: for those who are now in their 65/70ies compared to those who are now over 80]' (participant 6) IT1*

▶ **Discrimination/Rejection/Ignorance/Forgotten:**

- *'They see you (the society) and inferior compared to them. What can the old man or old lady tell us?' (participant 3) CY1*
- *Don´t be too big weight for society' (participant 5) FIN*
- *Old person is very discriminated and bad treated' (participant 6) POR2*
- *'There is that mistrust of the elderly' (participant 1) ROM1*

What are the needs of older persons? (both groups)

- ▶ Performing activities of daily living (hygiene and food)
- ▶ Access to health care services
- ▶ Communicate / social interaction
- ▶ Emotional support and love
- ▶ **Respect/Recognition**

In addition to the above, older persons also mentioned:

- ▶ Transportation
- ▶ Using ICT

Competences of the care workers (according to both groups)

- ▶ Basic care / nursing skills
- ▶ **Communication Skills - Active listening**
- ▶ ICT Skills

- Humane qualities
- Patience
- Respect towards the older person
- Empathy

Barriers and facilitators to good quality of care

	Barriers	***Facilitators***
Older persons	▶ Care workers not speaking the local language ▶ Time pressure	▶ Personal attitudes of the care worker ▶ Training
Care workers	▶ Care workers not speaking the local language ▶ Being under-staffed	▶ Being experienced ▶ Training

Competence profile

This chapter includes the description of the competences that, based on the outcomes of the focus groups conducted in the different countries, should form the ideal set of competence on humanistic care and ICT for care workers of older persons.

Although the professional requirements to perform this job vary across the partner countries, we outlined a profile referring to professionals with a qualification between the third and fourth level of the European Qualification Framework.

We identified seven areas of competences, each of which is described in terms of knowledge, skills and attitudes according to Bloom's taxonomy of learning, which is based on three domains of educational activities: cognitive, affective, and psychomotor. The cognitive domain relates to mental skills (knowledge), the affective domain for growth in feelings or emotional areas (attitudes), while the psychomotor domain is concerned with manual or physical skills (skills)[3].

Because of the limited scope and duration of the Tenderness for Life project training, not all the domains listed in the ideal profile could be addressed in its framework. That's why, as an appendix of the training curriculum developed in IO2, we list which of the competences described in this document have been incorporated as learning outcomes of the Tenderness for Life curriculum.

[3] Winterton, J., Delamare-Le Deist, F., & Stringfellow, E. (2006). Typology of knowledge, skills and competences: clarification of the concept and prototype. Luxembourg: Office for Official Publications of the European Communities.

Autonomy

Definition

Autonomy is Greek for “self-rule,” and it’s basically another word for liberty. If you have autonomy, you are able to make your own choices and go your own direction.

Therefore, in a care setting Autonomy is an important concept which relates to a care recipient’s ability to make their own decisions about the treatment they receive, when and where they receive it and who administers their care.

Care recipient autonomy does not mean that the care provider does not educate and provide guidance to the care recipient to make informed choices however this information, advice and guidance should be done in a way which empowers the care recipient to understand all the issues and consequences of the choices they make and enables them to ask relevant questions to the right people at the right times.

It involves the care provider gaining consent from the care recipient and therefore entering into an agreed care plan which will be reviewed at regular intervals with the care provider and the care recipient.

“The principle of respect for autonomy is usually associated with allowing or enabling care recipients to make their own decisions about which health care interventions they will or will not receive”

A Care recipient’s autonomy refers to a care recipient’s sense of self-determination, of being able to make choices regarding the direction of their own actions, including the freedom to pursue these choices.

Key behavioural indicators

Knowledge (he/she …)	1. Knows what autonomy is and the basic ethical principles related with it
	2. Knows how to seek and value open feedback from care recipients when developing individual care plans
	3. Understands the impact of cognitive abilities of the care recipient on his/her capacity of taking own decisions and understanding of the risks they may take.

	4. Knows how to find innovative solutions in order to encourage and empower to understand their care needs and therefore make informed decisions about their care.
	5. Knows how to manage and prioritize daily activities and make appropriate decisions about when, where and who is involved in discussions with care recipients about their ongoing treatment
	6. Knowledge about the abilities and personal preferences of the care recipients in order to encourage activities that promote autonomy
	7. Has knowledge about the effects of aging on the human body and how it will impact their care recipient to safely encourage choice and independence in daily tasks.
	8. Has knowledge on psychology/motivational strategies to encourage care recipients to participate in decision making and daily tasks.
	9. Has knowledge of technologies to assist care recipients to make informed choices and facilitate independent living.
Skills (he/she is able to…)	1. Develop an sustain empowering relationship with care recipients which enable them to make informed choices
	2. Encourage care recipients to establish personal goals and support them to achieve it
	3. Able to support care recipients to think and act independently, as well as adapting to ongoing changes in everyday life order to receive the best care
	4. Educate care recipients to understand how to deal with setbacks and personal failures whilst learning and developing from such experiences
	5. Enable care recipients to be adaptable and learn how to manage various situations
	6. Support care recipients to be involved in their care
	7. Able to equip care recipients to recognize their own health changes
Attitudes (he/she is…)	1. Empowering
	2. Decisive
	3. Creative

	4. Flexible
	5. Adaptability to the changing needs of care recipient
	6. Assertiveness
	7. Person Centered care

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Quality of life

Description

The concept of quality of life in the field of care in general, is extensive and complex. It involves and is influenced by a broad range of individual factors such as physical health, psychological state, personal beliefs, social relationships and the individual's relationship with their environment.

The World Health Organization defines quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. As a result, an individual's quality of life has an important impact on their mental and physical status, making it an area for both assessment and intervention in the field of elderly care.

Understanding the concept of quality of life, with all its influencing factors, will help the care giver develop a better relationship with the person they are caring for, since it focuses the care effort on the individual needs, values and desires of each recipient of care, while also improving the quality of provided care and the work related satisfaction for the care worker. The person being cared for will also have a better care experience as a result of the comprehensive evaluation needed to evaluate and improve their quality of life. Quality of life must be a constant and central factor considered in the development and monitoring of any care plan, especially in long term elderly care, where issues like personal likes/dislikes, beliefs and values, that in ordinary short term care plans are more or less not considered to have an important impact on the outcome of care, can be central to the evolution of the older person in residential care.

The concept implies the right of every care recipient to live a good quality life, as perceived by the care recipient themselves, as well as an active commitment of the care professionals to assess the objective and subjective needs of the care recipient and implement all the needed steps to ensure a better quality of life for all. Care recipients input and feedback are crucial in a quality of life based approach. Care focused on improving quality of life should be both an organizational goal as well as a personal and professional goal for the care workers working in home care or an institutional care setting, since it implies putting the person as a whole, with all their particularities at the center of the system of care.

A wide range of assessment tools can be used to evaluate the quality of life, but aspects as maintaining a good mental health and a good functional level as well as developing and maintaining social contacts and engaging in leisure activities are very important in maintaining and improving the quality of life for the older persons.

Although mental and physical health, high-quality relationships, and social participation are important, quality of life can be maintained in their absence if the older person value and enjoy other meaningful aspects of their life.

Key behavioural indicators

Knowledge (he/she …)	1. Knows how to evaluate care worker– care-recipient relationships.
	2. Knows how to include care recipients and extended families / friends in the care team / care planning.
	3. Knows the existing assessment tools for the evaluation of all aspects of Quality of Life of older persons
	4. General knowledge of the aging process and common older persons diseases
	5. Knows basic intervention procedures for common health issues as well as a knowledge of available technical aids.
	6. Knows the institutional or personnel related factors that may influence the quality of care provided (burnout, busy schedules, personal dislikes, space design, crowding, etc)
	7. Knows standard operation procedures applicable in the institution and is familiarized with all other institutions that may become involved in the care of the older person.
	8. Knows the different types of communication methods applicable both in a homecare and an institutional setting.
Skills (he/she is able to…)	1. Take into account the individual nature of each care recipient (their particularities). Include/ involve the care recipient's needs, desires, and perspectives in the care process.
	3. Build trust and affection in their relationship with the care recipient.
	4. Transmit a sense of calm and security as well as a respectful closeness to the care recipient.
	5. Foster care recipient's dignity, autonomy, privacy and self–determination.
	6. Analyse his/her own feelings and actions where care recipients are concerned.
	7. Recognize changes in the physical/mental/social status of care recipients and take necessary measures according to his/her professional role.
	8. Recognize his/her own limitations with regards to knowledge and abilities as well as a willingness to learn new skills.
	9. Acknowledge abilities and skills both in care recipients and colleagues.
Attitudes	1. Committment

(he/she is able to develop…)	2. Empathetic behaviour
	3. Respectful
	4. Understanding
	5. Cooperative
	6. sensitive to the changing needs of care recipients
	7. Open-minded
	8. Concerned
	9. Attentive

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Privacy

Description

Privacy was defined as a fundamental human right in the Universal Declaration of Human Rights but there is no consensus on what constitutes privacy. Today, it is defined as the right to maintain control over personal information about oneself, including information about one's possessions, communications, conducts, and other affairs (Kayaalp 2018). Privacy also includes the right of being alone and keep personal matters and relations within one's self.

Privacy protection covers both physical, psychological and social integrity/intimacy and personal data (who is using /correcting/deleting the data). Supporting privacy is based on promotion of functional capacity of the individual. Technology can be used to protect privacy and prevent the transfer of personal data to the third parties

Professional privacy requires compliance with:

- Confidentiality (keeping private information secret)
- Professional secrecy (a duty related with some professions to keep confidential the information that are shared with them by their care recipients)
- Discretion (communicating in such a way as to avoid revealing confidential information).

Key behavioural indicators

Knowledge (he/she …)	1. Knows what is physical, psychological, social and informational privacy
	2. Knows what information is considered as confidential data
	3. Knows the legislation relating to data protection
	4. Knows the ethical principles in securing private data
	5. Knows his/her specific professional ownership where care recipient data is concerned
Skills (he/she is able to…)	1. Secure care recipient's personal information which are processed in occasion or because of the care tasks performed
	2. Apply the values that underpin quality care from a privacy and confidentiality perspective .

	3. Apply appropriate legislation on confidentiality and data protection
	4. Secure care recipient's data and privacy
	5. Protect health and well-being while using health technologies
	6. Protect social privacy in a institutional and homecare settings
Attitudes (he/she is…)	1. Responsible
	2. Respectful
	3. Knowledgeable
	4. Tactful
	5. Detail-oriented
	6. Focused

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Digital competences

Description

Digital competence is defined by the DIGCOMP PROJECT as “the confident, critical and creative use of ICT to achieve goals related to work employability, learning, leisure, inclusion and/or participation in society (Retrieved fromhttps://ec.europa.eu/jrc/en/digcomp/project-background)(1)

According to DigComp 2.0, we identify 5 key areas: information and data literacy (browsing, searching, filtering, evaluation, managing an applying information online), communication and collaboration (interacting, sharing, engaging in citizenship, collaborating, netiquetting, managing digital identity), digital content creation (developing, integrating, re-elaborating, copyright, licenses, programming), safety (protecting devices, personal data and privacy, health and well-being, protecting the environment) and problem solving (technical problems, needs and responses, use creatively and identifying gaps (2).

We can distinguish in these five key areas of DigComp 2.0 framework the concept of eHealth literacy. eHealth literacy has been defined by Norman and Skinner (3) and includes 6 core literacies including Health literacy, traditional literacy and numeracy, Media literacy, Information literacy, Computer literacy and Science literacy.

If we need to present a framework related to the digital competences of care workers or carers we encounter a number of projects that have already dealt with this topic as for example: (www.carenetproject.eu, Carer+, eLILY) (4,5). In the majority of cases, we find the areas of DigComp project with specific competences related to care (e.g. Care-specific digital competences: independent living and social participation of the older person, personal development and social integration of carer, care management, administration or supervision).

In Carer+ project, partners have also included a 3rd domain including digital competence in social care (subdomains: acceptance, adaptation, progression and support) (5)retrieved from https://www.carerplus.eu/sites/all/libraries/Toolkit_developping_digital_competences.pdf?dl=0)

Trying to combine all the existing frameworks and to integrate the information that we have obtained by the T4L focus groups on the needs of older people and competences of care workers we could defined the digital competence area of care workers including 3 key areas: eHealth literacy skills, Safety issues (DigComp 2.0), Communication and collaboration (DigComp 2.0). We have added also here the motivation to use new technologies as a separate area that underline all the other 3.

Key behavioural indicators

	1. Knows the basic concepts related with the digital communication process (source, transmitter, destination…)
	2. Has basic knowledge about Internet use
	3. Has basic knowledge of the most common the digital tools and sources of information for promoting a healthy lifestyle
	4. Has basic knowledge of medical terminology (e.g understands medical leaflets)
	5. Knows what electronic confidential data are
	6. Knows what digital identity is
	7. Knows and understands national and European regulations of digital safety
Skills (he/she is able to…)	1. Basic use of PC and mobile devices (smartphones, tablets)
	2. Use of the internet (browsing, google search, navigation in a website, videos, media, social networks, images, writing a text, downloading apps and software)
	3. Organise, store and retrieve data, information and content in digital environments (basic level)
	4. Able to search, find and assess information and health-related information in everyday life through different media (internet, newspaper, TV, friends, health care professionals)
	5. Communicate effectively using the correct terminology with the doctor, family and care-recipient in a digital environment
	6. Identify media (internet, TV, radio) evidence-based health data.
	7. Search online and use eHealth tools that facilitate everyday living for the care-worker and care-recipients
	8. Facilitate care recipient in the use of eHealth instruments and tools and technology in general (e-Banking, shopping online, entertainment, social life)
	9. Interact and communicate through synchronous and asynchronous digital technologies (such as e-mails, chats, sms…) choose the right tool according to the goals and the recipients of the communication process
	10. Manage efficiently digital identity (personal data and privacy of health -related information)

	11. Collaborate with other service providers through digital technologies
Attitudes (he/she is…)	1. Motivated and active
	2. Empowered
	3. Self-sufficient

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Collaboration and communication

Description

Webster's Dictionary defines communication as "the imparting or interchange of thoughts, opinions, or information by speech, writing, or signs." It is important to consider that communication is not just verbal in form. One study state that 93% of communication is more affected by body language, attitude, and tone, leaving only 7% of the meaning and intent based on the actual words said. Whereas the spoken words contain the crucial content, their meaning can be influenced by the style of delivery, which includes the way speakers stand, speak, and look at a person.

Communication is described also as a method of sending and receiving messages by combining verbal and non-verbal communication competencies (Arnold & Boggs, 1995 and Balzer-Riley,1996). Cherry (1978) describes communication as "the exchange of information for some purposes". In human being communication is essential in everyday life, creates sense of belonging, enhance growth and self-development. Everyone has his/her unique way of communicating. People learn how to communicate through experiences and social relationships. Environment can also influence ways in which people communicate.

According to Manning (1992) a persons' daily encounters and way of speaking can be influenced by environment and social rules under which he/she operates. Communication on the other hand can be affected by person's ability and disability thereby influencing the context of interaction. Diseases like aphasia and dementia can compromise person's ability to communicate. For good care to be given, professionals in social and healthcare must master good way of communicating.

Care workers should possess competent communication skills while caring for the older persons suffering from different diseases, so as to be able to influence the care, provide individual centred care and create good interpersonal relationships. With competent communication skills, care workers have the ability to assess an older person's concerns, show understanding, empathy, support and provide comfort.

The older person who is the consumer in the health care setting, feels the need to trust that the care worker does care about them and is bound to their well-being. The care worker thus has to be able to communicate effectively by showing interest, being alert, keeping good eye contact, being a good listener and asking considerate questions. Non-verbal behaviour such as one's tone, attitude, gestures and facial expressions can all have an impact on the older care recipients.

Collaboration within the care process means that care professionals are assuming complementary roles, are cooperatively working together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans for older person care. Collaboration between care workers, physicians, nurses, and other health care professionals increases team members' awareness of each other's type of knowledge and skills, leading to continued improvement in decision-making.

Good communication encourages collaboration, fosters teamwork, and helps prevent errors.

Key behavioural indicators

Knowledge (he/she …)	1. Is an independent user of the local language
	2. Knows how to read, count and write in own language and in care recipients' language
	3. Knows the importance of non-verbal communication, body language and communication difficulties related to care recipients who are not able to speak.
	4. Knows the communication styles (passive, aggressive, passive-aggressive and assertive)
	5. Knows the challenges that can raise in the communication process and possible solutions
	6. Knows the basics of effective communication theories
	7. Knows the principles of teamwork
	8. Knows social interaction methods - empowerment and involvement in community services
	9. Knows key strategies to involve the family/other professionals in the care process
	10. Knows the different types of communication methods applicable in the working context
Skills (he/she is able to…)	1. Present information in different formats, including written and verbal
	2. Develop and maintain communication with the care recipient and his/her family
	3. Listen actively the care recipient and his/her family about concerns related to the care process
	4. Recognize and respond to non-verbal signs, especially for care recipients with speech and other language difficulties.

	5. Adapt his/her communication to the capacities of the person with whom he/she is interacting
	6. Structure a discussion, break down information into short statements that the care recipient is able to understand
	7. Work in partnership with others (professionals and older person / family)
	8. Create a trusting relationship and communicate in an empathic way
	9. Create a shame free environment, where the care recipient and his/her family feel free to talk or to ask questions
	10. Collaborate with other stakeholders to share information appropriately, being aware of the issue of confidentiality, to ensure that care recipient receive the best possible care
	11. Ensure that information is clear, concise, accessible so that it can be fully understood by others
	12. Encourage professional, open, respectful, empathetic communication, throughout the process of care.
	13. Communicate with care recipients in ways that are meaningful to them
Attitudes (he/she is…)	1. Assertive
	2. Acceptant
	3. Cooperative
	4. Empathetic
	5. Respectful
	6. Confidential
	7. Open minded
	8. Tolerant
	9. Responsible
	10. Patient

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Compassionate Care

Description

Compassion is a core value when dealing with person-centred care and allows for the respect of a care recipient's dignity. Compassionate care has many different approaches. The common understanding in the field of caring is related to «individual emotional, attitudinal and cognitive factors» (Crawford et al, 2014) – it is much connected to an «affiliative behaviour» (Cole-King & Gilbert, 2011).

Compassionate care is when you identify the suffering and distress of another and get impelled to solve it. The term derives also from empathy in the sense of acknowledging and being aware of another's feelings, but adds the commitment to work on it and even prevent it, by delivering a meaningful interaction.

Introducing compassionate care in organisations is a way to improve relationships and care recipient-care worker-experiences. Very often care recipients tend to value those care workers who are compassionate, kind and generous. Compassionate care can also be a trigger for better performance levels in caring: it enhances «staff efficiency», helps «elicit better patient information», thus leading to «better recovery and increased satisfaction» (Cole-King & Gilbert, 2011).

Key-behavioural indicators

Knowledge (he/she…)	1. Knows about the holistic approach of old people
	2. Knows basic strategies to provide emotional support
	3. Knows strategies to involve staff, older persons and families as active participants in the care process
	4. Knows the appreciative inquiry techniques
	5. Knows the diversity of health situations occurring with old people
	6. Knows basic care techniques and approaches in use in his/her working context
	7. Knows the deontological rules of his/her profession
Skills (he/she is able to…)	1. Elicit what the care recipient considers important in relation to his/her care
	2. Recognize another's feelings and intentions, and make sense of his feelings and your own emotional responses (empathy) –
	3. Stand back, think and reflect on personal behavior

	4. Take into account the point of view of others and to consider other's perspective
	5. Bear difficult emotions and work out with the other person what might be helpful (distress tolerance)
	6. Be caring, supportive and helpful to others (care for the well-being)
	7. Be concerned for the suffering of care recipient (sympathy)
	8. Notice when others need help (open attention)
	9. Find ways to work negative feelings out, deal with them to avoid burnout, prevent to absorb the traumatic stress of others (emotional self-control)
	10. Acknowledge the individuality of each care recipient
	11. Is comfortable to challenge care practice which do not express compassion
	12. Ask questions on feelings of the care recipient
Attitudes (he/she is…)	1. Committed
	2. Collaborative
	3. Non-judgmental
	4. Humane
	5. Sense of humor
	6. Humble
	7. Understanding
	8. Patient

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Respect for the dignity of the care recipient

Description

The term “dignity” is derived from the Latin “dignus” meaning worthy (Mairis, 1994), and the Oxford English Dictionary (2002) defined it as “the state or quality of being worthy of honour or respect”and (by extension) self-respect. Dignity in care, therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person’s self- respect regardless of any difference.

According to Nordenfelt (2004) dignity can be divided into four types including: merit, moral status, personal identity, and universal human dignity.

Universal human dignity is related to human worth, and is, according to Nordenfelt, universal and inherent. Nordenfelt claims that an individual has this kind of dignity in all cases, for example despite diseases like dementia, and it cannot be lost as long as the person exists.

On the other hand, dignity of identity is of the most relevance to discussion of dignity and ageing. Nordenfelt defines it as ‘the dignity that we attach to ourselves as integrated and autonomous persons, persons with a history and persons with a future with all our relationships to other human beings’. This kind of dignity can be taken away from individuals by external events, by the acts of other people (for example if an individual is humiliated or treated as an object) as well as by illness, injury and old age.

In light of the findings of previous research on the subjective experience of individuals diagnosed with dementia, it seems likely that these individuals are particularly at risk of suffering a loss of personal dignity as the result of the impact the disease has directly on their identity and sense of self, as well as indirectly via negative social interactions and experiences. However, the intensity with which the decline in personal dignity is experienced depends to a large degree on the social context of the individual (Van Gennip, 2016).

Since dignity is something that can be influenced by others and external factors, we assume that dignity can also be promoted through care practices.

Key behavioural indicators

Knowledge (he/she…)	1. Knows regulations regarding capacity and self-determination and ethical codes about dignity applicable in his/her working context
	2. Knows the different interpretations of the concept “dignity”
	3. Knows the dimensions of dignity (spiritual, psychic and bodily dimension, Edlund et al., 2013)
	4. Knows the ethical values underpinning dignity

	5. Knows the expressions of respecting human dignity (Papastavrou et al., 2016, Gallagher 2007)
	6. Knows national regulations regarding privacy and confidentiality
	7. Knows the concepts of human rights applied to older persons and elder abuses
Skills (he/she is able to…)	1. Acknowledge individual differences of care recipients
	2. Investigate and respects person's opinions, values and beliefs
	3. Involve care recipients in the decision-making process
	4. Make his/her care recipients feel in control by involving him/her in the care process
	5. Investigate, respect and act upon individual's wishes and preferences when they receive personal care and support.
	6. Maintain the privacy and respect the modesty of the individual(s) in his/her care
	7. Respect and promote the human rights of older persons
	8. Promote the safety of his/her care recipients protecting them from abuse
	9. Notice and challenge potentially abusive practices
	10. Promote a sense of self-worth in his/her care recipients
	11. Make his/her care recipients feel valued (i.e. solicit their opinions, asking feedbacks, expressing recognition…)
	12. Communicates with care recipients in ways that are meaningful to them
Attitudes (he/she is…)	1. Empathic
	2. Acceptant
	3. Respectful
	4. Non judgmental
	5. Confidential
	6. Sensitive

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The assessment tool

The tool includes a set of questions aimed to measure elderly care workers' performance and skills assessment (with correspondence to behavioural descriptors) to measure their level of proficiency and to identify training needs.

Methodology

Current evaluation of Patient Centred Care (PCC) includes a variety of assessment methods: direct observation, video- or audio-taped interviews, peer or patient evaluation, and self-assessment using simulations, standardized clinical encounters, or encounters with real patients. Among these approaches, self-assessment is valuable since self-evaluation has been identified as a key aspect of professionalism, which is deemed to be taught and encouraged. As a mechanism for identifying one's own weaknesses and strengths, it can determine learning needs and provide insight into an individual's thoughts, feelings, and emotions toward patients.[4]

One could argue that self-assessment may suffer of poor reliability compared to objective assessment. Researches in this field show for example that medical students do not significantly over- or underestimate their skills, but are more likely to overestimate performances related with communication, that involve more subjective interactions and evaluations than objective, knowledge-based performance measures.[5]

Another point that should be taken into account that when surveys use self-assessment, they are subject to social desirability bias, i.e. the tendency of subjects to respond to test items in such a way as to present themselves in socially acceptable terms in order to gain the approval of others.[6] This may limit the usefulness of these self-assessments.[7]

While being aware of the limitations of self-assessment approaches, the Tenderness for life partnership also acknowledges that there may be educational benefit simply by the process of

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[4] Gremigni, P., Casu, G., & Sommaruga, M. (2016). Dealing with patients in healthcare: a self-assessment tool. *Patient education and counseling*, *99*(6), 1046-1053.
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self-reflection. Reflection, both on the process and content of learning can help students to monitor their own learning. Studies have found that a greater effort of reflection is associated with a more positive or meaningful learning experience.[8]

Therefore, the goal of this tool is on one hand to allow healthcare personnel to get insight into their own ability to perform a particular PCC behaviour in day-to-day practice, while at the same time offering employers the opportunity to identify weaknesses in their staff and helping the professional to set appropriate learning goals.

The conceptual approach underlying the generation of the items was based on a set of "humanistic care competences" identified in an earlier stage of the Tenderness for life project and described in the report "**Tenderness for life competences description**".

The formulation of the items and of the response scale, instead, was inspired by the Provider-Patient Relationship Questionnaire (PPRQ).[9] The PPRQ was found to be a psychometrically sound measure that is not affected by socially desirable responding and it was applied in PCC-related training.

Same as in the PPRQ, in the preface we provide a rationale for the questionnaire by indicating that it reports common ways of dealing with patients in care setting. In order to recall a vivid day-to-day experience rather than a generic behaviour, respondents are asked to think about their last month of work and rate how they behaved in accordance with each statement using a 5-point scale (1 = "not at all" to 5 = "very much").

Items explore the different dimension of humanistic care identified in Tenderness for life competences description as follows:

Competence	*ITEMS*			
Autonomy	1	8	15	22
Quality of life	2	9	16	23
Privacy	3	10	17	24

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Digital competences	4	11	18	25
Collaboration and communication	5	12	19	26
Compassionate care	6	13	20	27
Respect of dignity of the care recipient	7	14	21	28

Table 1 - Competences / item correspondence

Assessment questionnaire

Please read the following statements which refers to common ways of dealing with users in care settings. Think about your last month of work and rate how you behaved in accordance with each statement using a 5-point scale from 1 = “not at all” to 5 = “very much”.

1. I have been able to allow my clients the time they need to eat by themselves.

1	2	3	4	5
Not at all				*Very much*

2. I have been able to take care of the social interaction with my clients as much as I take care of their personal care needs

1	2	3	4	5
Not at all				*Very much*

3. When performing care activities, I have been able to respect the modesty of the clients.

1	2	3	4	5
Not at all				*Very much*

4. I have been able to assess the reliability of health information found on the internet

1	2	3	4	5
Not at all				*Very much*

5. I have listened carefully to my clients and asked questions to better understand what they were saying.

1	2	3	4	5
Not at all				*Very much*

6. I have been able to understanding my clients and to connect emotionally

1	2	3	4	5
Not at all				*Very much*

7. I have been able to recognize that each client has different interests and expectations

1	2	3	4	5
Not at all				*Very much*

8. I have been able to encourage my clients to be resilient and persistent when trying to overcome challenges.

1	2	3	4	5
Not at all				*Very much*

9. I have been able to develop a care plan for a client taking into account his/her personal preferences, beliefs and values.

1	2	3	4	5
Not at all				*Very much*

10. I have been able to protect personal information of my clients, preventing unauthorized persons to have access to them

1	2	3	4	5
Not at all				*Very much*

11. I have been able to exchange documents by email or by other digital platforms with colleagues

1	2	3	4	5
Not at all				*Very much*

12. I have been able to establish a positive communication with the families of my clients.

1	2	3	4	5
Not at all				*Very much*

13. I have been able to use humor to redirect/divert attention and change the behavior of my client

1	2	3	4	5
Not at all				*Very much*

14. I have been able to explore and understand the wishes of clients with cognitive decline

1	2	3	4	5
Not at all				*Very much*

15. I have been able to support my clients suffering from memory impairment to continue performing their day to day activities as much as possible

1	2	3	4	5
Not at all				*Very much*

16. I have been flexible in adapting a care protocol to meet the needs of the client

1	2	3	4	5
Not at all				*Very much*

17. I have been able to balance the respect of privacy of my clients with my duty to protect them from risks

1	2	3	4	5
Not at all				*Very much*

18. I have been able to advise my clients to be cautious about what information they share on the internet.

1	2	3	4	5
Not at all				*Very much*

19. I have been able to work in a team.

1	2	3	4	5
Not at all				*Very much*

20. When a client had a challenging behavior, I have been able to control myself

1	2	3	4	5
Not at all				*Very much*

21. I have been able to challenge a practice that I considered detrimental for the dignity of the client

1	2	3	4	5
Not at all				*Very much*

22. I have been able to find a balance between protecting my clients to the risk of falling and allowing them to continue to move freely

1	2	3	4	5
Not at all				*Very much*

23. When I have faced a challenging situation in the work place, I have been able to stop and reflect on my immediate reactions in order to correct possible mistakes.

1	2	3	4	5
Not at all				*Very much*

24. I have been able to ensure confidentiality of personal information shared with me by my clients

1	2	3	4	5
Not at all				*Very much*

25. I have been able to search for clarifications for unknown medical terms on the internet.

1	2	3	4	5
Not at all				*Very much*

26. I have been able to give instructions to a colleague in such a way they were correctly understood

1	2	3	4	5
Not at all				*Very much*

27. I have been able to respect the time of my clients and not to interrupt them from activities they enjoy whenever possible.

1	2	3	4	5
Not at all				*Very much*

28. I have been able to make arrangements to ensure confidentiality when discussing a private matter with a client

1	2	3	4	5
Not at all				*Very much*

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