

Final Report on the Project

**Development and Coordination of a Network of Nurse
Educators and Regulators (SANCO/1/2009)**

to the European Commission, DG SANCO

Submitted by:



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1 Background and Objectives of the Project

Health professions in general and the care profession in particular are undergoing profound changes in Europe. The ageing of the population in many EU member states inevitably leads to an ageing health workforce with an insufficient number of recruits replacing the people who retire. According to an estimate, Europe expects a shortage of 1.000.000 health workers by 2020. This development is furthermore accompanied by an increasing demand for professional care services, which emerges due to longer life expectancy as well as decreasing informal care. Thus many EU member states already register a shortage of physicians and registered nurses. The recruitment of professionals from other countries as a short-term solution already led to an increasing mobility of employees within Europe. This is especially true for countries such as Estonia, Hungary, Poland, Slovakia and Romania; however the expected brain drain did not quite reach the feared dimension.¹ As noted by the European Commission in the Call for Proposal (DG SANCO 1/2009) this migration of health professionals into and out of the EU, the mobility within the EU and especially the movement of some health professionals from poorer to richer countries inside and outside the EU, enhances the effect of shortages in some regions. Following these developments, questions of quality management and patient security arise due to the different education norms within the EU member states. Special attention needs to be paid to the questions of proper training of the workforce and whether they are equipped to deal with the consequences of demographic change as well as medical and technological innovation. These include changing patterns of care, demonstrated in particular in the shift from acute care to long-term care.²

With regard to these issues of concern, the contec GmbH and its partners, on behalf of the European Commission, conducted the project “Creating a Pilot Network of Nurse Educators and Regulators” (Dec. 2010 – Dec. 2013). The project was carried out together with the IEGUS - European Institute for Healthcare Research and Social Economy and project partners from Finland, Germany, Poland and the United Kingdom.

The aim of this project was to initiate a Europe-wide exchange about educational standards and legal regulations of employment for assistant staff within the healthcare sector. The target group were healthcare assistants (HCA) and “lower skilled nurses”, i. e. care staff below the qualification level of “nurses responsible for general care” according to the Directive 2005/36/EC.³ Due to the skilled worker shortage this occupational group will be called into action more strongly in the following years and will have to take on more tasks that require adequate qualification.

¹ Wismar, Maier, Glinos et al. (Eds.) (2011): Health Professional Mobility and Health Systems, Observatory Studies Series 23, The European Observatory on Health Systems and Policies, WHO 2011, p. 44.

² Call for Proposal – SANCO 01/2009

³ “The training of nurses responsible for general care shall comprise at least three years of study or 4.600 hours of theoretical and clinical training,” Art. 31, 3. Directive 2005/36/EC.

In order to achieve the goal of the project the following work packages were identified:

- provide an overview of the current situation in education, training and employment for healthcare assistants in all participating countries,
- identify best-practice examples in view of future challenges in healthcare delivery as well as mobility issues, and
- derive recommendations for the further development of training programmes in order to better meet the future needs.

For a deeper understanding of the mentioned emerging changes and the profession in question of the project, a literature research and analysis was carried out at the beginning of the project. A broad range of topics has been looked at – for instance the different healthcare systems throughout Europe, the frameworks and challenges for education and training, the European agenda for new jobs and skills, literature related to mobility and migration of health workers and nurse regulation. In summary it turned out that there is little to be found with special focus on healthcare assistants and care support workers. Therefore it has been very important to collect basic empirical transnational data from the pilot network.

During the course of the project a Europe-wide pilot network of nurse educators and regulators from 15 countries has been established, a database on the legal framework and training regulations of the different EU countries was built and the scope of the skills and competences required of these staff within the EU was examined. Finally, recommendations for the framework of HCA education, training and employment have been derived, amongst others from best-practice examples of the different participating countries. These recommendations provide a basis for the development of national educational programmes.

2 Design of the Project

Partners and Course of Action

The project leader was Contec GmbH, Bochum. The project team consisted of the following partners from Germany, Finland, Poland and the United Kingdom:

Table 1: Project Partners

Institution	Contact person
<p>Contec Gesellschaft für Organisationsentwicklung mbH BioMedizinZentrum Ruhr Universitätsstr. 136 44799 Bochum, Germany</p>	<p>Dr. Grit Braeseke grit.braeseke@contec.de Phone: +49 234 45273-41</p>

Institution	Contact person
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ZAB Zentrale Akademie für Berufe im Gesundheitswesen GmbH Hermann-Simon-Str. 7, 33334 Gütersloh, Germany	Andreas Westerfellhaus westerfellhaus@zab-gesundheitsberufe.de Phone: +49 5241 708230

Overall, the project development followed the timetable structure illustrated in Table 1. The initial step was to identify and get in touch with nurse experts in other Member States in order to establish the pilot network representing at least 10 different countries. Parallel to that process the operationalization had been planned and prepared – i. e. the glossary, methodologies, questionnaires and organisational steps. The first part of data collection on the status quo of HCA education and training in each participating country had been performed right before the first meeting of the pilot network in Berlin (October 2011). The aim of the project, the glossary as well as the first set of data were thoroughly discussed and exchanged during this meeting and the agreed results built the basis to step forward with a common understanding. Afterwards more details about education and training were collected and an EU-data base was created to map all information properly.

Table 2: Timetable

Work-package	Timetable	Dec 10 - May 11	Jun 11	Jul - Aug 11	Sep 11	Oct 11 - May 12	Jun 12	Jul - Oct 12	Nov 12	Dec 12 - May 13	Jun 13	Jul - Sep 13	Nov 13	Nov - Dec 13	Jan 14 - Jun 14
	Literature research														
WP1	Development of a database for the pilot network														
	Making contact with experts from at least 10 Member States														
	1. Interim report on project progress (15th of June 2011)														
	Preparation kick-off workshop														
	Kick-off workshop (Berlin) with members of the pilot network														
WP2 & WP3	Collecting information from European countries on legal framework for employment and on the necessary qualifications and skills for lower skilled nurses														
	Development of a knowledge database and entering the information														
	Development of an EU-Map to legal framework and to the summary of the qualifications and skills (Interim technical implementation report) (15th of June 2012)														
WP4	Preparation 2. Workshop														
	2. Workshop (Brussels), defining evaluation criteria for Best-practice-examples in nursing education et al.														
	Development of a Best-practice-database (possibly as part of the knowledge database)														
	Gathering and recording information about best-practice concepts														
	Evaluation of Best-practice-examples (experts from the project team)														
WP5	Draft recommendations for training requirements for lower skilled nurses and care assistants														
	Draft recommendations for educational support for informal carers														
	Discussion of drafts among the pilot network														
	Conference in Brussels with the Commission, stakeholders and experts														
	Finalizing the recommendations and the project report - end of the project (14th of December 2013)														
	Preparing and submitting the final technical implementation report														

Key Work phase
 Workshop/Meeting
 Completion of deliverables/interim reports
 Completion final report



The next step forward was to gather best-practice examples from all participating countries in the fields of education and training as well as the terms of the employment of healthcare assistants. Additionally, the issue “educational support for informal carers” has also been addressed.

Finally, the project team analysed all data extensively and developed draft recommendations for education and training of HCA in the future in order to cope with the demographic challenges and to meet the requirements of modern care settings. After having discussed these recommendations within the pilot network a workshop with different stakeholders took place in Brussels. The valuable results of the discussions there have been considered in the final version of the project recommendations.

There was a continuous research and revision of literature throughout the whole project.

Creating the Pilot Network of Nurse Regulators and Nurse Educators

At the first internal project meeting on 13th April 2011 in Berlin the project partners agreed to include one nurse regulator and one nurse educator from each participating country into the pilot network of at least 10 EU member states. Since issues regarding the employment of healthcare assistants had been in focus of the project too, nurse management representatives were included as well.

In order to reach this goal, more than 10 member states had been addressed in the first round. Hence 18 countries were asked to participate in the pilot network of nurse educators and regulators. Finally the project partners were able to include the following 15 countries (14 EU-member states and Switzerland) into the pilot network:

Table 3: Population of Participating Countries

Country	Population ⁴
Austria	8.451.860
Belgium	11.161.642
Bulgaria	7.284.552
Czech Republic	10.516.125
Denmark	5.602.628
Finland	5.426.674
Germany	80.523.746
Ireland	4.591.087
Italy	59.685.227
The Netherlands	16.779.575
Poland	38.533.299
Slovenia	2.058.821
Spain	46.704.308
United Kingdom	63.896.071
Sum	361.215.615
EU 28 Population	505.701.172
Switzerland	8.039.060



Figure 1: Participating Countries

These 14 Member States, accounting for about 71 % of the whole population in the European Union, represent a broad range of different countries in terms of old and new Member States, geographic region (East-West, North-South), large and small states and in view of their social security approach (i. e. financing and organizing healthcare systems).

⁴ EUROSTAT
<http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=de&pcode=tps00001&plugin=1>

Members of the Pilot Network

Table 4: Members of the Pilot Network

Country	Name	Expertise	Institution	Job Title
Austria	Dir. Barbara Zinka	Nurse Expert for Education	Pflegeakademie der Barmherzigen Brüder Wien	School Director and Lecturer for Healthcare and Nursing
	Ingrid Rottenhofer	Nurse Expert for Regulation	Gesundheit Österreich Gesellschaft (GÖG)	Head of the working field healthcare professions; scientific consultant
Belgium	Prof. Anne Lekeux	Nurse Expert for Education	FINE (European federation of nurse educators) and FEDESUC (Federation of higher education French speaking community of Belgium)	Prof. International coordinator in the Nursing Department
Bulgaria	Assoc. Prof. MD PhD Lidia Mladenova Gorgieva	Nurse Expert for Education	Faculty of Public Health, Medical University	Assoc. Professor in Department of Social Medicine and Healthcare Management
Czech Republic	Karolina Moravcová	Nurse Expert for Education	Vysoká škola zdravotnická, o.p.s (Medical College in Prague)	Professor at the Faculty of Nursing and Specialization in Healthcare
Denmark	Prof. Inger Just (RN)	Nurse Expert for Education	University College Lillebælt	Study Coordinator
Finland	M.Sc. MHPE Taina Viiala	Nurse Expert for Education	Laurea University of Applied Sciences	Director
	Annele Ranta	Nurse Expert for Education	Vantaa Vocational College Varia	Director in the Field of Education
Germany	Dr. Dag Danzglock	Nurse Expert for Regulation	Ministry of Education and Cultural Affairs in Lower Saxony	Principal
	Jens Reinwardt	Nurse Expert for Education	Akademie für Gesundheit Berlin/Brandenburg e.V.	Managing Director
Ireland	Patrick Glackin	Nurse Leader	Office of Nursing and Midwifery Services Director, Health Service Executive (HSE)	Interim Area Director of Nursing and Midwifery Planning and Development
Italy	Gennaro Rocco	Nurse Expert for Education and Regulation	Ipasvi National	National Vice President
	Alessandro Stievano	Nurse Expert for Education and Regulation	Italian Representation	
The Netherlands	Anna van Luijn	Nurse Leader and Educator	VU Amsterdam	Project Manager and Lecturer
	Maud Pellen	Nurse Leader	University Medical Centre Utrecht	Head Nurse

Country	Name	Expertise	Institution	Job Title
Poland	Dr. Ewa Kuriata	Nurse Leader and Expert for Education	Medical University of Wrocław	Senior Lecturer in Nursing at the Faculty of Health Sciences
	Anna Wilmowska	Nurse Regulator	University of Rzeszów	Director of Institute of Physiotherapy
Slovenia	Miha Okrožnik	Nurse Expert for Regulation	Nurses' and Midwives' Association Slovenia	Orthopaedic Technologist
	Martina Škrabec (RN)	Nurse Expert for Education	Nurses and Midwives Association Slovenia	Teacher in Nursing
	Dr. Brigita Skela-Savič	Nurse Leader	College of Nursing Jesenice	Dean, Associate Professor
Spain	MSc PhD Teresa Moreno-Casbas (RN)	Nurse Leader	Nursing and Healthcare Research Unit (Investéniscii)	Head of Unit
Switzerland	MPH Roswitha Koch Heepen (RN)	Nurse Expert for Regulation	SBK Swiss Nurses Association	Responsible Professional Development
	Sophie Ley	Nurse Expert for Education	Hôpital du Valais	Responsible for nursing development and education
United Kingdom	Dr. Mary Gobbi	Nurse Expert for Education	University of Southampton, Faculty of Health Sciences	Senior Lecturer in Nursing at the at the Centre for Leadership and Innovation, Faculty of Health Sciences
	Tanis Hand	Nurse Expert for HCA and AP	Adviser to Royal College of Nursing	RCN HCA/AP Advisor

The project management at Contec GmbH was responsible for setting up the IT-infrastructure to service the expert network. The majority of information has been collected via online surveys. Additionally, Contec investigated basic information on the healthcare systems of the participating countries.

2.1 Glossary

When conducting a project in cooperation with several EU member states, central terms used in the survey needed to be defined first in order to facilitate a common understanding. Different frameworks and regulations in each member state as well as in Switzerland and information and data in the countries' own languages could cause misinterpretations and considerable problems in collecting and evaluating the material. Therefore a glossary focussing on specific issues of the regulation of education/training and the occupation of the target group had been started at the beginning of the project and was extended whenever necessary. These definitions were partly transferred from the "Tuning Project"⁵ which offers a list of English terms applied in the field of development and evaluation of education programs. Other terms (e. g. best-practice example or EU-mobility) were defined according to work packages of the present project. The complete glossary is attached in the appendix.

⁵ The tuning project can be reviewed at <http://www.unideusto.org/tuningeu/>.

2.2 Process of Data Gathering

The process of data gathering was started in July 2011. The network members used their own sources to provide the relevant information. These sources basically consisted of legal documents, reviewed papers, press releases or online services of statistical and political institutions in the national languages. Generally, the experts did not state their sources when they provided general information. However, statistical data or information on the regulation based on specific legal documents (e.g.) had been cited in most cases. Though structured very clearly and presented with an easily accessible methodology for all participating parties within the project, some obstacles had to be overcome. Some of the obstacles partly occurred due to language barriers, lack of time or misunderstandings when it came to expected and delivered data. Some problems could be solved through telephone calls or Email contact. Other requests were simply not answered at all, resulting in missing data, especially within the best-practice examples and the survey about the situation of informal carers.

1. Survey 1 (Conducted from 12th July to 19th September 2011)

The first survey was based on general questions about the occupational group of healthcare assistants in the respective country. The survey essentially consisted of questions about the occupational title in national language, licensing, registration, compulsory qualification and expected learning outcomes. It was also asked to provide examples of the content of a training program (compulsory or not) for the target group employees.

2. Kick-off Meeting (21st October 2011 in Berlin with all experts)

During the first meeting of the pilot network the experts were asked to introduce their home country with a statement on the situation of regulation and education of healthcare assistants and to provide a brief estimation of future trends and developments in the national health and care sector. These situation statements were included in the development of the country profiles.

Furthermore the timeline shown below for the next organisational steps had been agreed upon:

Timeline for the EU-Project Creating a Pilot Network of Nurse Educators and Regulators (SANCO/1/2009)

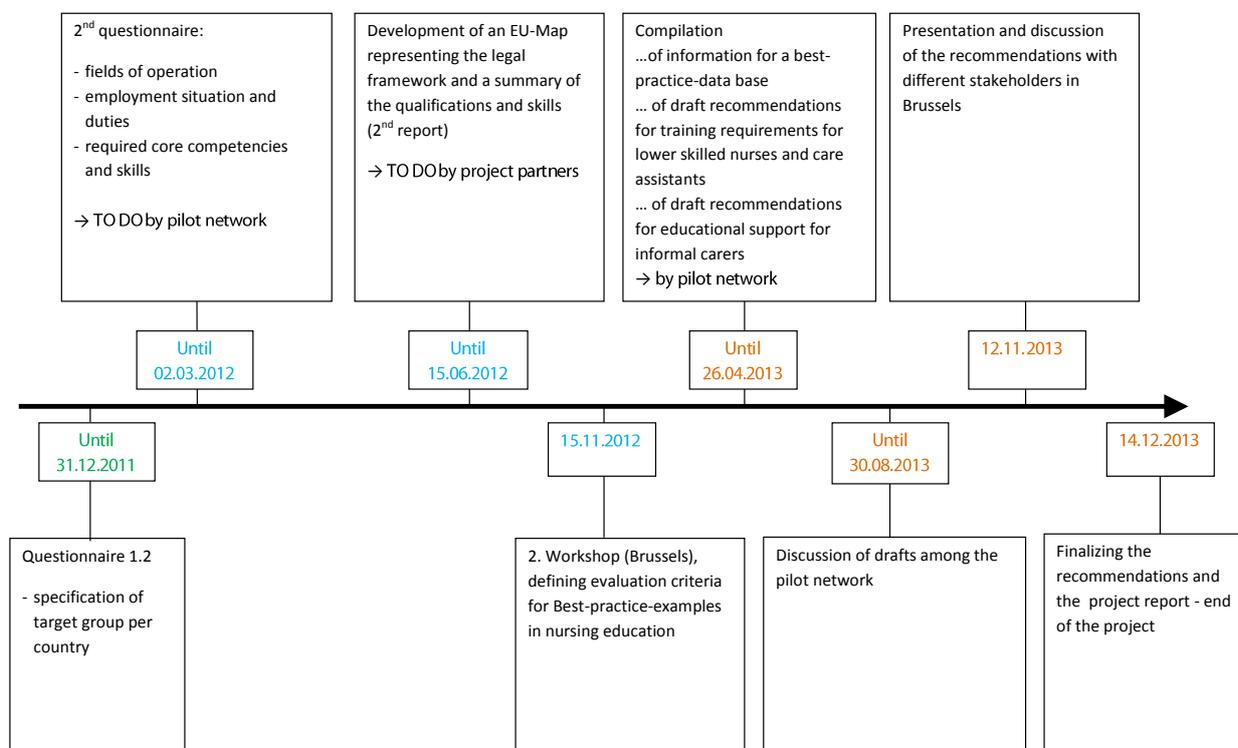


Figure 2: Timeline of the Project

3. Survey 1.2 and Generation of Country Profiles (Conducted in December 2011 and January 2012)

The update on survey 1 had become necessary because at the meeting in Berlin modifications of the definition of the project's target group had been made. In consequence survey 1 was applied in version 1.2 where the countries' experts could modify their original statements. Additionally, survey 1.2 was executed on an interactive platform with open answer spaces to enable for more complex responses. The experts could enter the survey as often as necessary and modify or add to their answers.

Most of the project relevant country data was gathered in the so-called country profiles. These profiles were central for mapping the educational, regulatory and employment related characteristics of the countries and served as basis for the interactive database. The search for a useful and self-explanatory content structure led to the development of a diagram which shows the central aspects included in this research concerning education, regulation and employment of healthcare assistants (view figure 3 below).

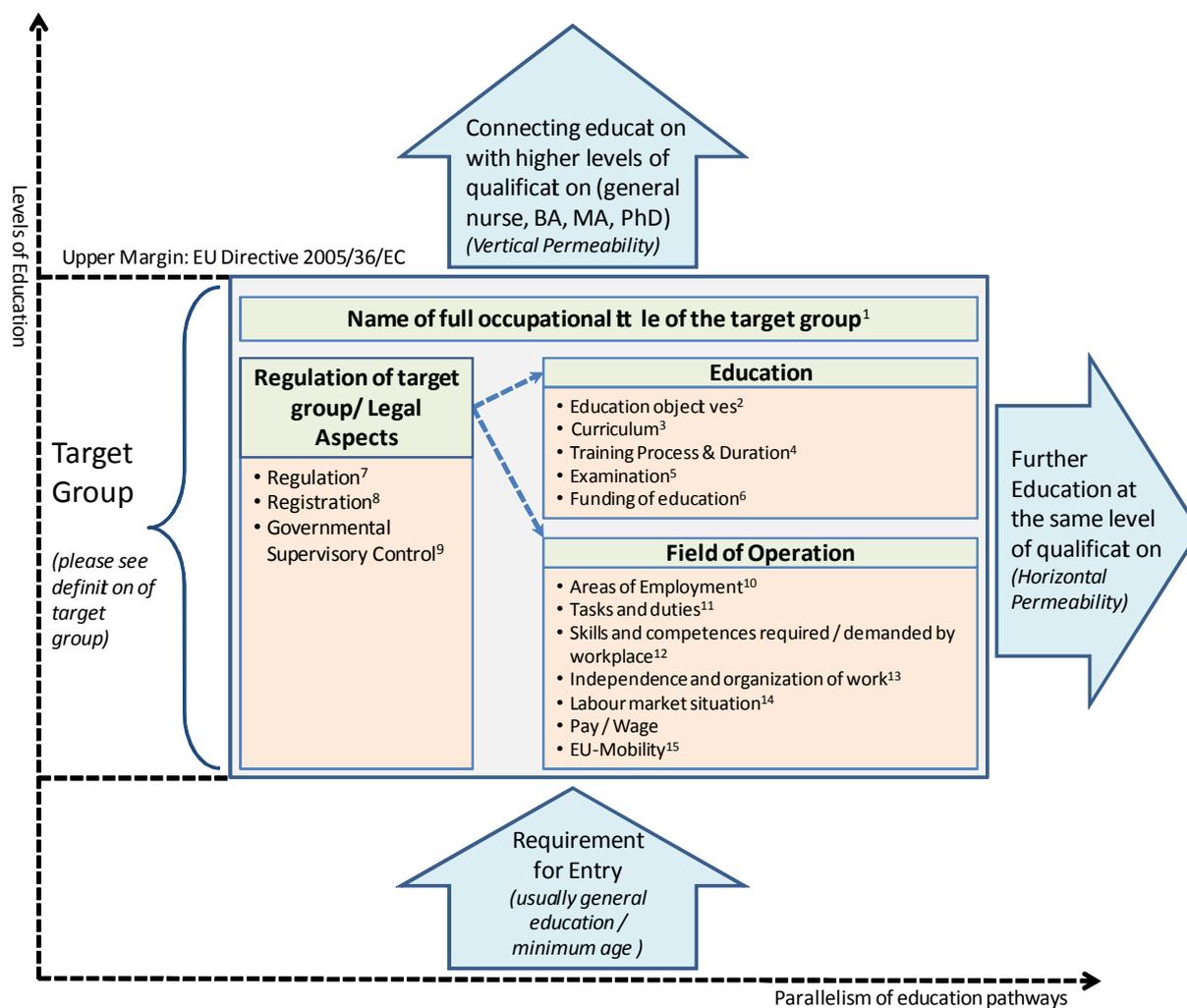


Figure 3: The Structure of General Information and Data Concerning HCA in the Database

It became necessary to specify and diversify the sections of the three sectors in order to catch the diversity of the countries' situations on the one hand and to make them comparable on the other hand. As a further help additional descriptions of what the expected content of each section was supposed to encompass were added. These short text passages helped to transfer information correctly from a source into a single country profile and were used as a guide for the country experts when trying to modify and supplement content. In figure 3 these text passages are represented by footnotes from 1 to 15:

- ¹ E. g. Healthcare Assistant (HCA)
- ² Education objectives of the qualification should be identified and communicated in English by the country experts without shortening of content (plain original text parts please) if available by an official curriculum or another source of information. The project team can filter the text respective knowledge, competencies, capacities, skills, future rights and duties afterwards.
- ³ Curriculum:
 1. Is there any curriculum? If yes, what is its content?
 2. Does it cover theoretical as well as practical parts of education?
 3. What is the relation between practical and theoretical parts?
 4. In what kinds of facilities does the practical part take place?

- 4 Training process and duration:
1. How is the training process designed in timely manner?
 2. Is there full time or part time education, also work-based learning?
- 5 Examination:
1. State examination, officially recognized or internally organized examination?
 2. Practical, written or oral examination?
- 6 How is the training funded:
- a) public funding (eg taxes, national bodies)
 - b) private funding (eg insurances, private employers)
 - c) self-funding (eg personal monies) or
 - d) mixed funding source (please specify)
- 7 Regulations below Registered Nurse! The following questions or categories should be specified separately:
1. Information relating to what is regulated (e.g. education, employment) → no details of the content (e. g. single tasks or duties)!!!
 2. Who regulates?
 3. Sources of regulation (e.g. laws or decrees) with their official names
 4. History of regulation (if provided)
- 8 Registration:
1. Is there any?
 2. What institution does it?
- 9 Accountable to whom?
- 10 Areas of employment:
1. Areas of employment respective occupational areas should be listed here and may be differentiated according to caring for patients/clients in their own homes, community settings, nursing/residential care homes and hospital settings.
 2. General development regarding the areas of employment and the “care market”.
- 11 The tasks and duties can be subject to regulation, but don't have to be. They should be described here in detail and be set in relation to the areas of employment if they differ respectively.
- 12 In comparison to the description of educational objectives (certain knowledge, skills, competencies etc.) above here we concentrate on the actual demand / requirements of the workplace.
- 13 Some of the practical consequences of regulatory issues can be described here. If the occupation is not regulated the organization of work and the dependence or independence in working may also follow general rules or conventions which should be described here. It is most important to state how the target group employees relate to registered nurses regarding the organization of their work and delegated tasks and responsibilities.
- 14 Requirements for employment are “requirements for entry” and should be listed there! The following issues should be differentiated here:
1. The situation of demand and supply (of jobs)
 2. Statistical numbers in relation to the labour market situation of that occupational group in focus
 - a) Number of employed and unemployment rate
 - b) Number of examinations/year
 - c) Age pattern
 - d) Gender distribution
 - e) Average time spend in this occupation (job retention)
 - f) Pay/annual wage
- 15 EU-Mobility: Is there a lot of EU-mobility (incoming and leaving) of that occupational group in focus in the respective country? What are the ones who enter required to be accepted?

4. Survey 2 (Conducted from 20th February to 10th March 2012)

This survey contained 17 questions focusing on fields of operation, tasks and duties, required core competences and skills and the labour market situation of target group employees. Survey 2 was conducted using the same online platform as survey 1.2.

5. Revision of Country Profiles (May and June 2012)

Comments and questions were attached to the text in the country profiles' sections after a thorough evaluation of each profile's content. This step was needed to fill gaps, to clear ambiguous text passages and to foster a basic standard of comparability among all profiles. In conclusion, the sources used in the current version of country profiles are: Survey 1, Situation Statement, Survey 1.2, Survey 2, and answers to direct questions attached to a country profile's content.

6. Best-Practice Examples (November 2012 until May 2013)

Best-practice examples with regard to education and training of healthcare assistants in the different participating countries of the pilot network were gathered. The complete list of best-practice examples can be found on the www.hca-network.eu homepage. Most of them are also described in chapter 4 as part of the recommendations.

7. Survey Informal Carers

An additional task, which had not been covered so far, was the question whether healthcare assistants are trained to give support for informal carers. Hence, from January 2013 until May 2013 the country experts were asked whether the training of HCAs prepares them to understand the role of informal carers and whether the education covers this issue. If so, how does it cover it and what does the teaching of support and interaction with the informal carer consist of? Furthermore, depending on the need of the patient/client, support may be required for information and/or direct help with regard to a number of issues: Specialist voluntary organisations (Diabetes, Stoma Care, Alzheimer, Cancer Care, Age UK etc. to name but a few). In some countries there might be such local or national organizations which can provide additional support and guidance for the patient/client who needs additional help. In that case, does the HCA know how to establish contact with those organizations in order to help informal carers? Are the HCA empowered to refer directly or do they have to follow established protocols?⁶

The results of the survey show that the only countries with systematic approaches of integrating the cooperation with and guidance for informal carers in HCA training seem to be Bulgaria, Finland and partly the UK. The complete survey can be found on the website as well.

⁶ Please note: professional guidance of informal carers is usually done by registered nurses. HCA can not and should not substitute it. But HCA may contribute to it on a simple level (i. e. demonstrate simple limb movements).

2.3 The Expert Knowledge Data Base

On the basis of the data collected a data base of the EU displaying the different legislative frameworks for the employment and duties of healthcare assistants, the scope of the skills and competences required of these staff within the EU and the best practices in training for healthcare assistants has been established. The structure was developed gradually whilst filling in the contents. The final data base containing the revised results of the surveys was shaped by the data processing department of the contec GmbH with the software application Microsoft Access. The results are now presented using Joomla CMS (a content management system). This enables the website visitor to view the information selectively by doing direct queries in the data base.

The data provided was clustered into several categories and is now comparable with regard to the following key-aspects and between all of the participating countries:

Table 5: Country Profile Categories

Occupational Title
Regulation (Subject, Bodies)
Official Registration (and Bodies)
Minimum Age at the Beginning of Education
Education (Objectives, Duration, Structure and Funding)
Curriculum (Content)
Examination (Regulation, Types and Modes)
Connectivity of Education (Horizontal and Vertical Permeability)
Employment Areas, Labour Market Situation
Official Regulation of Employment
Tasks and Duties, Work Independence
Workplace Skills and Competences
Average Age of Workforce and Gender Distribution
Working Hours and Payment
Care Market Trends
EU-Mobility

In order to provide easy access to the knowledge database, an own project website under the domain <http://www.hca-network.eu/> has been set up for the project, which stands for “Healthcare Assistant Network Europe”.

To the public user the website only shows general information about the project including the Call for Proposal and the Management Summary with the project’s purpose. Additionally, the target group definition and information about the project partners could be accessed through the public area of the

homepage during the course of the project. In this way it could be assured that confidential information and work results were protected.



Figure 4: Public Area of the Project Website (Source: Own Presentation)

For the project partners and members of the pilot network, the website offers an internal sector with password. The user name is “hca”, the password is “hca_public”. It has been possible to download all files with the working results of the project as well as a list with contact information of all the country experts from this internal website area. Furthermore the mentioned EU map with the knowledge database about HCAs in the participating countries could be accessed and compared through this internal sector.



Figure 5: Internal Area of the Project Website, "Database" Source: Own Presentation

At the end of the project the database and findings of the project, as well as the final report will be accessible to the public users as well, allowing everyone who is interested in HCA education and training throughout Europe to gain a broad insight into the topic.

3 Main Findings of the Project

In the following a general overview of the situation of education, training and employment for health-care assistants in the countries involved in this project will be given. The informations summarise the manifold and detailed data from each country gathered during the last three years (2011 – 2013). These data are available as country profiles for further information and research in the aforementioned database which can be accessed online at www.hca-network.eu.

3.1 Definition of the Target Group in Focus of the Project

At the beginning it has been crucial to clearly define the occupational group in focus of the project, in order to reach a consensus about the object of investigation among all experts involved in the pilot network. This definition specifies the description in the call for proposal of the European Commission DG SANCO 2009/1, which referred to the target group as “healthcare workers, healthcare assistants and lower-skilled nurses”.

According to the term “lower-skilled” the occupational group in focus of this project can be distinguished from nurse education by the number of education hours and/or duration of education and the amount of education credits. As an upper margin, the education for nurses encompasses at least 4.600 hours of education and a minimum amount of 180 ECTS. In this project, the focus laid on the health-care staff below this educational level. Participation in the Bologna Process aims to make academic degree standards and quality assurance standards comparable. Reality still shows some variation between countries. E. g. Denmark’s BSc Nursing degree takes 3.5 years resulting in 210 ECTS, while a BA Nursing (standard degree) in the UK is a 3 year course that covers 180 ECTS. In Spain, the BA Nursing is a 4 year course and requires 240 ECTS. Norway defines one ECTS point as 20 hours of study while the Netherlands defines it as 28 hours. As a result, 60 ECTS per annum amount to between 1.500 –and 1.800 hours. These figures may have shifted somewhat recently but many differences remain.

It is therefore advisable to provide an additional criterion for the description of the target group. This has been found in the position of the target group among other health professions and hence it can be described as “staff who works under the supervision of (registered) nurses”. In many countries there is a clear distinction between the operational areas of the occupational group in focus and that of (registered) nurses. This differentiation is based in law where the title “nurse” is protected and connected to higher level studies. This leads to a differentiation in levels of responsibilities and competencies at work and is therefore relevant here.

The most appropriate English term referring to this occupational group is “**healthcare assistants (HCA)**”. The experts agreed not to use the term “lower-skilled nurse” in the project because of its negative connotation “lower-skilled”. According to the International Standard Classification of Occupations (ISCO), provided by the International Labour Organization (ILO), the denomination “healthcare assistant” fits best the target group of this project since it includes different institutional settings as well as both the health and care sector. The ISCO framework classifies professions according to job

characteristics e. g. tasks and the skills/competences related to them. The latest update from 2008 (ISCO-08) includes the following groups with respect to nursing and care:

- 22 Health professionals
 - 222 Nursing and midwifery professionals
- 32 Health associate Professionals
 - 322 Nursing and midwifery associate professionals
 - 3221 **Nursing associate professionals**
Lead Statement: Nursing associate professionals provide care for the sick and injured, and those in need of nursing care due to disability or age. They usually work in support of nursing and midwifery professionals and medical doctors.
- 53 Personal care workers
 - 532 Personal care workers in health services
 - 5321 **Healthcare assistants**
Lead Statement: Healthcare assistants provide assistance, support and direct personal care to patients and residents in a variety of institutional settings such as hospitals, clinics, nursing homes and aged care facilities. They generally work in support of health professionals or associate professionals.
 - 5322 Home-based personal care workers
Lead Statement: Home-based personal care workers provide routine personal care, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in their own homes or in independent residential care facilities.

In relation to the ISCO-08 unit-groups the present project's target group definition contains *nursing associate professionals* (3221) and *healthcare assistants* (5321). To make it simple throughout the project the terminus "healthcare assistants" has been used for both of these groups.

3.2 Essential Findings about HCA Education and Training in Europe

The country profiles of all 15 participating countries and the list of best-practice examples of each country are the main results of research about the status quo of HCA education and employment throughout Europe. The country profiles show how heterogeneous the target group is when compared among different European countries. Especially the length of the education and training shows a very large range from 8 months in Denmark to 4 years in the Czech Republic and Slovenia. In Ireland there is no regulation on the length of the training.

In 13 of 15 cases for example (Germany, where no nationwide regulation for HCA exists, is listed with one Federal State Lower Saxony), there is a clear outline of the curriculum. In the United Kingdom and Ireland there is no official examination, curriculum or employment regulation. It needs to be noted that the UK consists of four countries (England, Wales, Scotland and Northern Ireland) and there is some guidance on minimum training standards for HCAs in Scotland, Wales and Northern Ireland. In England recently there has been a significant policy development and the government has announced that there will be a Care Certificate developed that will set the fundamental standards for all health and social care support workers from early 2015.

In 12 countries of the 15 given examples there is no national standardisation of the HCA education and training. Other countries organize their HCA education in a clearly defined manner.

Education Regulation and Education Objectives

In the countries with the yellow dots, the **education** is officially regulated. In the countries with the green dots the **education objectives** are officially regulated.

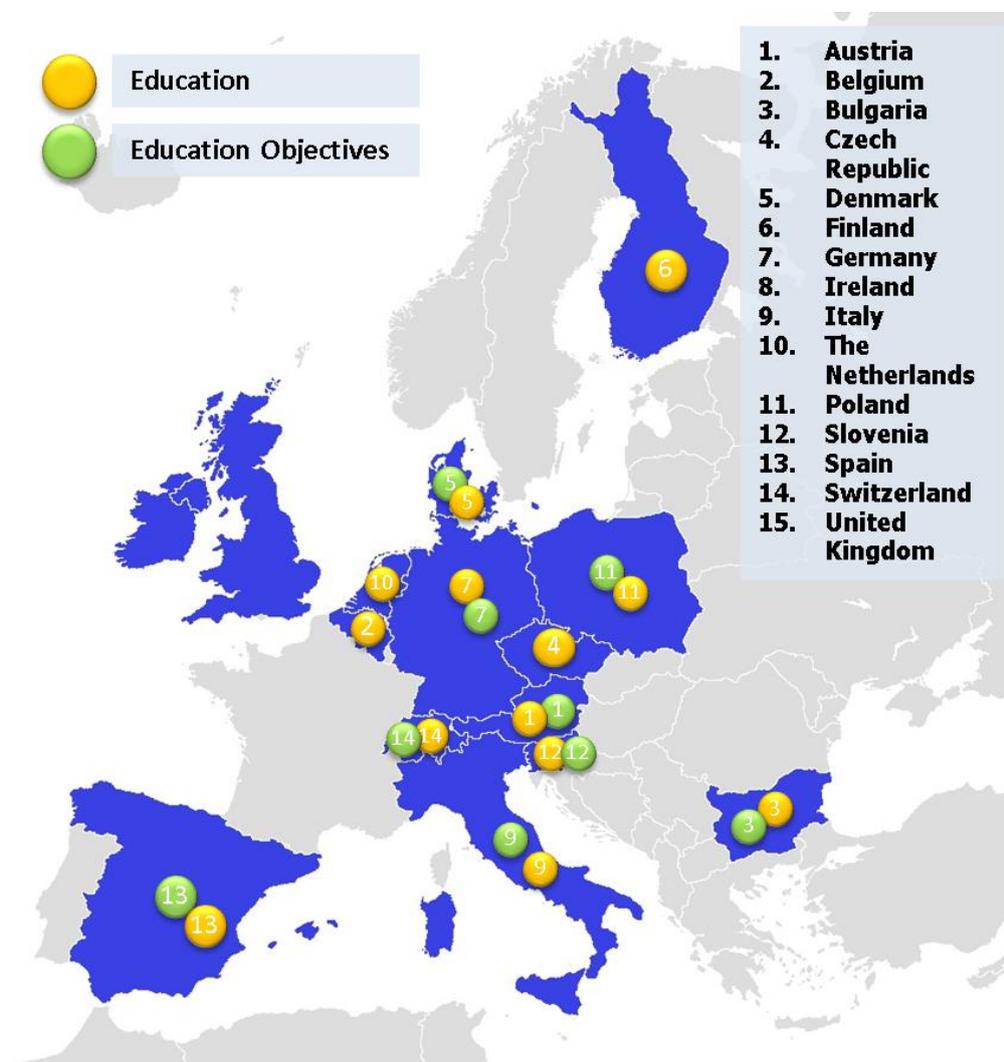


Figure 6: Participating Countries with Official Education and Education Objectives

Table 6: General Aspects of HCA Education and Training within the Participating Countries

Country	Min. Age at the Beginning of the Education	Occupational Title	Duration of Education	Average Age of the Occupational Group	Share of Male Employees	Average Annual Income
Austria	17	PflegehelferIn	1 year	30-32	17%	21.600 €
Belgium	18	Aide Soignante	1 year	20-40	1%	13.000 - 14.000 €
Bulgaria	18	Health Assistants	Not specified	--	--	1.500 - 2.000 €
Czech Republic	15	Medical Assistants	4 years	--	27,1%	12.200 €
Denmark	--	Social/ Healthcare Assistant	8-12 months	36	--	34.800 €
Finland	16	Practical Nurse	3 years	45	1%	30.000 €
Germany (Lower Saxony)	16	PflegeassistentIn	24 months	--	15%	20.000 €
Ireland	--	Healthcare Assistant	No regulation, but generally part-time over 8 months	40-59	20%	25.000 - 32.000 €
Italy	17	Auxiliary Staff, Social and Health Auxiliary Workers	1 year	30-40	50%	15.000 – 20.000 €
The Netherlands	--	Carers Individual Healthcare; Assistants Health and Welfare; Care Assistant	1-3 years	--	17%	19.800-34.300 €
Poland	16	Medical Carer, Child Carer	2 years	35	1%	4.300-6.000 €
Slovenia	15	nurse assistant, Health care technician, practical nurse	4 years	55-65	12%	15.000 - 20.000 €
Spain	16	Assistant Practitioners, "Auxiliares de clínica»	2 years	49	10%	20.000 €
Switzerland	15	Assistant(e) en soins et santé communautaire (ASSC), Fachfrau/-mann Gesundheit, EFZ Sek: II	3 years	--	10%	50.000 €
United Kingdom	--	Healthcare Assistants, Health Care Support Workers, Nursing Assistants, Nursing Auxiliaries, Clinical Support Workers ⁷	Will be regulated as from 2015. At present variable lengths and mainly part-time.	43-50	--	17.000 - 27.300 €

⁷ In the United Kingdom the Healthcare Assistants form the occupational group in focus of this project because they work under the supervision of RNs as indicated in the definition of the target group. In terms of performed working tasks Assistant Practitioners, who are a level above the HCAs are also relevant and comparable to examples given from other countries. Assistant practitioners work with greater independence and may in some cases even supervise HCAs.

Official Regulation and Registration of the Occupational Group

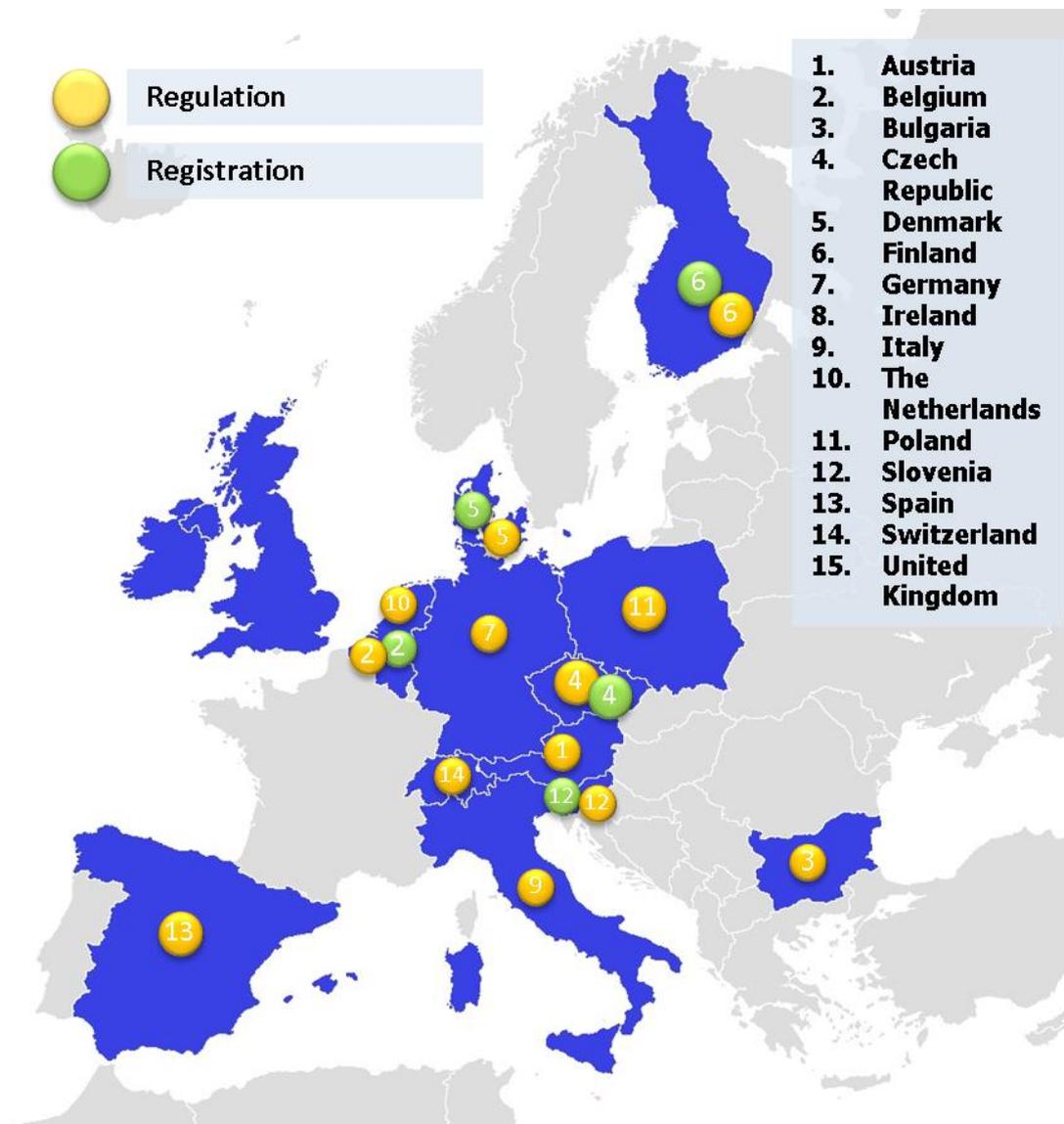


Figure 7: Participating Countries with Official Regulation and Registration

In the countries with the green dots there is mandatory **registration** for the occupational group. In the countries with the yellow dots the occupational group is officially **regulated**.

Regulation Subject

Only 3 of the participating countries do not have an official regulation of the healthcare assistant occupational group, namely Ireland, Switzerland and the United Kingdom. In Austria, Bulgaria, the Czech Republic, Denmark, Finland, Italy and Slovenia, the occupational group (work tasks and duties) of healthcare assistants as well as their education are regulated. This regulation goes along with the requirement to obtain a licence to practise after finishing the HCA education and training.

In Belgium, Germany, The Netherlands, Poland, Spain and Switzerland only the education of healthcare assistants is officially regulated, there is no regulation of the occupational group in general, which other countries reward through a compulsory license to practise.

Regulatory Bodies

The HCA occupational group is regulated in all of the participating countries except for the United Kingdom, Ireland and Switzerland. In Germany the federal government of each of the 16 federal states is responsible for the regulation of the profession and its educational design. A similar arrangement is true for Italy where the regional authorities are responsible for the licensing. Presently, there are 21 regions in Italy (e.g. the licensing body is Regione Piemonte, Lombardia, Lazio etc.). Rules for practice are furthermore dictated by the National Board of Registered Nurses Ipasvi. The education is designed and regulated by the Ministry of Health, The Ministry of Work and Social Politics and the Conference of the Italian regions.

In Ireland the recognised qualification for healthcare assistants is authorised by the Further Education and Training Awards Council (FETAC), formerly the National Council for Vocational Awards (NCVA Level 5), but not regulated. In Switzerland the Federal Office for Professional Education and Technology (OPET) within the Federal Department of Economic Affairs (national ministry of economic affairs) is responsible for the education in the field of health. The cantons are then responsible for the supervision of the vocational education; coordination between all parties (employer, school and trainee) the quality of the schools, final exams and the respect of the contracts.

Within Austria, Bulgaria, Belgium and Poland general regulation of the target group happens through different bodies which entail the countries' Ministry of Health and in the case of Poland also the Ministry of National Education and the Ministry of Labour. In Spain the responsible ministry is the Ministry of Education, since the nursing assistants in Spain do not have a professional body.

In Denmark, Finland, Slovenia, the Netherlands and the Czech Republic there are designated authorities specialized for health professions/nursing. Thus in Denmark the Danish Authorization approves the use of the occupational title (licensing body). It is an official authorization from the Danish Health authorities giving permission to work as a HCA in Denmark. In Finland these tasks lay with the National Supervisory Authority for Welfare and Health (Valvira) and in Slovenia with the Nurses and Midwives Association of Slovenia. In the Netherlands the Board of Calibris (Landelijke Kwalificaties intermediate vocational education Verzorgenden IG) is responsible for the accreditation of training companies and the maintenance of the qualification for the sectors Care, Welfare and Sport. Other legislative institutions for the occupational group are again the Ministry of Education, Culture and Science together with Regional Education Center. Lastly in the Czech Republic the National Institute for Nursing is responsible for the registration. The regulation of the education and occupation is managed by the Ministry of Health. Both institutions cooperate.

Regulation Sources

The above mentioned regulation bodies for HCA education and training within the participating countries are based upon different legislative foundations which are listed and described in the respective country profiles (see www.hca-network.eu).

Supervisory Control

Within the participating countries there are various organs executing the supervisory control over the education and practice of healthcare assistants. In Slovenia, the supervisory control rests with the Nurses and Midwives Association. In Austria the governmental supervisory control is administrated by the respective federal state sanitary agency attached to each federal state government and in Switzerland the different cantons are responsible for this task.

In the Czech Republic internal and external audits ensure control over healthcare assistant education and training. Finland and the Netherlands in turn have special institutions responsible for the supervisory control of healthcare assistants being the National Supervisory Authority for Welfare and Health in Finland and a knowledge centre, called CALIBRIS, which is acknowledged by the government in the Netherlands.

Education Process Design

The data showed, that in five of the countries, the HCA education and training can be completed on either a full-time or part-time basis. These countries are Germany (Lower Saxony), Finland, the Czech Republic, Poland and Austria.

In Belgium, Denmark, Italy, Spain and the Netherlands (health and welfare assistant and care assistant) where the education and training lasts only around one year, it is meant to be completed in full-time mode. The same applies for Slovenia where the four years of education are divided into three general parts containing theoretical and practical education/training. The Swiss HCA education is usually in full time mode, partly in a practical setting, partly at school. There are possibilities for part time mode, as HCAs can also have a role as carers, parents. But usually it is 3 years full time education. The Irish HCA education and training can be completed in part-time mode.

Curriculum

In all but one country (UK) there is an official curriculum for HCA education and training and furthermore, except for Ireland and Bulgaria, also an officially recognised examination (see figure 9 below).

In the countries with the yellow dots there is an official **curriculum**. In the countries with the green dots there is an official **examination**.

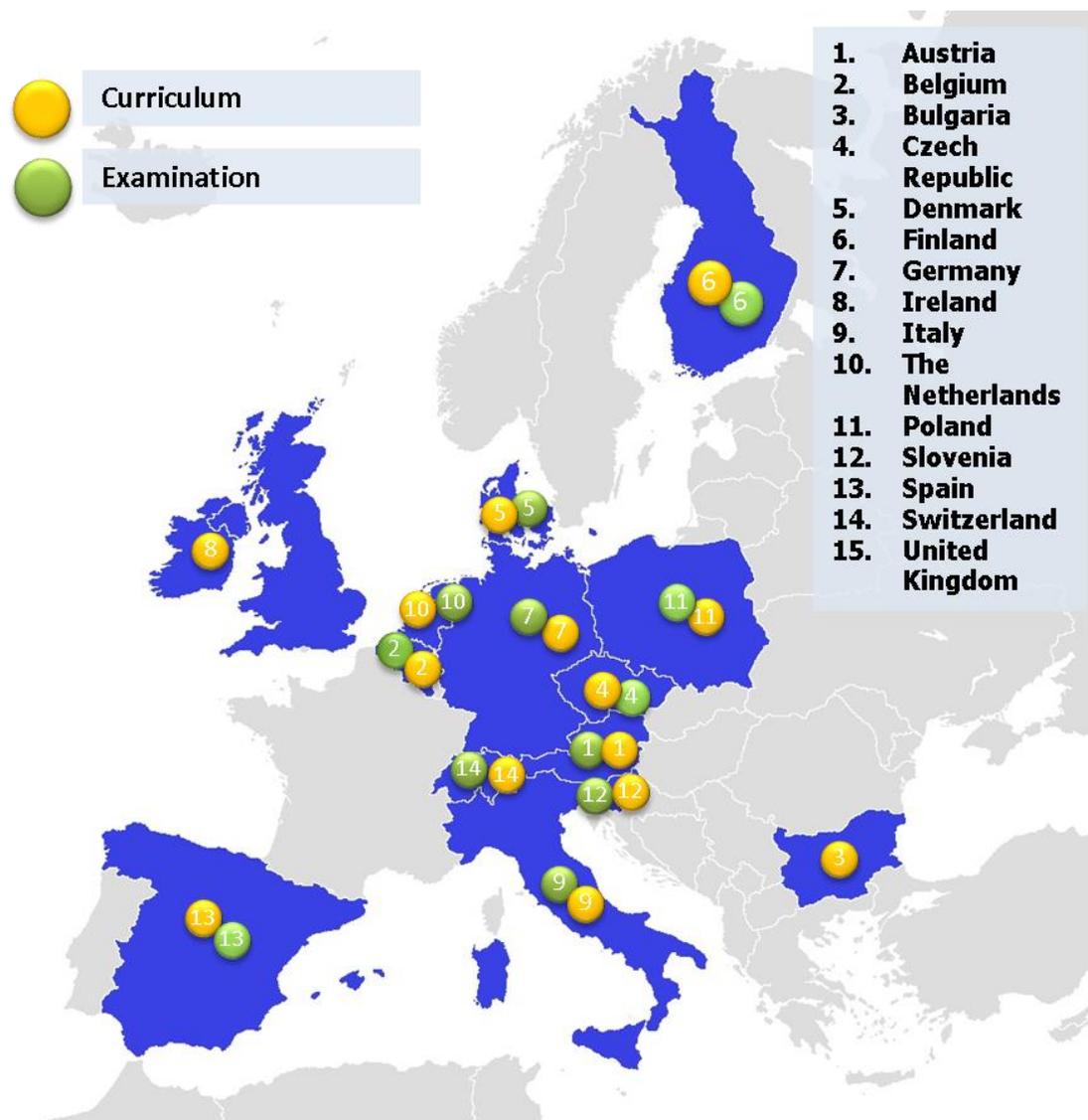


Figure 8: Participating Countries with Official Examination and Curriculum

Curriculum Theory/Practice Relation

The HCA education and training in all participating countries entails theoretical as well as practical parts. In Austria and Belgium the relation is 50/50 and in the Czech Republic it is a relation of 4/6. Within the Danish HCA education and training there are 32 weeks of formal education and 54 weeks of on the job training.

In the German example of Lower Saxony, the curriculum entails 1.800 hour of theoretical and a minimum of 960 hours of practical training, in Spain this relation between theoretical and practical part is 960/440 hours. With 720 hours theory and 160 hours occupational practice in Poland (medical carer) the share of practice is much smaller compared to other countries.

In addition to theory and practice, the Slovenian example also includes 200 hours of “interest activities”⁸. Hence, the relation between practical and theoretical parts is 1.700/1.018 hours. These consist of 1.500 hours of theoretical professional education, 200 hours of interest activities, 714 hours of practical training at school and in practice (210 in school cabinets, 504 in health and social institutions - under supervision of school mentor) and 304 hours of practical training in healthcare facilities. The curriculum in Finland is subdivided into a practical and a theoretical part as well. The training includes a minimum of 29 credits of on-the-job learning in practice, which adds up to a duration of half a year. The Irish program as well includes both theoretical and practical skills teaching. The following modules have a practical component: Infection Prevention and Control; Care Skills; Activities of Living Patient Care; Care of Older Person; Intellectual Disability Studies; Understanding Mental Health. The theory/practice relation is here 550/450 hours.

Only the information provided from Bulgaria, the Netherlands and the United Kingdom showed that the relation of practical and theoretical training elements varies according to the course/subject taught and does not have a standard format. While the United Kingdom does not have a standard format, the certification will still be aligned to the national qualifications framework.

Practical Training Place

In 11 of the 15 participating countries the practical training place for healthcare assistants can be within various kinds of facilities ranging from acute care to rehabilitative and long-term care, from hospitals to nursing homes, rehabilitation centres, ambulatories, dental clinics or privates practices.

Exceptions to this are Ireland, the Netherlands, Poland and Slovenia. In Ireland the practical training takes place not only within clinical settings but also in skills labs. The Netherlands also have skills labs with hospital imitated settings for the practical training part. In Poland workshops in schools and medical facilities are held and in Slovenia the practical part of the HCA education and training is con-

⁸ Interest activities include cultural activities, sports, social volunteer work etc. Selective modules are professional modules.

ducted at schools, hospitals, nursing homes, special hospitals and primary healthcare centres, always supervised by a clinical mentor or a school mentor.

Examination Mode

Within the 12 participating countries that stated to have officially recognized examinations for HCAs there are still some variations to be noticed. For instance Austria, Belgium, the Czech Republic, Finland, Spain, Poland and the Netherlands carry out their examinations in a theoretical (almost written) and a practical part. Germany, Ireland and Slovenia have an oral part of the examination in addition to the theory and practice part. Switzerland also has an officially recognized exam for HCAs. The standards are defined at national level, the exam is carried out and evaluated at cantonal level.

In Italy the exam is a written and oral one, in Denmark it is only a written exam. Bulgaria and the United Kingdom do not have an officially recognized exam for healthcare assistants.

Sources of Funding for HCA Education

The different funding sources for the healthcare assistant education and training are listed in the following table:

Table 7: Education Funding

Country	Public	Private	Mixed	Employer
Austria	X	X	X	
Belgium	X			
Bulgaria	X			
Czech Republic	X			
Denmark	X			
Finland	X			
Germany (Lower Saxony)	X			
Ireland	X			
Italy			X	
The Netherlands	X			
Poland	X	X		
Slovenia	X	X		
Spain	X		X	
Switzerland	X			
United Kingdom		X		X*

* In UK employers in healthcare are publicly funded through the National Health Service (NHS).

Care Market Trends

The Danish statement below best represents the situation in most European countries (a detailed list with the answers provided by the countries can be found in appendix 5.2.):

“The (labour) market for healthcare assistants is characterized by a number of challenges. The core area of their employment is in the patient care and development support, which includes a number of practical, organisational and social tasks. But working in that field has become more difficult by physical and psychosocial stress, by absenteeism of staff and problems with the retention of employees. Hospitals restructure their processes and shorten the average length of stay, meanwhile outpatient care services are intensified. At the same time hospitals are getting more specialized and focused on innovative therapies. That leads to a re-integration of several outpatient care services into the processes of hospitals. Next to hospitals, the community and primary care is a large workspace for (*social*) *healthcare assistants* in the care of elderly. Not at last, the share of responsibilities between the regions and municipalities are changing in the current process of reorganization [...] In consequence, new job opportunities with a different spectrum of tasks and new employee profiles with different skill mixes are evolving and are taking effect on the job market.”

Tasks and Duties of HCA

Table 8: Tasks and Duties of HCAs by Country

<p>Austria</p>	<p>According to GuKG 1997 § 84 (see section “regulation”) the services of care assistants encompass:</p> <ul style="list-style-type: none"> • The accomplishment of care measures. • The assistance with (health) care measures including the social support of patients and clients and the accomplishment of housekeeping activities. • The accomplishment of (health) care measures may only be done under instruction and observation of members of the higher civil service for healthcare. Off-site instructions are to be given in written form. • The accomplishment of (health) care measures especially includes the accomplishment of basic care methods, the accomplishment of basic mobilization methods, personal hygiene and nutrition, surveillance of the sick, preventative care measures, documentation of care measures and care, cleaning and disinfection of devices • The assistance with therapeutic activities may only be done in particular cases by a written order of a doctor and under the observation of members of the higher civil service for healthcare or under the observation of doctors. It includes medication, giving subcutaneous insulin injections and conducting specialized nutrition of patients with laying stomach tubes (PEG-tubes), excluding the off-site scope.
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Belgium	<p>General tasks and duties of healthcare assistants in Belgium include the accomplishment of basic care methods, the accomplishment of basic mobilization methods, personal hygiene and nutrition, surveillance of the patient, preventative care measures and infection control (care, cleaning and disinfection /logistic of the material of care). HCA work in basic care under the supervision of general nurses. They are responsible for various tasks and duties including taking into account factors such as religion, culture, age, gender, habits, living conditions and the environment of the patient, supporting the daily personal care, dressing and undressing, giving food and beverages, mobilizing the patient, technical activities under supervision of the nurses such as measuring the blood pressure or pulse and temperature, changing bandages, giving medication or conducting simple laboratory tests, cleaning the used material, giving first aid, cooking, making the bed, washing and cleaning at the place where the patient is cared for administrative or organizational tasks and helping at the reception of care facilities.</p>
Bulgaria	<p>Healthcare assistants service the patients by assisting them in feeding, toileting, transport and providing comfort and good hygiene in the patients' room. Professional activities that healthcare assistants can perform as appointed by the nurse or doctor according to Ordinance 1 of the Ministry of Health from 2011, section X include: nutrition, a common toilet, transportation and support for examinations, normal daily activities and providing comfort and hygiene in the hospital environment.</p> <p>Professional activities that health assistants may perform in sterilizing units are preparing material for surgery and other material for sterilization in accordance with the approved working rules for chemical and microbiological control of the sterilization process.</p>
Czech Republic	<p>The tasks and duties of healthcare assistants include providing basic care (washing, feeding, measurement of physiologic functions, etc.), hygiene, measurement of blood pressure and sense of pulse, measurement of temperatures, evaluation of fluids, communication with patients and monitoring the patients' needs. Other activities may only be done under supervision.</p>
Denmark	<p>Tasks and duties include practical and personal help, personal care nursing tasks, health promotion and prevention activities, coordination, supervision and instruction and activity and rehabilitation.</p>
Finland	<p>Duties of the target group employees include nutrition, guidance towards healthy lifestyles, maintenance of functional capacity, providing pharmaceutical care, promoting individual patients' or clients' interaction with their environment and in activities of daily living, working ergonomically and in compliance with the principles of business operations and sustainability, ability to work proactively, cooperatively and in a quality-conscious and service-oriented manner, use of ICT technology, ability to assess ones own work performance and develop one vocational skills and the ability to manage work-related interactive situations in one foreign language and both national languages.</p>
Germany	<p>In Germany, the distinction between the tasks of nurses and care assistants is difficult because the tasks of nurses are not regulated by law. The German system is quite physician-centred, nursing is not considered a relevant part. The notion still predominates that nurses only assist to the physicians.</p>

Ireland	<p>The healthcare assistant must report to and work under the supervision and direction of a Registered Nurse in relation to their tasks and duties and must be integrated into the ward or area team. Nursing staff will delegate duties in accordance with their professional judgement and within the competence of the healthcare assistant. Nursing staff must not allocate any duty to the healthcare assistant for which he/she has not been trained.</p> <p>Key Activities include assistance in some or all activities of daily living, assisting the nurse in the implementation of the care as determined by the nurse e.g. to assist clients in maintaining standards of personal hygiene, laundry, dietary intake, physical and mental health. Also HCAs are obliged to report any incident or potential incident which may compromise the health and safety of clients, staff or visitors, and take appropriate action.</p>
Italy	<p>The examples of tasks and duties provided where so detailed that they can be found in the Italian country profile.</p>
The Netherlands	<p>(There are 3 levels of HCA in the Netherlands and the following includes tasks of all levels.) Tasks and duties as stated by the National Qualification MBO (education board) include provision of care and support based on the care plan, making a care plan, support in basic personal care, providing palliative care, support for household and living, monitoring of health in both somatic and psychosocial areas, provision of information, advice and instruction, working on promotion and monitoring of quality, tuning of the different care actions, evaluation of care, keeping the living space of the care recipient clean, maintaining working material, provision of food and drinks, taking care of the laundry, simple repairs to clothing or linens and maintenance of footwear.</p>
Poland	<p>Medical carers have the tasks and duties they are thought and prepared for in their education). More generally that includes:</p> <ul style="list-style-type: none"> • identifying and resolving problems in caring for an ill or dependent person at different degrees of disease severity and different age • helping an ill and dependent person in meeting biological, psychological and social needs • assisting the nurse and other medical personnel during treatments • maintenance and disinfection of utensils and tools used during treatments • co-operation with a caring and therapeutic team in the provision of medical care for an ill and dependent person. <p>Tasks and duties of a <i>medical carer</i> and <i>child carer</i> include nursing and caring services often called care-giving services. These include basic nursing and care: helping to meet basic life needs of ill and dependent people. Consequently, the core duties of the <i>carers</i> include the support in fields like nutrition, excretion, body hygiene and movement (transportation). Furthermore medical carers help with the accomplishment of regular everyday activities. They maintain accurate temperature and the tidiness in a disabled person's home. They are responsible for providing a stock of clean and appropriate clothes or bed sheets. They try to enable a safe and functioning environment for the ill or disabled person. Most generally, they support a person by helping her/him in the accomplishment of routine tasks of everyday life.</p>
Slovenia	<p>The tasks and duties of healthcare technicians/practical nurses include undertaking health and nursing interventions by life activities in healthcare of adult patients, children and young persons, cooperating</p>

	<p>in diagnostic and therapist interventions by following doctors' and nurses' instructions, performing healthcare of adult patients, children and young persons, administering first aid, emergency medical aid and basic resuscitation procedures until the arrival of the doctor on the scene, using healthcare appliances and apparatuses, caring for one's own health, for patient's health and positive attitude to healthy lifestyle, identifying needs of patients and special needs persons and quickly adapt to working process conditions, using contemporary ICT, providing healthcare to the chronically ill and dying; offer help and support to family members of the chronically ill, dying and dead.</p>
Spain	<p>The main role of nursing assistants lays within the clinical practice, although they have some administrative tasks like helping nurses to organize the work unit or even collaborate in teaching (teaching self-care in maternal care and immunization e.g.). Nursing assistants are forbidden to perform the following tasks:</p> <ul style="list-style-type: none"> • Parenteral medication administration. • Scarification, punctures or any other diagnostic or preventive technique. • The application of curative treatments that are not related with medication. • The administration of medication or any specific medication when it is necessary to use equipment or skills of trained nurses. • Assist the medical staff during a surgical intervention. • Assist the doctor with the external consultation.
Switzerland	<p>Healthcare assistants work in basic care under the supervision of nurses. There is no official list of tasks, indicating what HCAs are allowed to do or not. As generalists they are responsible for a various field of tasks and duties such as – under supervision of a nurse - helping with the care for the patients, taking care of the factors such as religion, culture, age and gender of the patients, helping with the daily personal care (getting up in the morning, dressing and undressing), supporting patients with food and beverages, supporting patients with their first walking attempts and encourage their agility and quality of life. Also, healthcare assistants are responsible for easy medicinal-technical activities, taking the pressure from the professionals of the laboratory, the care and physiotherapy. They check blood pressure, pulse and temperature, make bandages change, prepare a blood samples, give medication and tube feeding or they conduct simple laboratory tests, clean the used material, distinct and sterilize. Besides they recognize emergency situations. If necessary, they do first aid or take care of help by professionals in the ambulatory treatment field, they accompany experts from healthcare, residents of private households or residential communities in the care, living and disabled people section. They bring them medicine, care for them and support them with their day structure. Depending on the medical condition of the patients they do the household or support them in doing that (cook, make the bed, wash and clean), they animate them to play with them or go to festivals with them. Moreover healthcare assistants are responsible for administrative or organisational tasks and they help at the reception, conveying patient charts, compiling accounts and taking care of post and phone services.</p>

<p>United Kingdom</p>	<p>Duties range from core nursing tasks relating to the activities of daily living to more complex roles including wound care, catheterisation, venepuncture, cannulation, care of feeding tubes and assisting with medication. They administer some vaccinations and can give some intramuscular injections using patient specific directions. In all cases the healthcare assistants and assistant practitioners must be trained and have been assessed as competent to perform the delegated tasks. More information on important workplaces and duties of the target group can be found here:</p> <p>For England: http://www.nhscareers.nhs.uk/</p> <p>For Northern Ireland: http://www.n-i.nhs.uk/index.php?link=jobs</p> <p>For Scotland: http://www.scotland.gov.uk/Topics/Health</p> <p>For Wales: http://www.wales.nhs.uk/sitesplus/829/page/36090 - info about NHS careers which will give a broad view of roles.</p>
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Workplace Skills and Competences

Table 9: Workplace Skills and Competences by Country

<p>Austria</p>	<p>Skills of care assistants include conducting basic techniques of care, conducting basic techniques in mobilization, personal care and nutrition, observation of the ill, preventive measures of care, documentation of the conducted care measures, care, cleaning and disinfection of equipment, giving pharmaceuticals, giving subcutaneous insulin injection and conducting of tube feeding applied at laying feeding tubes [PEG-sensors] only in the extramural area (= retirement house and care home etc.)</p>
<p>Belgium</p>	<p>Required skills by workplace are basic techniques of care, sociability, communication skills, empathy, observational skills, practical comprehension, support/assistance to listen to the needs, keeping up safety in the care setting, sense of responsibility, ability to organize, ability to work in a team, service orientation, psychic stability at the work setting, good health condition and flexibility due to irregular working times (shifts and work at weekends).</p>
<p>Bulgaria</p>	<p>Generally it is required of the health assistants to possess enough knowledge about hygiene, to have competences in physiology and pathology, ethics, communication, general care for patients etc. There are 34 required skills and competences and they are very well defined in the Ordinance № 72 of 26 September 2012 of the Ministry of Education and Science.</p>
<p>Czech Republic</p>	<p>Healthcare assistants' competences comply with Law No 96/2004 (regulates types and categories of medical workers) and Law No. 424/2004 (describes competences of these types and categories).</p>
<p>Denmark</p>	<p>Social healthcare assistants tend to stay in specific departments for a long time and thus develop very specific skills and competences according to the tasks they have to perform there. Those skills and competences can't be transferred to another workplace easily. Because of that kind of "on the job specialization" social healthcare assistants do not change the employer or the workplace as often as the other healthcare personnel.</p>

Finland	<p>Most important skills needed are the ability to function independently and as members of multidisciplinary networks, the knowledge of how to guide and assist clients and patients in an individual, equal and resource-driven manner; the knowledge of how to provide instruction on maintenance of functional capacity and healthy lifestyles.</p> <p>They have to act in a holistic, humane and tolerant manner in their work.</p> <p>A further requirement to work as a licensed practical nurse in Finland is to have good language skills in one of the two official languages (Finnish and Swedish). All applicants need to study Finnish but only some of them need to show an official language certificate to Valvira</p>
Germany	<p>Care assistants are professionally qualified assistants in the fields of nursing, care, assistance of people. In principle, they are responsible for the basics in nursing and care. General skills are professional capacity (process-oriented activities, taking account of standards), planning skills (taking into account the resources and problems, the individual biography of targeted people), aspects of staff competency such as perception, empathy, responsibility, commitment and creativity. As part of the social skills one should be friendly, unbiased and show respectful behaviour, have good interpersonal skills, cooperation and teamwork, communication skills, ability to criticize and ability to reflect.</p>
Ireland	<p>Healthcare assistants should conduct themselves in a manner that conveys respect of the individual and ensures safe patient care. The personal characteristics that indicate these principles should include confidentiality, courtesy, accountability, communication, dignity and privacy, health and safety.</p>
Italy	<p>Skills and competences of the OSS in Italy are commensurate with the tasks and duties acquired in their training.</p>
The Netherlands	<p>The skills and competences demanded by the workplace differ in each level. General important skills of all three levels are to give physical and emotional support for those who are in need of these. For individual healthcarers (level 3) also the nursing procedures like medication, injections, feeding tubes and other technical nursing procedures are very important skills.</p>
Poland	<p>The required skills for the workplace depend upon the kind of the medical or care facility. It is different in home environment, social care homes and hospitals, the duties are assigned to the position or related to the patient strategy.</p>
Slovenia	<p>The skills and competences of healthcare technicians/practical nurses required by their workplaces can partly be derived of the stated tasks and duties they have to perform in their occupational practice and of the list of educational contents and objectives. Sometimes they may also be required to perform tasks which exceed their competences/skills acquired through education.</p>
Spain	<p>Skills and competences of nursing assistants can be derived of the list of tasks and duties stated in section “educational objectives”.</p>
Switzerland	<p>Required skills by workplace are sociability, communication skills, empathy, observation skills, practical comprehension, neat hands, careful functioning, sense of responsibility, ability of organizing, teamwork skills, attendance awareness, psychic capacity, good health condition, attendance to work at irregular times.</p>

<p>United Kingdom</p>	<p>The general skills of healthcare assistants and assistant practitioners are core caring skills, communication, knowledge of confidentiality, consent, record keeping, infection prevention and control, dignity awareness and compassion. Clinical skills relating to the area in which the healthcare assistant and assistant practitioner is working may include taking of physiological measurements (BP, pulse, BMI, temperature), venepuncture, cannulation, ECG recording, spirometry and lung function testing, wound care, administration of medication, administrative tasks e.g. stock control, call and recall for clinics.</p> <p>NOTE: Assistant Practitioners are distinct from HCAs as they undertake a 2 year foundation degree or equivalent.</p>
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Independence and Organization of Work

Table 10: Independence and Organization of Work for HCAs by Country

<p>Austria</p>	<p>The occupational profile of a care assistant or a home helper generally contains the care of the ones in need. With that they support the staff of the higher civil service in healthcare. The engagement of care assistants and home helpers in nurse-led units is successful if there are multi-professional teams with nurses who are responsible for the coordination and assignment of care assistants and home helpers. More nurses have to be well trained in professional leadership and competent in the delegation of tasks. Patient situations can change rapidly, therefore the decision on the care assistants' activities and responsibilities in a specific situation must be taken by a nurse who is able to evaluate complex situations. In practice, it is up to the institution / the nurse in charge to decide on the activities to delegate to a care assistant or a home helper, always within the scope of competences attained during education. In areas without direct patient involvement (logistics, housekeeping, administration) care assistants and home helpers can work more independently.</p>
<p>Belgium</p>	<p>Healthcare assistants in Belgium work in structural support to nurses who delegate tasks to them. This situation is regulated by law where delegable tasks are defined according to the care situation of patient (law/AR 2006).</p>
<p>Bulgaria</p>	<p>In some cases and at some more simple tasks HCAs work independently but under control and supervision of nurses. Generally they work as appointed by a doctor or by a nurse under supervision.</p>
<p>Czech Republic</p>	<p>Healthcare assistants work under the supervision of registered nurses or registered midwives.</p>
<p>Denmark</p>	<p>Social healthcare assistants are accountable to the nurses. It is taken care of that the recruited social healthcare assistants show enough competences to be able to adapt to the specific work tasks.</p>
<p>Finland</p>	<p>Practical nurses are registered, and their professional name "Practical nurse" is protected. They can work independently within the legal framework of their profession. This is especially the case in elderly care and outpatient nursing care (also known as mobile care). When practical nurses work together with registered nurses, registered nurses are the first line manager in the workgroup.</p>
<p>Germany</p>	<p>They are working under the responsibility of registered nurses.</p>
<p>Ireland</p>	<p>Healthcare assistants are accountable for their actions in the delivery of patient care and must not undertake any duty related to patient care for which he/she is not trained, in accordance with their educational qualifications. The healthcare assistant must report to and work under the supervision and direction of a Registered</p>

	<p>Nurse in relation to their tasks and duties and must be integrated into the ward or area team.</p> <p>Nursing staff will delegate duties in accordance with their professional judgement and within the competence of the healthcare assistant. Nursing staff must not allocate any duty to the healthcare assistant for which he/she has not been trained.</p> <p>From a nursing/midwifery perspective, the concept of delegation to healthcare assistants has met with difficulties from a regulatory perspective. One of the reasons underpinning such a difficulty has been that healthcare assistants are not regulated and that an agreed and structured education programme is not mandatory.</p>
Italy	<p>The OSS only work under supervision of registered nurses or other staff with higher qualification. They perform a subsidiary role, e.g. they must not administer drugs or perform tasks which belong to the occupation spectrum of nurses.</p>
The Netherlands	<p>In the Dutch healthcare system the qualification of the levels 5 and 4 contain the registered nurses. The employees of the levels 3 to 1 are working under surveillance and on delegation of the levels above them. Each of the levels has their own regulations regarding tasks and duties, but they are supposed to be balanced when the respective staff works together on wards. This means that the different levels often have different tasks and responsibilities but their function profile also has some tasks and duties that are the same. So if these levels are working together, they need to agree on who does what.</p>
Poland	<p>In practice, the medical carer and child carer do not work independently from the nurses but are supervised by them. They support and cooperate with the healthcare personnel of higher qualification levels.</p>
Slovenia	<p>In Slovenia, there is a national document on specific nursing interventions performed by healthcare personnel. This list contains 1.576 such interventions of which the RN is allowed to perform 100 %. The healthcare technicians/practical nurses can perform 88 % (521 interventions) of the basic nursing care interventions, 43 % (234) of special nursing interventions and 65 % (295) of other nursing interventions. In average healthcare technicians/practical nurses are allowed to perform 66,6 % of the 1.576 nursing interventions. The RN is responsible for a holistic care approach and she is the leader of the nursing team. All healthcare technicians/practical nurses work under supervision of RN and tasks may be delegated by them.</p>
Spain	<p>Nursing assistants are care professionals that provide auxiliary care to the patients and act according to the health situations of their environment under the supervision of a registered nurse or doctor. For the work under supervision it is common that one nursing assistant is working for 3-4 nurses, in nursing homes it is opposite (one nurse guides 3-4 nursing assistants).</p>
Switzerland	<p>There is a common agreement that healthcare assistants only work on delegation by registered nurses, perhaps in some situations also on delegation by physicians. In the health field healthcare assistants work with sick or vulnerable people being more or less dependent on their carers. Additionally, patient situations can change rapidly, therefore the decision on the healthcare assistants' activities and responsibilities in a specific situation must be taken by a nurse who is able to evaluate complex situations. In practice, it is up to the institution/the nurse in charge to decide on the activities to delegate to a healthcare assistant, always in the scope of competences attained during her or his education. In hospitals healthcare assistants are more in the role of assistants, being part of a team with several nurses. There are hospitals having projects with one healthcare assistant working in a close team relation with one nurse (tandem/twinning). In psychiatric settings, healthcare assistants have a clear assistant role, too. In nursing homes or home based care, the responsibility and scope of practice</p>

	<p>can be larger due to job profiles adapted to their competencies or lack of qualified nurses, especially in nursing homes for the elderly. In nursing homes or home based care, healthcare assistants focus on assisting people in managing their daily needs and activities. In areas without direct patient involvement (logistics, housekeeping, administration) healthcare assistants can work more independently.</p>
<p>United Kingdom</p>	<p>HCA work in a broad range of areas - primarily but not exclusively with patient contact. In clinical areas, they will usually be managed by a healthcare professional, for example a dietician, nurse, occupational therapist, midwife, physiotherapist, operating department practitioner, or healthcare scientist. They work with some autonomy but within specified areas and under supervision both in primary and secondary care, including mental health and learning disabilities.</p> <p>Also the tasks of healthcare assistants are delegated by registered nurses who have to comply with the Nursing & Midwifery code of conduct and guidance in delegation. Whilst registered nurses use their knowledge and experience to make clinical judgements and to delegate appropriately the roles of healthcare assistants and assistant practitioners are different. Hence healthcare assistants have their nursing tasks delegated to them and are supervised by registered professionals. They are guided by protocols and act within these protocols at all times. They perform tasks according to their competence levels (Career Framework levels 2 and 3 – Skills for Health 2008). They must demonstrate competence supported with the required level of knowledge before being delegated particular tasks. They have a duty to inform the delegating professional if they do not have competence to perform a task. They should not be required to make ‘stand-alone’ clinical judgements and plan the care of patients based on those judgements.</p> <p>Assistant practitioners have a level of knowledge and skill beyond that of healthcare assistants. They support the work of registered professionals and may transcend professional boundaries. They make judgements requiring a comparison of options. They plan straight forward tasks and work guided by standard operating procedures and protocols and they may undertake the ongoing supervision of routine work of others such as HCA.</p>

EU Mobility

Table 11: EU Mobility of HCAs by Country

Austria	Regarding home helpers, there is no such information available. There are no experiences in regard to target group employees leaving Austria to work in other EU member states and no account on how many workers from other EU countries are working within the target group in Austria.
Belgium	Most of the healthcare assistants coming from foreign countries to work in Belgium in their occupational field come from Romania, Bulgaria, Latvia and some French speaking African countries. There are no reliable numbers on how many foreign workers enter Belgium in the target group or how many healthcare assistants leave to work abroad.
Bulgaria	There are no reliable accounts of target group employees entering Bulgaria coming from other EU-countries to work. But there are some health assistants from Bulgaria leaving the country in order to find work in other EU or non-EU countries.
Czech Republic	Many of those with language knowledge and professional education leave for the UK, Germany, Italy, Austria, Switzerland or for the UAE, the USA, Kuwait, etc.. In the Czech Republic, there are 3.000 employees from Slovakia (no language and educational problems), 162 employees from Ukraine (there are language and educational problems) and a small group of employees from Moldova, Russia and Bulgaria (also with language and educational problems). There are no numbers on how many target group employees from other EU-countries are working in the Czech Republic.
Denmark	There are no experiences with the target group employees leaving Denmark. Some of the target group employees are coming from Sweden in order to add certain training/education modules to their profile. That accounts specifically to psychiatric content. There are no numbers on the EU-mobility of target group employees in Denmark.
Finland	In 2008, there were 3% foreigners by birth in all social and healthcare professions.
Germany	Because registration is not compulsory in Germany there are no reliable employee numbers. Foreign workers are employed as care assistant, e.g. from Poland.
Ireland	There are no numbers on how many workers from other EU countries are working within the target group. There are healthcare assistants and equivalent grades working in the Irish Health Service from other EU Countries, but did not necessarily transfer here as healthcare assistants. There is no information on target group employees leaving the country to work in other EU countries or in non-EU countries.
Italy	Because of the high rate of unemployment there are not many target group employees from other countries trying to enter the Italian job market. Only a few employees from other countries are currently working in Italy as an OSS. There are no notations on Italian target group employees leaving the country to work elsewhere.

<p>The Netherlands</p>	<p>Only few foreigners without Dutch passport are employed within the occupational group. The few employees from other countries are mainly from non EU countries and are employed as care assistants (Level 1). The migrants are trained in combination with a language course. Working abroad is more common among level 4 and 5 (nurses). There is no official statistical information in regard to the number of foreign employees working in the Netherlands within the fields of the project's target group. A study of the University of Amsterdam from 2005 states that it is very difficult to quantify their number as they do not register like the nurses. The study expects that less than 0,5 % of the level 1, 2 and 3 employees were from foreign countries (in 2004) the biggest group coming from Poland.</p>
<p>Poland</p>	<p>There are no official and reliable statistics on target group employees leaving Poland or entering the Polish healthcare system from other countries. Polish schools for medical or child carers sometimes use the perspective of going and working abroad as an incentive to attract more students to their programmes. And actually, because salaries are very low in Poland, to go working abroad is the central reason for starting this education in lots of cases. But because in some EU countries there is no equivalence for this kind of education, medical carers and even nurse graduates are hired for supporting roles in healthcare systems in some other countries.</p>
<p>Slovenia</p>	<p>Experiences with foreign target group employees working in Slovenia are very little. Healthcare technicians/practical nurses of Slovenia are well accepted in Austria and Germany..</p>
<p>Spain</p>	<p>In Spain, employed nursing assistants from other countries amount to 0,2 % of the workforce according to statistics (without distinction between their origin in a EU member state or non EU member state). Less than 0,5 % of Spanish nursing assistants leave the country to work abroad.</p>
<p>Switzerland</p>	<p>In Switzerland, 22 % of the whole working population had a foreign nationality in 2006. In the scope of the secondary level II (Sekundarstufe II), 19,5 % of all employees in the German speaking part of Switzerland and 39,3 % in the French speaking part had a foreign nationality. However, in the healthcare assistant field there are enough domestic employees available. The country's statistic does not give any account of where a target group employee was trained and educated or where they were born and what nationality they have. Especially close to the French border there is a lot of cross border mobility to work in Switzerland. There are no records of target group employees leaving Switzerland to work somewhere else. It can be assumed that none of the healthcare assistants leave the country.</p>
<p>United Kingdom</p>	<p>Healthcare assistants from other EU countries work in the UK. However this is not recorded formally. As healthcare assistants and assistant practitioners are not regulated in the UK, there is a limited amount of information that is held centrally on the country of origin of HCAs. There are also some healthcare assistants from the UK going to other countries to work, but that also is not recorded formally.</p>

Labour Entry Requirements for Foreign Workers (EU and non-EU)

Table 12: Labour Entry Requirements for Foreign Workers

	Written Request	Proof of Residence	Diploma/ Certificate	Curriculum Vitae	Passport	Proof of Prior Employment	Proof of Marriage	Proof of Language Skills	Entrance Assessment/ Exam	Additional Classes if Necessary	Accreditation of Qualification
Austria	X	X	X	X	X	X	X				
Czech Republic								X	X		
Denmark			X					X			
Finland			X							X	
Germany (Lower Saxony)								X			
Ireland			X			X		X	X		
Italy								X			X
The Netherlands			X					X			
Poland			X						X		
Slovenia	X		X	X	X			X	X	X	X
Spain	X		X		X	X		X			X

Belgium, Bulgaria, Switzerland did not provide any information on this question because there are not many instances of foreign HCAs wanting to work there. In the United Kingdom there are a lot of foreign workers working as healthcare assistants but there are no implemented mechanisms of recording or reporting them.

Student Entry Requirements

Table 13: Student Entry Requirements

Austria	Successful graduation from compulsory education (9 years of school), suitable health condition attested by a physician, trustworthiness attested by a criminal records bureau check and at least 17 years of age.
Belgium	12 years of compulsory education (6 years of primary education and another 6 years of secondary education).
Bulgaria	16 years of age or older, secondary education or acquired right to take state exams.
Czech Republic	14-15 years of age, leaving elementary school then with a minimum school grade of 2,3. The grading scale is 1 for being the best until 5 being the worst (failure). In addition a medical check according to notice 258/2000/protection/public health is needed.

Denmark	Completion of basic social and healthcare training (1 year and 2 months). Alternatively the student can acquire permission by suitable qualification through training or work experience or a combination of it.
Finland	Successful graduation from comprehensive school and a 9-year elementary education.
Germany	Completion of a nine-year general secondary education.
Ireland	A relevant certificate in healthcare support at FETAC Level 5 or, a minimum of one year experience in a healthcare setting. Age restrictions shall only apply to a candidate where he/she is not classified as a new entrant (within the meaning of the Public Service Superannuation Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age.
Italy	Completion of 8 years of general education and a minimum age of 17.
The Netherlands	No admission requirement for Level 1. For Level 2 and 3 one needs to attend to 6 years of basic school. After the education in level 2 and 3 a trainee has an education time of 9 years.
Poland	12 or 13 years of basic school education.
Slovenia	Completion of elementary education and minimum age of 15.
Spain	Certificate of compulsory secondary education studies (ESO), or certificate of technical assistant. They may also hold an equivalent academic studies/training certificate to be accepted. They can also get access to the nursing assistant education if they pass a special exam designed to give access to vocational training for students over 16 years of age.
Switzerland	Completion of the compulsory general education at the age of 15 or 16.
United Kingdom	HCA require relevant experience but there is no stipulated educational qualification required other than completed compulsory national education. Entry requirements for assistant practitioners vary, depending upon the post and level of responsibility. For some posts, assistant practitioners may need a qualification on level 3 of the national vocational qualification system and care experience – for others they may need a BTEC higher diploma or foundation degree in a subject relevant to their area of work (e. g. science or health and social care).

Access, Development and Progression (Permeability)

The concept of permeability is rooted in European educational projects such as the Bologna process which incorporates the goals of furthering international mobility and employability. Cornerstones are Lifelong Learning, social integration and furthering personal development leading to access to educational qualifications. As already has been illustrated in Fig. 3 (see p. 14) a distinction is drawn between horizontal and vertical permeability: further education at the same level of qualification is called horizontal permeability and education connecting with higher levels of qualification (nurse) is considered vertical permeability.

Table 14: Horizontal Permeability

Austria	Currently, there are no alternative specializations or transmobility from home helper qualification to care assistant education.
Belgium	For any healthcare assistant there are possibilities to improve knowledge, skills and competences by specializations at the responsibility of the employer.
Bulgaria	A health assistant can obtain a specialization while working.
Czech Republic	No information provided.
Denmark	It is possible to take additional academic courses on top of the classes necessary in order to become a social healthcare assistant. Those courses save the students 1 year in the nursing program. There is also an education for social workers at the same level as social healthcare assistants in which their former education is accredited in parts.
Finland	It is possible only to complete parts of the education and thus get no final exam. One can enter working life in that case, but one cannot use the title practical nurse. The informal title care assistant would then be used.
Germany	There is no qualification in other occupational work fields at the same level of qualification.
Ireland	There are several other FETAC Level 5 programmes that can be accessed in other specialties. These include Customer Care, Catering, Food, Safety and Hygiene, Domestic Services, Complementary Therapies, Disability, Community Care etc.
Italy	There is no qualification in other occupational fields at the same level of qualification.
The Netherlands	Target group employees can work in different work fields but do not specialize.
Poland	After working for 3 years a medical carer can become a senior medical carer.
Slovenia	There is a continuing professional development in special areas of knowledge.
Spain	No information provided.
Switzerland	There is no formal further education in place. There are courses offered by hospitals, associations, nursing schools but not with a national certificate or diploma at the end.
United Kingdom	It is possible for HCA to gain additional experience and responsibility by broadening the existing role and remain at level 4 of the career framework. Healthcare assistants can move sideways into the allied health professions, administrative roles, can develop within their role to become senior healthcare support workers or may be given the opportunity to progress to more senior support roles, such as those at assistant practitioner level. Assistant practitioners will be expected to maintain their knowledge and skills. This might involve attending courses or seminars.

Table 15: Vertical Permeability

Austria	There are no bridging courses because education can be done consecutively and might be followed by a shortened education in nursing. Care assistants can enter the second year of the vocational education in the higher civil service in healthcare (nursing). In future, 50% of healthcare assistant trainees are expected to attend general education courses to prepare for the Federal Vocational Baccalaureate Examination and enter Universities of Applied Sciences UAS for nursing studies. [situation statement] However, there is no reliable evidence how many of the target group have chosen this way so far.
Belgium	There are not many healthcare assistants who enter further studies in nursing. Currently the system of bridging courses between the qualification of healthcare assistants and the qualification of nurses is being redesigned in the French part of Belgium by the local Ministry of Secondary Education. The system of bridging courses is different in the three parts of Belgium (Flemish, French and German-speaking community).
Bulgaria	Some of the health assistants are nurse students who, of course, progress into higher qualification levels as that of HCA. Apart from that there are no bridging courses to access nursing studies.
Czech Republic	There are certified courses to higher qualification studies authorized by the Ministry of Health. There are about 26 of these courses such as peritoneal dialysis, finished with a certificate of attendance, not by a graduate diploma. Moreover, there are about 40 courses accredited by the National Institute of Nursing (which is under the Ministry of Health), such as psychiatry, paediatrics, lab methods etc. These are only certificates, too, no University diplomas. Healthcare assistants become general nurses after 3 years practice in hospitals or after 3 years secondary school (14-18 years) plus bachelor in nursing studies of 3 years. Nurses studying two more years at the university or at the college receive their master degree in nursing. One more year at the university or college leads to a PhD. or another 3 years to the PhD. Employees with a master's degree or a PhD. Work mostly in top management position in the healthcare system, or as directors of nursing, ward sister, sister in charge, teaching.
Denmark	There are bridging courses to higher studies. Social healthcare assistants who passed their classes in Danish at C-level, their classes in science at C-level and classes in English at D-level save 30 ECTS in the nursing program (equivalent to 2 modules). They also benefit from a reduction of training time in basic nursing with focus on the provision of basic clinical practice (equivalent to 15 ECTS). Furthermore, they can spare the theoretical and clinical training in either the area of the chronically ill or the area of mental health (equivalent to 15 ECTS). Consequently, the student may spare the following modules of the national curriculum for nurses: Module 4: "basic clinical practice" (15 ECTS), Module 6 or 8: "chronically ill patients and citizens in their own homes" or "mentally ill patients / citizens and vulnerable groups" (each 15 ECTS). Thus, there is the possibility of an individual assessment which may save the student up to 60 ECTS.

Finland	Three-year trainings give general eligibility to apply for studies at universities and polytechnics. In order to enter bachelor studies to become a registered nurse, one needs 12 years of elementary school. Alternatively, the practical nurse training can also be counted as an admission requirement. From those who start the nursing education, about 20 % are practical nurses (in youngster education) and about 60 % are in adult education. Due to the fact that practical nurses can apply straight into nursing studies, there are no bridging courses. If a former practical nurse starts to study at Bachelor level, it is possible to get accredited some of the practical courses of the vocational training from the practical nurse education.
Germany	When the vocational education of a care assistant is completed, the student is given the qualification of 10th year of school (Realschulabschluss). The education of care assistants according to EQF has not been done yet. Care assistants may enter the nurse education programmes without bridging courses. They have the right to enter that program by law. In certain cases they can use their work experience and their education certificate of a care assistant education to shorten the training and education programme of the nurse education (up to one year).
Ireland	There is no accurate data available on how many of the healthcare assistants have entered higher nursing studies so far. However, approximately 380 healthcare assistants or equivalent grades were awarded sponsorships to undertake nursing/midwifery since 2002 as mature students. Healthcare assistants can apply to the Central Application Office as mature students to undertake nursing education. The duration of the nurse training for mature students is identical to all other students on the same programme.
Italy	The OSS can progress to the next step in the qualifying process which leads to the title specialised support worker. For that they have to undertake 300 hours additional study of theory. Personnel with that qualification level is still not being employed in Italy because there are political issues that arise from the uncertain effects on the nursing profession. The regulators are concerned under this present financial climate that it would worsen the tough situation of registered nurses they already have. Consequently, the training programme has been stopped for now. There are no bridging courses that enable the target group to access entry into nursing studies. About 10-15 % of the OSS enter the registered nursing profession after further studies at academic level.
The Netherlands	In order to become a nurse, trainees have to accomplish a high school degree program. As a level 4 nurse one needs to have finished the 10th grade (after 4 years of high school), for level 5 it would be the 11th grade (one year more than the intermediate high school). For level 3 employees there are bridging courses that enable to access nursing studies. Graduates from level 3 can obtain their level 4 nursing diploma within one year instead of 4 because they can get several exemptions. It differs individually how much exemptions a student gets. That depends on his official qualification documents.
Poland	There are no bridging courses for the occupational group to work in a higher level. Only if you are already a nurse there are pathways to a bachelor diploma in nursing. At present, in order to acquire nursing qualifications it is necessary to pass the mature exam and then apply for 3 years of bachelor studies in nursing. It is not possible to build nursing qualifications based on the education and work experiences of medical carer and child carers.
Slovenia	Healthcare technicians/practical nurses with a 4 year education (secondary level) have acquired the admission to enter the nursing colleges and do a Diploma degree of nursing (tertiary level). If they want to

	attend to bachelor programmes they have to complete general matura preparations, lasting 1 year and after that they have to pass the general matura exam (national external exam).
Spain	There are no bridging courses. If nursing assistants want to continue with academic studies in nursing they have to graduate in Superior Grade Training Cycle programs in relation with sanitary area (e.g. laboratory technician). The university nursing schools offer only limited study places. These places (vocational training quota) are distributed by a system of “credit points” which result from a calculation of grade points average from previous studies and other requirements. Relating to how many of the target group employees enter the nursing profession after further study: Around 15 % of all nursing assistant graduates have entered nursing studies before 2010. After 2010 the share has risen to around 25 % due to new regulations at the university level.
Switzerland	The connecting education in Switzerland is well designed. Trained healthcare assistants have direct access to nursing schools and to Universities of Applied Sciences offering study programmes such as nursing, physiotherapy, midwifery, etc.
United Kingdom	<p>There are good access opportunities for HCA to further develop their career provided they meet the entry requirements for nurse or other care related education which is based at first degree level in Higher Education Institutions (HEI). Accreditation of Prior Learning (APL) or Recognition of Prior Learning (RPL) supports widening access for HCA and Assistant Practitioners (AP). The UK Nursing and Midwifery Council (NMC) regulates how APL and RPL mechanisms may contribute towards reduction of length of the nurse degree programmes. The provision of opportunities for individuals to develop their careers has been greatly enhanced by the introduction of the European Qualification Framework.</p> <p>HCA who have demonstrated work based competences and accredited vocational qualifications at levels 3 & 4 may be able to use these qualifications as an entry pathway into pre-registration nursing studies or use an “Access to Nursing” course. Suitable HCA are sometimes supported by their employer to expand their competencies and knowledge base by undertaking an Assistant Practitioner course which would be the first step in their career development. Assistant Practitioner (AP) qualification is normally at Foundation Degree or higher national diploma level and therefore higher than the levels attained by HCA. These qualifications give the opportunities to enter various professional studies in addition to nursing. These could be occupational therapy, physiotherapy, radiography, speech & language therapy. APs with those higher qualifications and competences meet the learning outcomes of the 1st year nursing studies programme (Recognition of Prior Learning) and may be accepted by HEIs to enter nursing studies in the second year. Secondment into such programmes may be provided by the employer whilst the student undertakes those studies on a part-time basis whilst working. Where a career framework exists it proves valuable for both the employee and employers.</p>

3.3 Support for Informal Carers

As mentioned above, the questionnaire about guidance and support for informal carers showed that Bulgaria, Finland and the United Kingdom are currently the countries with systematic approaches of integrating the cooperation with and guidance for informal carers in HCA training.

Thus in **Bulgaria** the 2012 approved Ordinance № 72 on the acquisition of the vocational qualification “Health Assistant” issued by the Ministry of Education and Science states that it is part of the HCAs duties to inform the patient and his relatives for local institutions that provide different types of services and support (health, social, administrative, etc.) and mediate in the implementation of social contact between the patient and his entourage.

In **Finland** the HCA education and training also prepares the future HCA to deal with the demand of guidance of informal carers and to understand their role. The assessment criteria of the national curriculum state that the student:

- supports the family caregiver in his/her work actively and in a variety of ways.
- surveys the client’s needs for changes in his/her social benefits, services, aid-devices and housing conditions in a variety of ways. Guides the client and his/her family in seeking and using different benefits, services and aid-devices, cooperating with experts.
- guides and encourages clients or patients towards stimulating and social activities, creatively and with functional methods, which helps maintain and build up their networks. Also safeguards the opportunity for social participation

Depending on the need of the patient/client, support may be required for information and/or direct help with regards to a number of issues: Specialist voluntary organisations (Diabetes, Stoma Care, Alzheimer, Cancer Care, Age UK etc. to name but a few). In some countries there might be such local or national organizations which can provide additional support and guidance for the patient/client who needs additional help. In Finland, the HCA knows how to establish contact with those organizations and is empowered to refer directly.

In the case of the **United Kingdom** the certificates and diplomas in health and social care can be accessed by HCA but it is normally not mandatory. They contain units which directly refer to this topic. One of the learning outcomes is: “explain why it is important to work in partnership with others” (others may include Team members and colleagues, other professionals, individuals who require care or support, families, friends, advocates or others who are important to individuals). HCAs are not empowered to make direct referrals or contact other organisations on behalf of their clients. They work under the supervision of a registered practitioner/nurse who has the ultimate responsibility for assessing needs and making any referrals as needed. The action of notifying other organisations may be delegated to the HCA by the Registered Nurse or other healthcare practitioner⁹ following assessment

⁹ A health care practitioner is a trained person such as a nurse, physiotherapist, occupational therapist etc. HCA are not included in that terminology.

and taking into consideration the observations of the HCA. Assessing the needs of a client requires the ability to identify options and interpreting a situation that might be complex and HCA's training does not equip them with the relevant level of competence. In order to avoid inappropriate referrals and to ensure that issues of confidentiality and risk are fully addressed, a potential referral may be made by a HCA only with the agreement of a RN. The complete answers of the questionnaire about informal carers can be found on the internal download area of the project homepage.

3.4 Excursus: European Care Certificate

Irrespective of HCA education a European project shall be mentioned here which aims at providing an easy access to basic knowledge in social care – the European Care Certificate (ECC). This offers a possible entry into the field of care **below the level of HCA** and could also serve as an educational support for informal carers.

With regard to the fast developing circumstances within the care sector in Europe, the Leonardo Da Vinci project and the European Commission developed this very basic entry certificate for persons without any experience in care-giving. The LEONARDO project is carried out as a joint-project between 17 member states, aligning with the principles of the UN convention on the Rights of People with Disabilities. Everyone who passes the European Care Certificate Exam will be awarded with the certificate stating that one has basic knowledge about safely working with care-dependent patients with regard to Basic Social Care Learning Outcomes (BESCLO). It is up to each individual in which way he or she obtains the necessary knowledge to pass the exam. The exam, in paper or online-form consists of TRUE or FALSE questions which check whether the applicant could apply basic knowledge within standard care situations. Consisting of 96 questions in eight sections the exam takes around 60 minutes to complete. Upon obtaining the European Care Certificate it will let the future employer know what knowledge the respective person has gained and can build upon this knowledge. Furthermore everyone who passed the exam will be registered in a central database in Brussels which facilitates international mobility.¹⁰ This certificate needs special attention because the largest group of care-givers is in fact unlearned and situated below the addressed target group of this project. The ECC could thus serve as an instrument to obtain at least some basic care-giving skills or even as a first step towards entering a career path in healthcare.

4 Recommendations for HCA Education and Employment

4.1 Structure of the Recommendations

The final step of the project was the development of recommendations for appropriate educational concepts by the project team which were also revised and commented by the experts of the pilot net-

¹⁰ <http://www.eccertificate.eu/united-kingdom/what-is-the-ecc.html>

work. The main goal for an appropriate framework of education and training for healthcare assistants is to ensure high quality of care, patient safety and consumer protection. When thinking of high quality healthcare, according to the results of a EUROBAROMETER survey in 2010,¹¹ the most important criterion for patients is well-trained medical staff. In view of the demographic change and shortages of healthcare professionals HCAs can make an increasingly useful contribution to the skill mix in different healthcare settings. But a clear definition of role boundaries between staff groups is needed in order to derive advantage from team work as well as an appropriate education and training.

According to the European Commission's mandate, a special focus was put on cross-border mobility as well. Mobility of health professionals can be defined as: "*Any intentional change of country after graduation with the purpose and effect of delivering health-related services, including during training periods*".¹² Health professional mobility within the EU and worldwide is playing a growing role, thus raising a variety of issues from workforce planning to self-sufficiency of health systems and financial implications. These issues are not addressed here. Our focus clearly lies on the correlation between mobility and quality and safety issues in healthcare delivery. A common standard of HCA education and training throughout the EU will facilitate this.

In order to structure the recommendations the following nine different criteria for describing a framework concerning education and employment of HCA have been defined:

1. **The Structure of HCA Education and Training.**(duration, theory/practice balance, use of IT/ electronic learning support)
2. **Curriculum** for HCA education (nationwide core curriculum? theory and praxis, ...)
3. **Methods of Assessments** (methodology of assessment for theoretical and practical work, ongoing assessment or examination, who performs the assessment...)
4. **Access, Development and Progression Opportunities (Permeability)** (possibility to access HCA education with prior work experience and followed by progressing after HCA education to further education possibilities such as nurse education)
5. **Registration** (*present situation*)
6. **Competences** (Does the HCA education meet the needs of today's and future health systems?, Relationship between generalization and specialization/ broad basic knowledge, possibility to specialize, possibility to change between long term care, outpatient and inpatient sector)
7. **Relationship between HCA and RN** (is there a demonstrable line of accountability from HCA to RN, ultimate decision-making responsibility for action: does it rest with the RN or HCA? Level of authority of HCA to act independently)
8. **Guidance and support of informal carers by HCA** (are there guidelines to follow, can HCA make referrals independently etc.)
9. **EU mobility for HCA**

¹¹ European Commission (2010): EUROBAROMETER Patient safety and quality of healthcare, download at ec.europa.eu/public_opinion/archives/ebs/ebs_327_en.pdf (19.02.2014).

¹² Wismar, Maier, Glinos et al. (Eds.) (2011): Health Professional Mobility and Health Systems, Observatory Studies Series 23, The European Observatory on Health Systems and Policies, WHO 2011, p. 14.

For each category a definition, recommendations, a justification and relevant best-practice examples are given.

4.2 The Final Recommendations

4.2.1 The Structure of HCA Education and Training

A. Definition

The category “structure of HCA education” covers the framework and general conditions of the HCA education. It contains aspects such as length of the education process, recognised educational institutions, the freedom of choice within the educational process, possibilities of part time education, balance of theory and practice and elective training programs as well as the use of IT and electronic learning.

B. Recommendations

- The HCA training process should start after the successful completion of national compulsory education.
- It should take place at state accredited health specialized vocational schools and be supported in practice. The duration of the training should be 2 - 3 years of full time study (level 4 EQF).
- HCA education and training should be made up of theoretical and practical as well as combined theoretical/practical modules.
- The training should include a minimum of 50 % of on-the-job supported learning in practice. The practical training of the study program can take place in hospitals, health centres, kindergardens, homes for the elderly, home help services and service units for people with learning disabilities and persons with mental health problems.
- A part time education or education in direct connection with a working contract in health or social care should also be possible – in this case the duration of the education will be longer depending on the time share between working and training.
- Elective training can be part of mandatory training or further education. The elective training programs that could be offered to the trainees include emergency care, children’s and youth care and education, adult care, oral and dental care, care for the disabled, care for the elderly, rehabilitation and substance abuse.
- The successful completion of HCA education and training should lead to a recognized certificate or license.
- During the HCA training the use of IT and electronic learning should be an important part of the education process. Each trainee should have the possibility to use electronic learning in addition to and partly also instead of participating in courses at the vocational school. Also the use of electronic equipment for example for planning and documentation purposes should be part of the HCA training.

C. Justification of the Recommendations

HCAs are a group within the healthcare professions, which will gain increased importance in the future because of the demographic development with growing numbers of elderly people and the expanding

need for care and support. Therefore the HCA education has to be sound, both theoretical and practical and as flexible as possible to meet the multiple and changing needs of different user groups within the society.

The access to the HCA education after completion of national compulsory education gives the possibility to start a working career within the healthcare sector without having finished an upper secondary school. This meets the growing needs of healthcare workers in the future. A 2 - 3 year training program for HCAs is necessary in order to give the trainees a good basis for working in practice after the completion of the HCA training. A combination of theoretical and practical training gives enough background knowledge both for theory and practice. The possibility to specialize addresses the need to enable HCAs to practice in different parts of healthcare. The possibility of part time and full time education programs opens up opportunities for different trainee groups with different backgrounds.

D. Best-practice Examples

Finland

The best fit example to the recommendation can be found in Finland (Practical nurse): The training for Finnish Licensed Practical Nurses (HCA) is nationally regulated with a compulsory educational preparation and a national core curriculum. It consists of three years vocational education with theoretical and practical parts and gives the possibility for different specialisation programs. The entry requirement to start the training for HCAs is the completion of nine years of comprehensive school.

Ireland

In Ireland (Healthcare Assistant) the candidates must have a relevant certificate in healthcare support at FETAC Level 5 or a minimum of one year experience in a healthcare setting. The training consists of a unified approach to the curriculum which entails 5 core and 3 elective modules which are publicly funded. It includes practical skills training as well as theory-based modules. The programmes are delivered by experienced Nurse Tutors with support from experienced clinicians. Of particular interest here are the 21 Critical Mass Sites that ensure sufficient persons are trained to meet the needs of the service. The Critical Mass (CMS) approach to training of healthcare assistants and other healthcare support staff aims to ensure that a large number of healthcare assistants, support staff and support service managers from one particular employer/location go through the program at the same time. In this way interprofessional collaboration is encouraged.

Switzerland

Similarly, the training for HCAs in Switzerland (different terms are used: Fachmann/Fachfrau Gesundheit EFZ der Sekundarstufe II; Assistent/Assistentin Gesundheit und Soziales EBA, Assistant en Soins et Santé Communautaire ASSC) is also regulated by the state and consists of three years vocational education with theoretical and practical parts. The vocational training and education begins after termination of the compulsory general education at the age of 15 or 16. At the end of the training the student of vocational education and training receives a federal vocational certificate (CFC or EFZ) which is granted by the national authorities.

The Netherlands

The vocational training for individual health carers in the Netherlands (Verzorgende IG, level 3) is also a good example for the delivery of HCA education. It is a three year program and is nationally regulated on the basis of a national curriculum. However, a specialisation within the education program is not possible. In order to begin the vocational training for individual health carers one needs to attend 6 years of basic school. Thus after the education in level 3 a trainee has an education time of 9 years in total.

4.2.2 Curriculum

A. Definition

A curriculum is a document which describes the desired outcomes of the learning process. It is a program of study which maps the planning and delivery of the subject matter that avoids individual interpretation of the learning content. Learning outcomes are measurable, can be scrutinised and are comparable with other institutions and/or with the European Qualification Framework (EQF).

B. Recommendations

Following the above definition and transferring it to a curriculum whose contents are suitable to the aims of managing specific life and professional situations, it is recommended that:

- The framework within which the curriculum is being developed follows national and/or legal requirements of the respective country. Furthermore, it takes into account examples of evaluated best practices.
- The development of the curriculum rests with teachers with relevant competences (nursing, teaching).
- The respective modular contents of the theoretical and practical training relate primarily to care and address the linking of theory and practice.
- The curriculum is based on knowledge, skills and competences. Specific competences should be acquired which enable targeted occupational situations to be managed effectively.
- The curriculum defines the responsibilities and accountabilities of the HCA and, in particular, demonstrates the demarcation between those of a registered nurse and a HCA.
- The curriculum defines learning outcomes that can be assessed. The everyday working life of healthcare assistants, as well as their complex work situations, are reflected in the cognitive, affective and psychomotor skills training.
- A continuous quality management system must be embedded in the curriculum. It should define specific quality criteria and evaluation measures.
- The curriculum should reflect that attention has been given to current and future requirements of the job.

C. Justification of Recommendations

A curriculum that is evidence-based and meets expected best practices in its development, delivery and application in practice will ensure greater safety for patients, ability to support the nursing workforce effectively and pave the way for stepped career development through Life Long Learning. The

value of competency-based learning enhances the confidence of the future HCA and reduces drop-out rates.

D. Best-practice Examples

Denmark

The curriculum is competency based and there is evidence of good balance between skills learning and academic learning. It is structured on a nursing model, fit for purpose and is adaptable to future needs. Of particular interest is the emphasis on internships to enable HCA learners to acquire vocational competences which are relevant to supporting patients and nurses.

Finland

The curriculum is competency based throughout the education process and follows national prescribed outcomes. It is a national approach that aims to meet the needs of patients and health workers. The tri-partite approach used from start of selection process of potential learners to their final assessments is noteworthy.

Germany (Lower-Saxony)

Only Lower Saxony has unified the curriculum for HCAs in Germany. It is competency based and addresses contemporary requirements for the job market in Germany and wider afield. Teaching and learning is delivered in classrooms and in practice settings. Teaching methods used are varied according to the sections being taught: Face-to-face teaching, group work, tutorials, role-play.

Switzerland

The educational preparation for HCAs is undergoing change in Switzerland. The new curriculum is based on a generic minimum of 1.440 hours study which has a particular emphasis on achieving the relevant competencies for HCAs. Early indications show that it is proving successful.

United Kingdom

The curriculum offers a good balance between statutory and flexible modules that are rigorous in standard and measured outcomes.¹³ As the statutory modules are for all health professionals it reduces risk. Other additional tailor-made modules for different workplaces add flexibility and can lead to innovations that are noted nationwide. They enable HCAs to move from a generic type of employment into more specific supportive roles. A standardised framework for this is provided by a national organisation (Skills for Health). Training can be delivered by training providers either on site or through e-learning. Skills for Health provides resources and learning outcomes and additional modules can be added for HCA training according to local need. Diverse teaching methods are tailored to individual modules: face to face tuition, role play or through workbooks and e-learning. The use of Information Technologies has a particular role in the on-going training of HCAs in conjunction with the Open University (OU). Some of the core skills require annual updates. In the UK there are currently no mandatory training standards or regulation for healthcare support workers. However there are some re-

¹³ Griffin R (2012) Better care through better training - evaluation of an HCA development program, British Journal of Healthcare Assistants 06,1.35-38

quirements for statutory training for healthcare employees such as fire safety, infection prevention and control.¹⁴

4.2.3 Methods of Assessments

A. Definition

The outcome of HCA education can be measured by different types of examinations and assessments. An exam refers to a test which can include written and/or oral parts with the goal of verifying knowledge gained. An assessment can test practical skills attained and/or evaluate the student's progress over a period of time. Throughout Europe there are different approaches used to determine fitness to practice as a HCA. These approaches range from local to externally validated examinations as well as nationally organized and recognized examinations and assessments.

B. Recommendations

Due to their wide range of acquired theoretical and practical knowledge, HCAs have very wide terms of reference involving not only the ill or dependent persons but also nursing staff and family members. Hence, knowledge, skills and competences have to be examined before qualifying.

It is recommended that:

- There should be examinations and assessments for HCAs based on national standards. Examples for such assessments with regard to the EU Commission Key Competences in Education and Training encompass for instance standardized tests with questions directed towards the development of specific key competences, attitudinal questionnaires or performance-based assessments, optionally in combination with standardized tests or (observational) assessments.¹⁵
- The examination should consist of practical as well as theoretical parts (written and oral).
- Each stage of the learning process should be assessed continuously.
- Progression in training should be dependent on completion of each module of the curriculum.
- There should be a certification procedure.

C. Justification of Recommendations

An examination of HCAs has to be held with regard to the diverse tasks and problems that they will be faced with. These include the ability to recognize and solve tasks surrounding ill and dependent per-

¹⁴ The difference between mandatory and statutory training is defined as follows: **Statutory training** is that which an organisation is legally required to provide as defined by law or where a statutory body has instructed organisations to provide training on the basis of legislation. **Mandatory training** is that which is determined as essential by an organisation for the safe and efficient running (of the organisation) in order to reduce organisational risks and comply with policies, government guidelines.

¹⁵ European Commission (2012) Commission Staff Working Document: Assessment of Key Competences in initial education and training: Policy Guidance, *Accompanying the document* – Communication from the Commission – Rethinking Education: Investing in skills for better socio-economic outcomes, p. 22.

sons, motivate the patients to increase practical self-reliance and to support social activity. In addition they have to help patients to meet the essential daily living needs, to cooperate with the therapeutic teams in nursing operations in healthcare institutions and in household conditions and to support the nursing staff in the patient's care. Lastly, HCAs also have to be able to give families emotional support with the sick person and to encourage pro-health behaviour. A unified approach to examination & assessment contributes to a generic professional image and assures employers, other staff groups and, in particular, patients that HCAs have reached agreed national or regional set standards and competences.

The proposed recommendations of this category are in alignment with the statements made within the 2012 working document "EU Commission Key Competences in Education and Training". Therein, assessment is regarded as an important step towards the development of key competences, because it focusses on designated learning outcomes, showing that the respective competences are priority within teaching and learning. Furthermore, the working document states that assessments provide information about the learner's progress which in term can be an indicator for the need to adjust the used teaching and learning methods.¹⁶

D. Best-practice Examples

In Finland, Poland and Slovenia the examination systems for HCAs are well developed and can serve as a model for others. It is worth noting that all these countries have different approaches to HCA education and have examination systems adapted to their education systems.

Finland

In Finland the examination has a written part, a practical part by a skills demonstration (usually at the places of the student's practical training) and an oral part. Competence is being assessed by using the assessment methods which suit the study methods and support the student's learning process. The students must have an opportunity to show his/her competences in various ways and also to assess his/her competence him-/herself. Skills in vocational modules are assessed using a skills demonstration and other ways of assessing competences. As far as possible skills demonstration is used to assess the competence determined in vocational skills requirements. If necessary, other additional forms of competence assessment are used depending on requirement of the skills to be assessed. The education provider decides on the other methods to assess competence in its assessment implementation plan. The students' mentors are responsible for assessments and have received special training in assessment methods.

The Finnish study programme on "Vocational Qualification in Social and Health Care, Practical Nurse, 2010" provides clear definitions for mentioned assessment of learning and assessment of competences. In an attached chart, the respective criteria for assessment are listed and also the question of

¹⁶ European Commission (2012) Commission Staff Working Document: Assessment of Key Competences in initial education and training: Policy Guidance, *Accompanying the document* – Communication from the Commission – Rethinking Education: Investing in skills for better socio-economic outcomes, p. 8.

assessing students with a different mother tongue is addressed in this study programme. These paragraphs and charts can be found in the appendix of this report.

Poland

An examination confirming qualifications, also called a vocational examination, is a form of assessment of the candidate's level of knowledge and skills. The vocational exam is an external exam. It offers comparable and objective assessment of the candidate's level of personal performance through the application of standardized requirements, evaluation criteria and rules for conducting the examination, developed by external institutions, which functions independently of the education system. The Central Examination Board and Regional Examination Commissions appointed by the Ministry of Education in 1999 have taken on the role of the external institutions. Regional Examination Commissions, within the area of its authority, prepare, organize and carry out the external vocational examinations. Exams are evaluated by the external examiners. Vocational examination is made up of a written part and a practical part. The successful candidate who passed the exam receives a diploma confirming vocational qualifications.

Slovenia

There is an officially recognized final exam for healthcare technicians/practical nurses in Slovenia. The final examination consists of a written and oral exam in theoretical nursing and a practical and oral exam in practical nursing. An additional examination after the first 6 months of initial working period is organized internally.

4.2.4 Access, Development and Progression Opportunities (Permeability)

A. Definition

The concept of permeability is rooted in European educational projects such as the Bologna process which incorporates the goals of furthering international mobility and employability. The cornerstones of widening access are Lifelong Learning, social integration and furthering personal development leading to access to educational qualifications. The aims are to achieve comparable modes of studies, length of courses with mutually recognizable qualifications within the European Qualification Framework¹⁷ (EQF) in order to meet the expected shortfall of a qualified workforce. Its aim is also to offer progression routes such as for healthcare assistants into nursing and other health professions or social care. The object of permeability is to formally acquire competencies through educational qualifications; this may also include acquisition and recognition of competencies through life experience and

¹⁷ European Parliament Council (2008): Recommendations of the European Parliament and of the Council on the establishment of the European Qualifications Framework for lifelong learning: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=oj:c:2008:111:0001:0007:en:pdf>.

other informal learning opportunities. This requires agreed and transparent processes of Accreditation of Prior Learning (APL) and Accreditation of Experiential Learning (APEL).

B. Recommendations

Prior to the start of HCA training, consideration should be given to previous formal and informal acquired knowledge through competence assessment which could lead to a reduced length of training. The defined understanding of permeability (widening access) facilitates access to HCA training and for accessing programs of study that lead to further/higher qualifications after the HCA training. On completion, each qualification stands alone. However, the HCA training should enable further progression towards a higher qualification through Lifelong Learning. The completion of the HCA training should lead to a recognized qualification which can contribute to later access to nursing education provided that the EU guideline 2013/55/EU (former 2005/36/EU) is fully met. Such access routes are already operational in some countries and will be described further on.

C. Justification of Recommendations

Healthcare assistants are an important part of the healthcare team. Their training and regulation should ensure that they are able to support patients and the nursing team with confidence. Their training and experience should enable them to progress into nursing or other professions thus achieving:

- Retention of valuable manpower
- Providing a platform for up-skilling and motivation for healthcare assistants
- Contributing to a solution to nursing shortages
- Safer selection and easier access to healthcare assistant training through clearly stated expected outcomes of training
- Enhancement of employment mobility possibilities for HCAs

The proposed recommendations are congruent with the statements found within the European Commission's 2012 paper on "Vocational education and training for better skills, growth and jobs". Therein the Commission pleads for an improved permeability between the various education and training systems ranging from school education, VET and higher education to adult education. A desired outcome here is an European area in which transparent qualification systems enable recognition of acquired qualifications and competences, transfer and accumulation of learning outcomes and ultimately a facilitated EU-wide mobility.¹⁸

The 2012 "EU Commission Partnership and flexible pathways for lifelong skills" working paper similarly states that individuals should have the possibility to move between the different educational tracks, vertically as well as horizontally. Special attention is here put on the suggestion that vocational path-

¹⁸ European Commission (2012): Commission Staff Working Document: Vocational education and training for better skills, growth and jobs – *Accompanying the document* Communication from the Commission - Rethinking Education: Investing in skills for better socio-economic outcomes, p. 3.

ways should lead to the possibility of access to higher education. “Recognition of work experience or other learning achievements” is one suggested option towards this goal, which was also covered by the above stated recommendation.¹⁹

D. Best-practice Examples

Finland

Persons working in a healthcare setting are able to access a shortened healthcare assistant education programme. This is subject to individual assessment. After completion of healthcare assistant education, the student is eligible to enter Higher Education. There is a clear pathway for those wishing to progress their career. The development and support of students is on-going and contributes to the management of future demand for nurses.

Germany (Lower Saxony)

The new approach to the education of HCAs in Lower Saxony has responded to the need to address further learning opportunities for qualified HCA. There are two opportunities:

- it enables them to access nursing studies (no shortening of length of nursing study)
- and/or entitles them to access the Older Person Nursing qualification/ elderly care (Altenpflegeausbildung) with a one year reduction of length of training.

Ireland (Republic of Ireland)

Healthcare assistants can progress into Higher Education as mature students and 'have the opportunity to apply for a limited number of sponsorships to undertake nursing or midwifery training. There is also the possibility for HCAs to access first line management/supervision courses. Widening access and supporting Lifelong Learning are embedded in the 'FETAC approach of HCA selection and training.

Switzerland

It is part of the Swiss educational system to support Lifelong Learning. This applies also to the new HCA education model and research evidences that up to 50 % of trained HCAs who have followed the new model enter nursing studies at university level at a later stage. This model has not yet been fully evaluated but early indication is that it is a potential sound approach to contemporary HCA training. It can support the nursing workforce in a number of settings and offers varied and good opportunities for succession planning and workforce development.

United Kingdom

Healthcare assistants who demonstrate an interest and aptitude in their work have good opportunities for development. The generic skills taught in the foundation module allow the HCAs to work in a number of settings. The next step on the career progression ladder can lead to a Higher Education Certifi-

¹⁹ European Commission (2012) Commission Staff Working Document: Partnership and flexible pathways for lifelong skills development, *Accompanying the document* – Communication from the Commission – Rethinking Education: Investing in skills for better socio-economic outcomes, p.18-19.

cate²⁰ and qualification as Assistant Practitioner with enhanced responsibilities. Ultimately, with support from their employer, they can access a nursing or other clinical or social degree.

Flexibility for the employer as well as for HCAs offers opportunities whilst ensuring measurable standards at recognised levels of qualification. Additionally, electronic learning modules allow the students to work at their own pace and accumulate learning credits on which they can build. The Open University reaches all corners of the UK (and abroad) and is one of the Higher Education providers that supports affordable access to students and works in close partnership with the NHS. The work places, training and the emerging new roles for HCAs and Assistant Practitioners and their impact are widely researched²¹ and evidenced.

4.2.5 Registration

A. Definition

Registration is defined as formal (legal) process by a public authority or a professional board such as nursing, midwifery, social work, physiotherapy etc. Before a recommendation for registration can be given, it has to be stated that registration without successful completion of HCA education and training is not possible.

B. Recommendations

We recommend a registration of HCAs through an organ of self-administration of the occupational group or a state agency. This registration should be seen in conjunction with the necessity of sustained continued education and self-improvement.

C. Justification of Recommendations

In the country profiles and best-practice examples there is a great range from compulsory registration to no registration at all. In five of sixteen countries a registration of HCAs is compulsory. The registration may be implemented through a state agency (Denmark and Finland) or an organ of self-administration of the occupational group (Slovenia, Czech Republic). In Slovenia the registration has to be renewed every seven years with the evidence of completed specialised further education. Examples of no compulsory registration can be found in Switzerland. There is for example only one administration of diplomas but no compulsory registration.

There are compelling arguments for a registration in combination with compulsory continued education and self-improvement. These refer to:

²⁰ Access to Certificate in Higher Education/Foundation Degree: Health and Social Care Management. University of Cumbria, <http://www.cumbria.ac.uk/FDHealth>.

²¹ Manthorpe J; Martineau, S (2008) Support workers: their role and tasks. A scoping review. King's College London, Social Care Workforce Research Unit.

The Quality of Care

The responsibility to renew one's knowledge lies within the individual. If registration and a regular obligation for continued education and self-improvement are combined it can be assured that HCAs renew and expand their knowledge in order to perform at a high level of care. Thus it is clear that a registration of the HCAs within their respective country ensures a consistent quality standard which is of particular importance with regard to EU-mobility. With a consistent approach to registration and licensing not only the necessary level of the training are ensured but simultaneously an easier and safer migration within EU-countries becomes possible.

The Patient Safety

Additional to the quality of care, registration contribute to patient safety. Thus a functional correct and qualitative upscale implementation of care measures can be assured.

The Recipients of Care and the Organisation

The registration of HCAs creates security for the care recipient and assures organisations that HCAs are regulated and trained according to known standards.

The Health Policy of a Country

An up-to-date database of registered HCAs contributes to an overview of the HCA occupational group and enables a targeted planning approach. This enables to obtain information on numbers of HCAs, age pattern, geographical distribution and qualification. Moreover, registration enables the target groups to be reached systematically.

The Occupational Group

Although the main purpose of registration is to ensure public protection and patient safety, it will also strengthen the position of HCA within the healthcare economy and with other occupational groups. This does not only refer to registered nurses but also to HCAs who pursue similar interests within the same sector.

D. Best-practice Examples

Examples for registration through a state agency:

Denmark

In Denmark licensing and registration are regulated by the state: There is compulsory registration for this occupational group. The registration body is the same as the licensing body (Danish Authorization).

Finland

Finland is one of the countries that regulate registration through a state agency. There is compulsory registration for this occupational group. The registration body is the same as the licensing body (National Supervisory Authority for Welfare and Health).

Slovenia

One example for the regulation of the registration through an organ of self-administration is Slovenia: The Nurses and Midwives Association of Slovenia is also responsible for HCA registration. In Slovenia registration is compulsory for HCAs. In order to keep the registration, continued education and self-improvement in regular intervals is obligatory. Slovenia is furthermore the only EU-country in which the re-registration of HCAs after seven years is connected to a mandatory state regulated continued education.

4.2.6 Competences

A. Definition

Competences represent a dynamic combination of cognitive and meta-cognitive skills, knowledge and understanding, interpersonal, intellectual and practical skills. Fostering these competences is the object of all educational programs. Competences are developed in all course units and assessed at different stages of a program. Some competences are subject-area related (specific to a field of study), others are generic (common to any course). It is normally the case that competence development proceeds in an integrated and cyclical manner throughout a program.

B. Recommendations and Justification for Recommendations

HCA education and training has to be competence based and should enable the future HCAs to meet their expected work requirements. The basic principles have to be developed by teachers, practitioners and employers. Competences can be measured and evaluated, they are transferable and fit the desired outcomes for HCA work environments.

Depiction of the Competences

The European Qualifications Framework (EQF), which aims to relate different countries' national qualifications systems to a common European reference framework, distinguishes between eight reference levels describing what a learner knows, understands and is able to do – “learning outcomes”. At present the HCA-qualification in different EU-countries refer to different levels of the EQF. In the future the HCA should be placed at levels 4 in all EU member states. This will promote workers' and learners' mobility between countries in Europe (see also point 8 mobility).

A generalist training of HCAs (as described in point 2 “curriculum”) has to impart the competences which are crucial in supporting nursing staff responsible for care and supervision of patients of different target groups in various settings. The ability to work with different occupational groups is a required outcome of this training. It is useful to divide the aspired professional competences for the HCA training into competence fields and focus on significant and important professional competences in order to not simply reduce competences of HCAs to skills.

Subject Specific Competence:

All insights, skills and competences which are necessary in order to apply concepts of care so that they conform to the respective situation of the care recipient are to be integrated in this category (e.g. his/her recovery and independence, mobilisation or rest, frailty or end of life care). Transferred to the range of duty of HCAs these competences include for example: performing basic/essential nursing in stable care environments as well as recognizing and acting upon emergency situations or changes within the care situation through targeted observation (Corner-stone of the training for assistant and care occupations lying within country responsibility).

Social-communicative Competence:

Empathetic understanding of the perspective of the care recipient and the ability to build, hold and end relationships are to be included in this category. Social-communicative competence also refers to the ability to take constructive criticism and deal with conflict. For HCAs, these competences include for example socializing with care recipients, fostering a respectful contact with them, supporting them in the area of primary care with regard to essential preventative measures, recognizing resources within their frame of actions and competences and integrating them into their care actions, as well as supporting care recipients in shaping their everyday life with special regard to their personal history, culture and religion (Corner-stone of the training for assistant and care occupations laying within country responsibility).

Methodological Competence:

These competences focus on gaining and keeping knowledge as well as on the ability to co-responsibly participate within promotion of health, care and accompaniment of the recipients of care. Applied to the situation of HCAs this includes for example: supporting the compilation (or documentation) of a history and care schedule, updating the care report and documenting one's own activities independently. (Corner-stone of the training for assistant and care occupations lying within country responsibility)

Personal Competence:

Finding a balance between closeness and distance is a central element of personal competence. It is about the ability to avoid anticipated stressors and handle them independently. This includes for example to reflect on the situation and one's own role in cooperating with other occupational groups. (Corner-stone of the training for assistant and care occupations lying within country responsibility)

C. Best-practice Examples

The following best practice examples can be highlighted for the formulation of the competences:

Germany (Lower Saxony)

A categorization into areas of competences takes place in the German example of Lower Saxony – here the training is divided into three areas of competences. They provide assistance to people with their

needs of basic nursing and essential care and in the performance of everyday activities. The care assistant is sensitive towards individual abilities and needs of a person in the context of very particular situations. In Lower Saxony general skills are defined in the following way:

- As part of the knowledge base professional capacity (process-oriented activities, taking account of standards) planning skills (taking into account the resources and problems, the individual history of client/patient and the scope of the lawful responsibilities of HCAs)
- As part of staff competency perception, empathy responsibility independent within the scope of lawful responsibilities of HCAs
- Commitment creativity
- As part of the social skills friendly, unbiased and respectful behaviour
- interpersonal skills
- cooperation and teamwork
- communication skills
- ability to communicate concerns
- ability to reflect

Slovenia

An interesting way was proposed in Slovenia, namely to divide the duties conducted by nursing care personnel. "There is a national document which lists specific nursing interventions performed by healthcare personnel. This list contains 1.576 such interventions of which the RN is allowed to perform 100%. The healthcare technicians/practical nurses can perform 88% (521 interventions) of the basic nursing care interventions, 43% (234) of special nursing interventions and 65% (295) of other nursing interventions. On average healthcare technicians/practical nurses are allowed to perform 66,6% of the 1.576 nursing interventions. The RN is responsible for a holistic care approach and he/she is the leader of the nursing team."

Denmark

Denmark differentiates between competences that should and have to be attained. But also a content-related differentiation into various areas of competences can be detected. The purpose of the studies of social healthcare assistants is regulated in the Danish act no 343 from 16. 5. 2001. Paragraph 1 states:

Relating to that regulation the training should contribute to the development of the students' vocational, academic and personal skills. The student has the opportunity to take basic Danish, science and English courses to be able to apply for admission to the nursing education afterwards. It should also take into account the labour market, the occupational mobility and the students' needs.

- The training must contribute to the development of the students' ability to formulate an independent position, to cooperate and to communicate productively.
- It must also promote the ability to solve academic and social problems, to develop an initiative attitude, flexibility and a sense of quality in work.

- The training as a social healthcare assistant also includes the development of basic skills, particularly in mathematics, reading, oral and written communication and information technology.
- The education must generally contribute to the development of the students' innovative and creative skills, relating to the development of branch specific products or services, and should stimulate business oriented thinking as a foundation for establishing an own business.
- The programs should generally encourage personal students' skills for employment and training.

Ireland

Ireland differentiates skills, knowledge, competencies and insight. The following list represents education objectives in line with The Qualifications and Quality Assurance Authority of Ireland (QQAI) [see <http://www.fetac.ie>] to enable the learner to acquire the knowledge, skills and competence to work under supervision in a variety of healthcare settings to enhance their role in service provision to service users or to progress to further and or higher education and training:

Knowledge: Demonstrate a broad range of knowledge relating to the provision of health service skills and to the health and wellbeing of clients in a variety of healthcare settings. Demonstrate knowledge of the range of theories, practice guidelines and legal requirements relating to the provision of health service skills.

Know-how and Skills: Demonstrate a broad range of practice, evidence based, interpersonal and caring skills in providing health service skills to a varied range of client groups in a variety of healthcare settings. Evaluate and utilise information to assess, plan, implement and evaluate appropriate strategies to a varied range of client groups, whilst working under specific direction and supervision within a support capacity.

Competences: Apply knowledge, skills and attitude within a range and specific healthcare contexts in accordance with accepted practice guidelines, current and emerging legislation that applies to the healthcare setting. Contribute under supervision to planning, implementing and evaluating care delivered to a specified client group, thereby facilitating an understanding of the needs of clients in relation to the maintenance of their independence, dignity, respect, self-esteem and choice.

Insight: Utilise reflective practice skills to inform personal practice, self understanding and personal growth and development whilst working with clients and their families."

The following best practice example can be highlighted with regard to this topic:

Finland

The presented country profile from Finland shows that a two-year basic qualification with subsequent specialization within nine specialist fields is possible. These fields refer to different target groups of care (Emergency care (paramedics), rehabilitation, children and youth care and education, mental health and substance abuse, welfare work, nursing and care, oral and dental care, care for the disabled, care for the elderly, customer services and information management). The training is designed to last three years of full time study. In the first two years all participants have common classes and

study the same courses. In year three, students can choose out of nine different elective courses for their speciality. For instance, one can either choose a specialty in caring for elderly people or working in rehabilitation. Practical nurses are also able to work in kindergardens and special schools due to their broad education. However, the majority work in hospitals and nursing homes caring for elderly people. Later on, one still has the chance to specialise in another field of work. It is to be highlighted that work experience can be accredited to the training.

4.2.7 Relationship between HCAs and Registered Nurses

A. Definition

HCAs are working in support of nurses. This implies a close co-operation with nurses and other clinical staff and requires that attention is given to the following aspects:

- Clarity of the scope of responsibility and accountability of HCAs
- Supervision arrangements of HCAs
- Recognition of differences between delegated and allocated tasks to HCA
- Mentoring and supporting HCAs
- Collaborative working within a safe framework

B. Recommendations

Healthcare assistants work together in a team with registered nurses within the occupational fields of nursing, care and maintenance of people of all age-groups in all diverse acute care settings as well as in primary care environments.

Since the HCA training in most of the participating countries is not oriented towards an independent occupation, healthcare assistants should regularly work under the supervision of higher qualified clinical staff. Consequently, they learn during their training how to be able to work in a team according to their allocated tasks and how to be integrated into the workforce. HCAs carry out delegated nursing tasks, which were planned, supervised and reviewed by registered nurses. Within stable care-giving environments this responsibility to delegate also includes a more concrete instruction to the HCAs. This form of labour organization requires for a clear differentiation in order to be able to distinguish between the fields of registered nurses from those of the healthcare assistants. This requires a legal framework, as can be found in Finland.

C. Best-practice Examples

The analysis of the 15 country profiles showed that in 14 of them HCAs work mainly under supervision of nurses and, exceptionally, physicians. Finland is an exception and it is related to education system of HCA personnel. In Finland practical nurses can work independently within the legal framework of their profession. This is especially the case in elderly care and outpatient nursing. When practical nurses work together with registered nurses, registered nurses are the first line manager in the workgroup.

Ireland

In Ireland healthcare assistants are accountable for their actions in the delivery of patient care and must not undertake any duty related to patient care for which he/she is not trained, in accordance with the educational qualifications. The HCAs must report to and work under the supervision and direction of a Registered Nurse in relation to their tasks and duties and must be integrated into the ward or area team. Nursing staff will delegate duties in accordance with their professional judgement and within the competence of the HCAs. Nursing staff must not allocate any duty to the HCA for which he/she has not been trained.

4.2.8 EU-Mobility for HCAs

A. Definition

EU mobility means the possibility to work as HCA in other EU countries than the country of origin resp. of education, normally without new or additional education. It includes the migration of health professionals into and out of the EU.

B. Recommendations

Based on the current situation it is recommend that an EU-wide recognition of the HCA training and education framework which leads to free movement of HCAs. A HCA who is a national of an EU-country and received her/his qualification in an EU/EEA country will have the right to work in all EU member states indefinitely. In order to do so, all HCAs must have adequate language and communication skills in the official language(s) of the respective country according to the national standards.

In order to ensure patient safety, greater mobility within the EU requires:

- Proof of registration as a HCA in the country of origin
- Detail of level of qualification
- Information about past relevant experience
- Agreed adaptation systems

C. Justification of the Recommendations

The actual situation without an EU-wide regulation for HCAs presents itself in the following way:

- The respective licensing authority evaluates if the applicant's qualification is equal or different to the national HCA education.
- If the evaluation shows that the HCA education is equivalent, the applicant gets the right to be registered as HCA and to work as HCA.
- If the evaluation shows that the HCA education is not equivalent, the applicant may undertake extra courses or further adaptation measures in order to be able to work as a licensed HCA.
- Compensation measures are defined as an aptitude test and an adaptation period. The aptitude test measures general nursing skills and the adaptation period describes the period of time one need to work under the supervision.

- The applicant should have the possibility to choose between the test and the adaptation period.

As long as there is no EU wide regulation of HCAs, it is seen as necessary to evaluate whether the HCA education in the country of origin is equivalent to the country in which the applicant wants to work. In principle, mobility within the EU should be possible also for HCAs without any restrictions. But it is realistic that this will be possible only after a minimum of EU regulation for the HCA education is agreed. Especially the growing need for HCAs in many and perhaps all European countries is an important reason for securing EU safe mobility for HCAs and to ensure patient safety and adequate support for the nursing profession.

Until such an EU wide mobility is possible, bilateral agreements between countries might be an alternative, as already suggested by the WHO Prometheus study. Therein it was stated that bilateral mobility arrangements can help establishing systems that mutually recognize diplomas. If, in addition, international workforce planning frameworks are implemented, cross-border collaborations could provide a solution for local workforce issues. In the long run, such a strategy could result in the possibility of European health workers that can rely on a large range of colleagues trained in Europe.²²

Another way to address the issue of EU mobility is the recently modernised Professional Qualifications Directive (2005/36/EC, now 2013/55/EU). This directive introduces the possibility to set up "common training frameworks" (article 49) and "common training tests", aimed at offering a new avenue for automatic recognition. A common training framework should be based on a common set of knowledge, skills and competences necessary to pursue a profession. A common training framework or test could be set up if the profession concerned or the education and training leading to the profession is regulated in at least one third of the Member States. Qualifications obtained under such common training frameworks should automatically be recognised in the other participating Member States. This regulation can contribute to transnational HCA recognition.

D. Best-practice Examples

Due to the fact that the HCA education in many EU countries is not regulated and there is no formal registration process for this occupational group, it is difficult to find good best practice examples for the category EU Mobility. However, the already existing Europass, initiated by the European Commission, constitutes an instrument, which helps the European citizens to depict their competences, qualifications and skills in a unified and clear way.²³

²² Wismar, Maier, Glinos et al. (Eds.) (2011): Health Professional Mobility and Health Systems, Observatory Studies Series 23, The European Observatory on Health Systems and Policies, WHO 2011, p. 84.

²³ <http://www.bibb.de/de/wlk8646.htm>

4.2.9 Guidance and/or Support of Informal Carers by HCAs

A. Definition

HCAs are often in contact with informal carers when they work in their patient's/client's own home or in other community care settings. Informal carers can be relatives, spouses, partners, friends or volunteer helper. The HCA education should prepare the future HCAs to deal with the demand of giving guidance to informal carers.

B. Recommendations

In this regard, the training of HCAs has to prepare them to understand the role of informal carers. Important aspects of the HCA education in this field are:

- to support the family caregiver in his/her work actively
- to observe the client's needs for changes in his/her social benefits, services, aid-devices and housing conditions in a variety of ways
- to guide the client and his/her family in seeking and using different benefits, services and aid-devices, cooperating with experts and specialist voluntary organisations
- to learn, how to establish contact with experts and organizations in order to help informal carers

Lastly the HCAs have to follow established protocols. In case they work independently, they should be empowered to refer directly.

C. Justification of the Recommendations

Informal carers play an important role in the future development of healthcare, especially of elderly care. Help of informal carers is important to meet these developing needs for care in a society with more and more elderly and chronically ill people. Thus there is clear evidence for the need of cooperation between healthcare professionals of all educational levels with informal carers. HCA education prepares future HCAs for working in different parts of the healthcare system. Especially in elderly care it is usually necessary to cooperate with and give guidance to informal carers. Part of such guidance is guiding the informal carer in all questions of cooperation with experts and different organizations and authorities.

5 Summary – Thoughts for Future Actions

In most of the European countries healthcare assistants (HCA) play an important role in ensuring care for the population. Facing the trend of an ageing population and at the same time an ageing healthcare workforce, the importance of and need for HCA will even grow to ensure a sufficient healthcare workforce also for the future. The regulation, education and examination of HCA within Europe are very heterogeneous. The length of education ranges from one to four years, and in many of the countries no national standardisation of the HCA education and training exists. Nevertheless the number and importance of HCA within the skill mix of healthcare workers is growing steadily. HCA are already today one backbone of ensuring care for people in need for care, even if the situation differs from country to country. Registration of HCA is regulated very non-homogeneously with only six countries with a mandatory registration. Also the range of accountability and the possibility of working partly independently or always under the supervision of registered nurses show a heterogeneous picture. That means at the same time, that development and progression opportunities (permeability) and EU-mobility for the group of HCA at present are very difficult.

Taken all this into account, changes into the direction of EU-wide accepted education standards and work descriptions for HCA are needed. The recommendations, which are the results of the gathered material about HCA in the different countries, the discussions between the experts from the pilot network and the partners of this project and a special workshop on the EU Project Establishing an Expert Network & Database on HCA Education and Training in Brussels with experts and stakeholders from different countries and organisations, show, in which direction this change could and should go to ensure healthcare workforce also for the future and – at the same time – allow higher patient safety, care quality, job satisfaction and consumer protection.

As the project outlined, there is a need to address the present and future nursing workforce to enable them to maximise their potential and to be able to delegate safely tasks that can be undertaken by healthcare assistants. Education is only one building block towards greater safeguarding of the patients and clients. It should be coupled with established frameworks of registration and continuous practice development. These three components create a foundation which supports further two key elements: enhanced safe mobility of the healthcare assistant workforce with the EU and the development of that workforce which offers enhanced career opportunities.

The horizontal and vertical career development opportunities which our recommendations outline contribute towards addressing the highly relevant issues of demographic changes and need for skilled assistants for healthcare professionals. Relevant to this is also the 2010 “Agenda for new skills and jobs: A European contribution towards full employment”²⁴ which consequently are declared EU goals.

Given the great variety of support personnel in health and care throughout Europe today, it must be emphasised that during the project the need for achieving a common understanding of the role, core

²⁴ European Commission (2010): An Agenda for new skills and jobs: A European contribution towards full employment, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0682:FIN:EN:PDF>.

competencies and standards for enhanced education and training programmes for healthcare assistants was identified. This should be further strengthened with an agreement about a “common training framework” for healthcare assistants according to the modernised Professional Qualifications Directive (2013/55/EU). The new article 49a on “common training framework” further extends the currently existing system of automatic recognition to new professions/occupational groups on the basis of those training and test frameworks. If in at least one third of Member States access to a particular profession is regulated, a common training framework or test can be established. The qualifications obtained under such frameworks or tests would then be automatically recognised in all the participating Member States.

It should be emphasized, however, that enhanced education and training programmes for healthcare assistants first and foremost should aim at ensuring self-sufficiency concerning the national health workforce needs. Co-operation and tuning with other European member states will lead to comparable standards and ensures common quality levels and thus encourages career development and progression opportunities for employees within the EU. Thus mobility and cross-border co-operation will be facilitated. Thus a newly aligned healthcare assistant qualification would ultimately lead to economic synergy effects which also address the desired outcomes outlined in this report.

THE NEXT STEPS – THOUGHTS FOR FUTURE ACTIONS

This project has led to heightened awareness of the fragmented approach to regulation and education of HCA in Europe. Healthcare providers and experts who contributed to this project, indeed all who participated in gathering information, have had the opportunity to learn from each other and to share this within their sphere of influence and practice. This has led to an accelerated understanding that the momentum for changes to be implemented must not be lost.

In order to further benefit from the pilot network that has been established the following needs to take place:

- The cooperation within the existing pilot network needs to be continued and adapted as necessary
- The database requires annual updating (via survey among the network members)
- The project homepage will be maintained and updated and is seen as a powerful tool for health economists, healthcare educators and researchers
- Consideration should be given to establish a pilot that brings together participants from a small number of EU member states who establish an agreed framework of education for HCA that draws on examples of best practice identified.

This project has not only created a database of facts but also a deeper acknowledgement from all participants that the momentum for change must not be lost. An opportunity to reap the full benefit of this project would lead to a grounded investment towards a sustainable healthcare workforce that benefits patients and carers. This requires a coordinated and managed approach which, we hope, will be recognised by the commissioners of this report.

6 Appendix

6.1 Glossary

Ability

Ability refers to an acquired or natural capacity, competence, proficiency or talent that enables an individual to perform a particular act, job or task successfully.

Best-practice example (re education, regulation and employment of target group)

A training, regulation or employment model that shows the highest compatibility of that trained person and comparability of alternative qualifications with other European countries and hence offers the greatest possible effect on increasing work mobility throughout European countries.

Competences

Competences represent a dynamic combination of cognitive and meta-cognitive skills, knowledge and understanding, interpersonal, intellectual and practical skills, and ethical values. Fostering these competences is the object of all educational programs. Competences are developed in all course units and assessed at different stages of a programme. Some competences are subject-area related (specific to a field of study), others are generic (common to any degree course). Normally competence development proceeds in an integrated and cyclical manner throughout a program.

Cross-border mobility

Cross-border mobility describes the right of EU-citizens to move and reside freely within the Member States as well as to take up paid employment in another Member State under the same condition as that Member State's own citizens. (≠ Migration: Process of persons moving across borders to live and work, generally implying non-EU citizens moving into or within the EU)

ECTS (European Credit Transfer System)

ECTS is a learner-centred system for credit accumulation and transfer based on the transparency of learning outcomes and learning processes. It aims at facilitating planning, delivery, evaluation, recognition and validation of qualifications and units of learning as well as student mobility. ECTS are widely used in formal higher education and can be applied to other lifelong learning activities.

European Qualification Framework (EQF)

The EQF is a controlling tool for the professional qualification in Europe. It was developed in order to pursue two objectives: the promotion of mobility between the member states and to make lifelong learning easier. The EQF encompasses general education, adult education, further education and continued professional education as well as the access to university education. Central to the EQF are eight levels of reference which describe the whole spectrum between most basic education and highest level qualification. These levels describe the knowledge, skills and competences of the students independently from the origin of the respective education. This covers all qualifications from school leaving certificate to the highest level of academic or professional education. The EQF will serve all citizens and employers as an instrument of reference in comparing the different educational systems of countries.

Formal/professional care

Formal or professional care refers to the care provided by a person who holds a formal qualification, to agreed standards and values. This person can assess, determine (prescribe), deliver and evaluate the care given.

Formal qualification

Any degree, diploma or other certificate issued by a competent authority attesting the successful completion of a recognized programme of study counts as formal qualification.

Informal care

The opposite of formal care is informal care which is care provided e.g. by a relative, friend or volunteer and given to dependent persons, such as the sick and elderly. This form of care takes place outside of the framework of organized, professional work. Informal carers may have some basic training but are generally unpaid.

Learning outcomes

A learning outcome may be described as a statement of what a learner is expected to know, understand and be able to demonstrate after completion of a process of learning. Learning outcomes are expressed in terms of the level of competence to be obtained by the learner. They relate to level descriptors in national and European Qualifications Frameworks

Nurse educator

A nurse educator is a person who is actively involved in nurse education and training as well as formally involved in a nursing educational institution. The person should be familiar with the national standards and criteria of nursing education and is ideally involved in the further development of these standards as an expert. Nurse lecturers normally hold a nursing qualification as well as a teaching qualification.

Nurse leader

In the context of this project, this term is used to denote a person who works (or has worked) in nursing management and/or education and can give advice on the skills and competencies needed concerning the target group workforce as well as on the deficits in training outcomes actually observed.

Nurse regulator

Person who works for a (state) body or regulatory authority, which is responsible for the regulation of nursing in the public interest (i.e. registration/licensing of nurses, development of competency standards and curricula for education and training, governance of nursing education establishments). The person should be familiar with the national standards and criteria of nursing education and is ideally involved in the further development of these standards.

Occupational group (in the context of healthcare provision and education, UK)

An occupational group is a group of professionals with the same health and/or social care background.

Registration of occupational group

Registration in this context refers to formal (legal) registration with a public authority or a professional board such as nursing, midwifery, social work, physiotherapy etc.

Regulation of occupational group

This refers to the legislative requirements of the professional group.

Skills

A skill is the learned capacity to achieve pre-determined results often with the minimum outlay of time, energy, or both. Skills are often divided into general/generic and subject specific skills.

6.2 Care Market Trends by Country

Austria	Healthcare assistants are already working in all possible occupational work fields, however, the number of employees in each field differ. For instance there are very few health-care assistants in medical ordination/surgery or in the freelance sector.
Denmark	<p>The labour market for social healthcare assistants is characterized by a number of challenges. The core area of their employment is in the patient care and development support, which includes a number of practical, organisational and social tasks. But working in that field has become more difficult by physical and psychosocial stress, also by absenteeism of staff and problems with the retention of employees. Hospitals restructure their processes and shorten the hospitalization span, meanwhile outpatient care services are intensified. At the same time hospitals are getting more specialized and focused on innovative therapies. That leads to a re-integration of several outpatient care services into the processes of hospitals. Next to hospitals, the community and primary care is a large workspace for social healthcare assistants in the care of elderly. Not at last, the share of responsibilities between the regions and municipalities are changing in the current process of reorganization. Relating to the structural reformation of the sector currently taking place, attention is concentrated on the effective use of human resources and the quality of personnel. One consequence of the reorganization of the sector is that viable residential units are being installed. They are designed according to the financial resources of the ones in need of care and the wishes of the elderly (e.g. to participate actively in the daily household). In consequence, new job opportunities with a different spectrum of tasks and new employee profiles with different skill mixes are evolving and are taking effect on the job market.</p> <p>According to that trend, more patients or elderly persons have to be taken care of at their own homes. Because of that, more of the social healthcare assistants are employed in municipalities now. That also leads to challenging tasks in home care settings and requires more diverse skills and competencies. Job requirements in occupational fields of prevention or rehabilitation are therefore changing to more specialized knowledge of complex diseases, for example respective patients with mental diseases and dual diagnoses, in consequence. It is being thought of to set up courses in nutrition, palliative care and psy-</p>

	chiatric diseases.
Finland	In the future, the range of workplaces offered to that occupational group will even rise. Caused by the fact that thousands of healthcare workers will retire in the near future, new employees are needed to ensure the availability of healthcare services. Another fact is that the ageing population and the need for social and healthcare services will increase. The proportion of care for the elderly will increase and diversify to a significant extent. There will be also a need for lifting the retirement age. Well-being at work will play a more important role.
Germany	In principle, the increase of employment in this sector is expected.
Ireland	Due to the fact that there is no national regulation it is pursued to establish the title healthcare assistant (H.C.A.) nationally. Staff being engaged in the role of healthcare assistants but have not yet completed this programme will continue in their role and the agreed job description will apply to them. This cohort together with all newly recruited healthcare assistants will be required to undertake the programme as soon as it can be available to them. It is recognised that in exceptional circumstances individual staff members may not be in a position to undertake and complete the programme and in this context the job description will apply consistent with the appropriate delegation of duties from the nurse / midwife.
Italy	No information provided.
The Netherlands	In The Netherlands, the current trend in the focused field of this project is strongly related to the development of the “care packages” (zorgzwaartepakketten, zzp) introduced in 2009 that determine how much care a single client may receive (with respect to financing). With the regulations in consequence to these renovations, there are changes in practice and the care institutions have to adapt correspondingly. Tasks and responsibilities of the single occupational groups on the mentioned levels of qualification are also supposed to shift. Next to the regulatory influences on the healthcare system, there is the demographic impact in this sector. Modern lifestyles let the average person live longer (higher survival rate, average age of females in care homes is 82) but they can also lead to welfare diseases among the younger aged population and increase their need for care. Also, it is generally expected that more elderly people will have to be cared and nursed in their own homes.
Poland	The care market trends in Poland resulted in creating several professions focusing on care needs of different groups of people (disabled, elderly, pensioners of social care homes, people with chronic conditions, people taking long rehabilitation, ill and disabled children). Some professions like medical carer and child carer are prepared to work in the clinical environment (technicians) and other are prepared to work in more general environment like social care homes and home environment. It focuses on holistic approach to care where acute hospital/ambulatory care is linked with rehabilitation and home environment long term care accompanied with social integration. Poland is looking for solutions helping solving shortages in human and financial resources in the health care sys-

	tem.
Slovenia	There is currently a national strategy in Slovenia which aspires to raise the share of RN up to 70 % in relation to healthcare technicians/practical nurses who should amount up to 30 % of the healthcare workforce. In past years the nursing management was considerably lacking RN. Therefore, in the past 6 years new education faculties have opened and today nursing managers can choose between different applicants again. It is still being discussed and considered how many educational facilities will have to be put to operate in order to secure enough labour.
Spain	No information provided.
Switzerland	Healthcare assistants seem to be best integrated in the long-term care. According to a recently published survey, healthcare assistants feel more comfortable in the home based care setting. However, as the healthcare assistant profile is still new, it can be imagined that more workplaces could be covered by healthcare assistants in future. This is not without risk. There are records of healthcare assistants who are used beyond their competences in some settings, especially in nursing homes where they are sometimes forced to tasks of higher professional responsibility.
United Kingdom	The increased specialisation and demands made on RN has raised the awareness that HCA require better educational preparation in order to perform delegated tasks safely. In 2013 Robert Francis QC called for the regulation of HCA. There is strong support for this from the nursing profession but this has not yet been achieved. There is still a lack of compulsory and consistent training of all HCA. However, this is in the process of being addressed but progress remains slow and patchy.

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 - LGBl. Nr. 52/2005 Stück 36: Kundmachung des Landeshauptmannes von Burgenland vom 8. Juli 2005 betreffend die Vereinbarung gemäß Art. 15a B-VG zwischen dem Bund und den Ländern über Sozialbetreuungsberufe.
 - LGBl. Nr. 42/2011 Stück 23: Verordnung der Burgenländischen Landesregierung vom 31. Mai 2011 über die Ausbildungseinrichtungen sowie über die Ausbildung zur Heimhelferin oder zum Heimhelfer (Burgenländische Heimhilfeausbildungs-Verordnung – Bgld. HAV).
 - LGBl. Nr. 4/2008 Stück 2: Gesetz vom 16. Oktober 2007, mit dem die Sozialbetreuungsberufe geregelt werden (Steiermärkisches Sozialbetreuungsberufegesetz – StSBBG) und das Steiermärkische Pflegeheimgesetz 2003 geändert wird.
 - LGBl. Nr. 9/2009 5.Stück: Gesetz vom 12. November 2008 über die Sozialbetreuungsberufe (Tiroler Sozialbetreuungsberufegesetz – TSBBG).
 - LGBl. Nr. 46/2009 20.Stück: Verordnung der Landesregierung vom 19. Mai 2009 über die Ausbildung in der Heimhilfe (Heimhilfe-Ausbildungsverordnung) Aufgrund des § 42 des Tiroler Sozialbetreuungsberufegesetzes, LGBl. Nr. 9/2009.
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Belgium

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Denmark

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- AMI rapport nr. 58: Fastholdelse og rekruttering af social og sundhedshjælpere og assistenter, Antal, flow og årsager til frafald under og efter endt uddannelse. Baseret på litteratugennemgang. Ellen Bøtker Pedersen Arbejdsmedicinsk klinik, Bispebjerg Hospital, Arbejds miljøinstituttet, København DK 2004. (this report describes reasons for interruption of the training, places of employment after graduation and reasons for retirement.)
- Social- og sundhedsassistent – en profil i bevægelse, Jobprofil på social- og sundhedsassistentområdet Juni 2007, Teknologisk Institut, Arbejdsliv. Gregersvej 2630 Taastrup. DK.

Finland

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Germany (Lower Saxony)

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Ireland

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Italy

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- Vocational standards issued by the National Reference Point for Occupational Qualifications Slovenia: NRP SLO: <http://www.nrpslo.org/poklicni-standard.aspx/72300100>.
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- Vocational activities and competences described by The Nurses and Midwives Association of Slovenia: http://www.zbornica-zveza.si/dokumenti/Poklicne_aktivnosti_in_kompetence08.pdf.
- National document on specific nursing interventions performed by healthcare personnel: http://www.zbornica-zveza.si/dokumenti/Poklicne_aktivnosti_in_kompetence08.pdf.

Spain

- <http://www.auxiliar-enfermeria.com/>
- Official publication about qualification and competences:
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- <http://www.emagister.com/grado-medio/ciclo-grado-medio-cuidados-auxiliares-enfermeria-stematica-153.htm>.
- http://www.msc.es/gl/novedades/docs/Estudio_necesidades_enfermeria.pdf
- BOLETÍN OFICIAL DEL ESTADO, Jueves 19 de enero de 2012, Sec. I. Pág. 4329, ANEXO DCLXIX, CUALIFICACIÓN PROFESIONAL: CUIDADOS AUXILIARES SANITARIOS (official description of competences, qualifications and workplaces, in Spanish).
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http://www.msc.es/gl/novedades/docs/Estudio_necesidades_enfermeria.pdf.
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