Older people's views on professional competences

Authors:

C. Soares, Polythechnic Institute of Setúbal, Portugal

A. Marques, Polythechnic Institute of Setúbal, Portugal

P. Clarke, Liverpool John Moores University, UK

R. Klein, Carinthia University of Applied Sciences, Austria

L. Koskinen, Savonia University of Applied Sciences, Finland

D. Krasuckiene, Kaunas University of Applied Sciences, Lithuania

O. Küçükgüçlü, Dokuz Eylul University, Turkey

E. Lamsodiene, Kaunas University of Applied Sciences, Lithuania

K. Leitner, Carinthia University of Applied Sciences, Austria

V. Piscalkiene, Kaunas University of Applied Sciences, Lithuania

B. Söylemez, Dokuz Eylul University, Turkey

Project work group: Portugal (Lead), Austria, Finland, Lithuania, Turkey, UK

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Introduction

Ageing has become a central topic in modern societies as it is associated to a number of complex challenges that individuals, institutions, politics, science, and society in general need to face. Since the 1990's, academics and professionals from different disciplines have dedicated much more attention to the rapid growth of the ageing population (Pike, 2013). From the perspective of education and training of professionals who will work with older people in the future, institutions of higher education play an essential role on the development of innovative expertise related to the promotion of positive ageing during later adulthood.

ELLAN project - European Later Life Active Network –, was conceptualized and developed within this context and follows the Strategic Plan of the Steering Group of the European Partnership on Active and Healthy Ageing ("Strategic Plan of the Steering Group", 2011). Identifying and removing obstacles to innovation in the fields of health and social care are among the partnership goals, since innovation is essential to reconceptualise the environment older people are living in, especially in the demanding economic situation Europe is facing. Increasing by two the average number of years of healthy life in the EU by 2020 is a desired aim for this partnership.

Ageing is understood as an opportunity rather than a burden and the importance of ageing must be recognised as Europe's opportunity for the future. In former ageing studies, higher education institutions were not so much involved and the outcomes of projects have not been properly exploited in education ("Strategic Plan of the Steering Group", 2011). However, developing health and active ageing conceptions and taking it into practice form an essential role of higher education institutions. Thus, delivering proper training to professionals and staff working with older people is crucial to accomplish the goals of active and healthy ageing paradigm.

ELLAN project involves a multidisciplinary partnership with experts from different domains and with different perspectives on ageing. The main aim of this project is to develop an agreed European Core Competences Framework for working with older people in the fields of health and social care. Results from this project will be used for curricula development in all partner countries. The core competences will be developed within a Pan-European

perspective and will inform education in health and social care professions at an international level.

This report presents one research conducted in Austria, Finland, Lithuania, Portugal (Leader), Turkey and United Kingdom, within ELLAN's work package four (WP4). The main purpose of this WP was to identify a transnational thematic framework that can inform on the most relevant competences of health and social care professionals working with older populations from the perspective of European older people themselves. This way it will be possible to give an active voice to these social actors when developing an European core competences framework for health and social care professions (WP8).

Hence, the main aim of WP4's research study was to explore older people's perceptions and ideas about the required and desired competences of professionals working with older populations in different European countries. Specifically, it aimed at identifying and analyzing meaningful dimensions emphasized by older European citizens considering their representations and their personal experiences with health and social care professionals.

Literature Review

According to the main aim of this study, literature review of WP4 has been anchored in two key dimensions: conceptual definition of competences and older adult's views on competences of health and social care professionals.

Conceptual definition of competences

On the subject of competence's definition, and based on the literature review and outputs from WP3, competence can be understood as "the proven ability to use knowledge, skills, and personal, social and/or methodological abilities, in work or study situations and in professional and personal development" (European Parliament, 2008, p. C 111/4). In the context of this project, competences represent a combination of essential knowledge, abilities, skills and values required for health and social care professionals working with older persons.

The Royal College of Physicians and Surgeons of Canada have developed a competency-based framework, the CanMEDS Physician Competency Framework, which describes the

core knowledge, skills and abilities of specialist physicians ("CanMEDS 2005 Framework", 2005). The primary goal of CanMEDS is to improve health and health care outcomes. This framework consists of seven roles: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar, and Professional. It has been previously adapted to other professions, and in WP3 a description of the modified CanMED roles for health and social care professionals working with older people has been conducted.

The Expert Professional on health and social care is the main role, which combines and interconnects the other six roles. Key competences of this role are related to assessing, diagnosing and designing interventions to support, promote and improve older people's physical and mental well-being, social participation/activities and housing-living conditions.

As Communicators, health and social care professionals are expected to apply communicational competences in several contexts and with different actors involved in the care process. Professionals must possess interpersonal communication skills, maintain relationships, perform interviews, provide explanations, summarize information, promote empowerment, and coach.

Collaborator role addresses professional work within health and social care teams in order to optimize support and care to older people. The core competences are focused on description, recognition and respect for diversity of professional roles, peer cooperation, and formal/informal support and care.

As Managers/Organizers, health and social care professionals are integral participants in social and healthcare organizations and have the common purpose of ensuring continuity and safety in the support and care of older people. These actions require competences of planning, coordination and programming of support and care, participating and chairing in meetings.

As Personal Advocates/Networkers, social and health care professionals use their expertise and influence to promote health and well-being of older individuals, communities and populations. Desired competences are connected to social networking, social mapping, social media, prevention, active ageing and health promotion and identifying underserved and/or vulnerable populations.

The Scholar role entails a permanent commitment to reflective learning, and also creation, dissemination, implementation, and translation of ageing related knowledge, which requires competences in research and innovation.

The Professional role is guided by codes of ethics, regulations, standards of behaviour, and engagement with the well-being of older people. Thus, commitment to elderly adults, managing conflicts of interest, complying with ethical principles, confidentiality, legal frameworks, guarantying safety, quality, and innovation are part of the required competences for this role.

Another conceptual approach to competence is the one proposed by Epstein and Hundert (2002), which was built on previous definitions for medical practice, and conceives professional competence as the "habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p. 226).

This description comprises cognitive, integrative, relational and affective/moral functions. The cognitive dimension focuses on the acquisition and use of knowledge to solve real-life problems; the integrative dimension relies on the combination of biomedical and psychosocial data in clinical reasoning; the relational dimension is associated with effective communication with patients and colleagues; and the affective/moral dimension reflects the willingness, patience, and emotional awareness to use these skills judiciously and humanely.

For Epstein and Hundert (2002) professional competence is developmental, changeable, and context-dependent. Within this framework competence entails a relationship between ability (in the person), a task (in the world) and the ecology of the health systems and clinical contexts in which those tasks occur. This perspective of competence is distinctive from others focusing on abstract sets of attributes that professionals acquire (e.g. knowledge, skills, and attitudes), and that are assumed to be effective in all situations of practice. Changes in professional practice and the context of care can call for redefinitions of competence (Epstein & Hundert, 2002).

Older adult's views on competences of health and social care professionals

The second main dimension of theoretical background in this research is related to older people's views on the required and desired competences of health and social care professionals working with older adults. Even if the literature on this topic is not abundant

throughout different dimensions and contexts of research those perceptions of competence could be addressed.

One relevant aspect of professional competence found in literature is associated with the ability to promote positive relationships with clients. Several studies conducted with older people have underlined the importance of person centred relationships, focused on individuals and on personalized care (Bastiaens, Van Royen, Pavlic, Raposo & Baker, 2007; Berkelmans, Berendsen, Verhaak & van der Meer, 2010; Bridges, Flatley & Meyer, 2010; Frank, Su, & Knott, 2003; Manthorpe et al., 2008). According to older people, positive relationships require availability of professionals (Frank et al., 2003) and imply the possibility of shared decision making with older clients (Berkelmans et al., 2010; Brown, McWilliam & Mai, 1997).

On the other hand, several studies show that older adults believe professionals must have good communicative and listening skills (Bayliss, Edwards, Steiner & Main, 2008; Berkelmans et al., 2010; Brown et al., 1997; Frank et al., 2003; Manthorpe, et al., 2008; Rodriguez-Martin, Martinez-Andres, Cervera-Monteagudo, Notario-Pacheco & Martinez-Vizcaino, 2013;). In different contexts of intervention, older clients want to receive suitable information and understandable explanations about issues related to care (Brown et al., 1997; Poole & Rowat, 1994; Vieder, Krafchick, Kovach & Galluzzi, 2002; Watson, Marshall & Fosbinder, 1999). Patience, thoroughness, clarity and time spent to provide adequate information about treatment procedures are also valued by older adults (Vieder et al., 2002).

Emotional competence and caring attitudes of professionals are also appreciated by older people, namely friendliness, courteousness, sense of humour (Watson et al., 1999), showing good will, affection, kindness, cheerfulness, warm care, providing support, and being calm (Rodriguez-Martin et al., 2013). Manifestations of good mood, understanding, genuineness, patience and respect (Poole & Rowat, 1994) are also valued during interactions with professionals.

Availability to integrate families in care (Brown et al., 1997), acknowledgement and recognition of individual needs (Bayliss et al., 2008; Bridges et al., 2010) were also pointed out by older people as relevant aspects of professional competence.

Technical dimensions are also part of the descriptions of competence, and these include ability and expertise manifested during care (Watson et al., 1999), having specific training

in geriatrics (Rodriguez-Martin et al., 2013), doing technical procedures, and coordinating services (Poole & Rowat, 1994).

Thus, from our literature review it seems that relational aspects of care and psychosocial characteristics of carers are mentioned more often by older people when compared to technical aspects of competence. For instance, in relation to nursing, Van der Elst, de Casterlé and Gastmans (2012) concluded that even though participants find technical knowledge and skills shown during physical care to be important attributes, these seem to be interconnected with the nurse's attitudes in a way that the former couldn't be well accomplished without the latter.

Methods

Aim, Methodological and Epistemological Frame

The aim of this study was to explore significant discourses among European older people towards the required and desired competences of social and health care professionals working with individuals during later adulthood. To achieve this aim empirical work was conducted in six European countries (Austria, Finland, Lithuania, Portugal, Turkey, UK). Because the focus of this study was to analyse people's subjective sense of their world and experience, and following a constructionist approach, a qualitative methodology was chosen (Howitt, 2010).

Participants

Each of the six partner countries has selected a convenience sample of 16 participants (N=96, Appendix 1). Globally, participants were aged over 60, living either alone/with family or institutionalized, without cognitive impairments, and experiencing different health conditions.

Considering our total sample, 59% of participants were female, with a mean age of 74,14 years (SD: 7,67; age range: 56 to 94). At the time of data collection 51 of our respondents were receiving some type of support from formal services.

Table 1 summarizes the main socio-demographic aspects of participants in our study.

Table 1: Socio-demographic characteristics of participants

	Country	AT	FI	LT	PT	TK	UK	Total	(%)	
Age (N)**	<60	1	0	0	0	0	0	1	1	M=74,14; SD= 7,67 (56-94)
	60-69	4	4	6	3	4	8	29	30	
	70-79	5	8	8	6	8	6	41	43	
	≥80	6	4	2	7	4	2	25	26	
Sex (N)	F	11	12	8	10	8	8	57	59	
	M	5	4	8	6	8	8	39	41	
Education completed*** (N)	Low	6	*	7	14	7	*	20		
	Medium	9	*	3	0	5	*	17		
	High	0	*	6	2	4	*	12		
Formal services (N)	Receiving	6	5	2	13	8	*	34		
	Not receiving	10	11	14	3	8	*	46		
Household composition (N)	Lives alone	*	7	4	9	6	6	32		
	With others	*	9	12	7	10	10	48		

***Data not provided**
**** Definition of old as in National Institute on Aging (NIA) & National Institutes of Health (2011)**
***** Low: primary/basic education; Medium: Secondary education; High: university education**

Instruments and Data Collection

To explore the discourses of European older people towards the required and desired competences of professionals working with individuals during later adulthood semi-structured interviews have been used for data collection. All six partners have followed a common interview script (Appendix 2), which was flexible enough to accommodate different national, cultural and individual realities.

The analytic dimensions of the script were structured around relevant thematic areas

identified in scientific literature, namely: representations/expectations related to health and social care professionals; relational and communicational aspects; and self-management in daily life. At the same time, a set of key topics was associated with the analytic dimensions, so that each thematic could be explored in a dialogical way during the process of interview. The inclusion of these key topics allowed creating enough flexibility in the dialogue between interviewer-interviewee, and relevant contents that were not spontaneously elicited by participants could be further explored throughout interviews. Data collection was conducted between May and July 2014 in each partner's country, either at participants' homes or at their institutional contexts. Interviews length varied between a minimum of 24 minutes and a maximum of 1 hour and 55 minutes.

Ethical considerations

An ethical application was submitted to an ethics committee in each partner's country whenever required. All participants received clear information about the aims of the study, conditions for voluntary participation and were asked to sign a consent form.

Data analysis

Data analysis was conducted using the method of thematic analysis (Braun & Clarke, 2006), which is one of several possible methods for qualitative data analysis. According to these authors, one advantage of this method is flexibility, since it is applicable to a wide range of research questions and epistemologies. Even if thematic analysis is not attached to any particular theoretical position, the product of analysis can be rich and insightful. Another advantage of thematic analysis is the possibility to summarize core aspects of large amounts of data, and to offer 'thick descriptions' of data sets. Other benefits brought by this method are related to the dissemination of results. On one hand, the general public is able to comprehend and manage results delivered by thematic analysis; on the other hand, results may be suitable to inform policy development (Braun & Clarke, 2006). Based on the proposal of these authors, the analysis of data collected in the six countries involved the following sequence of steps:

i. Data collected through interviews were fully transcribed in the original language (by

each partner)

ii. Initial codes were generated in each national corpus of data and illustrative quotations were translated into English (by each partner);

iii. The pool of codes generated in the six countries was aggregated into potential themes (by the Portuguese team);

iv. Themes identified in the previous step were actively reviewed and a thematic 'map' of analysis was created (by the Portuguese team);

v. Final themes were defined and labelled (by the Portuguese team);

vi. Final report was written by the Portuguese team and reviewed by key partners.

From the methodological point of view, the main goal of this thematic analysis was to identify and describe significant dimensions of meaning across the six countries. For this reason, data analysis was based on an inductive approach and followed a realistic method, which focuses on the description of participants' reality (Braun & Clarke, 2006).

Credibility

Credibility refers to the strategies used to ensure the accuracy of results from the perspective of participants, researchers, and readers of the study (Creswell & Miller, 2000). It is similar to concepts such as reliability and validity often used in quantitative research. To guarantee the credibility of information collected and analysed in this study we have used the following procedures:

. To ensure that interviews shared a common frame in all countries, a semi-structured interview script was developed and accepted by all partners;

. To guarantee a common conceptual frame in the process of initial coding of data in each country, a guiding model was developed by the leading team and shared with all partners;

. To reach an agreement on the codes generated by each country, the process of initial coding was fully reviewed by the leading team and discussed with each partner;

. To guarantee the quality of the final thematic map, steps iii and iv of data analysis were undertaken by two researchers of the leading team; researchers have discussed contents of their analysis together and a consensual definition of themes was reached.

Results

Following the analysis of discourses from participants of the six countries involved in this study we were able to identify four major themes: *Recognizing the person I am, Connecting the space between us, Fulfilling your professional knowledge and skills* and *Disclosing professionalism in you.*

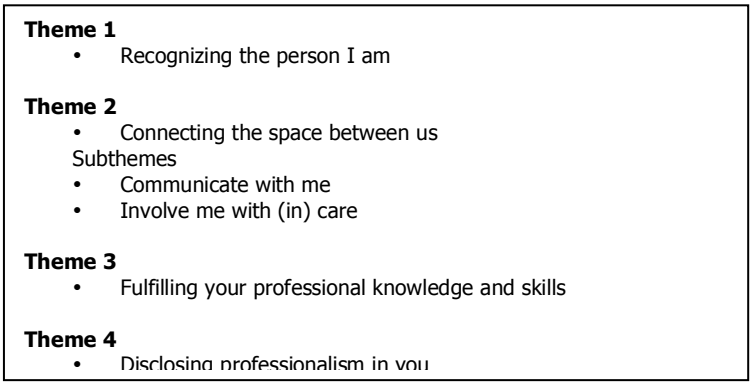

Figure 1 –Themes description

Theme 1

The first major theme '**Recognizing the person I am'** addresses the topic of personhood and focuses on the importance of being known as an individual, with a particular identity, history, and background. This theme describes older people's need and desire to see their individuality recognized and their dignity and privacy respected by social and health care professionals.

This theme is organized around five dimensions that should be reflected in the provision of care delivered by professionals: knowing the person, understanding its specific needs; knowing the person's life conditions, social and family background; respecting individuality and recognizing older people's idiosyncrasies; respecting personal wishes, dignity and privacy.

Participants appreciate to be known and understood as unique persons, with distinctive developmental pathways and individual needs. Thus, they expect to be addressed by professionals in a way that discloses that recognition. Such perceptions were expressed in

'knowing the person, understanding its specific needs'.

Delivery of care needs to be adapted and personalized to users and to achieve such goal professionals must be well aware of the individual client:

> *The better the staff knows the patient (background information) the better the treatment is. If they do not know about the condition of the patient, it has reflections in the contact. (P17FI.69M)*

> *I also can imagine one occupational therapist paying more attention to a person's disease and to its problem; they should work more personally. (P41LT.67F)*

> *I have the opinion that they should act more sincere more heart-to-heart, in such a way that they are able to understand patient's psychology. (P75TR.76F)*

To attain adjusted and customized care professionals should rely on a deep understanding of older people's specific needs and limitations, as reflected in the following statements:

> *Because everyone has different needs and you can't just lump them all together, you know. (P12AT.71F)*

> *Well, to start with the social, first of all they will be people with a good human preparation. That learned to know people and study them (...). Therefore, first it is to know the person's needs, to be able to identify it, to know the reason why, many times, she has got old sooner, for example, that's an important thing. And therefore, building a contact and once the person is understood, it may be a way to help the person to overcome its difficulties, problems. (...) (P54PT.90M)*

> *I would expect them to listen to me, you know, what my needs are, and to see me as an individual, not somebody who has these health issues or this person suffers with that, so do many other people. It's not them that turn up, I don't care about the other people but I'm, you know, concerned about me. And if they see me as that person with those health issues and address them, that's what I would like and expect.* (P87UK.65M)

Recognizing the person is also related to professionals' availability to know their life conditions, family and social contexts. These elements of people's life are diverse and must be approached otherwise the understanding of older clients will be disconnected from their social being and contextual reality. For instance, participants have underlined the use of different intervention methods, such as house visits, making appointments and

involving the family in the process of care:

> *It is important that they recognize the different conditions people are living in and also personal problems and needs. This requires that professionals do home visits. This cannot be assessed only through talking. This gives much information if the professional sees the home environment. (P19FI.70F)*

> *Those from the social area must try to know the family, since the elderly is part of a household. Therefore, they need to know the family and recognize the reason why he is depressed, why he has so few visits. I think it's very important to establish that connection with the family. (P55PT.78F)*

Having a comprehensive perspective of the older person requires an understanding of their life situation, the available resources and the type of support provided by family:

> *(...) an understanding of the lives people have, a more intimate understanding of their lives, their problems and the way you deal with those problems. (...) they need to understand the lives people have and how they cope. Because a lot of them, I don't think, realize just what the needs are of people and how they cope, and the stressful life that people lead' (P92UK.79M)*

> *We can only judge a person if we get to know her right? They must have a real contact with people, with populations, with the houses they inhabit, with what they do, what they have to eat (...) and knowing for real what they are going through, because they don't. (P49PT.91F)*

> *A social worker should just pay more attention to the living situation because some people don't have opportunities to, for example, reach the hospital or any other institution, he should pay more attention to the person himself. Because there are situations when family members are not able in helping to solve some problems, but the person needs their help because he is not able to do it on his own. I am talking about transportation and stuff. (P41LT.67F)*

Respecting individuality and being aware of personal idiosyncrasies reveals the importance of recognizing older people as a group marked by diversity and individual differences. Thus, professionals should avoid making generalizations during care:

> *The individuality of experience should be respected not the categorization of people. (P26FI.69F)*

> *I think physical therapist should treat people more as individuals and pay less attention to general*

features. How could I put this in a right way, I know they have an exercise system but they should think less generally, see people's individual capability... (P41LT.67F)

As indispensable agents to the well-being of older people one thing they all must have is respect for a person's individuality. And that's absolutely necessary. (...) Yes, they can't treat all in the same manner. (P55PT.78F)

Everybody is different in how they deal with their own problems, aren't they? And the professional would have to be able to understand that and see that different person's personality, and how they deal with their diagnosis. (P96UK.75F)

Participants also emphasized respect for personal wishes, dignity and privacy during interviews. Personal wishes and making choices promotes self-affirmation and integrity of older clients:

Well, I would certainly arrange for a living will to be made, so that, if I can no longer expect a certain quality of life, or if the life-sustaining measures can no longer bring back my health, that my relatives or the doctors no longer need to extend my life with artificial measures. (P12AT.71F)

Well, it is important that (professionals) concern with what a person wants and that a person would not be taken to situations that are uncomfortable or bad and depressive. Not that. If people are treated like from conveyor belt without taking into the consideration how that person feels. (P21FI.74F)

Dignity is also relevant for the recognition of self and comes intertwined with a sense of lifelong continuity, despite the particular conditions or situations of present life:

I can only say, an old person in his helplessness, often even with all his limitations is still a human being, so they shouldn't call you 'you Mitzi' or 'you Franz', but they should say 'Mr. Müller' or 'Mrs. Meier' instead. (P6AT.74M)

Well, a lot about respect for the elderly, and not just see a poor man who can't wee properly. Respect that this gentleman was a fine young man, and he never thought he was going to end up ... now most of the nurses do have that respect, but not always in the hospitals because they're just, sort of, there to change their bedpans. So they need to be taught more empathy and respect for who they're dealing with. (P93UK.68F)

Respect for privacy is also reflected on the theme of personhood and identity. Respect and preservation of intimacy co-exists with experiences of personal invasion and public exposure:

> *Usually conversation starts from greeting, he comes to the ward, calls your name and if there are more people he asks them to leave the room or takes me to another room... (P47LT.65M)*

> *(...) a nurse came to see him and she stood and said, quite audibly for me and I think the rest of the ward could hear – a small ward – you're wet, aren't you? (P85UK.75M)*

> *When physicians talk loudly about their patients, saying that they come here, they do this and that or they take that medicine or why they take it. (P64PT75M)*

Theme 2

'**Connecting the space between us**' is the second major theme identified across interviews and addresses the topic of interpersonal skills and interpersonal exchange in situations of care. Communicational and relational aspects of professional competence represent the core dimensions of this theme. The former is anchored on a set of standard communicational skills that are expected from professionals but also on notions of advocacy that can stimulate empowerment and health promotion/management in older people. These elements illustrate the subtheme **Communicate with me**. The second significant dimension of meaning of this theme is associated with the nature and quality of relationships established between professionals and older clients, which is reflected in the subtheme **Involve me with (in) care**.

Subtheme 1: Communicate with me

The importance of professionals' communicational skills was emphasized by participants throughout interviews. They feel that professionals need to promote communication and dialogue so that older people may feel free to express themselves and to share all relevant information in different situations:

They always speak to me politely, start by asking why did I come, what problem do I have and what am I expecting from that meeting and then they ask what's bothering me. (part38LT.69M)

(…) I like the way they talk to me and I go on answering. (…) I feel comfortable, (…) they make me feel comfortable and I go on talking. (…) And I feel good, and leave the room feeling a different person. (part61PT.68F)

They must ask "how are you, do you have anything to tell me?". (part65TR.89M)

And when she came out, he said: did you tell him about such and such? Oh, no, he didn't ask me about that. And that was her main problem and she'd never mentioned it, because he didn't ask her' (part86UK.79M)

Professionals must be aware of the language they use and adapt it to the level of understanding of older clients. Technical terms or 'jargon' hinders comprehension of what is being told:

When they tell me in simple country terms, then I understand. If they tell me in medical terms, then I have to ask for explanations. But then they straighten things out right away and explain everything in a way that I can understand". (part33LT.72F)

I have experience on all professionals and also from the laboratory technology staff. Among there the competence has been diverse. For me mainly good but from the doctors I expect that they would speak face-to-face to the client and with the language the client understands. (part29FI.72F)
Sometimes he uses some words that are unknown to me. Too much medical words… (part80PT.64F)

It is also expected that caregivers can be able to communicate bad news in an adjusted and supportive manner, and to be sensible to the amount of information that older people are prepared to receive:

They say directly towards the face and may hurt the patient in particular if he/she is severely ill. I had such a case with my late husband. He was supposed to be operated to collect fluid from his lungs. The anaesthesiologist said (slammed) that such operation cannot be done on a person who will die in two weeks. … This hurt him and secondly he lost everything after that, as the hope was taken away from him. He had to be fed after that as he could not eat by himself anymore. (part18FI.71F)

To avoid a shock in the patient, sometimes the situation is hidden from him. (part54PT.90M)

And if the news is bad, well, then they'll tell me the news is bad, that's what's going to happen. They're going to be telling me that one day, but I want to be told it nicely' (part86UK.79M)

In the space of interaction, professionals are expected to listen, to give feedback and to exhibit sings of understanding about what is being told by older people:

That they discuss everything with me, that I can express my wishes and needs, that they let me finish speaking, that they understand me and listen to me, that they really listen to me and try to understand. I don't mean anything special, I don't know how much I can say, well if it is possible that one's needs are fulfilled, as far as it is possible. (part8AT.75F)

I do not really know what you have in your education, but my desire is naturally that the patients would be heard and considered in the arrangements of treatments and care (part17FI.69M)

Other good and important feature would be listening because it is really important to feel like the doctor listens to your needs. (part42LT.66M)

'... Sometimes people will have their own baggage that they've got on board and they don't want to give you the time, they won't listen to you. They're hearing but they're not listening, so they're not really understanding what's going on' (part96UK.75F)

According to participants, professionals' communication skills are also related to non-verbal communication such as visual contact and showing signs of attention during their encounters with older people:

What can I say, the communication has always been nice, the eye-contact has always been kept while we were connecting, they used to sit in front of me and smile, ask me what's bothering me and other similar questions. What I really liked was constant eye contact. I have never felt like I was talking to a wall. (part48LT.72F)

This happens too often and I used to experience this frequently, for example when I had problems with my hip fracture and used to visit the doctor; many of them did not even look at my face, the way they were talking without looking at my face did hurt me indeed. At that moment I wanted to get out of the room immediately and scream out that what they were doing was not right, but I could not do it; however the feeling remains and I still regret it. (part75TR.76F)

So you just feel their heads are down working away, it's unavoidable, they're putting information onto these computers. But as I came round to reception, say, you don't get eye to eye contact. And I stood there waiting for them to speak to me and you wait, you know, five minutes or so before you even get a little look or a smile, or whatever. (part94UK.63F)

This subtheme is also associated with a much more technical use of communication, which is relevant for provision of information, health promotion and empowerment of older people. Participants expect to be informed and counselled on aspects related to their health/illness, treatments or procedures. They wish to understand what is happening in their particular situation and that professionals can be clear and truthful about the solutions they can provide:

Another problem came when I read the instructions for eye drops. My eyes are not dry and I did not understand that it was internal dryness and I got a terrible pain and became anxious and called to hospital. Well the doctor soon called back and asked whether I have used the eye drops. Then I started to use the drops, the symptoms disappeared and that was the solution. I explained my problem and the doctor responded and everything went so well. (part24FI.66F)

Before tests and examinations they don't clarify why do we even need them, same with the procedures. Sometimes I start doubting if I even need them, they really don't clarify their use and efficiency, why they are necessary, how they work or if there could be some side effects afterwards. (part41LT.67F)

I think the information given is insufficient. I want them to illuminate me when making the decision but I am embarrassed if they do not give information. I expect an explanation but he/she doesn't give any information or explanation that can satisfy me (part75TR.76F)

And the advice and help has been delivered in a professional manner and in a comforting manner, you know, in a confident manner. You can come home and you can sit down and you can say, well, yes, I understand that, yeah, I can see why that should be done, you know' (part84UK.76M)

Older people recognize the role of professionals in terms of education for self-management and health promotion behaviours. However, this process requires time, and must engage clients in order to enhance their autonomy and independence:

Well, quite generally, they are good. But I know, from friends, that simply at the hospital, with the visual impairment, nobody has time anymore, they tell you what button you have to press, but that's no help to me, you know. I have to put my hand on it, feel it with my fingers, so that I know exactly where to press. Well, they don't do that at all. (part12AT.71F)

I feel almost like home at nursing home. Specialists don't control us a lot but if they notice that I'm doing something wrong they tell me right away what I'm doing wrong. All the specialists claim that I can do everything if I really want to. (part37LT.86M)

They should not do for old people. They should have patience to stand and wait for the old person to do himself. Just stand there as support and have a look how he succeeds himself. No such technical aids should be brought that make elderly passive. … This is a terrible direction. Professionals only do those operations (injections…) that the patient cannot do himself…. Allowance of self-determination is important. (part26FI.69F)

Patience, knowledge of their clients; and the wherewithal to give their client the power to try and do better, without being domineering but try and encourage them to do better. (part84UK.76M)

Subtheme 2: Involve me with (in) care

The second subtheme of '**Connecting the space between us'** focuses on the nature and quality of relationships established between older people and professionals. Openness, symmetry, trust, warmth, and support constitute some key aspects contributing to skilled relational behaviour.

Participants expect positive and balanced relationships with professionals, rooted in symmetry, reciprocity and mutual acceptance. They also expect that professionals are open enough to discuss on equal terms and in an honest way:

Every human being wants company, every human being wants to be accepted. Everyone wants love, affection. Nevertheless, one has to add that all people only get that if they are willing and in a position to give. So if they can give, they will receive. (part6AT.74M)

Free, easy and honest, and not go around in circles. The discussion should be carried out on the same level. (part25FI.70M)

We can never succumb ourselves to the proud of being in a position of very important people just

because we are patients and are going to talk to someone. Or, that someone who is a technician hides behind the shield of his training and thinks 'I'm the one who knows how things are'. (part54PT.90M)

Now you go to the GPs and it's sacrosanct. Well, why do you want to know? Well I want to know because I follow it through. Oh, no, you've no need to know, the doctor doesn't need to see you. If he needs to see you, we'll tell you. (part82UK.69M)

Participants are also sensitive to professionals' ability to provide support, being helpful, and reassure them:

When people have received the right training, have the expertise, they can also talk in the right way, touch, be compassionate and give people the feeling they are not alone and that the right thing is being done. That people have the feeling that 'the right person is with you', that they are 'in the right hands and nothing bad can happen to you now'. (part7AT.73M)

I feel the support. I get a lot of support from the social worker, she always tells me that she'll take care of the transport, that I have nothing to worry about, she knows that I have problems with my nerves, so she tries to avoid stressful situations, always says something to calm my nerves down. (part39LT.78M)

Sometimes when I visit the doctor, when I hear his/her sincere talk and attitude, it makes me fell even more pleased; I feel as if my illness is over (...). (part75TR.76F)

So as I say, that day I came away and the first place I went to was the Cancer Support Centre, who is absolutely fantastic place, really, really is. And they just took me to one side and supported me in every way they could. They even offered to go to the hospital with me to the consultant. They offered to help me telling my family. (part96UK.75F)

Training on personal and humane qualities is appreciated by older people and some even argue that an excessive investment on technical skills may threaten the development of relational qualities:

I don't know so much about your education. I cannot propose any suggestions. I believe they put into your minds that in encountering people you have to be social (part20FI.75F)

Improving medical technique makes specialists degenerated, they lack good characteristics and

humanity. (part45LT.71F)

You need to behave nicely, you tell them that they should get in the soul of the elderly, teach this, and make them feel that they will also get old (part73TR.76F)

I think largely the making of healthcare professionals a much more highly qualified group academically than was once the case, I think this has had an effect, which has, to some extent, diminished the value they have in caring for patients. (part85UK.75M)

The possibility of joint decision-making and the valorisation of client's complaints are also seen to be relevant for the establishment or maintenance of balanced relationships between professionals and older people:

I've had no good experience. Well, they always say everything is in order, but I am always in pain. It hasn't changed either. But surely I must know better than them where I feel the pain. (part16AT.82F)

I have had only good experiences. But I am always searching for information also from the internet. This way I get quite long in the discussions with the doctor. In a way we reflect together. For instance when I had this eye thing, I googled about it and could react. I have only good experiences but it results from better abilities than most elderly. (part24FI.66F)

I'm a very independent person (…) and if someone tells me: do this, and do that, you can't do this"; try to talk to the person and give her the impression that, in a way (…) she was able to decide for herself. (part55PT.78F)

I was compos mentis, I could fight for myself. You get some poor old bloke or woman, and they'd just accept it, wouldn't they? ' (part82UK.69M)

Undoubtedly, relational skills require availability from health and social care professionals, and service users appreciate and hope for interventions provided with calm and without haste, even though they recognize professionals' workload:

A little bit of talking, taking their time for the elderly people, well, yes… there's never time for that. (part10AT.61F)

I noticed that in doctors, they are always in a rush; they run because they always have too much

work to do. (part145LT.71F)

Nice, they treated me so well, everywhere. Whenever I made some request they complied, only if it's fewer staff they may not comply promptly. (part57PT.62F)

From the health care point of view they are excellent, even at the slightest discomfort they immediately come without fail. If something happens at night, nurses and doctors immediately come for certain (part69TR.63F)

Professionals' warmth was highly valued across interviews. This emphasizes the importance attributed to affection and other emotional dimensions during the provision of health and social care. Older people underlined the importance of caring with kindness, friendliness, and compassion:

And that they treat me and care for me kindly, that would be my wish for the old people's home too, not only at hospital. I'd want to be treated with a human touch, because an elderly person can be moody at times, even more so than the young, and they are often very critical; the nurses have to deal with quite a lot as it is, I think. (part8AT.75F)

It's being kind and always trying to help, so that we can collaborate with them. That's what I think. (part61PT.68F)

They are compassionate, they are good, that is what we expect, compassion, and they provide that. (part67TR.75M)

I like the friendly smile as I come through the door. That reassures you. If you get this serious face, you immediately think, oh. So yeah, the friendliness, the confidence. (part94UK.63F)

Theme 3

Descriptions of technical competence are reflected on the third theme: '**Fulfilling your professional knowledge and skills**'. During interviews participants also have stressed the relevance of technical knowledge and procedures, and on how these contribute to the adaptation of older people to health/illness and to experiences of social integration. This theme is focused on different aspects of care provision, such as specialisation and expertise, training and education, performance of specific procedures, professional

experience, and teamwork.

Older people value professionals who have specialised training in their field of work, showing confidence and ability in the performance of their job:

> *That they could recognize what was wrong with me and then made the right decisions; and everything with full commitment. Yes, that they could identify the situation and do the right thing based on their knowledge and training, and that it was successful. (part7AT.73M)*

> *Physical therapists and occupational therapists restore man's movements, helps to get back on feet after traumas. Their job demands a lot of patience and responsibility, and they have to know how to do certain things so that it would help the patient, not hurt him. (part48LT.72F)*

> *That the person knows quite well what she is doing, and that she is quite aware of her profession. That the person knows quite well what she is doing (…). (part49PT.91F)*

> *But now you hear such terrible things, you'll have to wait and see what the person's like, approaching manner. Of course, they can be as nice as nine pence when they come in, but if they don't know their job properly, they could be anybody. (part83UK.80F)*

According to our participants, professional expertise is also underpinned in specialised knowledge about older people and ageing processes. Thus, education and training of (future) health and social care professionals' needs to cover for specific features and demands of this target population:

> *And then the elderly should be concerned. Young people do not necessary understand that a person's mind can be clear even though the speech is not as smooth as before. The ability to address older people with various disabilities. Not the same to everyone. (…) You [professionals] should pose questions from the point of view that a person is not out of the game if he/she is immobile. (…) This is what we need. (part24FI.66F)*

> *They need to know how to treat an elderly person, depending on his illness, either in a hospital or at a day care center. (part53PT.80M)*

> *In education of medical students, I believe that the studies regarding the patient's psychology must be covered (part75TR.76F)*

> *It doesn't matter what areas they're working in, but they have to have these similar qualities and the*

understanding of the elderly as a group (…) understanding of the elderly and how they function. (part81UK.67F)

Several tasks and specific procedures of social and health professions have been mentioned during interviews. Social intervention, financial help, provision of transportation, promotion of socio-cultural and recreational activities, diagnosis, prescription of exams and medication, drug administration, and helping in personal hygiene reflect the most significant examples. Globally, it seems that older people are pleased with professionals' performance since they consider it positive and suited to their condition:

It has been mainly that I go and ask for doing this and taking x-rays from that. (part25FI.70M)

At the moment I am dependent on the staff in this nursery home. They bring me food and medication, they wash my clothes, change bed sheets and diapers. Social worker visits me from time to time to ask how I'm doing. What else would I need? (part40LT.69M).

He explained what I had and how it should be treated, and prescribed the right medication. But then the problem was me, I couldn't buy it, because this medication is not subsidized. (part57PT.62F)

They provide us transport to and from the hospital. I had a broken leg, they took me to the hospital; they always take good care of the patients (part65TR.89M)

Even if older people are pleased with procedures and interventions performed by professionals, some participants claim that the quality of execution of technical tasks seems to be influenced by professionals' age and experience:

The doctor and the entire staff need practice (…) to be able to see the focus. Such an experience comes with time. Interest towards older people is needed as well. This area has been forgotten in the health care area. (part24FI.66F)

Like in that [laboratory] where that same nurse was, there was an older one who is remarkably good with blood tests! (…) The other one, the youngest, god forbids her (…). (part62PT.73M)

Gets there and he still couldn't make his mind up what to do, and he had to go and speak to one of

the other doctors. But he was a training GP, a registrar but a training GP. So to me, that was a waste of time really because he didn't know what he was doing. (part82UK.69M)

According to older people, adequacy of care is also related with the action of multidisciplinary teams, articulation and continuation between services, and with the coordination between the available resources:

It is also essential that the doctor and the nurse collaborate well and that there are no authorities or superiority. The patient must feel that the staff invests on her/him and that each staff member has their own role and change information. (…) They must collaborate and respect each other (part824FI.66M)

(…) About a year ago I had a hernia surgery and I received good care, but on the next day they threw me out (…). They didn't do anything [at the health care center] because "oh! That was in the hospital, so you should go to the hospital". And they are always pushing from one service to another. (part60PT.79PT)

(...) well, something a bit like this course I did a few ... you know... teaching them to liaise carefully with each other, you know, and never leave something not quite well understood. Ask twice if necessary. Ask three times if necessary, you're dealing with a person's life. (part88UK.74M)

Theme 4

Disclosing professionalism in you is the last theme identified throughout analysis and focuses on the subject of professionalism, which is seen as an essential requirement for all of those who embrace health and social care professions. Discourses about professionalism are anchored in representations about vocation, commitment and ethics. Situations of negligence and expressions of ageist attitudes in care are also reflected here and highlight negative manifestations of professional action.

According to participants, a good professional working in health and social care is someone who must have an inner personal orientation to this kind of job. A sense of vocation and caring devotion is needed and must be felt and reflected by people who embrace these professions:

Are you in it because you need the money or are you in it because it's a vocation? Because if it isn't a vocation, don't go in for nursing because nursing is not an ordinary job' (part91UK.87F)

Well if you choose this speciality you must be as much devoted to it as much as you're devoted to God. (part45LT.71F)

You need to have patience… and this is something personal, that you are born with… you have that instinct and you have that calmness and that ability to work with older people (part62PT.73M)

Being educated in a specific area or field may not be enough for developing what participants consider to be a natural appeal or personal essentials of good professionals:

In terms of education, there should be a desire to become into this profession do this work. Maybe there are cases that a person does not get in to any other education and they apply for the nurse assistant education. … It is clear that all will not be ideal nurses and doctors even though they may have high grades. If the person is not suitable for the profession they cannot be good professionals. (part29FI.72F)

'And maybe it's something which you have to start with maybe at the screening for whoever will enter this training programme must be such that you find people who are naturally compassionate – because I don't think you can teach compassion...' (part85UK.75M)

Whatever you do, after all they must feel inside. Whatever you teach them, they must grow affection for elderly inside. They shouldn't do it only for the sake of education. They should heal our loneliness, they should chat with us, approach with affection and care, should give us peace (part69TR.63F)

Older people value professionals that regardless their status or duties are still available to help their clients with any need they may have, with seriousness, interest and commitment:

Yes, but there have been several people, quite good doctors, also good nurses, etc. who really had a very good training and great knowledge and a lot of commitment; they wholeheartedly did everything they could to help me get well again. (part7AT.73M)

Some are so spoilt that wouldn't barely lift a finger without a bribery. That is not good because if

you only help a person only for money, you can't help him enough, because you can't do the job right when there is no sincere commitment to it. (part44LT.76M)

... all the way through it, I think you need dedication to your profession, you need a kind heart; you need to be able to see things, you know, not necessarily ... when they're unspoken, see when a person is suffering or afraid. (part88UK.74M)

In addition to professional commitment, participants have reflected on the importance of being conscious about moral conduct and professional codes of ethics, which must be respected and guide professionals' action:

Naturally expertise is the most important thing and also that they get along with others; in other words, a naughty person does not belong to health care. (part20FI.75F)

An ideal doctor? It's a person to whom I could talk to about my problems, misfortunes, maybe sometimes joys because sometimes some of them really influence the disease, we shouldn't be afraid that we'll be mocked or laughed at. Well I should trust that he is definitely not going to tell that to anyone, he should be like a priest, keep my secrets (part41LT.67F)

They must carry out some training. Moral! Ethical… that's very important. (part49PT.91F)

If the previous dimensions are not part of professionals' attitudes and behaviours the risk of neglect increases. In those circumstances older people will feel professional's disinterest more intensely, and may experience lack of basic care and compliance to their requests:

The fact that the people I deal with are human beings and are not going to do anything about me, something I cannot understand. I always want to do what is best for other people, and I hope that others will do the same for me. (part7AT.73M)

If it's one of those patients that go to the hospital and stay there for too long (…) ring the bell and no one comes. And they suffer a lot, if they ring the bell it's because they are in pain, it's because they have something. (part49PT.91F)

(...) the first time she went into hospital, I went to visit her. And her meal was on the bedside table. And I said to her, oh, you haven't eaten your lunch. And she said, I couldn't get at it. And I said, didn't someone come to see? She said, no, they just put the meal on the side and it's been there ever since. So that was one big problem. No one bothered to see if she could get at her food.

(part92UK.79M)

Professionalism is threatened by age discrimination towards older people. Participants talked about the expression of ageist attitudes within the context of health and social care. They also reflected on the loss of social value that older people are facing in modern societies. Hence, age based discrimination in care may lead to perceptions of inequality and disinvestment in older adults:

> *Now I am retired… it has been stable, but sometimes I get the feeling: Well, she is retired and not productive and not any reason to worry about. The only importance is to get rid of the client quickly. This I also hear from others often, that elderly are not taken seriously although they often suffer from many illnesses (part29FI.72F)*

> *But the weird thing is that after some time you actually start to think and believe that maybe it is normal and maybe I am too old to hope for an improvement? You know this viewpoint of doctors actually makes people think so as well. That's why our society gets old so fast and become incapable. (part41LT.67F)*

> *I find that if I talk to somebody, a medical professional over the phone, it's fine, until they read my date of birth and then the voice changes... Talking slower and trying to... do you understand? I went for a flu jab a while ago, and this nurse gave me a form to sign. And she said, date of birth? So I said, Oh, I'll fill that form in for you, it'll be quicker. So I ended up with a wrestling match trying to get the form off her because by then, I was going to fill that form in. But voices do change and attitudes change when people realise that you're over a certain age. (part95UK.69F)*

Discussion

The research conducted during WP4 aimed at exploring professional competences desired by older people who are users of social and health care services. Results from our qualitative study have provided clear insights on the most valued attributes and qualities of professionals who deliver health and social care. Following the perspective of participants we were able to identify four major themes that inform on the specific contents of such professional attributes and qualities.

On theme 1, "Recognizing the person I am", older people emphasized the importance of

seeing their individuality recognized as well as their personal and social background. According to our interviewees this acknowledgment can be achieved through means of communication and positive relationships between professionals and service users. These aspects are described in theme 2, "Connecting the space between us".

Themes 1 and 2 are mainly focused on personal and interpersonal levels of care, but even if the later seems to be more central in participants' discourses other dimensions of care also have been underlined during interviews. Our participants expressed their desire to be cared by professionals who are experts and experienced in their field of work, skilled in technical procedures, with specific knowledge about ageing processes, and who are able to work in teams. Personal vocation and commitment with the profession, compliance with the professional code of ethics, in terms of values, attitudes and behaviours, are also relevant within the context of care. These dimensions were present and described in themes 3, "Fulfilling your professional knowledge and skills", and 4, "Disclosing professionalism in you".

Thus, according to our main findings and based on the adapted CanMed roles it is possible to identify a set of professional competences that should be considered in social and health care. On the other hand, some of these are in line with previous findings from literature, where similar roles and competences were also described.

Themes 1 and 2 are related to the role of communicator, which describes knowledge, skills and abilities such as knowing the person and its limitations (Bayliss et al., 2008; Bridges et al., 2010), acknowledging family and contextual background of older people, promoting communication and information (Brown et al., 1997; Poole & Rowat, 1994; Vieder, Krafchick, Kovach & Galluzzi, 2002; Watson, Marshall & Fosbinder, 1999), shared decision making (Berkelmans et al., 2010; Brown, McWilliam & Mai, 1997), involving the family in the care process (Brown et al., 1997), and establishing a trustful relationship with older clients. Theme 2 is also linked to the role of personal advocate through competences related to health promotion, orientations towards active ageing and empowerment.

Competences described in theme 3 are anchored on the roles of collaborator, organizer/manager and scholar. The first one involves effective teamwork to improve the wellbeing and care provided to older people; the organizer role entails planning care interventions and referrals, while ensuring articulation between colleagues, teams and services (Poole & Rowat, 1994); and the scholar role requires engagement to lifelong

learning and specialized training in ageing (Rodriguez-Martin et al., 2013), creation and dissemination of innovative knowledge which should result in improved quality of care.

Finally, theme 4 reveals some competences related to the professional role, such as vocation and commitment to work and to older people's care, respecting ethical values and managing conflict of interests.

To sum up, personal and interpersonal aspects of care are largely reflected on the roles of communicator and health advocate while technical/professional dimensions appear more associated to collaborator, manager, scholar and professional roles.

When describing the desired relationship with professionals, older people highlighted emotional aspects they highly value during provision of care, namely kindness, friendliness, and compassion. Descriptions of these affective and emotional aspects have also appeared in other studies (Watson et al., 1999; Rodriguez-Martin et al., 2013; Poole & Rowat, 1994), and seem to mirror an important component of care to this target group. Nevertheless, this affective component does not seem to fit explicitly on the professional competences profile of CanMeds framework.

Epstein and Hundert (2002) conceptual formulation provides a alternative description of professional competences since it encompasses communication, knowledge, technical skills, reasoning, emotions, values and reflection in daily practice of professionals. This framework of competence combines the use of cognitive, integrative, relational and affective/moral dimensions, and therefore it seems appropriate to accommodate the complexity of older people's claims regarding care practices.

Although respondents had the opportunity to talk about professionals in both health and social domains, they have mainly focused on health care. One possible explanation for the centrality of health care concerns could be that people are living longer and for that reason exposure to risk factors is higher, comorbidities and polymedication increase, and health complications are more frequent. Therefore, health care is an indispensable and permanent part of older people's lives. On the other hand, social services play a less pervasive role in their daily life, except for those who benefit from long-term formal services of care. And in many occasions, it is due to losses in health status and to the increasing of dependency that social services will be required and needed, and in some situations not by older people themselves but by caregivers. However, some will seek social services by their own initiative, for example to collect information regarding the

available services, financial aid or recreational centres and activities.

Finally, it is worthwhile to reflect on the cultural inscription of our findings. The focus of the analysis carried out with the data collected by the six partners was to explore valued competences in health and social care professions according to common significant dimensions across countries. Considering the methodological options that guided this study it is not reliable to argue that our findings present clear cultural differentiations country-based. Even if it was possible to recognize some variations on the relevance/frequency of a few dimensions in some countries (e.g., the value of human touch in Turkey and Austria, deeper reflections on neglect and dehumanization of care in the UK) it is not obvious that these nuances in data reflect different national values or concerns. It can be argued that distinctive features in some discourses can be rooted in different social, educational, and professional backgrounds of interviewees of each country and not a result of national culture by itself. Hence, from this point of view, and even if this was not the main aim of our study, this can be seen as a limitation of WP4 research. To achieve a proper analysis on the significance of cultural differences in these findings a survey-based research can be conducted in future studies. This would permit to analyse the importance of different levels of cultural meaning on the competences framework (e.g. nationality, education, gender, profession).

Conclusions

According to the findings of this study, the ideal professional respects the unique and complex history of older people, is someone available, who promotes communication and effectively addresses any relevant issue. Balanced, fair, supportive and warmth relationships are a central concern to him/her. Simultaneously, the ideal professional reveals his/her ability, confidence and specialized skills in the performance of the job, always committed to his/her profession and complying with ethical values and normative recommendations.

So, if older people's desired competences surpass the quality of technical performance, and if interpersonal sensitivity and person centred care represent a relevant part of its core dimensions, some changes may be in fact necessary to improve the type of care that will be provided to this population within the near future.

In the present socio-economic context, the quantification of intervention results may be a priority for health and social care systems. However, this approach may conflict with the one desired by older care recipients, but still this is a challenge higher education institutions must embrace in order to find adequate solutions. By doing so, institutions will be better equipped to initiate and establish a new model of competences for future health and social care professionals.

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